COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years 2023-24 through 2025-26



Behavioral Health Services

June 13, 2023

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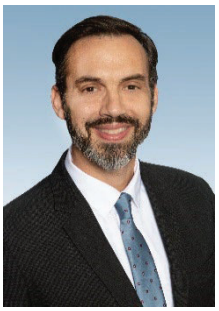
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A LETTER FROM THE BEHAVIORAL HEALTH SERVICES DIRECTOR



The Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years (FY) 2023-24 through 2025-26 (Three-Year Plan) is an opportunity for the County of San Diego (County) Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) department to inform stakeholders, partners, consumers, and community members of MHSA-funded programs, funding priorities, as well as a moment to highlight key accomplishments from FY 2021-22.

As part of overarching work to transform the behavioral health Continuum of Care (COC) from a system driven by crisis to one rooted in chronic and continuous care, BHS recently debuted the Optimal Care Pathways (OCP) model. The OCP model is a data-driven algorithm that calculates the ideal state of the local behavioral health care system and identifies opportunities to recalibrate and expand the system to fully meet behavioral health needs in San Diego County. The model proposes a rebalanced continuum that removes barriers for individuals trying to access care, reduces cost, and most importantly, promptly connects people to the care and housing they need to ensure long-term wellness, while serving the medical, social, and environmental needs of BHS clients. It is anticipated that this model will be integral to the transformation of the local behavioral health care system and will play a pivotal role in ensuring parity and equity in care across the continuum. Some additional notable highlights within MHSA-funded services and programs, include:

- Planning for the implementation of the Community Assistance, Recovery & Empowerment (CARE) Court program, which will include new and enhanced services, housing, and supports for individuals with untreated mental health and substance use disorders.
- Strengthening partnerships with key stakeholders, including justice partners, hospitals, community health centers, community-based providers, and community members to inform the development of services.
- Continuing to enhance the behavioral health continuum of care through increased investments.
- Emphasizing preventative services for all ages, with an emphasis on screening and connecting children, youth and transition-age youth to care to improve their outcomes and reduce health disparities.
- Expanding crisis diversionary services, including the regional Mobile Crisis Response Teams and crisis stabilization units to connect individuals in crisis to behavioral health care.
- Advancing efforts outlined in the behavioral health workforce strategy to address the challenges in recruiting, training, and retaining a behavioral health workforce.

In the near term, BHS will be assessing the potential impact of the Governor's proposed 2024 ballot measure to improve California's Mental Health System that, if approved, would modernize the Mental Health Services Act and enhance investments toward dedicated housing for individuals with behavioral health conditions. We anticipate these changes providing our county with increased flexibility in how we utilize MHSA to meet the needs of the community and we look forward to working with various partners at the State and locally to ensure we achieve success.

Sincerely,

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

MHSA OVERVIEW

BACKGROUND

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

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

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

As required by the Welfare and Institutions Code, counties must complete a three-year plan and subsequent annual updates for MHSA-funded programs. The most recent MHSA Three-Year Plan for Fiscal Years (FY) 2020-21 through 2022-23 provided program and expenditure information for the five MHSA components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). This Three-Year Plan provides an overview of the recent Community Planning Process (CPP) and outlines program for FYs 2023-26.

INVESTMENTS

The proposed MHSA Three-Year Plan budget for Fiscal Years (FY) 2023-24 through 2025-26 is outlined in the chart below. The budget for FY 2023-24 is $274.9 million reflecting an increase of over $44 million from the MHSA budget for the previous fiscal year. By the end of FY 2025-26, it is estimated that the County will have invested over $3 billion in MHSA programs since its inception.

MHSA Component	FY 2023-24 Budget	Percent of MHSA Budget	FY 2024-25 Budget	Percent of MHSA Budget	FY 2025-26 Budget	Percent of MHSA Budget
Community Services and Supports (CSS)	$ 228,266,016	83%	$ 239,628,451	84%	$ 239,628,451	84%
Prevention and Early Intervention (PEI)	$ 38,271,033	14%	$ 39,461,818	14%	$ 39,461,818	14%
Innovation (INN)	$ 1,522,280	1%	$ -	0%	$ -	0%
Workforce Education and Training (WET)	$ 6,879,317	3%	$ 7,536,121	3%	$ 7,536,121	3%
Capital Facilities and Technological Needs (CFTN)	$ -	0%	$ -	0%	$ -	0%
Total	**$ 274,938,646**	**100%**	**$ 286,626,390**	**100%**	**$ 286,626,390**	**100%**

Figures may not add up to 100% due to rounding.

The MHSA budget is based on priorities identified during the CPP in conjunction with staff recommendations.

A summary of the proposed expenditures by each MHSA component for FYs 2023-24, 2024-25, 2025-26 is available in Appendix A. Summaries of all programs funded with MHSA dollars are available in Appendix C.

LIVE WELL SAN DIEGO

Implementation of the MHSA demonstrates the County's commitment to the *Live Well San Diego* vision of achieving a healthy, safe, and thriving region. BHS is committed to providing accessible, community-based, and client-oriented services to all six Health and Human Services Agency (HHSA) service regions: North Coastal, North Inland, North Central, Central, East, and South. The MHSA enhances access to services, and encourages self-sufficiency, health, and well-being in children, adults, and families as demonstrated by the personal stories embedded throughout this report. By collaborating with individuals, community partners, local government, schools, and others, the County continues its goal of achieving healthy, safe, and thriving communities through collective impact. In FY 2021-22, MHSA-funded programs provided services to more than 65,000 children, transition-age youth, adults, and older adults in the San Diego County, with an emphasis on individuals who were previously unserved or underserved.



ADVANCING DIVERSITY AND HEALTH EQUITY

The vision of the MHSA is to build a system in which mental health services are equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals who are experiencing SMI or SED with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. BHS serves individuals of all ages, including the County's most vulnerable, and underserved low-income populations, such as individuals experiencing homelessness, LGBTQIA+, Black Indigenous and People of Color (BIPOC), children who are commercially sexually exploited, children and adults with justice involvement, people with complex behavioral health needs, and vulnerable age groups including children, youth, transition age youth, and older adults.

To identify and address unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs, BHS partnered with the University of California, San Diego (UCSD) to develop the Community Experience Partnership (CEP). It is a joint initiative to promote behavioral health equity. The CEP formed a workgroup consisting of community members that prioritized the domains to be included in the Behavioral Health Equity Index (BHEI). The BHEI is a quantitative measure of behavioral health needs and equity across the County to help determine where investments should be made. It combines Census data, care utilization data, and community survey data with data collected in collaboration with communities and community coalitions through a Community Based Participatory Research Model. Outlined below are some of the major CEP accomplishments:

1. Created a **Behavioral Health Equity Index (BHEI)** conceptual model with participation of community members to prioritize domains. The BHEI is a service planning tool that compiles data about the root causes, or social determinants of behavioral health, into a single index which can be used to help identify neighborhoods and populations that could benefit from additional resources, supports, and services. The

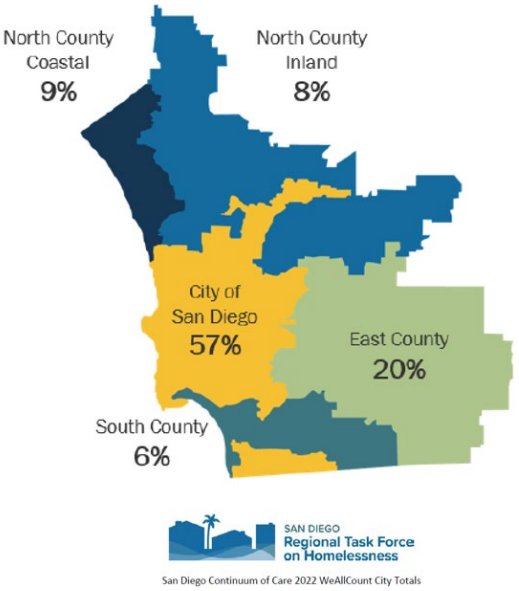
BHEI is one component of a larger initiative to advance behavioral health equity. The first step in creating the BHEI was to develop a conceptual model to identify the social determinants, domains, and indicators that comprised the index.

2. Created a **BHEI survey** to gather expert feedback on the relative importance of various root causes and social determinants of behavioral health equity in San Diego County. This information was utilized to assign weights to the BHEI domains.

3. Developed an interactive **Community Experience Dashboard** that allows users to investigate behavioral health experiences by subpopulation (e.g., race/ethnicity, sexual orientation, etc.) and subregional area using timely community data sources to drive the decision-making process by BHS. A public version of the dashboard was released in the Fall of 2022 and is available at communityexperiencepartnership.com. For demonstrations on the dashboard, view the following short videos: Community Experience Part 1, and Community Experience Part 2.

The Community Experience Partnership engages community members and key stakeholders through partner's meetings and online surveys in the identification, collection, analysis and interpretation of data, weighting of the BHEI, and development of plans for action. The CEP creates reports and profiles to meet needs at the service, administrative, and community levels. This promotes a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans that will aid in informing the design of BHS programs, including services funded through MHSA.

HOMELESSNESS AND HOUSING



Obtaining stable housing is critical in achieving health and wellness for individuals who are experiencing homelessness, or who are at risk of experiencing homelessness, and struggling with serious mental illness (SMI). The Point-in-Time Count is an annual effort to identify the number of persons experiencing homelessness that is conducted by hundreds of volunteers and outreach workers across San Diego County. The Regional Taskforce on the Homeless (RTFH) conducted its annual Point-in-Time Count of unsheltered persons in January 2023. Data from the 2023 Point-in Time Count was not released in time for inclusion in this report. Comparing the 2022 data to 2020, there was a 10% increase in overall homelessness (sheltered and unsheltered) and a 3% increase in unsheltered homelessness.

According to the 2022 WeAllCount Report[1], an estimated 8,427 (4,321 sheltered and 4,106 unsheltered) men, women, and children identified as experiencing homeless in San Diego County. Of those, 7% were veterans, 18% were chronically homeless, 8% were unsheltered youth, and 2% were families. MHSA programs continue to provide extensive outreach, engagement, treatment services, and permanent supportive housing to individuals with SMI who are experiencing homelessness. The map above outlines the homeless population, by region, identified in the 2022 WeAllCount Report.

HHSA has developed a framework to operationalize the County of San Diego Board of Supervisors' guiding principles on homelessness that align the existing work throughout the region to assist people experiencing homelessness or at-risk of experiencing homelessness, with the ultimate goal of ending homelessness. The Framework for Ending Homelessness (Framework) is anchored in five strategic domains: (1) Root Cause and Upstream Prevention, (2) Diversion and Mitigation, Services, (3) Treatment and Outreach, (4) Emergency/Interim Housing and Resources, and (5) Permanent Housing and Support. The Framework encompasses the County's ongoing work and provides a unified strategic approach to support forward, collaborative, and impactful progress. It was adopted by the Board of Supervisors in November 2021.

PROJECT ONE FOR ALL (POFA)

In February 2016, the San Diego County Board of Supervisors implemented Project One for All (POFA) with a goal of connecting 1,250 individuals with SMI who are experiencing homelessness to housing and behavioral health services. POFA provides adults with SMI who are experiencing homelessness with fully integrated services, including outreach, case management, mental health treatment services, substance use disorder (SUD) services, referrals to primary health care, social services, and housing to ensure stability and live their best life. As of December 2022, a total of 2,238 individuals experiencing homelessness were housed and received BHS services through POFA.

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM (SNHP)

The County has dedicated more than $53 million of MHSA CSS funds to the California Housing Finance Agency (CalHFA) for the Local Government Special Needs Housing Program (SNHP) and its predecessor, the MHSA Housing Program. Upon completion, these programs will result in approximately 413 permanent supportive housing units.

1 San Diego Regional Task Force on Homelessness, 2022 WeAllCount Report, retrieved on 1/18/2023 from <https://www.rtfhsd.org/reports-data/>

Of the 413 units, 397 units have been operationalized and 16 units are under construction or planned for development.

Status of Housing Units	# of Housing Units
Operationalized	397
Under Construction or Planned for Development	16
Total Housing Units	**413**

NO PLACE LIKE HOME

In 2016, the No Place Like Home Act (NPLH) was signed into law dedicating $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons with SMI who are experiencing homelessness or are at risk of experiencing homelessness. NPLH funds may be used to finance capital costs of rent-assisted units in rental housing developments, including costs associated with acquisition, design, construction, rehabilitation, or preservation. The bonds will be repaid with funds reallocated from MHSA funds.

The State of California, Department of Housing and Community Development issued the final program guidelines for the NPLH program in July 2017. According to the guidelines, the County is eligible to receive a total of approximately $125 million, resulting in an annual estimated MHSA revenue reduction of $11 million. Counties eligible to receive NPLH funding must commit to provide mental health services and help coordinate access to other community-based supportive services. Proposition 2, the ballot initiative to implement the NPLH Act of 2018, was approved by voters statewide.

In FY 2018-19, MHSA funds were allocated to fund County staff dedicated to support the implementation and administration of the NPLH program. Beginning in FY 2019-20, funding for debt service is excluded from MHSA revenue received by the counties. As of January 2023, there are 3 operational developments totaling 108 NPLH units. There are another 11 upcoming developments, totaling 135 NPLH units, with conditional NPLH funding and services commitment.

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION PARTNERS

Many MHSA programs provide access and support for individuals either entering or exiting juvenile detention, jails, or courts. Programs collaborate with the courts, the San Diego County Sheriff's Department, the County Probation Department, and other law enforcement agencies to support successful reintegration of clients into the community through prompt and appropriate identification and treatment of behavioral health issues.

Additionally, BHS continued collaboration with justice partners on the Board directed *Alternatives to Incarceration* efforts to divert individuals from justice involvement or repeated justice involvement by developing strategies to instead engage and connect individuals with behavioral health conditions to care and housing.

In FY 2023-24, the total estimated investment in justice-related MHSA programs will be $48.5 million. See Appendix D for a list of MHSA programs that serve justice-involved clients.

THE JOURNEY AHEAD

BHS continues to make progress in shifting how residents of San Diego County access care and support for their behavioral health needs by enhancing the regional Continuum of Care. The County continues to make financial, staffing, and other resources available for behavioral health services to meet demand and pivot funding as necessary to support the continuation of programs. In looking forward, we will continue to make critical investments in services, capacity, and workforce.

The following are highlights to some projects and programs utilizing MHSA funding:

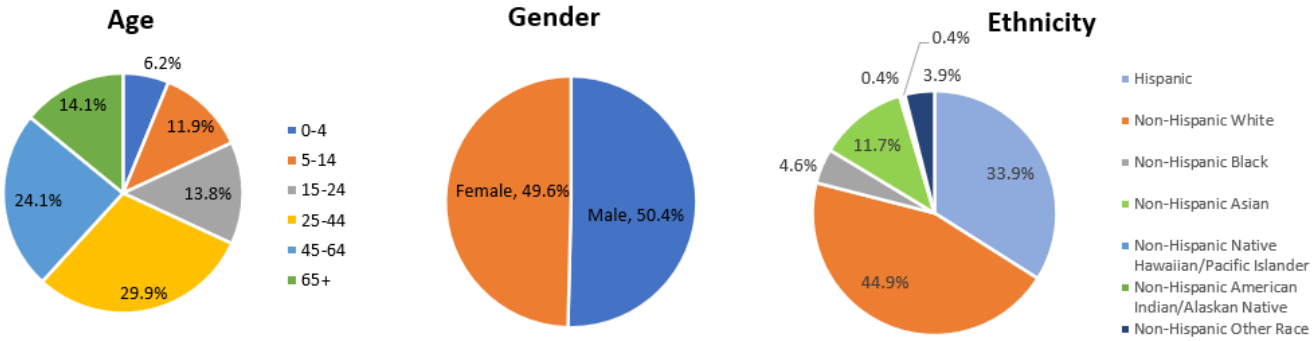
- Assertive Community Treatment (ACT) programs will receive additional MHSA funding to support the implementation of withdrawal management and medicated assisted treatment services and will increase the number of clients served, while addressing the cost-of-living increases in staff salaries and housing cost rates.
- Investments in the Biopsychosocial Rehabilitation (BPSR) services will focus on the increase in staffing to support mobile outreach and dedicated staffing for a 40-hour/week urgent walk-in component which will assist more individuals accessing services.
- BHS will continue to address behavioral health workforce recruitment, training, and retention, by advocating for competitive compensation, pursuing administrative relief opportunities, establishing regional training hubs, and others. This includes investing in the Community Psychiatry Residency Program and the Behavioral Health Training Program to build out the public behavioral health workforce.
- Enhancements for Age-wise Institutional Case Management, Strengths Based Case Management, Addition Consultation & Family Support, and Psychiatric Emergency Response Teams (PERT) and will provide cost of living adjustments for providers to maintain the same level in the delivery of services.
- Programs such as Short-Term Bridge Housing, Employment Solutions, and Clubhouses for laundry and shower services will receive MHSA funding to assist with accreditation and staff retention goals, and to provide an online component via virtual communities to ensure accessibility for all members.
- MHSA funding will support the Employment Solutions program to help adults with Serious Mental Illness (SMI) obtain competitive employment and Clubhouse programs by adding laundry and shower services and providing an online component via virtual communities to ensure accessibility for all members.
- BHS is prioritizing support and funding for crisis diversion programs such as Crisis Action and Connection which provides mental health services and intensive case management to youth and the Crisis Stabilization Unit in Vista which provides immediate mental health support and treatment services in a therapeutic setting to individuals in acute behavioral health distress.
- Funding has been earmarked for programs to support transition age youth (TAY) with transitional housing, supportive services, and recuperative care for TAY clients who have been diagnosed or are at risk of developing SMI with a safe place to receive support and transitional housing while finding their recovery path bridging the gap for between discharge from psychiatric hospitalization and recovery.
- MHSA Funding will support Prevention programs such as the Positive Parenting Program and Father 2 Child Program that provide parenting and caregiver skills development services to improve attitudes towards fathering and strengthening engagement of fathers in their children's lives to prevent and address risks associated with Adverse Childhood Experiences (ACEs) will be expanded so that youth and the adults who care for them have optimal health outcomes.
- Planning efforts are underway for new Innovation and PEI projects with estimated projections for expenditures. See Appendix A for projected expenditures.

DEMOGRAPHICS

San Diego County, California is located near the Pacific Ocean in the far southwestern part of the United States, has nearly 70 miles of coastline, and shares an 80-mile international border with Mexico. It is among the nation's most geographically varied regions with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. According to the U.S. Census Bureau, San Diego County has an area of 4,526 square miles, of which 4,210 square miles are land and 316 square miles are water[2]. San Diego County's population for 2020 was 3,323,970[3], making it the second-most populous county in California and the fifth-most populous county in the United States.

The culturally diverse region boasts robust technology and health industries, a business-friendly climate, green practices, and a high quality of life. It is home to world-class educational institutions and a large military presence. Over 210,611[4] veterans are estimated to reside in the region along with additional active military personnel and their families.

The estimated demographics for San Diego County based on 2016-2020 U.S. Census data from the American Community Survey 5-year estimates[5] [6]:



The region is expected to further diversify with a steady increase in the Hispanic population. The two most widely spoken languages at home are English and Spanish, with nearly 45 percent of county residents being bilingual. The county's threshold languages are Somali, Arabic, Chinese (Mandarin), Korean, Persian (including Farsi and Dari), Spanish, Tagalog, and Vietnamese. Additional demographic data for San Diego County is in Appendix E.

[2] U.S. Census Bureau, 2020 Gazetteer Files, Single State Counties Gazetteer File: California, retrieved on 1/18/2023 from <https://www2.census.gov/geo/docs/maps-data/data/gazetteer/2020_Gazetteer/2020_gaz_cousubs_06.txt>

[3] U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table B01003 retrieved on 1/18/2023 from <https://data.census.gov/table?q=Population+Total&g=0500000US06073&y=2020&tid=ACSDT5Y2020.B01003>

4 U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table S2101 retrieved on 1/18/2023 from <https://data.census.gov/table?q=veterans&g=0500000US06073&y=2020>

[5] U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table B01001 retrieved on 1/18/2023 from <https://data.census.gov/table?q=B01001&g=0500000US06073&y=2020&tid=ACSDT5Y2020.B01001>

[6] U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table B03002 retrieved on 1/18/2023 from <https://data.census.gov/table?q=+B03002&g=0500000US06073&y=2020&tid=ACSDT5Y2020.B03002>

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

A central requirement of the Mental Health Services Act is a collaboration process known as the Community Program Planning Process (CPP) – a mechanism to provide stakeholders with opportunities to provide feedback, identify issues and priorities related to mental illness, and suggest recommendations on ways in which MHSA funds could best address the needs of County residents. This input is vital to effective program development and helps ensure the voices and needs of San Diego County's diverse communities are reflected in planning and allocation of MHSA funds. Ongoing CPPP activities help inform the development of MHSA Three-Year Plans and subsequent Annual Updates.

CPP activities conducted this fiscal year focused on providing insights to develop the County's Three-Year Plan for FYs 2023-24 through 2025-26. These activities are part of a broader set of community engagement activities held by BHS. The main goal of the department's community engagement efforts is to build trust with the community, enlisting new resources and allies, creating better communication, and improving health outcomes. Furthermore, the aim is for the marginalized or oppressed individuals and groups of San Diego County to gain greater control over their lives and environment, acquire valuable resources, basic rights, and achieve important life goals. BHS works to ensure the vision of MHSA in which a system for mental health services is equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals experiencing Serious Mental Illness (SMI) or Social-Emotional Disturbance (SED) with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. BHS programs serve individuals of all ages, providing support to the County's most vulnerable, unserved, and underserved populations. BHS solicits feedback from the community, inclusive of all stakeholders, about behavioral health needs with the end goal of positive changes in the services provided by the County of San Diego.

Through contracts and partnerships with the UC San Diego Health Partnership, BHS maintains regular contact with the public and stakeholders through community input and engagement activities, including standing meetings for advisory boards and interactive councils, to inform program planning and ongoing development and improvements to BHS' Continuum of Care. It also continues to collaborate on the Community Experience Partnership (CEP) Joint Initiative, which focuses on examining available data to help identify and address unmet behavioral health needs within the region, and the systemic and regional inequities that lead to them.

The community engagement process builds upon existing networks to identify stakeholder engagement opportunities to identify a wide range of potential community partners. In its inaugural year, the UC San Diego Health Partnership in collaboration with BHS, has also developed a stakeholder outreach and engagement framework to enhance facilitation of countywide processes for CPP which ensure commitment to MHSA-defined priority population groups. Outreach efforts were facilitated through the UC San Diego Health Partnership's extensive network of community connections and participation in a variety of community meetings occurring throughout San Diego County. Several activities were performed to help capture and leverage community resident and stakeholder behavioral health input regarding challenges and prevention strategies to inform the BHS' Continuum of Care. Information was collected via listening sessions, focus groups, and interviews, as well as active participation in community events and meetings hosted by grassroots, faith-based, and other nonprofit organizations. This information was used to determine the community and regional behavioral health needs, assets, and recommendations for this MHSA Three-Year Plan. This was done in addition to year-round engagement with the County's Behavioral Health Advisory Board (BHAB) and BHS' various longstanding System of Care (SOC) Councils. These groups are explicitly designed to generate feedback from multiple stakeholders to inform the delivery of behavioral health services for specific target populations. BHAB and SOC Councils have cross-

disciplinary membership and work with system partners to respond to gaps in access to care, to explore new opportunities for collaboration, and provide system and level of care recommendations to the BHS Director.

BHS updated its approach to the MHSA CPP this year as part of broader departmental efforts to build out a continuous, sustainable engagement infrastructure in alignment with key learnings from the COVID-19 pandemic, updates to the County's General Management System, and changes within BHS' and HHSA's workforce. New County staff have been hired to oversee the development and implementation of comprehensive communication and engagement plans, public messaging campaigns, and outreach and education efforts. BHS is enhancing coordination with HHSA's Department of Homeless Solutions and Equitable Communities (HSEC), the Office of Strategy and Innovation, and the Live Well San Diego (LWSD) Support Team to cross-thread behavioral health information and support dissemination of information in new and already established convenings across the region, including opportunities to participate in the CPP. BHS and the UC San Diego Health Partnership are also working with newly established positions within HSEC, including Community Health Workers (CHW) and CHW Liaisons to expand regional outreach and education efforts to improve reach to unserved and/or underserved populations. This collaboration is supporting increased promotion of opportunities for stakeholder participation in CPPP and other community engagement activities, ensuring participating stakeholders reflect the diversity of the county and community members drive the activities for collection of input and feedback.

Full details of related CPPP activities can be found in the Community Engagement Report in Appendix F.

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD

A draft of the MHSA Three-Year Plan for Fiscal Years 2023-24 through 2025-26 was posted on the BHS website from April 4 through May 4, 2023 for public review and comments. The Program and Expenditure Plan was sent to BHS stakeholders, including the San Diego Mental Health Coalition, Mental Health Contractors Association, and hospital partners for review and comment.

The County's Behavioral Health Advisory Board (BHAB) is comprised of consumers, family members, prevention specialists, and professionals from the mental health and substance use disorder fields who represent each of the five County Supervisorial districts. BHAB held a public hearing via a hybrid model, in-person and a virtual option on May 4, 2023, at the conclusion of the 30-day public review and comment period for the MHSA Annual Update.

Stakeholder comments on the MHSA Three-Year Plan are available in Appendix Q. The MHSA Issue Resolution Process for filing and resolving stakeholder concerns related to the Community Program Planning and ensuring consistency between program implementation and approved plans, is available in Appendix G.

MHSA FUNDED PROGRAMS

The sections below summarize all MHSA-funded programs for Fiscal Years 2023-24 through 2025-26, including a brief summary of accomplishments from FY 2021-22. Changes are outlined for each of the five MHSA components, including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). A detailed budget by component can be found in Appendix A.

COMMUNITY SERVICES AND SUPPORTS (CSS)

CSS provides comprehensive services for children, youth, families, adults, and older adults experiencing SMI or SED. CSS programs enhance the mental health system of care resulting in the highest benefit to the client, family, and community, with a focus on unserved and underserved populations. In FY 2023-24, the estimated total budget for CSS programs is $228.3 million.

Up to $6.9 million of CSS funds annually will be transferred to the Workforce Education and Training (WET) component to continue funding programs identified in the WET section of this report.

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

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

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

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

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

CSS Programs for Children, Youth, and Families



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

Children's FSP programs include school-based outpatient services, walk-in assessments, mobile assessment teams, medication support, intensive mental health services, case management, referrals and linkages, and assessments and interventions for people with co-occurring disorders. The FSP FY 2021-22 outcome report for children and adolescents is available in Appendix I.

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

In FY 2023-24, the estimated total MHSA budget for CY-FSP programs is $21,218,845. In FY 2023-24, the estimated annual cost per client served in CY-FSP programs is $7,354, inclusive of all funding. The estimated number of clients to be served is 8,758.

Children's Full-Service Partnerships (FSP) (CY-FSP)

A countywide, community-based children's outpatient FSP mental health program is designed to serve youth and TAY who are experiencing homelessness. These comprehensive services are trauma-informed, data driven, integrated, and aimed to support the mental health needs of the youth while attending to their safety and housing needs. The program provides outreach services to locate and engage homeless and runaway youth within San Diego County. In FY 2021-22, the program served 218 clients.

Children's School-Based Full-Service Partnership (FSP) (CY-FSP)

School-based FSP programs provide culturally competent outpatient services in easily accessible locations throughout the county, including clinics, schools, homes, and the community. Services include individual therapy, family therapy, case management, rehabilitation support, and medication management to children, youth, and their families. The services are client- and family-driven, and are provided by specialized teams of staff, including family partners who are employees with lived experience. Services offered are trauma informed and recognize that a whole person approach is critical to promote overall well-being. Partnership with the family, primary care, and education is a primary focus of successful treatment. In FY 2021-22, there were 26 school-based FSP programs serving a total of 7,052 clients representing a 4% increase from prior fiscal year.

Family Therapy (CY-FSP)

The family therapy participation engagement program is a component of selected outpatient mental health clinics which uses peer support specialists with lived experience to provide education and support to caregivers of children and youth with SED. The program educates caregivers on the benefits of being actively engaged in the treatment process and works collaboratively with the family to address and resolve barriers to participation. In FY 2021-22, 562 clients had family engaged through this process.

INCREDIBLE YEARS (CY-FSP)

Incredible Years provides a full range of family focused, strength based, comprehensive, and integrated mental health services to children up to age five and their families, using the Incredible Years evidence-based program. This evidence-based program is designed to teach positive interaction skills, social problem-solving strategies, anger management, and appropriate school behaviors to young children. The programs also strengthen parent-child relationships and help parents develop positive behavior guidance strategies. The program includes parent/teacher training and treatment services for children within a preschool setting. In FY 2021-22, the program provided services to 150 clients.

THERAPEUTIC BEHAVIORAL SERVICES (TBS) (CY-FSP)

The TBS program provides intensive, individualized, one-on-one coaching to children and youth who are experiencing an emotional or behavioral challenge. TBS supports children/youth and families with learning new methods to increase successful behaviors and improve skills to manage challenging behaviors. In addition to the one-to-one coaching, the program provides family education and supports with events that promote family connections and resiliency building. In FY 2021-22, TBS served 497 clients.

WRAPAROUND SERVICES (WRAP) - CHILD WELFARE SERVICES (CWS) (CY-FSP)

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth who are involved with the County of San Diego Health and Human Services Agency, Child Welfare Services (CWS) or Probation, and their families. The program provides team-based care planning and coordination of needs and services to facilitate the youth in returning home from a group-care setting or staying in their home. During FY 2021-22, the program served 259 clients.

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

In FY 2023-24, the estimated total MHSA budget for CY-OE programs is $352,890 and the estimated cost per client is $2,219, inclusive of all funding, and the estimated number of clients to be served is 159.

PARENT PARTNER SERVICES (CY-OE)

Family & Youth Partnership Program (FYPP) provides supportive behavioral health services to residents in the Southeastern region of San Diego County which includes case management, support and education groups, community resource fairs, and focus groups to learn about the community needs. They also provide linkage to behavioral health treatment and education services. By providing linkage to services, the program can prevent clients from entering higher levels of care by engaging youth and their families before mental health issues arise. In FY 2021-22, 139 youth received case management services.

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

In FY 2023-24, the estimated total MHSA budget for CY-SD programs is $12,562,451; the estimated cost per client served in CY-SD programs is $6,791, inclusive of all funding; and the estimated number of clients is 3,457.

ADMINISTRATIVE SERVICES ORGANIZATION (ASO) -TERM (CY-SD)

Optum San Diego serves as the Administrative Services Organization (ASO) for BHS, facilitating the County of San Diego'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.

ADOLESCENT DAY REHABILITATION (CY-SD)

Adolescent day rehabilitation provides a specialized curriculum within a congregate-care setting for foster youth that offers independent living skills. These services support the youths' transition into adulthood by increasing their knowledge of community resources, providing employment development services, teaching life skills, and encouraging self-sufficiency. In FY 2021-22, the program provided life skills training to 22 clients.

BRIDGEWAYS (CY-SD)

Bridgeways provides individual, group, and family therapy with medication management to youth that are at risk or currently involved in the juvenile justice system and have mental health or co-occurring substance use needs. Services are provided in the community or home to offer better access to services. Bridgeways also provides psychoeducational groups and coordinates with the youth's probation officer to assist with linkage to services. In FY 2021-22, Bridgeways served 53 clients.

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC) (CY-SD)

The CSEC program serves youth that are at risk for, or currently a victim of, commercial sexual exploitation and have mental health or co-occurring substance use recovery needs. Individuals have access to individual, group and/or family therapy with psychiatric medication management seven days a week. These drop-in centers offer supportive services such as caregiver support groups, internship programs, and peer support. The program provides a safe place for youth to receive behavioral health and supportive services. In FY 2021-22, the program served 127 youth at risk for or currently a victim of being commercial sexual exploitation.

COUNTY OF SAN DIEGO - JUVENILE FORENSIC SERVICES (CY-SD)

The Juvenile Forensic Services (Stabilization, Treatment and Transition) STAT Team provides a full range of mental health services to SED youth currently on probation. The STAT Team services are designed to meet the individual need of the youth's family and cultural dynamics. The goals of the team, in addition to providing crisis mental health services, are to maximize successful transitions into the community, to reduce recidivism, and improve mental health outcomes.

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

The Crisis Action and Connection program provides children and youth who have had a recent acute psychiatric episode with intensive support and linkage to services and community resources. This program improves access to, and benefits of, mental health services to children, youth, and their families, which helps to divert or prevent use of acute services. The overall program was strengthened through two MHSA components known as Rapid Response and Intensive Respite. Rapid Response partners with PERT to expedite deployment of clinicians to support the youth and avoid escalation. Intensive Respite supports the mental health needs of youth who are in a short-term respite setting. In FY 2021-22, the program served 355 clients.

EMERGENCY SCREENING UNIT (ESU) (CY-SD)

The Emergency Screening Unit provides crisis stabilization services with the goal of stabilizing a psychiatric crisis and when appropriate facilitate admission to an inpatient psychiatric hospital. The facility is centrally located in Hillcrest and has 12 beds available. In FY 2021-22, the program provided 1,818 screenings and 1,575 assessments. The program successfully diverted nearly 70% of individuals who received ESU services from entering into a higher level of care.

INCREDIBLE FAMILIES (CY-SD)

The Incredible Families program provides parenting support groups and outpatient mental health treatment services for children and families involved with CWS and promotes the reunification of children with their families. The program enhances parenting skills and strengthens the bond between parent and child.

Incredible Families receives all referrals from CWS and collaborative efforts include treatment planning and outreach to support the child/youth and family goal of reunification. In FY 2021-22, the program served 63 clients.

MEDICATION CLINIC (CY-SD)

The Medication Clinic program provides ongoing medication management to children and youth who have successfully completed mental health treatment, and have medication needs that are too complex for their primary care physician to manage. During FY 2021-22, a total of 588 children and youth were served under the Innovation (INN-22) component. As of January 2023, the program transitioned to CSS-SD and in addition to complex medication management, the program supports the medication needs of youth in Short Term Residential Therapeutic Programs (STRTPs) and youth transitioning out from juvenile detention facilities.

MENTAL HEALTH SERVICES - FOR LESBIAN, GAY, BISEXUAL, TRANSGENDER OR QUESTIONING (LGBTQ) (CY-SD)

Our Safe Place provides individual, group, family therapy and medication management to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, and their families. The program also operates four drop-in centers with a fifth drop-in center as of February 2023. The drop-in centers provide supportive services such as youth groups, social activities, and educational trainings in an environment that emphasizes acceptance for LGBTQ youth and their families. The program serves one of San Diego's most vulnerable populations, LGBTQ youth, to appropriately manage and overcome non- supportive environments in their homes, schools, and communities. In FY 2021-22, the program served 112 clients.

PERIPARTUM PROGRAM (CY-SD)

The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program provides outpatient mental health treatment services for pregnant women and adolescents and new mothers experiencing peripartum depression or anxiety. Program services include individual, group, and family therapy, crisis intervention, case management/care coordination, medication services, peer support, and services (directly or by referral) for individuals with co-occurring mental health and substance use needs. ADAPT works closely with Public Health Nursing programs such as Maternal Child Health and Nurse Family Partnership to provide comprehensive and supportive care for peripartum individuals at high risk, including offering consultations and case conferences for program participants with complex needs. ADAPT services are accessible for diverse populations, in person and by telehealth, and provided in the language of the participant and family, by bilingual staff or with professional interpreters. ADAPT was originally launched as an Innovation (INN-18) program shifting to CSS in FY 23-24.

PLACEMENT STABILIZATION SERVICES (CY-SD)

Placement Stabilization Services provides case management and rehabilitation services, intensive care coordination, and crisis intervention services to foster youth with the goal of stabilizing their current placement and preventing placement in a higher level of care. The programs provide supportive services to stabilize the youth's behavior in their current placement and support the transition back to their families. Within Placement Stabilization Services program, the Comprehensive Assessment Stabilization Services (CASS) contract provides a full array of specialty mental health services for children/youth placed at County level foster homes, also known as, Resource Family Homes. Program services aim to improve the child/caregiver relationship and stabilize the placement to reduce the impact and disruption that a change in placement would have on the child/youth. The Polinsky Children's Center (PCC) provides a full array of specialty mental health services to children/youth placed in the County's temporary shelter. In FY 2021-22, the programs served 339 clients.

RURAL INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES (CY-SD)

Rural Integrated Behavioral Health and Primary Care Services provide behavioral health education, treatment, and support in a collaborative care model within various primary care clinics in rural communities to expand access to care. The program helps individuals of all ages manage their whole-person wellness, including emotional and behavioral concerns. Services include behavioral health consultation services, brief interventions, evidence-based medication and/or treatments, and referrals to other providers. In FY 2021-22, the program served 21 clients.

SUPPLEMENTAL SECURITY INCOME (SSI) ADVOCACY SERVICES (CY-SD)

Supplemental Security Income (SSI) Advocacy services submits SSI applications for eligible individuals to the Social Security Administration and provides follow-up, if needed. The program is able to expedite SSI awards to individuals, and provide training, consultations, outreach, and education. In FY 2021-22, SSI Advocacy Services completed 160 child-specific applications, of which 82 resulted in an award.

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



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

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

The FSP/ACT outcome report for TAY, adults and older adults is available in Appendix J. The Five Year (2022-27) Strategic Housing Plan is available in Appendix K. View details of the housing projects funded through MHSA CSS funds.

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

In FY 2023-24, the estimated total MHSA budget for TAOA-FSP programs is $68,694,797 with estimated cost per client served in TAOA-FSP programs at $11,629 inclusive of all funding and the estimated number of clients to be served is 8,789.

Adult Residential Treatment (TAOA-FSP)

The adult residential treatment program provides a broad range of services in a residential environment to assist individuals improve their quality of life and work towards independent living. These services include physical health screening and referrals to primary care professionals, wellness groups, peer support services, mentoring, and employment and education assistance. In FY 2021-22, the program served 20 clients.

Assisted Outpatient Treatment (AOT) (TAOA-FSP)

Assisted Outpatient Treatment is an intensive, community-based service for persons who establish an AOT court settlement agreement, persons who are court-ordered to receive AOT, and persons who otherwise meet the AOT eligibility criteria. This program integrates behavioral health and rehabilitation treatment and recovery services for adults with a serious mental illness who have been identified as potential AOT candidates by the County of San Diego. In FY 2021-22, the program served 81 clients with 25 of those newly enrolled during that period.

Behavioral Health Court (TAOA-FSP)

Behavioral Health Court provides FSP/ACT services to adults who have been incarcerated, are misdemeanor or felony offenders, and who have been referred by the Collaborative Behavioral Court of the San Diego County Superior Court. The program provides intensive and community-based treatment for mental health and/or substance-induced psychiatric disorders, clinical case management, and specialized treatment. The

program goal is to improve the overall quality of life and prevent recidivism into the criminal justice system. In FY 2021-22, the program served 41 clients.

CARE COURT SERVICES (TAOA-FSP)

The Community Assistance, Recovery & Empowerment (CARE) Court services include, but are not limited to, outreach and engagement, clinical evaluation, service coordination, and behavioral health treatment services for individuals with serious mental illness who meet eligibility criteria and have a civil court ordered CARE plan, which may include treatment, housing, medication, and other social supports. This new program will start in FY 2023-24.

COUNTY OF SAN DIEGO - INSTITUTIONAL CASE MANAGEMENT (ICM) (TAOA-FSP)

Institutional Case Management provides funding to support five case management positions to a variety of County of San Diego-operated programs to provide stabilization and linkage to services for individuals with SMI or SED. In FY 2021-22, the program served 819 clients.

COUNTY OF SAN DIEGO - PEER SUPPORT SERVICES (PSS) (TAOA-FSP)

County of San Diego - Peer Support Services provides funding for the Medi-Cal Peer Support Specialist Certification Program to ensure that Peers Support Specialists meet state standards, qualifications, and core competencies required for certification. Peers use their lived experience to support engagement, education on recovery, advocacy, and assistance with navigating the service system and accessing needed services, and resources to behavioral health clients. FY 2021-22 outcome data is not available as this new program started in FY 2022-23.

COUNTY OF SAN DIEGO - PROBATION (TAOA-FSP)

The Probation Department provides a Probation Officer for FSP/ACT programs through behavioral health court. The staff provides interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re-offending while placed on probation by the courts.

COUNTY OF SAN DIEGO - STRENGTHS-BASED CASE MANAGEMENT (SBCM) (TAOA-FSP)

Strength Based Case Management (SBCM) is designed to provide continuity of care within the County-run behavioral health service to adults, living with serious and persistent mental health and co-occurring disorders. County case managers provide psychosocial rehabilitation intervention services along with resource management to assist individuals in obtaining optimum independence. Service plans might include assistance with accessing psychiatric treatment at the appropriate level, help with housing, educational and vocational planning, crisis management, life skills training, advocacy, and linkage and referral with other services such as physical health care, government assistance, legal services, and community based spiritual supports. In FY 2021-22, the program served a total of 401 clients in two locations.

CRISIS RESIDENTIAL SERVICES - NORTH INLAND (TAOA-FSP)

The North Inland Crisis Residential program is a short-term crisis residential facility with 16 beds that serves adults with SMI and co-occurring disorders. It is open twenty-four hours a day, seven days a week and provides mental health outpatient services as an alternative to hospitalization or step down from acute care within a hospital. In FY 2021-22, the program served 248 clients.

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

FSP/ACT programs provide intensive community-based services for persons who are homeless or at risk of homelessness, have an SMI, and who may have a co-occurring substance use disorder to achieve success and independence. These programs employ a “whatever it takes” model to help clients avoid the need for emergency services such as crisis stabilization, crisis outpatient, crisis residential, and services provided at the

psychiatric hospital. ACT teams provide medication management, mental health services, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community. In FY 2021-22, the program served 4,839 clients.

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

FSP/ACT housing programs provide housing and supports to persons experiencing SMI who are homelessness or at-risk of homelessness. Programs offer an array of short-term, transitional, and permanent supportive-housing resources, including housing subsidies provided through partnerships with local housing authorities. Homeless-dedicated ACT programs have MHSA housing funds for rental and non-rental housing assistance, as well as dedicated housing staff such as housing coordinators and housing specialists to provide housing navigation and ongoing tenancy support services. In FY 2021-22, the program served 106 clients.

FULL SERVICE PARTNERSHIP (FSP) / ASSERTIVE COMMUNITY TREATMENT (ACT) -STEP DOWN FROM ACUTE (TAOA-FSP)

The FSP/ACT step down from acute program provides ACT services to clients with SMI who are homeless or at risk of homelessness and who are stepping down from acute care. These clients are not connected to outpatient services and are being discharged from an acute-care facility back into the community. The stepdown program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The ACT program also provides strength-based case management (SBCM) services to clients who are not able to transition to a stand-alone SBCM program. In FY 2021-22, the program served 119 clients.

FULL SERVICE PARTNERSHIP (FSP)/ASSERTIVE COMMUNITY TREATMENT (ACT) - STEP DOWN FROM INSTITUTIONS OF MENTAL DISEASE (IMD) (TAOA-FSP)

The FSP/ACT step down from IMD program provides ACT services to clients with SMI who are homeless or at risk of homelessness and stepping down from a long-term care facility such as a skilled nursing facility, state hospital or IMD. These clients are not connected to outpatient services and are being discharged from a long-term care facility back into the community. The step-down program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The program also provides strength-based case management (SBCM) services to clients who are not able to transition to a stand-alone SBCM program. In FY 2021-22, the program served 134 clients.

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

The FSP/ACT transitional residential program provides ACT services to adult clients with SMI who are homeless or at risk of homelessness within a transitional residential program to increase independent living and reduce hospitalizations through educational and employment opportunities. Clients are not connected to outpatient services. The program increases clinical and functional stability through a variety of mental health services, housing opportunities, and educational and employment support. The program also provides SBCM services to clients who are not able to transition to a stand-alone SBCM program. In FY 2021-22, the program served 98 clients.

NORTH COASTAL MENTAL HEALTH CENTER AND VISTA CLINIC (TAOA-SD, TAOA-FSP)

North Coastal Mental Health Center and Vista Clinic provide outpatient mental health rehabilitation and recovery, crisis services, peer support, homeless outreach, case management, and long-term vocational support. The goal is to increase mental health services for TAY while decreasing homelessness and increasing self-sufficiency through development of life skills. In FY 2021-22, the program served 1,334 clients.

SHORT-TERM MENTAL HEALTH INTENSIVE CASE MANAGEMENT - HIGH UTILIZERS (TAOA-FSP)

The program provides short-term, intensive case management services utilizing the ACT treatment model. Teams work toward preventing unnecessary hospitalization, improving quality of life, and improving client function. The program uses evidence-based models of intervention, such as ACT and SBCM. Participation in the program results in reduced hospitalizations, reduced recidivism, and improved quality of life. In FY 2021-22, the program served 117 clients.

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

The SBCM programs provide case management services along with physical health referrals, peer counseling, linkage to services, and access to resources for persons who have SMI or SED. In FY 2021-22, the program served 232 clients.

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

In FY 2023-24, the estimated total MHSA budget for TAOA-OE programs is $1,998,384; the estimated cost per client served in TAOA-OE programs is $7,530, inclusive of all funding; and the estimated number of clients to be served is 331.

COUNTYWIDE HOMELESS OUTREACH PROGRAM (CHO) (TAOA-OE)

The County Homeless Outreach Program conducts outreach and engages persons 18 and older with serious mental illness and/or substance use conditions who are unsheltered to provide a Behavioral Health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources. In FY 2021-22, the program served 331 unique clients.

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

In FY 2023-24, the estimated total MHSA budget for TAOA-SD programs is $76,814,587 the estimated cost per client served in TAOA-SD programs is $3,877, inclusive of all funding; and the estimated number of clients to be served is 38,350.

AUGMENTED SERVICES PROGRAM (ASP) (TAOA-SD)

ASPs provide additional services to individuals with SMI in licensed residential care facilities, also referred to as board and care facilities, to help them maintain or improve functioning in the community and to prevent or minimize institutionalization. These services are available at 7 licensed board and care facilities, with the primary goal of stepping down to a lower level of care. In FY 2021-22, the program served 311 clients.

BEHAVIORAL HEALTH ASSESSORS (TAOA-SD)

Behavioral health assessors screen, assess, and provide linkage for individuals being discharged from jail into behavioral health treatment and services in the community. 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 program goal is to reduce incarceration, reduce homelessness, and provide timely access to services.

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

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

level of functioning, quality of life, and housing status, as well as linkage to services, obtaining employment, and linkage to primary care services. In FY 2021-22, the program served 10,356 clients.

CLUBHOUSE (TAOA-SD)

Clubhouses provide rehabilitative, recovery, vocational services, and support to adults throughout the county. The program assists members with improving social skills, reducing isolation, and achieving independent functioning. Clubhouses aim to increase client self-sufficiency through the development of life skills, creating and maintaining relationships, sustaining housing, and supporting employment and education. In FY 2021-22, the program served 3,361 clients.

CONSUMER ADVOCACY (TAOA-SD)

The Consumer Advocacy program is designed to provide Advocacy Training to individuals with lived experience and family members for developing a Consumer Advocacy Council to assess system of care activities and providing recommendations. Program components include Advocacy Training for individuals interested in participating in the Consumer Advocacy Council, participants in the Augmented Services Program (ASP), or interested in increasing their self-advocacy skills. There is no FY 2021-22 outcome data as program started in FY 2022-23.

CRISIS STABILIZATION UNIT (CSU) - EAST REGION (TAOA-SD)

CSU provides voluntary and "5150" coded crisis stabilization services lasting less than 24 hours to persons in a psychiatric crisis due to a mental health condition that requires a timelier response than a regularly scheduled visit to prevent decompensation. The center provides a safe, alcohol and other drug-free sobering services to adults identified as intoxicated by law enforcement and/or adults with symptoms of intoxication referred by health, safety, and law enforcement agencies.

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

The CSU North Coastal Oceanside is a 24-hour community-based CSU located at the North Coastal Live Well Health Center that provides critical care services in a non-hospital setting for individuals experiencing a psychiatric crisis to stabilize and connect them with ongoing services that meet their individual needs. In addition, the CSU is co-located with the North Coastal Mental Health Clinic, the Mariposa Clubhouse, and the McAlister North Coastal Regional Recovery Center allowing the facilitation of a warm handoff to ongoing outpatient services when appropriate. In FY 2021-22, the program served 1,623 clients.

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

The CSU North Coastal Vista is a 24-hour community-based CSU that will provide critical care services in a non-hospital setting for individuals experiencing a psychiatric crisis to stabilize and connect them with ongoing services that meet their individual needs. In FY 2021-22, the program served 840 clients.

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

The North Inland CSU at Palomar Health provides critical treatment services in a hospital-based setting adjacent to the emergency or urgent care unit at Palomar Hospital in Escondido for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual needs. The CSU provides 24-hour services to vulnerable patients in a safe setting under the direct and constant supervision of behavioral health staff to reduce risk of a psychiatric hospitalization. Patients have access to emergency department services if medical crises arise. In FY 2021-22, the program served 1,332 clients.

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

The South Region CSU provides critical treatment services in a hospital-based setting for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual

needs. The CSU provides 24-hour services to vulnerable patients in a safe setting under the direct and constant supervision of behavioral health staff to reduce risk of a psychiatric hospitalization. Patients have access to emergency department services if medical crises arise. In FY 2021-22, the program served 993 clients.

FAITH-BASED SERVICES (TAOA-SD)

The Faith-Based Services program provides community education, and faith-based behavioral health training and education in the North, Central, and North Central Regions, along with faith-based wellness and a mental health ministry that provides services countywide. The program focuses on client-driven services to improve functioning, quality of life by decreasing isolation, and increasing values and self-sufficiency. Faith-Based In-Reach service is a collaboration with the Sheriff and jails that pairs a mental health clinician with a member of the clergy to provide a "bridging service" between custody and community. In FY 2021-22, the program served 1,023 clients.

FAMILY EDUCATION (TAOA-SD)

The Family Education program is designed to provide curriculum-based education to family members of consumers who experience mental health and/or substance use conditions. A monthly support group provides additional support system for family members, which does not require participation in the curriculum-based training. There is no FY 2021-22 outcome data as program started in FY 2022-23.

IN-HOME OUTREACH TEAMS (IHOT) (TAOA-SD)

IHOT teams are mobile clinicians who visit individuals with SMI who are difficult to engage and typically will not seek treatment on their own. IHOT teams visit individuals in their homes to assess and engage them, with the goal of linking them to the appropriate treatment services. The program served 648 persons in FY 21-22 with 496 admissions.

INPATIENT AND RESIDENTIAL ADVOCACY SERVICES (TAOA-SD)

Inpatient and Residential Advocacy Services offers on-going support, advocacy services, and training to staff and residents who are currently in County-identified skilled nursing facilities and County-identified board and care facilities. The program provides patient representation at legal proceedings when denial of rights is concerned and handles patient complaints or grievances in these facilities.

INSTITUTIONAL CASE MANAGEMENT (ICM) - OLDER ADULTS (TAOA-SD)

The ICM program serves older adults, 60+ years old, with SMI who are in a locked setting with case management services to help support their reintegration into the community. In FY 2021-22, the program served 53 clients.

JUSTICE SYSTEM DISCHARGE PLANNING (TAOA-SD)

The Justice System Discharge Planning program provides comprehensive 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, institutionalization, and homelessness, while providing timely access to services. This program primarily serves the African-American and Latino populations and provides linkage to services which helps participants successfully navigate from custody to community to increase independence and reduce recidivism. In FY 2021-22, the program served 239 clients.

MENTAL HEALTH ADVOCACY SERVICES (TAOA-SD)

The Mental Health Advocacy program provides outpatient education and advocacy services including client outreach and engagement to clients receiving outpatient and non-residential services. In FY 21-22, the program opened 1,446 cases and closed 1,553 cases. They also advised or represented 2,228 people.

NORTH INLAND MENTAL HEALTH CENTER (TAOA-SD)

The North Inland Mental Health Centers provide outpatient mental health rehabilitation and recovery services, urgent walk-in appointments, peer support services, homeless outreach, case management, and long-term vocational support services to adults with SMI, including individuals with co-occurring SUD. The program is designed to increase access to mental health services and overcome barriers such as language, wait times, and lack of knowledge or awareness of available services. In FY 2021-22, the program served 1,215 clients.

NO PLACE LIKE HOME (NPLH) BHS (TAOA-SD)

The NPLH housing team within BHS supports the implementation of NPLH, which will provide approximately $125 million to the San Diego region to build permanent supportive housing for individuals with SMI and/or SED who are homeless, chronically homeless, or at-risk of chronic homelessness. The support team allows BHS to implement NPLH care coordination and related services for these funded developments. The program will reduce homelessness among clients, and it provides access to permanent supportive housing.

NO PLACE LIKE HOME, DEPARTMENT OF PUBLIC WORKS (DPW), ENVIRONMENTAL SERVICES UNIT (TAOA-SD)

To facilitate planning and support of the implementation of the No Place Like Home initiative, funding for required environmental reviews are conducted by DPW.

NO PLACE LIKE HOME, HOUSING & COMMUNITY DEVELOPMENT SERVICES (TAOA-SD)

To facilitate planning and support of the implementation of the No Place Like Home initiative, funding was added for new County of San Diego positions under the County of San Diego Health and Human Services Agency, Housing and Community Development Services (HCDS). Funding will allow HCDS to issue and monitor NPLH loans to housing developers. NPLH will reduce homelessness among BHS clients and provides access to permanent supportive housing.

PEER ASSISTED SUPPORT SERVICES (TAOA-SD)

The Peer-Assisted Support Services program provides coaching and social support services. The program focuses on improving mental health, reducing substance use, and increasing social support to individuals with SMI who are not connected to services. The program engages with individuals in inpatient or crisis residential programs and continues engagement until after discharge to ensure they are connected to the appropriate services. In FY 2021-22, the program served 265 clients.

PUBLIC DEFENDER - BEHAVIORAL HEALTH ASSESSOR (TAOA-SD)

The Public Defender Behavioral Health Assessors are licensed mental health clinicians who provide discharge planning, care coordination, referral and linkage, and short-term case management to persons with SMI who have been referred by the Court. The BHS clinicians are part of the Public Defender's office and provide assessment and linkage to community programs for individuals in-custody with SMI. In FY 2021-22, the program served 1,405 clients.

SAN DIEGO EMPLOYMENT SOLUTIONS (TAOA-SD)

The San Diego Employment Solutions program provides job opportunities to help adults with SMI obtain employment. The program uses a comprehensive approach that is community-based, client- and family-driven, and culturally competent. In FY 2021-22 the program assisted over 100 individuals in seeking competitive employment. There were 1,747 supportive services, 1,612 job preparation, and 1,827 job placement activities facilitated.

SAN DIEGO HOUSING COMMISSION (TAOA-SD)

The San Diego Housing Commission provides housing subsidies and supports up to 180 homeless clients with SMI and co-occurring disorders to link them to housing and sustain their recovery. The 180 housing subsidies are part of SDHC's commitment of 733 subsidies to support Project One for All (POFA).

SHORT-TERM ACUTE RESIDENTIAL TREATMENT (START) (TAOA-SD)

The Short-Term Acute Residential Treatment program provides 24-7 crisis residential services as an alternative to hospitalization or to step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have co-occurring substance use conditions, and are residents of San Diego County. In FY 2021-22, the program served 1,265 clients.

SHORT-TERM BRIDGE HOUSING (TAOA-SD)

Short-Term Bridge Housing program provides emergency and transitional housing in a residential setting throughout the county. Safe, sanitary housing is available on a nightly basis, and services are coordinated with designated homeless outreach workers (HOWs) and peer support services. The goal is to decrease homelessness for persons with SMI by connecting clients to housing supports and mental health services. Seven sites are located countywide and served 197 homeless individuals in FY 2021-22.

SUPPLEMENTAL SECURITY INCOME (SSI) ADVOCACY SERVICES (TAOA-SD)

Supplemental Security Income (SSI) Advocacy services submits SSI applications for eligible individuals to the Social Security Administration and provides follow-up, if needed. The program can expedite SSI awards to individuals, and provides training, consultations, outreach, and education. In FY 2021-22, SSI Advocacy Services completed 160 child-specific applications, of which 82 resulted in an award.

TELEMEDICINE (TAOA-SD)

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. In FY 2021-22, the program served 2,261 clients.

TENANT PEER SUPPORT SERVICES (TAOA-SD)

The Tenant Peer Support Services program provides housing support for homeless clients to link them to appropriate resources and assist them with the tools to sustain housing. The program is dedicated to serving the homeless population. TPSS was named a 2022 National Association of Counties (NACo) Achievement Award winner, which recognizes programs for innovative approaches to providing new or needed services, improving administration of existing programs, or promoting intergovernmental cooperation and coordination. In FY 20-21, TPSS provided housing navigation and tenancy support services to TPSS provided housing navigation and tenancy support services to 705 people.

CSS Programs for All Ages (ALL)

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



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

In FY 2023-24, the estimated total MHSA budget for ALL-OE programs is $4,128,336; the estimated cost per client served in ALL-OE programs is $947, inclusive of all funding; and the estimated number of clients to be served is 4,374.

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

This program improves access to mental health services for survivors of trauma and torture, and/or asylum seekers who are experiencing or at risk of SMI, including co-occurring substance use conditions or SED and are at risk of developing new or worsening behavioral symptoms. Through culturally specific outreach and education, the program goal is to increase access to, and use of, mental health services, outreach, and education to the specific population. The program is Medi-Cal Certified and provides services in 47 languages. In FY 2021-22, they served 204 clients.

Behavioral Health Services and Primary Care Integration Services (ALL-OE)

The Behavioral Health Services and Primary Care Integration Services program facilitates the implementation of a collaborative care model by providing evidence-based treatment to individuals with behavioral health conditions in primary care settings. A short-term, solution-focused treatment model, including medication management services and behavioral health consultation services, is used to provide behavioral health services to primary care clients at multiple Federally Qualified Health Centers throughout the county. In addition, an annual integration summit is held to promote collaboration and knowledge sharing about integrated care services with primary care, mental health and substance use disorder providers in the community. In FY 2021-22, they served 963 adult clients.

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

This program provides outpatient mental health services, case management, and integrated SUD treatment and rehabilitation services tailored to individuals with SMI who are deaf and/or hard of hearing, to achieve a more adaptive level of functioning. The program includes group or individual sessions, crisis intervention, and referrals to other community-based organizations. In FY 2021-22, the program served 11 clients.

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

This member-operated clubhouse provides social skill development and rehabilitative, recovery, vocational, and peer support services for individuals who are experiencing SMI and are deaf or hard of hearing. In FY 2021-22, the program served 48 clients.

Psychiatric and Addiction Consultation and Family Support Services (ALL-OE)

The Psychiatric and Addiction Consultation and Family Support Services program provides behavioral health consultation services for primary care and behavioral health providers as well as client and caregiver support services for children, adolescents, and transitional age youth under the age of 21. The program

improves the confidence, competence, and capacity of primary care and behavioral health providers in treating behavioral health conditions and increases the identification and treatment of behavioral health issues in youth through consultations, education, referrals, and linkages. In FY 2021-22, the program provided 3,148 services to providers and clients.

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2023-24, the estimated total MHSA budget for ALL-SD programs is $12,721,898; the estimated cost per client served in ALL-SD programs is $2,157, inclusive of all funding; and the estimated number of clients to be served is 9,345.

CHALDEAN AND MIDDLE-EASTERN SOCIAL SERVICES (ALL-SD)

The Chaldean and Middle-Eastern Social Services program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle-Eastern descent who are experiencing SMI or SED. Children and youth with SED have access to outpatient clinical services and may be connected to acculturation groups. In FY 2021-22 the program outcomes included over 73% of clients showed clinical improvement or stabilization and nearly 55% of clients showed functional improvement or stabilization over the previous six-month period and served 133 clients.

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

The MCRT is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. During FY 2021-22, the program has diverted 92% of clients from higher level services.

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

The PERT program partners 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 encounters with local law enforcement agencies and/or who need immediate mental health crisis intervention. In FY 2021-22, 47% of the crisis intervention contacts that PERT provided were diverted from hospitalization. PERT EMS provided 59 crisis intervention contacts and 1,877 community and engagement contacts to high utilizers.

CSS Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2023-24, 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	FY 2023-24 Proposed Budget (All Funding)	FY 2023-24 Estimated Number of Clients Served					FY 2023-24 Estimated Cost Per Client
		Children	TAY	Adult	OA	Total	
CY-FSP	$ 64,405,640	7,756	1,002			8,758	$ 7,354
CY-OE	$ 352,890	159				159	$ 2,219
CY-SD	$ 23,477,130	2,787	670			3,457	$ 6,791
TAOA-FSP	$ 102,211,306		767	5,363	2,659	8,789	$ 11,629
TAOA-OE	$ 2,492,544			331		331	$ 7,530
TAOA-SD	$ 148,667,091		5,179	29,595	3,577	38,350	$ 3,877
ALL-OE	$ 4,143,718	2,534	406	1,370	64	4,374	$ 947
ALL-SD	$ 20,156,418	1,550	1,319	4,909	1,567	9,345	$ 2,157
Total CSS	**$ 365,906,737**	**14,786**	**9,342**	**41,568**	**7,866**	**73,563**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included.
- The FY 2023-24 estimated cost per client figures are based on the total proposed FY 2023-24 budget divided by the actual number of clients broken down by population served in FY 2021-22, plus the estimated new clients to be served in FY 2023-24. FY 2021-22 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figure will vary by service and contract based on the contracted rate, level of care, and a number of clients.
- The annual projected unique clients for FY 2023-24 will vary from the number of unique clients served in Appendix H, I, and J because some programs no longer exist, and new programs will be added in FY 2023-24. Additionally, clients may receive one or more different services, so there may be duplication of clients across work plans.
- CSS data collection and reporting may have been impacted starting March 2020 due to COVID-19.

PREVENTION AND EARLY INTERVENTION (PEI)



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

In FY 2023-24, the estimated total budget for PEI programs is $38,271,033. As required by MHSA, a majority of funding for PEI programs must be directed to programs that serve persons less than 25 years of age. In FY 2023-24, this requirement will be met with nearly 60% percent of the budget for PEI programs budgeted for programs serving persons less than 25 years of age.

A detailed budget for PEI may be found in Appendix A. The FY 2021-22 PEI system-wide summary report can be found in Appendix L. A summary of the estimated cost per client is available at the end of the PEI section.

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA)

The California Mental Health Service Authority (CalMHSA) is a Joint Powers Authority (JPA) created by counties to administer statewide PEI projects. CalMHSA supports 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 trainings to diverse audiences and building the capacity of higher education institutions to reduce stigma and prevent suicide. These programs include Each Mind Matters, Walk in Our Shoes, Directing Change, and Know the Signs. In FY 2023-24, BHS contributed $400,000 of MHSA or other funds to CalMHSA for statewide PEI programs.

CHECK YOUR MOOD - STIGMA & DISCRIMINATION REDUCTION (PEI-ADMINISTRATION)

Check Your Mood is an annual event (held on October 6, 2022) in conjunction with National Depression Screening Day which engages and encourages San Diegans to monitor and assess their emotional well-being. Organizations across the San Diego region come together to provide free mental health resources, information, and Check Your Mood screenings to the community which helps to raise awareness and reduces the stigma related to mental health. BHS and other County of San Diego staff partnered with local businesses, healthcare agencies, community partners, and volunteers to provide these services at 43 sites throughout the county.

INTEGRATED PEER & FAMILY ENGAGEMENT (CO-03)

The Integrated Peer and Family Engagement program provides comprehensive, SUD counselor and peer support specialist based care coordination, mental health and substance use disorder screenings, brief treatment, and system navigation to adults with behavioral health issues. The program focuses on whole-person health, self-management, self-care skills, and linkage to treatment and community resources. In addition, support, education, and advocacy services are provided to enrolled family members. In FY 21-22, the program enrolled 309 clients.

ALLIANCE FOR COMMUNITY EMPOWERMENT (DV-03)

Alliance for Community Empowerment (ACE) is a community response-team program that engages siblings of identified gang members to teach and encourage resiliency. The ACE team members engage children and youth in schools, recreational centers, and their homes. Parents are also engaged and supported with various activities which increase resilience, coping skills, and improve overall quality of life. In FY 2021-22, the program served 779 unique families through the Community Violence Response Teams.

COMMUNITY SERVICES FOR FAMILIES - CHILD WELFARE SERVICES (CWS) (DV-04)

Through this program, parents receive in-home training through a partnership with CWS about risk factors for child neglect and physical abuse. The curriculum teaches parenting skills and how to interact in a positive manner with their child, responding appropriately to challenging behaviors, recognizing hazards in the home, and responding to symptoms of illness and injury. The training program, known nationally as SafeCare, is conducted by CWS in cooperation with several community-based agencies. Through weekly in-home sessions, the goal is for children to remain safely in their home with the appropriate resources and linkage to services. In FY 21-22, the program served 330 clients.

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

The Positive Parenting Program is a training class which strengthens skills for parents with children in Head Start, Early Head Start and elementary school settings, who are exhibiting behavioral and/or emotional challenges. Families requiring specialty mental health services are linked directly to services and remain connected after completing the program and have the opportunity for individual consultations for up to six months. Through education and training, the program reduces child abuse, mental illness, behavioral and emotional problems, delinquency, and school failure. In FY 2021-22, despite continued impacts of the pandemic and public health orders in place, the Positive Parenting Program provided services for over 1,653 parents and caregivers of over 3,253 children.

EARLY INTERVENTION FOR PREVENTION OF PSYCHOSIS (FB-01)

The Kickstart program identifies and trains community leaders to identify the indicators of early psychosis. These leaders refer teens and young adults with potential behavioral health issues to clinicians who provide crisis intervention, treatment, individual and group therapy, and in-home services. Additionally, these youth can be transitioned to outpatient programs if needed. Early treatment of behavioral health issues results in increased well-being, school success, family involvement, improved functioning, and the reduction of hospitalizations. In FY 2021-22, 310 clients and their families were provided services demonstrated to increase well-being, school success, family involvement and improved functioning.

NATIVE AMERICAN PREVENTION AND EARLY INTERVENTION (DREAM WEAVER) (NA-01)

The Dream Weaver program is a partnership with three Native American health clinics that joins cultural practices with evidence-based practices. It operates on reservations and in urban areas and provides education and outreach at community events, cultural and social gatherings, and health clinics. The program provides information on available mental health services and behavioral health issues to prevent mental illness and promote wellness activities in American Indian/Alaska Native communities and increases involvement in child abuse prevention activities. In FY 2021-22, the program served 8,281 clients which represented an increase of 53% from the previous year due to lifting of pandemic restrictions.

COMMUNITY-BASED SERVICES - FOR OLDER ADULTS (OA-01)

The Elder Multicultural & Support Services (EMASS) program convenes Promotores, members of the community who are leaders in social circles and who are experienced working with people experiencing SMI in underserved communities, including Filipino, Latino, African refugee, African American, and Middle Eastern.

The Promotores are trained by professionals to provide outreach and engagement to older adults, and engage them in group and individual activities, including recreation, exercise, mental health education, and counseling to prevent mental illness. EMASS provides referrals to multilingual mental health providers, transportation services, and translation services during medical and mental health appointments. In FY 2021-22, there were, 2,030 older adults served by the program which was selected as part of the California Master Plan for Aging webinar series.

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

Positive Solutions provides home-based outreach, prevention, and intervention services to older adults who are homebound and socially isolated. The program reaches out to these adults and engages them with the Program to Encourage Active and Rewarding Lives which is an evidence-based program that provides mental health screening, assessment, counseling, and referral and linkage to care. In FY 2021-22, the program served 1,667 clients with 91% of the clients reported reduced symptoms of depression after program completion.

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

The Caregiver Support for Alzheimer's and Dementia Patients program provides education, training, and early intervention to prevent or decrease symptoms of depression and other mental health issues among caregivers of people suffering from Alzheimer's and dementia. The program raises awareness of the mental health needs of caregivers and encourages them to access County of San Diego-funded prevention and early intervention services to improve wellness. In FY 2021-22, the program provided PEI services to over 95,759 caregivers and older adults, highlighting the continued need for caregiver supports as the population of older adults grows.

BREAKING DOWN BARRIERS (PS-01)

Breaking Down Barriers is an outreach campaign that engages underserved communities including Latino, African American, Native American, African immigrants/refugees, and LGBTQ individuals to increase access to mental health services. The program reduces stigma and discrimination through increased awareness and acceptance of mental illness and treatment choices and increases access and use of available services. In FY 2021-22, the program served 6,340 clients which is nearly a 60% increase due to greater interest and more programming availability than the previous year during the pandemic.

CLUBHOUSE SERVICES PROGRAM (PS-01)

The Clubhouse program provides prevention and early intervention services through the provision of personal care assistance including showering and laundry services to persons experiencing homelessness to promote and assist participants with increased resiliency and self-care. The program also conducts outreach to underserved populations, including black, indigenous, people or color (BIPOC) and unhoused individuals in the Downtown area of East Village to increase recognition of early signs of mental illness and access and linkage to treatment program. There is no FY 2021-22 outcome data as the program started in FY 2022-23.

COUNTY OF SAN DIEGO - COMMUNITY HEALTH & ENGAGEMENT (PS-01)

Staff responsible for community health and engagement efforts within HHSA's Department of Homeless Solutions and Equitable Communities (HSEC) and Aging & Independence Services (AIS), in partnership with BHS staff, serve as community ambassadors for behavioral health PEI activities and initiatives. Staff collaborate with BHS to identify and address community priorities and programming gaps and, subsequently, develop and coordinate population-specific and/or region-specific community activities. Tailored activities promote resources to increase community awareness, literacy, and utilization of services that support mental health and wellness, suicide prevention, substance use prevention, harm reduction, and stigma reduction. Staff also conduct activities related to key observances such as Check Your Mood Day, May is Mental Health

Matters Month, International Overdose Awareness Day, Recovery Happens, and Suicide Prevention Awareness Month among others.

COME PLAY OUTSIDE (PS-01)

The Come Play Outside program offers community-based programming inclusive of Parks after Dark curriculum to support the health and wellness of children, youth, and families. The program will aim to connect participants with outdoor activities within their community to increase prosocial interactions, promoting wellness, positive self-image while emphasizing confidence, respect, and a sense of responsibility. There is no FY 2021-22 outcome data as the program started in FY 2022-23.

ACES PREVENTION PARENTING PROGRAM FOR FATHERS (PS-01)

The Adverse Childhood Experiences (ACEs) Prevention Parenting Program for Fathers (Father2Child) provides a best practice parenting program to unserved and underserved fathers that enhances fathering knowledge, skills, and positive attitudes while connecting the relationship between reducing mental health stigma and having a successful fathering relationship with the child(ren). In FY 2021-22, the program served 178 fathers.

FAMILY PEER SUPPORT PROGRAM (PS-01)

The Family and Adult Peer Support programs, Friends in the Lobby and In Our Own Voice, provide outreach and awareness through training and the dissemination of education materials in primary care, senior centers, faith-based forums, and other venues. Individuals with lived experience promote social and emotional wellness for adults, older-adults, and their families who are visiting individuals that have been hospitalized in psychiatric units. The programs reduce stigma and discrimination, increase acceptance of mental illness and awareness of treatment choices, and increase access and use of available services, especially in unserved and underserved communities. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the County. In FY 2021-22, the program served 5,323 clients which is a 13% increase from prior fiscal year.

MENTAL HEALTH FIRST AID (PS-01)

The Mental Health First Aid program provides individuals the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The program provides county-wide, community-based education and training services. In FY 2021-22, the program trained 2,649 unique community members.

RECUPERATIVE SERVICES AND SUPPORT PROGRAM FOR TRANSITIONAL AGE YOUTH (PS-01)

This program provides short term recuperative services and supports (up to 120 days) for Transition Age Youth (TAY) ages 18-25 who have been diagnosed or are at risk of developing Severe Mental Illness (SMI), including those who may be experiencing first episode psychosis and may also have a co-occurring substance use disorder. Program aids with Instrumental Activities of Daily Living (ADLs), coordination of transportation for appointments, connection to services including employment, education, psychiatric assessments, and reduction of stigma associated with mental health condition. There is no FY 2021-22 outcome data as the program started in FY 2022-23.

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

County-wide media and marketing efforts, collectively known as BHS' "*It's Up to Us*" campaign, focuses on educating the public about behavioral health topics, stigma reduction, and increasing public awareness around resources to support individuals' mental and emotional well-being. The campaign provides awareness of the stigma of mental illness, promotes individual acceptance of mental illness, and provides materials and information on options for intervention, treatment, and recovery. During the first year, new campaign materials from February 2021 to January 2022, *It's Up to Us* had 128 million media impressions with TV, Radio,

billboards, YouTube, and paid social and digital marketing reaching most of San Diego County's 3.2 million residents. In addition, there were 19.9 million social media engagements as measured by video completion, audio completions, clicks, reactions and saves to social media posts.

SUICIDE PREVENTION ACTION PLAN (PS-01)

The San Diego Suicide Prevention Council establishes the Suicide Prevention Action Plan to increase public awareness, increase understanding of suicide risks and warning signs, and reduce stigma and harmful outcomes. The plan has a special focus to reach some of the most vulnerable communities such as LBGTQ, TAY, veterans, and older adults. The program increases the number of individuals who able to recognize and prevent the immediate risk of suicide. View the plan at https://www.sdchip.org/initiatives/suicide-prevention-council/action-plan/. The San Diego County Suicide Prevention Action Plan published in October 2018 will be updated and disseminated to increase understanding and awareness of suicide and implement strategic initiatives for the prevention of suicide.

SUPPORTED EMPLOYMENT TECHNICAL CONSULTANT SERVICES (PS-01)

The Supported Employment Technical Consultant services program provides technical expertise and consultation on countywide employment development, partnership, engagement, and funding opportunities for adults with SMI. Services are coordinated and integrated through BHS to develop new employment resources.

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

Rural Integrated Behavioral Health and Primary Care Services provide behavioral health education, treatment, and support in a collaborative care model within various primary care clinics in rural communities to expand access to care. The program helps individuals of all ages manage their whole-person wellness, including emotional and behavioral concerns. Services include behavioral health consultation services, brief interventions, evidence-based medication and/or treatments, and referrals to other providers. In FY 2021-22, the program served 21 clients.

INDEPENDENT LIVING ASSOCIATION (ILA) (RE-01)

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. As of June 30, 2022, the ILA had 97 member homes that total 875 beds.

SCHOOL-BASED PREVENTION AND EARLY INTERVENTION (SA-01)

The School-Based PEI program utilizes a family-focused approach and evidenced-based curriculum to provide social-emotional support groups for children in preschool up to third grade who struggle with emotional and behavioral issues, and their parents. The services are provided in elementary schools in all six HHSA regions. Services include screening, child skill groups, parent skill groups, classroom skill lessons, community linkage and referrals, and outreach and engagement. In FY 2021-22, the program served 14,110 students.

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

The Helping, Engaging, Reconnecting and Educating (HERE) Now program provides school-based suicide prevention education and intervention services to middle-school students, high-school students, and TAY. Presentations on bullying, depression, and warning signs of suicide are provided to students, teachers, staff, and parents to increase awareness, promote conversations, and inspire connections. In FY 2021-22, the program served 22,559 clients.

VETERANS & FAMILY OUTREACH EDUCATION (VF-01)

The Courage to Call program provides confidential outreach, education, peer counseling, referrals, and support services to veterans and their families to increase awareness of mental illness and reduce mental-health risk factors. The program increases awareness of mental illness in the veteran community through these efforts to reduce mental-health risk factors. Services are provided to veterans and their family members. In FY 2021-22, the program the program served 2,037 veterans their families.

PEI PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2023-24, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA PEI Work Plan	Population Served	FY 2023-24 Proposed Budget (All Funding)	FY 2023-24 Estimated Number of Clients Served	FY 2023-24 Estimated Cost Per Client
CO-03 Integrated Peer & Family Engagement	ALL	$ 3,158,045	309	$ 10,220
DV-03 Alliance for Community Empowerment	Children, Youth	$ 907,920	779	$ 1,165
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$ 504,408	330	$ 1,529
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$ 1,395,098	4,906	$ 284
FB-01 Early Intervention for Prevention of Psychosis	Children, TAY	$ 1,790,620	310	$ 5,776
NA-01 Native American Prevention and Early Intervention	ALL	$ 2,127,686	8,281	$ 257
OA-01 Community-Based Services for Older Adults	OA	$ 574,162	2,030	$ 283
OA-02 Home Based Services - For Older Adults	OA	$ 583,652	1,667	$ 350
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$ 1,090,271	75,000	$ 15
PS-01 Education and Support Lines	ALL	$ 11,862,672	23,378	$ 507
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$ 1,723,141	736	$ 2,341
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$ 302,640	-	$ -
SA-01 School Based Prevention and Early Intervention	Children, Youth	$ 6,716,875	14,110	$ 476
SA-02 School Based Suicide Prevention & Early Intervention	Children, Youth, TAY	$ 2,478,136	22,559	$ 110
VF-01 Veterans & Family Outreach Education	ALL	$ 1,420,390	2,037	$ 697
Total PEI		**$ 36,635,716**	**156,432**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs and PEI assigned funds are not included.
- The following program does not have client count data:
  - RE-01: Independent Living Association
- The FY 2023-24 estimated cost per client figures are based on the total proposed FY 2023-24 budget divided by the actual number of clients served in FY 2021-22, plus the estimated new clients to be served in FY 2023-24. FY 2021-22 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figure will vary by service and contract based on the contracted rate, level of care, and a number of clients.
- The annual projected unique clients for FY 2023-24 will vary from the number of unique clients served in Appendix L.
- PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.

INNOVATION (INN)



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

In FY 2023-24, the estimated INN expenditures will be $1,522,280. A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix N. A summary of the estimated cost per client is available at the end of this INN section.

PERIPARTUM PROGRAM (INN-18)

The Peripartum Program provides outreach and engagement to new or expecting parents with mood and anxiety disorders to reduce and manage postpartum depression and anxiety. The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) model identifies at-risk peripartum women for engagement and provides services for women and their partner. Referrals to ADAPT from public health nursing programs were substantially reduced as public health resources were largely diverted to address the COVID-19 emergency. ADAPT responded by expanding referral sources to include hospitals and birthing centers and transitioned to telehealth to maintain client access to services. In FY 2021-22, the program achieved positive outcomes that included significant decrease in depressive and anxiety symptoms, improved well-being, and a high level of client satisfaction to 117 clients.

TELEMENTAL HEALTH (INN-19)

Telemental Health provides 24/7 mental health treatment via electronic devices for tele-therapy to children, youth and adults who frequently use psychiatric emergency services and are not connected to a mental health provider. The goal is to reduce re-hospitalization and psychiatric emergency services for individuals by connecting them to mental health services via tele-therapy modality. In FY 2021-22, these services were provided to 148 individuals. Of the 148 individuals that received services, 116 were newly enrolled during FY 2021-22.

EARLY PSYCHOSIS EVALUATION AND LEARNING HEALTH CARE NETWORK (INN-24)

The Early Psychosis Evaluation and Learning Health Care Network program was a new INN program approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) for implementation in FY 2018-19. The program is a statewide collaborative led by the University of California, Davis, Behavioral Health Center of Excellence in partnership with other universities and multiple California counties. The program gives clinicians the opportunity to share and discuss outcomes with clients immediately upon completion, allows programs to learn from each other through a training and technical assistance collaborative, and allows the State to participate in the development of a national network to inform and improve care for individuals with early psychosis across the country.

INN ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2023-24, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA INN Work Plan	Population Served	FY 2023-24 Proposed Budget (All Funding)	FY 2023-24 Estimated Number of Clients Served	FY 2023-24 Estimated Cost Per Client
INN-18 Peripartum Program	TAY, Adults	$ 563,251	300	$ 1,878
INN-19 Telemental Health	ALL	$ 1,132,972	250	$ 4,532
INN-24 Early Psychosis Evaluation and Learning Health Care Network	Youth, TAY	$ 201,626	245	$ 823
Total INN		**$ 1,897,849**	**795**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included
- The FY 2023-24 estimated cost per client figures are based on the total proposed FY 2023-24 budget divided by the estimated proposed number of clients to be served in FY 2023-24, based on estimated from the programs.
- The estimated average cost per client is a summary of the work plan.

WORKFORCE EDUCATION AND TRAINING (WET)



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

In FY 2023-24, the estimated WET expenditures will be $6,879,317.

Annually, up to $6.9 million in CSS funds will be transferred to the WET component to continue funding programs. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually.

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

BEHAVIORAL HEALTH TRAINING CURRICULUM (BHTC) (WET-02)

The Behavioral Health Training Curriculum provides training and technical assistance to behavioral health and contracted behavioral health staff on trauma informed care, cultural competency, and mental health/substance use co-occurring disorders and primary care/behavioral health integration. Training is provided in-person and virtually via eLearning and webinar. In FY 2021-22, this program provided in-person training to approximately 1,486 county and contracted staff. RIHS offered a range of training topics that included, Motivational Interviewing, Relapse Prevention, Care Coordination, Incorporating Trauma, Informed Parenting into your Clinical Practice, Assessing and Addressing High Risk and Crisis Behaviors, and Enhanced Case Management. In addition, 14,155 individuals (both County and contract staff) accessed eLearnings or webinars that are offered by RIHS, with many individuals participating in trainings that focused on cultural competency and skills development.

INTERFAITH BEHAVIORAL HEALTH WORKFORCE CENTERS OF EXCELLENCE (WET-02)

The Behavioral Health Workforce Centers of Excellence is a regional training center of excellence that provides training, education, and licensure to the workforce to advance career opportunities and fill behavioral health positions. The regional training center will provide opportunities for diverse populations to enter the behavioral health workforce and provide connected care to historically underserved communities.

CULTURAL COMPETENCY ACADEMY (WET-02)

The Cultural Competency Academy (CCA) provides training to behavioral health and contracted behavioral health staff focused on multicultural populations. The goal of the CCA is to provide awareness, knowledge, and skill-based trainings, while ensuring the information provided is trauma informed. In FY 2021-22, the program provided one 5-day foundational series with 12 participants and one executive series with 7 executives completing the program.

TRAINING AND TECHNICAL ASSISTANCE (WET-02)

The Regional Training Center provides administrative and fiscal support to Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) for training, consultations, and conferences which include the Early Child Mental Health Conference, Behavioral Health Workforce Collaborative, Racial Equity Training Series and Medication Assisted Treatment. In FY 2021-22, the program served 1,793 clients.

PUBLIC MENTAL HEALTH ACADEMY (WET-03)

The Public Mental Health Academy (PMHA) prepares students for local employment opportunities in entry-level public behavioral health systems. The PMHA provides academic counseling and support for students interested in pursuing a career in public behavioral health. It was created to address the shortage and lack of diversity in public mental health service providers. The program provides a career pathway in public behavioral health by offering coursework leading to a Mental Health Work Certificate of Achievement. During the 2021-22 academic year, there were 482 students enrolled in the program, with seventy-five percent (75%) reporting they have lived mental health experience. In Fiscal Year 2021-2022, there were 31 graduates from the program with most graduates continuing their education to earn their AA degree, transferring to a university work working within public behavioral health. Fifty-four students were enrolled in the Public Mental Health Academy (PMHA)/Mental Health Work Certificate program with 43 students completing their certificate, which brings the total to 355 total graduates since the program's inception. Over 589 academic counseling appointments were held to provide individuals with on-going support and guidance.

COMMUNITY PSYCHIATRY FELLOWSHIP (WET-04)

The UCSD Community Psychiatry Program places psychiatric mental health nurse practitioner (PMHNP) trainees side-by-side with psychiatry residents throughout the entire program. This program was created to address the shortage of psychiatrists working in public behavioral health. The goal is to engage psychiatry residents to continue their fellowship within public behavioral health. In FY 2021-22, the program had three residents who graduated from the fellowship program. Since 2017, nine of the thirteen psychiatry residents who have graduated from the fellowship program have continued to work in public behavioral health settings.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)



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

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

MHSA DATA COLLECTION AND ANALYSIS

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

OPTUM SAN DIEGO

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

UCSD CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

UCSD HEALTH SERVICES RESEARCH CENTER

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

CASRC and HSRC works in collaboration with the BHS to evaluate and improve behavioral health outcomes for county residents. Aspects of the outcomes and service demographics are referenced throughout this MHSA Report with full reports in Appendices I, J, L and N.

APPENDICES

APPENDIX A

MHSA EXPENDITURE PLAN

Appendix A
FY 2023-26 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Diego

	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Totals
A. Estimated FY 2023/24 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	$ 2,634,988	$ 41,279,275	$ 35,652,832	$ 1,585,476	$ -	$ 33,478,186	$ 114,630,757
2. Estimated New FY 2023/24 Funding*	$ 299,006,789	$ 74,751,697	$ 19,671,499	$ -	$ -	$ -	$ 393,429,985
3. Transfers in FY 2023/24a/	$ (6,900,000)	$ -	$ -	$ 6,900,000	$ -	$ -	$ -
4. Access Local Prudent Reserve in FY 2023/24							$ -
5. Estimated Available Funding for FY 2023/24	$ 294,741,776	$ 116,030,972	$ 55,324,331	$ 8,485,476	$ -	$ 33,478,186	$ 508,060,742
B. Estimated FY 2023/24 MHSA Expenditures	**$ 228,266,016**	**$ 38,271,033**	**$ 1,522,280**	**$ 6,879,317**	**$ -**		**$ 274,938,646**
C. Estimated FY 2023/24 Unspent Fund Balance	**$ 66,475,760**	**$ 77,759,939**	**$ 53,802,051**	**$ 1,606,159**	**$ -**	**$ 33,478,186**	**$ 233,122,095**
1. Estimated Unspent Funds from Prior Fiscal Years							
2. Estimated New FY 2024/25 Funding*	$ 198,689,743	$ 49,672,436	$ 13,071,694	$ -	$ -	$ -	$ 261,433,872
3. Transfers in FY 2024/25a/	$ (7,000,000)	$ -	$ -	$ 7,000,000	$ -	$ -	$ -
4. Access Local Prudent Reserve in FY 2024/25							$ -
5. Estimated Available Funding for FY 2024/25	$ 258,165,502	$ 127,432,375	$ 66,873,745	$ 8,606,159	$ -	$ 33,478,186	$ 494,555,967
D. Estimated FY 2024/25 MHSA Expenditures	**$ 239,628,451**	**$ 39,461,818**	**$ -**	**$ 7,536,121**	**$ -**		**$ 286,626,390**
E. Estimated FY 2024/25 Unspent Fund Balance	**$ 18,537,051**	**$ 87,970,557**	**$ 66,873,745**	**$ 1,070,038**	**$ -**	**$ 33,478,186**	**$ 207,929,577**
1. Estimated Unspent Funds from Prior Fiscal Years							
2. Estimated New FY 2025/26 Funding*	$ 196,038,358	$ 49,009,589	$ 12,897,260	$ -	$ -	$ -	$ 257,945,208
3. Transfers in FY 2025/26a/	$ (7,000,000)	$ -	$ -	$ 7,000,000	$ -	$ -	$ -
4. Access Local Prudent Reserve in FY 2025/26							$ -
5. Estimated Available Funding for FY 2025/26	$ 207,575,409	$ 136,980,147	$ 79,771,005	$ 8,070,038	$ -	$ 33,478,186	$ 465,874,785
F. Estimated FY 2025/26 MHSA Expenditures	**$ 239,628,451**	**$ 39,461,818**	**$ -**	**$ 7,536,121**	**$ -**		**$ 286,626,390**
G. Estimated FY 2025/26 Unspent Fund Balance	**$ (32,053,042)**	**$ 97,518,329**	**$ 79,771,005**	**$ 533,917**	**$ -**	**$ 33,478,186**	**$ 179,248,395**

Projected expenditures due to ongoing planning efforts							
FY 2023/24							$ -
FY 2024/25	$ 13,000,000	$ 15,000,000	$ 15,000,000				$ 43,000,000
FY 2025/26	$ 15,000,000	$ 30,000,000	$ 15,000,000				$ 60,000,000
Total	**$ 28,000,000**	**$ 45,000,000**	**$ 30,000,000**	**$ -**	**$ -**	**$ -**	**$ 103,000,000**
Projected FY 2025/26 Unspent Fund Balance	**$ (60,053,042)**	**$ 52,518,329**	**$ 49,771,005**	**$ 533,917**	**$ -**	**$ 33,478,186**	**$ 76,248,395**

		Prudent Reserve Detail	
H. Estimated Local Prudent Reserve Balance	**Total**	*CSS*	*PEI*
1. Estimated Local Prudent Reserve Balance on June 30, 2023	$ 33,478,186	26,712,351	$ 6,765,835
2. Contributions to the Local Prudent Reserve in FY 2023/24	0	0	0
3. Distributions from the Local Prudent Reserve in FY 2023/24	0	0	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	$ 33,478,186	26,712,351	$ 6,765,835
5. Contributions to the Local Prudent Reserve in FY 2024/25	0	0	0
6. Distributions from the Local Prudent Reserve in FY 2024/25	0	0	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	$ 33,478,186	$ 26,712,351	$ 6,765,835
8. Contributions to the Local Prudent Reserve in FY 2025/26	0	0	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	0	0	0
10. Estimated Local Prudent Reserve Balance on June 30, 2026	$ 33,478,186	$ 26,712,351	$ 6,765,835

Assumptions

- Estimated expenditures are being projected for PEI and INN projects due to ongoing planning efforts.
- A reassessment of the Prudent Reserve is required every five years under Senate Bill (SB) 192, Chapter 328 of the Statutes of 2018, and the Department of Health Care Services (DHCS). The last update occurred in FY 2019/20; therefore, the next adjustment will occur in FY 2024/25.

Highlights

- San Diego County has reverted $0 dollars since the inception of the MHSA, illustrating the County's efficient management of revenue streams.

* Balances projected utilize State consultant revenue estimates as of March 2023. Revenue is closely monitored, and projections are updated regularly. Expenditures and funding sources would be adjusted as needed in the out-years to prevent a negative balance in MHSA components.

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.

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP)	$ 3,232,630	$ 2,454,455	$ 493,455		$ 284,720	
Children's School Based Full Service Partnership (FSP)	$ 47,220,949	$ 11,079,730	$ 31,804,686		$ 4,336,532	
Family Therapy	$ 1,086,895	$ 1,086,895				
Incredible Years	$ 932,131	$ 280,541	$ 651,590			
Therapeutic Behavioral Services (TBS)	$ 4,907,812	$ 3,995,660	$ 912,152			
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 7,025,223	$ 2,321,563	$ 2,811,214		$ 1,892,446	
TAOA-FSP Full Service Partnerships for Children & Youth						
Adult Residential Treatment	$ 997,779	$ 997,779				
Assisted Outpatient Treatment (AOT)	$ 1,441,696	$ 886,896	$ 554,800			
Behavioral Health Court	$ 2,899,406	$ 1,808,733	$ 590,673		$ 500,000	
CARE Court Services *	$ 2,017,600	$ 2,017,600				
County of San Diego - Institutional Case Management (ICM)	$ 692,787	$ 483,965	$ 12,822		$ 196,000	
County of San Diego - Peer Support Services	$ 255,512	$ 255,512				
County of San Diego - Probation	$ 605,280	$ 244,604			$ 360,676	
County of San Diego - Strengths Based Case Management (SBCM)	$ 788,949	$ 788,949				
Crisis Residential Services - North Inland	$ 1,770,267	$ 1,152,971			$ 617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 63,363,126	$ 35,503,781	$ 22,755,664		$ 5,103,681	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 16,776,627	$ 15,763,550	$ 570,359		$ 442,717	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,030,706	$ 1,417,711	$ 612,996			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,127,623	$ 1,271,907	$ 855,716			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 3,861,028	$ 3,751,028			$ 110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	$ 338,152				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	$ 517,896	$ 233,109			
Strengths Based Case Management (SBCM)	$ 1,493,763	$ 1,493,763				
Total Full Service Partnership (FSP) Programs	**$ 166,616,946**	**$ 89,913,642**	**$ 62,859,236**		**$ 13,844,068**	
Non-FSP Programs						
All-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	$ 469,447				
Behavioral Health Services and Primary Care Integration Services	$ 1,562,089	$ 1,562,089				
Behavioral Health Services for Deaf & Hard of Hearing	$ 368,212	$ 352,830	$ 15,382			
Clubhouse - Deaf or Hard of Hearing	$ 439,975	$ 439,975				
Psychiatric and Addiction Consultation and Family Support Services	$ 1,303,994	$ 1,303,994				
All-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 625,335	$ 288,630	$ 336,705			
Mobile Crisis Response Team (MCRT)	$ 8,776,721	$ 5,426,641	$ 1,675,040		$ 1,675,040	
Psychiatric Emergency Response Team (PERT)	$ 10,754,362	$ 7,006,627			$ 3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Parent Partner Services	$ 352,890	$ 352,890				
CY-SD System Development for Children & Youth						

* **Initial budgeted investment of $2.0 million that will be adjusted in the FY24-25 Annual Update**

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2023/24					
	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
Administrative Services Organization (ASO) - TERM	$ 2,853,200	$ 1,615,876	$ 1,237,324			
Adolescent Day Rehabilitation	$ 100,880	$ 60,880			$ 40,000	
BridgeWays Program	$ 564,928	$ 171,709	$ 169,219		$ 224,000	
Commercially Sexually Exploited Children (CSEC)	$ 1,250,912	$ 89,286	$ 661,626		$ 500,000	
County of San Diego - Juvenile Forensic Services	$ 1,109,680	$ 1,109,680				
Crisis Action and Connection	$ 2,464,716	$ 1,612,087	$ 338,765		$ 513,864	
Emergency Screening Unit (ESU)	$ 5,897,179	$ 3,980,732			$ 1,916,448	
Incredible Families	$ 1,961,329	$ 937,859	$ 231,784		$ 791,686	
Medication Clinic	$ 1,552,543	$ 259,893	$ 1,292,650			
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,957,072	$ 1,003,500	$ 353,572		$ 600,000	
Peripartum Program	$ 509,608	$ 502,957	$ 6,651			
Placement Stabilization Services	$ 2,789,332	$ 922,243	$ 1,867,089			
Rural Integrated Behavioral Health and Primary Care Services	$ 141,810	$ 91,810			$ 50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	$ 182,640			$ 120,000	
Telemedicine	$ 21,300	$ 21,300				
TAOA-OE Outreach & Engagement for Ages 18-60+						
Countywide Homeless Outreach Program	$ 2,492,544	$ 1,998,384			$ 494,160	
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 12,802,322	$ 11,152,322			$ 1,650,000	
Behavioral Health Assessors	$ 691,028	$ 387,028			$ 304,000	
Bio-Psychosocial Rehabilitation (BPSR)	$ 53,508,189	$ 19,064,847	$ 27,080,075		$ 7,363,267	
Clubhouse	$ 5,083,826	$ 4,867,589	$ 216,237			
Consumer Advocacy	$ 1,266,704	$ 817,721			$ 448,984	
Crisis Stabilization - East Region						
Crisis Stabilization - North Coastal Oceanside	$ 7,666,880	$ 2,888,578	$ 4,778,302			
Crisis Stabilization - North Coastal Vista	$ 7,631,363	$ 1,013,839	$ 6,617,524			
Crisis Stabilization - North Inland	$ 10,245,258	$ 2,330,244	$ 6,680,872		$ 1,234,142	
Crisis Stabilization - South	$ 7,628,401	$ 5,060,295	$ 1,130,435		$ 1,437,672	
Faith Based Services	$ 1,464,037	$ 1,464,037				
Family Education	$ 1,045,769	$ 1,045,769				
In-Home Outreach Teams (IHOT)	$ 4,288,276	$ 4,288,276				
Inpatient and Residential Advocacy Services	$ 723,541	$ 683,041	$ 40,500			
Institutional Case Management (ICM) - Older Adults	$ 1,118,526	$ 784,053	$ 133,265		$ 201,208	
Justice System Discharge Planning	$ 1,149,403	$ 779,403			$ 370,000	
Mental Health Advocacy Services	$ 446,644	$ 446,644				
North Coastal Mental Health Center and Vista Clinic	$ 3,386,828	$ 764,738	$ 2,622,090			
North Inland Mental Health Center	$ 3,388,778	$ 710,088	$ 2,678,690			
No Place Like Home BHS	$ 525,520	$ 317,146			$ 208,374	
No Place Like Home Dept Pub Works Envir Svcs Unit	$ 27,742	$ 3,742			$ 24,000	
No Place Like Home Housing & Community Dev Svcs	$ 1,209,708	$ 340,864			$ 868,844	
Peer Assisted Support Services	$ 900,853	$ 900,853				
Public Defender - Behavioral Health Assessor	$ 242,112	$ 146,112			$ 96,000	
San Diego Employment Solutions	$ 1,990,288	$ 1,535,119			$ 455,169	

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2023/24					
	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
San Diego Housing Commission	$ 121,056	$ 109,056			$ 12,000	
Short Term Acute Residential Treatment (START)	$ 14,310,876	$ 9,396,374	$ 2,137,251		$ 2,777,251	
Short-Term Bridge Housing	$ 1,519,434	$ 1,519,434				
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	$ 504,400				
Telemedicine	$ 469,895	$ 335,146	$ 109,749		$ 25,000	
Tenant Peer Support Services	$ 3,309,433	$ 3,157,831			$ 151,602	
Total Non-Full Service Partnership (FSP) Programs	**$ 199,289,790**	**$ 108,578,547**	**$ 62,410,799**		**$ 28,300,445**	
CSS Administration	$ 29,773,828	$ 29,773,828				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	**$ 395,680,565**	**$ 228,266,016**	**$ 125,270,035**		**$ 42,144,514**	
FSP Programs as Percent of Total	73.0%					

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP)	$ 3,232,630	$ 2,445,874	$ 502,036		$ 284,720	
Children's School Based Full Service Partnership (FSP)	$ 48,389,650	$ 9,598,383	$ 34,454,735		$ 4,336,532	
Family Therapy	$ 1,086,895	$ 1,086,895				
Incredible Years	$ 932,131	$ 245,237	$ 686,895			
Therapeutic Behavioral Services (TBS)	$ 4,907,812	$ 3,919,685	$ 988,127			
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 7,869,590	$ 2,555,128	$ 3,422,016		$ 1,892,446	
TAOA-FSP Full Service Partnerships for Children & Youth						
Adult Residential Treatment	$ 997,779	$ 997,779				
Assisted Outpatient Treatment (AOT)	$ 1,441,696	$ 840,686	$ 601,010			
Behavioral Health Court	$ 2,985,383	$ 1,831,850	$ 653,533		$ 500,000	
CARE Court Services	$ 2,017,600	$ 2,017,600				
County of San Diego - Institutional Case Management (ICM)	$ 692,787	$ 482,897	$ 13,891		$ 196,000	
County of San Diego - Peer Support Services	$ 255,512	$ 255,512				
County of San Diego - Probation	$ 605,280	$ 244,604			$ 360,676	
County of San Diego - Strengths Based Case Management (SBCM)	$ 788,949	$ 788,949				
Crisis Residential Services - North Inland	$ 1,770,267	$ 1,152,971			$ 617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 67,748,015	$ 37,001,800	$ 25,642,535		$ 5,103,681	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 19,919,520	$ 18,607,929	$ 868,873		$ 442,717	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,454,794	$ 1,727,684	$ 727,110			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,546,463	$ 1,557,194	$ 989,269			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 3,861,028	$ 3,751,028			$ 110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	$ 338,152				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	$ 508,534	$ 242,471			
Strengths Based Case Management (SBCM)	$ 1,493,763	$ 1,493,763				
Total Full Service Partnership (FSP) Programs	**$ 177,086,703**	**$ 93,450,134**	**$ 69,792,501**		**$ 13,844,068**	
Non-FSP Programs						
All-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	$ 469,447				
Behavioral Health Services and Primary Care Integration Services	$ 1,562,089	$ 1,562,089				
Behavioral Health Services for Deaf & Hard of Hearing	$ 498,916	$ 440,793	$ 58,123			
Clubhouse - Deaf or Hard of Hearing	$ 466,171	$ 466,171				
Psychiatric and Addiction Consultation and Family Support Services	$ 1,344,419	$ 1,344,419				
All-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 625,335	$ 264,078	$ 361,256			
Mobile Crisis Response Team (MCRT)	$ 13,893,190	$ 8,007,192	$ 2,942,999		$ 2,942,999	
Psychiatric Emergency Response Team (PERT)	$ 10,919,337	$ 7,171,602			$ 3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Parent Partner Services	$ 667,713	$ 667,713				
CY-SD System Development for Children & Youth						

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Administrative Services Organization (ASO) - TERM	$ 2,853,200	$ 1,615,876	$ 1,237,324			
Adolescent Day Rehabilitation	$ 100,880	$ 60,880			$ 40,000	
BridgeWays Program	$ 564,928	$ 157,615	$ 183,313		$ 224,000	
Commercially Sexually Exploited Children (CSEC)	$ 1,250,912	$ 47,170	$ 703,742		$ 500,000	
County of San Diego - Juvenile Forensic Services	$ 1,109,680	$ 1,109,680				
Crisis Action and Connection	$ 2,541,122	$ 1,629,466	$ 397,792		$ 513,864	
Emergency Screening Unit (ESU)	$ 5,897,179	$ 3,980,732			$ 1,916,448	
Incredible Families	$ 2,027,626	$ 974,992	$ 260,949		$ 791,686	
Medication Clinic	$ 1,552,543	$ 193,887	$ 1,358,656			
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,957,072	$ 997,870	$ 359,202		$ 600,000	
Peripartum Program	$ 1,019,215	$ 1,005,913	$ 13,302			
Placement Stabilization Services	$ 2,838,587	$ 806,245	$ 2,032,341			
Rural Integrated Behavioral Health and Primary Care Services	$ 146,551	$ 96,551			$ 50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	$ 182,640			$ 120,000	
Telemedicine	$ 21,300	$ 21,300				
TAOA-OE Outreach & Engagement for Ages 18-60+						
Countywide Homeless Outreach Program	$ 2,492,544	$ 1,998,384			$ 494,160	
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 12,802,322	$ 11,152,322			$ 1,650,000	
Behavioral Health Assessors	$ 691,028	$ 387,028			$ 304,000	
Bio-Psychosocial Rehabilitation (BPSR)	$ 55,537,726	$ 18,585,505	$ 29,588,954		$ 7,363,267	
Clubhouse	$ 5,299,980	$ 5,065,733	$ 234,247			
Consumer Advocacy	$ 1,266,704	$ 817,721			$ 448,984	
Crisis Stabilization - East Region	$ 5,422,823	$ 1,197,272	$ 3,272,983		$ 952,568	
Crisis Stabilization - North Coastal Oceanside	$ 7,666,880	$ 2,881,693	$ 4,785,187			
Crisis Stabilization - North Coastal Vista	$ 7,865,275	$ 563,387	$ 7,301,888			
Crisis Stabilization - North Inland	$ 10,245,258	$ 2,124,584	$ 6,886,532		$ 1,234,142	
Crisis Stabilization - South	$ 7,628,401	$ 5,060,295	$ 1,130,435		$ 1,437,672	
Faith Based Services	$ 2,575,402	$ 2,575,402				
Family Education	$ 1,045,769	$ 1,045,769				
In-Home Outreach Teams (IHOT)	$ 4,288,276	$ 4,288,276				
Inpatient and Residential Advocacy Services	$ 738,673	$ 694,123	$ 44,550			
Institutional Case Management (ICM) - Older Adults	$ 1,163,289	$ 819,054	$ 143,026		$ 201,208	
Justice System Discharge Planning	$ 1,255,474	$ 885,474			$ 370,000	
Mental Health Advocacy Services	$ 446,644	$ 446,644				
North Coastal Mental Health Center and Vista Clinic	$ 3,390,767	$ 687,960	$ 2,702,807			
North Inland Mental Health Center	$ 3,388,778	$ 486,974	$ 2,901,804			
No Place Like Home BHS	$ 525,520	$ 317,146			$ 208,374	
No Place Like Home Dept Pub Works Envir Svcs Unit	$ 27,742	$ 3,742			$ 24,000	
No Place Like Home Housing & Community Dev Svcs	$ 1,209,708	$ 340,864			$ 868,844	
Peer Assisted Support Services	$ 1,150,805	$ 1,150,805				
Public Defender - Behavioral Health Assessor	$ 242,112	$ 146,112			$ 96,000	
San Diego Employment Solutions	$ 3,363,747	$ 2,908,578			$ 455,169	

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
San Diego Housing Commission	$ 121,056	$ 109,056			$ 12,000	
Short Term Acute Residential Treatment (START)	$ 14,310,876	$ 9,396,374	$ 2,137,251		$ 2,777,251	
Short-Term Bridge Housing	$ 1,519,434	$ 1,519,434				
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	$ 504,400				
Telemedicine	$ 469,895	$ 330,168	$ 114,727		$ 25,000	
Tenant Peer Support Services	$ 3,309,433	$ 3,157,831			$ 151,602	
Total Non-Full Service Partnership (FSP) Programs	**$ 216,596,794**	**$ 114,922,433**	**$ 71,153,389**		**$ 30,520,972**	
CSS Administration	$ 31,255,885	$ 31,255,885				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	**$ 424,939,382**	**$ 239,628,451**	**$ 140,945,890**		**$ 44,365,041**	
FSP Programs as Percent of Total	73.9%					

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP)	$ 3,232,630	$ 2,445,874	$ 502,036		$ 284,720	
Children's School Based Full Service Partnership (FSP)	$ 48,389,650	$ 9,598,383	$ 34,454,735		$ 4,336,532	
Family Therapy	$ 1,086,895	$ 1,086,895				
Incredible Years	$ 932,131	$ 245,237	$ 686,895			
Therapeutic Behavioral Services (TBS)	$ 4,907,812	$ 3,919,685	$ 988,127			
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 7,869,590	$ 2,555,128	$ 3,422,016		$ 1,892,446	
TAOA-FSP Full Service Partnerships for Children & Youth						
Adult Residential Treatment	$ 997,779	$ 997,779				
Assisted Outpatient Treatment (AOT)	$ 1,441,696	$ 840,686	$ 601,010			
Behavioral Health Court	$ 2,985,383	$ 1,831,850	$ 653,533		$ 500,000	
CARE Court Services	$ 2,017,600	$ 2,017,600				
County of San Diego - Institutional Case Management (ICM)	$ 692,787	$ 482,897	$ 13,891		$ 196,000	
County of San Diego - Peer Support Services	$ 255,512	$ 255,512				
County of San Diego - Probation	$ 605,280	$ 244,604			$ 360,676	
County of San Diego - Strengths Based Case Management (SBCM)	$ 788,949	$ 788,949				
Crisis Residential Services - North Inland	$ 1,770,267	$ 1,152,971			$ 617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 67,748,015	$ 37,001,800	$ 25,642,535		$ 5,103,681	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 19,919,520	$ 18,607,929	$ 868,873		$ 442,717	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,454,794	$ 1,727,684	$ 727,110			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,546,463	$ 1,557,194	$ 989,269			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 3,861,028	$ 3,751,028			$ 110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	$ 338,152				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	$ 508,534	$ 242,471			
Strengths Based Case Management (SBCM)	$ 1,493,763	$ 1,493,763				
Total Full Service Partnership (FSP) Programs	**$ 177,086,703**	**$ 93,450,134**	**$ 69,792,501**		**$ 13,844,068**	
Non-FSP Programs						
All-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	$ 469,447				
Behavioral Health Services and Primary Care Integration Services	$ 1,562,089	$ 1,562,089				
Behavioral Health Services for Deaf & Hard of Hearing	$ 498,916	$ 440,793	$ 58,123			
Clubhouse - Deaf or Hard of Hearing	$ 466,171	$ 466,171				
Psychiatric and Addiction Consultation and Family Support Services	$ 1,344,419	$ 1,344,419				
All-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 625,335	$ 264,078	$ 361,256			
Mobile Crisis Response Team (MCRT)	$ 13,893,190	$ 8,007,192	$ 2,942,999		$ 2,942,999	
Psychiatric Emergency Response Team (PERT)	$ 10,919,337	$ 7,171,602			$ 3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Parent Partner Services	$ 667,713	$ 667,713				
CY-SD System Development for Children & Youth						

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Administrative Services Organization (ASO) - TERM	$ 2,853,200	$ 1,615,876	$ 1,237,324			
Adolescent Day Rehabilitation	$ 100,880	$ 60,880			$ 40,000	
BridgeWays Program	$ 564,928	$ 157,615	$ 183,313		$ 224,000	
Commercially Sexually Exploited Children (CSEC)	$ 1,250,912	$ 47,170	$ 703,742		$ 500,000	
County of San Diego - Juvenile Forensic Services	$ 1,109,680	$ 1,109,680				
Crisis Action and Connection	$ 2,541,122	$ 1,629,466	$ 397,792		$ 513,864	
Emergency Screening Unit (ESU)	$ 5,897,179	$ 3,980,732			$ 1,916,448	
Incredible Families	$ 2,027,626	$ 974,992	$ 260,949		$ 791,686	
Medication Clinic	$ 1,552,543	$ 193,887	$ 1,358,656			
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,957,072	$ 997,870	$ 359,202		$ 600,000	
Peripartum Program	$ 1,019,215	$ 1,005,913	$ 13,302			
Placement Stabilization Services	$ 2,838,587	$ 806,245	$ 2,032,341			
Rural Integrated Behavioral Health and Primary Care Services	$ 146,551	$ 96,551			$ 50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	$ 182,640			$ 120,000	
Telemedicine	$ 21,300	$ 21,300				
TAOA-OE Outreach & Engagement for Ages 18-60+						
Countywide Homeless Outreach Program	$ 2,492,544	$ 1,998,384			$ 494,160	
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 12,802,322	$ 11,152,322			$ 1,650,000	
Behavioral Health Assessors	$ 691,028	$ 387,028			$ 304,000	
Bio-Psychosocial Rehabilitation (BPSR)	$ 55,537,726	$ 18,585,505	$ 29,588,954		$ 7,363,267	
Clubhouse	$ 5,299,980	$ 5,065,733	$ 234,247			
Consumer Advocacy	$ 1,266,704	$ 817,721			$ 448,984	
Crisis Stabilization - East Region	$ 5,422,823	$ 1,197,272	$ 3,272,983		$ 952,568	
Crisis Stabilization - North Coastal Oceanside	$ 7,666,880	$ 2,881,693	$ 4,785,187			
Crisis Stabilization - North Coastal Vista	$ 7,865,275	$ 563,387	$ 7,301,888			
Crisis Stabilization - North Inland	$ 10,245,258	$ 2,124,584	$ 6,886,532		$ 1,234,142	
Crisis Stabilization - South	$ 7,628,401	$ 5,060,295	$ 1,130,435		$ 1,437,672	
Faith Based Services	$ 2,575,402	$ 2,575,402				
Family Education	$ 1,045,769	$ 1,045,769				
In-Home Outreach Teams (IHOT)	$ 4,288,276	$ 4,288,276				
Inpatient and Residential Advocacy Services	$ 738,673	$ 694,123	$ 44,550			
Institutional Case Management (ICM) - Older Adults	$ 1,163,289	$ 819,054	$ 143,026		$ 201,208	
Justice System Discharge Planning	$ 1,255,474	$ 885,474			$ 370,000	
Mental Health Advocacy Services	$ 446,644	$ 446,644				
North Coastal Mental Health Center and Vista Clinic	$ 3,390,767	$ 687,960	$ 2,702,807			
North Inland Mental Health Center	$ 3,388,778	$ 486,974	$ 2,901,804			
No Place Like Home BHS	$ 525,520	$ 317,146			$ 208,374	
No Place Like Home Dept Pub Works Envir Svcs Unit	$ 27,742	$ 3,742			$ 24,000	
No Place Like Home Housing & Community Dev Svcs	$ 1,209,708	$ 340,864			$ 868,844	
Peer Assisted Support Services	$ 1,150,805	$ 1,150,805				
Public Defender - Behavioral Health Assessor	$ 242,112	$ 146,112			$ 96,000	
San Diego Employment Solutions	$ 3,363,747	$ 2,908,578			$ 455,169	

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
San Diego Housing Commission	$ 121,056	$ 109,056			$ 12,000	
Short Term Acute Residential Treatment (START)	$ 14,310,876	$ 9,396,374	$ 2,137,251		$ 2,777,251	
Short-Term Bridge Housing	$ 1,519,434	$ 1,519,434				
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	$ 504,400				
Telemedicine	$ 469,895	$ 330,168	$ 114,727		$ 25,000	
Tenant Peer Support Services	$ 3,309,433	$ 3,157,831			$ 151,602	
Total Non-Full Service Partnership (FSP) Programs	**$ 216,596,794**	**$ 114,922,433**	**$ 71,153,389**		**$ 30,520,972**	
CSS Administration	$ 31,255,885	$ 31,255,885				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	**$ 424,939,382**	**$ 239,628,451**	**$ 140,945,890**		**$ 44,365,041**	
FSP Programs as Percent of Total	73.9%					

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2023/24						
	A	B	C	D	E	F	
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	PEI Category
PEI Programs							
1. CO-03 Integrated Peer & Family Engagement	$ 3,158,045	$ 2,908,045			$ 250,000		P
2. DV-03 Alliance for Community Empowerment	$ 907,920	$ 907,920					P
3. DV-04 Community Services for Families - Child Welfare Services	$ 504,408	$ 504,408					P
4. EC-01 Positive Parenting Program (Triple P)	$ 1,395,098	$ 955,098			$ 440,000		P
5. FB-01 Early Intervention for Prevention of Psychosis	$ 1,790,620	$ 139,878	$ 940,742		$ 710,000		EI
6. NA-01 Native American Prevention and Early Intervention	$ 2,127,686	$ 1,411,480			$ 716,206		P
7. OA-01 Community-Based Services for Older Adults	$ 574,162	$ 346,500			$ 227,661		P
8. OA-02 Home Based Services - For Older Adults	$ 583,652	$ 583,652					P
9. OA-06 Caregiver Support for Alzheimer & Dementia Patients	$ 1,090,271	$ 1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / P
ACEs Prevention Parenting Program for Fathers	$ 1,606,514	$ 1,606,514					
Breaking Down Barriers	$ 441,653	$ 441,653					
Clubhouse Services Program	$ 504,400	$ 504,400					
Come Play Outside	$ 504,400	$ 504,400					
County of San Diego - Community Health & Engagement	$ 877,350	$ 877,350					
Family Peer Support Program	$ 200,307	$ 200,307					
Mental Health First Aid	$ 623,862	$ 623,862					
Recuperative Services and Support Program for Transitional Age Youth	$ 846,935	$ 427,161			$ 419,774		
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 5,320,444	$ 5,320,444					
Suicide Prevention Action Plan	$ 717,663	$ 717,663					
Supported Employment Technical Consultant Services	$ 219,143	$ 219,143					
11. RC-01 Rural Integrated Behavioral Health and Primary Care Services	$ 1,723,141	$ 1,723,141					P / EI
12. RE-01 Independent Living Association (ILA)	$ 302,640	$ 302,640					O
13. SA-01 School Based Prevention and Early Intervention	$ 6,716,875	$ 6,716,875					P / EI
14. SA-02 School Based Suicide Prevention & Early Intervention	$ 2,478,136	$ 2,478,136					SP
15. VF-01 Veterans & Family Outreach Education	$ 1,420,390	$ 1,420,390					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	$ 4,939,700	$ 4,939,700					
PEI Assigned Funds	$ 400,000	$ 400,000					
Total PEI Program Estimated Expenditures	**$ 41,975,416**	**$ 38,271,033**	**$ 940,742**		**$ 2,763,641**		

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2024/25						
	A	B	C	D	E	F	
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	PEI Category
PEI Programs							
1. CO-03 Integrated Peer & Family Engagement	$ 3,158,045	$ 2,908,045			$ 250,000		P
2. DV-03 Alliance for Community Empowerment	$ 907,920	$ 907,920					P
3. DV-04 Community Services for Families - Child Welfare Services	$ 504,408	$ 504,408					P
4. EC-01 Positive Parenting Program (Triple P)	$ 1,536,434	$ 1,096,434			$ 440,000		P
5. FB-01 Early Intervention for Prevention of Psychosis	$ 1,790,620	$ 61,523	$ 1,019,097		$ 710,000		EI
6. NA-01 Native American Prevention and Early Intervention	$ 2,186,106	$ 1,467,004			$ 719,102		P
7. OA-01 Community-Based Services for Older Adults	$ 574,162	$ 346,500			$ 227,661		P
8. OA-02 Home Based Services - For Older Adults	$ 583,652	$ 583,652					P
9. OA-06 Caregiver Support for Alzheimer & Dementia Patients	$ 1,090,271	$ 1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / P
ACEs Prevention Parenting Program for Fathers	$ 2,057,952	$ 2,057,952					
Breaking Down Barriers	$ 441,653	$ 441,653					
Clubhouse Services Program	$ 504,400	$ 504,400					
Come Play Outside	$ 504,400	$ 504,400					
County of San Diego - Community Health & Engagement	$ 910,955	$ 910,955					
Family Peer Support Program	$ 200,307	$ 200,307					
Mental Health First Aid	$ 633,950	$ 633,950					
Recuperative Services and Support Program for Transitional Age Youth	$ 891,686	$ 471,912			$ 419,774		
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 5,320,444	$ 5,320,444					
Suicide Prevention Action Plan	$ 728,212	$ 728,212					
Supported Employment Technical Consultant Services	$ 367,128	$ 367,128					
11. RC-01 Rural Integrated Behavioral Health and Primary Care Services	$ 1,846,829	$ 1,846,829					P / EI
12. RE-01 Independent Living Association (ILA)	$ 302,640	$ 302,640					O
13. SA-01 School Based Prevention and Early Intervention	$ 6,716,875	$ 6,716,875					P / EI
14. SA-02 School Based Suicide Prevention & Early Intervention	$ 2,530,381	$ 2,530,381					SP
15. VF-01 Veterans & Family Outreach Education	$ 1,463,002	$ 1,463,002					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	$ 5,095,020	$ 5,095,020					
PEI Assigned Funds	$ 400,000	$ 400,000					
Total PEI Program Estimated Expenditures	**$ 43,247,452**	**$ 39,461,818**	**$ 1,019,097**		**$ 2,766,537**		

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2025/26						
	A	B	C	D	E	F	
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	PEI Category
PEI Programs							
1. CO-03 Integrated Peer & Family Engagement	$ 3,158,045	$ 2,908,045			$ 250,000		P
2. DV-03 Alliance for Community Empowerment	$ 907,920	$ 907,920					P
3. DV-04 Community Services for Families - Child Welfare Services	$ 504,408	$ 504,408					P
4. EC-01 Positive Parenting Program (Triple P)	$ 1,536,434	$ 1,096,434			$ 440,000		P
5. FB-01 Early Intervention for Prevention of Psychosis	$ 1,790,620	$ 61,523	$ 1,019,097		$ 710,000		EI
6. NA-01 Native American Prevention and Early Intervention	$ 2,186,106	$ 1,467,004			$ 719,102		P
7. OA-01 Community-Based Services for Older Adults	$ 574,162	$ 346,500			$ 227,661		P
8. OA-02 Home Based Services - For Older Adults	$ 583,652	$ 583,652					P
9. OA-06 Caregiver Support for Alzheimer & Dementia Patients	$ 1,090,271	$ 1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / P
ACEs Prevention Parenting Program for Fathers	$ 2,057,952	$ 2,057,952					
Breaking Down Barriers	$ 441,653	$ 441,653					
Clubhouse Services Program	$ 504,400	$ 504,400					
Come Play Outside	$ 504,400	$ 504,400					
County of San Diego - Community Health & Engagement	$ 910,955	$ 910,955					
Family Peer Support Program	$ 200,307	$ 200,307					
Mental Health First Aid	$ 633,950	$ 633,950					
Recuperative Services and Support Program for Transitional Age Youth	$ 891,686	$ 471,912			$ 419,774		
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 5,320,444	$ 5,320,444					
Suicide Prevention Action Plan	$ 728,212	$ 728,212					
Supported Employment Technical Consultant Services	$ 367,128	$ 367,128					
11. RC-01 Rural Integrated Behavioral Health and Primary Care Services	$ 1,846,829	$ 1,846,829					P / EI
12. RE-01 Independent Living Association (ILA)	$ 302,640	$ 302,640					O
13. SA-01 School Based Prevention and Early Intervention	$ 6,716,875	$ 6,716,875					P / EI
14. SA-02 School Based Suicide Prevention & Early Intervention	$ 2,530,381	$ 2,530,381					SP
15. VF-01 Veterans & Family Outreach Education	$ 1,463,002	$ 1,463,002					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	$ 5,095,020	$ 5,095,020					
PEI Assigned Funds	$ 400,000	$ 400,000					
Total PEI Program Estimated Expenditures	**$ 43,247,452**	**$ 39,461,818**	**$ 1,019,097**		**$ 2,766,537**		

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2023/24					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding *	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-18 Peripartum Program	$ 563,251	$ 557,809	$ 5,442			
2. INN-19 Telemental Health	$ 1,132,972	$ 564,287	$ 568,685			
3. INN-24 Early Psychosis and Learning Health Care Network	$ 201,626	$ 201,626				
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 198,558	$ 198,558				
Total INN Program Estimated Expenditures	**$ 2,096,407**	**$ 1,522,280**	**$ 574,127**			

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding *	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-18 Peripartum Program						
2. INN-19 Telemental Health						
3. INN-24 Early Psychosis and Learning Health Care Network						
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration						
Total INN Program Estimated Expenditures	**$ -**	**$ -**	**$ -**			

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding *	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-18 Peripartum Program						
2. INN-19 Telemental Health						
3. INN-24 Early Psychosis and Learning Health Care Network						
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration						
Total INN Program Estimated Expenditures	**$ -**	**$ -**	**$ -**			

Appendix A
FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2023/24					
	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	$ 2,793,677	$ 2,793,677				
2. WET-03 Mental Health Career Pathway Programs	$ 100,880	$ 100,880				
3. WET-04 Residency and Internship Program	$ 3,984,760	$ 3,984,760				
WET Administration	$ -	$ -				
Total WET Program Estimated Expenditures	**$ 6,879,317**	**$ 6,879,317**				

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-02 Training & Technical Assistance	$ 3,046,961	$ 3,046,961				
2. WET-03 Mental Health Career Pathway Programs	$ 100,880	$ 100,880				
3. WET-04 Residency and Internship Program	$ 4,388,280	$ 4,388,280				
WET Administration	$ -	$ -				
Total WET Program Estimated Expenditures	**$ 7,536,121**	**$ 7,536,121**				

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-02 Training & Technical Assistance	$ 3,046,961	$ 3,046,961				
2. WET-03 Mental Health Career Pathway Programs	$ 100,880	$ 100,880				
3. WET-04 Residency and Internship Program	$ 4,388,280	$ 4,388,280				
WET Administration	$ -	$ -				
Total WET Program Estimated Expenditures	**$ 7,536,121**	**$ 7,536,121**				

APPENDIX B

CERTIFICATIONS AND MINUTE ORDER

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, JUNE 13, 2023

MINUTE ORDER NO. 22

SUBJECT: RECEIVE AND APPROVE THE MENTAL HEALTH SERVICES ACT THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FISCAL YEARS 2023-24 THROUGH 2025-26 AND SUNSET TIME-CERTAIN REPORTING (DISTRICTS: ALL)

OVERVIEW

Under the leadership of the San Diego County Board of Supervisors (Board), the County of San Diego (County) Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) continues making strides to advance the transformation of the behavioral health system to a system of regionally distributed services that are accessible to all individuals and families in need.

The Mental Health Services Act (MHSA) is a critical resource that provides dedicated ongoing funding to counties to address a broad continuum of mental health services needs including prevention, early intervention, and treatment services, along with funding for information technology and workforce development and training. MHSA provides funding for critical programs that serve individuals with serious mental illness or serious emotional disturbance, supporting some of San Diego County's most vulnerable and unserved populations through services that are responsive to cultural and linguistic needs. The MHSA is comprised of five components: Community Services and Supports; Prevention and Early Intervention; Innovation; Workforce Education and Training; and Capital Facilities and Technological Needs. As mandated by the MHSA, the Three-Year Plan, inclusive of all programs and expenditures funded by the MHSA, requires approval by the Board prior to submission to the California Mental Health Services Oversight and Accountability Commission. Today’s action requests the Board receive and approve the recommended MHSA Three-Year Plan and Expenditure Plan for Fiscal Years (FY) 2023-24 through 2025-26, which includes MHSA funding of $274.9 million in FY 2023-24, $286.6 million in FY 2024-25, and $286.6 million in FY 2025-26, inclusive of all programs and expenditures funded by the MHSA as required to comply with MHSA regulation.

Additionally, today’s action requests the Board direct the Interim Chief Administrative Officer to sunset time-certain reporting for the MHSA-funded Mobile Crisis Response Team program which was requested in an action brought forward on April 6, 2021 (9). BHS has completed all actions set forth by the Board and has provided seven quarterly updates on progress to date.

Today’s actions support the County’s vision of a just, sustainable, and resilient future for all, specifically those communities in San Diego County that have been historically left behind, as well as our ongoing commitment to the regional *Live Well San Diego* vision healthy, safe, and thriving communities. This will be accomplished by enhancing access to behavioral health services, promoting well-being in children, adults, and families, and encouraging self-sufficiency.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER

1. Receive and approve the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2023-24 through 2025-26 (Three-Year Plan) and authorize the Agency Director, Health and Human Services Agency, to submit the Three-Year Plan to the Mental Health Services Oversight and Accountability Commission.

2. Direct the Interim Chief Administrative Officer to sunset time-certain reporting for the MHSA-funded Mobile Crisis Response Team program to coincide with significant developments.

EQUITY IMPACT STATEMENT

The vision of the Mental Health Services Act (MHSA) is to build a system in which mental health services are equitable and accessible to all individuals and families within the region who are in need. According to 2021 data from the California Department of Healthcare Access and Information, Black/African American residents experienced higher emergency department rates of serious mental illness, self-inflicted injury/suicide attempt, and substance related disorders compared to others. Additionally, according to the California Health Interview Survey conducted by the University of California Los Angeles in 2021, 10% of San Diegans reported experiencing serious psychological distress in the past month. However, residents living below 200% of the federal poverty level, those who reported a history of incarceration, or who identified as black, Hispanic/Latino, Asian, or multiracial, reported higher percentages of serious psychological distress compared to others.

MHSA funding provides individuals who are experiencing serious mental illness or serious emotional disturbance with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. The County of San Diego (County) Health and Human Services Agency, Behavioral Health Services (BHS) serves diverse individuals of all ages, especially those historically underserved by behavioral health resources as well as those disproportionately impacted by behavioral health related morbidity and mortality. BHS strives to reduce these inequities among impacted populations, including individuals experiencing homelessness, black, indigenous and, people of color, children who are commercially sexually exploited, children and adults with justice involvement, people with complex behavioral health needs, and individuals in at-risk age groups. Behavioral health services offered through County-operated and contracted programs address the social determinants of health by being accessible and capable of meeting the needs of a diverse population, with the intent to equitably distribute services to those most in need. In support of these efforts, BHS utilizes a population health approach, along with evidence-based practices and robust data analysis, to identify needs and design services that are impactful, equitable, and yield meaningful outcomes for clients. This includes facilitating community engagement forums to solicit input from the community, stakeholders, consumers, family members, community-based providers, and healthcare organizations through formal and informal convenings, along with cross-collaboration with other County departments and community partners. Additionally, through the establishment of the Community Experience Partnership in collaboration with the University of California, San Diego and the recent launch of the Behavioral Health Equity Index, BHS is leading the development of a tool for measuring behavioral health equity to inform program planning, siting of services, and allocation of resources in a way that supports the most pressing community needs.

SUSTAINABILITY IMPACT STATEMENT
Mental Health Services Act (MHSA) programs support the County of San Diego's (County) Sustainability Goal #1 to engage community in meaningful ways and continually seek stakeholder input to foster inclusive and sustainable communities. MHSA provides services to children, youth, and families, transition age youth, adults, and older adults in a community-centric approach taking into consideration language and cultural barriers to ensure equitable access for those in need of behavioral health services. The County Health and Human Services Agency, Behavioral Health Services engages the community through the Community Planning Process to collaborate and encourage internal and external stakeholders to partner and participate in decisions that impact their lives and communities. In addition to maintaining regular contact with the public through interactive councils and advisory boards and stakeholder engagement throughout the year and as part of the development of the Fiscal Year 2023-24 through 2025-26 MHSA Plan, a 30-day public comment period was offered, during which the public provided feedback on the proposed plan.

Additionally, MHSA programs support the County's Sustainability Goal #2 to provide just and equitable access through the regional distribution of services by allowing chronically underserved communities and individuals with behavioral health conditions to receive care near where they live. Services are provided at numerous County locations, as well as through community-based providers to ensure care is geographically dispersed throughout the region.

FISCAL IMPACT
Funds for this request are included in the Fiscal Year (FY) 2023-25 CAO Recommended Operational Plan for the Health and Human Services Agency. If approved, this request will result in estimated Mental Health Services Act costs and revenues of approximately $274.9 million in FY 2023-24, inclusive of $400,000 dedicated to the California Mental Health Services Authority, to continue participation in statewide prevention and early intervention campaigns and local initiatives. The funding source is the Mental Health Services Act. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

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

AYES: Vargas, Anderson, Lawson-Remer, Desmond
ABSENT: (District 4 Seat Vacant)

State of California)
County of San Diego) §

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

ANDREW POTTER
Clerk of the Board of Supervisors

Signed by Andrew Potter

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: County of San Diego

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Luke Bermann, Ph. D.	Name: Brian Ruehle
Telephone Number: 619-563-2766	Telephone Number: 858-694-2199
E-mail: Luke.Bergmann@sdcounty.ca.gov	E-mail: Brian.Ruehle@sdcounty.ca.gov
Local Mental Health Mailing Address: 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.

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

LUKE BERGMANN, Ph.D., Director Digitally signed by LUKE BERGMANN, Ph.D. Director Date: 2023.05.02 10:16:50 -07'00'
Signature Date

I hereby certify that for the fiscal year ended June 30, 2022, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/18/22 for the fiscal year ended June 30, 2022. I further certify that for the fiscal year ended June 30, 2022, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

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

Signature 5/2/23
Signature Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: County of San Diego

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

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three Year Plan 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 Three Year Plan and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 13, 2023.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Luke Bergmann — Local Mental Health Director/Designee (PRINT)

Signature — Date: 6/15/23

County: San Diego

Date:

APPENDIX C

MHSA PROGRAM SUMMARIES

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	ALL-OE	Behavioral Health Services - Victims of Trauma and Torture	Survivors of Torture International (SOTI) Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC)	An outpatient Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) that is a Short-Doyle Medi-Cal (SD/MC) certified Mental Health Clinic in the County of San Diego Health and Human Services Agency's Countywide to serve residents of San Diego age 18+ who experienced trauma and torture in their home countries and/or their journeys to the United States, including refugees and/or asylum seekers, and have serious mental illness (SMI), including those who may have a co-occurring substance use disorder.	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	TAY age 18-25, adults age 26-59, and older adults age 60+ of uninsured, unserved individuals with SED and SMI who are victims of trauma and torture.	• Bio-psychosocial rehabilitation services recovery • Urgent Walk-In • Culturally appropriate outreach, engagement, assessment, case management/brokerage, rehabilitation, crisis intervention, medication management, therapy, mobile outreach and other indicated treatment	Survivors of Torture International (619) 278-2400	All
CSS	ALL-OE	Behavioral Health Services and Primary Care Integration Services	Behavioral Health and Primary Care Integration Services	Provides Enhanced Screening, Brief Intervention and Referral to Treatment through a Collaborative Care model for adult patients identified with behavioral health needs based on screenings at primary care sites	Provide brief, effective, evidence-based treatment and increase access to behavioral health care in a primary care setting	Adults 18 years and older	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network dba Health Quality Partners 3710 Ruffin Rd San Diego, CA 92123 (619) 542-4300	All
CSS	ALL-OE	Behavioral Health Services for Deaf & Hard of Hearing	BPSR Deaf and Hard of Hearing	Adult outpatient mental health clinic provides video, secure email, and phone consultation in a mental health walk-in outpatient clinic within San Diego County	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Adult/older adults, transition age youth and children who are deaf and hard of hearing and who have a serious mental illness, including those with co-occurring substance disorders	• 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	4
CSS	ALL-OE	Clubhouse - Deaf or Hard of Hearing	Recovery and Skills for Deaf and HOH/Clubhouse	Recovery and skill center/clubhouse for the Deaf or Hard of Hearing	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Transition Age Youth, Adults/Older Adults, who are deaf or hard-of-hearing who have or are at risk of a serious mental illness or co-occurring disorder	• Member-operated recovery and skill development clubhouse program • Services include social skill development, rehabilitative, recovery, vocational and peer support	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	4
CSS	ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Psychiatric and Addiction Consultation and Family Support Program	Provides psychiatric and addiction consultation and family support services for primary care and pediatric providers who serve patients with Medi-Cal or who are uninsured, throughout San Diego County, as well as for Youth under the age of 21 and caregivers	Enhance primary care and behavioral health providers levels of competence, confidence, and capacity to assess and appropriately treat clients with behavioral health needs; improve identification and treatment of behavioral health issues in youth, including suicide and overdose risk; provide education, referrals, and linkages to support youth and families	Children, Transition Age Youth	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8825 Aero Dr, #315 San Diego, CA 92123 (858) 956-5906	All
CSS	ALL-SD	Chaldean and Middle-Eastern Social Services	Chaldean and Middle-Eastern Social Services (Children/Adult)	Outpatient mental health clinic provides treatment, rehabilitation, and recovery services to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	Provide culturally competent treatment, services and referrals for individuals of Middle Eastern descent who experience mental health issues or a serious mental illness	Adults 18 years and older and eligible for Medi-Cal funded services	• Outpatient mental health clinic which provides treatment, rehabilitation, and recovery services • Referrals and linkage support	Chaldean and Middle-Eastern Social Services 875 El Cajon Blvd. El Cajon, CA 92020 (619) 662-4100	2
CSS	ALL-SD	Mobile Crisis Response Team (MCRT)	Regional Mobile Crisis Response Team	The MCRT is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care.	The goal of the MCRTs is to respond to community (non-911calls) urgent/emergency calls and provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. These services are performed by trained clinicians and peers in the field.	Services to individuals experiencing a behavioral health crisis in the community including adults and older adults, as well as children, youth and families in the community.	Provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. The MCRTs are available 24 hours/7 days per week.	Telecare Corp 409 Camino Del Rio South, Suite 201, San Diego, CA 92108 619-346-8484 Exodus Recovery, Inc. 536 W. Vista Way, Ste. A Vista, CA 92083 760-758-1650	All
CSS	ALL-SD	Psychiatric Emergency Response Team (PERT)	Psychiatric Emergency Response Team (PERT)	Pairs law enforcement officers with licensed mental health clinicians to serve children and adults experiencing a behavioral health crisis and come have come in contact with law enforcement throughout the County	Improve collaboration between the mental health and law enforcement systems with the goal of more humane and effective handling of incidents involving law enforcement officers and mentally ill and developmentally disabled individuals	Children, Transition Age Youth, Adults/Older Adults, with a focus on veterans, homeless populations.	• Case coordination • Descalation and crisis intervention services • Training for law enforcement personnel	Community Research Foundation (CRF) 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0892	All
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	Outpatient diagnostic and treatment services for children and youth who require specialty mental health services who reside in County of San Diego Foster Family Agency (FFA) homes. Services includes the oversight of Therapeutic Foster Care (TFC) services, including the provision of specific Specialty 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 children, youth and their families	Children and youth up to age 21, involved in Child Welfare Services and residing in Foster Family Agency homes, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Intensive Home-Based Services • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Therapeutic Foster Care	San Diego Center for Children - FFAST 2655 Camino Del Rio N Suite 450 San Diego, CA 92108 (858) 277-9550 North County 145 Vallecitos de Oro, Suite 210 San Marcos, CA 92069 (858) 633-4115	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Connections Community Counseling	Engages homeless and runaway youth for the purpose of increasing access to mental health services and family reunification as indicated. Individual/group/family services provided at schools, community, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline Inc. Connections Community Counseling 4180 Ruffin Rd Ste 295 San Diego CA 92123 (760) 842-6202	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Crossroads	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 700 N. Johnson Ave, Suite P El Cajon, CA 92020 (619) 441-1907	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Douglas Young	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, peer support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• 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 7917 Ostrow St., Suite A San Diego, CA 92111 (858) 300-8282	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Housing Case Mangement/Monarch Supportive Housing	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment. Housing case management component for children and families in the Monarch program.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who may be attending a Juvenile Court and Community School (JCCS) and meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Mobile Adolescent Services Team 1260 Morena Blvd., Suite 200 San Diego, CA 92110 (619) 398-3261	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mobile Adolescent Services Team (MAST)						
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Nueva Vista	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle Central & East	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers - Logan Heights 2130 National Ave. San Diego, CA 92113 (619) 255-7859 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-5444	1,2,4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community and School Based Counseling Services (CSBCS)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Cornerstone	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd., Suite 14 San Diego, CA 92115 (619) 640-3269	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central Region Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Children's Mental Health (CMH) School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	4, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North County Outpatient School-Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	New Alternatives Inc 1529 Grand Ave. Suite A San Marcos CA 92078 (760) 798-0299	3, 5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Oceanside & Vista School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline - Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900 North County Lifeline - Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland/North Coastal & Fallbrook School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Coastal Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, peer support, and/or co- occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Coastal 3605 Vista Way, Suite 258 Oceanside, CA 92056 (760) 758-1480	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Inland 2125 W. Citacado Pkwy., Suite 200 Escondido, CA 92025 (760) 294-9270	2,3,5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Family Wellness Center - East County Outpatient Program	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment. PCIT utilized when indicated	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children East Region Outpatient 6386 Alvarado Ct San Diego CA 92120 (619) 668-6200	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Behavioral Health Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services 1870 Cordell Ct., Suite 101 El Cajon, CA (619) 448-9700	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Learning Assistance Center Escondido & North Inland	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill Foundation - Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation - North Inland Ramona 1012 Main St., Suite 101 Ramona, CA 92065 (760) 788-9724	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Merit Academy (East Region)	Day School Services provides individual, group and family services at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familias	Individual/group/family services provided at pre-schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, and peer support	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children up to age 5 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach and Engagement	Episcopal Community Services Para Las Familias 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central East South Region (CES) School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-8471	1, 2, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Youth Enhancement Services (YES) School Based	Individual/group/family services provided at schools, home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Ysidro Health Center Youth Enhancement Services 1666 Precision Park Lane, San Diego, CA 92173 (619) 428-5533	1

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mi Escuelita South Region School Based	Individual/group/family services provided at schools, pre-schools, home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	Individual/group/family services provided at schools, home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	YMCA-TIDES 4394 30th St. San Diego, CA 92104 (619) 543-9850	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Multi-Cultural Community Counseling	Culturally specific individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment. The focus of this program is to provide services to underserved Asian Pacific Islander (API) and Latino clients	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity	•Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) 5348 University Ave, Suite 108 San Diego, CA 92105 619-455-2108	All
CSS	CY-FSP	Incredible Years	ChildNET Incredible Years North Costal & North Inland	Individual/group/family services provided at pre-schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management and peer support	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children through five years old, and their families, using the Incredible Years evidence-based curriculum	Children through age 5 who meet medical necessity and their families	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 945 Vale Terrace Dr Vista CA 92084	2, 3, 5
CSS	CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services (TBS)	Ancillary short term one-to-one behavioral coaching for children & youth, who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	Support permanency as well as promote successful return of children/youth to their family or family-like setting	Children up to age 21 who are Medi-Cal eligible and who are receiving specialty mental health reimbursable services and experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	• One on one behavioral coaching	New Alternatives - TBS 8755 Aero Drive, Suite 230 San Diego, CA 92123 (858) 256-2180	All
CSS	CY-FSP	Wraparound Services (WRAP) - Child Welfare Services (CWS)	WrapWorks - CWS	Wraparound offers team based intensive and individualized case management to children/youth in CWS/Probation systems working within the context of their support system, leveraging both formal and informal supports	Assist children/youth in reducing symptoms/behaviors so they can remain in their family setting or return to a family or family-like setting, as well as to support permanency and reduce recidivism	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 • Individual & family treatment • Crisis intervention • Medication management • Outreach at schools and the community	San Diego Center for Children 3002 Armstrong Street San Diego, CA 92111 (858) 569-2170 235 W 5th Avenue, Ste 130 Escondido, CA 92025 3322 Sweetwater Spring Blvd, Ste 104 Spring Valley, CA 91977	All
CSS	CY-OE	Parent Partner Services	Youth & Family Support Services	Provide care coordination, focus groups, support and education groups, and community resource fairs provided by peers who make linkages to behavioral health treatment when indicated	Outreach and Engagement services for children, youth, up to age 21, and their families	Latino, Asian, and African American children and youth up to age 21	• Outreach and Engagement • Peer Support • Case management • Focus groups • Support and Education Groups • Community Presentations	Harmonium 5275 Market St, Ste E San Diego, CA 92114 (858) 226-1982	4
CSS	CY-SD	Adolescent Day Rehabilitation	SDCC Residential Outpatient Children's Mental Health Services	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and youth up to age 18, residing at San Diego Center for Children, who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CSS	CY-SD	BridgeWays Program	BridgeWays Program Svcs	Individual/group/family services provided at office/clinic, home, or other community locations. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use interventions	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families who are at risk of involvement or currently involved in the Juvenile Justice System	Children and youth up to age 21, who are at risk of involvement or currently involved in the Juvenile Justice System, who meet medical necessity	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Home Based Services • Crisis intervention • Medication services • Outreach and Engagement • Substance use services	TBD	All
CSS	CY-SD	Commercially Sexually Exploited Children (CSEC)	I CARE	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use interventions. Supportive services at drop-in center	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth and their families that are at risk for or are victims of commercial sexual exploitation	Children and youth up to age 21 who are at risk for or are victims of commercial sexual exploitation and who meet medical necessity. 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 • Peer Support • Mentors	San Diego Youth Services I CARE 3660 Fairmount Ave. San Diego, CA 92105 (619) 521-2550 x 3816	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	CY-SD	County of San Diego - Juvenile Forensic Services	County of San Diego - Juvenile Forensics	Provides behavioral health services to youth transitioning out of the juvenile detention and rehabilitative institutions.	Prepare youth for transition back to the community and work with probation youth who have been released and are living in the community	Youth transitioning out of juvenile institutions	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services	Youth Transition Campus 2801 Meadlow Lark Drive 1st Flr. San Diego, Ca 92123-2711 (858) 298-6070 East Mesa Detention Facility 446 Alta Road San Diego, CA 92158 (619) 671-6558	All
CSS	CY-SD	Crisis Action and Connection	Crisis Action and Connection	Provides intensive support and linkage to services and community resources for children/youth who have had a recent psychiatric episode	Improve the ability of children and youth and their families to access and benefit from mental health services in order to divert or prevent readmission to acute services	Children and youth up to age 21 who meet medical necessity and meet set criteria	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services • Case Management	TBD	All
CSS	CY-SD	Emergency Screening Unit (ESU)	Emergency Screening Unit	Provides crisis stabilization to children and youth experiencing a psychiatric emergency	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth under age 18 who are experiencing a psychiatric emergency	• Crisis stabilization services for high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Emergency Screening Unit 4309 Third Ave. San Diego, CA 92103 (619) 876-4502	All
CSS	CY-SD	Incredible Families	Incredible Families for Child Welfare Services (CWS)	Behavioral health outpatient services to children and their families that are Dependents of the Juvenile Courts hence involved with Child Welfare Services (CWS).	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Families and their children 2-14 years old who are dependents of Juvenile Dependency Court due to abuse and/or neglect	• Weekly multi-family parent and child visitation event and meal for all family members • Utilization of the Incredible Years evidence-based curriculum • A primary therapist is assigned to each family • Clinical support during family visitation events, as well as, during individual and family therapy	New Alternatives Inc. Incredible Families Central 8765 Aero Dr Suite 310A San Diego, CA 92123 (619) 207-0396 Incredible Families North 1020 S. Santa Ana Ave Suite D-1 Vista, CA 92084 Incredible Families South 730 Medical Center Court Chula Vista, CA 91911	All
CSS	CY-SD	Med Clinics	Center for Child & Youth Psychiatry Medication Clinic	Outpatient psychiatric evaluation and medication support services utilizing face-to-face and telepsychiatry/telehealth practices for children and youth with complex psychiatric pharmacological needs inclusive of children and youth who may be involved in the juvenile justice or child welfare systems or have co-occurring needs	Promote stabilization by providng psychotropic medication support to children and youth, who require complex medication management.	Children and youth up to age 21 requiring on-going medicaiton support who have successfully completed a comprehensive mental health treatment with a system of care provider.	• Medication management • Psychiatric consultation • Psycho-educational seminars and groups for families	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, Ca 92123 (858) 514-5100	All
CSS	CY-SD	Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	Our Safe Place	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use interventions. Supportive services at 5 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 and youth who identify as LGBTQ+ and their families	LGBTQ+ children and youth up to age 21 who meet medical necessity. Any LGBTQ+ youth who would benefit from supportive services at the drop-in centers	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • General Education Diploma (GED) preparation • Support groups • Peer Support • Mentors	San Diego Youth Services Our Safe Place 3427 4th Ave. Second Floor San Diego, CA 92103 (619) 525-9903	All
CSS	CY-SD	Placement Stabilization Services	Comprehensive Assessment & Stabilization Services (CASS)	Outpatient mental health services including a comprehensive behavioral health assessment, individual and family therapy, casemanagement, individual rehab and psychiatric services/med management for children and youth placed by Child Welfare services in a resource family home and at risk of change of placement disruption.	Stabilize current placement, deter children and youth from placement in a higher level of care and support transition of children and youth back to their biological families	Foster children and youth up to age 21 who recently experience placement disruption and meet medical necessity	• Assessment • Case management and rehabilitative services • Intensive Care Coordination • Intensive Home-Based Services • Crisis intervention • Medication management	TBD	All
CSS	CY-SD	Placement Stabilization Services	Placement Stabilization Svcs Polinsky Children's Center	Short-term mental health supportive services for children and youth placed at County ten-day assessent center, Polinsky Children's Center (PCC)	Support emotional needs of children and youth while at PCC to promote stabilization	Children and youth up to age 18 who meet medical necessity 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	TBD	All
CSS	CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	Provides Collaborative Care Model in rural community primary clinics, including routine screening, behavioral health consultation/education, prevention, early intervention, brief treatment, and assisting in accessing care.	Prevention, early identification, education and intervention, and treatment to prevent development of more serious mental health or substance use conditions, and increase access to care for children, transitional age youth and adults/older adults	Children, Transition Age Youth, Adults/Older Adults	• Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725	2, 5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	CY-SD	Supplemental Security Income (SSI) Advocacy Services	Children SSI Advocacy	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and youth up to age 18, residing at San Diego Center for Children, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CSS	TAOA-FSP	Adult Residential Treatment	Residential Dual Diagnosis Treatment Program - SNF	Residential facility for adults with serious mental disorders	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach to assist the client's recovery and return to independent living.	Adults 18 years and older with disabling psychiatric disorder requiring a 24-hour Mental Health Rehabilitation Center	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299	All
CSS	TAOA-FSP	Assisted Outpatient Treatment (AOT)	Assisted Outpatient Treatment (AOT)	A time-limited Assertive Community Treatment (ACT) Team services for persons who are assigned to court-ordered Assisted Outpatient Treatment (AOT), and for persons who otherwise meet AOT criteria and agree to participate in these services as an alternative to court-ordered AOT.	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 In-Home Outreach Team, have agreed to an AOT court settlement, or have AOT status resulting from a contested court hearing	Adults 18 years and older meeting Title 9 criteria as established under Laura's Law	• Assertive Community Treatment with a rehabilitation and recovery focus	Telecare Corporation 1660 Hotel Circle N., Suite 101 San Diego, CA 92108 (619) 481-3840	All
CSS	TAOA-FSP	Behavioral Health Court	Collaborative Behavioral Health Court	Uses the Assertive Community Treatment model to enhance the lives of individuals experiencing a serious mental illness and co-occurring conditions through case management and mental health services	Integrate mental health, substance-induced psychiatric disorder rehabilitation treatment, and recovery services for adults with serious mental illness to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system	Underserved adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corporation 4930 Naples St. San Diego, CA 92110 (619) 276-1176	4
CSS	TAOA-FSP	County of San Diego - Institutional Case Management (ICM)	County of San Diego - Institutional Case Management (ICM)	County Operated Direct Service Program: Provides care coordination and rehabilitation case management services to individuals 18-59 years of age who are on permanent conservatorship, through Public Conservator's Office on LPS conservatorship, that are receiving treatment in institutional settings including behavioral health units, jails, skilled nursing facilities, institutes of mental disease (IMDs) and state hospitals.	Stabilization and linkage to services	Clients who reside in a State Hospital or in out-of-county or in-county Institutes of Mental Disease (IMD) or Skilled Nursing Facilities (SNF)	• Services consist primarily of linking, coordinating, and monitoring functions. • Operate a case management program offering Institutional Case Management services to adults who are seriously mentally ill and who meet eligibility criteria in accordance with Title 9, AOA/BHS policy, and the Organizational Provider Operations Handbook (OPOH), including assessment, individual and group counseling, case management/brokerage, rehabilitation, crisis intervention, and other rehabilitative and recovery interventions including supportive housing.	1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715	All
CSS	TAOA-FSP	County of San Diego - Probation	Probation Officers MOU, Annual COLA based on County Comp Ordinance	• Probation Office for Behavioral Health Court • 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	• Stabilization and linkage to services • Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	• Transition Age Youth, Adults/Older Adults • Transition Age Youth and Adults who have a serious mental illness	• Transition services • Mental health assessments • Interventions • Case Management • Outreach and engagement	County of San Diego Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
CSS	TAOA-FSP	County of San Diego - Strengths Based Case Management (SBCM)	County of San Diego - Strengths Based Case Management (SBCM) (Central/North Central & East)	County Operated Direct Service Program: Strengths Based Case Management (SBCM) is designed to provide continuity of care within the behavioral health system in San Diego County. Services are delivered to adults, 18-59 years of age, living with serious and persistent mental health and co-occurring disorders who meet eligibility criteria for SBCM.	Obtain medical and psychiatric treatment, maintain housing, obtain financial assistance, case management services also help clients link with other community services, such as: education, work and social programs	Seriously and persistently mentally ill with co-occurring disorders, possibly on LPS Conservatorship, 18-59 years of age, living in the Central, North Central or East County community. Services are for SSI/Medi-Cal, SSA/Medicare and/or indigent populations.	• Strengths Based Case Management (SBCM) • Rehabilitation and recovery services • Care Coordination to needed services • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to Supportive employment/vocational and educational services	North Central 1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715 East County 1000 Broadway Suite 100 El Cajon, CA 92021 (619) 401-5424	2,3,4
CSS	TAOA-FSP	Crisis Residential Services - North Inland	Esperanza Crisis Center	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	• Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Esperanza Crisis Center 490 North Grape Street Escondido, CA 92025 (760) 975-993	5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT North Coastal	Provides an Assertive Community Treatment, Full Service Partnership program for persons 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adult 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for persons who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes housing component	Mental Health Systems Inc. (MHS) 2122 El Camino Real #102 Oceanside, CA 92054 (760) 290-8170	5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT Senior Impact (High Utilizer Integrated Services)	Offers intensive, comprehensive, community - based integrated behavioral health services	Increase timely access to services and supports to assist Older Adults and family/ caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes	Adults 60 years and older who are homeless or at risk of homelessness and have serious mental illness	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) 928 Broadway San Diego, CA 92102 (619) 977-3716	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Senior Impact Supported Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Central IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or 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 18-59 who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central and North Central Regions of San Diego	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Central IMPACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Downtown IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or 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 18-59 who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central and North Central Regions of San Diego	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Downtown IMPACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Inreach to Long Term Care-Pathway to Recovery	Assertive Community Treatment and In-Reach for adults in and discharged from long-term care	Provide Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialist, vocational specialist, housing specialists, nurses, physician's assistants, medical doctors, and substance use disorder specialists.	Adults 18-59 years old with serious mental illness and are, or recently have been, in a long-term care institutional setting	• Provide Assertive Community Treatment Team • Multidisciplinary, wraparound treatment and rehabilitation services for adults discharged from long-term care facilities who have a serious mental illness and needs that cannot be adequately met through a lower level of care • Includes an in-reach component for some persons served by the county institutional case management program • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Inreach to Long Term Care-Pathways to Recovery Member Housing II						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Persons with High Service Use	Provides an Assertive Community Treatment, Full Service Partnership program for person 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness who may also have a co-occurring use disorder.	Adults 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3101	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Persons with High Service Use (HOUSING)						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Agewise	Strengths-Based Case Management and Institutional Case Management for Older Adults	Provide SBCM and ICM services to adults over age 60 who suffer from serious mental illness and who may have a co-occurring substance use disorder. ICM population is on Public Conservatorship.	Older Adults (60+ y/o). ICM population is 60+ y/o and on Public Conservatorship	• Strengths-Based Case Management and Institutional Case Management	Telecare Corporation 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT- City Star (Central and North Central Regions)	Full Service Partnership Assertive Community Treatment team and recovery services program will use a "Housing First" approach	Provide Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff.	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnosis of substance abuse	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. (MHS) 8775 Aero Dr., Suite 132 San Diego, CA 92123 (858) 609-8742	3 & 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-City Star (Central and North Central Regions) Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT North Inland	Full Service Partnership/Assertive Community Treatment with supportive housing and Strengths-Based Case Management. Project-One-For-All (POFA) 100 Central/North Housing	Reduce homelessness and provide comprehensive ACT 'wraparound' mental health services for adults with most severe illness, most in need due to severe functional impairments, and who have not been adequately served by the current system	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless. Adults 18-59 years old who are eligible for Medi-Cal funded services or are indigent	• Strengths-based case management • Rehabilitation and mental health services with a focus on adults who meet eligibility criteria • Supportive housing component	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3,5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Housing						

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Strength Based Case Management (SBCM)	Program uses strength based case managment team approach to deliver comprehensive, community based servics and support for adults who are transitioning from higher levels of care.	Recovery-oriented strengths-based clinical case management services to persons with serious mental illness	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless	• Strengths based case management	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 103 Escondido, CA 92025 (760) 294-1281	3, 5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	ACT Step Down from Long Term Care (La Luz)	Full Service Partnership/Assertive Community Treatment	The ACT FSP program is designed to improve the mental health and quality of life of adults in the community who are homeless or at-risk of homelessness who are not connected to outpatient services, 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 serious mental illness, and are in a long-term care facility setting and are not connected to outpatient services	• Assertive Community Treatment Services • Includes housing component	Telecare La Luz 3489 Kurtz San Diego, CA 92110 619-320-2404	3
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Step Down from Long Term Care Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	Step Down from Acute Care (Tesoro Act)	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from acute behavioral health hospital.	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	• Assertive Community Treatment Services • Includes housing component	Telecare Tesoro 489 Kurtz San Diego, CA 92110 619-320-2404	3
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Step Down from Acute Care Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT Justice Involved Svcs (Vida ACT and Start up)	Full Service Partnership/Assertive Community Treatment - Justice Involved	Provides Assertive Community Treatment Services to persons with serious mental illness who are justice involved	Adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Telecare Corporation 3491 Kurtz Street, Suite 150 San Diego, CA 92110	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Justice Involved Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice	24-hour community -based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness	Provides Assertive Community Treatment Services to persons with very serious mental illness	Adults 25 to 59 years old who have a serious mental illness and adults 18 years and older who may have been homeless	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. (MHS)/TURN BHS 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice HOUSING)						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Catalyst for TAY	Transition Age Youth Assertive Community Treatment Full Service Partnership. Services are team-based, available around the clock, are primarily delivered on an outreach basis, and have a participant-to-staff ratio that is approximately 10-12 to 1	Provide Assertive Community Treatment Team intensive, multidisciplinary, wraparound treatment and rehabilitation services for Transitional Age Youth who have a serious mental illness, may be on LPS Conservatorship, and have needs that cannot be adequately met through a lower level of care	Transition Age Youth with a serious emotional disturbance or serious mental illness (who may have a co-occurring mental illness and substance use disorder) that have been homeless or may be at risk of being homeless	• Assertive Community Treatment (ACT) mental health • Includes housing component	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Catalyst for TAY Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION East	This homeless project is a collaborative effort between the County of San Diego and Housing and Community Development which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Provide permanent supportive housing services integrated with serious mental illness (SMI) and substance use disorder (SUD) treatment services for the homeless in East Region. This hybrid program provides Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder.	Homeless Transition Age Youth, Adults/Older Adults with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	• Mental health rehabilitation Treatment and recovery services for clients with substance use disorder • Integrated case management services with substance use disorder treatment and recovery services • Supportive housing component	Mental Health Systems Inc. (MHS)/TURN BHS ACTION East 10201 Mission Gorge Rd., Suite O Santee, CA 92071 (619) 383-6868	2
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	POFA Homeless Project EAST Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	POFA Homeless Project South - South Bay Impact	Full Service Partnership Assertive Community Treatment team and recovery services program will use a "Housing First" approach	Ensure clients are provided access to good quality housing in the South Region of San Diego County	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnoses of substance abuse	• Mental health rehabilitation Treatment and recovery services for clients with substance use disorder • Integrated case management services with substance use disorder treatment and recovery services • Supportive housing component	South Bay IMPACT (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 934-5770	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	POFA Homeless Project South - South Bay IMPACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	100 Homeless Project-City of San Diego (Central)-Action Central	The 100 Homeless Project is a collaborative effort between the County of San Diego and San Diego Housing Commission which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Integrate wrap-around services with accessible housing that supports the homeless population	Homeless Transition Age Youth, Adults/Older Adults who have a serious mental illness and may have a co-occurring diagnosis of substance use disorder	• Medication management and monitoring Individual therapy • Outpatient substance use disorder treatment • Intensive case management, Employment support • Peer counseling • Supportive housing component	Mental Health Systems Inc. (MHS) /dba TURN BHS ACTION Central 6244 El Cajon Blvd., Suite 15-18 San Diego, CA 92115 (858) 380-4676	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	100 Homeless Project-City of San Diego (Central)-Action Central-Housing						

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Project-Based Subsidy Program for Homeless - Safe Haven AB2304 - C-HRT Safe Haven	Residential transitional housing program that provides supportive services for those who are experiencing homelessness and have a serious mental illness. The C-HRT services are for individuals experiencing homelessness and have a substance use conditions.	Provide residential support, crisis intervention, and transitional housing services to clients experiencing homelessness who are enrolled in Assertive Community Treatment (ACT) services. C-HRT clients are to be serviced by the C-HRT program.	Adults/Older Adults with a serious mental illness or substance use conditions who are experiencing homelessness	• Transitional housing for eligible individuals • Provide food • Case management	Uptown Safe Haven 2822 5th Ave. San Diego, CA 92103 C-HRT Safe Haven 3690 Couts Street, San Diego, CA 92110 (858) 828-6857 (619) 294-7013	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Transitional Residential and Adult Residential Facility	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility. Program provides transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co-occurring disorders.	Provide transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co-occurring disorders.	Adults eighteen (18) years of age or older, with primary serious mental illness diagnosis	• Functional adaptation skills training; • Integrated co-occurring disorder services; • Wellness Recovery Action Plan; • Cognitive Behavioral Therapy and Dialectical Behavioral Therapy; • Problem solving • Independent living skills	Crestwood Behavioral Health, Inc. 5550 University Ave, Suite A San Diego, Ca 92105 (619) 481-5447	All
CSS	TAOA-FSP	North Coastal Mental Health Center and Vista Clinic	Vista/North Coastal TAY	BPSR recovery centers provide a Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) that are Short-Doyle Medi-Cal certified Mental Health Clinics in the North Coastal Region to serve residents of San Diego age 18+ who have serious mental illness (SMI) including those who may have co-occurring substance use.	The goal of the program is to provide integrated behavioral health treatment and rehabilitation services and recovery services to TAY age 18-25, Adult (age 26-59) and older adults (age 60+) who are low income or Medi-Cal eligible who have SMI (including those with co-occurring substance use).	Adults, Older Adults, TAY (age 18-25)	• Urgent Walk-In • Transitional Age Youth Services • Older Adult Services • Supported Employment (SE) • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Mobile Outreach • Weekend capability • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues	Mental Health Systems, Inc. (MHS)/TURN BHS 1701 Mission Avenue Ste. 230 Oceanside, CA 92058 760-227-1490	5
CSS	TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Safe Connection Program	NHA Safe Connections delivers SC/MC certified Care Coordination/Short-term intensive case management services.	Provides Short-Doyle/Medi-Cal-certified care coordination and short-term intensive clinical case management services for clients with serious mental illness who have had high service use	Adults 18 years of age and older who are eligible for Medi-Cal funded services or are indigent, have a serious mental illness (including those with co-occurring substance use), and reside in San Diego County.	• Provide care coordination/short-term intensive clinical case management. • Connect clients with appropriate behavioral health services and short term housing if the client is homeless	Safe Connections Neighborhood House Association 286 Euclid Ave. Ste. 104 San Diego, CA 92114 (858) 285-0979	4
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Case Management	South Region (Northern Area) strengths-based case management	Provide strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental clinic • Strengths-based case management	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661	1
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Maria Sardinas WRC SBCM	South Region (Southern Area) strengths-based case management	Provide strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Transition Age Youth population and Probation-funded AB 109 component	• Outpatient mental clinic • Strengths-based case management	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
CSS	TAOA-OE	Countywide Homeless Outreach Program	Countywide Homeless Outreach Program	The program conducts outreach and engages persons 18 and older with serious mental illness and/or substance use conditions who are unsheltered to provide a behavioral health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	To assist persons experiencing homelessness by connecting them with housing, improving health and quality of life, and connection to community resources.	Persons served will be adults/older adults age 18 or older, with serious mental illness and/or substance use conditions and are homeless	• Provides behavioral health screening and short term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	PATH San Diego's Connections Housing 1250 Sixth Ave., San Diego, CA 92101 (619) 810-8600	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Casa De Oro Residential Care Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	Anthem Compassionate Care LLC 3602 S. Cordoba Ave Spring Valley, CA, 91977 (619) 303-3717	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Carroll's Residential Care Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	Carroll's Residential Care 655 S. Mollison Street El Cajon, CA, 92020 (619) 444-3181	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Fancor Guest Home Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will 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	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-SD	Augmented Services Program (ASP)	Orlando Residential Care Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	Olando Guest Home 297-299 Orlando Street El Cajon, CA, 92021 (619) 444-9411	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Rancho Digius - Enhanced Augmented Services Program (EASP)	Enhanced Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	Rancho Digius 2445 Broadway Ave San Diego, CA, 92102 (619) 468-5700	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Carroll's Community Care Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will 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	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	Casa El Cajon 306 Shady Lane El Cajon, CA, 92021 (619) 440-1335	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Augmented Services Program (ASP)	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	TBD	All
CSS	TAOA-SD	Behavioral Health Assessors	Pilot Project for Lemon Grove Family Resource Center (FRC) - 2 Clinicans (non-County Staff)	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long term vocational support	Provide transitional services to support youth to be released from detention	At risk African-American and Latino citizens who are incarcerated adults or Transition Age Youth at designated detention facilities and will be released in San Diego County	• Advocacy, assessment, engagement, and resource connection	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 207 San Diego, CA 92114 (619) 766-5994	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	North Central Region BPSR WRC (Douglas Young clinic)	North Central Region Adults Region Adults/Older Adults Bio-Psychosocial Rehabilitation Wellness Recovery Center	Increase the number of Transition Age Youth with serious mental illness receiving integrated, culturally specific mental health services countywide	Adults/Older Adults who have a serious mental illness, including those with co-occurring substance use disorder, and Medi-Cal eligible or indigent	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support	Community Research Foundation (CRF) - Douglas Young Clinic 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	3
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	BPSR Wellness Recovery Center	Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, and case management services.	Client access to timely care, retention in treatment, reduction of substance use relapse, reduction in justice involvement, and improvement in quality of life	TAY age 18-25, Adults aged 26-59, and Older Adults age 60+ who are low-income or Medi-Cal eligible with substance use disorder, including co-occurring mental health	Culturally appropriate outreach, engagement, assessment, case management/brokerage, rehabilitation, crisis intervention, medication, therapy, mobile outreach	Healing Oaks Clinic 286 Euclid Ave. Suites 101,102, and 304 San Diego, CA 92114 (619) 266-2111	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Counseling & Treatment Center (CTC - AOA & TA BPSR & Geriatric)	Central Region Bio-Psychosocial Rehabilitation Services	Outpatient Mental Health treatment.	BPSR and walk-in services to adults 18 years of age or older who have SMI including those with co-occurring substance use disorders and eligible for Medi-Cal funded services or are indigent.	Individual and group counseling, and medication managment.	CTC Mid-City 5348 University Avenue, Suite 101, San Diego, CA 92105 (619) 229-2999 CTC Serra Mesa 8745 Aero Drive, #330 San Diego, CA 92123 (858) 268-4933	3 & 4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Promise Wellness Center	Outpatient mental health clinic that serves residents of central San Diego age 18+ who have a serious mental illness (SMI), including those who may have a co-occurring substance use.	Provide integrated mental health, rehabilitation and recovery services to improve mental health and quality of life in the community	Adults, older adults and TAY 18 years of age and older who have a serious mental illness (including those with co-occurring substance use conditions,) and who are Medi-Cal beneficiaries, eligible for Medi-Cal funded services or are indigent.	Culturally appropriate outreach, engagement, assessment, case management/brokerage, rehabilitation, crisis intervention, medication, therapy and mobile outreach	Union of Pan Asian Communities (UPAC) Main site 995 Gateway Center San Diego, CA 92102 Satellite Site: 1035 25th Street San Diego, CA 92102 (619) 232-6454 Satellite Site 286 Euclid Avenue, Suite 102 San Diego CA 92114	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	BPSR for Central/North Central for Latino & TAY (Alianza)	Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, and case management services.	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge awareness or awareness of available services	Adult/Older Adults individuals who have serious mental illness/co-occurring disorder and are eligible for Medi-Cal or are indigent	• Bio-psychosocial rehabilitation wellness recovery center • Outpatient treatment, case management/brokerage, and peer support • Rehabilitative, recovery, and vocational services and supports	MHS Inc.TURN BHS Alianza Wellness Center 5555 Reservoir Dr. Ste. #204-A San Diego, CA 92120 (619) 822-1800	4

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Central Region BPSR WRC-Areta Crowell (ACC) Housing	Bio-Psychosocial Rehabilitation Wellness Recovery Center provides urgent walk-in triage, assessment, treatment planning, individual and group treatment/psychotherapy, medication prescription, and support, case management/brokerage, crisis intervention, care coordination, co-occurring substance use services, peer and family support and engagement, and rehabilitative and recovery activities.	The goal is to increase access to unserved and underserved individuals and families by reducing disparities in the service system; Improve both access to and mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Transitional Age Youth, Adult and Older Adult who have a serious mental illness including those who may have a co-occurring substance use disorder living in zip codes: 92101, 92102, 92103, 92104, 92105, 92113, 92114, 92115, 92116, 92134, 92136, 92139, and 92182	SD/MC-Certified Outpatient Mental Health Clinic providing treatment, rehabilitation, and recovery services to transitional age youth, adult and older adult who have serious mental illness. Services provided at a Bio-Psychosocial Rehabilitation Wellness Recovery Center with Supported Housing, Supported Employment, and Mobile Outreach services	Areta Crowell Wellness Recovery Center 1963 4th Ave. San Diego, CA 92101 (619) 233-3432	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Central Region Urgent Walk-In Program (AKA: Jane Westin Center)	Urgent Walk-In Services for Mental Health Evaluation	Provide short-termed services to include mental health evaluation, psychiatric consultation, and linkage in the community to assist clients on their path to recovery	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder	Mental Health and substance abuse recovery services including, assessment, urgent walk-in services, medication support, case management/linkage, and crisis intervention.	Jane Westin Center 1045 9th Ave San Diego, CA 92101 (619) 235-2600 ext. 201	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Bio-Psychosocial Rehabilitation (BPSR) (East - Heartland)	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery service	Provide outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery • Probation-funded AB 109 component	Community Research Foundation (CRF) East Region Heartland Center 460 North Magnolia Ave., Suite 110 El Cajon, CA 92020 (619) 440-5133	2
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Heartland Center-East Region BPSR	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery service	Provide outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery • Probation-funded AB 109 component	Community Research Foundation (CRF) East Region Heartland Center 460 North Magnolia Ave., Suite 110 El Cajon, CA 92020 (619) 440-5133	2
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Maria Sardinas WRC BPSR	South Region (Northern Area) BPSR Wellness Recovery Center that is Short-Doyle/Medi-Cal-Certified (SD/MC) outpatient mental health center and Strengths-Based Case Management	Provide outpatient mental health services and 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. Adult, older adult, and transitional age youth population	• Outpatient mental clinic • Strengths-based case management • Walk-in Services	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	South Bay Guidance Center BPSR-South Region	South Region (Northern Area) BPSR Wellness Recovery Center that is Short-Doyle/Medi-Cal-Certified (SD/MC) outpatient mental health center and Strengths-Based Case Management	Provide outpatient mental health services and 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. Adult, older adult, and transitional age youth population	• Outpatient mental clinic • Strengths-based case management • Walk-in Services	South Bay Guidance Center 1196 3rd Ave Chula Vista, CA 91911 (619) 427-4661	1
CSS	TAOA-SD	Clubhouse	Adult/Older Adult Mental Health Clubhouse/SSI Advocate Services	Member-operated, Clubhouse International Accredited Clubhouse Program in the Central Region for adults/older adults ages 18 and older with a serious mental illness (SMI) including those who may have a co-occurring substance use disorder. The program provides rehabilitative, recovery, health and vocational services and support to the target population. The Warm Line is an essential peer support service for persons recovering from mental illness who are living in the community by providing support, understanding, information, and referrals.	Overall goals of this program include: member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Underserved adults/older adults located in the Central-Downtown Region with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, or are indigent, including those with co-occurring substance use. The persons may have been previously unable to work, and are interested in improving their social, healthy living and vocational skill sets.	• Provides rehabilitative, recovery, health and vocational services and supports • Supplemental Security Income (SSI) application and advocacy services.	The Meeting Place 2553 State St. Ste 101 San Diego, CA 92101 (619) 294-9582	4
CSS	TAOA-SD	Clubhouse	Escondido Clubhouse (North Inland)	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems, Inc. (MHS) 474 W. Vermont Ave., Suite 105 Escondido, CA 92025 (760) 737-7125	3
CSS	TAOA-SD	Clubhouse	Mariposa Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems (MHS), Inc. 1701 Mission Ave, Suite 120 Oceanside, CA 92058 (760) 439-2769	5
CSS	TAOA-SD	Clubhouse	Connection 2 Community Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members. In addition, the clubhouse provides street outreach to engage homeless adults with serious mental illness, including veterans, who may also have co-occurring substance use disorder	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Homeless Adults/Older Adults who have a serious mental illness; Services are in Central Region with an emphasis in downtown San Diego	• Group counseling Social support • Employment and education services • Support access to medical, psychiatric, and other services	National Alliance on Mental Illness (NAMI) San Diego C2C Clubhouse 101 16th Street San Diego, CA 92101 (619) 776-8605	4
CSS	TAOA-SD	Clubhouse	East Wind Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to monolingual and/or limited English proficient Asian/Pacific Islander Adult members who have a serious mental illness, including those who may have a co-occuring substance use disorder.	• Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness. • 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	• 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 • Group counseling • Social support • Employment and education services • Case management • Mobile outreach	UPAC East Wind Clubhouse 8745 Aero Dr., Suite 330 San Diego, CA 92123 (858) 268-4933	4

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-SD	Clubhouse	Adult Peer Support Line (Warm Line)	A non-crisis telephone and live chat service	Promote stability and reduce problematic situations that may lead to a crisis. Provide information on community resources, training and employment opportunites.	Adults 18 and older who are in recovery from a mental illness and who are low income, indigent, Medi-Cal beneficiaries, or Medi-Cal eligible.	• A telephone and live chat service to provide peer support, information, resources, referrals, and non-crisis intervention	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6590	All
CSS	TAOA-SD	Clubhouse	East Corner Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serous mental illness	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	East Corner Clubhouse 1060 Estes St., #104 El Cajon, CA 92020 (619) 631-0441	2
CSS	TAOA-SD	Clubhouse	PCS Clubhouse Oasis Program	To provide mental health-related recovery group counseling, social support services and employment development to transition age youth members	Member-driven center that assists to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Transition Age Youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	• Provides clubhouse services to transition age youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	Pathways Community Services 3330 Market St. #A San Diego, CA 92102 (858) 300-0470	All
CSS	TAOA-SD	Clubhouse	NAMI SD - Mental Health Clubhouse in Central Region	Provides mental health-related recovery group counseling, social support services and employment development to members	Member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Adults/Older Adults 18 years and older who have a serious mental illness and who are eligible for Medi-Cal funded services or are indigent, including those with co-occurring substance use disorders	• Provides rehabilitation services • Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Casa del Centro Clubhouse - NAMI San Diego 2754 Imperial Ave San Diego, CA 92102 (619) 951-9007	1
CSS	TAOA-SD	Consumer Advocacy	Consumer Advocacy	Recovery-oriented services provided to all BHS service recipients and their families, who have experience with their own behavioral health conditions and recovery process, and/or who are seeking to or are already working or volunteering within the County's Behavioral Health System of Care. In addition, collective consumer voice obtains consumer feedback and elevates to the BHS continuum of care	Intent of improving services delivery for consumers receiving services in the Behavioral Health system of care and to create a Trauma Informed System of Care to minimize re-traumatization of consumers who continue to receive services in San Diego's Behavioral Health System	All BHS service recipients and their families, including Transition Age Youth (TAY), Adult, and Older Adults	• Recovery-oriented services which include advocacy training and peer support for persons and family members	National Alliance on Mental Illness (NAMI) San Diego 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	4
CSS	TAOA-SD	Crisis Stabilization - East Region	Crisis Stabilization and Expanded Recovery Bridge Center – East Region	Twenty-four (24) hour, seven (7) days a week community-based Crisis Stabilization Unit (CSU) in the East Region of the County, Health and Human Services Agency (HHSA) for adult and older adults, including individuals who are Medi-Cal beneficiaries, indigent and/or underserved, and 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 alcohol and other drug-induced conditions. The Expanded Recovery Bridge Center is space for public inebriates or intoxicated individuals dropped off by health, safety, and law enforcement agencies with inebriated individuals to be kept a minimum of four (4) hours for sobering purposes in lieu of incarceration.	CSU: Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting. ERBC: To provide safe, alcohol and other drug-free sobering services to adults identified as intoxicated by law enforcement and/or adults with symptoms of intoxication referred by health, safety and law enforcement agencies	Transition Aged Youth 18-25 years, 25-59 years and older adults 60 years and up who have SMI including those with co-occurring substance use, eligible for Medi-Cal funded services or who are indigent. Also voluntary clients and those on WI 5150 hold who are experiencing a pyschiatric crisis referred by health, safety, and law enforcement agencies in the East County region.	• Rapid access to mental health evaluation and assessment, crisis intervention, medication, collateral, care coordination and disposition planning.	TBD	2
CSS	TAOA-SD	Crisis Stabilization - North Coastal Oceanside	Crisis Stabilization Unit North Region	Crisis Stabilization Unit 24 hours/7days a week for adult and older adults, including individuals who are Medi-Cal beneficiaries, indigent and/or underserved, and 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 alcohol and other drug-induced problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting. CSU services shall last less than 24 hours (23.59 hours).	Services provided o transition aged youth (TAY) 18-25 years, 25-59 years and older adults aged 60 years and up, who have a serious mental illness including those with co-occurring substance use and who are eligible for Medi-Cal funded services or who are indigent Includes voluntary clients and those on WI 5150 hold who are experiencing a psychiatric crisis of such magnitude that it would place the health or safety of the individual or others.	• Psychiatric assessment • Transfer to inpatient services • Physical health assessment • Crisis intervention • Medication management • Linkage and care coordination • Transportation to short-term housing • Flex funds	Exodus Recovery, Inc. 1701 Mission Ave, Ste 130 Oceanside, CA 92058 Main: (760) 305-4848 Fax: (760) 305-4845	5
CSS	TAOA-SD	Crisis Stabilization - North Coastal Vista	North Coastal CSU	• Provide Telepsych prescriber services on an on-demand basis • Provide 24/7 crisis stabilization services to individuals experiencing a psychiatric emergency	• Outpatient psychiatric prescriber services for children, and adult mental health consumers utilizing Telehealth practices and technology • Reducing the severity of a person's level of distress and/or need for a higher level of care	• WIAC and CSU: Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder • Telehealth: all ages	• Telehealth prescriber services • Crisis stabilization services	Vista Walk In Assessment Center 524 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5
CSS	TAOA-SD	Crisis Stabilization - North Inland	Crisis Stabilization Unit North Region	Crisis Stabilization Unit in the North Inland Region for San Diego County residents who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting.	Voluntary and involuntary adults with a serious mental illness	• Provide a twenty-four hour, seven days a week hospital-based Crisis Stabilization Unit (CSU) for adult and older adult Medi-Cal beneficiaries.	Palomar Health 2185 Citracado Parkway Escondido, CA 92029 (760) 480-7901	3, 5

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CSS	TAOA-SD	Crisis Stabilization - South	Crisis Stabilization South Paradise Valley	South Region 24-hour hospital based crisis stabilization unit for Adults who are experiencing a psychiatric emergency.	Impact unnecessary and lengthy involuntary inpatient treatment, as well as promote care in voluntary recovery oriented treatment settings.	Voluntary and involuntary adults and older adults with a serious mental illness.	• 24-hour, seven days a week, hospital-based crisis stabilization as an alternative to emergency room services. • Behavioral Health Assessments • Medication management • Case management • Linkage to community services	Prime Health Paradise Valley Bayview Crisis Stabilization Unit 330 Moss Street Chula Vista, Ca. 91911 (619) 426-6310	1
CSS	TAOA-SD	Faith Based Services	Faith Based Wellness and Mental Health In-Reach Ministry (Formerly INN-13 Faith Based Initiative)	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life. The Faith-Based Wellness and Mental Health In-Reach Ministry will provide support services consistent with pastoral counseling and the individual's faith in addition to information, linkage and education about community-based resources.	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 209 San Diego, CA 92114 (619) 737-2639	All
CSS	TAOA-SD	Faith Based Services	Faith Based Behavioral Health Training and Education Academy & Ccommunity Education (Formerly INN-13 Faith Based Initiative)	Provides training and education to FBBHEA participants using the developed curriculum for both faith leaders and behavioral health providers. The program outreaches, engages, and provides educational opportunities for faith based leaders and behavioral health providers to participate in FBBHEA combined trainings. This includes creating educational materials to address faith/spirituality principles and values, wellness, behavioral health conditions, and resource information to the African-American and Latino communities in designated regions.	Increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health. The FBBHEA and its community education trainings will facilitate behavioral health awareness and connection to resources within their community. Identify Faith-Based and Behavioral Health Champions (faith leaders and behavioral health professionals who have successfully completed FBBHEA), who together provide Community Educational Presentations. These champions form a Cadre of Facilitator Trainers within the HHSA North Coastal and North Inland Regions.	Faith-based leaders, behavioral health providers, provide resource information to African American and Latino communities in designated regions. Faith-based organizations, churches, synagogue, temples, mosques and other places of worship, to support them and establish a ministry or group, designed and created by its members, to assist their membership in the area of behavioral health.	Faith-based behavioral health training and community education	Interfaith Community Services, Inc. 613 W. Valley Parkway Escondido, CA 92025 (760) 204-2025	3, 5
CSS	TAOA-SD	Family Education	Family Mental Health Education & Services	Culturally appropriate outreach and engagement for the purpose of increasing access to mental health services	Provide education and support that is built around goals and tools to help family members and friends understand, cope with, and respond to issues that arise due to mental illness, and shall promote the natural supports of family and friends' encouragement on recovery and resiliency	Family members and friends of persons with behavioral health conditions	A series of educational classes presented by staff and/or family members using an established family education curriculum to provide education and support for persons who have relatives or close friends with behavioral health issues	Central Region St. Timothy's Lutheran Church 2602 Reo Drive San Diego, CA 92139 New Creation Church 3115 Altadena Ave. San Diego, CA 92105 North Central La Jolla Presbyterian Church 7715 Draper Ave. La Jolla, CA 92037 The Rock Church at Liberty Station 2277 Rosecrans St. San Diego, CA 92106 St. Gregory the Great Catholic Church 11451 Blue Cypress Drive San Diego, CA 92131 North Coastal: North Coast Calvary Church 1130 Poinsettia Lane Carlsbad, CA 92011	All
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team (IHOT)	IHOT provides mobile in-home outreach teams and engagement services to individuals with Serious Mental Illness (SMI) who are reluctant to seek outpatient mental health services and to their family members or caretakers.	The goal of IHOT is to reduce the effects of untreated mental illness in individuals with Serious Mental Illness (SMI), increase family member satisfaction with the mental health system of care while protecting public safety.	Adults/Older Adults 18 years of age and older reluctant to seek outpatient mental health services and to their family members	IHOT shall provide in-home assessment, crisis intervention, short term case management and peer and family/care-taker support services, psycho-education, linkage to outpatient mental health care, rehabilitation, recovery and other services to individuals with SMI, and their family or caretakers, as necessary. IHOT outreach and engagement program shall facilitate follow up services that may include outpatient specialty mental health services, crisis intervention, acute care, alternatives to psychiatric hospitalization, conservatorship and case management services.	Telecare Corporation - IHOT 1080 Marina Village Pkwy,. Suite 100 Alameda, CA 94501 (619) 961-2120	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-SD	Inpatient and Residential Advocacy Services	Patient Advocacy Service	Patient Advocacy Services for mental health clients will be expanded to County-Identified Skilled Nursing Facilities	Provide on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities. Expands services for County-Appointed Patient Advocate	Children, Transition Age Youth, Adults/Older Adults	• Provides inpatient advocacy services for adults and children/adolescents receiving mental health services in any covered 24-hour facility • Provides client representation at legal proceedings where denial of client rights are concerned • Handles client complaints and grievances for clients in these facilities	Jewish Family Service 8788 Balboa Ave. San Diego, CA 92123 (619) 282-1134	All
CSS	TAOA-SD	Institutional Case Mgmt (ICM) - Older Adults	Agewise Supported Housing	Strengths-Based Case Management, and Institutional Case Management for Older Adults	Provide SBCM and ICM services to adults over age 60 who suffer from serious mental illness and who may have a co-occurring substance use disorder. ICM population is on Public Conservatorship.	Older Adults (60+ y/o). ICM population is 60+ y/o and on Public Conservatorship	• Strengths-Based Case Management and Institutional Case Management	Telecare Corporation 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All
CSS	TAOA-SD	Justice System Discharge Planning	Central Region Inreach (Project Enable) Jail Discharge Planning	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 207 San Diego, CA 92114 (619) 766-5994	All
CSS	TAOA-SD	Mental Health Advocacy Services	Adult SSI Advocacy	Supplemental Security Income Advocacy services. Responsible for the submission of applications to the Social Security Administration and further follow-up as needed	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC) (Vista)	BPSR recovery centers provide a Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) that are Short-Doyle Medi-Cal certified Mental Health Clinics in the North Coastal Region to serve residents of San Diego age 18+ who have serious mental illness (SMI) including those who may have co-occurring substance use.	The goal of the program is to provide integrated behavioral health treatment and rehabilitation services and recovery services to TAY age 18-25, Adult (age 26-59) and older adults (age 60+) who are low income or Medi-Cal eligible who have SMI (including those with co-occurring substance use).	Adults, Older Adults, TAY (age 18-25)	• Urgent Walk-In • Transitional Age Youth Services • Older Adult Services • Supported Employment (SE) • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Mobile Outreach • Weekend capability • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues	Mental Health Systems, Inc. (MHS)/TURN BHS 550 West Vista Way Ste. 407 Vista, CA 92083 760-758-1092	5
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	North Coastal Mental Health Center (N. Coastal MHC)	BPSR recovery centers provide a Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) that are Short-Doyle Medi-Cal certified Mental Health Clinics in the North Coastal Region to serve residents of San Diego age 18+ who have serious mental illness (SMI) including those who may have co-occurring substance use.	The goal of the program is to provide integrated behavioral health treatment and rehabilitation services and recovery services to TAY age 18-25, Adult (age 26-59) and older adults (age 60+) who are low income or Medi-Cal eligible who have SMI (including those with co-occurring substance use).	Adults, Older Adults, TAY (age 18-25)	• Urgent Walk-In • Transitional Age Youth Services • Older Adult Services • Supported Employment (SE) • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Mobile Outreach • Weekend capability • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues	Mental Health Systems, Inc. (MHS)/TURN BHS 1701 Mission Avenue Ste. 230 Oceanside, CA 92058 760-227-1490	5
CSS	TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Clinic	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	Mental Health Systems, Inc. (MHS) 125 W. Mission Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Escondido, CA 92025 (760) 480-2255 Kinesis North WRC--Ramona 1521 Main St. Ramona, CA 92065 (760) 736-2429 MHS-WRC with MHSA and Satellite North Inland 474 West Vermont Suite 101 Escondido, CA 92025 (760) 480-2255	3
CSS	TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Clinic (Kinesis)						

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-SD	Peer Assisted Support Services	Peer Assisted Support Services (Formerly INN-15 Peer Assisted Transitions)	A culturally competent, recovery-focused Peer Assisted Support Services program for adults with serious mental illness who are not connected to County operated or Contracted Behavioral Health Services (BHS) and present at Behavioral Health Units or Crisis Residential programs in the Central region. The Peer Assisted Support Services program engages with individuals in inpatient or crisis residential programs and continues engagement with these individuals after discharge from these programs to ensure they are connected to BHS. The program provides linkages and a warm handoff to needed mental health, substance use, and social services with the goal of decreasing hospitalization and crisis residential acute care by increasing connections to ongoing behavioral health services.	The goal of the Peer Assisted Support Services project is to increase the depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are unconnected with Mental Health services, Substance Use Disorder services or community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.	Transition Age Youth, Adults/Older Adults with serious mental illness. Adults diagnosed with a serious SMI, including co-occurring Substance Use Disorder and are not currently connected to County Operated Outpatient Clinics or contracted mental health or substance use programs and who are present at the designated 24/7 programs in the Central Region: Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as County designated Crisis Residential facilities.	• Peer specialist coaching • Connecting participants to relevant services	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6586	4
CSS	TAOA-SD	Public Defender - Behavioral Health Assessor	Public Defender - Mental Health Assessor (Case Management) COLA increase based on County Comp Ordinance)	Licensed mental health clinicians will provide discharge planning, care coordination, referral and linkage, and short term case management to persons with a serious mental illness who have been referred by the Court for services	Public Defender Treatment Unit will reduce untreated mental illness by ensuring persons are connected to system of care	Adults 18 years and older with a serious mental illness who are incarcerated or Transition Age Youth at designated detention facilities who will be released in San Diego County	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender 450 B St., Ste 1100 San Diego, CA 92101	All
CSS	TAOA-SD	San Diego Employment Solutions	Employment Solution	Supported employment services and opportunities for Transition Age Youth, Adults and Older Adults with serious mental illness	Increase competitive employment of adults 18 and older who have a serious mental illness and who want to become competitively employed	Adults 18 years and older who have a serious mental illness and need assistance with employment	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness obtain competitive employment • Use a comprehensive approach that is community-based, client and family-driven, and culturally competent	MHS Inc/TURN Behavioral Health Services Employment Solutions 10981 San Diego Mission Rd. # 110 San Diego, CA 92108 (619) 521-9569	All
CSS	TAOA-SD	San Diego Housing Commission	SDHC Admin Home Finder Program	Administrative support for 180 San Diego Housing Commission subsidies	Provide support for housing	Adults 18 years and older who have a serious mental illness and are experiencing homelessness in the city of San Diego.	• Housing Vouchers/subsidies	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400	1, 2, 3, 4
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Halycon	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Halcyon Crisis Center 1664 Broadway El Cajon, CA 92021 (619) 579-8685	2
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Jary Barretto	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Jary Barreto Crisis Center 2865 Logan Avenue San Diego, CA 92113 (619) 232-4357	1
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START New Nueva Vista	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary.Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF New Vistas Crisis Center 734 10th Avenue San Diego, CA 92101 (619) 239-4663	1
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Turning Point	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Turning Point Crisis Center 1738 South Tremont Street Oceanside, CA 92054 (760) 439-2800	5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Vista Balboa	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Vista Balboa Crisis Center 545 Laurel Street San Diego, CA 92101 (619) 233-4399	4
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Del Sur Crisis Center	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Del Sur Center 892 27th Street San Diego, CA 92154 (619) 575-4687	1
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Interfaith Community Services 550 W. Washington St., Suite B Escondido, CA 92025 (760) 489-6380	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Residential transitional housing program that provides supportive services for adults who are experiencing homelessness and have a serious mental illness.	• The provision of housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. • Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	United Homes 515 North Horne St. Oceanside, CA 92054 (760) 612-5980	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-term & Bridge Housing for Transitional Age Youth (TAY) with serious mental illness or serious emotional disturbance who are experiencing homelessness	The provision of housing and support services to TAY with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients	Transitional Age Youth, 18 to 24 years of age, who have a serious emotional disturbance or a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Emergency shelter and transitional beds • Case Management	Urban Street Angels, Inc. 1404 Fifth Ave San Diego, CA 92101 (619) 415-6616	4
CSS	TAOA-SD	Short-Term Bridge Housing	Short Term Bridge Housing	Residential transitional housing program that provides supportive services for adults who are experiencing homelessness and have a serious mental illness.	• The provision of housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. • Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, age 18+, who have a serious mental illness, and who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Rooted Life 5356 Redding Rd., San Diego, CA 92115 and 5223 East Falls View Drive, San Diego, CA 92115 (619) 357-6472	5
CSS	TAOA-SD	Short-Term Bridge Housing	Short Term Bridge Housing	Residential transitional housing program that provides supportive services for adults who are experiencing homelessness and have a serious mental illness.	• The provision of housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. • Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, age 18+, who have a serious mental illness, and who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	4
CSS	TAOA-SD	Supplemental Security Income (SSI) Advocacy Services	Adult SSI Advocacy	Supplemental Security Income Advocacy services. Responsible for the submission of applications to the Social Security Administration and further follow-up as needed	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
CSS	TAOA-SD	Tenant Peer Support Services	Tenant Peer Support Services (TPSS)	Housing navigation and support for persons with SMI who are experiencing homelessness.	On-going support for clients experiencing homelessness who are connected to permanent supportive housing resources. Services include housing navigation and tenant support services. Includes nonclinical services for MHSA developed units, such as NPLH units.	Adults 18 years and older with serious mental illness who are experiencing homelessness. Small number of families who are accessing family MHSA units will also be served.	• Support identifying and securing safe and affordable housing • Provides flex funds to support resident retention. • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project 3808 El Cajon Boulevard Suite 102 San Diego, CA 92105 (619) 542-1877	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
INN	INN-18	Peripartum Program	Accessible Depression And Anxiety Peripartum Treatment (ADAPT)	Identifies at-risk peripartum women for engagement and provides services for peripartum women and families	Reduce incidence and impact of postpartum depression and anxiety	Peripartum women and partners, especially in underserved communities	• Outreach and engagement through public health nurses • Trauma-infromed Interventions to treat and reduce negative consequences of postpartum depression and anxiety.	Vista Hill Foundation 6070 Mission Gorge Road San Diego, CA 92120 (858) 514-5100	All
INN	INN-19	Telemental Health	BHConnect	Outpatient mental health services including crisis intervention, individual and family therapy, individual rehab,case management services utilizing tele-therapy/technolgy platform for children, youth and adults discharging from an emergency psychiatric service setting who are unconnected to a mental health provider.	Prevent re-hospitalization and psychiatric emergency services with follow up mental health services for successful connection to mental health treatment following a psychiatric emergency	Children, Transition Age Youth, Adults/Older Adults who have accessed psychiatric emergency services but are unconnected.	Follow-up mental health treatment and stabilization via tele-therapy including; • individual/family treatment • care coordination • case management • rehabilitative services • outreach and engagement	Vista Hill Foundation 8825 Aero Dr., Suite 315 San Diego, CA 92123 (858) 877-0179	All
INN	INN-21	ReST Recuperative Housing	Rest Recuperative Housing	Provides post-institutionalization recuperative residential services, includes wrap-around services, case management, and permanent housing help	Prevent re-institutionalization and homelessness; encourages successful re-integration following institutionalization	Transition Age Youth	• Wrap-around services • Case management • Voluntary residential services • Employment and permanent housing support	Urban Street Angels, Inc. 3304 Idlewild Way San Diego, CA 92117 (619) 255-1842	All
INN	INN-24	Early Psychosis Evaluation and Learning Health Care Network	Statewide Early Psychosis Learning Health Care Network	Provide a collaborative Learning Health Care Network to support quality improvements, consumer engagement and provide use of measurement-based care in early psychosis (EP) programs.	Develop an Early Psychosis LHCN software app to support ongoing collaborative data-driven learning and program development to evaluate the effect of San Diego provider on consumer and program level outcomes.	Individuals served by Pathways Community Services' Kickstart program (contract 552662)	This is a software development contract	University of California, Davis 4701 X St. #1207 Sacramento, CA 95817 (916) 734-3247	All
PEI	CO-03	Integrated Peer & Family Engagement Program	Integrated Peer & Family Engagement Program - Next Steps	Provides comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and/or substance use disorders. Services aim to engage clients by linking them to appropriate treatment and support services spanning the entire continuum of care, including behavioral health and primary care clinics to reduce the need for hospitalizations.	The program assists participants with increases resiliency and self-care, reduced consumption of alcohol and drugs, improved medication adherence, decreased depression and anxiety, reduced problems commonly associated with SUD, and improved mental and physical wellness. The program also links to participants to treatment and other community resources as needed.	Adults 18 years and older	• Walk-in center and services in community clinics and SDCPH • Screening, brief treatment, and referrals and linkages to resources and services in the community	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	DV-03	Community Violence Services - Alliance for Community Empowerment	Community Violence Services (ACE)-Central	Provides trauma informed, community centered, family driven and evidenced based Community Violence Response services, support, referrals and linkages to care countywide	Increase in resilience; increased knowledge of services; increased problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma	Community members including middle-school age youth boys and girls affected by community violence	• Immediate support and assistance, referrals and linkages to care after an incidence of community violence. • Grief counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities (UPAC) 5348 University Ave., Suites 101 and 102 San Diego, CA 92105 (619) 232-6454	All
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Home Start 5005 Texas St., Suite 203 San Diego, CA 92108 (619) 629-0727	2
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	3, 5
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Social Advocates for Youth 8755 Aero Dr., Suite 100 San Diego, CA 92123 (858) 565-4148	4
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	EC-01	Positive Parenting Program (Triple P)	Positive Parenting Program	Provides mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum	Specialized culturally and developmentally appropriate mental health PEI services to promote social and emotional wellness for children and their families	Countywide parents and families; parents and guardians of children enrolled in Head Start, Early Head Start, elementary school and community center locations	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Service 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3000 ext. 3006	All
PEI	FB-01	Early Intervention for Prevention of Psychosis	KickStart	Provides Prevention and Early Intervention (PEI) services for persons who have emerging 'prodromal' symptoms of psychosis	Reduce incidence and severity of mental illness and increase awareness and usage of services	Countywide youth 10 to 25 years old in San Diego County and their families & substantial public component on psychosis	• Prevention through public education • Early intervention, through screening potentially at risk youth • Intensive treatment for youth who are identified as at-risk and their families	Pathways of California Kickstart Program 6160 Mission Gorge Rd., Suite 100 San Diego, CA 92120 (858) 637-3030	All
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides PEI and substance use disorder prevention and treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; North Regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in North County	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides PEI services for Native American Indian/Alaska Native urban youth	Increase community involvement and education through services designed and delivered by Native American communities	At risk and high risk urban American Indian and Alaska Natives children and Transitional Age Youth	• Specialized culturally appropriate prevention and early intervention services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center	San Diego American Indian Health Center 2602 1st Ave., Ste. 105 San Diego, CA 92103 (619) 234-1525	4
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides PEI and substance use disorder prevention and treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in South and East County	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
PEI	OA-01	Elder Multicultural Access & Support Services (EMASS)	Older Adult Prevention and Early Intervention (PEI) Community-Based Program	Provides outreach and support to older adults, especially non-Caucasian/non-English speaking	Reduce ethnic disparities in service access and use. Increases access to care	Multicultural Seniors, refugees, 60 years and older who are at risk of developing mental health problems	• Outreach and education • Referral and linkage • Benefits advocacy • Peer counseling • Transportation services • Home and community based services	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	All
PEI	OA-02	Home Based Services - For Older Adults	Older Adult Prevention and Early Intervention (PEI) Services Homebound Program	Provides outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduces stigma associated with mental health concerns and disparities in access to services	Homebound older adults 60 years and older who are at risk for depression or suicide	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	1, 4, 5
PEI	OA-06	Caregiver Support for Alzheimer & Dementia Patients	Older Adult Prevention and Early Intervention (PEI) - Caregiver Support Services	Provides caregiver education, training, and early intervention services to prevent or decrease symptoms of depression and other mental health issues among caregivers	Reduce incidence of mental health concerns in caregivers of patients that have Alzheimer's and other types of dementia. Improve the quality of well-being for caregivers and families. Provides services to an underserved/unserved population	Adult Caregivers 18 years and older	• Outreach • Information dissemination • Early intervention • Prevention Education	Southern Caregiver Resource Center 891 Kuhn Dr, Ste 200 Chula Vista, CA 91914 (800) 827-1008	All
PEI	PS-01	Breaking Down Barriers (BDB) Initiative	Breaking Down Barriers	Outreach, engagement and community organizing across all communities to reduce the stigma associated with mental illness and improve mental health well-being	Reduce mental health stigma to culturally diverse, unserved and underserved populations	Unserved and underserved populations; Latino; Native American; African; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); African-American	• Outreach and education to reduce mental health stigma to culturally diverse, unserved and underserved populations • Collaboration with community based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Jewish Family Services of San Diego 8804 Balboa Ave San Diego., CA 92123 (858) 637-3000	All
PEI	PS-01	Come Play Outside	Come Play Outside	Offers community-based programming inclusive of Parks After Dark curriculum to support the health and wellness of children, youth, and families.	The program aims to connect participants with outdoor activities within their community to increase pro-social interactions, promoting wellness, positive self-image while emphasizing confidence, respect, and a sense of responsibility.	• Children, youth and their families	• Outreach and engagement • Socialization, pro-social and wellness activities	City of San Diego Parks & Recreation Department 202 C W St. San Diego, Ca 92101 (619) 525.8211	All
PEI	PS-01	Family Peer Support Program	Family Adult Peer Support	Provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes	Family members and friends of psychiatric inpatients	• Resources and support to family and friends visiting loved ones in psychiatric inpatient units in San Diego area • Public education	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	PS-01	Mental Health First Aid	Mental Health First Aid (MHFA)	Mental Health First Aid is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis	Provide county-wide community- based mental health literacy education and training services	Adults/Older Adults who work with youth	• Interactive class that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All
PEI	PS-01	Program Father2Child	ACEs Prevention Parenting Program for Fathers	To provide a best practice parenting program to unserved and underserved fathers that enhances fathering knowledge, skills, and positive attitudes while connecting the relationship between reducing mental health stigma and having a successful fathering relationship with the child(ren).	Goal is to create a greater awareness of the program and change the underserved community by increasing father skills, knowledge, and attitude towards family resiliency.	Adults, Fathers, Mothers, Children and Youth	• Education and outreach • Referrals	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All
PEI	PS-01	Recuperative Services and Support Program for Transitional Age Youth	Just Be You	Short Term Recuperative Services and Supports (up to 120 days) for Transition Age Youth between ages 18-25 who have been diagnosed or are at risk of developing with Severe Mental Illness (SMI), including those who may be experiencing first episode psychosis, and may also have a co-occurring substance use disorder. Program will prioritize services for TAY with the greatest vulnerabilities, including those who are homeless or at risk of homelessness, are unconnected to services, and are repeat utilizers of acute/emergency mental health services. Program provides short-term assistance with Instrumental Activities of Daily Living (ADLs), coordination of transportation for appointments, connection to services for mental health and substance use services, and others.	Improve outcomes of TAY at risk of developing or diagnosed with SMI through engagement and stabilization through recuperative services and connection to ongoing treatment, housing and supportive services. Other goals include employment, education, reduction in stigma associated with their symptoms or mental health condition and increase in knowledge of how to access behavioral health services and housing supports.	Transitional Age Youth (TAY), ages 18-25	• Mental health and psychiatric assessment • Linkages to employment and/or education goals	TBD	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
PEI	PS-01	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	Primary/Secondary Prevention - Suicide Prevention Action Plan (Up 2 Us Media Campaign)	Countywide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increases awareness of available mental health services	Countywide individuals with mental illness; families of individuals with mental illness; general public	• Public media campaign to education and promote mental health awareness • Print, radio, and TV ads • Printed materials	Rescue Agency Public Benefit, LLC 2437 Morena Blvd San Diego, CA 92110 (619) 231-7555	All
PEI	PS-01	Suicide Prevention Action Plan	Suicide Prevention Action Plan	Provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies.	Reduce the number of suicides in San Diego County. Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	General population, mental health service consumers, local planners, and mental health organizations.	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives • Facilitate Suicide Prevention Council and workgroups	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	PS-01	Supported Employment Technical Consultant Services	Supported Employment Technical Consultant Services	Provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Services are coordinated and integrated through BHS to develop new employment resources	Supported Employment TA will develop 5-Year Strategic Plan and implement strategies within BHS programs that include Supported Employment. TA will also operate as sub-committee of the BHS Adult Council.	Service providers, employers, agencies, government organizations, and other stakeholders	• Promote employment opportunities for adults with serious mental illness	San Diego Workforce Partnership, Inc. 9246 Lightwave Ave. #210 San Diego, CA 92123 (619) 228-2900	All
PEI	RC-01	Rural Integrated Behavioral Health and Primary Care Services	SmartCare Integrated	Provides for prevention and early intervention services. Program works in partnerships with various primary care clinics in rural areas and utilizes a Screening, Brief Intervention and Referral to Treatment (SBIRT) model to identify persons at risk for behavioral health issues. Treatment services are strengths-based, time limited and embrace the concepts of resilience and recovery for adults and children with severe emotional disturbance (SED), and their families.	Program staff provide health education and community engagement events, brief behavioral health interventions, psychiatric consultations, case management services, wellness screenings and referrals to treatment.	Children, Transition Age Youth, Adults/Older Adults	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725	All
PEI	RE-01	Independent Living Association (ILA)	Independent Living Association (ILA)	Provide and manage an Independent Living Association and Recovery Residence Association, which are a resource to identify, promote, and develop independent living, build their capacity, and direct those individuals in need of such services to available resources in the community.	Promote the highest quality home environments for adults with severe mental illness and other disabling health conditions. Serve residents that do not need medication oversight, are able to function without supervision, and live independently	Member operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources countywide	• Education and training to member operators and residents. • Website listings • Resources to support clients • Resources to develop their business • Marketing tools • Advocacy support	Community Health Improvement Partners 5059 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-North Coastal	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary 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 elementary schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-Central & North Central	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary 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 elementary schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	3, 4
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-Central Southeastern	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary 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 elementary schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	4
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-East	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary 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 elementary schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Youth Services 3845 Spring Dr. Spring Valley, CA 91977 (619) 258-6877	2
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-South	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary 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 elementary schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-North Inland	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary 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 elementary schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation 1029 N. Broadway Escondido, CA 92026 (760) 489-4126	5
PEI	SA-02	School Based Suicide Prevention & Early Intervention	School Based Suicide Prevention & Early Intervention	Provides school based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth	Reduces suicide ideation, suicides, bullying and the negative impact of suicide in schools. Increases education of community and families.	Middle school, high school, and Transition Age Youth	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600	All
PEI	VF-01	Veterans & Family Outreach Education	Veterans & Family Outreach Education (Courage to Call)	Provides confidential, peer- staffed outreach, education, referral and support services to the Veteran community & families and its service providers	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors and/or stressors. Improves access to mental health and PEI services, information and support	Veterans, active duty military, Reservists, National Guard, and family members	• Education • Peer counseling • Linkage to mental health services • Mental health information • 7/24/365 Support hotline	Mental Health Systems, Inc. (MHS) 9465 Farnham St., Suite 100 San Diego, CA 92123 (858) 573-2600	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISCTRICTS
WET	WET-02	Behavioral Health Training Curriculum (BHTC)	Behavioral Health Training Curriculum (BHETA)	The Behavioral Health Training Curriculum provides training and technical assistance to County and County contracted behavioral health staff on best practices that incorporate principles of trauma informed care, cultural competency, and mental health/substance use co-occurring disorders and primary care/behavioral health integration. Training is provided in all mediums: in-person, eLearning, and webinar.				San Diego State University Research Foundation 5250 Campanile Dr. San Diego CA 92182 (619) 594-1900	All
WET	WET-02	Cultural Competency Academy	Specialized Training Modules (Cultural Competency)	The Cultural Competency Academy (CCA) provides training to BHS and BHS contracted staff with trainings focused on clinical and recovery interventions for multicultural populations. The goal of CCA is to provide awareness, knowledge and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications.				San Diego State University Research Foundation 5250 Campanile Dr. San Diego, CA 92182 (619) 594-1900	All
WET	WET-02	Training and Technical Assistance	Big Why Conference	Provide administrative and fiscal training support services to County of San Diego Health and Human Services, Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop and execute training contracts between RTC and trainers/consultants, coordinate with BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs.				Regional Training Center 6155 Cornerstone Ct., Suite 130 San Diego, CA 92121 (858) 550-0040	All
WET	WET-02	Training and Technical Assistance	Training and Technical Assistance (TTA)						
WET	WET-02	Training and Technical Assistance	We Can't Wait Annual Conference (Early Childhood)						
WET	WET-03	Public Mental Health Academy	Public MH Academy - Academic Counselor	Provide an academic counselor to support student success in the community based public mental health certificate program. This certificate program assists individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be matriculated into an Associates and/or Bachelor Degree program to assist in the career pathway continuum				San Diego Community College District 3375 Camino Del Rio South San Diego, CA 92108 (619) 388-6555	All
WET	WET-04	Community Psychiatry Fellowship	Residency Internship Programs Community Psychiatry Fellowship	Programs are for physicians and public mental health nurse practitioners with one program for adult psychiatry residents and fellows and another program for child and adolescent psychiatry residents and fellows and up to seven public mental health nurse practioners who are studying at local universities. Programs foster the development of leaders in Community Psychiatry and provide exposure to the unique challenges and opportunities, and targeted approaches to ethnically and linguistically diverse populations.				Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All

APPENDIX D

MHSA JUSTICE INVOLVED PROGRAMS

Population Served	*Program Name and Description*	*FY 2023-24 MHSA Three Year Plan Funding**	*MHSA Component*
All Ages	The **Mobile Crisis Response Team (MCRT)** is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care.	$ 8,700,159	CSS
All Ages	The **Psychiatric Emergency Response Team (PERT)** provides mental health consultation, case coordination, linkage to services and limited crisis intervention services for individuals with mental illness who come in contact with law enforcement officers.	$ 10,660,549	CSS
Youth	The **Bridgeways** program is a newly redesigned juvenile justice program that provides comprehensive services to address the behavioral health needs of justice involved youth or youth at risk of justice involvement. The program provides outpatient clinical services, field supportive services, and institutional services with the primary goal of establishing a unified continuum of care that allows for coordination of services within and outside the detention facilities.	$ 560,000	CSS
Youth	The **County of San Diego Juvenile Forensics** team provides mental health and case management services to children and youth in juvenile detention facilities to ensure they are able to successfully reintegrate into the community and to reduce recidivism.	$ 1,100,000	CSS
Youth	**Mobile Adolescent Service Team (MAST)** is an outpatient treatment program that serves children and youth in the community who are involved with the justice system. The program enhancement allows for increased psychiatry coverage.	$ 2,165,000	CSS
Transitional Age Youth	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) program for Transition Age Youth (TAY)** provides services to TAY who are homeless, may have been referred by jail services, are experiencing serious mental illness (SMI), and who may also have a co-occurring substance use disorder.	$ 5,999,968	CSS
Adults	The **Faith Based Wellness and Mental Health Inreach Ministry** program focuses on adults diagnosed with SMI while in jail and also engages individuals with schizophrenia or bipolar disorders to provide spiritual support, wellness education for physical and mental health, and linkages to community- based resources for reintegration into the community.	$ 926,485	CSS
Adults	The **Justice Integrated Full Service Partnership (FSP) Assertive Community Treatment (ACT)** program provides services to homeless adults with a SMI who may also have a co-occurring substance use disorder. Clients served are system involved and have received mental health services while in detention. An array of housing options is provided to enrolled clients. Includes new program rows added to Center Star.	$ 6,268,167	CSS
Adults	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) for Persons with High Service Usage and Persons on Probation** program provides multidisciplinary, wraparound treatment and rehabilitation services, along with housing.	$ 5,197,335	CSS
Adults	The **Collaborative Behavioral Health Court and Assertive Community Treatment** program focuses on adults in the Central Region who are referred by the Court for services as an alternative to custody.	$ 2,874,114	CSS
Adults	The **Public Defender Discharge and Short Term Case Management Service** adds two licensed mental health clinicians to provide discharge planning, care coordination, referral and linkage to services, and short term case management for persons with SMI who have been referred by the Court for services.	$ 240,000	CSS
Adults	**Justice System Discharge Planning**, or Project Enable, provides in-reach services to assist with discharge planning and short-term transition services for clients who are in jail and identified to have SMI, to assist in connecting clients with community-based treatment once released.	$ 1,139,376	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.	$ 600,000	CSS
Adults	The **Behavior Health Assessor** is a program within the Lemon Grove Family Resource Center that provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 250,000	CSS
Adults	The **BH Assessor** is a program for Courts in South and Central Regions the provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 435,000	CSS
Adults	The **Veterans & Family Outreach Education** program, or Courage to Call, is a veteran peer-to-peer support program staffed by veteran peers. The program provides countywide outreach and education to address the mental health conditions that impact veterans, active duty military, reservists, National Guard, and their families (VMRGF), and provides training to service providers of the VMRGF community. This program includes navigator assistance in Veterans' Court for those involved with the justice system	$ 1,408,000	PEI
Grand Total		**$ 48,524,154**	

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

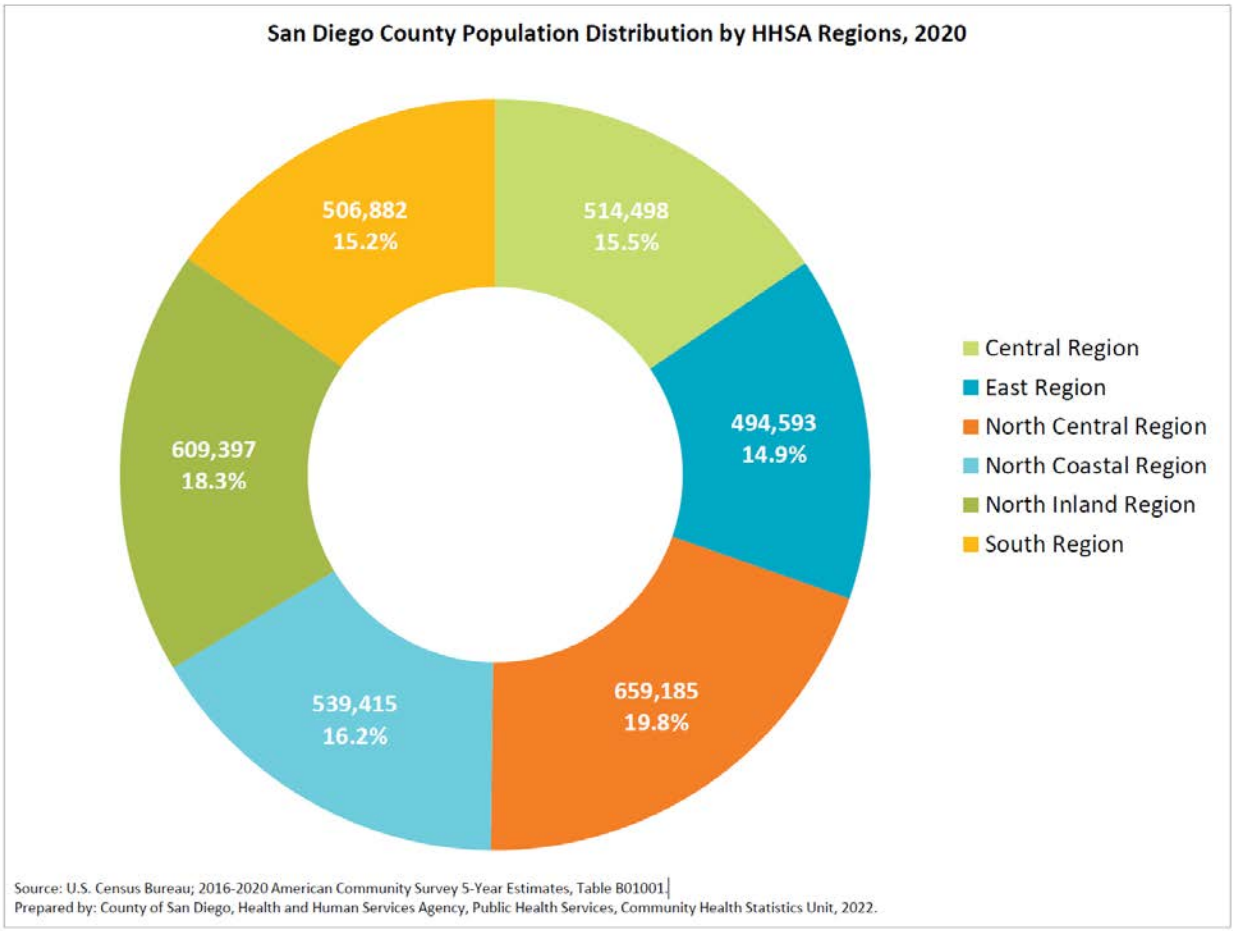
APPENDIX E

COUNTY OF SAN DIEGO DEMOGRAPHICS

POPULATION

HHSA Region	Population	%
Central Region	514,498	15.5%
East Region	494,593	14.9%
North Central Region	659,185	19.8%
North Coastal Region	539,415	16.2%
North Inland Region	609,397	18.3%
South Region	506,882	15.2%
San Diego County	3,323,970	100.0%

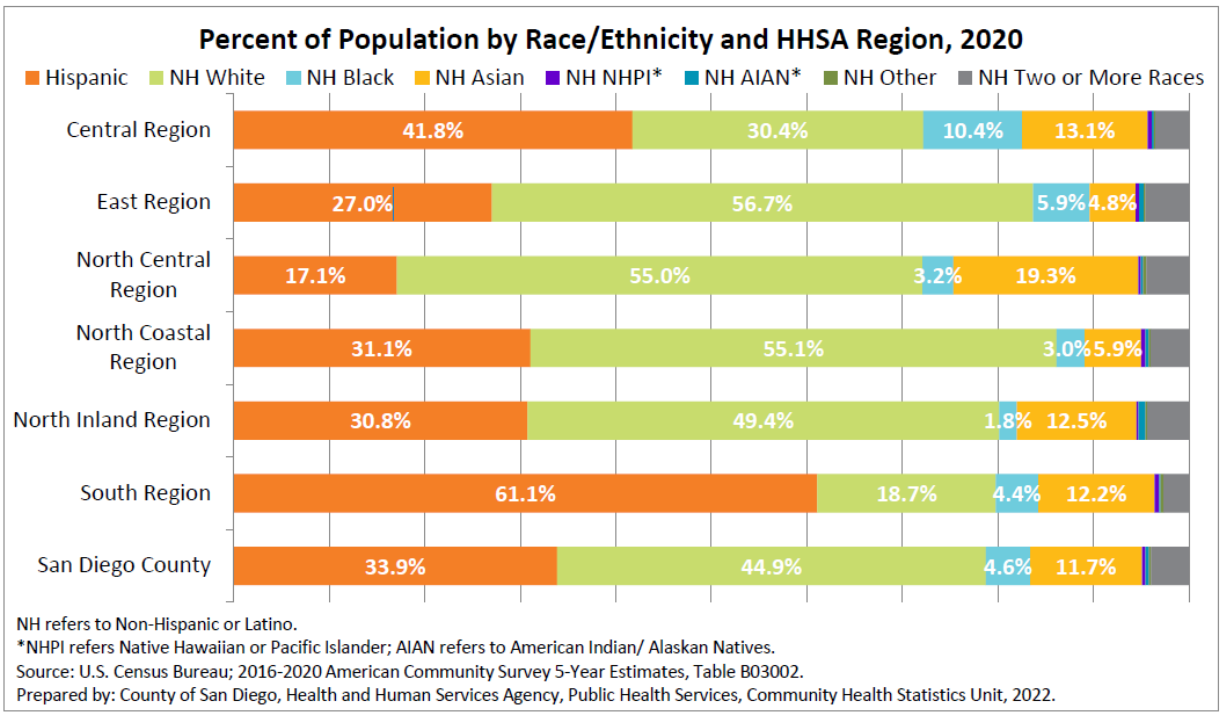
Source: U.S. Census Bureau; 2016-2020 American Community Survey 5-Year Estimates, Table B01001.
Note that percentages may not add up to 100% due to rounding.



RACE/ETHNICITY

HHSA Region	Hispanic	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic Native Hawaiian/ Pacific Islander	Non-Hispanic American Indian/ Alaskan Native	Non-Hispanic Other Race	Non-Hispanic Two or More Races
Central Region	214,923	156,542	53,252	67,502	2,381	1,088	725	18,085
East Region	133,693	280,242	29,186	23,923	1,795	2,412	852	22,490
North Central Region	112,795	362,662	21,251	127,480	1,872	1,602	2,335	29,188
North Coastal Region	167,593	297,080	15,960	31,768	2,594	1,822	1,039	21,559
North Inland Region	187,455	300,990	11,130	76,385	1,409	4,274	1,274	26,480
South Region	309,807	94,649	22,531	61,743	2,457	630	1,646	13,419
San Diego County	1,126,266	1,492,165	153,310	388,801	12,508	11,828	7,871	131,221

Source: U.S. Census Bureau; 2016-2020 American Community Survey 5-Year Estimates, Table B03002.

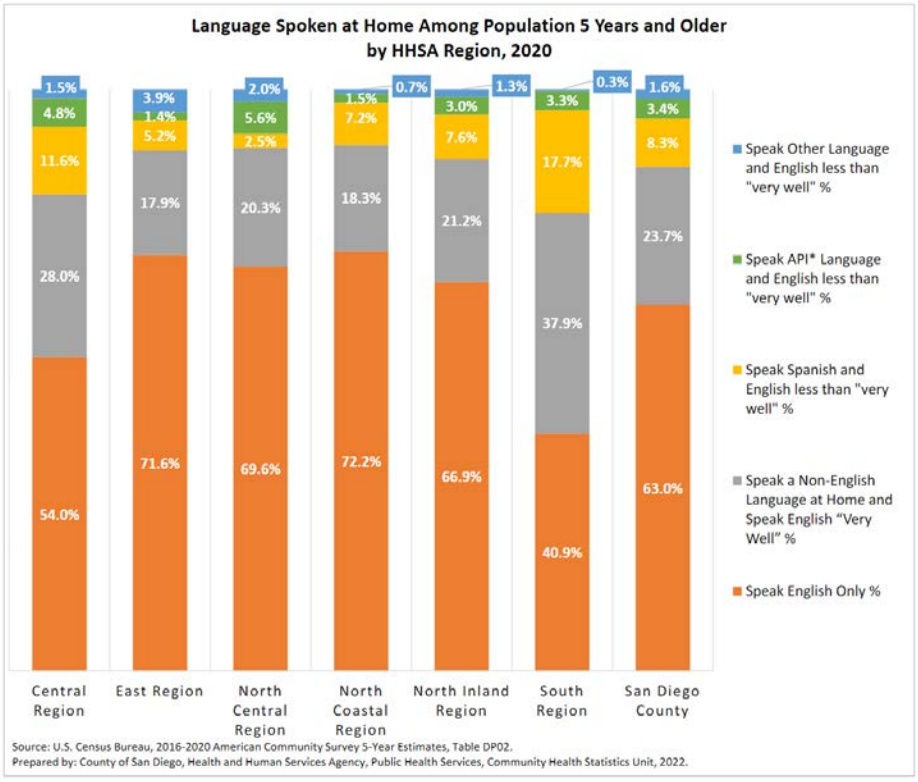


NH refers to Non-Hispanic or Latino.
*NHPI refers Native Hawaiian or Pacific Islander; AIAN refers to American Indian/ Alaskan Natives.
Source: U.S. Census Bureau; 2016-2020 American Community Survey 5-Year Estimates, Table B03002.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2022.

LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH (5 YEARS OLD AND GREATER)

HHSA Region	Population Age 5+	Speak English only	Speak a non-English language at home and English "Very Well"	Speak Spanish and Speak English less than "Very Well"	Speak Asian and Pacific Islander languages and Speak English less than "Very Well"	Speak Other Language and Speak English less than "Very Well"
Central Region	486,493	54.0%	28.0%	11.6%	4.8%	1.5%
East Region	461,541	71.6%	17.9%	5.2%	1.4%	3.9%
North Central Region	621,297	69.6%	20.3%	2.5%	5.6%	2.0%
North Coastal Region	504,575	72.2%	18.3%	7.2%	1.5%	0.7%
North Inland Region	568,479	66.9%	21.2%	7.6%	3.0%	1.3%
South Region	475,831	40.9%	37.9%	17.7%	3.3%	0.3%
San Diego County	3,118,216	63.0%	23.7%	8.3%	3.4%	1.6%

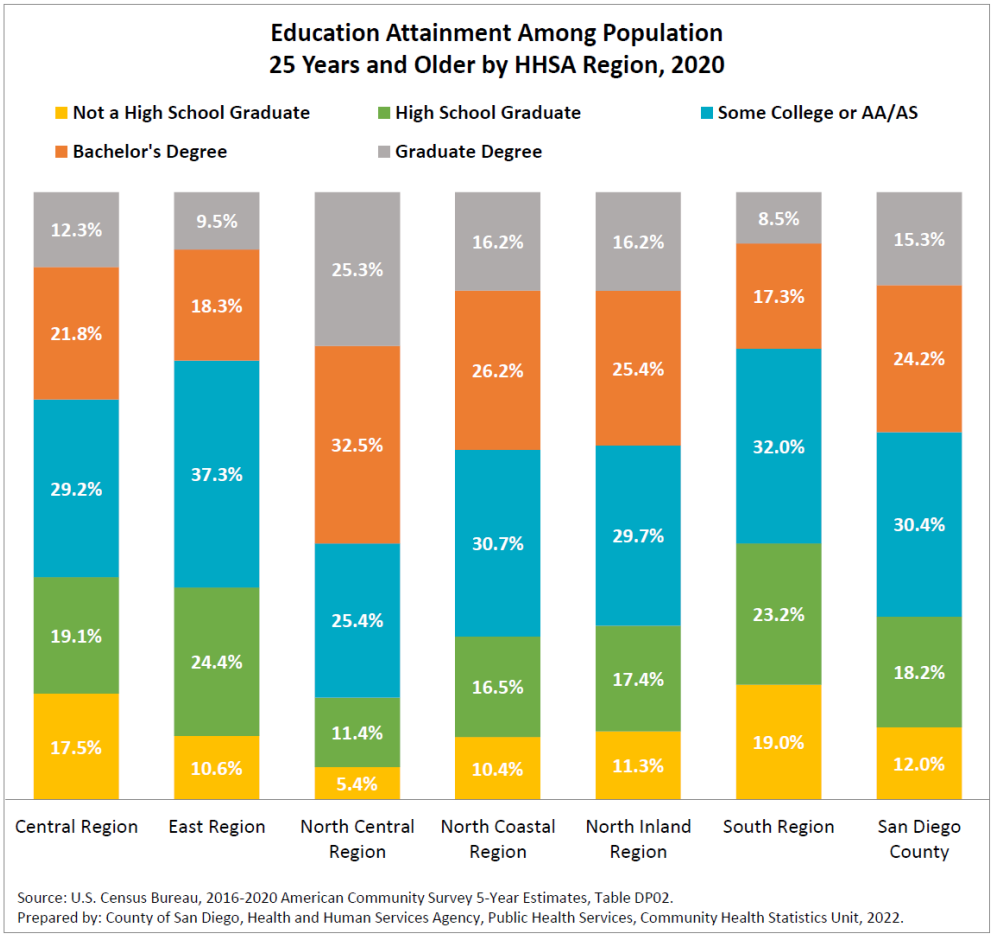
Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.



EDUCATIONAL ATTAINMENT AMONG POPULATION 25 YEARS AND OLDER

HHSA Region	Population Age 25+	Not a High School Graduate	High School Graduate	Some College or AA	Bachelor's Degree	Graduate Degree
Central Region	358,423	17.5%	19.1%	29.2%	21.8%	12.3%
East Region	338,602	10.6%	24.4%	37.3%	18.3%	9.5%
North Central Region	463,595	5.4%	11.4%	25.4%	32.5%	25.3%
North Coastal Region	356,185	10.4%	16.5%	30.7%	26.2%	16.2%
North Inland Region	413,361	11.3%	17.4%	29.7%	25.4%	16.2%
South Region	334,741	19.0%	23.2%	32.0%	17.3%	8.5%
San Diego County	2,264,907	12.0%	18.2%	30.4%	24.2%	15.3%

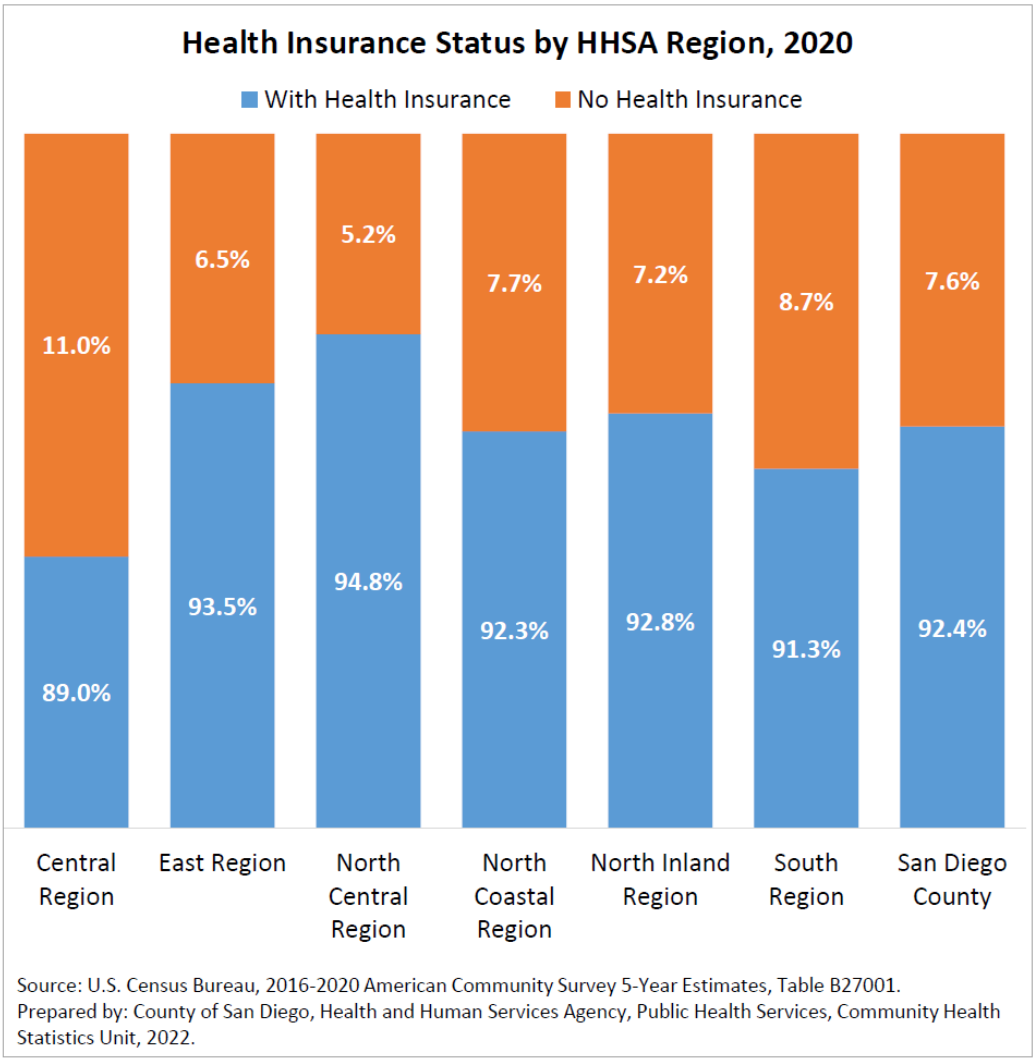
Source: U.S. Census Bureau; 2016-2020 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.



HEALTH INSURANCE STATUS

HHSA Region	With Health Insurance	No Health Insurance	0-18 w/ Health Insurance	19-25 w/Health Insurance	26-44 w/Health Insurance	45-64 w/Health Insurance	65+ w/Health Insurance
Central Region	89.0%	11.0%	94.8%	85.7%	84.3%	87.4%	98.7%
East Region	93.5%	6.5%	95.6%	89.3%	90.4%	93.1%	98.9%
North Central Region	94.8%	5.2%	97.7%	92.1%	92.0%	94.5%	99.1%
North Coastal Region	92.3%	7.7%	96.5%	87.4%	86.5%	91.5%	99.1%
North Inland Region	92.8%	7.2%	96.1%	85.3%	88.2%	92.4%	98.9%
South Region	91.3%	8.7%	95.3%	85.7%	87.0%	90.2%	98.3%
San Diego County	92.4%	7.6%	96.1%	87.8%	88.2%	91.8%	98.9%

Source: U.S. Census Bureau; 2016-2020 American Community Survey 5-Year Estimates, Table B27001.
Note that percentages may not add up to 100% due to rounding.



Source: U.S. Census Bureau, 2016-2020 American Community Survey 5-Year Estimates, Table B27001.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2022.

APPENDIX F

COMMUNITY ENGAGEMENT REPORT



BEHAVIORAL HEALTH SERVICES
COMMUNITY ENGAGEMENT

Fiscal Year 2022-2023 Annual Update

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

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Executive Summary

The Mental Health Services Act (MHSA) provides significant funding for the San Diego County Behavioral Health Services (SDCBHS) system. Primary aims of the MHSA are to increase access to unserved and underserved individuals and families by reducing disparities in the service delivery system for children, adults, and older adults (OAs) with Serious Mental Illness (SMI). To facilitate these efforts, the MHSA incorporates a Community Program Planning (CPP) process through which counties gather input from a diverse range of stakeholders as to the needs and priorities of community members. During Fiscal Year (FY) 2022-23, CPP engagement activities were designed with the goal of informing the development of the next MHSA Three-Year Plan, which will guide the provision of behavioral health services throughout the County of San Diego between 2023-2026.

In San Diego, the community engagement activities of the CPP process were led by the UC San Diego Health Partnership. The Partnership is committed to authentic community engagement efforts, focusing on equity and promoting community empowerment of unserved, underserved, and hard-to-reach populations. Stakeholders are considered partners in the community engagement process, and in order to fully realize the potential of the CPP process, the UC San Diego Health Partnership must be inclusive of stakeholders representing diverse communities, large and small behavioral health and non-behavioral health services, advocacy, faith-based, and other nonprofit organizations.

In its inaugural year of FY 2022-23, the UC San Diego Health Partnership, in collaboration with SDCBHS, developed a stakeholder outreach and engagement plan to facilitate a county-wide CPP process. Three primary types of community engagement activities were facilitated by the UC San Diego Health Partnership team to gather information from community stakeholders throughout San Diego County (SDC). Activities included: 1) Key Informant Interviews; 2) Focus Groups; and, 3) Listening Sessions. In addition, community trainings regarding the local impact of MHSA and the CPP conducted by the UC San Diego Health Partnership team allowed for participants to provide feedback regarding behavioral health services and needs. Outreach was facilitated through the UC San Diego Health Partnership's extensive network of first- and second-order community connections and through participation in a variety of existing community meetings occurring throughout SDC. Outreach efforts connected with MHSA-defined priority population groups, including Native American and American Indians (NA/AI), families of Middle Eastern descent, refugees, Veterans, and LGBTQ+ populations, among others. The information collected as part of the CPP process – via listening sessions, focus groups, interviews, and active participation in grassroots community events – was used to determine the community and regional behavioral health needs, assets, and recommendations for the MHSA Three Year Plan.

Key informant interviews were utilized to gather input from community leaders and advocates regarding essential understandings and vital steps needed for community engagement efforts within the San Diego community. Focus groups gathered insight into the existing strengths, resources, and needs of program services for specialized populations, using a consistent question guide with minor tailoring as needed for the specific population. Focus group participants were a mix of providers, community advocates, community groups, and consumers of the following identified specialized populations: Parents with lived experience navigating the system, providers/staff providing services to parents in the community, Transitional Age Youth (TAY), OAs, justice-involved, faith-based communities, Veterans and active military, perinatal and postpartum care, NA/AI, Latinx, rural, and Immigrants and Refugees. Key informant

interviews and focus groups were recorded, transcribed, and analyzed as part of the CPP report preparation process.

For the current reporting period, “Listening Sessions” were defined as instances where representatives of the UC San Diego Health Partnership developed and conducted structured feedback activities within an existing community meeting or event regarding behavioral health service needs, opportunities, and concerns, as well as the preferred mechanisms for communication and community engagement. These listening sessions took a variety of forms and reached a wide range of audiences, with an overarching goal of having the UC San Diego Health Partnership “go to” (either virtually or in-person) the places and spaces where people were already gathering to facilitate their ability to provide essential input. While some tailoring occurred across the listening sessions, the general format included a brief PowerPoint presentation introducing the UC San Diego Health Partnership and providing background on the MHSA CPP process and efforts. Participants were then led through a community engagement activity asking for feedback to a series of questions related to community strengths, mental health and substance use needs and priorities, and strategies for engagement. Each session included time for discussion of individual responses. Both the discussion notes and the structured feedback were documented and incorporated into the analyses discussed in this report.

Over 500 people attended CPP community engagement and feedback events during FY 2022-23, which included four MHSA trainings, eleven key informant interviews, nine focus groups, and nine listening sessions. The qualitative data collected from community engagement activities were thematically analyzed by UC San Diego Health Partnership. Findings were split into two general categories: 1) perceptions of behavioral health service needs, priorities, and experiences, and 2) feedback on meaningfully and effectively conducting community engagement as part of the CPP process.

The FY 2022-23 CPP process identified a wide range of behavioral health needs and ideas for how to improve and expand the existing system to better serve the diverse community needs, while also eliciting preferences regarding how best to conduct CPP work in SDC. Throughout the engagement activities, participants emphasized the strength and resilience within San Diego's diverse communities.

Community members’ priority needs were aligned around creating more integrated, accessible, culturally competent, and affordable behavioral health services and supports, the need for more prevention and treatment options for substance use disorders and co-occurring mental health needs, the need for targeted initiatives to support priority populations including, Veterans and the military, individuals experiencing homelessness, TAY, OAs, perinatal families, and immigrants and refugees, among others. Specific highlights from participants included the fentanyl crisis, the need for acute care, treatment for co-occurring disorders, the housing crisis, and the need for increased crisis services and the development of more accessible service entry points. Through all types of engagement activities, the need for culturally relevant and/or culturally appropriate services was prominent. Participants emphasized the need specifically for children and TAY programming, as well as continued prevention and early intervention efforts. Further, there was a great deal of coalescence around the potential of peer support models and the use of promotoras and community health workers in service delivery.

Improving access to behavioral health services was broadly identified as a priority need. Participants discussed the need for an integrated and affordable behavioral health services system in which silos were replaced with organizational collaborations and in which community members could connect to all their needed services in a centralized and supported integrated care setting. Notable challenges to accessing

resources were insufficient health care coverage, stigma, workforce issues, transportation, waitlists, and cultural and language barriers. It was also consistently noted that community members often were simply unaware of available services and/or of how to use them. While these themes were noted county-wide, there was some variability by region.

As depicted in Figure 14 (see page 65), a synthesis of the findings from the CPP community engagement activities for FY 2022-23 revealed that community stakeholders preferred a community-care based behavioral health system, focused on prevention and emergent behavioral health needs, while simultaneously implementing a robust and coordinated response when behavioral health crises occur. Community care was viewed as not only comprising the array of outpatient mental health and substance use treatment and support services that were expected to provide appropriate, accessible, and of high-quality care, but also the knowledge and resources of individuals, families, and communities needed to address and/or prevent behavioral health concerns in the first place. Within the CPP findings were a range of recommendations for how to make this conceptualization of behavioral health care more of a reality and make key services and resources available to more people living in SDC. The CCP findings formed the basis for the set of 18 primary behavioral health service change recommendations listed in Table 11 (see page 67). In addition to specifying the recommendations that emerged from the community feedback findings, Table 11 includes potential strategies that could be utilized, with community input and participation, to make progress towards achieving each recommendation.

When asked to define community engagement in their own words, the overarching theme of participant responses was building trust. Building trust in community engagement must include transparent communication, inclusivity, and credibility. CPP participants overwhelmingly emphasized the importance of holding community engagement events in neighborhood or community spaces and participating in existing community meetings to connect with people where they "are," rather than regularly expecting community members to "go to" externally held engagement events. Stakeholders also iterated the importance of understanding how their input is being used in program planning and decision-making and for the information to be available, inclusive, and consistent with the originally provided feedback. Accordingly, a successful CPP, above all else, includes feedback to the community that is clear and easy to understand.

Taken together, the feedback obtained through this initial year of the CPP process led by the UC San Diego Health Partnership illuminated key ingredients needed to realize the full benefits and potential of the CPP. Based on these findings, a multi-year community engagement plan to facilitate the CPP process will be developed to support the implementation of the FY 2023-2026 MHSA Three Year Plan. The Community Engagement Plan will be adapted as indicated and through data-driven decisions, with approval from SDCBHS leadership. Flexibility to community needs and preferences will be essential to a meaningful, authentic, and responsive CPP process. The UC San Diego Health Partnership will continue development of a community engagement approach that is welcoming, inclusive, and aligned with other behavioral health related engagement activities, as well as facilitating an ongoing, comprehensive outreach and engagement effort, in partnership with SDCBHS, with a particular emphasis on connecting with individuals from historically unserved and underserved communities.

Chapter 1 – The Mental Health Services Act (MHSA) & the Community Program Planning (CPP) Process

Introduction

The Mental Health Services Act (MHSA) provides a substantial amount of the funding for the SDCBHS Department. The fiscal support of the MHSA offers critical resources to support the SDC region's historically marginalized populations and serves all ages, including children, youth, TAY, adults, older adults (OA), and families. MHSA funding supports prevention and early intervention, treatment services, and the development of critical infrastructure, technology, and training to support the public mental health system. The MHSA aims to increase access to the unserved and underserved individuals and families by reducing disparities in the service delivery system for children, adults, and OAs with Serious Mental Illness (SMI). Integral to the MHSA is a required CPP process, through which counties gather input from a diverse range of stakeholders as to the needs and priorities of community members.

The MHSA Stakeholder Engagement Activities and CPP process is led by a University of California, San Diego (UC San Diego) team, who was awarded a five-year community engagement contract in May 2022 by the SDCBHS. In efforts to effectively engage community stakeholders, UC San Diego is partnering with Community Health Improvement Partners (CHIP), and Global Action Research Center (Global ARC) to support the community engagement efforts connected to the contract. CHIP has been a leader in innovative, collaborative solutions to address critical community health issues in San Diego for nearly 30 years. CHIP is well-known for bringing together diverse partners to assess community health needs, educate and advocate to create policy, systems, and environmental change in efforts to reduce health disparities. Global ARC works to bring the community's voice into the public dialogue, focusing on marginalized communities. By using a place-based approach, Global ARC works with residents in San Diego to build on and strengthen their existing social networks to empower them to effectively engage in the decisions that shape their community and their lives.

This collective group, the UC San Diego Health Partnership, creates a strong team with complementary capacities that together facilitate successful achievement of the CPP goals and the establishment of a sustainable community engagement process. The UC San Diego Health Partnership is committed to authentic community engagement efforts by having equity being the center of the engagement process along with promoting community empowerment directly to the unserved, underserved, and hard-to-reach populations.

Advancing Diversity and Health Equity

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

The community need for behavioral health services continues to increase, especially among the most vulnerable populations and in the wake of the COVID-19 pandemic. To guide clinical service design and placement, and to ensure effective outcomes are achieved, the SDCBHS continues to enhance data integration and health equity work through the establishment of the SDCBHS Data Sciences and Population Health units. Additionally, SDCBHS is partnering with UC San Diego, to develop the Community Experience Partnership (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs. The SDCBHS further demonstrates its commitment to implementing health equity, diversity, and inclusion initiatives through procurements and contracting, specifically requiring outreach and engagement with unserved, underserved, and historically hard-to-reach communities.

An essential component of the community engagement work is the direct acknowledgement of structural racism and historic inequity experienced by unserved and underserved populations. The UC San Diego Health Partnership is building a community engagement approach that intentionally de-centers the voice of the researcher and highlights the voices of those who have been historically silenced. The intent is to create an unduplicated community engagement process that is welcoming, inclusive, and aligned with other behavioral health-related engagement activities. The CPP process itself is an opportunity to build power for unserved and underserved communities. The UC San Diego Health Partnership works to incorporate a racial and ethnic equity perspective through several approaches. First, by developing capacity among racially marginalized communities by conducting listening sessions and focus groups/interviews that focus on understanding and responding to priorities determined by the community members. Additionally, communities are considered partners in the community engagement process and are acknowledged for their contribution. The UC San Diego Health Partnership has been working with community stakeholders to participate in the development of communications, materials, review summaries and key findings to ensure accuracy in reflecting the communities' voices prior to dissemination. Community participation at this level helps to ensure languages, images, and content are culturally relevant, engaging, and inclusive.

The basis of the enacted CPP process is that UC San Diego Health Partnership promotes community empowerment and equity, with local stakeholders co-leading the process, sharing in the development and interpretation of evaluation findings, as well as implementation and sustainability planning.

Background and Purpose

The MHSA is a California law passed in 2004, which aims to provide funding and resources for mental health services and programs for individuals with severe mental illnesses, individuals experiencing homelessness, and those who have experienced trauma. The CPP process is an essential component of the MHSA, emphasizing community involvement and participation in the planning and implementation of mental health services. The CPP process is based on the principle of "nothing about us without us," ensuring that individuals and communities that are directly affected by mental health issues are actively involved in the decision-making process.

The ongoing nature of the CPP process is critical, as it allows for continuous engagement with the community to gather feedback and input on their mental health needs. This feedback is then used to adapt and modify mental health and substance use services and programs to better serve the needs of

the community. By engaging individuals and communities who have been historically marginalized and underserved in mental health care, the CPP process ensures that their needs and voices are heard. This helps promote equity and social justice in mental health services, ensuring that the needs of all individuals and communities are addressed.

The CPP process helps inform the MHSA Three-Year Plan and subsequent Annual Updates. All components and aspects of the MHSA funding are driven by the MHSA Three-Year Plan. The County of San Diego's Three-Year Plan covers 2020-2023, with Annual Updates published each year containing summaries of programs, outcomes, and funding updates. Engagement efforts conducted this fiscal year are developed with the goal of providing insight to develop the next MHSA Three-Year Plan covering 2023-2026.

The current local community engagement efforts involve building trust, enlisting new resources and allies, creating better communication, and improving health outcomes. The SDCBHS and UC San Diego Health Partnership collaborate to solicit feedback from the community, inclusive of all stakeholders, about behavioral health needs to inform program planning and development of the SDCBHS continuum of care. Regular contact with the public through interactive councils, advisory boards, and stakeholder engagement throughout the year is maintained to inform program planning and development of the SDCBHS continuum of care.

In summary, the CPP process is a vital part of the MHSA, emphasizing ongoing community engagement, feedback gathering, and collaboration to create a more inclusive and responsive mental health system in SDC. The CPP process reflects the importance of listening to and acting on the needs of individuals and communities that have historically been left out of mental health discussions and services. The CPP process helps inform the MHSA Three-Year Plan and subsequent Annual Updates, which drive all aspects of MHSA funding. Ongoing community engagement efforts in SDC are essential to improving the quality of life and achieving important life goals for marginalized and oppressed individuals and groups.

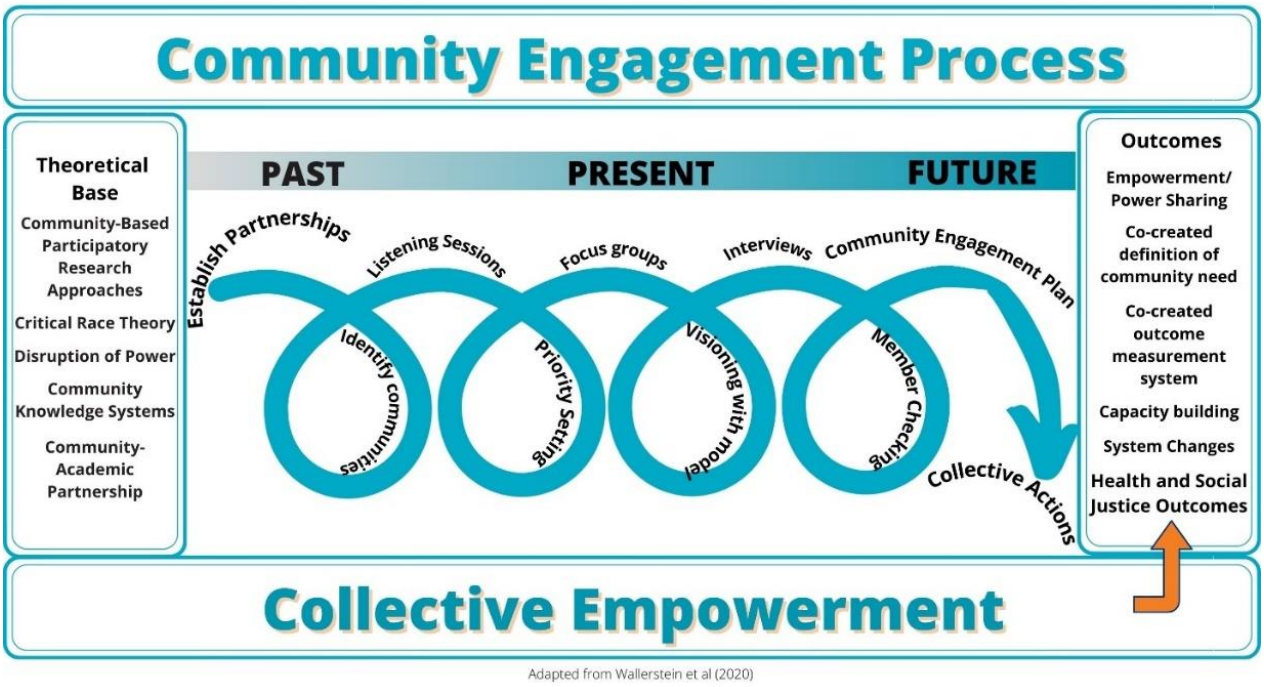
Best Practices

Relying on principles of community organizing and participatory research and evaluation, the UC San Diego Health Partnership's community engagement process employs an outreach approach consistent with Community-Based Participatory Research (CBPR) methods used to integrate key constituencies in the development and implementation of the comprehensive community engagement activities. CBPR is the most recognized form of health-focused, community-engaged research, integrating community partners throughout the process with the goal of promoting equity and reducing health disparities. As such, the UC San Diego Health Partnership provides a strong foundation for the community engagement process. However, to truly accomplish the CPP process, we must identify persons from a wide range of unserved and underserved communities throughout SDC and create safe, accessible, and supportive opportunities for sharing their behavioral health needs, experiences, and recommendations. This ultimately requires the involvement of many different community members and representatives from large and small behavioral health and non-behavioral health services, advocacy, and faith-based organizations.

As depicted in Figure 1, the UC San Diego-led community engagement process is rooted in approaches that promote community empowerment, ultimately coalescing in a strategic plan that will improve service delivery for unserved, underserved, and hard-to-reach populations. The UC San Diego Health Partnership

embraces the goals of community engagement – building trust, enlisting new resources and allies, creating better communication, and improving overall health outcomes – as fundamental to this endeavor. The community engagement approach utilizes a group-based participatory, developmental process through which marginalized or oppressed individuals and groups gain greater control over their lives and environment, acquire valuable resources and basic rights, and achieve important life goals and reduce social marginalization. In this context, empowerment is both a process and an outcome of community engagement.

Figure 1. UC San Diego Health Partnership Community Engagement Process



Adapted from Wallerstein et al (2020)

The UC San Diego Health Partnership is committed to authentic community engagement efforts by having equity being the center of the engagement process along with promoting community empowerment directly to the unserved, underserved, and hard-to-reach populations.

To develop capacity in and for unserved and underserved communities, engagement activities should focus on understanding and responding to priorities as determined by the community members. Communities are considered partners in the Community Engagement Process and will be acknowledged for their contribution. Community stakeholders should participate in the development of communications, materials, and reports and review summaries and key findings to ensure accuracy in reflecting the communities' voice prior to dissemination. Community participation at this level helps to ensure languages, images, and content are culturally relevant, engaging, and inclusive. The result will produce more useful information for SDCBHS. On the continuum of community engagement (see Figure 2), the UC San Diego Health Partnership's approach moves away from more traditional approaches (on the left) and towards those more collaborative, centering active community involvement at all phases of the process.

Figure 2. Continuum of Community Engagement



Outreach	Consult	Involve	Collaborate	Shared Leadership
Some community Involvement	*More community involvement*	*Better community involvement*	*Community involvement*	*Strong bidirectional relationship*
Communication flows from one to the other, to inform	*Communication flows to the community and then back, answer seeking*	*Communication flows both ways, participatory form of communication*	*Communication flow is bidirectional*	
Provides community with information	*Gets information or feedback from the community*	*Involves more participation with community on issues*	*Forms partnerships with community on each aspect of project from development to solution*	*Final decision making is at community level*
Entities coexist	*Entities share information*	*Entities cooperate with each other*	*Entities form bidirectional communication channels.*	*Entities have formed strong partnership structures*
Outcomes: Optimally, establishes communication channels and channels for outreach.	*Outcomes: Develops connections*	*Outcomes: Visibility of partnership established with increased cooperation*	*Outcomes: Partnership building, trust building*	*Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.*

Reference: modified by the authors from the International Association for Public Participation.

COVID-19 Impacts

The COVID-19 pandemic greatly impacted the delivery of behavioral health services within the community; however, the SDCBHS continued to make forward progression in shifting how residents of SDC access care and support for behavioral health needs. In Fiscal Year (FY) 2021-22 and FY 2022-23, the County infused additional financial, staffing, and other resources into behavioral health services that are even more critically needed post-pandemic. Although the delivery of behavioral health services has been impacted by the pandemic and outreach has been challenging in FY 2022-23, engagement efforts continued, incorporating stakeholder perspectives in multiple aspects of planning and service delivery.

To address the public health concern of COVID-19, UC San Diego continued to work with SDCBHS and held all community engagement activities (in-person or virtual) in accordance with state and local public health guidelines. In addition to the public health considerations regarding COVID-19, the ability to conduct virtual sessions afforded opportunities for those who are unserved, underserved, and/or otherwise facing barriers (e.g., transportation limitations, mental health barriers to large crowds, childcare, physical disabilities, compromised immune systems, etc.) to participate in the community engagement activities.

Chapter 2 – Community Engagement Efforts

Stakeholder Engagement Efforts

Background

In its inaugural year, the UC San Diego Health Partnership, in collaboration with SDCBHS Contracting Officer's Representative (COR) and BHS representatives, developed a stakeholder outreach and engagement plan to facilitate a county-wide CPP process that ensured commitment to MHSA-defined priority population groups (see Figure 3 below). Outreach efforts were facilitated through the UC San Diego Health Partnership's extensive network of first- and second-order community connections and participation in a variety of community meetings occurring throughout SDC. The UC San Diego Health Partnership, in collaboration with SDCBHS, was the foundational structure used to capture and leverage community resident and stakeholder behavioral health input regarding challenges and prevention strategies to inform the SDCBHS continuum of care. The information collected as part of the CPP – via listening sessions, focus groups, and interviews, as well as active participation in community events via grassroots, faith-based, and other nonprofit organizations – was used to determine the community and regional behavioral health needs, assets, and recommendations for this three-year plan.

Stakeholder outreach and engagement through various mechanisms are implemented year-round (e.g., Behavioral Health Advisory Board (BHAB) and BHS System-of Care (SOC) Council meetings). In addition to the year-round BHAB and SOC Council engagement efforts as part of the CPP process, the stakeholder engagement efforts of the CPP process were implemented through listening sessions, focus groups, and key informant interviews to identify priority and target populations. The section below describes the methodology and framework for the recruitment, implementation, and analysis process for each of those stakeholder engagement efforts.

Identifying & Engaging Hard to Reach Populations

Outreach efforts conducted in this community engagement process worked to connect with unserved and underserved communities, including communities that are historically unreached, such as NA/AI, families of Middle Eastern descent, refugees, and LGBTQ+ populations, among several others. To help establish trust with potential participants who may not be inherently comfortable engaging in available feedback opportunities, the UC San Diego Health Partnership collaborated closely with SDCBHS and existing community connections. Outreach with existing organizations and/or individual community members who have established relationships, predicated on a foundation of trust and respect, can encourage participants and provide assurance for the supportive process we seek to develop.

Figure 3. MHSA-Identified Priority Population Groups

Latinx (i.e., Hispanic/Latino)	➢ More than one-third of San Diego County residents
American Indian/ Alaskan Native	➢ A small (0.4%) but important percentage of San Diego residents ➢ National studies have shown that young adult males who identify as American Indian/Alaskan Native are more than twice as likely to die by suicide as any other gender, racial, and ethnic subgroups, making access to SDCBHS critical for American Indian/Alaskan Native San Diego County residents
Asian American and Pacific Islander	➢ More than 12% of San Diego County population ➢ A utilization study in San Diego County found that Asian/Pacific Islander individuals are underrepresented in mental health services, have more severe symptoms at intake, have longer lengths of stay, and higher percentages of day treatment usage than other groups
Black/African American	➢ Nearly 5% of the population in San Diego County yet experience the highest rates of poor health outcomes compared to any other racial or ethnic group in the County
Veterans/Military	➢ Veterans/military make up 8.6% of San Diego County residents and face multiple housing, income, and mental health disparities
TAY aged 17 to 25	➢ Of particular concern for public service agencies, as they transition from youth-based or pediatric services into adult service agencies ➢ TAY with mental health concerns are less likely to finish high school/be employed ➢ Nearly 20% of TAY in San Diego County are living below 100% federal poverty level, which represents the largest percentage of any age group in San Diego
Criminal Justice System Involved Individuals	➢ More likely to engage in heavy or binge drinking, and experience depression when compared to individuals who had no criminal justice involvement
Immigrant and Refugee populations	➢ More than 23% of San Diego County's population is comprised of foreign-born individuals, naturalized U.S. citizens, immigrants, temporary migrants such as foreign students, humanitarian migrants such as refugees and asylees, and unauthorized migrants.
Individuals with SMI	➢ It is estimated that 5% of San Diego County population may be living with SMI. Persons with untreated SMI often experience significant impairment which may make it difficult to maintain relationships, employment, and housing.
Individuals Experiencing Homelessness	➢ Despite the small percentage of residents experiencing homelessness in San Diego County, 15.5% of adults accessing County Mental Health Services and 30.9% accessing substance use disorder services reported experiencing homelessness.
Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)	➢ Represent 12.3% of adult SDCBHS clients in 2019-2020 ➢ Report unsatisfactory experiences with behavioral health providers due to prejudice, bias, or inability to comprehend the needs of LBGTQ+ clients ➢ LGBTQ+ individuals often experience higher rates of mental health needs due to depression, anxiety, and substance use.

Currently, over 1.4 million people live in SDC. By July 2021, more than one-quarter (26.9%, n=896,926) of SDC residents were enrolled in Medi-Cal. The six HHSA regions (see Figure 4) are highly diverse regarding demographic characteristics like race/ethnicity, education, single-parent households, unemployment, and income.

Figure 4. Map of HHSA Regions



Existing Networks

The community engagement process led by the UC San Diego Health Partnership has been working to build upon existing networks and create stakeholder engagement efforts to identify a wide range of potential community partners.

Behavioral Health Advisory Board (BHAB)

The BHAB is the primary council of SDCBHS, which serves as the primary oversight and engagement board for the SDCBHS system. BHAB in SDC assures that the MHSA Three-Year plan and subsequent annual updates involve community and professional input. Currently, BHAB is elevating its commitment to optimization of its utility and strategic planning over the next five years, by actively identifying improved communication channels from the SDC Board of Supervisors (BOS) to SDCBHS, SDCBHS to BHAB, direct correspondence from members to their elected officials, and cultivating provider and other stakeholder

engagement. The CPP process continues to build on the partnership and input of BHAB for the development of this three-year plan and subsequent annual reports.

Live Well San Diego Community Regional Leadership Team Meetings

Live Well San Diego (LWSD) Community Regional Leadership Team (CRLT) Meetings are comprised of diverse partners, agencies, and advocates who are working together to identify the needs and priorities of each region. The Live Well San Diego CRLT Meetings provide a space for networking, identifying regional priorities, sharing tools and resources, and facilitating collaborative action. The LWSD CLRT meetings also provide opportunities to engage community members of San Diego by utilizing the meetings to collect stakeholder feedback regarding the strengths, needs, and priorities of each region. There are five, regional LWSD CRLT monthly meetings: Central, South, East, North Central, and North County (comprised of North Inland and North Coastal).

SDCBHS System of Care (SOC) Councils

Six SDCBHS System of Care (SOC) Councils are explicitly designed to generate feedback from multiple stakeholder groups to inform the delivery of behavioral health services for the specific target populations. The Councils, which have cross-disciplinary membership, work with system partners to respond to decreases in access to care and to explore new opportunities for collaboration and provide recommendations to the SDCBHS Director. All SOC Councils work directly with the SDCBHS, system partners, and other SDCBHS Councils to address social determinants of health, including technology needs of consumers.

SOC Councils promote the *Live Well San Diego* Vision and SDCBHS Framework for Our Future, recognizing the pandemic and racial justice context, as well as considering population health and social determinants of health. Councils evaluate the SOC and advocate for needed adjustments with recognition of the economic effects of the pandemic and impacts to the community. Councils provide input for MHSA Community Engagement events and SDCBHS Forums.

See Figure 5 for a list of the six councils in the SDCBHS SOC.

Figure 5. SDCBHS SOC Councils

The Cultural Competence Resource Team (CCRT)

- Advisory board to the SDCBHS Director
- Provides framework to SOC Councils and their sub-committees to facilitate culturally competent activities
- Collaborates with all other SOC Councils to examine and address health care disparities and social determinants of health in unserved and underserved communities, particularly around access to care and workforce goals
- All SOC Councils' Vision, Mission, Principles and Framework include language of cultural competency

The Adult System of Care Council

- Oversees, plans and develops programs for the public Adult SOC for San Diego County

The Children, Youth, and Families (CYF) Behavioral Health System of Care Council

- Vision: wellness for children, youth, and families throughout their lifespan
- Mission: to advance systems and services to ensure that children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families
- Relies on 10 principles, ranging from collaboration and integration to ensuring that services and programs are child-, youth-, and family-driven

The Housing Council

- Facilitates design, implementation, and evaluation of housing for individuals with serious mental illness by providing feedback and recommendations to the SDCBHS Director and Executive Team
- Created a 5-year Housing Plan for the COSD through extensive stakeholder engagement to address the behavioral health needs of individuals at risk of or experiencing homelessness or housing insecurity

The Older Adult Council

- Makes recommendations related to the development of the OA SOC
- Provides consultation and feedback to help understand what is and what is not working for OAs
- Facilitates the exchange of information across all sectors of the SOC
- Provides representation and input for the integrity and advancemenet of all services and aspects of the SOC
- Provides recommendations and feedback to the COSD BHS Director regarding the progress and future expansion of all OA Behavioral Health programs and services

The TAY Behavioral Health System of Care Council

- Provides feedback and recommendations regarding TAY (ages 16 to 25) services in the Children, Youth and Families (CYF) and the Adult and Older Adult (AOA) systems of care
- Provides community representation and input for the integrity of all TAY services and advancement of all TAY related aspects of the systems of care

Other Community Networks

In efforts to enlisting new resources and allies, and work to reach and connect with the marginalized or oppressed individuals and groups of SDC, the UC San Diego Health Partnership and SDCBHS is collaborating with multiple existing networks. As will be discussed in more detail below, aligning outreach

and engagement efforts with existing platforms is a consistent recommendation from stakeholders for how best to engage communities – using existing platforms and trusted community groups to create a foundation for establishing successful and meaningful engagement.

Community Health Workers (CHWs)

The SDC Office of Equitable Communities (OEqC) Community Health Workers (CHWs) position was created in FY 2021-22 as new County staff positions for the specific purpose of expanding capacity for outreach and education and to ensuring unserved and underserved populations receive critical updates, including information on behavioral health resources. CHWs aim to uplift and increase the County's utilization of more grassroot approaches to community engagement, led by experts with lived experience and/or intimate knowledge of a particular race/ethnicity, community of shared identity, and/or geographic region. CHWs are trusted members of the community whose relationships enable them to serve as a liaison between health and social services and the community to share resources and improve service delivery quality. UC San Diego Health Partnership and SDCBHS are collaborating with CHWs to increase regional outreach efforts, refine outreach and presentation materials, and increase capacity to deliver information to stakeholders in a more tailored way through messengers with whom the community connects and can relate.

Suicide Prevention Council

The San Diego Suicide Prevention Council (SPC) is a collaborative community wide effort focused on realizing a vision of zero suicides in SDC. The SPC mission is to prevent suicide and its devastating consequences in SDC. The SPC's core values encompass a public health approach to prevention, collaboration and non-competitive partnerships, evidenced-based practices, and cultural and linguistic sensitivity. The primary strategy the SPC uses to work on its mission is enhancing collaborations to promote a suicide-free community. They conduct ongoing needs assessments to identify gaps in suicide prevention services and supports and provide resources to those affected by suicide and advance policies and practices that contribute to the prevention of suicide.

San Diego Veterans Coalition

The San Diego Veterans Coalition (SDVC) was organized in 2009 and incorporated as a non-profit in May 2011. SDVC utilizes the Collective Impact Model, which is based on leveraging relationships with other Veteran and family serving organizations so that they may provide Veterans and their families with a complete array of services and other opportunities. The purpose of the SDVC is to serve the needs of San Diego regional Veterans, their families, and significant others. They intend to improve collaboration and coordination among community service providers in all sectors so that delivery of services is more comprehensive and Veteran family-centric.

Dreamweaver Consortium

The Dreamweaver Consortium is a partnership with several NA/AI health clinics that join cultural practices with evidence-based practices to address mental health and substance use disorder prevention. The SDCBHS contracts with the following health clinics as part of the Dreamweaver Consortium: Indian Health

Council, Inc. (IHC), San Diego American Indian Health Center (SDAIHC), and Southern Indian Health Council (SIHC). The Dreamweaver Consortium programs provide behavioral health prevention and early intervention services to all age groups through intergenerational activities to NA/AI populations in SDC. Services are provided on reservations and in urban areas and include education and outreach at community events, cultural and social gatherings, and health clinics.

Community Experience Partnership

The Community Experience Partnership (CEP) is a joint initiative between SDCBHS and the UC San Diego Child & Adolescent Services Research Center (CASRC) and Health Services Research Center (HSRC). The vision of the CEP is the integration of data and community engagement to promote behavioral health equity in SDC. The mission of the CEP is to promote a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans. The CEP is designed to identify and address unmet behavioral health needs, and the systemic and regional inequities that lead to these unmet needs. The final product will promote a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans. The primary components of the CEP include: the **Community Experience Dashboard (CED)**, the **Behavioral Health Equity Index (BHEI),** and **Community Profiles and Action Reports**.

Integral to the CEP is the solicitation of community input in each phase and CEP deliverables reflect recommendations from community partners. To that end, the first phase of the Community Experience Committee was created, by invitation to "*a limited series workgroup as part of the Community Experience Committee (CEC) to provide input to UC San Diego to help develop a community survey."* The CEC is envisioned as a diverse group of stakeholders (service providers, community advocates, clients, and leaders in San Diego behavioral health) that will help highlight community resources and strengths and identify priorities for behavioral health equity and action. The CEC was represented by consumer/peer advocates, family members, and CCRT members.

Community Experience Dashboard

The CED allows the public to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Data sources include surveys, vital records, hospitalization and emergency department data, and service and outcome data for individuals served by the Behavioral Health Services system. Users can explore indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement and more.

In FY 2021-22, the second development phase of the CED was completed which included finalizing suppression methodology and applying data suppression for confidentiality and reliability, data enhancements (i.e., diagnosis, co-occurring substance use, and social determinants of health. Successes include the creation of CEP web portal (Dashboards | Community Experience (communityexperiencepartnership.com)) and the launch of public-facing dashboards.

The CED was presented at multiple meetings for input, including:

- BHS Quality Improvement Performance Improvement Team (QI-PIT)
- Executive Quality Improvement Team (EQIT)
- Quality Review Council (QRC)
- BHAB Stakeholder Engagement Workgroup
- Community Experience Committee (CEC) Workgroup
- CCRT
- HHSA Leadership
- Live Well San Diego Advance

FY 2022-23 efforts around the CED include accessibility enhancements, including soliciting community input to enhance ease of use and interpretability along with education on how to best utilize the dashboard for to help with community engagement efforts. Furthermore, additional data enhancements are being considered on the following topics:

- Addition of FY 2020-21 and FY 2021-22 service data for adults/OAs
- Addition of FY 2021-22 service data for children, youth, and families
- Expand adult population health indicators
- Emergency department and inpatient discharge and mortality rates utilizing data processed by the SDCBHS's Population Health epidemiologists
- Priority data as identified by County and community partners

BHEI

Working in collaboration with the SDCBHS's CEC and contracted community facilitators, UC San Diego developed a BHEI model for the County of San Diego. BHEI indicators were selected and sorted into domains, aligned with social determinants of health established by the U.S. Department of Health and Human Services.

Operationally, not every domain would be considered an equally important determinant of behavioral health equity. Therefore, it was decided to create a weighting algorithm for domains according to their relative importance, as determined by a BHEI weighting survey, which was administered to the CEC Workgroup and the SDCBHS leadership.

BHEI Community Engagement

The BHEI is a service planning tool that compiles data about the root causes, or social determinants, of behavioral health into a single index (see Appendix A for an overview of the BHEI domains and neighborhood level data elements). The index can then be used to help identify neighborhoods and populations that could benefit from additional resources, supports, and services. The BHEI is one component of a larger SDCBHS initiative to advance behavioral health equity. The first step in creating the BHEI was to develop a conceptual model to identify the social determinants, domains, and indicators that will comprise the index. The model was developed in collaboration with community experts, representatives from SDCBHS, and UC San Diego researchers who collectively comprised the Community Experience Committee (CEC) Workgroup during a four-part workgroup series conducted between January and April 2022, and aligned with social determinants of health established by the U.S. Department of

Health and Human Services (https://health.gov/healthypeople/priority-areas/social-determinants-health).

The CEC Workgroup provided input on selection of indicators and categorization of those indicators within eight domains. Primary feedback from the CEC Workgroup was regarding how the BHEI would be presented to communities, and how it would (or would not) be used by the SDCBHS. Community experts respectfully challenged the development of a needs-based model that might further alienate marginalized communities. A strong recommendation to augment or supplement the model with strengths-based variables was issued. This valuable dialogue led to a critical shift in the broader engagement and implementation plan. As it is assumed that not every domain is an equally important determinant of behavioral health equity in SDC, domains should be weighted according to their relative importance towards determining equity. There are various methods available to select weights when creating indices. UC San Diego has adopted a process that prioritizes feedback from experts familiar with the social determinants of health and their influence on achieving behavioral health equity in SDC. The next step in the BHEI construction will be to gather, finalize, standardize, and aggregate the neighborhood level BHEI indicators to form eight domain scores. The scores will then be weighted and summed to develop a single index.

BHEI Next Steps

- Spring 2023: Conduct a diverse focus group consisting of community subject matter experts to gather feedback, providing additional data to weight the BHEI
- Gather, interpolate (as needed), standardize, and aggregate the neighborhood level BHEI indicators to form eight domain scores
- Finalize weights and calculate BHEI
- Integrate BHEI map and indicators into visualization platform to allow users to explore the data in order to inform planning (Power BI or Shiny application). Revise as needed based on expert review and community feedback.
- Support the new SDCBHS community engagement contract in the development of a strengths-based survey, if needed

Community Profiles and Action Reports (CP/AR)

This Community Profiles and Action Reports (CP/AR) component will be initiated in the next phase of the CEP in FY 2022-23 and FY 2023-24. UC San Diego and the SDCBHS will collaborate to engage community members and key stakeholders in the development of plans for action. Community engagement procedures will likely include partners' meetings and online surveys that will be ongoing throughout the life of the project. Reports and community profiles will be developed to meet needs at the service, administrative, and community levels.

Community Experience Partnership videos:

- Part I: https://youtu.be/A6IBVP8bNf4
- Part II: https://youtu.be/7ZOXoniW8ro

Outreach Events

Meeting of the Minds

The Meeting of the Minds is an annual behavioral health services-related conference held in San Diego. to share the latest research, programs, resources, and policies relevant for promoting the behavioral health of County residents. The 2022 conference was held on October 12th with presentations on a wide range of behavioral health topics (e.g., rebuilding after suicide loss, harm reduction and housing, reducing stigma among first responders, and voices of recovery). In addition, program resource booths provided additional information and networking opportunities.

A resource booth was staffed by the UC San Diego Health Partnership throughout the entirety of the conference. This booth was utilized for community members and providers to have space to ask questions about the community engagement efforts, as well as share their thoughts and insight to the UC San Diego Health Partnership team so that they could bring that information forward to SDCBHS decision-makers. Also provided at the resource booth was a data-enabled tablet which linked attendees to a set of questions about mental health and substance use needs and resources in the community. If preferred, a flyer was provided with the QR code and interest form link to allow any interested individuals to provide feedback or contact information. Also, an interest form was available for individuals to write down their email address to be contacted in the future. All resources were provided in English and Spanish languages.

Live Well Advance

The Live Well Advance was a conference held on December 8, 2022 that included a sizable gathering of various programs, researchers, providers, and professionals all dedicated to connecting each other to resources that would benefit health within the San Diego community. The conference was intended to bridge people working to improve the health of the community by sharing resources, organizations, and opportunities that might have been difficult to otherwise facilitate.

At this conference, there was a resource booth held by the UC San Diego Health Partnership team. The resource booth encouraged conference attendees to provide feedback regarding the behavioral health resources within their community. The goal of gathering feedback was to learn more about the availability and efficiency of existing resources, areas with a high need for more resources, along with individuals or groups in need of more resources. This solicited feedback was either collected on a provided tablet connected to a set of questions to be completed at the booth or a flyer was provided with the QR code and interest form link. Also, an interest form was available for individuals to write down their email address to be contacted in the future. All resources were provided in English and Spanish languages.

Recovery Happens

The SDC held a gathering on September 17, 2022 revolving around the concept of celebrating recovery among community members called “Recovery Happens.” This celebration brought together organizations, motivational speakers, information on prevention and treatment of substance abuse, and outlets for creative expression intended to promote the overall behavioral health of San Diego residents.

Numerous organizations designed resource booths to display at The Recovery Happens event, using the event as an opportunity to spread awareness of their respective goals. The UC San Diego Health Partnership hosted a booth throughout the entirety of the event to gather the perspectives of those in attendance regarding behavioral health services within the community. The booth contained a tablet connected to a set of questions to be completed at the booth or a flyer was provided with the QR code and interest form link to allow any interested individuals to provide feedback or contact information. Also, an interest form was available for individuals to write down their email address to be contacted in the future. All resources were provided in English and Spanish languages.

Change Your Mind Mental Health Festival

Interfaith Community Services organized the inaugural "Change Your Mind" mental health-oriented festival held on September 10, 2022, in Carlsbad. The overall objective of this free community event was to "change the conversation surrounding mental health – one mind and one life at a time." The festival comprised workshops, panels, and breakout sessions on a range of topics including Belonging, Destigmatizing Mental Health, Tools to Survive and Thrive, and Healing through the Arts, among others. There were also interactive enrichment activities such as live music, dance performances, yoga, guided meditation, and sound baths to promote learning and engagement. A wide range of community groups and organizations also participated in the festival, including the UC San Diego Health Partnership, through resource and information sharing booths set up throughout the event space.

The UC San Diego Health Partnership booth was active for the duration of the all-day event and engaged in discussions with attendees about their perceptions of behavioral health needs and services. In addition, flyers were distributed with a QR code to a brief community survey and an interest form link to be contacted for future outreach and education opportunities. All resources were provided in English and Spanish languages.

MHSA Trainings

An integral component of the MHSA CPP process is the provision of training to educate SDC staff, behavioral health providers, and community stakeholders, regarding the MHSA laws, components, and CPP process. For the FY 2022-23 CPP, the UC San Diego Health Partnership scheduled and facilitated four community-facing MHSA training sessions. In alignment with the local guidelines of COVID-19 along with the effort to provide outreach to numerous individuals in the San Diego community, three of these trainings were conducted virtually via Zoom and one of the trainings was held in-person at the Meeting of the Minds Conference.

Flyers advertising the virtual training sessions were distributed in both Spanish and English in a variety of spaces, including the UC San Diego Health first and second-order contacts, SDCBHS mailing lists, SDC 211 calendars, and posted at local community spaces, including coffee shops and the YMCA. The flyers included date, time, and a brief description of the MHSA training topics and intended learning outcomes. Registration instructions, including a registration link and a QR code, were provided on the flyers.

Of the MHSA training sessions held, unique individuals were in attendance who represented all six HHSA regions. Training participants identified themselves as community members, consumers of behavioral health services, family members of consumers, current and former BHAB members, representatives and staff of community-based organizations and nonprofits, and academic and research organizations. The

trainings were conducted in English, with live Spanish interpretation for participants who preferred to listen in the Spanish language.

The training sessions were introduced by either Nadia Privara Brahms, Assistant Director, Chief Strategy & Finance Officer for the SDCBHS or Katherine Briggs, Chief of Agency Operations, Communication & Engagement. The overarching goal of the MHSA trainings is to inform attendees of the most important and relevant aspects of MHSA and the CPP process. Specifically, the presenters discussed history, laws, specific components of the MHSA as well as the CPP process. Interactive questions were included during the training sessions. In the second half of the trainings, an open-ended question was presented to the audience: What is the main behavioral health need of your community? Answers from participants included housing, more support for the workforce, better access to services, and community engagement. Participants were asked to complete a training session satisfaction survey at the end of the training. Full findings from the MHSA training sessions are included in Chapter 4. An example of the training flyer is provided in Appendix B. An example of the training presentation is in Appendix C.

Chapter 3 – Community Engagement: Methodology

There were three primary types of community engagement activities that the UC San Diego Health Partnership team facilitated as part of the FY 2022-23 CPP process to gather information from community stakeholders through SDC. Activities included: 1) Key Informant Interviews; 2) Focus Groups; and, 3) Listening Sessions.

Key Informant Interviews

In order to gather stakeholder input from community leaders and advocates regarding the essential understanding and vital steps needed for community engagement efforts within the San Diego community, key informant interviews were conducted with identified key personnel in the San Diego community who have been working in the behavioral health field, along with target populations. UC San Diego in partnership with SDCBHS identified the individuals for the key informant interviews. UC San Diego researchers contacted the identified individuals to explain the CPP process and determine a conducive time to schedule a virtual interview.

Key Informant interviews were scheduled via Zoom to last between approximately 45 to 60 minutes and were audio and video recorded. The audio files were transcribed, and the transcripts were used in data analysis (described in more detail in Chapter 4). A consistent key informant interview guide was used with minor tailored questions, when relevant for a specific individual. The discussion guide served as blueprint for each interview, however, it is acknowledged and embraced that the conversation, at times, strayed from the guide when insightful and interesting discussions emerged naturally. Participants of each key informant interview were asked to complete a Qualtrics survey to collect demographic information to summarize and included in analysis and results. A sample demographic survey is located in Appendix D.

Focus Groups

To gather insight into the existing strengths, resources, and needs of program services for specialized populations, focus groups were held throughout FY 2022-23. The goal of each focus group was to understand the strengths and resources currently available to each target population, along with the working to identify the challenges to accessing resources for behavioral health and unique ideas to address priority needs for each population. Also, focus groups were utilized to try to learn how to best

communicate with community members to create effective feedback loops for this community engagement process.

Focus groups participants were comprised of a mix of providers, community advocates, community groups, and consumers of the following identified target specialized populations: Parents with lived experience navigating the system, providers/staff providing services to parents in the community, TAY, OAs, Justice involved, Faith-based communities, Veterans and Active Military, Perinatal and Postpartum Care for Women, NA/AI, Rural, Latinx, and immigrant and refugee.

Focus Groups Led by the UC San Diego Health Partnership

Recruitment for focus groups involved reaching out to community partners and individuals who expressed interest verbally during CPP engagement efforts, via email to the "mhsavoices" email, and/or submitted contact information through the developed Qualtrics survey (shared at the aforementioned outreach events) regarding interest in future CPP engagement efforts. Also, in collaboration with SDCBHS and CHWs and relying on the UC San Diego Health Partnership, first and second order contacts, community partners and individuals who may have specific insight into each priority population were distributed flyers and the link to complete an interest form for each identified special population focus group. When appropriate and accessible, flyers were also created for specific population focus groups to be shared via social media platforms. A sample flyer is provided in Appendix E.

Varied approaches to conduct focus groups were utilized for each special population to meet the needs for each community. However, due to the COVID-19 pandemic and the effort to increase accessibility to attend, the majority of focus groups were provided virtually via Zoom. Focus group typically were 60-90 minutes in duration. The focus group discussions were recorded, and the transcripts were used in data analysis (described in more detail in Chapter 4). A consistent focus group guide was used with minor tailored questions, when relevant for a specific specialized population. The discussion guide served as blueprint for each focus group sessions, however, it is acknowledged and embraced that the conversation, at times, strayed from the guide when insightful and interesting discussions emerged naturally. Participants of each focus group were asked to complete a Qualtrics survey to collect demographic information to summarize and included in analysis and results of each focus group. A focus group interview guide sample is in Appendix F.

Focus Groups Led by the SPC in Partnership with UC San Diego

Recruitment for SPC focus groups was conducted by the SPC to gather information on community strengths, needs, priorities, and ideas used to guide the Suicide Prevention Action Plan (SPAP) 2023 update. The goal of the evaluation plan for the SPAP Update 2023 was to guide the collection and use of data to monitor progress of community level outcomes and SPC functioning. Community engagement strategies for the SPAP Update 2023 consist of focus groups, an online survey, and key informant interviews. Focus groups were coordinated in partnership with numerous host organizations, who leveraged their status as trusted brokers and service providers. Flyers and a link to the registration of the focus group were circulated to community partners, partnered organizations with CHIP, and any individuals who may have insight into each targeted population identified for each focus group.

To align efforts with the SPC community engagement focus groups, UC San Diego Health partnered with SPC for the Latinx and Asian American/Pacific Islander focus groups conducted in January 2023 to collect input from these two specialized populations for this MHSA 3-year annual report. The focus groups were held virtually via Zoom.

The following two questions specific to the CPP process were included in the SPC focus group guide to collect input from the Latinx and Asian American/Pacific Islander populations:

- What would you say are the strengths of the community that are important to hear when thinking about mental health and substance use needs?
- What kind of mental health and/or substance use services do you need to make sure you, your family, and the community are cared for? What challenges are important for us to know about that impact your community in using behavioral health resources and services?

In the spirit of authentic partnership, the UC San Diego team reciprocated inclusion of several integral questions related to key topics of interest to the SPC into the UC San Diego-led focus groups regarding behavioral health services. In this regard, it is anticipated that this mutually beneficial partnership between UC San Diego Health and SPC data collection activities will continue in future years to expand the reach into the community beyond what each network could accomplish individually.

Listening Sessions

For this reporting period, "Listening Sessions" were defined as instances where representatives of the UC San Diego Health Partnership developed and conducted structured feedback activities within an existing community meeting or event regarding behavioral health service needs, opportunities, and concerns as well as the preferred mechanisms for communication and community engagement. These listening sessions took a variety of forms and reached a wide range of audiences, with an overarching goal of having the UC San Diego Health Partnership "go to" (either virtually or in-person) the places and spaces where people were already gathering in order to facilitate their ability to provide essential input.

While some tailoring for time and group orientation occurred across the listening sessions, the general format included a PowerPoint presentation introducing the UC San Diego Health Partnership and providing background to the MHSA CPP process and efforts. Then the participants were led through a community engagement activity asking for them to provide input via sticky notes (for in-person listening sessions) or virtual whiteboard (i.e., Mentimeter) for each of the following four questions:

- What are the most pressing issues related to mental health and substance use in your community?
- What are some of the biggest challenges to accessing resources for behavioral health?
- What ideas can you share for addressing the priority behavioral health needs of the rural community?
- What are some ways to successfully engage with our communities?
    - How can we authentically reach harder-to-reach groups and populations?
    - What are some misconceptions to be aware of?

After each question, there were opportunities for participants to discuss and engage individual responses. Detailed notes were taken of the conversation and where feasible, the discussion was recorded to be transcribed and utilized in analyses. The ideas listed on the sticky notes/virtual whiteboard were also documented and incorporated into the analysis. Following are more detailed discussions of select listening session events conducted by the UC San Diego Health Partnership team.

Live Well Advance Conference

Listening sessions activities were utilized at the Live Well Advance conference as an opportunity to convene stakeholders from throughout the San Diego community, for the purpose of gathering input from underserved and unserved communities, to inform the continuum of care and to advance behavioral health equity.

The UC San Diego team led two listening sessions at the LiveWell Advance conference (detailed below). These sessions were comprised of a PowerPoint slide presented to the attendees, followed by a community engagement activity among the group members at each table to facilitate community input and discussion. The community engagement activity entailed sticky notes to be provided to each participant to write down their responses to the designated questions during each session. Small groups of three to seven participants were formed with one UC San Diego or CHIP representative leading each group. A specific color sticky note was designated for each question and participants were allowed to write as many desired sticky note responses for each question. Each small group were allowed 5-10 minutes to fill out the small colored sticky notes to answer each question, add it to the large sticky note paper for each small group, and discuss their response. After going through all questions, participants were brought back together as a larger group and the most significant takeaways of those smaller discussions were then shared with the rest of the group.

Session 1: "Supporting Wellness, Recovery, and Resilience Through Community Input"

The presentation at this session began by introducing the UC San Diego Health Partnership then provided background on MHSA and the CPP process and how it is related to SDCBHS programs and services. The MHSA CPP process was further detailed to how individuals may participate and get involved to provide feedback and input that impact how SDCBHS can use MHSA funding for behavioral health services and programs. Attendees were then transitioned into the community engagement activity to answer the following questions:

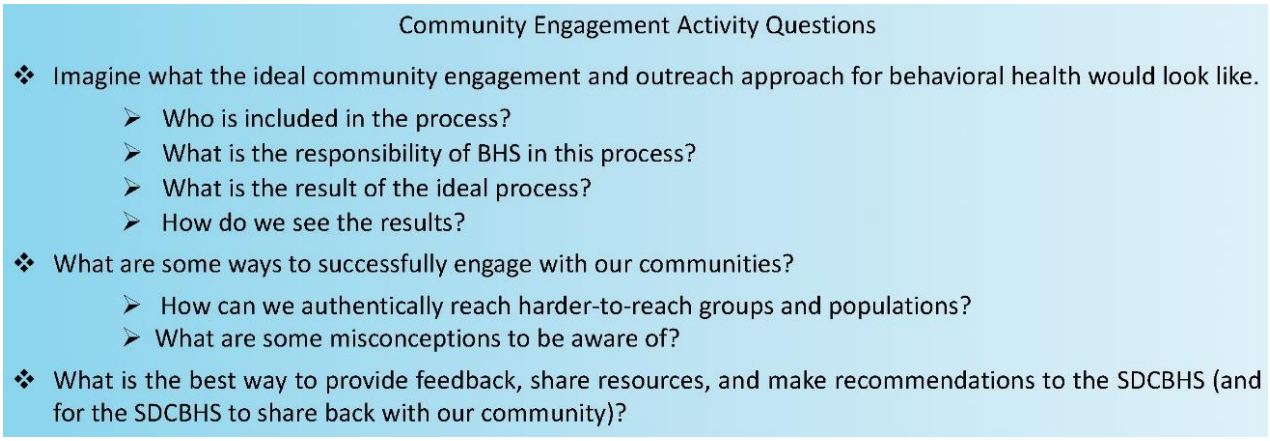
- What are the most pressing issues related to mental health or substance use in our community?
- What resources exist in your community for mental health or substance use?
- What are the biggest challenges to accessing resources for behavioral health in your community?
- What ideas can you share for addressing the priority behavioral health needs of your community?

At the end, the listening session provided volunteer opportunities to discuss answers as a larger group to any of responses community members provided to the questions. The ideas listed on the post-it notes were documented and incorporated into the analysis. The presentation utilized is provided in Appendix G.

Session 2: "Building an Alliance for Behavioral Health Equity Based on Community Efforts and Expertise"

During this session's presentation, attendees were provided with summary information on the CPP process and the crucial role of stakeholder involvement. We also highlighted the UC San Diego Health Partnership's commitment and goals for community engagement, which focused on initiating planning conversations to support mental health, prevent substance misuse, and improve behavioral health equity. Following the presentation, attendees were led into a community engagement activity that aimed to further explore the topic. A list of questions presented during the activity can be found in Figure 6.

Figure 6. Live Well Advance Community Engagement Activity Questions



At its conclusion, the listening session provided volunteer opportunities to discuss answers as a larger group to any of responses community members provided to the questions. The ideas listed on the sticky notes were documented and incorporated into the analysis. The presentation is provided in Appendix H.

Regional Community Engagement Forums in partnership with the Live Well San Diego Community Regional Leadership Teams

To foster engagement among members of the San Diego community at a regional level, community engagement forum activities were implemented in five of the six HHSA regions of San Diego. As mentioned above, current SDC HHSA has Live Well San Diego Community Regional Leadership Team Meetings (LWSD CRLT) held on a monthly basis in each of the six HHSA regions. These LWSD CRLT meetings are comprised of diverse partners, agencies, and advocates who are working together to identify the needs and priorities of each region. In collaboration with the SDCBHS and each SDC LWSD CRLT meeting coordinators, the UC San Diego Health Partnership utilized the standing regional meetings to engage the community through regional community engagement forums. The goal of each regional community engagement forum was to convene stakeholders and the community for the purpose of gathering input regarding resources, services, and barriers specific to each HHSA region to inform SDCBHS continuum of care and improve the behavioral health equity at a regional level. In further collaboration with the SDCBHS, the UC Health Partnership held a comparable listening session with the BHAB and SOC Council members.

Partnering with the LWSD CRLT coordinators to maximize input opportunities while minimizing community burden, the UC San Diego Health Partnership utilized in-person and virtual community engagement efforts based on the preference and needs of each regional LWSD CRLT (Please see table below for details on each regional forum community engagement effort). Each community engagement effort began with a presentation to introduce the UC San Diego Health Partnership then provide background on MHSA and the CPP process and how it is related to SDCBHS programs and services. The MHSA CPP process was further detailed to how individuals can participate and get involved to provide feedback and input that impact how SDCBHS can use MHSA funding for behavioral health services and programs. Attendees were then transitioned into the community engagement activity to answer the following questions either via written response, when in-person, or via Mentimeter, when in a virtual setting.

Figure 7. Community Regional Leadership Teams Community Engagement Activity Questions

Community Engagement Activity Questions

- What are the most pressing issues related to mental health and substance use in your community?
- What are some of the biggest challenges to accessing resources for behavioral health?
- What ideas can you share for addressing the priority behavioral health needs of the rural community?
- What are some ways to successfully engage with our communities?
- How can we authentically reach harder-to-reach groups and populations?
- What are some misconceptions to be aware of?

At the end of the session, each regional forum provided opportunities for volunteers to discuss answers with the entire group about the responses they provided.

Chapter 4 – Community Engagement: Analysis & Results

As described in prior chapters, multiple types of engagement activities occurred during the FY 2022-23 CPP process. In this chapter, the community feedback and satisfaction data collected as part of the MHSA Training facilitation are discussed followed by a description of the analysis strategies and findings from the wide range of other community engagement and data collection activities. While most findings pertain to perceptions about behavioral health service needs and priorities, findings are also presented regarding community member thoughts about the CPP process and how to promote an authentic and effective partnership through the community engagement activities.

MHSA Trainings: Community Feedback and Satisfaction

As stated in Chapter 2, MHSA trainings were provided to members of the community to help improve their knowledge of the MHSA and how MHSA impacted services provided in SDC. Attendees were provided with an anonymous online Qualtrics survey (i.e., distributed via QR code and link during the session, and via email after the session), which asked about their satisfaction with the training (see Appendix I) and for other feedback. The survey was only completed voluntarily by attendees who wanted to provide feedback; there was no deadline nor incentive offered. Upon completion, these surveys were analyzed by the UC San Diego team. Details of this analysis are explained in more detail below.

Participants

Of the four MHSA training sessions held in FY 2022-23, there were 196 attendees. Of those attendees, 67 individuals voluntarily completed the survey for an overall response rate of 34%. Most of the individuals who participated in the survey (94%, N=63) attended a virtual training session. Even so, these individuals made up only 37% of all individuals who attended all virtual MHSA training sessions (N=166). As such, it is important to note that the survey only captured the views of some of the participants who attended the four MHSA trainings and is not necessarily representative of the diversity of participation these events received.

Community Representation

As shown in Table 1, participants both in the MHSA training and in the survey came from a variety of groups within the San Diego community. The surveys were completed primarily by community-based organization (CBO) staff or Behavioral Health service providers (43%). Community members made up the next largest group (22%). In general, members of the San Diego community made up a substantial portion of the survey respondents. Thirty-nine percent of respondents were either community members, consumers of Behavioral Health Services (BHS), or family members of consumers.

Table 1. Community Groups Represented by MHSA Training Survey Respondents

Community Group	N*	%
CBO staff/Behavioral Health Provider	29	43.0%
Community Member	15	22.0%
Consumer of BHS Services	7	10.0%
County of San Diego BHS Staff	10	15.0%
Family Member of Consumer	5	7.0%
Other County of San Diego Staff	5	7.0%
Other Nonprofit Organization	4	6.0%
Other	6	8.0%

**Participants could check more than one option.*

Demographics

Table 2 lists the characteristics of the people who completed the MHSA Training Satisfaction Survey. Most participants (78.7%) were between the ages of 25 and 59 years old. Eighteen percent were at least 60 years old, with only 3% of respondents being between 16 and 25 years old. Three percent of respondents preferred not to answer these questions. Most of the survey participants identified as non-Hispanic White (53.7%) with the next largest group identifying as Hispanic/Latinx (22.4%). Four participants declined to answer (6%). Participants were also asked about their sex assigned at birth, gender identity, and sexual orientation. Most of participants identified themselves as female (77%) and heterosexual (74%). Across all questions, between 5 – 10% of participants preferred not to answer these questions. Most participants (83.6%) reported English as their primary language. Other languages mentioned were Arabic (3.0%), Aramaic (7.5%), and Japanese (4.5%).

Table 2: Characteristics of MHSA Training Satisfaction Survey Respondents

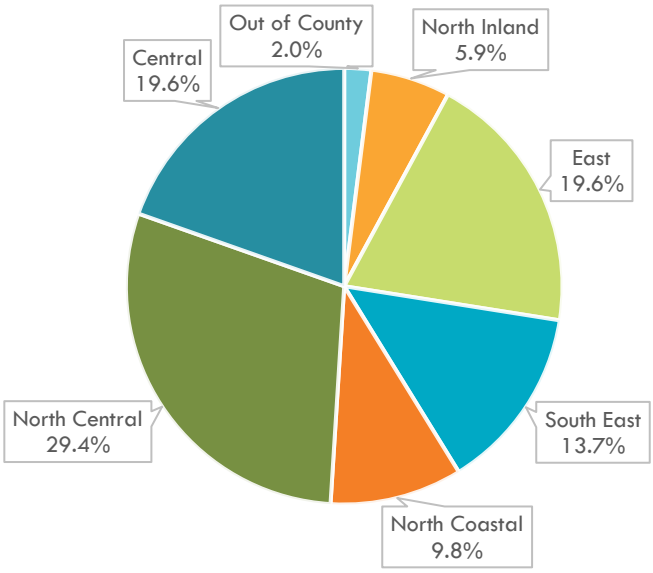
Age Group	N=61	%
16-25 years old	2	3.3%
25-59 years old	46	75.4%
60 years old and over	11	18.0%
Prefer not to answer	2	3.3%

Race/Ethnicity[1]	N=67	%
Black or African American	2	3.0%
Filipino	5	7.5%
Hispanic/Latinx	15	22.4%
Japanese	3	4.5%
White	36	53.7%
Another Race	2	3.0%
Declined to Answer	4	6.0
Primary Language	**N=61**	**%**
English	51	83.6%
Arabic/Spanish/Other	10	16.4%
Military Status	**N=57**	**%**
Never served in the military	55	97.5%
Preferred not to answer	2	3.5%
Sex Assigned at Birth	**N=53**	**%**
Male	8	14.8%
Female	43	79.6%
Prefer not to say	3	5.6%
Gender	**N=56**	**%**
Male	7	12.4%
Female	43	76.8%
Genderqueer/gender non-conforming	2	3.6%
Another Gender Identity (please specify): Intersex	1	1.8%
Prefer not to answer	3	5.4%
Sexual Orientation	**N=57**	**%**
Heterosexual or straight	42	73.7%
Gay or Lesbian	3	5.3%
Bisexual/pansexual/sexually fluid	2	3.5%
Queer	4	7.0%
Prefer not to say	6	10.5%
Disability[1]	**N=67**	**%**
Does not have a disability	54	80.6%
Has some form of disability	5	7.5%
Prefer not to answer	8	11.9%
Additional Groups that Participants Identify With[1]	**N=60**	**%**
Immigrant	12	20.0%
Refugee/Newcomer	1	1.7%
Veterans/Military	1	1.7%
Chaldean	1	1.7%
Homeless	1	1.7%
LGBTQI+	9	`5.0%
Other groups not mentioned above	1	1.7%
Prefer not to answer	2	3.3%
Do not identify as any of these additional groups	32	53.3%

[1] *Participants could select more than one option.*

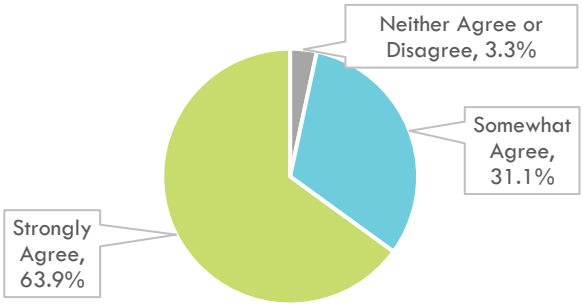
Participants voluntarily entered zip code information, which helped determine which HHSA regions of San Diego were represented in the survey. Participants lived in all six HHSA regions, though nearly half (49.0%) were from the North Central and Central regions. See Figure 8 for the complete distribution by region.

Figure 8. SDC HHSA Regions of Respondents



MHSA Knowledge and Satisfaction

Figure 9. MHSA Knowledge Improved



A primary outcome of the survey was to determine whether participants felt that the training had improved their knowledge of how MHSA is used in SDC. To that end, 95% of participants somewhat agreed or strongly agreed that their knowledge of MHSA improved after the training. No one disagreed the training resulted in gaining knowledge.

Further, 91% of participants were satisfied with the training and material, with more than half of participants expressing being 'Extremely Satisfied' (64%).

Important Issues

Another goal of the MHSA training survey was to learn more about other major issues impacting individuals across SDC. Survey participants were asked to list up to three major issues they found in their respective communities. Write-in responses were grouped together to form themes. The most common themes (i.e., endorsed by 10 participants or more) are listed in Table 3 below, alongside three statements that exemplify that theme.

Table 3. Top Themes of Qualitative Answers from Respondents on 3 Major Issues in their Communities

Theme: Diversification (Endorsed by 20.4%)		
"Mental health meds for the criminal justice population"	"Culturally reflective care"	"Innovation project to explore best practices for integrating Islamic faith in treatment"
Theme: Housing (Endorsed by 18.3%)		
"More permanent, affordable housing"	"More crisis houses"	"Pairing mental health treatment with housing. Mental health can't stabilize if you're homeless"
Theme: Increased Access (Endorsed by 15.5%)		
"Closing gaps to services such as mobile non-crisis services"	"Families & schools can't always ask for help - easy access is needed"	"Greater access, bringing services to where clients live"
Theme: Education (Endorsed by 9.2%)		
"Stigma, misinformation"	"Educating young people, suicide prevention"	"LGBTQ awareness and knowledge"
Theme: Support for Workforce (Endorsed by 7.7%)		
"Workforce development and increased pay rates in existing contracts"	"Behavioral health workforce shortage, more paid opportunities for current interns /students"	"Workforce compensation/ support to retain workers in high-burnout BHS programs such as SUD/OUD & crisis residential"
Theme: Children and Youth Services (Endorsed by 7.0%)		
"Better care for youth transitioning to adulthood"	"Taking care of our children, esp. depression, suicide prevention, and drug prevention"	"Support for families with children in need of behavioral health services"

Schedule

Finally, the survey was also used to gauge how well the training schedule worked for participants. Prior to launching MHSA trainings, concerted attention was aimed at determining the dates and times that would maximize the ability for a diverse cross-section of community stakeholders to attend. The schedule was chosen with specific attention towards common workday hours to facilitate participation from providers and consumers. The overwhelming majority of respondents indicated the training fit with their schedule, with the largest preference being midday on Friday.

Table 4. MHSA Training Dates and Times

Date/Time	Format	% of Survey Respondents Indicated	
		Day of Week was a Good Fit	Time was a Good Fit
Tuesday September 20th 12:00pm-1:15pm	Zoom Webinar	95%	70% Agreed 40% Strongly Agreed Results indicated preference is Fridays at Noon
Friday September 23rd 12:00pm-1:15pm	Zoom Webinar		
Wednesday September 28th 5:00pm-6:15pm	Zoom Webinar		
Wednesday October 12th 2:15-3:15[1]	In-person	N/A[2]	

[1]The October 12th MHSA training was held as a workshop during the Meeting of the Minds conference that was open to all conference attendees. [2]This question was not asked to participants of the in-person training on October 12th, as they had registered for the full day conference event in advance and according to their schedule.

Communications

Of all 67 survey respondents, 80% indicated they would like to be emailed regarding future events, and 20% preferred not to be contacted.

Future Events

Survey respondents were asked if they would prefer to have future events in-person or virtual/online. The responses clearly indicated that online/virtual events to be the preference at 82%. Forty-one percent of participants agreed that answers for future events, "depends on the COVID-19 situation".

Provide Future Input

Finally, when participants were asked how they would like to provide their input in future events, the largest number of responses (i.e., 65.7%) selected a forum/listening session.

Table 5. Respondent's Preferences on Method of Providing Future Input

Suggestion	N*	%
Forum/Listening Session	44	65.7
Focus Groups	27	40.3
Individual Interviews	12	17.9
Other: Survey	3	4.5
Other: Work with current efforts happening in the community	3	4.5
Other: Involve/interview specific community groups (Veterans, refugees)	2	3.0
Total	**91**	

**Participants could select more than one option.*

Qualitative Analysis

Data collection included individual interviews with community stakeholders, focus groups, and community listening sessions. The interview and focus group recordings were transcribed verbatim in Otter.ai (https://otter.ai/) and then uploaded into Dedoose qualitative coding software (https://www.dedoose.com). The short-answer responses collected through community listening sessions were transcribed in Microsoft Excel and uploaded into Dedoose. An internal quality assurance process was conducted on all data, with a minimum of two members of the UC San Diego Health Partnership providing to ensure reliability and consistency.

The interview and focus group data were analyzed first using deductive and inductive content analysis (Krippendorff, 2018). Deductive content analysis is an approach to qualitative analysis that starts with an existing theory or framework and applies conceptual categories to the data using a category application process to extend understanding of the research question (Hsieh & Shannon, 2005; Mayring, 2004). When content emerged in the transcripts that expanded upon the existing conceptual categories, an inductive content analysis approach was used to generate new codes within the conceptual framework (Hsieh & Shannon, 2005). After the initial content analysis was conducted, thematic analysis (Braun & Clarke, 2006) was used to highlight themes central to how community members viewed the components of the community planning process. The thematic analysis helped to distinguish salient themes across the interviews and focus groups related to how community members understood the strengths and barriers of the community planning process and priority community needs.

The short-answer responses to the four questions asked at the community listening sessions were analyzed separately from the interview and focus group data using quantitative content analysis (Krippendorff, 2018). The goal of the analysis was to identify how community members identified the strengths and challenges in their communities relative to substance use and mental health, and to identify community feedback related to addressing priority behavioral health concerns.

Community Program Planning Process: Participants

Table 6 lists out key information for each CPP event regarding the focal audience, the process of engagement and how data were collected as well as the number of participants.

Table 6. Summary of CPP Process Events

Listening Sessions	Format	Community Engagement Effort Conducted	N
Live Well Advance Conference Session 1	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes	~ 80
Live Well Advance Conference Session 2	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes	~ 40
LWSD North Region	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes	~ 60 – 70
LWSD North Central	Virtual (Recorded)	Presentation & Community Engagement Activity utilizing Mentimeter	37

LWSD Central	Virtual (Recorded)	Presentation & Community Engagement Activity utilizing Mentimeter	~ 50
LWSD East	Virtual	Presentation & Community Engagement Activity utilizing Mentimeter	~ 40
BHAB & SOC Councils	Virtual (Recorded)	Presentation & Community Engagement Activity utilizing Mentimeter	~21
Latinx North Region	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes	20
Rural Mountain Collaborative East Region	Virtual	Presentation & Community Engagement Activity utilizing Mentimeter	32
Focus Groups	**Format**	**Community Engagement Effort Conducted**	**N**
Faith-Based	Virtual (Recorded)	Focus Group	5
Justice Population	Virtual (Recorded)	Small Group Interview	2
NA/AI	Virtual	Focus Group	4
Older Adult	Virtual (Recorded)	Small Group Interview	2
Prevention and Early Intervention in Children and TAY, Veterans and Active Military, and Culturally Responsive populations	Virtual (4 separate sessions)	Focus Groups	36
Perinatal and Postpartum Care for Women	Virtual (Recorded)	Focus Group	9
Somali Family Service Immigrant/ Refugee	Virtual (Recorded)	Focus Group	16
TAY	Virtual	Focus Group	10
Veterans and Active Military	Virtual (Recorded)	Focus Group	6

Interviews	Format	Community Engagement Effort Conducted	N
Community Leaders	Virtual (Recorded)	Virtual meeting to discuss Community Engagement with key leaders in the community	11

As shown in Table 7, most participants (76.3%) were between the ages of 25 and 59 years old. Twelve percent were at least 60 years old, with the last 11.3% of respondents being between 16 and 25 years old. The largest group of respondents identified as White (46.4%) with the next largest group identifying as Hispanic/Latinx (21.6%) and 18.6% identifying as Black or African American. Notably, 13.4% of participants selected that they identify with a racial or ethnic group not listed in the survey options. Most participants (88.8%) reported English as their primary language. Approximately 9.3% of participants indicated that they were a Veteran.

Table 7: Characteristics of Persons Participating in Engagement Activities

Age Group	N=97	%
16-25 years old	11	11.3%
25-59 years old	74	76.3%
60 years old and over	12	12.4%
Race/Ethnicity[1]	**N=97**	**%**
Hispanic, Latino/a, or Spanish origin: Mexican, Mexican American, or Chicano	21	21.6%
American Indian	5	5.2%
Black or African American	18	18.6%
White	45	46.4%
Race or Ethnic Identity not Captured Above	13	13.4%
Declined to Answer	1	1.0%
Primary Language	**N=89**	**%**
English	79	88.8%
Arabic/Spanish/Other	10	11.2%
Military Status	**N=97**	**%**
Never served in the military	88	90.7%
Identifies as a Veteran	9	9.3%
Sex Assigned at Birth	**N=97**	**%**
Male	23	23.7%
Female	73	75.3%
Prefer not to say	1	1.0%
Gender	**N=97**	**%**
Male	23	23.7%
Female	72	74.2%
Another Gender Identity	2	2.1%

Sexual Orientation	N=97	%
Heterosexual or straight	84	86.6%
Another orientation (i.e., Gay, Lesbian, Bisexual, Queer)	9	9.3%
Prefer not to say	4	4.1%
Disability[1]	**N=95**	**%**
Does not have a disability	76	80.0%
Difficulty Seeing	5	5.3%
Chronic health condition/Chronic pain	8	8.4%
Other disability not listed above	8	8.4%
Prefer not to answer	1	1.1%
Additional Groups With Whom Participants Identify	**N=97**	**%**
Immigrant	16	16.5%
Refugee/Newcomer	6	6.2%
Veterans/Military	10	10.3%
African	5	5.2%
LGBTQI+	6	6.2%
Other groups not mentioned above	9	9.3%
Do not identify as any of these additional groups	45	46.4%

[1] *Participants could select more than one response so values may total to more than 100%.*

Participants were also asked about their sex assigned at birth, gender identity, and sexual orientation. Most of the participants identified themselves as female at birth (75.3%), female gender (75.3%) and heterosexual (86.6%). Across all questions, less than 5% of responding participants preferred not to answer these questions.

To better understand the needs of respondents, they were asked to self-identify specific disabilities they were facing. The question covered a range of physical and mental impairments (other than mental illness), such as difficulty seeing or hearing, learning disability, developmental disability, and more. Participants also had the option to indicate other specific conditions. About 19% of survey respondents indicated that they had a disability.

Another survey item allowed participants to share which, if any, of the following additional groups they identify with: immigrant, refugee/newcomer, asylee, Veterans/military, homeless, African, Chaldean, LGBTQI+, and to write in any other group they identified with that was not listed. They were also able to select 'Prefer not to Answer.' Of note, 16.5% self-identified as an immigrant. Other groups endorsed were refugee/newcomer (6.2%), LGBTQI+ (6.2%), and African (5.2%). Notably, 9.3% of participants reported that they identify with a group not listed in the survey options.

Community Program Planning Process: Findings

Participants Define Community Engagement

A foundational element of CPP is stakeholder participation. As part of this year's engagement efforts, participants were asked to define community engagement in their own words – the overarching theme of their responses was ***building trust***. Building trust is essential for community engagement, as it establishes a basis of mutual respect and open communication.

According to community stakeholders, building trust in community engagement should include the following:

1. **Transparent communication:** Encourage open and transparent communication, listen actively to the concerns and perspectives of community members, and provide regular updates on progress.
2. **Inclusivity:** In community engagement, an inclusive process means involving all community members regardless of race, ethnicity, age, sex at birth, gender identity, gender expression, disability, socio-economic status, sexual orientation, national origin, religion, marital status, or political affiliation. This process requires making intentional and ongoing efforts to reach out to all community members, inviting their participation, and ensuring that community engagement events are scheduled with advance notice. It also includes making the community sessions accessible to everyone, including people with disabilities and those who may face language or cultural barriers.
3. **Credibility:** Demonstrate a commitment to the community by following through on promises and being accountable for actions.

By being transparent, inclusive, and credible, it is possible to build trust and establish a positive relationship with the community, leading to more effective and sustainable outcomes.

Participants also defined community engagement through two phases of participation, which the UC San Diego Health Partnership is defining as ***preparatory and informative participation***. ***Preparatory participation*** is a process that involves educating and informing individuals and communities about a particular issue or decision before they decide to participate in a more formal engagement process. The purpose of preparatory participation is to ensure that individuals have the information and understanding they need to make informed decisions and contribute effectively to the engagement process. Preparatory participation can take many forms, such as informational meetings, workshops, community forums, and online resources. The focus is on providing the information, tools, and resources needed to engage meaningfully and effectively in the decision-making process.

Informative and decision-making participation refers to the process of actively involving individuals and communities in the decision-making process and allowing them to provide input and feedback that can shape the outcome. This type of participation goes beyond simple education or awareness-raising and enables individuals to have a real and meaningful impact on the decisions that affect their lives and communities. Informative and decision-making participation can take many forms, such as public meetings, town hall events, online consultations, and stakeholder committees. The focus is on ensuring that individuals have a voice in the decision-making process and that program planners take their input into consideration. This process can involve providing opportunities for individuals to ask questions, provide feedback, and participate in developing solutions.

Collaborative Brainstorming Responses

Nine listening sessions were held between October 2022 and February 2023 to obtain community input. SDCBHS collaborated with the CPP team and reached out to all six SDC regions. This allowed the CPP team to use existing LWSD meeting spaces to conduct listening sessions. However, due to scheduling conflicts and time constraints, a listening session was unable to be conducted for the South region prior to the end of data collection for this reporting period. During these listening session participants had the opportunity

to share short responses either through a virtual board or post-it notes. The following regions were represented in these listening sessions.

Table 8: Listening Sessions by Region

Region	Number of Sessions
Central	1
Countywide	3
East	2
North Central	1
North*	2
Total	**9**

***North includes North Coastal and North Inland regions.*

Content analysis was used to provide counts of the most frequently reported themes in the brainstorming session, the findings of which are included below. The counts are based on the number of times the theme was mentioned. Some regional differences are noted that may help in making geographical decisions when planning the MHSA programs.

Behavioral Health Needs

Table 9 shows the ten themes most often mentioned during the listening sessions' brainstorming activity. Where meetings were focused on a particular region, responses pertaining that region were noted. The heat map presented in Table X below indicates the themes based on frequency of response. The darker the green color in the table, the more frequently the response was mentioned. This heat map helps to quickly distinguish differences in responses per region represented, compared to all regions.

Table 9: Most Pressing Behavioral Health Issues

Need	All Regions	Central	East	North	North Central	Unspecified SDC Region
Children's and TAY programming	92	8	14	27	13	30
Culturally appropriate services	77	3	8	9	4	32
Prevention and early intervention	39	9	1	9	8	12
Peer support/promotoras/ community health workers	39	1	0	2	12	24
Resources/resource list	38	3	5	3	8	19
One-stop hub or integrated system	34	1	1	13	1	18
School-based services	27	1	6	10	3	7
Substance use treatment	24	0	1	12	3	8
Acute and crisis services needed	22	3	1	8	5	5
Fentanyl crisis addressed	17	3	0	3	5	6

Generally, participants shared that the greatest need was for ***programs for children and TAY***. However, the second and third greatest need varied a little by region and included needs for ***culturally appropriate services***, prevention and early intervention, a one-stop hub or integrated system, and peer support/promotoras/community health workers.

"The most pressing issues related to mental health or substance use in our community is having access for clients to detox facilities, substance abuse programs, and crisis mental health facilities." (North Coastal)

Many participants shared their desire for resources and services to be provided at a younger age, which relates directly to the greatest needs expressed being for children and TAY programming as well as prevention and early intervention. Ideas for programs for children and TAY included school-based services that include prioritizing mental health and well-being, youth prevention training, suicide prevention, replication of the San Marco's Unified School District program, mental health services at colleges and universities, mental health curriculum included in health education, safe spaces for students, peer support, and in-person nicotine treatment.

Participants in the North region more frequently shared the need for a ***one-stop hub or integrated system***. Overall, there was concern about not having enough services in North County – this also included the need for regional detox substance use services.

North Central region participants shared the need to utilize ***peers, promotoras, or community health workers*** to bridge services when there are staffing shortages, long wait lists, and the need to connect a client with a resource. This included ensuring that these vital staff had access and were paid to attend training, as would be expected for any other behavioral health professional. Countywide, the use of peers, promotoras, or community health workers emerged as a theme of high importance as well.

"Leveraging community health workers and peers to act as connectors to access points for services." (BHAB/SOC)

Participants representing the Central region had their highest priority as ***prevention and early intervention*** *and* ***TAY and children's programs***. Ideas for prevention programs included psychoeducation, community workshops, and resources on coping strategies, especially after loss.

"Focus on coping strategies and prevention resources and trainings." (Central)

Some of the regions shared the importance of including the primary care physician in prevention strategies. Patients may trust their existing primary care more than a new specialist. Thus, primary care has an important role in providing prevention resources, especially in promoting inclusive client-centered services.

The East region mirrored the Countywide consensus for need regarding ***TAY and children's programs*** and ***culturally appropriate services***. Some ideas for culturally appropriate services included cross-generational mentoring groups (elders and youth), resources in preferred languages, culturally diverse clinicians as part of the mobile crisis teams, and culturally matched providers.

Challenges Accessing Resources

Participants who provided brainstorming responses noted several challenges frequently impacting access to resources and services throughout the County. Table X shows the ten most frequency reported responses.

Table 10: Challenges Accessing Resources by Region

Challenge	All Regions	Central	East	North	North Central	Unspecified SDC Region
Insufficient health care coverage	68	1	12	39	7	9
Stigma	63	4	11	22	11	15
Staffing issues	63	1	11	17	8	26
Transportation	62	2	19	25	2	14
Unaware of services available	59	5	9	25	14	6
Waitlists and scheduling	55	3	10	11	13	18
Cultural and language barriers	46	2	9	17	4	14
Technology barriers	18	1	6	5	0	4
Basic needs are not met	15	0	2	10	0	3
Government regulations	15	0	1	2	1	6

Participants who noted ***insufficient health care coverage*** voiced concern about limited assistance from insurance carriers to provide accurate provider lists, the cost of services, insufficient Medi-Cal coverage, restrictions regarding the number of sessions covered by insurance, limited coverage based on geographic location, difficulty navigating insurance referrals, not enough providers based on insurance coverage, and eligibility barriers.

"Need providers that take more than just Medi-Cal" (East)

Stigma was also frequently shared as a challenge. This included both social stigma around mental health and substance use, but also historical trauma. Social stigma surrounding behavioral health refers to negative attitudes and beliefs that society holds about individuals with behavioral health conditions. This stigma can lead to discrimination and misunderstanding, which can prevent people from seeking help for their behavioral health concerns. Examples of social stigma include:

- Dangerousness: The belief that people with mental illness are violent or dangerous, which can lead to fear and avoidance of those with mental health conditions.
- Weakness: The idea that individuals with mental illness lack willpower, strength, or resilience, and that they could simply "snap out of it" if they wanted to.
- Shame: The notion that mental illness is a personal failing or weakness, leading many people to feel ashamed or embarrassed about seeking help.

Part of the conversation regarding stigma also touched on historical trauma experienced by specific populations. This included historical trauma due to cultural differences and trauma from prior experiences with the behavioral health system, which is described in greater detail below.

Frustration was aired regarding ***staffing shortages*** throughout the County. Challenges regarding staffing also led to difficulties with ***waitlists and scheduling appointments***. This included times when an appointment was offered, but the participant could not make the appointment time due to work or family responsibilities. The concern that individuals who quickly needed services would have to wait months before seeing a provider, especially one close to their residence, contributes to individuals not following up on services.

> *"Not enough locations that are accessible to clients at the moment. There is a small window of time that clients are willing to get help – and if the location is too far – it won't work." (North)*

Location of services and lack of ***transportation*** were challenges voiced across the County, but particularly noted for East and North regions. On the other hand, participants shared that while many services may be available in their region, community members do not know how to access these services and are thus ***unaware of services available***. Even with resources such as 211, participants noted getting passed from one resource to the next and needing to advocate for themselves or a family member.

> *"Calling 211 is often promoted, but 211 will bump you to the Access Crisis Line because it's beyond a general question." (North Central)*

Cultural barriers included ***language barriers***, specifically in providing therapists and support staff who can speak the client's language of preference. Additionally, challenges with language also impacted outreach and resources provided as participants noted they often were unavailable in a diverse array of languages.

Technology barriers were due to the recent transition to more virtual services, caused in part by the COVID-19 pandemic. This included lacking infrastructure for appropriate technology and internet connectivity, difficulty in using telehealth services, being uncomfortable with virtual appointments, and lack of computer access.

While all the above were noted as significant barriers, the underlying reason for some individuals not seeking services was the desire to address ***basic needs*** first. It can be difficult for individuals to seek behavioral health services when their basic needs are not met. Basic needs can include physical needs such as food, shelter, and clothing, as well as emotional needs like safety, stability, and a sense of belonging.

> *"…access to housing, employment, nutrition/food." (East)*

There were a few region-specific themes that are important to highlight. For the East region, the participants noted an additional barrier due to ***rural or social isolation***. Specifically, that the rural and social isolation could lead to boredom and then result in substance use or depression. Participants in the North region also addressed ***immigration status*** as a challenge. Those who are immigrants may be hesitant to seek behavioral health services due to perceived implications or consequences of their immigration status.

Ideas for Addressing Behavioral Health Needs

The discussion about community behavioral health needs was often a catalyst for sharing innovative ideas about how to address these needs. This section provides some specific ideas that were shared during the brainstorming sessions.

Educate community about the roles of peers and other supporters

Throughout the listening sessions, participants consistently shared a need to utilize peers, promotoras, or community health workers for behavioral health service delivery. During one community engagement session, participants suggested not only utilizing these roles more often, but also ensuring clients and consumers are aware that these individuals *could* be requested. With the recent ability to bill Medi-Cal for peer support, it could be beneficial to educate consumers about the benefit of having a peer support or other community health worker be a part of their mental health services and supports.

Flexible Scheduling

Flexible scheduling of mental health appointments was discussed as an important aspect of ensuring that individuals can access the care they need when they need it, especially when there are staffing shortages and long wait lists. A few ways in which providers can offer flexible scheduling to their patients include:

- Extended hours: Providers could choose to offer extended hours, such as early morning or evening appointments, to accommodate patients who have work or school during the day. This can make it easier for clients to schedule appointments without having to take time off work or school.
- Online scheduling: Providers could offer online scheduling, which would allow patients to book appointments at their convenience, even outside of regular office hours. Online scheduling systems can also send reminders to patients about upcoming appointments, which can help reduce the likelihood of missed appointments.
- Teletherapy: Teletherapy could be a good option for patients who have limited availability due to geographic or scheduling constraints. Teletherapy also eliminates the need for travel, which was noted as a barrier. Teletherapy may also be a preferred option for younger clients.
- Walk-in appointments: Providers could offer walk-in appointments, which allow clients to drop in without an appointment. This can be helpful for patients who need immediate support or who have difficulty scheduling appointments in advance. Next Steps, a prevention and early intervention (PEI) program, currently allows drop-in clients to access resources at the Next Steps program office.

Mobile Crisis Teams

The need for more crisis continuum services was noted, particularly in addressing suicide prevention. One participant noted *"…they need some place to just kind of cool off and stabilize. That's something that we do struggle with finding resources for."* Mobile teams such as the Psychiatric Emergency Response Team (PERT) and the Mobile Crisis Response Team (MCRT) improve community access and prioritize behavioral health to achieve overall well-being for the community. Also highlighted was the need for awareness educational campaigns of these crisis services to inform community members about available services.

Centralized Referral System

The idea for a centralized referral system for SDCBHS was presented while discussing the utility of care coordinator support. Such a system could help both the provider and the client navigate care and support timely access to services. This system could also be used as a clearinghouse for resources and services available Countywide; so when staff are looking for a particular service, they can use a search engine to help them find that service and complete a referral through a streamlined, consistent process.

Family Services

Lastly, in addressing the need for services to family and friends, several ideas were shared including family events, co-education of parents and children, resources to caregivers of adults with severe mental illness, post-intervention resources and groups, support to families who have relatives in addiction, and school-based resources and groups for parents. This included being aware of the responsibilities of parents and providing childcare or other supports and flexible schedules so that parents can attend groups, take their children to appointments, and participate in other meaningful ways in their child's mental health journey.

Strengths-Based Needs Assessment: Interview & Focus Group Findings

A strengths-based needs assessment is an approach to needs assessment that focuses on the strengths, resources, and capacities of individuals, families, and communities, rather than just their problems and deficiencies. The goal of this approach is to identify and ***build upon existing strengths to address needs*** and improve outcomes.

This approach recognizes that individuals and communities have valuable skills, knowledge, and assets that can be leveraged to address challenges and create positive change. By focusing on strengths and assets, rather than just needs and deficiencies, a strengths-based needs assessment can foster a more empowering and solution-focused approach to problem-solving.

The strengths-based needs assessment process typically involves the following steps:

1. **Identifying strengths**: The first step is to identify the strengths, resources, and capacities of the individuals, families, or communities being assessed. This might include skills, knowledge, relationships, and community assets.
2. **Understanding needs**: The next step is to understand the needs and challenges faced by individuals, families, or communities. This is done by engaging in open and respectful dialogue and asking questions to gain a deeper understanding of the situation.
3. **Building solutions**: The final step is to build solutions that are based on the strengths and assets of individuals, families, or communities, and that address their needs and challenges. This can involve developing action plans, identifying resources and support, and creating partnerships and collaborations.

A strengths-based needs assessment can lead to the community being actively engaged in helping make decisions on what should be funded under MHSA. This would result in more empowering, sustainable, and effective solutions that can help to build resilience and capacity in individuals, families, and communities.

Throughout the interviews and focus groups, community members shared their insights regarding the strengths of the diverse communities throughout SDC and discussed what they viewed as the most important behavioral health needs and challenges community members face while accessing services and support.

Community Behavioral Health Strengths



Participants in the interviews and focus groups noted the strengths and resilience within SDC's diverse communities. Participants were complimentary of the concerted efforts to advance behavioral health initiatives promoting health equity and inclusion. They also emphasized their appreciation for the many successful coalitions cultivating authentic and open dialogue and conducting outreach initiatives among underserved communities. A participant described the sentiment by saying, *"We have all these relationships and people coming to the table to engage with education and program development."*

Participants discussed the increasing awareness of behavioral health services – and the successes regional initiatives are having – in reaching communities that have been historically underserved and less engaged with the behavioral health services systems.

"It is becoming more of a conversation and people are feeling more comfortable . . . so I think it is a positive movement that is going on right now in the county of San Diego for mental health with the African American and Latinx populations. I think they are feeling more comfortable reaching out and getting help."

Participants highlighted the efficacy of building lasting relationships, coalitions, and programming aimed at cultivating an environment of inclusivity. Additionally, prioritizing community-led partnerships and strengths and leveraging existing community coalitions and faith centers.

"A great source of strength for the community is the faith-based centers. Our clients obviously practice different faiths. But I would say that faith is something that is really important. Whether they are really connected to a mosque or a church or something else, I think that is something that has been proven to be helpful for the communities that we serve."

Participants also noted a multitude of successful community initiatives and programs in providing access to crucial services and support alongside county-wide successes in bridging traditionally siloed service delivery systems with culturally appropriate community-based programs and services. *"Having community-based organizations where the staff are representative of the communities, they speak the language, they understand the culture, programs, and activities are designed with the community."*

Many participants referenced the success of the Promotores Coalition. The Promotores' model was discussed repeatedly as an exemplar of how SDC's behavioral health service systems can build upon and empower existing community resources and strengths to expand access to health and wellness support among diverse communities: *"We're also including those diverse voices and experiences . . . Promotores,*

community leaders, having them be more involved because they have more experience than we have in their communities and they have so much knowledge in their communities."

The increasing focus on incorporating peer support into the provision of care and prevention services was identified as a major strength of the behavioral health system. Participants also discussed the strengths and importance of existing community-driven models such as the youth ambassador programs. One participant described the strengths of the youth ambassador model being used to engage with youth and families in refugee communities: *"It is a youth-led model where the youth are the ambassadors, and they're the liaison between peers, and the community, and mental health system . . . it is a way to educate the community and also to destigmatizing mental health."*

The implementation of these types of programs was viewed with optimism by the many participants throughout the interviews and focus groups. Also highlighted was the potential for community engagement collaborations to promote the creation of efficacious, culturally appropriate, and accessible behavioral health services and supports.

"I think one of the greatest strengths found within the refugee community and the immigrant communities is the close-knit nature of the community. That is really a very strong protective factor. People support each other as a community. If someone is going through challenges, they know that they can rely on their community members for support."

Participants repeatedly noted that these models had the potential to build leadership capacity within underserved communities and help address many of the priority needs that were discussed throughout the interviews and focus groups.

In addition to the strengths that participants discussed around existing community coalitions, faith, communities, and the development of peer support networks, participants also noted the unique resilience of communities throughout the county. For instance, SDC is located on the unceded territory of the Kumeyaay and Luiseño people. One community member described how resilience is understood as a strengthening bond among Native communities and the importance of their cultural contributions and connection to the land: *"I use the term Rez-ilience as a specific term for the Native community . . . it is not just about survival and an individual approach . . . it encapsulates how the struggle is and how it brings a connection to the land . . . that spirit, that drive [in the community]."*

Community Behavioral Health Needs

Throughout the interviews and focus groups, community members described what they viewed as priority behavioral health needs across SDC and within its diverse communities. As shown in Figure 10, these priority needs were aligned around the goal of **creating more integrated, accessible, culturally competent, and affordable behavioral health services and support**, the need for **more prevention and treatment options for substance use disorders and co-occurring mental health needs**, and the need for **targeted initiatives to support underserved populations** such as individuals experiencing homelessness, TAY, OAs, perinatal families, immigrants, and communities experiencing structural oppression and marginalization.

Figure 10. Priority Behavioral Health Needs



Culturally Appropriate Resources and Services



Participants emphasized that a core component of increasing accessibility was the need to provide more culturally appropriate services. Participants consistently emphasized providing services that accord with community members' cultural, linguistic, and religious identities as a critical need for the behavioral health services system. Tailored programming that meets diverse cultural needs is central to promoting behavioral health equity, increasing health literacy, and engaging inclusively with communities that have been underserved across SDC.

Participants expressed the need for the behavioral health services system and community organizations to develop trusting collaborative relationships with leaders from Indigenous, Black, Latinx, and other communities of color that experience structural oppression. Partnerships with trusted leaders will facilitate learning about specific community needs. This, in turn, leads to program development that is respectful and responsive to community members and that acknowledges the harms done to these communities through systemic inequalities, violence, and marginalization.

> *"Really grounding it in historical practices and harm done by municipalities, government, and the county in the past. I'm acknowledging that because as we're moving forward with healing our communities and mental health resources, we really have to address what has happened historically. And very intentionally."*

> *"There is a need for therapists that have different backgrounds, who come from different cultures so that when members bring specific cultural issues into therapy the therapist understands."*

Community members repeatedly noted that including more culturally appropriate services and programming, as well as engaging faith leaders and other trusted community leaders, would help dispel the stigma surrounding the utilization of behavioral health services in many communities. Additionally, it would increase the ability of programs and services to address priority health and wellness

needs through more accessible, culturally congruent, and relatable mental health and substance use interventions and treatment. Participants repeatedly noted that there is a critical need to have more providers with shared linguistic and cultural backgrounds to promote trusting relationships, allow community members to feel represented in the behavioral health system, and access services from providers who share common cultural understandings and language.

Some strategies participants discussed for providing more culturally appropriate services included ensuring that food could be provided at meetings and outreach events, incorporating arts and dance into programming, and tailoring services to fit with community traditions and holidays. For instance, an Indigenous participant noted the need to incorporate cultural practices into service delivery and outreach in their community:

"A lot of federal and state funding does not allow the purchase of food. And that is a key element for working with Native people . . . That is what we do. And so that is a barrier right there. You know, a built-in racist barrier from the funders."

Participants also highlighted the need for culturally appropriate services, resources, and community outreach to be provided in the preferred language of community members. One participant noted the importance of cultural fluency in the translation and dissemination of information to community members for whom English is not their primary language.

"I think in-person is better, but the telephone is also acceptable – the problem that we are finding is that the translation is not accurate, because some of the terms that are used sometimes lead to medical errors, or the assessment or the culture is not understood when making an assessment of mental illness. And that is a problem that we've been finding."

Peer Specialists



Participants also noted that in many underserved communities, such as Indigenous and migrant communities, there are existing mechanisms for providing support that often does not accord with more formalized professional roles. These systems of care and mutual aid often rely on the expertise and relationships of community providers that may not have formal credentials. Participants stressed the need to increase the provision of culturally appropriate services and affirm community expertise by utilizing existing community health systems. For instance, one participant noted:

"Being more inclusive of the community members that are already working and doing things in the community and not looking at education levels. There are people that are in the communities that have been doing things because they know, they see the need in the community, and they know what they are doing. And sometimes having these educational standards gets in the way of getting support for community members."

Another participant discussed the importance to many communities of using resources they trust and are familiar with.

> *"The thing is to use the networks you know. I think BHS could connect with some of these folks who are already doing good work . . . and fund them for the work that they do."*

Community members stressed the need to further develop peer partner networks and increase the use of promotoras and community health workers to augment and empower existing community health networks and engage in effective outreach with hard-to-reach communities. Participants focused on the need to utilize members of the community and individuals with lived experience in the provision of services. This need was particularly emphasized during discussions of widespread staff shortages and high rates of turnover among providers. Participants noted that many of the significant community needs relating to staff shortages and high turnover rates could be partially addressed through the implementation of initiatives aimed at educating, training, and partnering with existing community leaders and prioritizing the use of localized outreach mechanisms developed for communities by community members. One participant noted the need to *"…leverage community health workers and peers to act as connections to access points for services and increase peer-to-peer supports."*

Another participant reiterated this by saying, *"[We need to] have representatives from grassroots organizations woven through and guiding the process. They have trusted relationships with the communities they serve and have proximity to share wisdom from community members and neighborhoods."*

The Fentanyl Crisis

Prevention and treatment for substance use disorder was identified as a priority need throughout the interviews and focus groups. In every community across SDC, participants described how more should be done to both prevent and treat drug addiction. Participants specifically highlighted the urgent need to address opioid use and the devastating impact of fentanyl on communities across the county. *"The biggest need is the opioid crisis."* Participants repeatedly discussed the impact fentanyl is having on communities and the increased rates of overdose deaths related to fentanyl they see in their communities. *"I know people are just dropping like flies around here."* Participants emphasized the need to develop strategies to address the fentanyl crisis and prevent overdose death.

One strategy that was highlighted multiple times around preventing deaths from overdose was the need for widespread access to Naloxone. Participants recommended that county behavioral health services and other community organizations enhance their promotion and distribution efforts of Naloxone.

"They didn't know what to do if somebody had a fentanyl overdose. [Naloxone] needs to get out into the communities . . . we need to make sure that people know that that's free. At every event, the county should have samples or things to give away . . . I would love to see something like that highlighted and more prioritized to get those in the hands of families."

Participants emphasized that Naloxone is a high-priority need, and the SDC BHS should ensure that Naloxone is *"readily and equitably available"* to all communities across the county.

Regional Detox Centers

Discussions around the fentanyl crisis also highlighted the urgent need for more addiction treatment services, particularly more regional detox centers across the county. Participants underscored the need for more accessible, inpatient substance use disorder treatment. Multiple participants noted the lack of

regional detox centers and the barriers many individuals face trying to access detox services. A participant noted, *"The most pressing issues related to mental health or substance use in our community is having access for clients to detox facilities, substance abuse programs, and crisis mental health facilities."*

Another participant recalled an experience in which he was assisting an individual experiencing opioid addiction, but there were no regional services for the individual to access: *"He wanted to get off heroin, he wanted to get Suboxone. There was nothing in East County."*

Regional Crisis Continuum and Acute Care for Behavioral Health

At the other end of the spectrum of services, participants noted how helpful crisis services are at diverting people from emergency room or hospital services, especially during a psychotic episode. There was a desire to see more crisis continuum services such as the Mobile Crisis Response Team (MCRT) or Psychiatric Emergency Response Teams (PERT). The positive response to current crisis continuum services was echoed by participants requesting more of these services in regions such as North and East County.

Likewise, participants recommended regional options for withdrawal management services, including detoxification services. Currently, the County has three withdrawal management programs and CPP participants would like to see more options for people with Medi-Cal. With a continued rise in opioid abuse, the need for a safe environment for withdrawal and support during recovery is vital in addressing the opioid pandemic. Withdrawal management services should include: medical monitoring to ensure safe withdrawal, options for the use of medications to manage withdrawal symptoms, assessment and treatment planning, safe physical and emotional environments, counseling and support, and case management for ongoing treatment and services.

Co-Occurring Disorders

Many participants in the interviews and focus groups also discussed how substance use disorders and mental health challenges are often reciprocally connected and thus identified the critical need for more services designed for individuals experiencing co-occurring disorders: *"The biggest gap is substance use treatment for people who are mentally ill, who are really struggling with more serious mental illness."*

This sentiment was reiterated by other participants: *"We need treatment programs, not where, okay, we're willing to take mentally ill people in our regular program, we need programs that are designed for people who are mentally ill, that start there on what they're capable of, and what changes could we look at to make for them."*

The Housing Crisis



In the interviews and focus groups, affordable housing throughout SDC was identified as a critical behavioral health need. The lack of affordable housing was linked to significant challenges in stabilizing individuals experiencing mental challenges and substance use disorders. Many participants communicated that the housing crisis, directly and indirectly, impacts community members' behavioral health: *"Safe, affordable, housing is a top priority because you can provide services to folks but if they do not have a safe house to live in or a safe place to go to … that is one of the root causes of behavioral and mental health challenges."*

One participant labeled the housing crisis *"the elephant in the room"* when it comes to any discussion regarding behavioral health needs in SDC: *"Our houseless population has significantly increased with housing becoming more unaffordable within San Diego County."*

Improving Services for Individuals Experiencing Homelessness

The increase in individuals experiencing homelessness across SDC, and the need to better provide services among this population, was a widely reported need among the interview and focus group participants. Many noted the association between experiencing homelessness and experiencing behavioral health challenges, particularly challenges regarding mental health and substance use disorders. Participants from across the county stressed the importance of developing initiatives aimed at providing people experiencing homelessness opportunities to find safe housing and to provide increased resources and services to support their heightened safety and behavioral health needs: *"We see a lot of homelessness, and those individuals need mental health services and may self-medicate with drugs. There is also a lack of space at shelters for homeless individuals and a lack of services."*

Crisis Services & Entry Points for Care

Participants across the county identified the urgent need for increased crisis services and the development of more accessible service entry points. Several participants noted that to access many programs an individual must first have a primary diagnosis. This was reported to limit many individuals from entering services. Participants underscored the need to provide expanded opportunities for individuals to seek help while experiencing behavioral health crises.

"We don't have any central entry points. Even mobile crisis response teams and the crisis stabilization units, and so much of the work that's being done for the continuum of care, that's so incredibly powerful, but the thing that is, it's hard to see that all of that work requires a primary mental health diagnosis. And so people who use drugs, people who are not yet identifying as having a mental health condition, there's no equivalent for that population of folks."

Addressing Suicide Prevention and Stigma



Participants also identified the critical need to address the stigma around suicide and provide increased crisis services. Participants identified the need for short-term crisis spaces designed to stabilize individuals experiencing suicidal ideation and other acute mental health needs that are accessible outside of business hours.

"Behavioral crises don't usually happen between 8:00 am to 5:00 pm or 9:00 am to 6:00 pm, but we look at the services that we provide, and they close at those times. So can we have some kind of urgent care or some type of services that provide services after the hours, when their regular service providers are closed?"

Another participant highlighted the need for more acute and crisis services that were not provided in a hospital emergency room setting: *"[There needs to be] a crisis house or immediate need placement. Some people just are not ready to go to the emergency room and that might not be a requirement for them, but they need someplace to just kind of cool off and stabilize. That's something that we do struggle with finding resources for."*

Participants discussed the critical need for having immediate access to resources for individuals experiencing a crisis. For instance, one participant underscored the difficulty to ensure that individuals seeking help receive services promptly.

"Does anybody else feel horrendous when we're teaching people to access services to learn about mental health services, and then when they go to actually get a service, there are no services available? They can't get in to see a provider. There are people who are in active suicidal ideation and have to wait for a month to get into an intensive, you know, an IOP. And I feel like once we educate people about the services, once we normalize mental health and asking for help, and then they can't do it. I feel like that's putting them in a worse position."

The need for targeted initiatives aimed at preventing stigma around seeking mental health care and suicidality was also identified. Participants noted the importance of addressing widespread stigma in communities concerning seeking mental health care and the need to increase efforts to destigmatize seeking help.

"I think the stigma against seeking help for mental health support is one of the barriers we are experiencing right now with accessing behavioral health resources . . . there is a stigma against showing weakness or being vulnerable. And so, that stigma is really affecting the community as a whole and it makes it a lot more challenging to bridge those gaps in receiving services."

Participants communicated the importance of county behavioral health services and community partners actively engaging diverse communities with media campaigns and targeted outreach. They noted that these outreach efforts should be culturally appropriate and presented in multiple languages, with a focus on destigmatizing seeking mental health care and preventing suicide.

PEI

CPP participants often shared that services and supports for behavioral health should start at younger ages and earlier in the behavioral health journey, thus focusing on Prevention and Early Intervention (PEI). PEI services should be comprehensive, evidence-based, and accessible to all children, youth, and TAY who need them. There should be increased access to evidence-based interventions for children and youth in places they already frequent, such as schools and primary care. This should include engaging youth and families in service planning to increase engagement and improve the effectiveness of services. Service planning should be culturally responsive and consider the unique needs of each family.

Current PEI and Innovations projects help address mental health stigma, which can be a significant barrier to seeking treatment. PEI services should continue to address stigma and promote mental health as an essential part of overall health and well-being, specifically through media campaigns and school-based services. However, CPP participants noted the need for more services for TAY. State PEI regulations currently require a focus on the provision of TAY services, which could include services for college students and TAY in the community who are not enrolled in college. Likewise, Innovation programs provide a creative opportunity to include programs designed to meet the specific needs of TAY, such as Just Be You.

PEI efforts can include evidence-based programs that promote social and emotional learning, such as programs that teach emotional regulation, empathy, and conflict resolution. Lastly, educators, school counselors, and other service providers for children and youth should be trained in recognizing the signs and symptoms of behavioral health issues and how to refer children and youth to appropriate behavioral

health services. This can be accomplished through PEI training for various groups that work with children and youth.

Services for TAY



The need for more supportive services for TAY was identified throughout the interviews and focus groups as a priority area. Participants noted, *"There are not a lot of TAY-specific mental health services in the county."*

Multiple participants discussed the challenges young people face during the transition from adolescence to adulthood. Participants identified the critical need to provide enhanced mental health support for TAY and the development of more programs specifically tailored to address widespread concerns such as housing and food insecurity.

Participants also discussed the need for more opportunities for prosocial connections among TAY, such as clubs, activities, and recreational spaces aimed at addressing issues of social isolation and building positive community and peer connections. Participants suggested TAY-specific outreach programs aimed at prevention and early intervention: *"Go upstream, do not just address the fires." "[TAY need] more meaningful programs and more of a focus on stigma reduction and creating tailored approaches and services."*

Participants also highlighted the alarming rates of mental health struggles among young people across the county. Providers noted critical needs for addressing high rates of depression, anxiety, and suicidality among TAY. Many expressed that there is a critical need for more *"inpatient crisis stabilization units for teens and youth."* Providers shared perspectives regarding their work with students in both local community colleges and universities and expressed the main behavioral health issues students are experiencing are related to depression, anxiety, and suicidal ideation. Participants confirmed the need for more prevention services, training, and community resources focused on teaching youth and TAY about mental health challenges and destigmatizing seeking help. They discussed the lack of community services for young people and the need for more programs that focus on social and emotional learning competencies such as self-regulation and coping strategies. Multiple community members noted the need for more arts programming in schools and communities, and an intentional focus on the prevention and early intervention of mental health challenges for youth in school.

Substance use prevention and treatment among youth and young adults were also highlighted by participants. Many noted the need for improved strategies to address substance use among TAY and its association with negative health and wellness outcomes: *"Many young people are struggling with anxiety and depression which is causing them to try different drugs and alcohol."*

Participants emphasized that to meet this critical need more education, prevention, and treatment programs should be developed that are TAY specific. They underscored the need for youth-led initiatives and peer support programs and noted that these programs should be community-driven and built with an understanding of the need for more nuanced services for youth experiencing substance use disorders.

"It is really complex to serve youth and to effectively look at the levels of care that we need within that population. Because for a really long time, we've looked at it as like, prevention or treatment. And you're either a good kid that's never tried drugs, and we should make sure you've never tried drugs, or you're a kid who has already done drugs and is already going to be part of the probation system and justice. And that's just not how kids are, there's so many in between."

Case Management and Improved Care Coordination

Another prominent need that emerged from the interviews and focus groups was the need for increased case management and care coordination. Participants described the challenges many individuals experience while trying to access and sustain behavioral health services and emphasized the importance of having support while navigating behavioral health systems. Participants noted that *"it is really hard to navigate care."* The need to provide more case management was widely reported. Participants stated:

"If we had the funding to literally take that person by the hand . . . and follow up with them and have the funding to support them or have a resource specialist available to really triage them, that would be awesome. Because we don't really have the funding to do something like that. So, we just give them resources, which is great. But to have someone follow them along, show them what to fill out, where to go, how to use apps, and go into detail."

"People do get lost in the system . . . there is not enough continuity of care."

"It's absolutely critical to have crisis response . . . But there's no long-term follow-up, there's no, okay, this person had a crisis. And, you know, three months later, six months later, how is that person doing?"

This need for improved case management was viewed as an important aspect of improving care coordination and providing individuals with sustained support as they navigated different programs and levels of care.

Ongoing case management was also viewed as an opportunity to develop relationships and support individuals in building long-term positive community connections. One practitioner elaborated on this critical aspect of long-term case management.

"Being able to stay with a family over time. Having an assigned case manager that follows them across whatever is going on for them is really helpful. Instead of them having to start over and tell their story over and over again. Until they're strengthened and building up their support system, their providers are the most stable thing in their lives. And think that's meaningful for individuals, especially when building the rapport can take so long."

Veterans and the Military Community

During focus groups regarding military and Veterans' behavioral health needs, many shared that a significant strength of this group is the existing resources, programs, and supports in San Diego for military and Veterans. A key component is the strong San Diego Veterans Coalition that has existed in some form since 1988. *"Use the resources that are there, you don't have to add any infrastructure to the County, you don't have to add any more layers of oversight… it's using the system that's already out there in a more effective way. You don't have to recreate the wheel."*

Many existing resources and services were noted when discussing the needs of the military and Veterans. Additionally, the infrastructure of the Veteran's Hospital and nonprofit organizations was noted as great support. However, the concern was that individuals are not aware of the services that exist. Veterans

spoke about experiences learning about resources when they were first discharged from their military branch of service, but it was not until later when they were engaged in their community again that they needed the resources and were not sure where or how to access them. Thus, there is a need for continued public awareness campaigns for military personnel and Veterans: *"But you know, really, it's using the system that's already out there in a more effective way."*

One specific need was for family care. Participants noted that while family and relationships are the most consistently reported protective factor, these can also be risk factors when it comes to suicidal ideation. Thus, there is a need to think about the interpersonal support part of services to the military and Veterans. This includes whole family care and support to family, caregivers, and friends of both enlisted members and Veterans to help strengthen social networks.

Stigma plays a unique role among active military members. While not a common occurrence, one participant noted an example of an enlisted individual whose wife reached out for help for her husband but the result included the young man losing his posting and thus losing his health care, his family's health care, and their income: *"That is a big part of military culture, a lot of service members do not seek help when it comes to mental health."*

In a military culture that prides itself on teamwork, structural stigma needs to be addressed so that active military can behavioral health treatment without fear of the impact on the well-being of their family: *"We have an incredibly strong and robust culture of looking out for each other."*

Perinatal and Postpartum Women (PPW)

The needs of women, specifically during the perinatal and postpartum time periods, focus on a couple of themes. First, there was the concern about historical trauma for women who had sought behavioral health care during or after pregnancy and the negative impacts on child custody and marriage. This could be a significant barrier to obtaining prenatal care and disclosing mental health or substance use concerns. Thus, it is important for providers and systems to encourage behavioral health transparency and help mitigate negative impact on the whole family.

Case management and peer support before and after pregnancy were also noted as lacking. Current services for PPW currently focus on mental health and substance use, however, sometimes a little extra support in the home to help with the children, chores, or just allow time to take a nap is needed to provide prevention for mental health conditions: "*We had someone recently that really what she's saying that she needs like a mother's helper, she like need someone that can help her in the house, so she can go take a nap. But how do you take a nap with twin infants that were in the NICU? And then you have three other children under the age of four?"*

Additionally, peers could provide encouragement and lived-experience support both to the mother *and* their provider. For example, for some marginalized communities, their mental health distress is centered around perceived traumatic birth events where their maternal and delivery care desires were not heard, especially pertaining to cultural preferences. Thus, a peer or advocate can serve as a voice before, during, and after labor.

"Perinatal case management is something that we are lacking in the community. Where someone can go out to the home and provide general support for the family long-term. So, they can have long-term successes in parenting, support, health care support, navigating the system for school, or job search. And just to have that in-home support. That's something that we're lacking over here. Because we are just focused primarily on mental health, emotional wellness, and substance use, but sometimes people just need that little extra support in the home with their children, you know, peer support."

Specific needs for PPW also included more detox and substance use recovery housing for women, particularly housing that allows mothers to keep their children with them. Some recovery centers do not allow children over the age of four. It is important to work with the mother to assess what is best for her; some mothers may desire to have their children with them during recovery, while others might prefer to move through parts of the recovery process on their own and then be reunited with their children.

Lastly, it was noted that providers need to recognize how biological changes can impact mood and ensure that they are having regular conversations at various stages of care, not just perinatal and postpartum:

"Being diligent in recognizing the vulnerability in all the biological changes [perinatal, postpartum, and menopause] and mood changes that can happen just during that stage. Especially if we know there's been any history before, and when you know hormonal changes are taking place and the vulnerability there. So, I think it's just making sure that we're having that conversation."

Older Adult Supports

Participants discussed the needs of Older Adults in the community. Many noted concerns about social isolation, housing instability, financial victimization, and limited transportation. Participants underscored that seniors were particularly challenged by the COVID-19 pandemic and needed more educational opportunities surrounding the use of technology, and the ability to have increased involvement in developing services and support to address their unique needs: *"We need to hear from seniors, rather than just providing the services, and ask them what services they really need. So, we want to be able to hear and respond."*

Participants specifically noted the need for more accessible senior centers that include case management alongside existing services such as Social Security assistance, health resources and education, immigration assistance, and technology support. Such centralized and accessible centers for OAs also provide greatly needed social support to reduce isolation risk: *"I think that one important service that needs a little bit more revamping is the senior centers. They are very supportive in terms of offering our seniors another outlet . . . but their logistics are a little difficult to maneuver, and in [some areas of the county] there are no senior centers."*

Participants also expressed that case management in Senior Centers or mental health support staff to connect Older Adults to services was lacking. While the centers provide multiple education opportunities, participants encouraged the use of one-to-one approaches for learning, rather than relying exclusively on group setting, as it was suggested Older Adults learn better through specific activities with another person.

Immigrants and Refugees

Participants discussed the importance of providing immigrant and refugee communities with culturally appropriate services in their preferred languages. Service also need to recognize the trauma that each

community may have experienced and how that impacts the mental health of each community differently. Culturally appropriate services should take into consideration an individual's cultural or spiritual practices that may impact care, such as the preference for a care provider with the same gender or recognizing spiritual practices as part of mental health treatment.

"Some of the larger populations that we serve, are the Arabic speaking communities, the Swahili speaking communities, as well as the Afghan community, in addition to the Somali community. I would say, each community experiences mental health, whether we're talking about the strength or challenges differently…."

Recent emergency resettlement for several groups to San Diego (and interstate resettlement) was noted as important factor as to whether behavioral health resources were adequate for populations such as Afghan, Somali, Arab, and many more. The process of resettlement itself has the potential to impact mental health and well-being and those who are resettling in San Diego need providers who understand their culture, trauma, and use their language.

"There are waitlists for just all the benefits and programs even between public sector and private sector, that at least the Afghan national population is trying to benefit from. But clearly, you know, the population size and scale at which resettlement happened is not matching up to the available services at the current moment."

Many participants championed the use of peer partner programs, such as the Promotores Coalition and other peer networks. Participants noted the importance of having trusted messengers who can access hard-to-reach communities and provide key bridges between immigrant/refugee communities and behavioral health services: *"Bring in case management, from their own culture…so they can engage with them … and communicate and open up."*

Additionally, peers and community health workers can assist the community members in navigating everyday systems and services. This includes making sure basic needs are met and transportation is available: *"We have a lot of refugees who don't even know how to ride the train or the bus, and no one is teaching them, so they're isolated. So that's very important."*

Participants also discussed the prevalence of stigma in many immigrant and refugee communities surrounding mental health care. Building trust is important and the close-knit immigrant and refugee communities rely on each other to learn about resources. Thus, both positive and negative experiences with behavioral health can have a tremendous ripple effect in the community and impact stigma towards seeking services.

"…once they know a great resource is identified and is being utilized by some members of the community, word tends to spread fast and word of mouth really is very effective within the community. So, I think if these services and resources become easier to access … there's less steps for the community members to navigate and it's actually found within a community setting, …then I think the word was spread fast among community members of this resource and tying it back into the whole stigma, issue with mental health. I think the more the community is able to feel empowered that they can navigate the system or the resource, the more they will access it without fear of community members finding out."

Need for Improved Resource Lists

The need for expanded resource lists and improved outreach initiatives to enhance community members' access to services was also identified throughout the interviews and focus groups. Participants highlighted

the critical need to provide resources in multiple formats aimed at specific audiences to ensure that more individuals across the county become knowledgeable of the services available and are provided sufficient information regarding how to access needed services and supports. Participants discussed strategies to help expand ways for community members to learn about accessing resources. Their suggestions included not solely relying on online resource pages, but also incorporating strategies to ensure that folks with limited online access can find and engage with community resources and services, such as conducting more in-person health fairs and community events, and providing public service announcements: *"We need more information for programs so people know there is support and know where to go. For all people and ages."*

Need for Centralized and Integrated Services

Improving access to behavioral health services was broadly identified as a priority need. Participants discussed the need for an integrated and affordable behavioral health services system in which silos were replaced with organizational collaborations, and community members could connect to all their needed services in a centralized and supported integrated care setting. Participants discussed the need to create a *"no wrong door"* approach, with the capacity to serve different health insurance coverages and where people could be connected to a diverse array of services without repeatedly completing extensive intake procedures: *"The network of integrated community partners is really important. The problem is that every partner is different, we all have our unique structures. And the same thing with funding, you know, some do Medicaid, some don't. It is getting more and more difficult to work with."*

Participants also emphasized the need for a centralized location where anyone could go and receive services on an ongoing basis.

"You need to have a central place."

"People need to know that there is someplace they can go, maybe not the same person throughout the years, but there is always a place that they can get services and get into the system and get out if they need to and not go through the screening process and the assessments, and then wait for months to get some sort of care."

Participants identified the necessity of developing centralized hubs and prioritizing technological innovations to coordinate care and create a more integrated system.

"We haven't thought of other community resources needing some sort of complex integration and the ability to serve anyone. And I think that's just because we're only now finally starting to acknowledge mental health is equally as important as physical well-being."

"We need a one-stop shop for services, so people stop getting lost and put back on the street."

One participant elaborated on the need to create more centralized service locations, using the example of Family Justice Centers where survivors of intimate partner violence have access to social workers, therapists, and wraparound services all in one location, noting that the same model should be used for an integrated behavioral health center.

Barriers to Accessing Behavioral Health Services

Throughout the focus groups and interviews, participants noted barriers community members face in accessing behavioral health services. Participants emphasized that engagement with behavioral health services is shaped by multiple factors across individuals' social ecologies. Participants underscored how social determinants of health differentially position individual and community relationships with behavioral health services. These factors frame individual and community knowledge and understanding of services, trust in and willingness to participate in the systems and services offered, and the timeliness, affordability, and accessibility of needed services and support.

> *"I think that is something the county could do better with. Just having centralized resources because there are so many resources out there, but it can be so difficult to find them because they are not all in one place, they're scattered."*



Community Awareness and Knowledge of Behavioral Health Services

Participants noted that one of the most common barriers faced by community members while accessing behavioral health services is a lack of awareness regarding what services are available and a clear understanding of how to engage with those services. One stakeholder noted, *"I think sometimes our community doesn't know the mental health process, like where do you start?"*

This lack of a clear understanding regarding service availability was echoed by multiple stakeholders from different communities. For instance, one participant working with the Veteran and military communities noted that many active-duty military members and their families have relocated multiple times and have moved to San Diego from other communities around the world and have limited knowledge of the local programs and services available. Another participant working with young adults discussed how many college students come to San Diego from other communities and lack specific knowledge regarding the availability of community behavioral health services and supports: *"Ask university students to identify mental health resources outside of the university setting, maybe 99% of the time they cannot."*

Participants consistently underscored that a crucial first step in mitigating barriers for community members is a collaborative system-wide emphasis, led by behavioral health services in partnership with community partners, to conduct outreach regarding resources and provide accessible direction and support for community members seeking services.

Participants highlighted the need for leadership from state and county agencies to prioritize developing coalitions, informational campaigns, and public health initiatives in partnership with community organizations, schools, faith communities, and other local stakeholders to increase health literacy, reduce stigma, and promote all community members to access high quality, culturally appropriate, and affordable behavioral health care in their communities. This type of outreach effort would represent a significant reduction in the barriers to access many community members currently face. Participants underscored that for many community members, the current process of initiating behavioral health services often

involves significant hurdles in navigating disparate and complex health systems and services. One participant provided an overview of the experience many community members navigate while initiating new services.

"If you are insured, you go to your insurance for a provider list. Oftentimes, it's up to you to call maybe 15 or 20 providers. And then if you are struggling with depression or anxiety, that can be a really difficult task . . . If you are struggling with mental health and you don't have an advocate or somebody to help you with that process it can be a real barrier to access."

This view was echoed by other participants who noted how these challenges of navigating community behavioral health systems and services are particularly heightened among uninsured and undocumented community members.

> *"It's hard to even start with access to services, especially for our migrant, uninsured, and underserved foreign worker population that we work with . . . and those barriers get compounded when English is not their first language."*

Practitioners discussed how these types of access barriers highlighted the need for behavioral health systems and county leadership to collaborate with community organizations. This collaboration would aid in developing mechanisms to support and increase community members' access to vital support services while supported by case management and community partnerships such as promotoras and community health workers. Participants repeatedly stressed the importance of collaboration among the many systems and organizations operating in the community and the development of an integrated resource and outreach system to educate the community about resources, promote health literacy, and provide clear guidance and support regarding how to engage services.

Lack of Health Insurance Coverage for Behavioral Health Needs

Participants noted that a lack of health insurance coverage is often a significant barrier for many people in the United States. These challenges were understood to stem from public policy factors related to healthcare access. Healthcare policy plays a key role in how behavioral health services are funded and delivered and shapes the way organizations and individuals navigate services and programming. One participant stated, *"In terms of a public level, it is hard because we already have health care issues around the country in terms of available services."*

Many individuals and families are not able to access adequate health coverage due to financial limitations and a lack of eligibility. For instance, undocumented community members are often unable to attain health coverage that provides behavioral health care. Many other community members are underinsured and have limited access to needed behavioral health support. Participants noted how these aspects of public health care policy drive community-level disparities in behavioral health access and highlighted the need for free or reduced-price behavioral health services. Participants noted that extending affordable access to behavioral health coverage to all community members is a vital facet of health equity and would significantly reduce key socioeconomic barriers to accessing care such as income and immigration status.

Staffing and Logistical Barriers to Accessing Behavioral Health Care

The lack of providers and high rates of staff turnover was highlighted consistently as critical barriers to accessing behavioral health services.

Participants noted the high rates of burnout among providers and low rates of pay as key drivers of the ongoing

> *"There is a big labor shortage . . . so it is hard to reach people when we don't have the staff to do it."*

staffing shortages. Participants emphasized the need for county agencies and provider organizations to work together to recruit, train, and sustain more providers. Participants noted that the staff shortages impacted multiple facets of accessibility and service sustainment.

Participants also noted long wait times for services due to a lack of providers. These extended wait times to access services and gaps between service provisions were understood to pose significant barriers to community members' ability to access services and to the continuity of their engagement with services. Additionally, the lack of providers located within smaller communities across SDC created significant transportation burdens on community members who often must travel long distances using public transportation to access appropriate care. One participant reflected on the significant transportation barriers many people experience: *"Transportation is just such a huge need. We can offer all the resources in the world but if they don't have a way to get to them that is easy, that is convenient, that they do not have to use a bus pass every single time they come, it is going to make a world of difference."*

Lack of Trust and Historical Trauma

Participants consistently discussed the ways structural oppression influences the willingness of individuals and communities to access needed services. Widespread mistrust in behavioral health services was noted by participants to foster reticence toward engaging with behavioral health services. Participants highlighted the importance of behavioral health systems and organizations building trust in historically underserved communities and establishing long-term sustainable relationships. Participants specifically emphasized the effect of historical trauma and stigma among specific communities, such as Black, Indigenous, communities of color, and immigrant communities.

The lack of trust fosters stigma that posed barriers to seeking services. This lack of trust was described by participants as a response to the fear of punitive reprisal from other public systems. For instance, participants noted that among young parents there was a fear that seeking support for mental health or substance use challenges might lead to interventions from child welfare services, particularly among those from marginalized communities. One participant said, *"It is the threat of potential child welfare involvement if they go seek help . . . So, I think that is a big layer to individuals accessing services, if there is that fear, or it has previously been a reality for them."*

Another participant articulated fear in his community surrounding seeking help for mental health needs, and that seeking help could potentially be met with police violence rather than supportive services.

"A huge concern for me being part of the Black and Brown community, for us, we feel like even if we do reach out to some of these services, when the rubber meets the pavement, we're not going to be met with these services, we're going to be met with something else. So, I think that fear of them not being available to Black and Brown people is something we should face head-on."

Participants stressed the importance of behavioral health systems acknowledging the harms perpetrated within communities of color and focusing on building trusting relationships over time through transparency, accountability, and cultural responsiveness that respects communities' cultural, linguistic, and religious identities and provided culturally appropriate services.

Community Input for the CPP Process

The CPP process is an integral component of the County of San Diego MHSA program development. In line with the ongoing commitment to authentic stakeholder engagement in the CPP, participants of the CPP interviews, focus groups, and listening sessions this year were asked to share what has worked well and what can be improved in the CPP in San Diego.

> *"We just have to meet them where they are, and speak their language, as opposed to inviting them into our space."*

Perceptions of What is Needed for Stakeholder Engagement

Across interviews and focus groups, the most common response regarding what is needed for stakeholder engagement in the CPP process is ***holding groups in the neighborhood or community space***. This includes using existing programs, services, and resources in the community to partner with and hold the groups. Some ideas of locations included Clubhouses, housing project shared spaces, and Indian Health Centers.

> *"The key to success…in Indian county and with urban Indians, is [to reach] out to organizations that have already been established."*

Likewise, participants suggested staff and community members can support CPP efforts as co-facilitators to engagement activities. The participants highly valued having a co-facilitator who has lived experience and/or was a "trusted messenger" in the community. This "trusted messenger" can be a bridge between community organizations and the UC SAN DIEGO Health Partnership to help encourage and support meaningful collaboration. Utilizing co-facilitators was also noted as a way to encourage ***shared language*** between the community and SDCBHS. As one participant noted, *"Not everyone understands what 'mental health' is… avoid assuming common knowledge."*

Consideration of the structure of CPP groups included having ***smaller groups rather than larger listening sessions***, ***bilingual groups,*** *and* ***incentives for participating***. A specific point was noted that when providing incentives to make sure they are to stores that are located within the neighborhood.

What Should be Improved

In asking participants to reflect on what has not worked well with CPP in the past, a few key themes highlighted where improvement should be made. The primary critique was an ***absence of implementing community input***. This was expressed with examples where community members have shared their needs, concerns, and desires in past CPP groups and felt they were not heard because they did not see their ideas being implemented as part of MHSA programs or elsewhere.

> *"There's no progress in the community. So, it's starting to feel like it isn't gross negligence; it's feeling like intent. If you can create a way…to ask us what we want and stop taking our information and giving us no solution."*

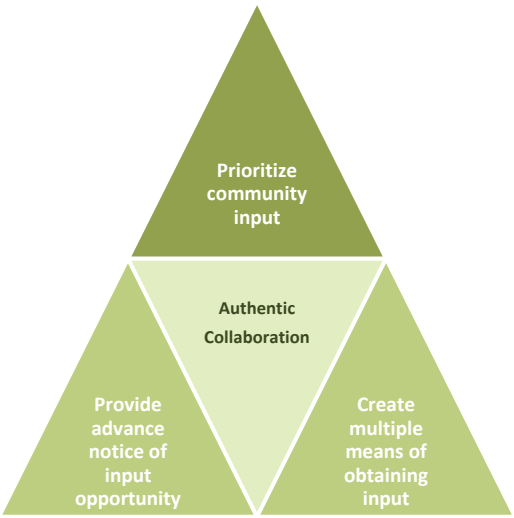
The next most frequent response concerned ***unbalanced representation***. This is important to note as unbalanced representation refers to the unequal representation of certain groups, which can result in reinforcing existing social and structural biases. Some groups shared a feeling that their community members were not involved in the CPP in prior years and that government agencies were designing the MHSA programs without community input.

When participants discussed a ***lack of collaboration between SDCBHS and the community*** it was regarding a feeling of inauthenticity. Community members want to participate in CPP, but prior experience leaves participants with concerns that collaboration has been inauthentic because they do not see their input being included in program development. Inauthentic collaboration can occur when people are impacted by external factors, such as short deadlines, funding restrictions, government regulations, or pressure from authority figures. In the next section, CPP participants provide insight into ways in which CPP can be an authentic collaborative process.

Identify Important Components of Collaboration

When collaboration is authentic, each person and community can bring their own unique perspectives, skills, and lived experience expertise to the table, leading to more diverse and comprehensive solution-building. Participants of the CPP identified several key components that make collaboration authentic and inclusive. Figure 11 shows the relationship of these three components. ***Prioritizing community input*** was noted as very important because the foundation for this goal requires ***providing advance notice of input opportunities*** and ***creating multiple means of obtaining input***. Participants explained that in order for community members to be involved they needed to know in advance when the focus groups or meetings would occur so that time could be scheduled to attend. This also included being inclusive in providing notice through means the community would recognize such flyers at community buildings, advertisements at public transportation, or social media. Additionally, providing diverse opportunities to provide input included surveys completed with clients, social media and virtual boards, call centers, focus groups, and community meetings. Including these two components of advance notice and multiple means of gaining input were not only foundational, but the participants expressed that incorporating these demonstrated that obtaining community input is truly prioritized and valued.

Figure 11: Components of Authentic Collaboration



Suggested roles of SDCBHS, the facilitating agencies, and the community in collaboration were described by CPP participants. The section below provides participants' ideas of the roles for each group.

Role of SDCBHS

According to the participants, the most important role for SDCBHS was ***informational transparency***. In the context of governmental organizations, informational transparency refers to the openness and accessibility of government information to the public. This includes things like government policies, decision-making processes, financial information, and data related to government operations and activities.

Informational transparency in government is important because it helps build trust and accountability between the government and its citizens. When the public has access to accurate and relevant information about how the government operates, they are better equipped to make informed decisions about the direction of their community. Informational transparency includes both the ***availability*** of information as well as the ***ease with which it can be understood***. When information is easily accessible and understandable, citizens can better understand the issues facing their communities and can be more engaged in the policy-making process, including providing input on MHSA program planning.

"I think they need to come in and engage our participants, I think they should visit every program that is providing services, not only the workers but the participants, the clients, they should have focus groups and they should come and meet them."

Participants also noted the desire to see SDCBHS staff more often engaging with programs and the community by ***being in the field***. Ideas included attending community meetings, visiting MHSA programs and meeting with staff and clients, holding client focus groups, and participating in community events. Underlying all these ideas was the desire for SDCBHS to authentically engage the community and really get to know its members.

It was mentioned that not only should SDCBHS be a part of the CPP process by attending meetings but should also be actively ***engaged in the CPP feedback process***. It was specifically important that SDCBHS explain to the community ***how the community feedback was included in MHSA programming***.

"Send information in writing or digitally to the same groups you went to for input."

Lastly, SDCBHS was noted to play a pivotal role in providing ***funding*** both to the CPP and the programs, with accountability being essential. Participants noted that funded programs should be held accountable if returns are not as expected. Additionally, funding needed to be flexible to meet the cultural needs of the community. A few historically minoritized and/or underserved groups noted funding should be flexible regarding providing snacks or meals at CPP meetings, as food is central to some cultures and could facilitate trust and relationship building.

Role of Facilitating Agencies

The facilitating agencies for the CPP process comprise the UC SAN DIEGO Health Partnership – the University of California, San Diego, Community Health Improvement Partners (CHIP), and the Global Action Research Center (Global ARC). Participants encouraged the facilitating agencies to attend existing community meetings. This would facilitate building trust, while also encouraging more input in the CPP process, as community members would already be at these meetings.

Another idea on how to obtain more input from the community was ***to partner with program staff to get client feedback***. This included ideas such as:

- ✓ Co-facilitate groups, especially for harder to reach communities, with staff from existing programs and/or individuals with lived experience.
- ✓ Utilize promotoras or individuals with lived experience to complete surveys with clients.
- ✓ Create a survey or short form that providers could give to their clients to obtain feedback.

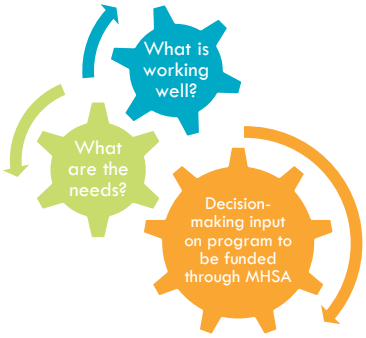
CPP participants specifically noted the importance of the facilitating agencies to ***analyze and report community input*** in a way that is both ***inclusive and truthful***. As best said by one participant *"I would like a report to come out of it that was true, transparent, and honest, rather than something that has been edited to be acceptable to send out to the public."* In an aim to be transparent reporters, various direct quotes from interviews and focus groups have been included in this report so that the authentic voice of the community is heard.

Lastly, participants noted their desire for the facilitating agencies to be a part of the feedback process, alongside SDCBHS.

Role of the Community

CPP participants identified the most important role of the community was ***providing input*** on various topics including:

- ✓ Explaining what is already working well.
- ✓ Sharing feedback on the needs of the community.
- ✓ Actively making decisions on what should be funded.



Obtaining community input on ***what is already working well*** is a crucial step in community engagement and planning. It helps to identify the strengths and positive aspects of a community and provides a foundation for future planning and development efforts. It is also an important place to begin the conversation as it encourages strength-based input and solutions providing a positive framework to then engage participants regarding the needs of the community. As defined in greater detail previously, this is why strength-based assessments are so valuable as they work to address needs by building on existing community strengths.

Follow-up Process for CPP

CPP participants regularly noted their desire to hear from both SDCBHS and the facilitating agencies on how their input was incorporated in the MHSA program planning process. As shown in Figure 12, there were four specific themes on the feedback process. When discussing the feedback process, participants shared about whom should receive the feedback and that it should be inclusive by reporting back to advisory boards (e.g., BHABs), committees (e.g., Live Well

Figure 12: CPP Feedback Process



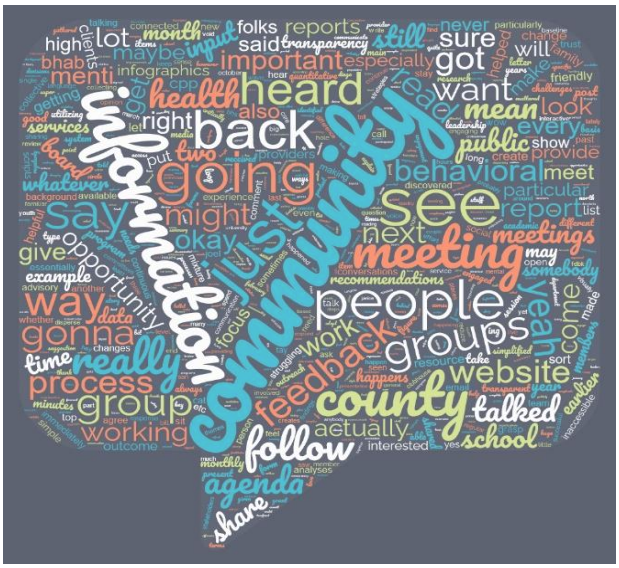
San Diego North central), community members (e.g., Latinx), and key informants (e.g., individuals interviewed).

It was noted that the feedback should be clear and easy to understand, while also being easily accessible. Thus, the feedback could be accessed via the internet, in short briefs, and presentations at meetings. To obtain a graphic of the most important components of the feedback process, the text responses from interviews, focus groups, and listening sessions were compiled into a single document. A word cloud generator was then used to visualize the most commonly used words where the response was noted ten or more times.

The word cloud presented in Figure 13 provides a unique compilation of the various responses received regarding the feedback process. Particularly it highlights that the most vital part of the feedback process is the community itself receiving information, so they feel heard. This could be accomplished through infographics, brief reports, meetings, websites, and dashboards.

Most importantly, participants mentioned that the feedback process is essential to build and establish trust. Some respondents noted that the lack of a strong and consistent feedback method could negatively impact future attempts of obtaining community input in the MHSA planning process.

Figure 13: Word Cloud for Feedback Process



Successful Outcomes

A few outcomes of a successful CPP were noted by participants. Foremost was ***feedback to the community that is clear and easy to understand***. Several participants expressed that infographics are very useful in making data visually relatable. An infographic is a visual representation of information or data, designed to present complex information quickly and clearly. It typically includes charts, graphs, images, and other visual elements to convey information in a way that is easy to understand and retain. Infographics can be used to present a wide range of subjects, including statistics, data trends, and focus group themes.

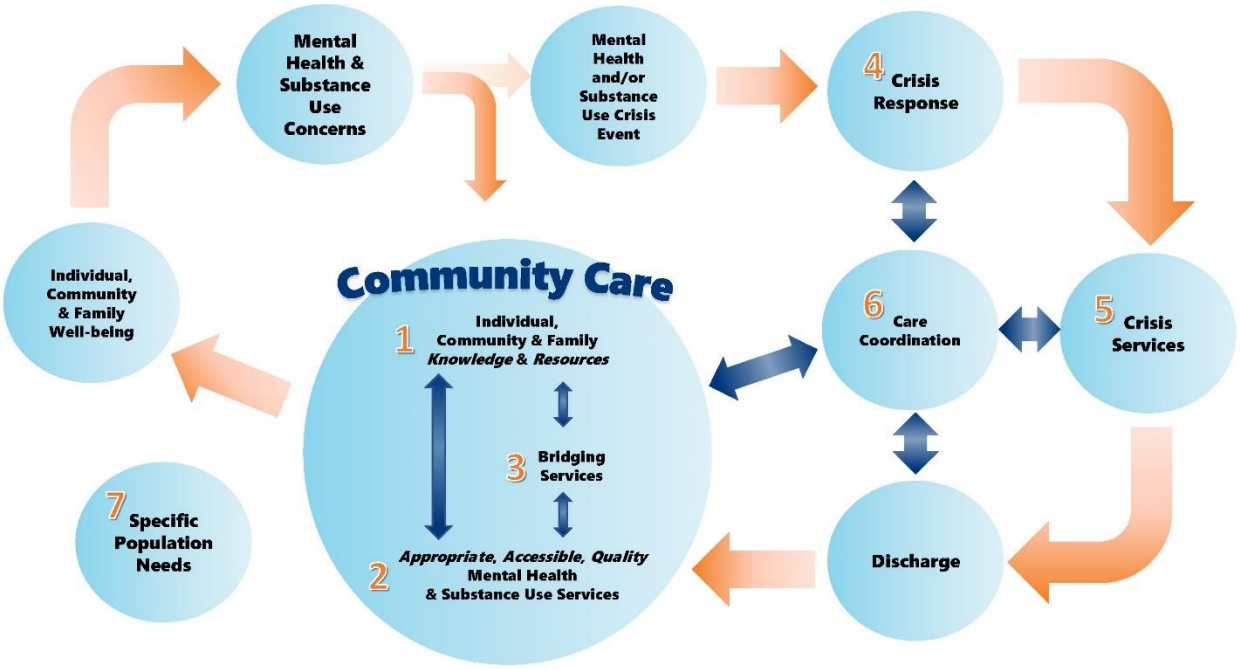
Other outcomes noted were specific to the MHSA process and programs. First, there was an expectation that if the community input was incorporated more often into MHSA program planning that there would be ***more bidders for Request For Proposals (RFPs)*** at the table. Likewise, if the community had more buy-in into MHSA programs by feeling that their ideas were incorporated, it was expected that ***more of the community would participate in the MHSA programs***. Thus, some responded that SDCBHS should consider poor engagement in a program to partially reflect low community buy-in.

> ***"I think from a provider standpoint people will be excited. I think there will be more bidders at the table. People will be excited to participate and potentially add that service line to their organization."***

Chapter 5 – Recommendations for Behavioral Health Services and Supports

A synthesis of the findings across the CPP community engagement activities for FY 2022-23 (as discussed in *Chapter 4. Community Engagement: Analysis and Results*), suggested that the community desired a behavioral health system that was focused primarily on community care to prevent and address emergent behavioral health needs, while simultaneously providing a robust and coordinated response when behavioral health crises occurred. Figure 14 provides a "big picture" visualization that depicts this approach to addressing local behavioral health needs.

Figure 14. Visualization of Optimal Approach to Addressing Local Behavioral Health Needs



At the center of this model is "Community Care". Community Care encompasses the knowledge and resources of individuals, families, and communities. The goal is to reach individuals with needs and/or prevent needs from becoming more urgent concerns. Community Care also includes the wide range of formal outpatient mental health and substance use treatment and support services.

Community expectations of behavioral health treatment services include care that is:

- Appropriate: culturally, linguistically, and/or tailored to specific population needs
- Accessible: geographically and/or technologically, no waitlists, and/or flexible scheduling
- High quality: achieves desired outcomes

Additionally, "Bridging services" are perceived as vital in facilitating the flow of knowledge and resources designed to address or prevent behavioral health needs or help make connections to formal treatment services when necessary. PEI programs, for example, often facilitate linkages to and engagement with care.

Thus, community care can be conceptualized as both the knowledge and resources of individuals, families, and communities as well as the available treatment programs and bridging services. This conceptualization is essential in identifying effective strategies that effectively build from existing community-based strengths and opportunities to improve behavioral health outcomes.

As depicted in Figure 14 above, the interaction of these community care strategies is expected to promote individual, family, and community well-being and address mental health and substance abuse related concerns before they become crises. However, crises do occur. When they do, they require an immediate behavioral health-informed response that focuses on prompt de-escalation, stabilization, and treatment. Programs such as MCRT and PERT exemplify this approach.

Following an initial crisis response, regionally available crisis-oriented treatment services within inpatient/residential care settings will be needed for some individuals prior to being discharged back into the community. Throughout these transitions, care coordination is an essential component to promote continuity of care across the array of behavioral health and other potential services that an individual and/or family may need to access. Additionally, at each point within the informal and formal behavioral health system, specific populations may exhibit unique characteristics that require tailored services, information, and/or resources.

As discussed in *Chapter 4. Community Engagement: Analysis and Results*, the findings from the community engagement activities identified a wide range of needs and ideas for how to improve and expand the existing behavioral health system to better the diverse community needs. While acknowledging that these findings do not comprehensively contain all potential ideas from all relevant stakeholders, certain themes and concerns emerged across multiple sources of information and/or were consistent with previously identified needs. These findings form the basis for the set of primary behavioral health service change recommendations listed in Table 11.

To help facilitate continued discussion with community members, service providers/administrators, and SDCBHS leadership about potential system improvement initiatives, the recommendations – identified through the collaborative CPP process – are organized in line with the most relevant aspect of the behavioral health system illustrated in Figure 14. In addition to specifying the recommendations that emerged from the community feedback findings, Table 11 includes a listing of potential strategies that could be utilized to make progress towards achieving each recommendation. When relevant, the region(s) where a recommendation was particularly salient is indicated.

Table 11. Primary Recommendations Identified from Community Feedback

	Recommendations	Potential Community-Driven Strategies to Act on Recommendation
Domain 1a: Individual, Family, & Community: *Knowledge*	(1) **Increase community education regarding stigma reduction and suicide prevention**	➢ Combat stigma by developing culturally appropriate and multilingual media campaigns, with a focus on suicide prevention ➢ Partner with local media outlets, community organizations, and mental health experts to develop and distribute effective messaging
	(2) **Increase awareness of mental health peer supports, promotoras and community health workers**	➢ Develop educational materials and outreach campaigns to increase public knowledge and utilization of peer support, promotoras, and community health worker (CHW) programs ➢ Develop materials in multiple languages to promote accessibility for diverse populations ➢ Disseminate materials through community organizations, healthcare providers, and public health departments about these roles and available services ➢ Target outreach toward underserved communities
	(3) **Improve knowledge of existing behavioral health services**	➢ Develop and implement a comprehensive education and outreach campaign to increase awareness and knowledge of available resources for behavioral healthcare ➢ Tailor messaging to the needs and preferences of diverse populations, with a focus on addressing stigma and promoting help-seeking behaviors ➢ Partner with local healthcare providers, community organizations, schools, and other stakeholders to disseminate information about available services, such as mental health and substance use treatment options, support groups, and crisis hotlines ➢ Utilize a variety of channels for dissemination, such as social media, print and digital advertising, and in-person outreach events
Domain 1b: Individual, Family, & Community:	(4) **Develop additional housing resources for persons with behavioral health needs**	➢ Develop supportive housing options for individuals with behavioral health needs, such as those experiencing homelessness or at risk of becoming homeless ➢ Partner with local housing authorities, community organizations, and behavioral health providers to identify and secure appropriate housing options ➢ Include access to on-site mental health and substance use services, as well as case management and support with daily living activities, in supportive housing ➢ This approach could help to reduce the likelihood of individuals with behavioral health needs becoming homeless or experiencing housing instability, while also promoting recovery and improved health outcomes.

	Recommendations	Potential Community-Driven Strategies to Act on Recommendation
Domain 2a: Services:	**(5) Facilitate trust/ engagement through culturally and linguistically appropriate services**	➢ Develop culturally appropriate resources and services, such as offering materials and assistance in languages other than English ➢ Hire bilingual staff, providing translated materials, and utilize cultural liaisons to ensure effective communication and understanding of cultural differences
Domain 2b: Services: *Accessibility*	**(6) Increase staffing/decrease waitlists at behavioral health treatment programs**	➢ Increase the number of mental health and substance use providers, particularly in North Region, East Region, and rural areas ➢ Offer flexible scheduling to increase options for accessing services ➢ Partner with local hospitals and clinics to recruit and train new providers ➢ Implement telehealth and remote care options to expand access to care
	(7) Reduce administrative barriers to accessing behavioral health services	➢ Reduce administrative barriers and increase access to behavioral healthcare by streamlining eligibility requirements and simplifying the enrollment process for behavioral health programs ➢ Partner with healthcare providers and community organizations to identify common barriers to accessing behavioral health services and developing strategies to address these barriers o Examples: Simplify enrollment paperwork or eliminate burdensome documentation requirements
Domain 2c: Services: *Quality*	**(8) Provide high quality services that result in improved health and well-being**	➢ Facilitate delivery of high quality, behavioral healthcare services by promoting the use of evidence-based practices and establishing mechanisms for monitoring and evaluating treatment outcomes ➢ Develop guidelines and training programs to support the adoption of evidence-based practices ➢ Implement standardized assessments to measure treatment outcomes and track progress over time ➢ This approach can also help to identify areas for improvement and promote ongoing quality improvement efforts
Domain 3: Bridging	**(9) Increase utilization of behavioral health-oriented peer supports, promotoras, and community health workers**	➢ Utilize peers, promotoras, and CHWs to provide a diverse and reliable workforce and promote continuity of care for and engagement with patients ➢ Hire and train peers, promotoras, and CHWs to provide health education, disease prevention, and support for patients in their communities

	Recommendations	Potential Community-Driven Strategies to Act on Recommendation
Domain 3: Bridging *(continued)*	**(10) Increase opportunities for prevention and early intervention (PEI) programs, particularly for children and youth**	➢ Review PEI services to ensure they are comprehensive, evidence-based, and accessible to children and youth in places they already frequent such as schools and primary care ➢ Engage youth and families in service planning to increase engagement and improve the effectiveness of services ➢ Service planning should be culturally responsive and consider the unique needs of each family
Domain 4: Crisis Response	**(11) Increase availability for crisis response by behavioral health professionals**	➢ Implement additional crisis services such as the Mobile Crisis Response Team (MCRT) or Psychiatric Emergency Response Teams (PERT), particularly in North and East regions to divert more people from emergency rooms and hospital-based services and/or interactions with the criminal justice system
	(12) Increase resources and services to address fentanyl/ overdose crisis	➢ Provide clinics, community organizations, and community members education about utilizing Narcan in case of overdose ➢ Facilitate distribution of Narcan to increase capability to respond in crisis situations
Domain 5: Crisis Treatment Services	**(13) Create additional regional detox centers to increase accessibility**	➢ Address substance use by establishing regional detox centers closer to residential areas, especially in the North and East Regions ➢ Partner with local hospitals and clinics to establish detox centers ➢ Provide education about Narcan and how to use it in case of overdose
	(14) Develop regional "one-stop hubs" for crisis care integrated with ongoing treatment services	➢ Develop plans to create one-stop hubs and an integrated healthcare system, particularly in North and East regions with a need for expanded services. ➢ Develop partnerships with local organizations and agencies to secure funding and establishing a clear roadmap for implementation

	Recommendations	Potential Community-Driven Strategies to Act on Recommendation
Domain 6: Coordinated Care	**(15) Increase care coordination across behavioral health and related services**	➢ Implement short- and long-term care coordination strategies to ensure seamless healthcare delivery and continuity of care ➢ Establish a centralized care coordination system paired with long term case management to facilitate communication between multiple service providers for each client
	(16) Implement centralized referral system into and between behavioral health service providers	➢ Establish a centralized referral system that facilitates and track referrals to mental health and substance use disorder providers as well as referrals for needed assistance to address the social determinants of health (e.g., Aunt Bertha community referral system)
Domain 7: Specific Population Needs	**(17) Increase availability of services TAY aged 18-25**	➢ Create and expand services for youth and TAY, with a focus on supporting young adults transitioning from youth to adulthood ➢ Provide mental health services, employment and education support, and housing assistance to help youth and TAY become self-sufficient and successful
	(18) Continue engagement with a diverse range of community groups to identify populations with unique outreach and treatment needs	➢ Build from and expand upon the findings presented in *Chapter 4: Community Engagement: Analysis and Results* that highlight unique needs of specific populations located throughout the County of San Diego ➢ Support mechanisms such as the CPP that will facilitate additional opportunities for outreach and engagement with population groups that may benefit from new or adapted services to meet their specific behavioral health needs

The recommendations listed in Table 11 cover many different types of behavioral health needs identified through the community engagement and feedback process. As indicated in the table, multiple strategies could be utilized to act on the recommendations. In these instances, continued engagement with relevant community members and leaders is encouraged so that any new initiatives are developed with the input and expertise of those who are most affected by and/or integral to enacting the recommendation. A commitment to acting on these recommendations will increase the capacity to prevent and address local behavioral health needs in a manner that promotes Community Care options wherever and whenever possible, while strengthening a coordinated crisis response and crisis treatment system that is able to promptly provide needed de-escalation and treatment services and then integrate care back into the community.

Chapter 6 – Future Directions

In FY 2022-23, the UC San Diego Health Partnership held community engagement activities in multiple formats and with a diverse set of community stakeholders, reaching over 500 people countywide. Through this formative effort, a substantial amount of feedback was collected, and the findings summarized in this report highlighted a wide range of important community needs, suggestions for resources, and

recommendations for how to best continue this work into the future. However, sometimes the power in one individual's words, such as a quote that represents an essential theme underlying many participants' comments, provides the conceptual framing from which to consider both the challenge of and potential for the CPP process.

*"You know, so from my perspective, what community engagement really, **where the power is**… is inviting people into a conversation or more, you'd hope, craving the opportunity to be invited into their conversation. You know, I think that that really is, you know, because … the example for years, you know, creating a seat at the table for people, but the reality is, **rather than creating a seat for them, let's, let's give them a table. And, and hope they give us a seat at their table.** Because we're gonna find out so much more about what works and what doesn't work."*

This idea of providing a space for historically underserved and unserved communities and then hoping for an invitation to that space can be enacted by reexamining the traditional methods of outreach and community engagement, which, if authentic and meaningful, will be inclusive, transparent, and based on building trust.

The feedback obtained through this initial year of the CPP process led by the UC San Diego Health Partnership illuminated key ingredients needed to realize the full benefits and potential of the CPP. In the following sections we highlight core components that should be imbedded within current and future iterations of the CPP process to maximize the contribution to improved behavioral health and wellbeing throughout the diverse communities of geography and identity that comprise the County of San Diego.

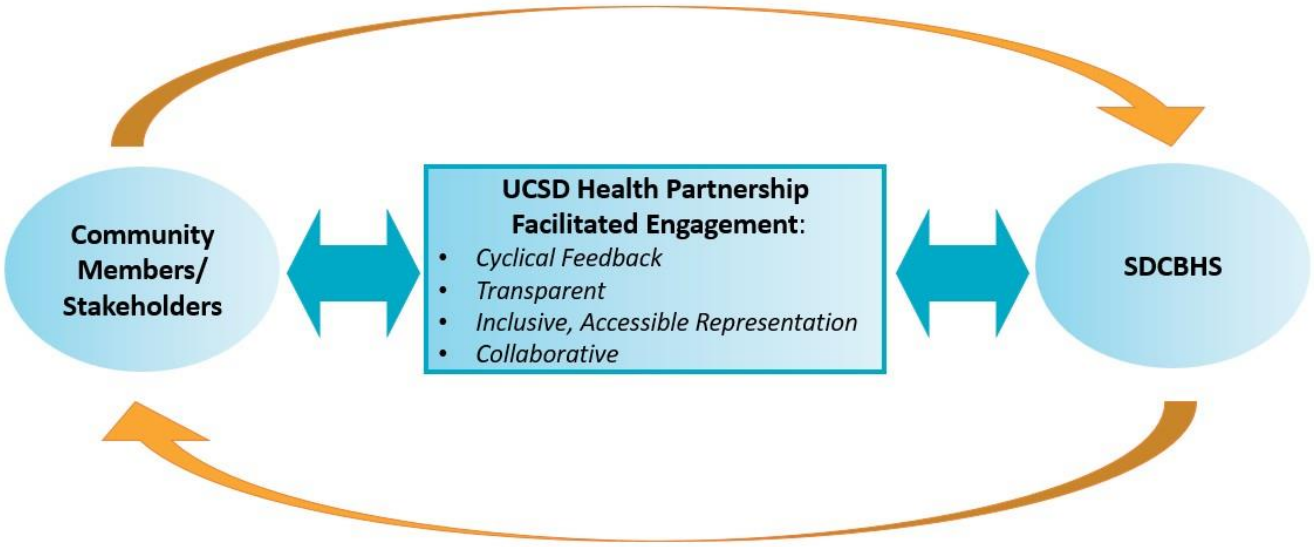
Cyclical Feedback

"… inform people of the things that have happened because of their input. Yes, you know, letting people know, upfront, you know, here's the way that the input has impacted the system previously, and now you have an opportunity to bring your voice forward and create, you know, the next wave of change or the next wave of opportunity in the county."

One of the most reported themes for the CPP process across all communities and groups was the importance of a cyclical feedback mechanism that utilizes a collaborative follow up process with the community that includes both the UC San Diego Health Partnership and SDCBHS. Synthesized perspectives of stakeholder responses on how to best facilitate an authentic and meaningful CPP process position the UC San Diego Health Partnership as an intermediary between the community stakeholders and SDCBHS.

Effective communication and feedback processes between government organizations and the community are essential for ensuring transparency, accountability, and responsive governance. Incorporating such feedback loops into the development process will ensure that the findings communicated in the final annual report to SDCBHS authentically reflect the experiences and ideas of those who participated in the community engagement activities. Perhaps most importantly, participants emphasized that the feedback process was essential to building and establishing trust. Some respondents noted that the lack of a strong and consistent feedback method could negatively impact future attempts of obtaining community input in the CPP process.

Figure 15. Conceptualization of UC San Diego Health Partnership Facilitated Community Engagement



Some steps that may be taken to facilitate the CPP feedback process include:

1. **SDCBHS response to community feedback:** Respond to feedback promptly and transparently. Acknowledge the feedback received and provide updates on the steps being taken to address the issues raised. This would be a combined effort of the UC San Diego Health Partnership and SDCBHS, initiated by regular communication (e.g., quarterly meetings) during which SDCBHS would share with the Partnership how the input from the community represented in the BHS Community Engagement report was integrated into MHSA programming and funding allocations.
2. **Follow up with community:** Follow up with the community to communicate how their feedback has been utilized to inform MHSA program planning. This could be attained through social media, an MHSA/CPP website, and attending community meetings. It will be essential to follow up with individuals who participated in interviews and focus groups and to continue to nurture the relationships established through regular communications. The follow up should also include a mechanism to evaluate the effectiveness of the CPP process (e.g., satisfaction questionnaires, email/phone line for suggestions/complaints, etc.) to make improvements.
3. **Encourage participation:** Efforts should be taken to encourage ongoing community participation by providing information about the feedback process and how it works thereby setting expectations of a regular, structured feedback process and establishing the importance of community participation. This can be done through outreach campaigns, public meetings, and other forms of communication.

> *"Reporting back to the community what the outcome was after this process."*

Transparency

A central theme which emerged from the CPP engagement activities was the importance of the facilitating agencies to analyze and report community input in a way that is both inclusive and truthful. The UC San

Diego Health Partnership is expected to conduct the CPP process with authenticity and accountability, to community stakeholders and SDCBHS.

"I expect for you guys [at UCSD] to go out and get the true information. And to take it back and to give [BHS] a report that hasn't been edited by the upper echelon to make it sound like they want it to sound . . . because if you truly go out and you hear, there are things in desperate need of being revitalized, rethought. I would like a report to come out of it that was true, transparent, and honest, rather than something that has been edited, to be acceptable to send out to the public."

To this end, the UC San Diego Health Partnership, has summarized all findings in this report based exclusively on the input of CPP participants. Further, the UC San Diego Health Partnership will: 1) encourage feedback on this report from those who have been involved in the process and 2) condense report finding into brief reports that are accessible, disseminated through multiple venues, and accurately reflect the recommendations of the community stakeholders. *"Transparency and sharing what feedback (you know), it's not always positive."*

Inclusivity, Accessibility, and Stakeholder Representation

The UC San Diego Health Partnership recognizes that substantial community interaction and engagement is essential for developing the relationships needed to obtain critical feedback about behavioral health needs, experiences, and ideas. Consistent with findings from this report, a cornerstone of the UC San Diego Health Partnership approach is the utilization of existing community spaces for outreach, engagement efforts, and data collection that are essential to informing SDCBHS program planning. The UC San Diego Health Partnership envisions team members regularly attending meetings where discussions are happening within communities - where the work is already being done to meet community needs - and folding that into the CPP process.

In addition to extensive grassroots outreach, the UC San Diego Health Partnership will continue to participate in (and expand upon) stakeholder meetings including SDCBHS Executive Leadership, the BHAB, SDCBHS Councils and Boards, and other stakeholder gatherings. All community connection efforts will be documented to allow for a systematic review of which strategies appear to be most successful at promoting linkages to distinct population groups as well as for tracking efforts to ensure diverse and thorough stakeholder representation.

Both UC San Diego Health Partnership and SDCBHS should continue to expand recruitment efforts to ensure all populations and communities are represented in future CPP endeavors. Further, it was recognized that the foundation for this goal requires providing substantial advance notice of input opportunities, creating alternative means of obtaining input (e.g., distributing surveys to persons unable to participate in a relevant feedback event), and ensuring that engagement activities are available in multiple languages, in settings where stakeholders are most at ease. *"Making it more accessible and engaging."*

Ideas to ensure inclusivity in stakeholder representation include:

1. **Identify additional community members to engage**: Compare the demographics of the community and those reached in the first CPP process. Then, identify individuals, groups, or organizations from the populations that were not represented, or represented to a limited degree, and request to attend their regular meetings and/or invite them to future sessions.
2. **Ongoing assessment of the CPP plan:** Revise the CPP plan to address further recruitment and retention efforts. This may include providing information about the planning process, including the goals and desired outcomes to the community through outreach campaigns, ensuring the information is available in preferred languages.
3. **Brief, online surveys:** Implement a brief, wed-based survey to gather input from a broad range of community members. In FY 2022-23, the UC San Diego Health Partnership collaborated with SDCBHS to develop a brief online survey which allowed for ongoing community feedback that could be incorporated into the CPP process. This survey was translated into Spanish, and piloted in the County. In subsequent years, this survey will incorporate the feedback received from community members, finalized, and translated into threshold languages to ensure as comprehensive participation as possible from historically unserved and underserved communities.
4. **Maintain participant database**: Ongoing maintenance and expansion of a participant database will facilitate recruitment, participation, reach, and feedback efforts.
5. **Develop incentives for community participation**: CPP planning participants acknowledge that the use of incentives could increase community participation. Ideas for incentives include refreshments, gift cards, educational opportunities (workshops or learning sessions), providing childcare, social events, and recognition for participation (awards, certifications, or public acknowledgement). It is important to view incentives as a tool to promote equity and fairness, particularly when asking people to contribute personal time and expertise to the CPP on a volunteer basis.
6. **Show appreciation:** An important part of recruitment is nurturing the new relationships by showing appreciation to community members for their input and involvement in the planning process.

Collaboration

Involving the community and collaborating with its members are cornerstones of efforts to improve public health. Relying on principles of community organizing and participatory research and evaluation, the UC San Diego Health Partnership will continue to employ an outreach approach consistent with Community-Based Participatory Research (CBPR) methods used to integrate key constituencies in the development and implementation of the comprehensive community engagement activities. CBPR is the most recognized form of health-focused, community-engaged research, integrating community partners throughout the process, with the goal of promoting equity and reducing health disparities. CBPR approaches are committed to principles of co-learning and health equity actions, with goals to equalize power between the academic institution and community participants. CBPR principles are the cornerstones of an effective CPP process.

To provide support and accountability to the CPP process, the development of the Community Partnership Council (CPC; i.e., a steering committee composed of key community partners and members), will be a priority for the next phase of work. The CPC will consist of the academic partners, BHS Advisory Board members, and community stakeholders/ providers, advocates, trusted messengers, and those with lived

experience, among others. The CPC will collaborate to ensure that outreach plans are feasible, appropriate, culturally responsive and inclusive to currently underrepresented groups. Further, this Council will ensure accountability to the feedback process and the effective implementation of the community engagement plan.

This approach allows for the fact that an extensive amount of initial communication and interaction with persons from many different communities will be required to better identify 1) who truly needs to be outreached and 2) the strategies most likely to be appropriate in conducting such outreach. Three core components are proposed for the CPC: 1) cultivating and maintaining productive partnerships, 2) training and support for bi-directional capacity building (e.g., increasing skills of community partners to systematically gather and communicate recommendations within the CPP and furthering the capacity of the UC San Diego Health Partnership as co-learners to conduct meaningful community engagement), and 3) develop meaningful approaches to collaboratively determine and prioritize the recommendations for the behavioral health system when not feasible to act on all identified needs. Throughout this process, CPC will pivot as needed to prioritize equity with the community, SDCBHS, and the UC San Diego Health Partnership.

Next Steps

A 3-year community engagement plan to facilitate the CPP process will be developed to support the implementation of the FY 2023-2026 MHSA plan. The Community Engagement Plan will be adapted as indicated and through data-driven decisions, with approval from SDCBHS leadership. Flexibility to community needs and preferences is a pivotal component of a meaningful, authentic, and responsive CPP process. An effective CPP process would result in impactful change for historically unserved communities.

"I feel like, even like, nothing comes out of those conversations. I think, once we do see that start to see like, there's more accessibility to mental health services."

The UC San Diego Health Partnership is seen as primarily responsible for ensuring accountability to the two phases of community engagement identified by stakeholders: ensuring stakeholders have the information and understanding to contribute to the CPP process, and actively involving communities in the decision-making process. As an intermediary entity for community and SDCBHS, the UC San Diego Health Partnership ensures that accountability and cyclical communication are part of the CPP process. As shown in Figure 15 above, our CPP process seeks to integrate community in ways in which that community prefers, as well as empowering historically unserved and underserved groups by co-creating meaningful information for program policy planning and funding.

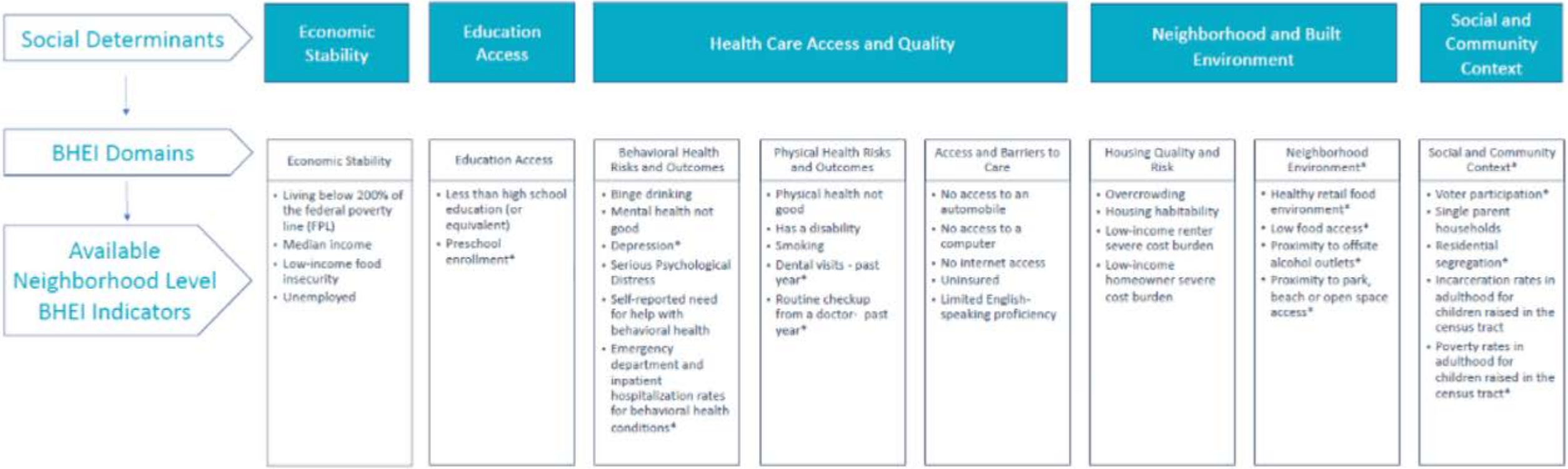
The UC San Diego Health Partnership is continuing to build a community engagement approach that intentionally de-centers the voice of the bureaucracy and highlights the voice of those who have been historically silenced. This community engagement approach is welcoming, inclusive, and aligned with other behavioral health related engagement activities. While the UC San Diego Health Partnership infuses its approach with these core principles, the Partnership also acknowledges its capacity and need for further improvements in future years to ensure that priority populations are included throughout the CPP process and that engagement activities exist in culturally relevant ways for diverse communities. The UC San Diego Health Partnership will continue to work towards providing a comprehensive outreach and engagement effort, in partnership with SDCBHS, for individuals in historically unserved and underserved communities. The overwhelming theme related to meaningful community engagement, as defined by the

participants throughout this year's activities, was the need to build trust. Establishing trust in the community is the fabric upon which the UC San Diego Health Partnership will facilitate all components of the CPP process. Collectively, what this Partnership will strive to accomplish as this work continues to move forward is being invited to all possible tables in the very diverse San Diego communities.

Appendix List

Appendix A: San Diego County Behavioral Health Index (BHEI) Conceptual Model
Appendix B: MHSA Training Flyer
Appendix C: MHSA Training Presentation Example
Appendix D: Demographic Survey
Appendix E: UC San Diego Focus Group Flyer
Appendix F: UC San Diego Focus Group Interview Guide
Appendix G: Live Well Advance Session 1 Presentation
Appendix H: Live Well Advance Session 2 Presentation
Appendix I: MHSA Training Satisfaction Survey

San Diego County Behavioral Health Equity Index (BHEI): Conceptual Model



*An asterisks indicates that the domain/indicator was added in response to feedback from the Community Experience Committee Workgroup.

NOTE: In the final BHEI tool, filters will allow users to focus on behavioral health equity among **special/priority populations.** Examples of these populations include veterans, active military, homeless, racial/ethnic minorities, individuals who are foreign born, have limited English-speaking ability, live in poverty, are from a high-risk age group, are Medicaid recipients, receive services from BHS, etc.
NOTE: In creating the final index, the indicator list may be revised slightly to improve the model.

COUNTY OF SAN DIEGO HHSA BEHAVIORAL HEALTH SERVICES (BHS)

Mental Health Services Act (MHSA) Stakeholder Training



The MHSA provides funding for prevention, treatment, workforce development, infrastructure, and technology needs. Integral to MHSA is stakeholder participation in the planning process so the County of San Diego BHS system can understand and respond to future needs.

WHY SHOULD I JOIN THIS VIRTUAL INFORMATIONAL SESSION?

If you participate, you will:

- **Learn about the MHSA**
- **Learn how MHSA funding is being implemented in San Diego County**
- **Learn about opportunities to provide input on how MHSA funding is used in the future**

Friday, June 24, 12:00 - 1:15 pm

Sign up with this link *OR* Scan the QR Code

https://tinyurl.com/MHSATraining062422

*optional Spanish interpretation available

Wednesday, June 29, 6:00 - 7:15 pm

Sign up with this link *OR* Scan the QR Code

https://tinyurl.com/MHSATraining062922

*optional Spanish interpretation available

For more information please contact:
Amanda Farr, afarr@health.ucsd.edu

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | UC San Diego Health

Servicios de Salud Conductual del Condado de San Diego (BHS)

Ley de Servicios de Salud Mental (MHSA) Capacitación para Partes Interesadas



La MHSA proporciona fondos para las necesidades de prevención, tratamiento, desarrollo de la fuerza laboral, infraestructura y tecnología. Una parte integral de la MHSA es la participación de las partes interesadas en el proceso de planificación para que el sistema BHS del condado de San Diego pueda comprender y responder a las necesidades futuras.

¿POR QUÉ DEBO UNIRME A ESTA SESIÓN INFORMATIVA VIRTUAL?

Si participa, usted podrá:

- **Informarse sobre la ley de MHSA**
- **Conocer cómo se implementan los fondos de la MHSA en el condado de San Diego**
- **Aprender acerca de oportunidades para dar su opinión sobre el uso de los fondos de MHSA en el futuro**

Viernes, 24 de Junio, 12:00 - 1:15 pm

Regístrese con este enlace *O* escanee el código QR

https://tinyurl.com/MHSATraining062422

*Interpretación opcional en español disponible

Miércoles, 29 de Junio, 6:00 - 7:15 pm

Regístrese con este enlace *O* escanee el código QR

https://tinyurl.com/MHSATraining062922

*Interpretación opcional en español disponible

Para más información, comuníquese con:
Amanda Farr, afarr@health.ucsd.edu

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

UC San Diego Health

MENTAL HEALTH SERVICES ACT TRAINING

June 24,2022 and June 29, 2022

LIVE WELL SAN DIEGO

UC San Diego Health

AGENDA FOR TODAY'S TRAINING

- Introduction: County of San Diego HHSA Behavioral Health Services
- Mental Health Services Act (MHSA): Background, Key Features, Program Values, & Core Requirements
- How MHSA is Implemented in San Diego
- Community Program Planning Process & Stakeholder Involvement

COUNTY OF SAN DIEGO
HHSA
BEHAVIORAL HEALTH SERVICES

Welcome by Nadia Privara Brahms

LIVE WELL SAN DIEGO

MENTAL HEALTH SERVICES ACT TRAINING

Facilitated by Amanda Farr, MPH & David Sommerfeld, PhD

LIVE WELL SAN DIEGO

UC San Diego Health

Mental Health Services Act

MHSA

2004

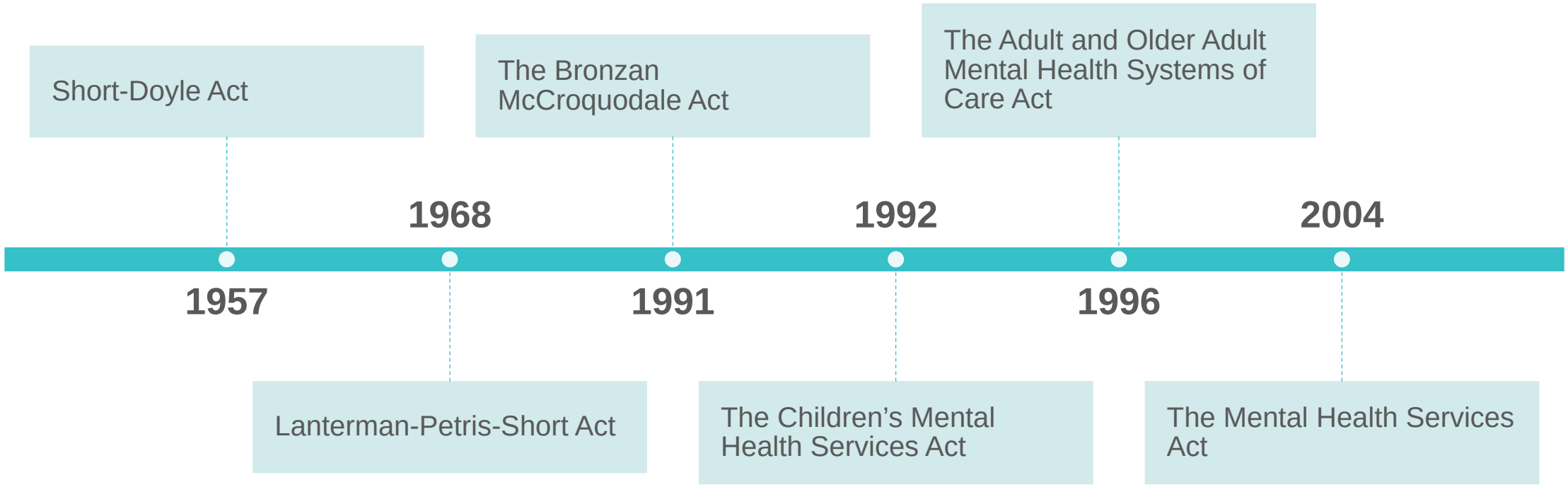
1% tax on income over $1 million

San Diego County

- More than $200,000,000 annually

MENTAL HEALTH SERVICES ACT

HOW DID WE GET HERE?

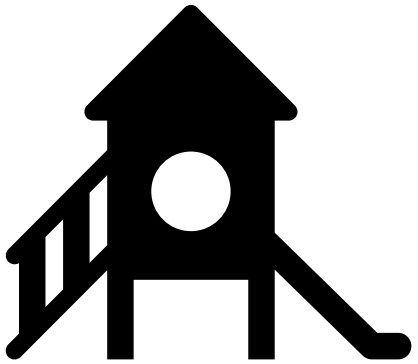


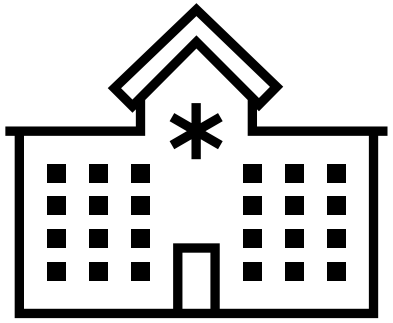
Mental Health Services Act

LIVE WELL SAN DIEGO

Transform Mental Health System

Close Service Gaps







Mental Health Services Act: The Law

HOW IT WORKS

- Welfare & Institutions Code (WIC)
- California Code of Regulations (CCR)
- State website:

https://www.dhcs.ca.gov/services/MH/Pages/MH_Prop63.aspx

Mental Health Services Act: Key Features



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MHSA PROGRAM VALUES

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MHSA PLEDGES A COMMITMENT TO INCLUSION

Counties shall "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."

(CA WIC 5848)

MENTAL HEALTH SERVICES ACT

PROGRAM VALUES

- Community Collaborations
- Cultural Competency
- Client-Driven Services
- Family-Driven Services
- Service Integration
- Wellness, Recovery, and Resilience

MHSA Priority Populations

Underserved: A client diagnosed with serious mental illness (SMI) and/or serious emotional disturbance (SED) receiving some services, but not provided with the necessary or appropriate opportunities to support their recover, wellness, and/or resilience

- At risk of homelessness, institutionalization, incarceration, out of home placement, or other serious consequences
- Includes members of racial/ethnic, cultural, and linguistic populations

Unserved: Those individuals who may have SMI and/or SED and are not receiving behavioral health services. Individuals who may have had only emergency or crisis-oriented contact with the county are also considered unserved

LIVE WELL SAN DIEGO

WHO ARE STAKEHOLDERS?

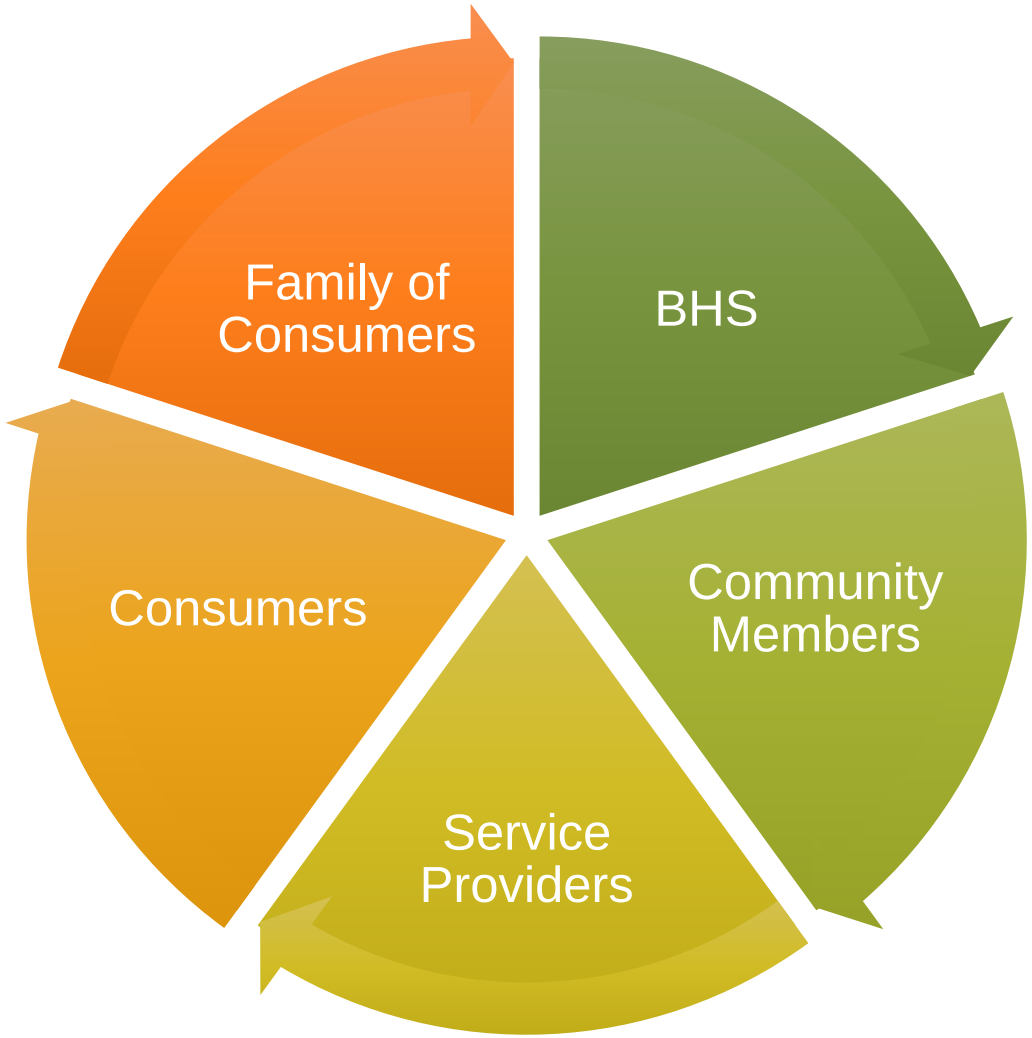
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- Adults & Seniors with SMI
- Families of children, adults & seniors with SMI
- Providers of Mental Health and/or Related Services
- Law Enforcement Agencies
- Educators and/or Representatives of Education
- Social Services Agencies
- Veterans
- Representatives from Veterans Organizations
- Providers of Alcohol and Drug Services
- Health Care Organizations
- Other important Interests

MHSA 3-YEAR PLAN

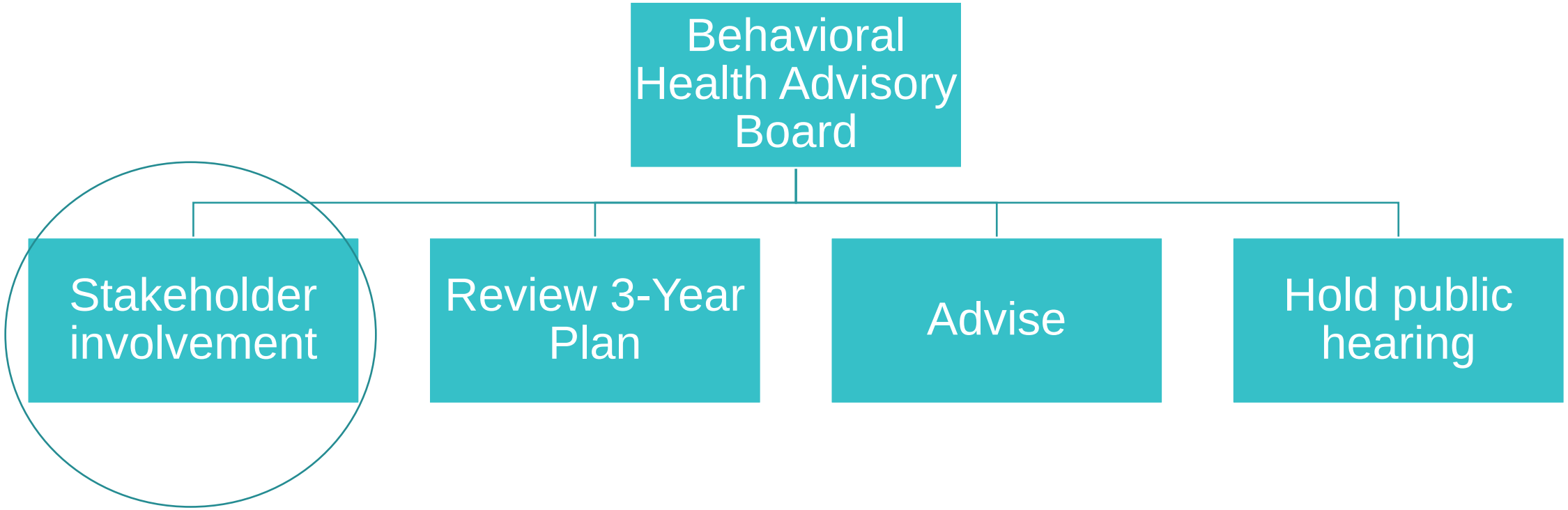
LIVE WELL SAN DIEGO

MHSA: DEVELOPING THE 3-YEAR PLAN



3-YEAR PLAN PROCESS

LOCAL REVIEW



MHSA SERVICE COMPONENTS

LIVE WELL SAN DIEGO

MHSA: FIVE FUNDED COMPONENTS

LIVE WELL SAN DIEGO

- Community Supports & Services: CSS
- Prevention & Early Intervention: PEI
- Innovations Programs: INN
- Workforce Education & Training: WET
- Capital Structure & Technological Needs

Community Services and Supports (CSS)

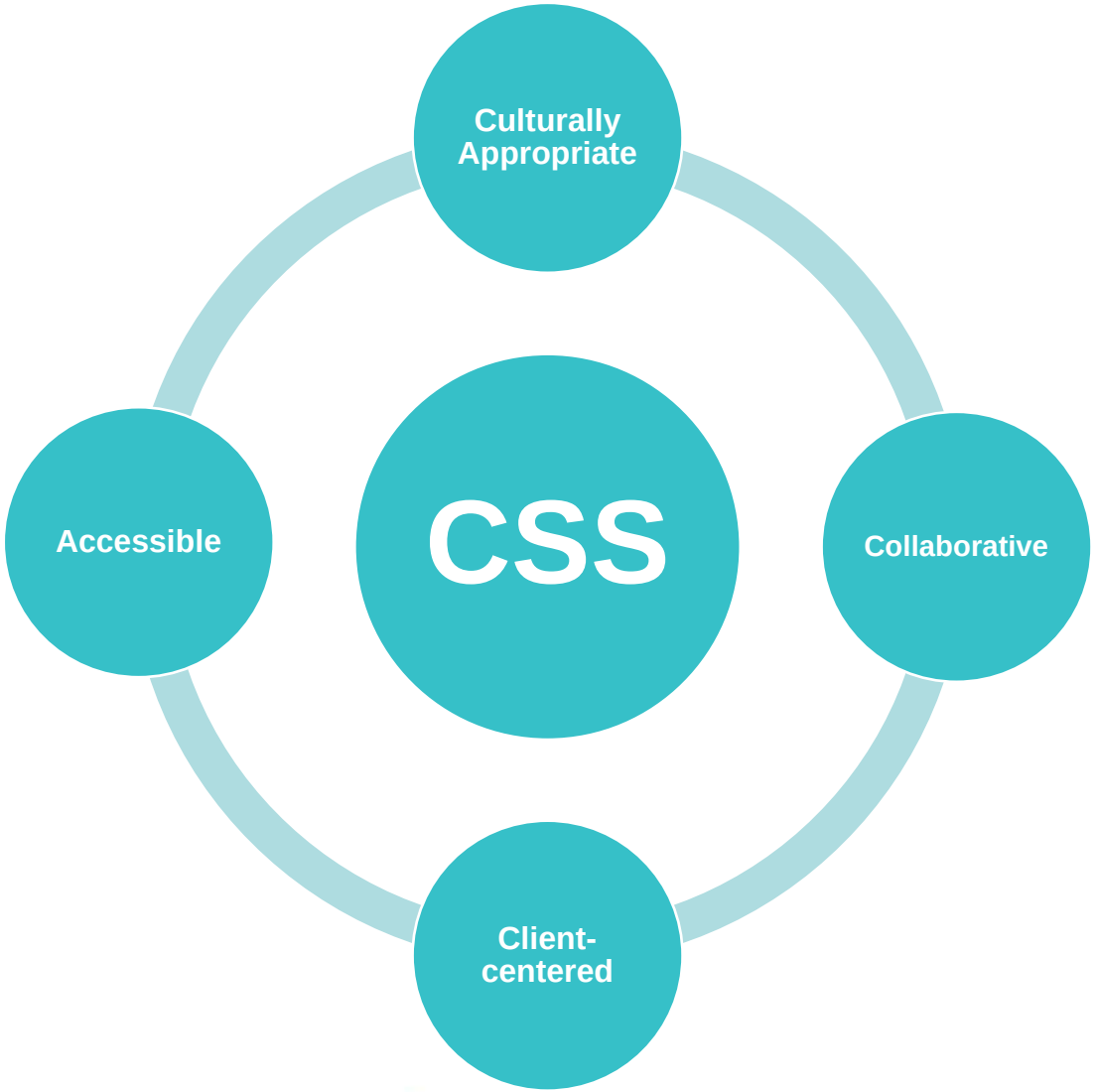
Largest MHSA component

Direct funding to programs for individuals – of all ages – with severe or serious mental illness, and their families

To achieve wellness in all parts of family life

LIVE WELL SAN DIEGO

Community Services And Supports



LIVE WELL SAN DIEGO

CSS: Full-Service Partnerships

The Full-Service Partnership (FSP) model offers integrated services with an emphasis on whole-person wellness

Promotes access to medical, social, rehabilitative, need-based community resources

Reduce institutionalization and incarceration

Reduce homelessness

Provide timely access to services:

- Intensive wraparound treatment
- Rehabilitation
- Case Management

LIVE WELL SAN DIEGO

CSS: Systems Development



IMPROVE EXISTING SERVICES AND SUPPORTS FOR INDIVIDUALS WHO CURRENTLY RECEIVE SERVICES



PROMOTE INTERAGENCY AND COMMUNITY COLLABORATION



CAPACITY DEVELOPMENT

LIVE WELL SAN DIEGO

CSS: Systems Development in San Diego County

- Peer Supports through wellness centers
- Education
- Advocacy
- Mobile crisis response teams

LIVE WELL SAN DIEGO

CSS: Outreach and Engagement

Focus on unserved and underserved populations to reduce health disparities

Collaboration as vital

LIVE WELL SAN DIEGO

CSS: Outreach and Engagement

Community-Based Organizations

Mental Health & Primary Care Partnerships

Faith-Based Agencies

Tribal Organizations & Health Clinics

Organizations Serving Individuals Experiencing Homelessness

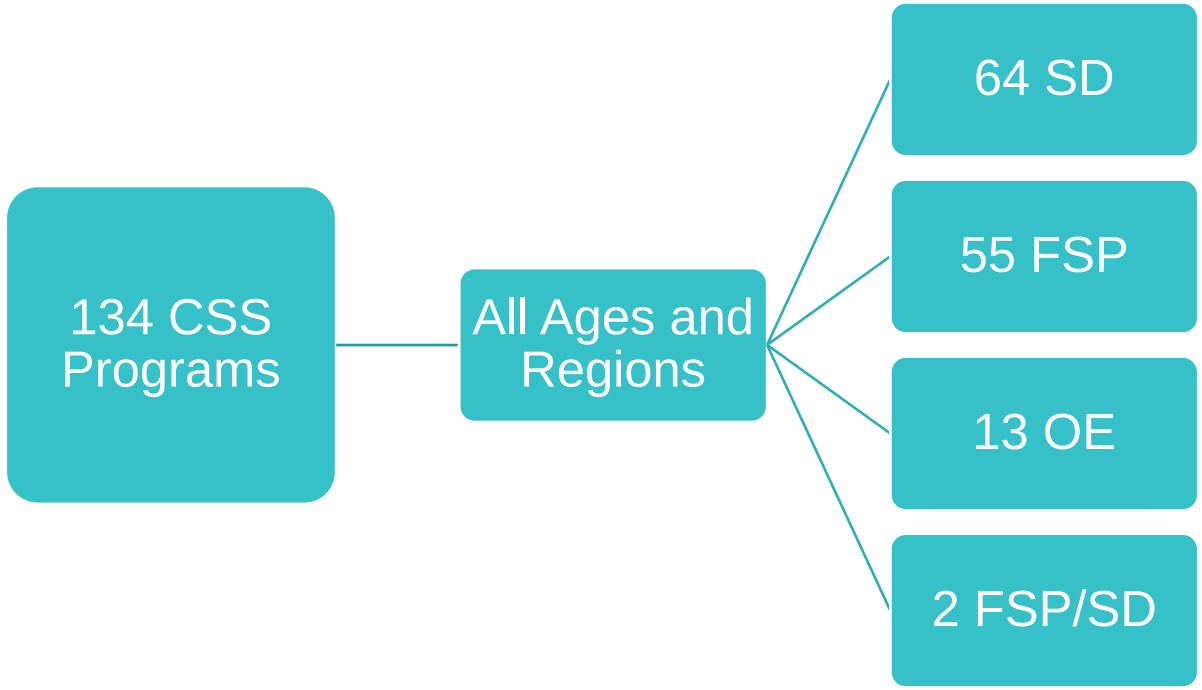
Organizations Serving Individuals Who Are Incarcerated

LIVE WELL SAN DIEGO

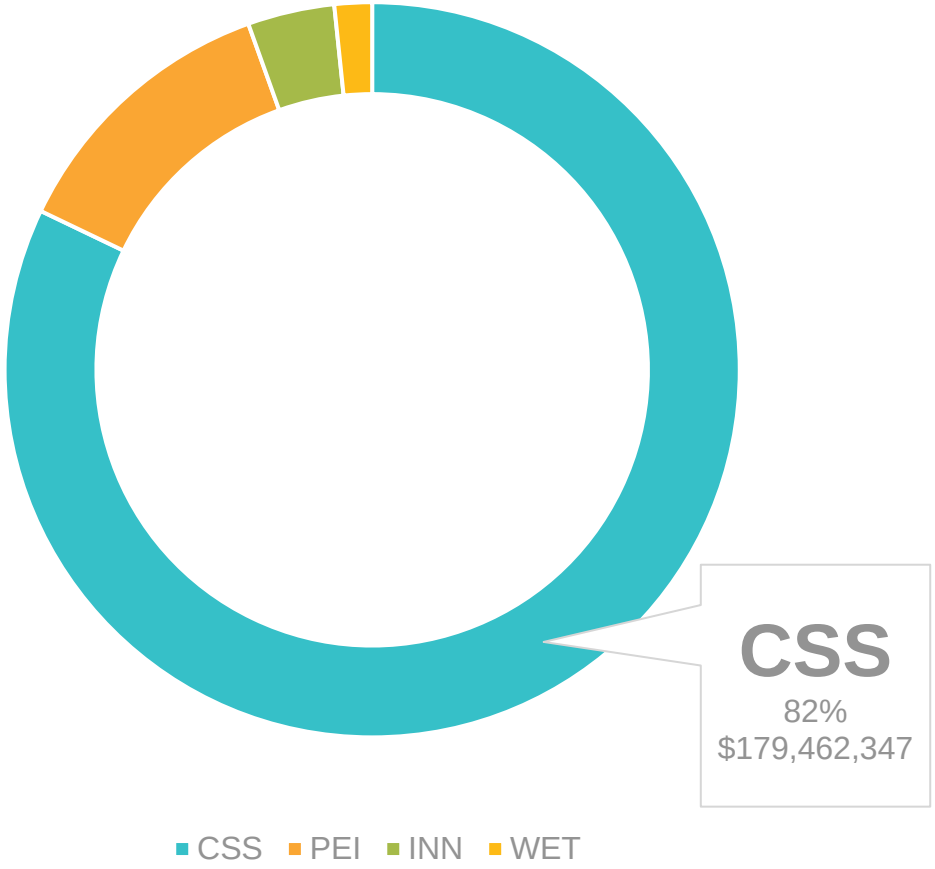
COMMUNITY SUPPORTS & SERVICES BY THE NUMBERS

LIVE WELL SAN DIEGO

PROGRAMS



MHSA FUNDING



CSS PROGRAMS

LIVE WELL SAN DIEGO

Survivors of Torture International	Behavioral Health Services and	Primary Care Integration	Deaf Community Services	Deaf Community Services	Clubhouse	Psychiatric and Addiction Consultation and Family Support Services SmartCare	Chaldean and Middle-Eastern Social Services	Psychiatric Emergency Response Team
Rady Central Psychiatry Clinic	Community Circle Central and East	Crossroads Family Center	Mobile Adolescent Services Team (MAST)	Nueva Vista Family Service	Counseling and Treatment Center	Douglas Young Youth and Family Services	East County Behavioral Health Clinic	East County Outpatient Counseling Program
Foster Family Agency Stabilization and Treatment (FFAST)	Learning Assistance Center	Merit Academy Day School Services	Multi-Cultural Community	North County Lifeline	Palomar Family Counseling Services	Para Las Familia	Pathways Cornerstone	Rady Outpatient Psychiatry North Coastal
Rady Outpatient Psychiatry North Inland	MHS - Community and School Based Counseling	School-Based Central-East-	South	South Bay Community Services (Mi Escuelita)	TIDES	Youth Enhancement Services	NewLife Counseling	Therapeutic Behavioral Services
WrapWorks	Family/Youth Support Partnership Services	San Diego Center for Children	Residential Outpatient Children's	Mental Health Services	Family Youth Liaison (YL)	BridgeWays Program Services	San Diego Youth Services – I CARE	Probation After Hours (STAT Team)

Crisis Action and Connection	Emergency Screening Unit (ESU)	Incredible Families	Children Seriously Emotionally Disturbed	Vista Hill - Juvenile Court Clinic	San Diego Youth Services – Our Safe Place

CSS PROGRAMS

LIVE WELL SAN DIEGO

Rural Integrated Behavioral	Health and Primary Care Services	Telecare Agewise	North Coastal ACT	Changing Options	Assisted Outpatient Treatment (AOT)	Collaborative Behavioral Health Court	Institutional Case Management
Probation Officer for Behavioral	Health Court	Probation-FSP-ACT Team	Esperanza Crisis Center	IMPACT	Downtown IMPACT	ACTION Central	ACTION East
Center Star ACT	Project One-for-All	Housing	Gateway to Recovery	North Star - Strengths Based Case Management (SBCM)	Pathways to Recovery	Senior IMPACT	Vida ACT
Catalyst	La Luz	Casa Pacifica	Hummingbird Healing House	Tesoro	Uptown Safe Haven	North Start ACT SBCM	Transition Team
Maria Sardinas Center	South Bay Guidance Wellness and Recovery Center	Bridges North Central	North Coastal Regional Recovery Center	South Regional Recovery Center	East Regional Recovery Center	North Inland Regional Recovery Center	Substance Use Disorder Recovery Center UPAC
Carrolls Residential Care	Areta Crowell Clinic	Community Wellness Center	Douglas Young BPSR Center	Heartland Center	San Pasqual Academy Children's Mental Health Services	Comprehensive Assessment and Stabilization Services (CASS)	Polinsky Children's Center Outpatient Services (PCC)

CSS PROGRAMS

LIVE WELL SAN DIEGO

Jane Westin Wellness & Recovery Center	Alianza Wellness Center	Project Enable Outpatient Program	Client Liaison Services	Client Operated Peer Support Services	Casa Del Sol Clubhouse (South Region)	Episcopal Community Services	Friend to Friend (F2F) Clubhouse (Central Region)
Escondido Clubhouse	Mariposa Clubhouse (North Coastal Region)	Neighborhood House Application Friendship Clubhouse	The Corner Clubhouse - Areta Crowell	The Meeting Place & Warm Line	Visions Clubhouse (South Region)	Oasis Clubhouse	East Region Clubhouse
EAST WIND	Crisis Stabilization Unit	Bayview Crisis Stabilization Unit	Crisis Stabilization Unit	Health & Wellness In-Reach	Ministry	Home Finder	In-Home Outreach Team IHOT - North Inland, North Central
In-Home Outreach Team IHOT Central/East/ South	UCSD-IHOT/AOT Evaluation	Patient Advocacy Services	Neighborhood House Association (Project Enable)	Project In-Reach (aka Project Enable)	North Inland Mental Health Center	Public Defender Discharge	San Diego Employment Solutions
Housing Subsidy program	START Vista Balboa, New Vistas, Halcyon, Crisis Center, Turning Point, Jary Barreto, Isis Crisis Center	United Homes	Rooted Life	Interfaith Community Services	Ruby's House Independent Living	Urban Street Angels	Alpha Project for the Homeless
			North County Walk in Assessment Center and Crisis Stabilization Unit	Family Mental Health Education and Support			

Prevention and Early Intervention (PEI)



Prevent onset

Decrease severity

Prevention and Early Intervention



LIVE WELL SAN DIEGO

PEI Priority Areas

Access to Treatment

Early Intervention

Outreach

Prevention

Stigma & Discrimination

Suicide Prevention

LIVE WELL SAN DIEGO

PREVENTION & EARLY INTERVENTION BY THE NUMBERS

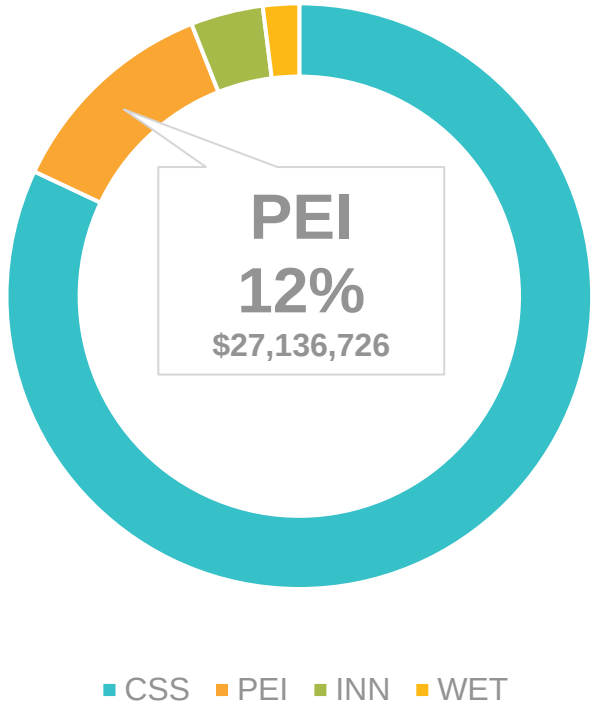
LIVE WELL SAN DIEGO

PROGRAMS

31 PEI Programs

- All ages
- All Regions

MHSA FUNDING



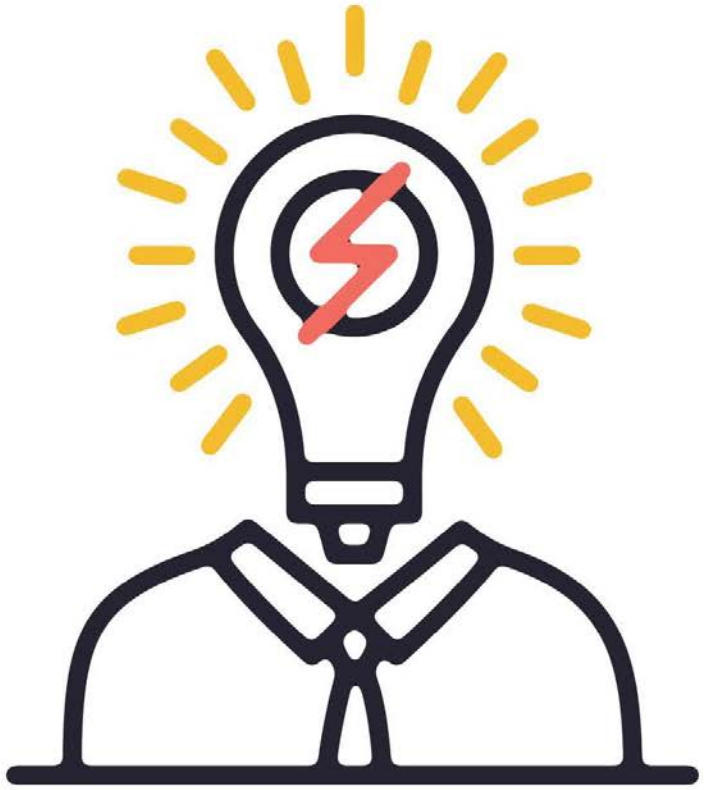
PEI PROGRAMS

LIVE WELL SAN DIEGO

Supplemental Security Income (SSI) Advocacy Services	Next Steps	Alliance for Community Empowerment	CSF - North Coastal/North Inland	CSF - South Region	CSF Central & North Central Regions	CSF East Region
Positive Parenting Program (Triple P)	Kickstart	Indian Health Council, Inc.	San Diego American Indian Health Center	Southern Indian Health Council, Inc.	Elder Multicultural Access & Support Services (EMASS)	Positive Solutions
Caregivers of Alzheimer's Disease and Other Dementia Clients Support Services	Father 2 Child	Breaking Down Barriers	Family Peer Support Program (In Our Own Voice & Friends in the Lobby)	Mental Health First Aid	Suicide Prevention & Stigma Reduction Media Campaign	Suicide Prevention Action Plan
Supported Employment Technical Consultant Services	Integrated Behavioral Health and Primary Care Services in Rural Communities	CHIP Independent Living Association (ILA)	Vista Hill - School Based PEI North Inland	South Bay Community Services - School Based PEI South	Palomar Family Counseling - School Based PEI North Coastal Region	San Diego Unified School District - School Based PEI Central and North Central

San Diego Unified School District - School Based PEI Central and Southeastern	San Diego Youth Services - School Based PEI East	HERE Now	Courage to Call

Innovations Projects (INN)



LIVE WELL SAN DIEGO

Innovations Projects



Intended to generate new learning

NOT fill a gap



Evaluation and analysis

System outcomes

Consumer outcomes

Implementation practices

LIVE WELL SAN DIEGO

Innovations Projects

Directly emerge from stakeholder feedback & priorities

INN projects have addressed:

- Telehealth services
- Partnerships between BHS and faith communities
- Partnerships between Public Health Nursing and mental health providers
- Holistic services for transitional age youth experiencing homelessness
- Hoarding reduction services for older adults

LIVE WELL SAN DIEGO

INNOVATIONS PROGRAMS BY THE NUMBERS

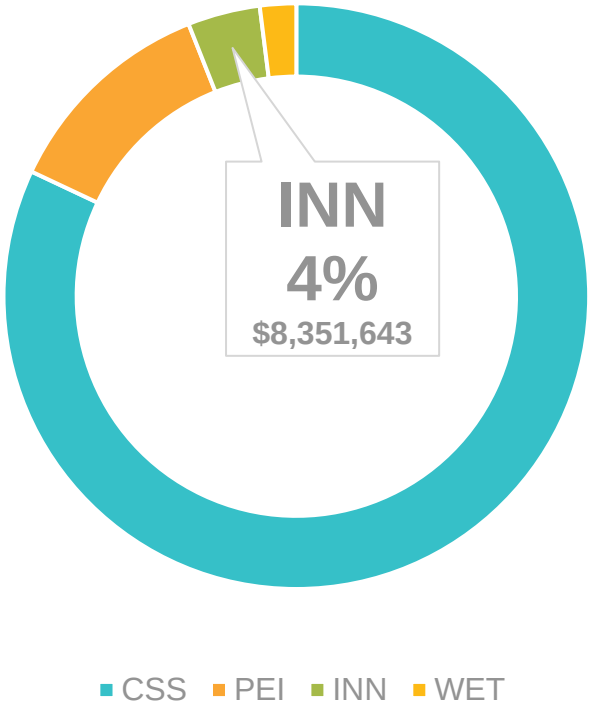
PROGRAMS

7 Current INN Programs

Spread throughout San Diego County

Reach all ages

MHSA FUNDING



FY 2021-22 INN PROGRAMS

LIVE WELL SAN DIEGO

- Accessible Depression and Anxiety Peripartum Treatment (ADAPT)
- BHConnect
- Roaming Outpatient Access Mobile Services (ROAM) - Indian Health Council
- Roaming Outpatient Access Mobile Services (ROAM) - Southern Indian Health Council
- Recuperative Services Treatment (ReST)
- Center for Child and Youth Psychiatry (CCYP)
- Early Intervention for Prevention of Psychosis; Kickstart

Workforce, Education, and Training (WET)



LIVE WELL SAN DIEGO

Workforce, Education, and Training



LIVE WELL SAN DIEGO

Workforce, Education, and Training

- Therapists
- Nurses
- Case Managers
- Psychiatrists
- Peer support specialists

LIVE WELL SAN DIEGO

WORKFORCE EDUCATION & TRAINING BY THE NUMBERS

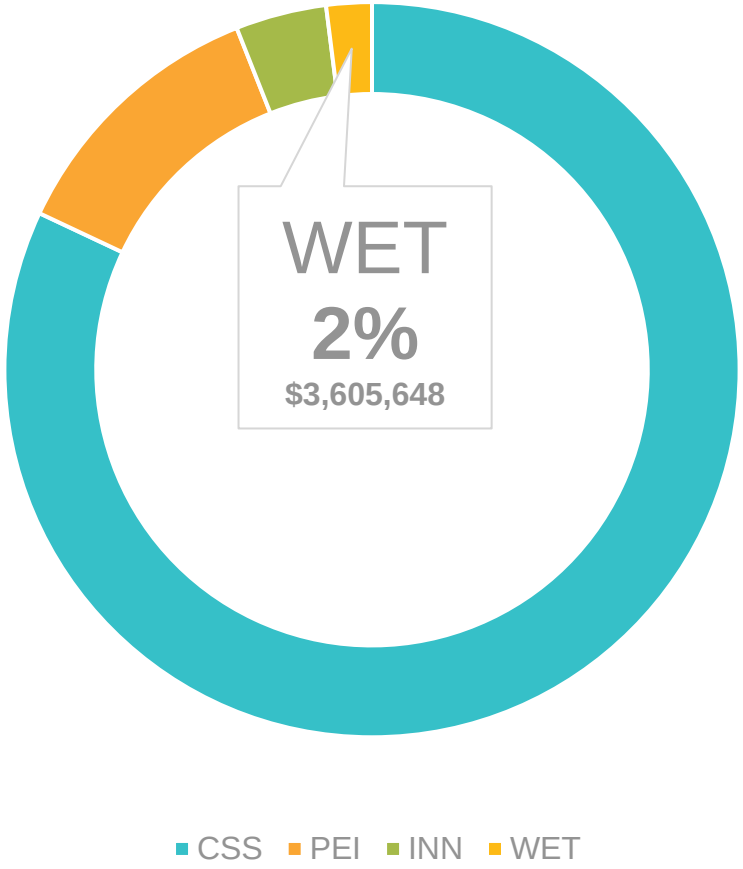
LIVE WELL SAN DIEGO

PROGRAMS

6 WET Programs

All regions of San Diego

MHSA FUNDING

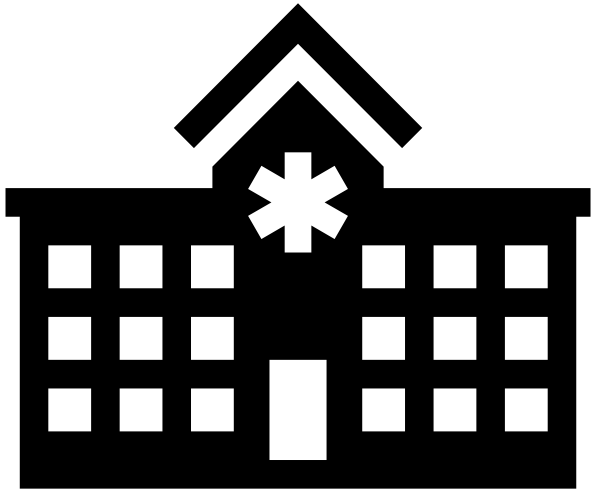


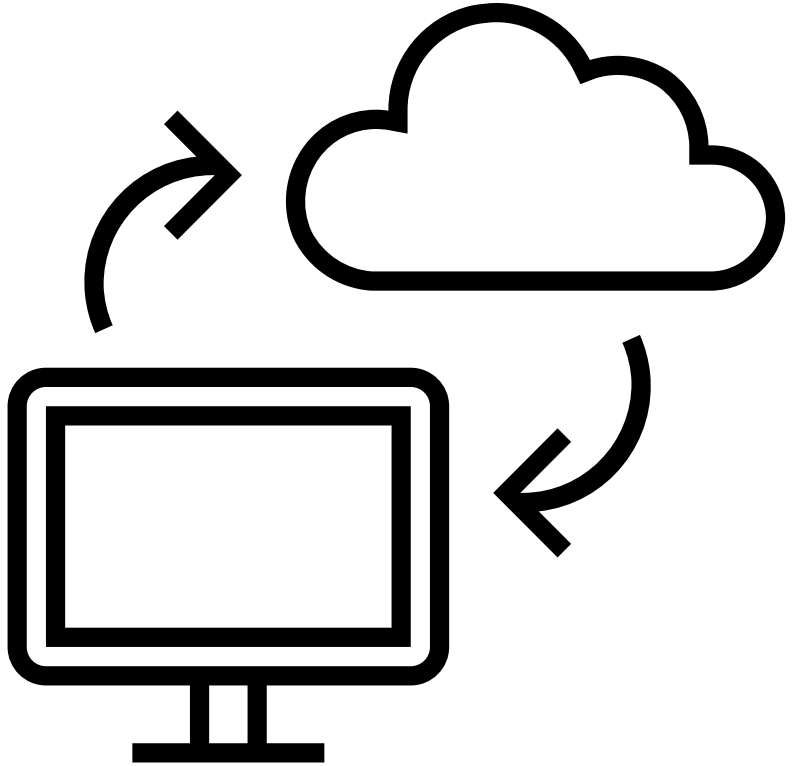
WET PROGRAMS

LIVE WELL SAN DIEGO

- Behavioral Health Training Curriculum
- The Residency and Internship Program (Community Psychiatry Program)
- Peer Specialist Training
- Cultural Competency Academy
- Public Mental Health Academy
- Training and Technical Assistance

Capital Facilities and Technology Needs





LIVE WELL SAN DIEGO

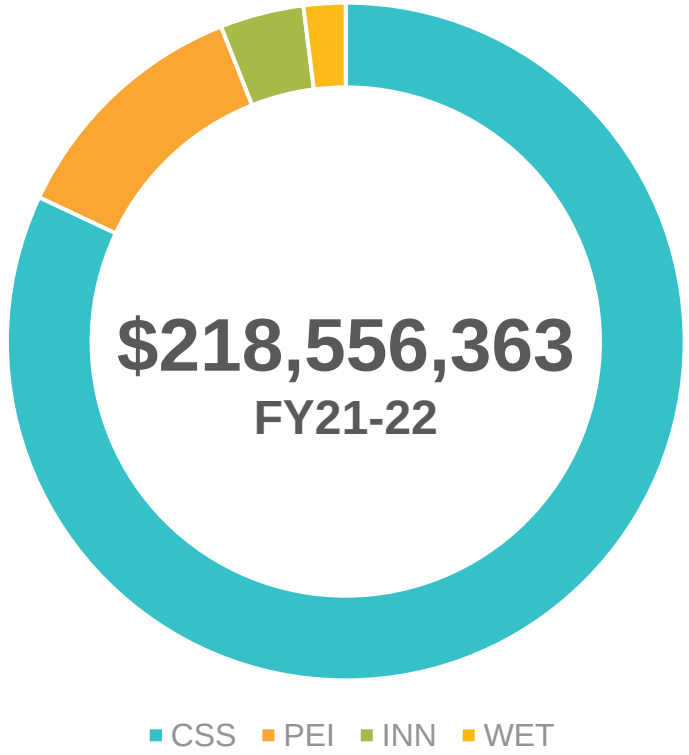
MHSA COMPONENTS SUMMARY

PROGRAMS

178 MHSA Funded Programs

- 134 CSS
- 31 PEI
- 6 WET
- 7 INN

MHSA FUNDING



Fiscal Transparency



BHS is accountable for providing annual MHSA revenue & expenditure reports



All reports are publicly available



https://www.dhcs.ca.gov/services/MH/Pages/MHSA-Fiscal-Oversight.aspx

LIVE WELL SAN DIEGO

COMMUNITY PROGRAM PLANNING PROCESS

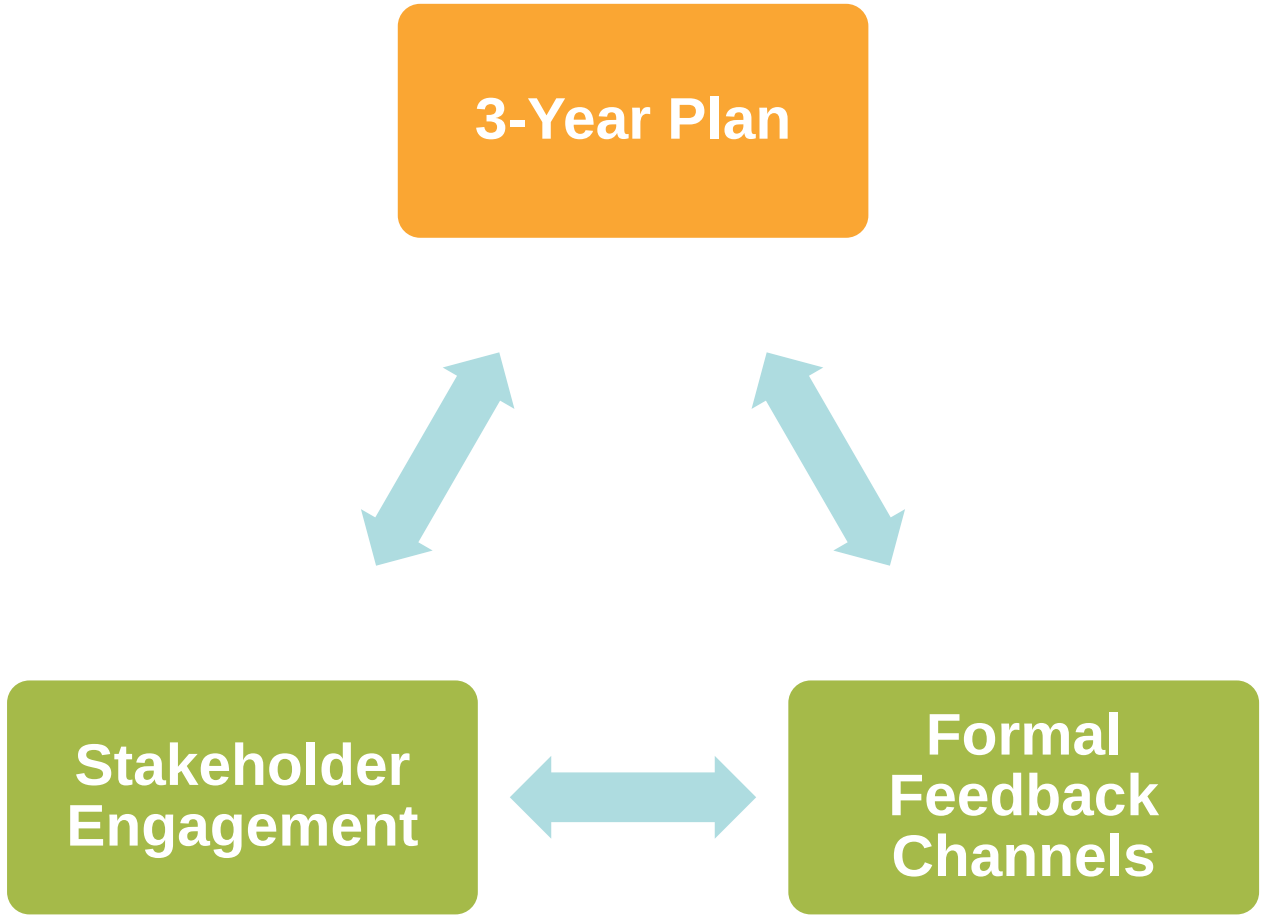
LIVE WELL SAN DIEGO

ENGAGEMENT

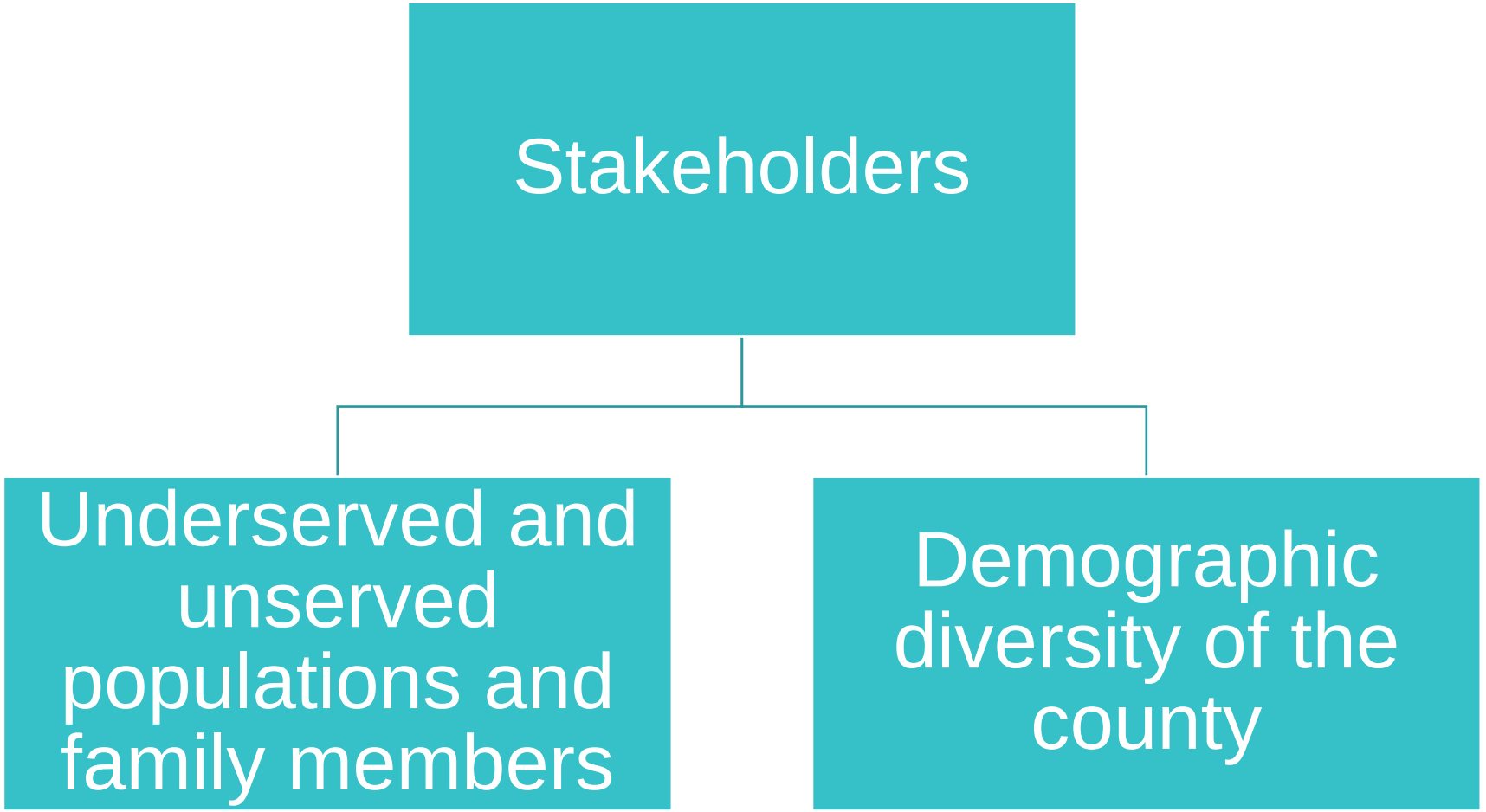
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CPP Process

OUTREACH



ENGAGEMENT PROCESS



CPP: BHS Formal Stakeholder Feedback Platforms

- BHS Council Meetings
- Cultural Competency Resource Team
- Letters/Email to Director
- MHSA call line/inbox

CPP: BHS COUNCIL MONTHLY MEETINGS

Meeting	Time	When	Contact
Adult Council	11:00am-12:30pm	2nd Monday	Andrea.Duron@sdcounty.ca.gov
Older Adult Council	10:00am-12:00pm	4th Wednesday	Loretta.Ramirez@sdcounty.ca.gov
Behavioral Health Advisory Board (BHAB)	2:30-5:00pm	1st Thursday	Dania.Barroso-Conde@sdcounty.ca.gov
Children Youth and Families System of Care	9:00-10:30am	2nd Monday	Edith.Mohler@sdcounty.ca.gov; Darwin.Espejo@sdcounty.ca.gov
Housing Council	11:30am-1:00pm	1st Thursday	Cynthia.Robles@sdcounty.ca.gov
Cultural Competency Resource Team	10:00-11:30am	1st Friday	Andrea.Duron@sdcounty.ca.gov
Transitional Age Youth (TAY) Council	3:00-4:30pm	4th Wednesday	Asheka.Huey@sdcounty.ca.gov

CPP: BHS Formal Stakeholder Feedback Platforms

- BHS Council Meetings
- Cultural Competency Resource Team
- Letters/Email to Director
- MHSA call line/inbox

CPP: Stakeholder engagement opportunities

LIVE WELL SAN DIEGO

FALL 2022: BE A PART OF CREATING THE NEW 3-YEAR PLAN!

Community listening sessions

Focus groups

Individual interviews

Grassroots outreach

And more!

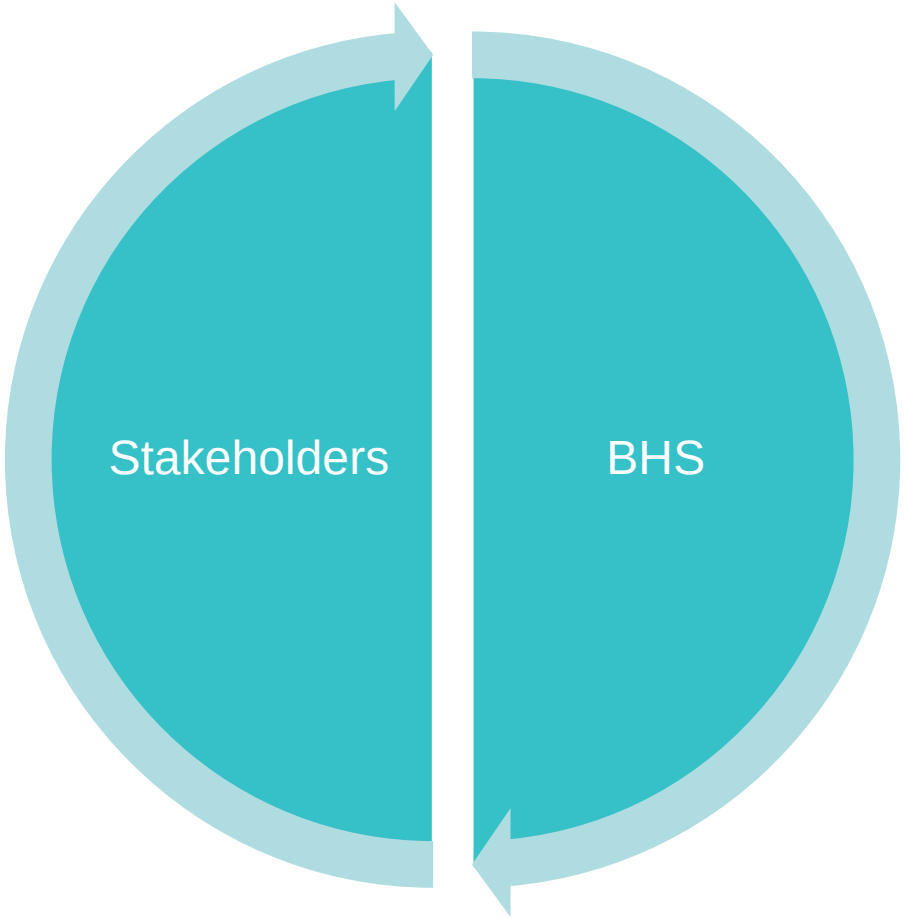
PARTICIPANT SURVEY

HTTPS://GO.UCSD.EDU/3A0DQ9Q

CPP Process: BHS requirements

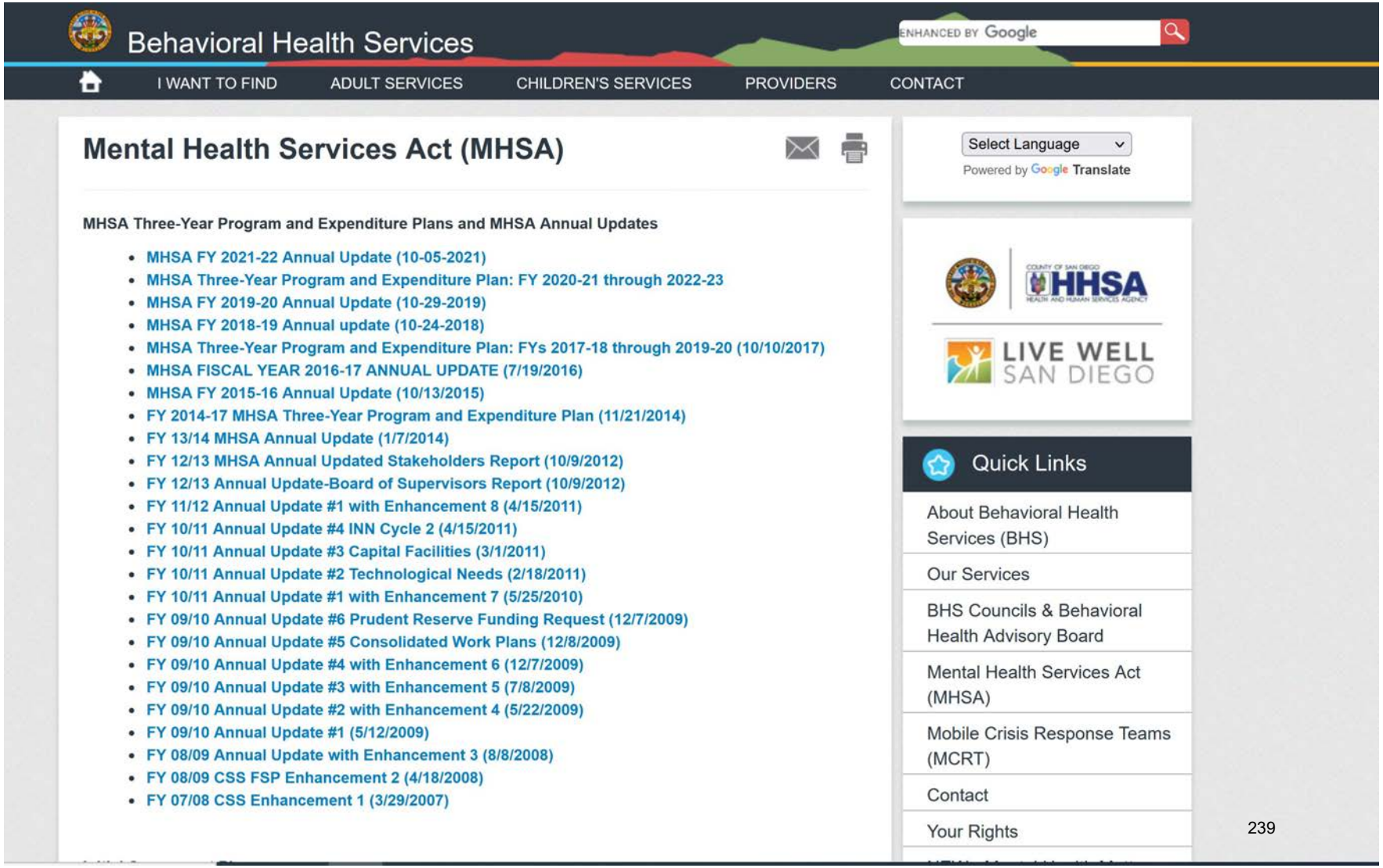
- Stakeholder meetings and other engagement activities
- Description of stakeholder involvement
- Description of how involvement was meaningful
- 30-day Review and Public Hearing
- Summary of input
- Explanations of accepted or rejected recommendations

COMMITMENT TO ONGOING COMMUNICATION & FEEDBACK



WHERE TO FIND SAN DIEGO MHSA INFORMATION

https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa_cosd_docs.html



San Diego MHSA Issue Resolution Process

Anyone can file an issue related to the MHSA Community Program Planning Process and/or inconsistency between approved MHSA Plan and implementation at any point and avenue within the system. The issue will be forwarded to the Consumer and Family Liaisons

County of San Diego MHSA Issue Resolution Process has a detailed look at the process

Contact BHS:

Phone: 619-584-5063; Toll Free: 888-977-6763
MHSProp63.HHSA@sdcounty.ca.gov

THANK YOU FOR YOUR TIME!

LIVE WELL SAN DIEGO

You have completed an MHSA Stakeholder Training

Next steps

- Fall 2022 stakeholder engagement information coming soon
- Follow up with questions/comments to Amanda Farr, Afarr@health.ucsd.edu

Thank You

BHS Sign-In/ Demographics

Start of Block: Default Question Block

Q1 The following demographic data collected on this form will be used only to generate summary reports about the training held by County of San Diego HHSA Behavioral Health Services and UC San Diego.

Q10 What is your home address ZIP Code?

O ZIP Code: (1) _____

Q21 Are you a Veteran?

O No (1)

O Yes (2)

O Other (Please specify) (3)
_____

O Prefer Not to Answer (4)

Q20 Do you have a disability?

If yes, please select all that apply. (For this survey, a disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.)

- ☐ No, I do not have any of these disabilities (1)
- ☐ Difficulty seeing (2)
- ☐ Difficulty hearing or having speech understood (3)
- ☐ Other communication disability (please specify) (4) _____
- ☐ Learning disability (5)
- ☐ Developmental disability (6)
- ☐ Dementia (7)
- ☐ Other mental disability not related to mental illness (please specify) (8) _____
- ☐ Physical/mobility disability (9)
- ☐ Chronic health condition/chronic pain (10)
- ☐ Other (please specify) (11) _____
- ☐ Prefer not to answer (12)

Q24 Do you identify with any of these additional groups? *(Select all that apply*)

- [ ] Immigrant (1)
- [ ] Refugee/Newcomer (2)
- [ ] Asylee (3)
- [ ] Veterans/Military (4)
- [ ] Homeless (5)
- [ ] African (6)
- [ ] Chaldean (7)
- [ ] LGTBQI (8)
- [ ] Prefer not to answer (9)
- [ ] Do not identify as any of these additional groups (10)
- [ ] Other (please specify) (11) _____

Q14 Please select your racial and ethnic identity. (Select all that apply)

- [ ] Hispanic, Latino/a, or Spanish origin: Mexican, Mexican American, or Chicano (1)
- [ ] Another Hispanic, Latino/a, or Spanish origin (please specify) (2) _____
- [ ] Alaska Native (9)
- [ ] American Indian (3)
- [ ] Asian Indian (10)
- [ ] Black or African American (5)
- [ ] Chinese (11)
- [ ] Filipino (12)
- [ ] Guamanian or Chamorro (17)
- [ ] Japanese (13)
- [ ] Korean (14)
- [ ] Native Hawaiian (6)
- [ ] Samoan (18)
- [ ] Vietnamese (15)
- [ ] White (7)
- [ ] My race or ethnic identity was not captured above. I identify as: (8) _____
- [ ] Decline to answer (20)

Q17 What is the primary language you speak or use at home?

- O English (1)
- O Arabic (2)
- O Farsi (3)
- O Spanish (4)
- O Tagalog (5)
- O Vietnamese (6)
- O Other (please specify) (7) _____

Q13 What is your age group? *(Please select one)*

- O Age 0-15 years old (1)
- O Age 16-25 years old (2)
- O Age 25-59 years old (3)
- O Age 60 years old and over (4)
- O Prefer not to answer (5)

Q23 What is your gender identity? (*Select one that best describes you)*

- O Male (1)
- O Female (2)
- O Transgender male/trans man (3)
- O Transgender female/trans woman (4)
- O Genderqueer/gender non-conforming (5)
- O Questioning/unsure of gender identity (6)
- O Another gender identity (please specify) (7)

  _____

- O Prefer not to answer (8)

Q19 What is your sexual orientation? (*Select one that best describes you)*

- O Heterosexual or straight (1)
- O Gay or lesbian (2)
- O Bisexual/pansexual/sexually fluid (3)
- O Queer (4)
- O Questioning/unsure of sexual orientation (5)
- O Another sexual orientation (please specify) (6)

  _____

- O Prefer not to say (7)

Q22 What sex were you assigned on your original birth certificate?

- O Male (1)
- O Female (2)
- O Prefer not to say (3)
- O Other (please specify) (4) _____

Q1 Please enter your name. (optional)

_____

End of Block: Default Question Block

We want to hear from you!



We are currently recruiting for a focus group to better understand the needs of transitional age youth (TAY) in San Diego County. The focus group will be held virtually via Zoom and will take anywhere from 60-75 minutes.

WHO?

Providers, Community Advocates, and Community Groups of Transitional Age Youth (TAY)

WHEN?

Thursday, December 15th, 2022

HOW?

Please complete our participant interest form

or https://bit.ly/TAYfocusgroup

UC San Diego Health

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Focus Group Interview Guide

Goals:

1. *Understand priority mental health and substance use needs of stakeholders/priority populations*
2. *Perceptions of what resources exist and challenges to accessing those resources.*
3. *Identify community strengths – areas of opportunity to meet behavioral health needs in innovative ways.*
4. *Understand successful community engagement for this group, including expectations around participation, feedback mechanisms, responsibility of BHS to the community?*

Introduction

Thank you for taking the time to talk with us. We are here today because we are partnering with the County of San Diego Behavioral Health Service system to inform the ways in which the system designs and implements programming to meet the needs of our very diverse San Diego community, and community members are a critical part of that conversation.

Our approach includes a community engagement process that is welcoming, inclusive, and aligned with other behavioral health related engagement activities. Today, we are here to specifically focus on the (**insert population**) community. will ask some questions focused on helping us understand what you see as the strengths of your (**insert population**) community, some priority areas for mental health and substance use and resources, and how best to do ensure community voice can be successfully included in the ways in which San Diego BHS creates and implements its programs. The information collected as part of these groups will be shared with BHS as a summary blueprint that includes (**insert population**) behavioral health needs, assets, and recommendations.

Guidelines

1. We are encouraging verbal dialogue for this engagement session. To make sure everyone is heard we encourage you to use the hand raise option, so that each person is heard. Explain where this is.
2. Secondary, you can use the chat if you prefer. Joel will be monitoring the chat and we may very likely review the chat feedback and possibly ask for further follow up on responses in the chat.
3. We will be recording this session today so that notes can be used to inform the behavioral health community planning process.
4. Please try to remain on mute while you are not speaking to decrease background sounds.
5. Any questions before we begin?

<u>Ground rules</u>

o Participation in the focus group is voluntary.
o It's all right to abstain from discussing specific topics if you are not comfortable.
o All responses are valid—there are no right or wrong answers.
o Please respect the opinions of others even if you don't agree.
o Try to stay on topic; we may need to interrupt so that we can cover all the material.
o Speak as openly as you feel comfortable.
o Avoid revealing very detailed information about your personal health.
o Help protect others' privacy by not discussing details outside the group.

As mentioned, so that we can be sure to capture everything that is shared, we will be recording this discussion. None of the information you share will be attached to your name in any way. The recording is to ensure that we are able to thoroughly listen and review later. We will start the recording now.

Ensure okay to start recording and GO!

INTRODUCTION: Let's take a minute to introduce ourselves to one another. Share your name, in what area of San Diego you live, and what brings you to this event today. (*Facilitator starts, then passes to F2, then F3, the just goes around the virtual room*.)

SECTION ONE: Community Strengths

1. We want to start with talking about the strengths of the (**insert population**) community. What would you say are the strengths of the community that are important to hear when thinking about mental health and substance use needs?

2. What characteristics of the (**insert population**) community are most impactful for program development and services? *Probe if needed: What important to keep in mind when developing behavioral health programs?*

SECTION TWO: Resources/Opportunities for Innovation

3. What services and programs/resources have been useful/available to you or people you know over the last year?

4. What challenges are important for us to know about that impact the (**insert population**) community in using behavioral health resources and services?

5. What kind of mental health and/or substance use services do you need to make sure you, your family, and the community are cared for?

6. Probe: Is there a specific, creative, innovative program that San Diego should consider creating for the (**insert population**) community?

SECTION THREE: Priority mental health & substance use needs

7. What would you see as the most pressing mental health concerns, right now, for you and people you know?
    a. To what degree are concerns they being met?
    b. What is going right when they are being met?
    c. What are the challenges when they are not being met?

8. What would you see as the most pressing substance use concerns, right now, for you and people you know?
    a. To what degree are concerns they being met?
    b. What is going right when they are being met?

c. What are the challenges when they are not being met?

SECTION 4: Outreach, Engagement, Expectations, & Accountability

9. What are some ways you think work best to successfully engage with your (**insert population**) communities?
    a. Where, in your experience, has this fallen short to date?
    b. Are there specifics that would be helpful to know when engaging with this community in a culturally sensitive way?

10. What types of communications and messages should be used to gather your input for behavioral health?
    c. How should SDCBHS communicate with your community about mental health, substance use, programming, and funding?
    d. How should community feedback/frustrations be communicated to BHS? How should BHS response be conveyed?

SECTION 5: Wrap-Up

11. As we are wrapping up, we want to hear how this conversation worked for you? Are we hearing you? Did the language we used about mental health and substance use make sense?

12. Is there anything else that is important for us to know that we did not ask about today?

SUPPORTING WELLNESS, RECOVERY, & RESILIENCE THROUGH COMMUNITY INPUT

Live Well Advance: Building an Equitable Future

Facilitated by: Danielle L. Fettes, PhD

LIVE WELL SAN DIEGO

UC San Diego Health

AGENDA FOR TODAY'S SESSION

Mental Health Services Act (MHSA): Background, Key Features, Program Values, & Core Requirements

How MHSA is implemented in San Diego

Community Program Planning (CPP) Process & Stakeholder Involvement

CPP… Including today!

Mental Health Services Act

MHSA

2004

1% tax on income over $1 million

San Diego County

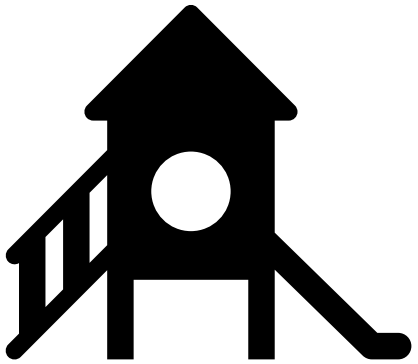
- More than $200,000,000 annually

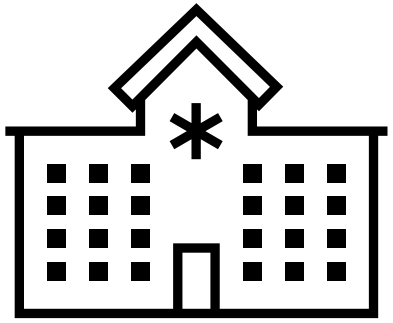
Mental Health Services Act

LIVE WELL SAN DIEGO

Transform Mental Health System

Close Service Gaps







Mental Health Services Act: Key Features



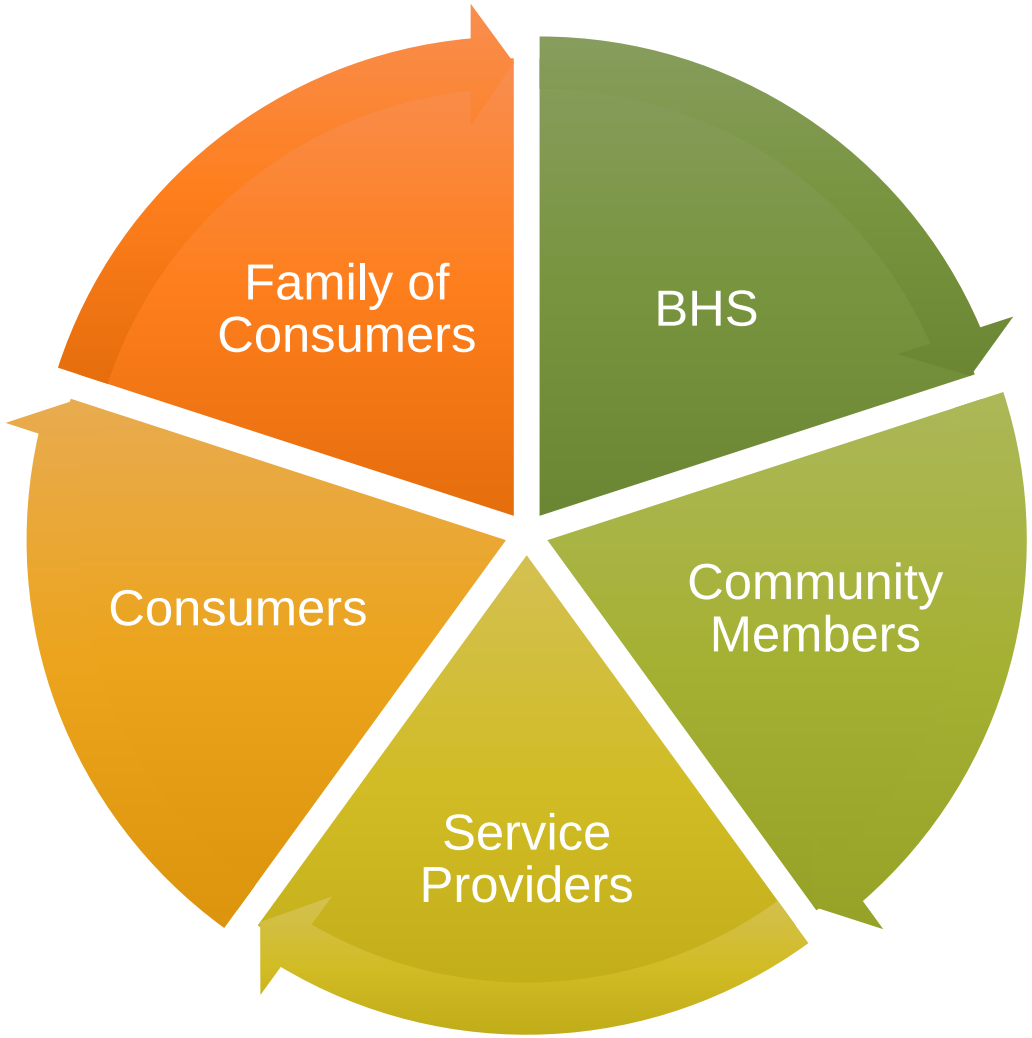
LIVE WELL SAN DIEGO

MHSA: FIVE FUNDED COMPONENTS

LIVE WELL SAN DIEGO

- Community Supports & Services: CSS
- Prevention & Early Intervention: PEI
- Innovations Programs: INN
- Workforce Education & Training: WET
- Capital Structure & Technological Needs

MHSA: THE 3-YEAR PLAN



MHSA PLEDGES A COMMITMENT TO INCLUSION

Counties shall "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."

(CA WIC 5848)

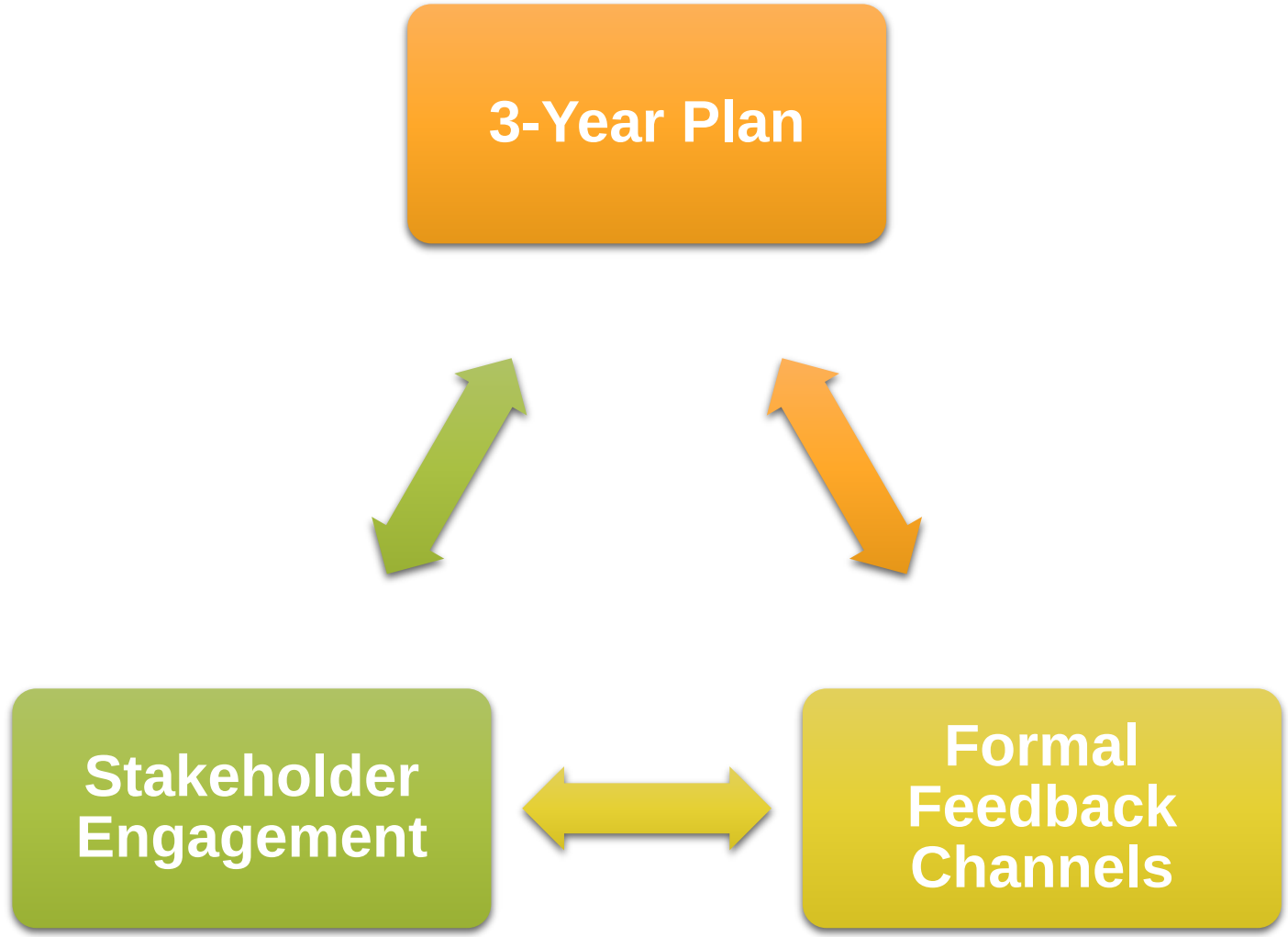
WHO ARE STAKEHOLDERS?

Consumers	Adults & Seniors with SMI	Families of children, adults & seniors with SMI	Providers of mental health and/or related services
Providers of alcohol and drug services	Law enforcement agencies	Educators and/or representatives of education	Social services agencies
Veterans	Representatives from Veterans' organizations	Health care organizations	Other important interests

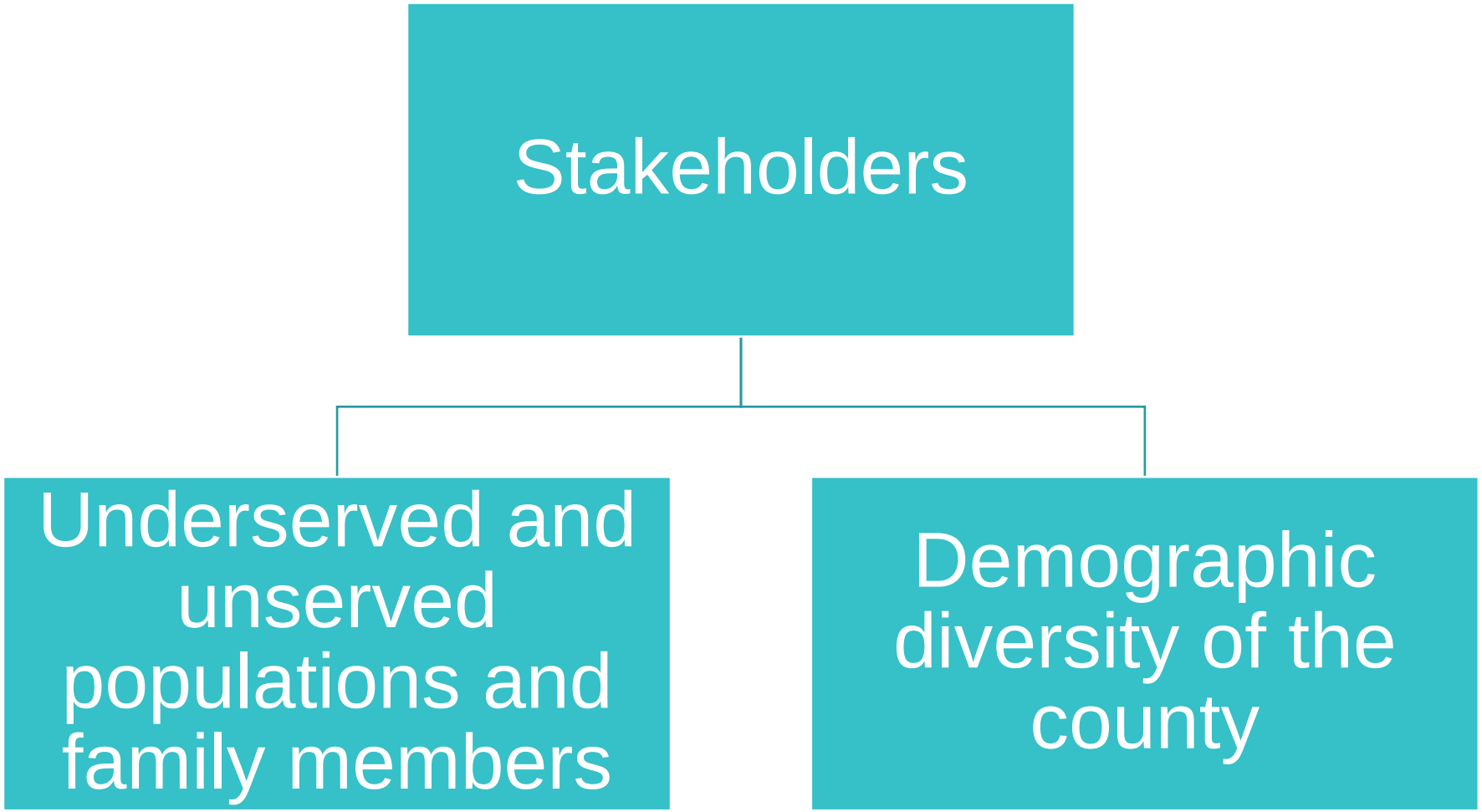
COMMUNITY PROGRAM PLANNING PROCESS

LIVE WELL SAN DIEGO

CPP Process


3-Year Plan
Stakeholder Engagement
Formal Feedback Channels

STAKEHOLDER ENGAGEMENT



CPP: BHS Formal Stakeholder Feedback Platforms

BHS Council Meetings

Letters/Email to Director

MHSA call line/inbox

CPP: Stakeholder engagement opportunities

LIVE WELL SAN DIEGO

BE A PART OF CREATING THE NEW 3-YEAR PLAN!

Community listening sessions

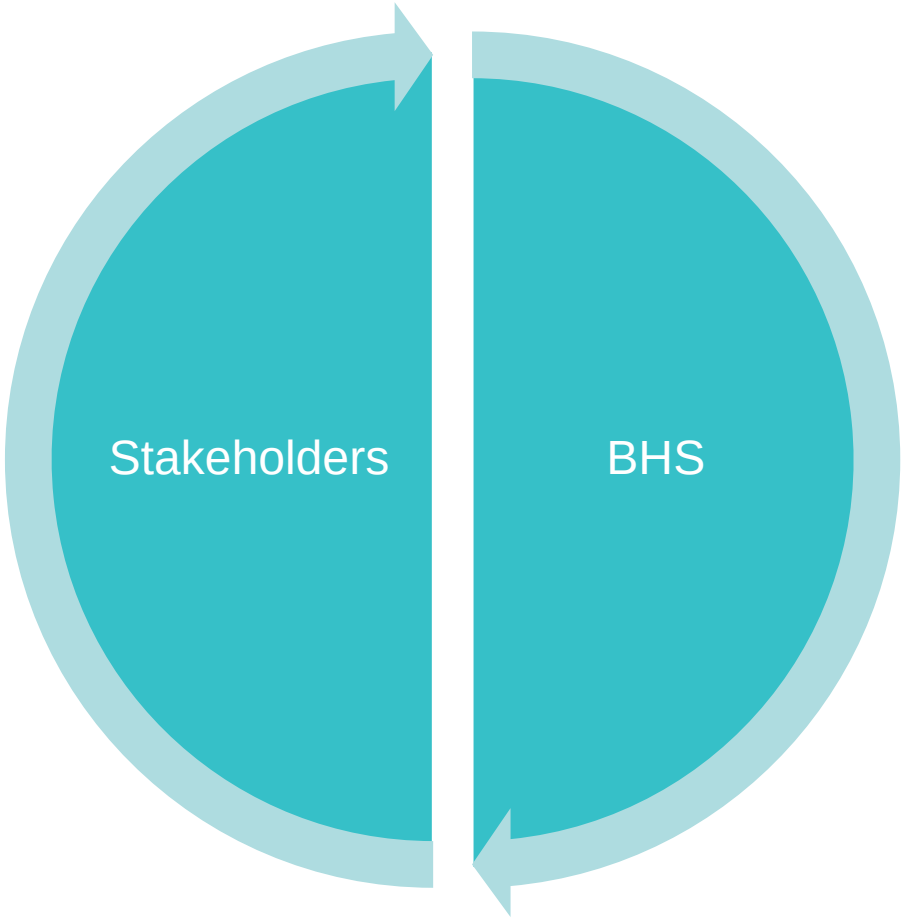
Focus groups

Individual interviews

Grassroots outreach

And more!

COMMITMENT TO ONGOING COMMUNICATION & FEEDBACK



OUR COMMITMENT TO AUTHENTIC ENGAGEMENT

LIVE WELL SAN DIEGO

Goals of community engagement:

building trust, enlisting new resources and allies, creating better communication, and improving health outcomes

Equity is centered

recognize and appreciate that all who are involved in engaging a community must be responsive to the needs of that community, *as defined by the community itself*

THE GLOBAL ARC
Global Action Research Center

COMMUNITY HEALTH IMPROVEMENT PARTNERS
making a difference together

UC San Diego Health

LET'S GET STARTED! STAKEHOLDER CONVERSATION

Table Conversations

What are the most pressing issues related to mental health or substance use in our community?

Table Conversations

What resources exist in your community for mental health or substance use?

Table Conversations

LIVE WELL SAN DIEGO

What are the biggest challenges to accessing resources for behavioral health in your community?

Table Conversations

What ideas can you share for addressing the priority behavioral health needs of your community?

TABLE SHARE OUT

Next steps



- Join us at 1:45 for Part 2 of today's conversation!
- Swing by our table in the Connection Hub!
- BHS reception at 4:30 today
- Email us: MHSAvoices@health.ucsd.edu

BUILDING AN ALLIANCE FOR BEHAVIORAL HEALTH EQUITY BASED ON COMMUNITY EFFORTS & EXPERTISE

Live Well Advance: Building an Equitable Future

Facilitated by: Danielle L. Fettes, PhD

LIVE WELL SAN DIEGO

UC San Diego Health

AGENDA FOR TODAY'S SESSION

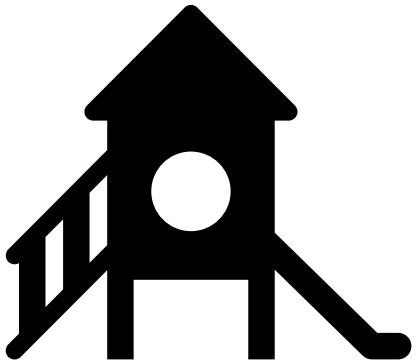
- Community Program Planning (CPP) & Stakeholder Involvement
- Why this conversation/define an alliance
- Planning conversation: help establish countywide mechanisms to improve behavioral health equity

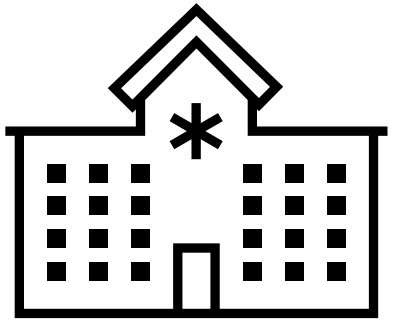
Mental Health Services Act

LIVE WELL SAN DIEGO

Transform Mental Health System

Close Service Gaps







Mental Health Services Act: Key Features



LIVE WELL SAN DIEGO

MHSA PLEDGES A COMMITMENT TO INCLUSION

Counties shall "demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on mental health policy, program planning, and implementation, monitoring, quality improvement, evaluation, and budget allocations."

(CA WIC 5848)

What does 'stakeholder involvement' mean to you?

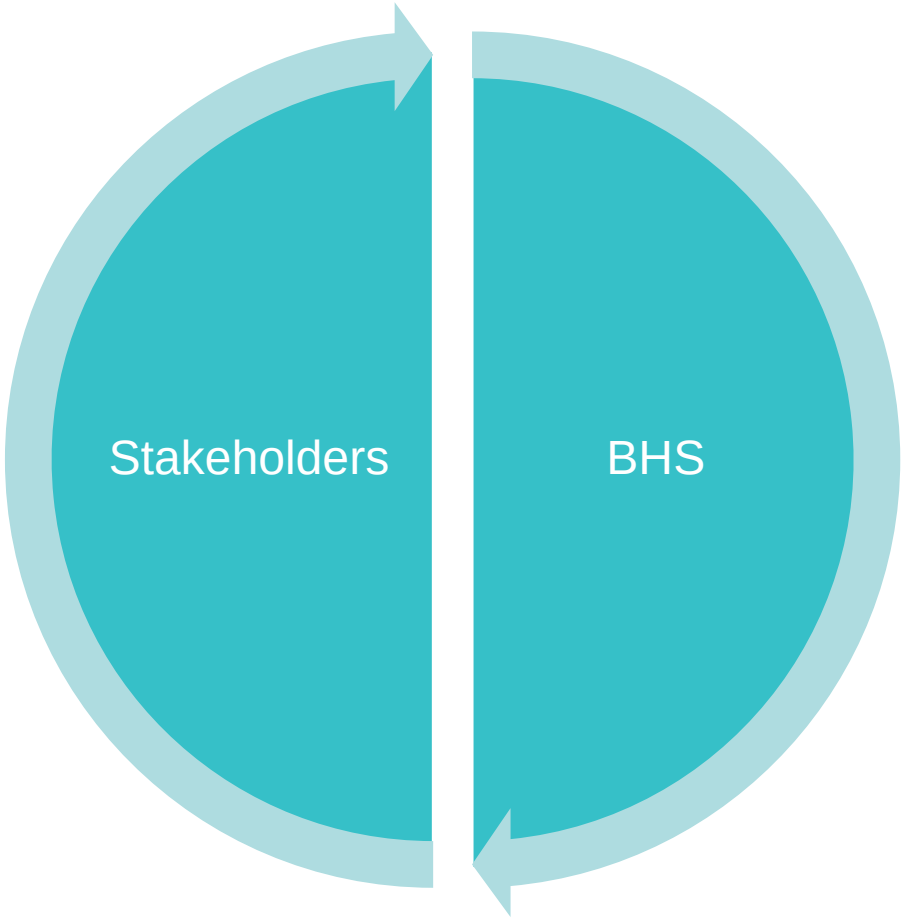


Menti.com: 6248 0218

WHAT IS AN "ALLIANCE?"

A group of people who work/collaborate/partner because of shared interests and/or goals

COMMITMENT TO ONGOING COMMUNICATION & FEEDBACK



OUR COMMITMENT TO AUTHENTIC ENGAGEMENT

LIVE WELL SAN DIEGO



Goals of community engagement:

building trust, enlisting new resources and allies, creating better communication, and improving health outcomes



Equity is centered



recognize and appreciate that all who are involved in engaging a community must be responsive to the needs of that community, *as defined by the community itself*

RESEARCH ACTION LEARNING

THE GLOBAL ARC
Global Action Research Center

C H I P

COMMUNITY HEALTH IMPROVEMENT PARTNERS
making a difference together

UC San Diego Health

LET'S GET STARTED! STAKEHOLDER CONVERSATION

IMAGINE THE IDEAL COMMUNITY ENGAGEMENT & OUTREACH APPROACH FOR BEHAVIORAL HEALTH

Who is included?

What is the result?

How do we see the results?

What are some ways to successfully engage with our communities?

How can we authentically reach harder-to-reach groups and populations?

Misconceptions to be aware of

LASTLY…

What is the best way to provide feedback, share resources, and make recommendations to the County of San Diego BHS (and for the County of San Diego BHS to share back with our community)?

TABLE SHARE OUT

LET'S CONTINUE THE CONVERSATION!

LIVE WELL SAN DIEGO

Today! 4:40-6:30 Behavioral Health Networking & Input Reception

Input sessions at LWSD leadership meetings – January 2023

Email us: MHSAvoices@health.ucsd.edu

THANK YOU!

pdated MHSA Training Satisfaction Survey

Start of Block: Knowledge

Q1 Thank you for participating in today's MHSA Stakeholder Training! We would like to hear your perspectives on this training, but also on how we can best engage you and your community in the Community Program Planning process, and on what you see are the behavioral health needs of your community. Please take a few minutes to answer the following questions. Your answers are not personally identifiable and will be used to help us plan future events

Q26 I took this training as a representative of this community group. (*Select all that apply*).

- ☐ Community Member (6)
- ☐ Consumer of BHS Services (7)
- ☐ Family Member of Consumer (8)
- ☐ County of San Diego BHS Staff (9)
- ☐ CBO staff/Behavioral Health Provider (10)
- ☐ Other County of San Diego Staff (please identify) (11) _____
- ☐ Other (please identify) (12) _____

Q10 What do you think are the 2-3 most important issues that must be addressed to improve behavioral health in your community? *(Select all that apply)*

- ☐ Issue One (please specify) (1) _____
- ☐ Issue Two (please specify) (2) _____
- ☐ Issue Three (please specify) (3) _____

Page Break

Q25 This training improved my knowledge of California's Mental Health Services Act

- Strongly agree (4)
- Somewhat agree (3)
- Neither agree nor disagree (2)
- Somewhat disagree (1)
- Strongly disagree (0)

San Diego County This training improved my knowledge of how the MHSA is used in San Diego County

- Strongly agree (4)
- Somewhat agree (3)
- Neither agree nor disagree (2)
- Somewhat disagree (1)
- Strongly disagree (0)

Q3 Overall, how satisfied were you with this webinar?

- Extremely satisfied (4)
- Somewhat satisfied (3)
- Neither satisfied nor dissatisfied (2)
- Somewhat dissatisfied (1)
- Extremely dissatisfied (0)

Q4 The day of week of this training was a good fit for my schedule

- Strongly agree (4)
- Somewhat agree (3)
- Neither agree nor disagree (2)
- Somewhat disagree (1)
- Strongly disagree (10)

Q5 The time of day of this training was a good fit for my schedule

- Strongly agree (6)
- Somewhat agree (7)
- Neither agree nor disagree (8)
- Somewhat disagree (9)
- Strongly disagree (10)

Page Break

Q6 How did you learn of this MHSA Stakeholder Training

- ○ Flyer (1)
- ○ Friend/Family Member (2)
- ○ Co-worker/Colleague (3)
- ○ Social Media (4)
- ○ Email From: (please specify) (5) _____
- ○ Other (please specify) (6) _____

Q7 In the future, would you like to receive training and engagement updates via email?

- ○ No (1)
- ○ Yes, please email me at: (2) _____

Q8 In the future, would you prefer to participate in virtual/online or in-person events? (*Select all that apply)*

- ☐ Virtual Events (1)
- ☐ In-person Events (2)
- ☐ Depends on the COVID-19 situation (4)

Q9 What is the best way to get your input on how MHSA funding should be used in the future? (*Please select all that are applicable.*)

- [ ] Community Forum/Listening Sessions (1)
- [ ] Focus Groups (2)
- [ ] Individual Interview (3)
- [ ] Other (please specify) (4) _____
- [ ] Other (please specify) (5) _____
- [ ] Other (please specify) (6) _____
- [ ] Other (please specify) (7) _____

Q11 Do you have any other comments to share with us?

_____

_____

_____

_____

_____

Page Break

Q12 The following demographic data collected on this form will be used only to generate summary reports about the training held by County of San Diego HHSA Behavioral Health Services and UC San Diego.

Q13 What is your age group? *(Please select one)*

- ○ age 0-15 years old (1)
- ○ age 16-25 years old (2)
- ○ age 25-59 years old (3)
- ○ age 60 years old and over (4)
- ○ prefer not to answer (5)

Q14 What is your race? *(Select all that apply)*

- [ ] African/African American/Black (37)
- [ ] African American (1)
- [ ] African (specify): (2) _____
- [ ] Other African/Black (specify): (3) _____
- [ ] Asian (38)
- [ ] Asian Indian/South Asian (4)
- [ ] Cambodian (5)
- [ ] Chinese (6)
- [ ] Filipino (7)
- [ ] Hmong (8)
- [ ] Japanese (9)
- [ ] Korean (10)
- [ ] Laotian (11)
- [ ] Mien (12)
- [ ] Vietnamese (13)
- [ ] Other Asian (specify): (14) _____
- [ ] Pacific Islander (39)

- [ ] Native Hawaiian (15)
- [ ] Samoan (16)
- [ ] Other Pacific Islander (specify): (17) _____
- [ ] American Indian/Alaskan Native (18)
- [ ] Other American Indian (specify): (19) _____
- [ ] Hispanic/Latino (40)
- [ ] Caribbean (20)
- [ ] Central American (21)
- [ ] Cuban (22)
- [ ] Dominican (23)
- [ ] Mexican/Mexican-American/Chicano (24)
- [ ] Puerto Rican (25)
- [ ] Salvadoran (26)
- [ ] South American (27)
- [ ] Other Hispanic/Latino (specify): (28) _____
- [ ] White/Caucasian (41)
- [ ] Chaldean (29)

- [ ] Eastern European (30)
- [ ] European (31)
- [ ] Iraqi (32)
- [ ] Middle Eastern (33)
- [ ] Other White/Caucasian (specify): (34) _____
- [ ] Other (specify): (35) _____
- [ ] Prefer not to answer (36)

Page Break

Q17 What is the primary language you speak or use at home?

- ○ English (1)
- ○ Arabic (2)
- ○ Farsi (3)
- ○ Spanish (4)
- ○ Tagalog (5)
- ○ Vietnamese (6)
- ○ Other (please specify): (7) _____

Page Break

Q18 In what region of San Diego County do you live?

- ○ a. I do not know/am unsure of the which region I live in. This is my zip code: (1) _____
- ○ b. Central (2)
- ○ c. South (3)
- ○ d. East (4)
- ○ e. North Central (5)
- ○ f. North Coastal (6)
- ○ g. North Inland (7)

Q19 What is your sexual orientation? (*Select one that best describes you)*

- ○ Heterosexual or straight (1)
- ○ Gay or lesbian (2)
- ○ Bisexual/pansexual/sexually fluid (3)
- ○ Queer (4)
- ○ Questioning/unsure of sexual orientation (5)
- ○ Another sexual orientation (please specify): (6) _____
- ○ Prefer not to say (7)

Page Break

Q20 Do you have a disability?

If yes, please select all that apply. (For this survey, a disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.)

- ☐ No, I do not have any of these disabilities (1)
- ☐ Difficulty seeing (2)
- ☐ Difficulty hearing or having speech understood (3)
- ☐ Other communication disability (please specify): (4) _____
- ☐ Learning disability (5)
- ☐ Developmental disability (6)
- ☐ Dementia (7)
- ☐ Other mental disability not related to mental illness (please specify): (8)
- ☐ Physical/mobility disability (9)
- ☐ Chronic health condition/chronic pain (10)
- ☐ Other (please specify): (11) _____
- ☐ Prefer not to answer (12)

Q21 Are you a Veteran?

- ○ No (1)
- ○ Yes (2)
- ○ Other (Please specify) (3) _____
- ○ Prefer Not to Answer (4)

Page Break

Q22 What sex were you assigned on your original birth certificate?

- ○ Male (1)
- ○ Female (2)
- ○ Prefer not to say (3)
- ○ Other (please specify) (4) _____

Q23 What is your gender identity? (*Select one that best describes you)*

- ○ Male (1)
- ○ Female (2)
- ○ Transgender male/trans man (3)
- ○ Transgender female/trans woman (4)
- ○ Genderqueer/Gender non-conforming (5)
- ○ Questioning/unsure of gender identity (6)
- ○ Another gender identity (please specify): (7) _____
- ○ Prefer not to answer (8)

Page Break

Q24 Do you identify with any of these additional groups? *(Select all that apply)*

- [ ] Immigrant (1)
- [ ] Refugee/Newcomer (2)
- [ ] Asylee (3)
- [ ] Veterans/Military (4)
- [ ] Homeless (5)
- [ ] African (6)
- [ ] Chaldean (7)
- [ ] LGTBQI (8)
- [ ] Prefer not to answer (9)
- [ ] Do not identify as any of these additional groups (10)
- [ ] Other (please identify) (11) _____

End of Block: Knowledge

Start of Block: Block 1

APPENDIX G

MHSA ISSUE RESOLUTION PROCESS

Mental Health Services Act Issue Resolution Process
Updated January 2023

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 Mental Health Services Act (MHSA) program planning process and implementation.

The Department of Health Care Services (DHCS) requires that the local issue resolution process be exhausted before accessing State venues such as the Mental Health Services Oversight and Accountability Commission (MHSOAC) or the California Mental Health Planning Council (CMHPC) to seek issue resolution or to file a complaint or grievance.

The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) has adopted an issue resolution process for filing and resolving issues related to the MHSA community program planning process, and consistency between program implementation and approved plans.

BHS is committed to:

- Addressing issues regarding MHSA in an expedient and appropriate manner;
- Providing several avenues to file an issue, complaint or grievance;
- Ensuring assistance is available, if needed, for the client/family member/provider/community member to file their issue; and
- Honoring the Issue Filer's desire for anonymity.

Types of MHSA issues to be resolved in this process:

- Appropriate use of MHSA funds
    - Allegations of fraud, waste, and abuse of funds are excluded from this process. Allegations of this type will be referred directly to the County Compliance Office for investigation.
- Inconsistency between approved MHSA Plan and implementation;
- San Diego County Community Program Planning Process.

Process:

- An individual may file an issue at any point and via any avenue within the system. These avenues include but are not limited to the BHS Director, BHS Assistant Directors, BHS Deputy Directors, BHS Councils, County of San Diego Compliance Officer, Issue Resolution Contact, Patient Advocacy Program, and BHS providers.
- The MHSA issue shall be forwarded to the contact listed below, for review within three (3) business days of receipt.
- The Issue Resolution Contract (IRC) shall provide the Issue Filer a written acknowledgement of receipt of the issue, complaint, or grievance within two (2) business days.
- The IRC shall notify the BHS MHSA Coordinator of an issue received while maintaining anonymity of the Issue Filer within two (2) business days if BHS not already in receipt of issue, complaint, or grievance.
- The IRC will investigate the issue.
    - IRC may convene an MHSA Issue Resolution Committee (MIRC) whose membership includes unbiased, impartial individuals who are not employed by the County of San Diego.
    - IRC will communicate with the Issue Filer every seven (7) days while the issue is being investigated and resolved.
- Upon completion of investigation, IRC shall issue a committee report to the BHS Director.
    - Report shall include a description of the issue, brief explanation of the investigation, IRC/MIRC recommendation and the County resolution to the issue.
    - IRC shall notify the Issue Filer of the resolution in writing and provide information regarding the appeal process and State-level opportunities for additional resolution, if desired.
- The BHS Director will provide a quarterly MHSA Issue Resolution Report to the Behavioral Health Advisory Board.

Issue Resolution Contact:

Consumer Center for Health Education & Advocacy – CCHEA
Carol Neidenberg
110 S Euclid Avenue
San Diego, CA 92114
(877) 534-2524
caroln@cchea.org

APPENDIX H

COMMUNITY SUPPORTS AND SERVICES (CSS) ANNUAL REPORT FY 2021-22

FY 2021-22 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

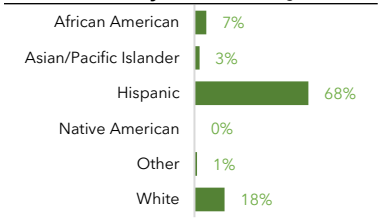
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Children & Youth – Full-Service Partnership (CY-FSP; n=7,574)

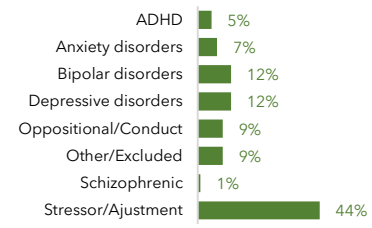
Living Situation	%
Correctional Facility	0%
Foster Home	3%
Group Home	0%
Homeless	1%
House/Apartment	94%
Institutional	0%
Other/Unknown	1%

Language	%
Arabic	0%
English	88%
Farsi	0%
Other/Unknown	0%
Spanish	11%
Tagalog	0%
Vietnamese	0%

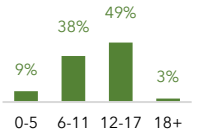
Race/Ethnicity (excludes missing/unknown)



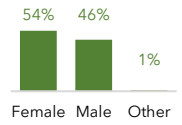
Diagnosis (excludes missing/invalid)



Age



Gender



Children & Youth – Outreach and Engagement (CY-OE; n=0)

CY-FSP **22%** (7,574)

Total CSS Clients (unduplicated) N = 34,870

CY-SD **8%** (2,895)

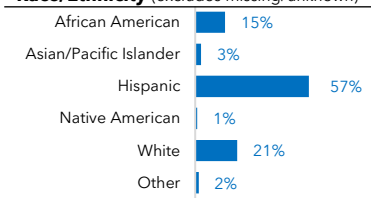
ALL-OE **<1%** (152)

Children & Youth – System Development (CY-SD; n=2,895)

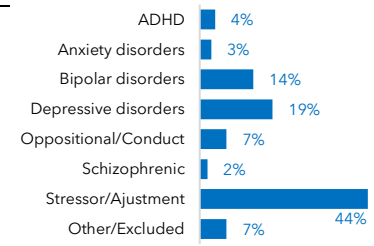
Living Situation	%
Children's Shelter	3%
Correctional Facility	17%
Foster Home	8%
Group Home	2%
Homeless	1%
House/Apartment	63%
Institutional	0%

Language	%
Arabic	0%
English	92%
Farsi	0%
Other/Unknown	0%
Spanish	7%
Tagalog	0%
Vietnamese	0%

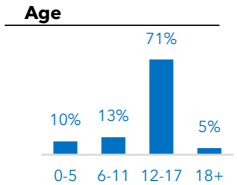
Race/Ethnicity (excludes missing/unknown)



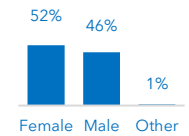
Diagnosis (excludes missing/invalid)



Age

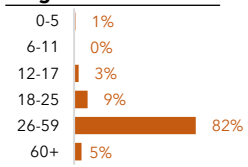


Gender

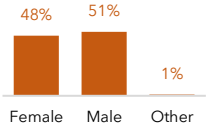


All CSS – Outreach and Engagement (ALL-OE; n=152)

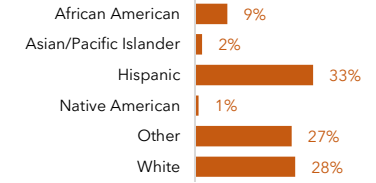
Age



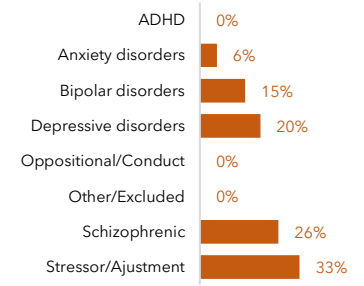
Gender



Race/Ethnicity (excludes missing/unknown)



Diagnosis (excludes missing/invalid)



Living Situation	%
Board & Care	11%
Correctional Facility	0%
Group Home	0%
Homeless	7%
House/Apartment	77%
Institutional	1%
Other/Unknown	5%

Language	%
Arabic	8%
English	52%
Farsi	3%
Other/Unknown	23%
Spanish	13%
Tagalog	0%
Vietnamese	1%

CSS Report | Source: Optum | Data Source: Optum Monthly data extracts.
Note: Clients may have received services from more than 1 CSS category within the fiscal year. Only CSS programs that enter data into CCBH are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. Percentages may not add up to 100% due to rounding.

Report Date: 12/18/2022

FY 2021-22 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

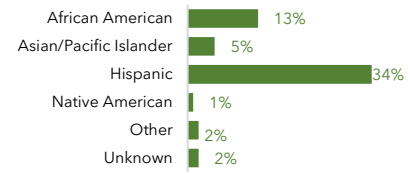
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

TAY, Adult, Older Adult – Full-Service Partnership (TAOA-FSP; n=8,338)

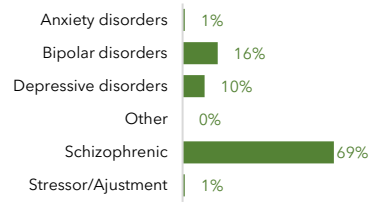
Living Situation	%
Board & Care	10%
Correctional Facility	1%
Homeless	11%
House/Apartment	59%
Institutional	11%
Other/Unknown	8%

Language	%
English	88%
Spanish	8%
Arabic	0%
Vietnamese	0%
Tagalog	0%
Farsi	0%
Other/Unknown	2%

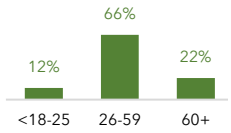
Race/Ethnicity (excludes missing/unknown)



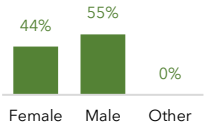
Diagnosis (excludes missing/invalid)



Age



Gender



TAOA-FSP **24%** (8,338)

TAY, Adult, Older Adult – Outreach and Engagement (TAOA-OE; n=0)

Total CSS Clients (unduplicated) N = 34,870

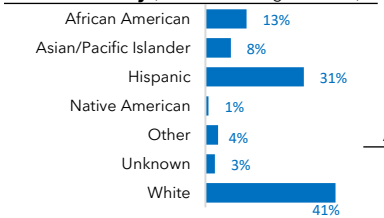
TAY, Adult, Older Adult – System Development (TAOA-SD; n=12,895)

TAOA-SD **37%** (12,895)

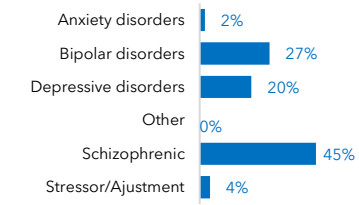
Living Situation	%
Board & Care	6%
Correctional Facility	1%
Homeless	17%
House/Apartment	67%
Institutional	8%
Other/Unknown	1%

Language	%
English	88%
Spanish	5%
Arabic	2%
Vietnamese	2%
Tagalog	0%
Farsi	0%
Other/Unknown	3%

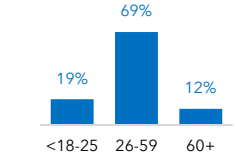
Race/Ethnicity (excludes missing/unknown)



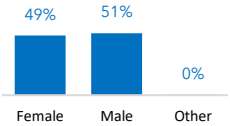
Diagnosis (excludes missing/invalid)



Age

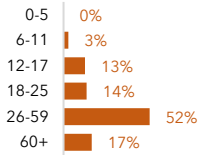


Gender

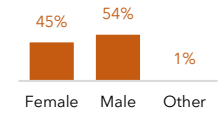


ALL-SD **26%** (9,043)

Age

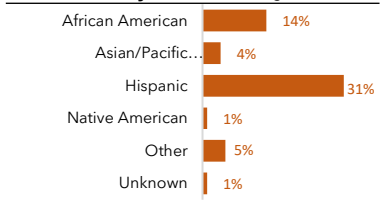


Gender

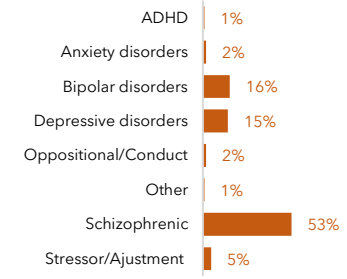


All CSS – System Development (ALL-SD; n=9,043)

Race/Ethnicity (excludes missing/unknown)



Diagnosis (excludes missing/invalid)



Living Situation	%
Board & Care	3%
Correctional Facility	1%
Group Home	0%
Homeless	20%
House/Apartment	70%
Institutional	2%
Other/Unknown	4%

Language	%
Arabic	2%
English	92%
Farsi	0%
Other/Unknown	2%
Spanish	4%
Tagalog	0%
Vietnamese	1%

CSS Report | Source: Optum | Data Source: Optum Monthly data extracts.
Note: Clients may have received services from more than 1 CSS category within the fiscal year. Only CSS programs that enter data into CCBH are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. Percentages may not add up to 100% due to rounding.

Report Date: 12/18/2022

APPENDIX I

FULL-SERVICE PARTNERSHIP (FSP) OUTCOMES REPORT FY 2021-22

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 2021-22***

What Is This?

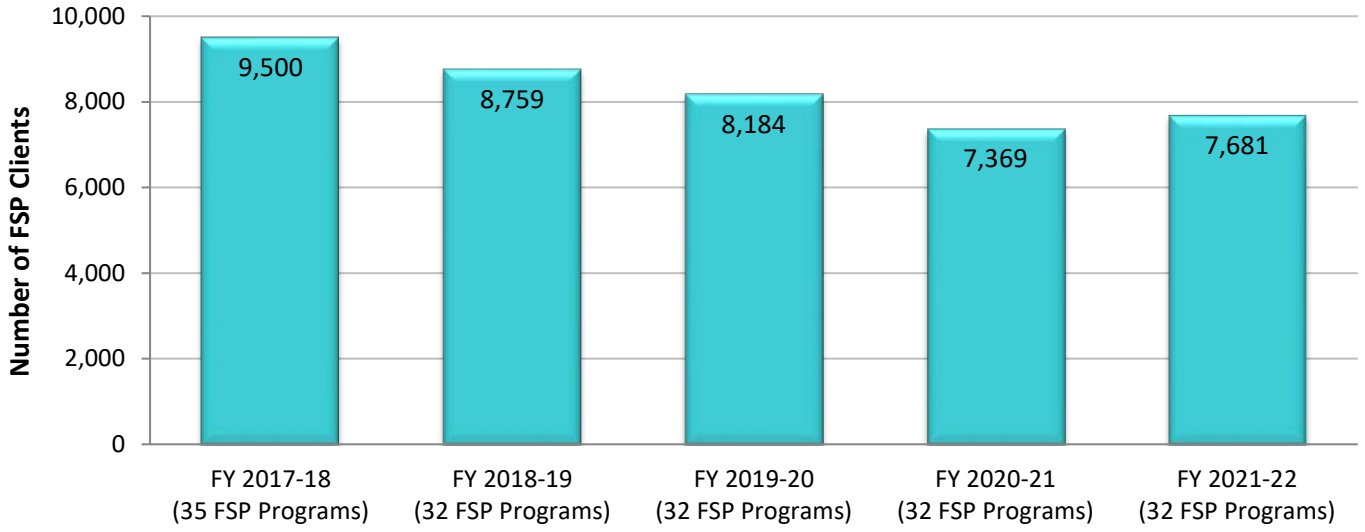
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals and treatment plan, and clients can access designated staff 24 hours a day, 7 days a week. FSP services comprehensively address client and family needs through intensive services, supports, and strong connections to community resources with a focus on resilience and recovery. An FSP offers ancillary support(s), when indicated, by case managers, Substance Use Disorder (SUD) counselors addressing co-occurring conditions, rehabilitation specialists, and/or family/youth partners. Services offered are trauma informed and promote overall wellbeing. Emphasis on partnership with the family, natural supports, primary care, education, and other systems working with the family is a recognized core value.

Why Is This Important?

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

Who Are We Serving?

In Fiscal Year (FY) 2021-22, a total of 7,681 unduplicated clients received services through 32 Children, Youth and Families (CYF) FSP programs, a 4% increase from 7,369 FSP clients served in 32 CYF FSP programs in FY 2020-21.



Who Are We Serving? (continued)

Data Collection and Reporting System (DCR)

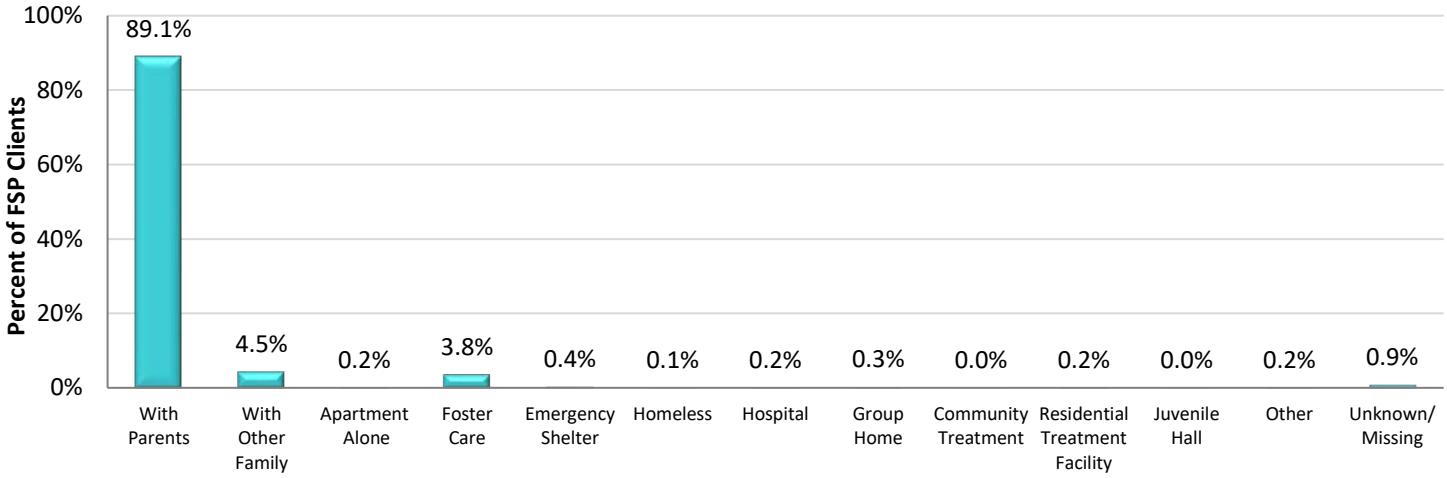
FSP providers collected client and outcomes data using the California Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR). Referral sources, living arrangement, and risk factors were entered for new clients to FSP programs in FY 2021-22.

Referral Sources (N = 4,265)*

FSP referrals for clients with an intake assessment in FY 2021-22 were as follows (in order of frequency): school system (44%), family member (20%), primary care physician (11%), mental health facility (8%), self-referral (6%), social service agency (5%), other county agency (2%), Juvenile Hall (1%), acute psychiatric facility (1%), emergency room (1%), friend (<1%), and substance abuse facility (<1%). The remaining <1% were referred by an unknown or unspecified source.

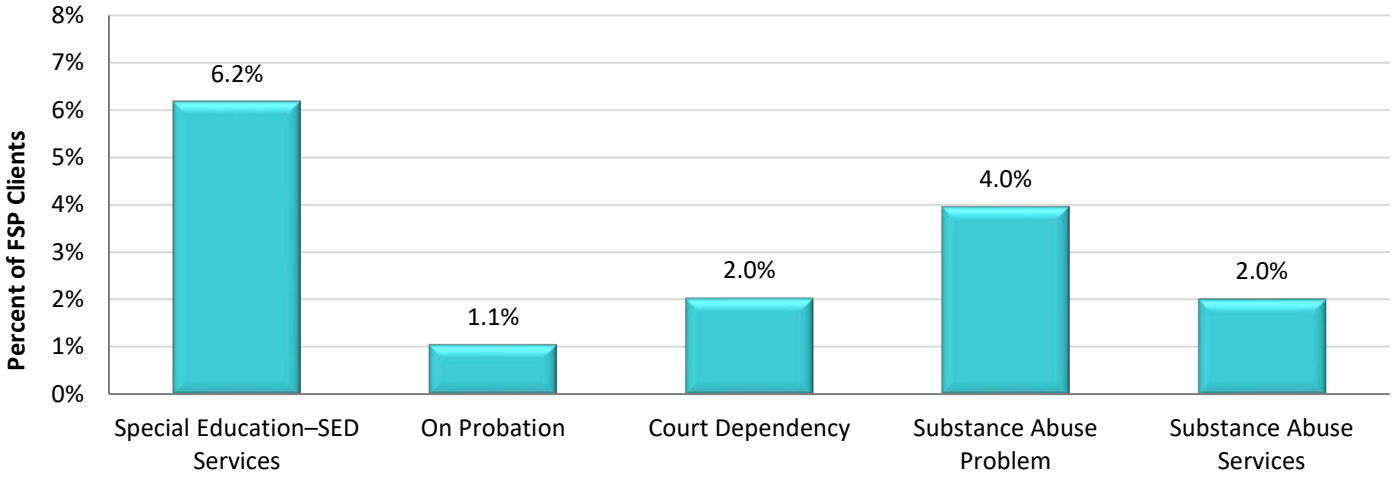
Living Arrangement at Intake (N = 4,265)*

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



Risk Factors at Intake (N = 4,265)*

The most prevalent risk factor for more intensive service utilization among youth entering FSP programs was related to Special Education - Serious Emotional Disturbance (SED) Services. A total of 3,474 (82%) of clients did not have a risk factor identified on the intake form. Clients with identified risk factors may have had more than one risk factor endorsed.



**Clients with intake assessment in the DCR within FY 2021-22.*
NOTE: Percentages may not add up to 100% due to rounding.

Who Are We Serving? (continued)

Client involvement in the juvenile justice sector was tracked by FSP providers.

Forensic Services

In FY 2021-22, a total of 7 FSP clients had an arrest recorded in the DCR.

Are Children Getting Better?

FSP providers collected outcomes data with the California Child and Adolescent Needs and Strengths (CANS and CANS-EC) and the Pediatric Symptom Checklist (PSC and PSC-Y). Scores were analyzed for youth discharged from FSP services in FY 2021-22 who were in services at least 60 days and who had both initial assessment and discharge scores completed. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP programs augmented with a Substance Use Disorder (SUD) component in FY 2021-22, who were in services for at least one month.

FSP PSC Scores

The PSC measures a child's behavioral and emotional problems; it is administered to caregivers of youth ages 3 to 18, and to youth ages 11 to 18. Improvement on the PSC is evaluated three ways:

Amount of Improvement

Percentage of all clients who reported an increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and a large improvement (9+ point reduction). This reflects the amount of change youth and their caregivers report from intake to discharge on the symptoms evaluated by the PSC/PSC-Y. Amount of improvement was calculated using Cohen's d effect size.

Reliable Improvement

Percentage of all clients who had at least a 6-point reduction on the PSC/PSC-Y total scale score. Reliable improvement was defined by the developers and means that the clients improved by a statistically reliable amount.

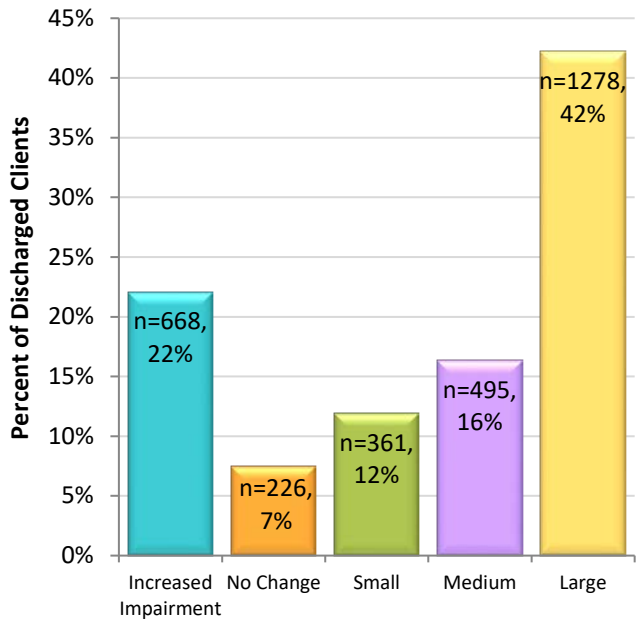
Clinically Significant Improvement

Percentage of clients who started above the clinical cutoff on at least one of the three subscales or total scale score at intake and ended below the cutoff at discharge. Additionally, these clients must have had at least a 6-point reduction on the PSC/PSC-Y total scale score. Clinically significant improvement was defined by the measures' developers and means that treatment had a noticeable genuine effect on clients' daily life and that clients are now functioning like non-impaired youth.

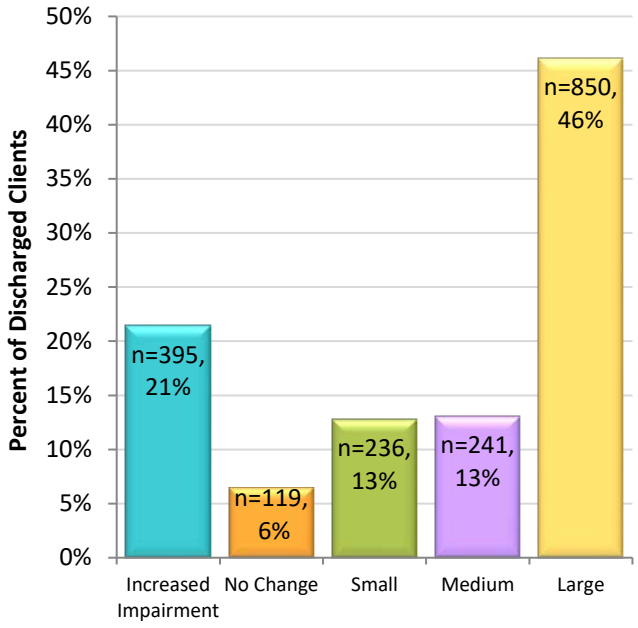
Are Children Getting Better? (continued)

PSC Amount of Improvement from Intake to Discharge

FSP Parent/Caregiver (N = 3,028)

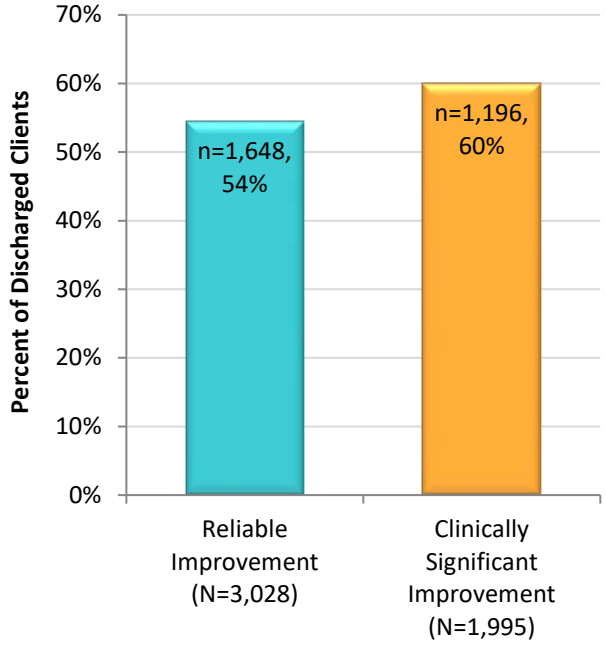


FSP Youth (N = 1,841)

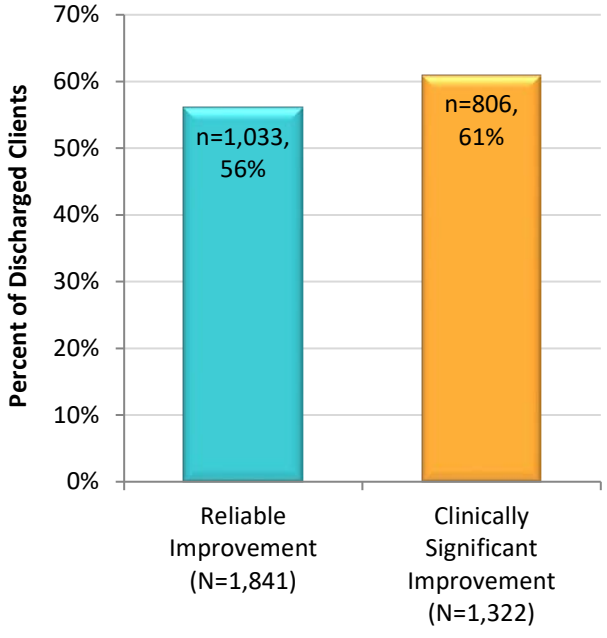


PSC Reliable and Clinically Significant Improvement from Intake to Discharge

FSP Parent/Caregiver



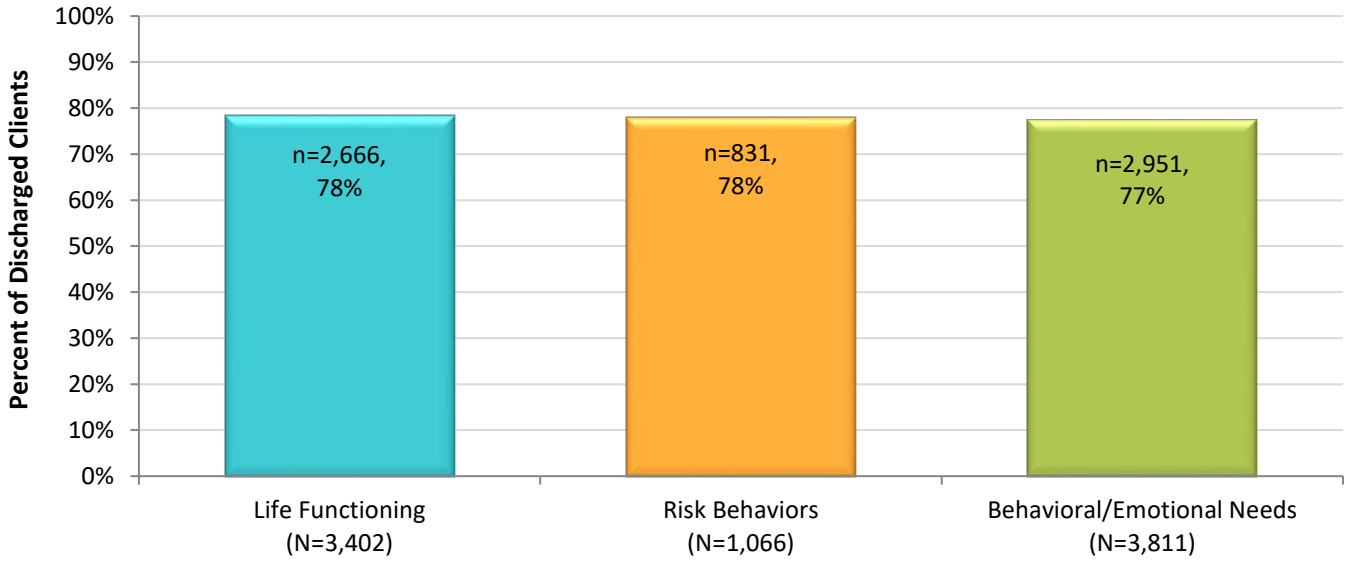
FSP Youth



Are Children Getting Better? (continued)

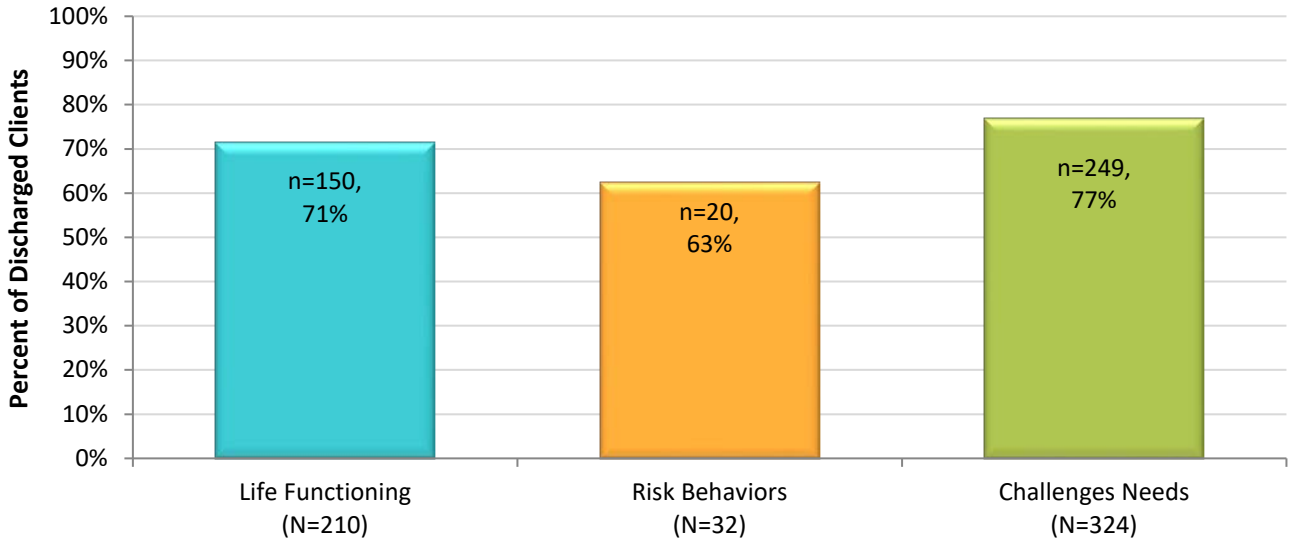
FSP CANS Scores

The CANS is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 6 through 21. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors, and/or Child Behavioral and Emotional needs (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment).



FSP CANS-EC Scores

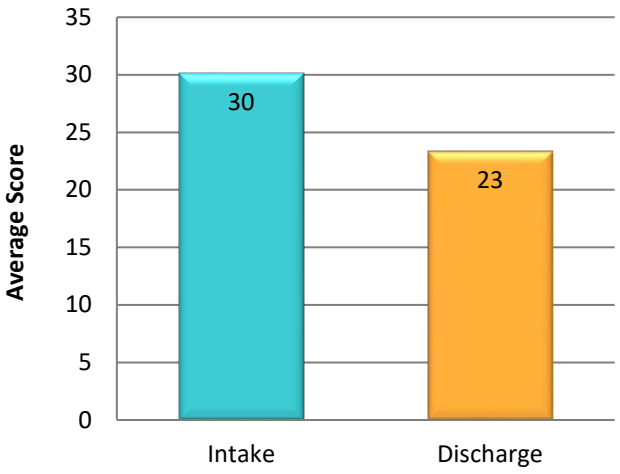
The CANS-EC is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 0 through 5. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors, and/or Challenges needs (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment).



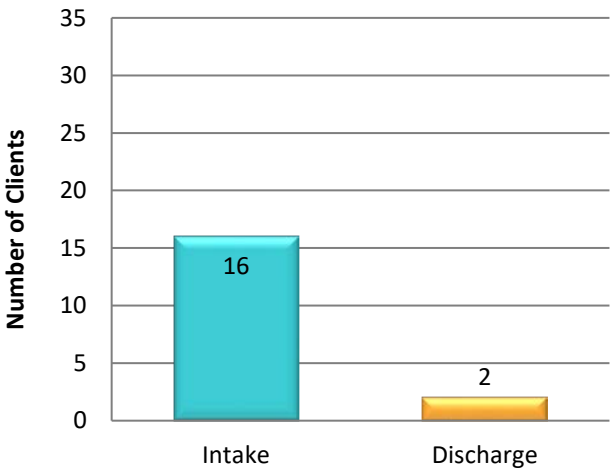
FSP PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their Substance Use Disorder (SUD) counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 56 discharged clients in FY 2021-22.

PESQ Severity Scale (N = 56)



PESQ Clinical Cutpoint



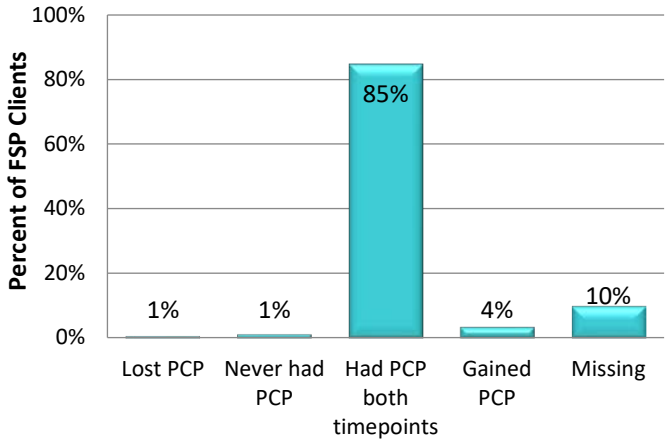


Are Children Getting Better? (continued)

FSP providers also collected client and outcomes data on primary care physician (PCP) status, school attendance, and academic performance; these were tracked in the DCR for continuing clients with multiple assessments. Outcomes are calculated for clients who meet the following eligibility criteria: (a) Discharged within the current fiscal year; (b) In services for at least 120 days; (c) Between the ages of 5 and 18; (d) Served by a primary program (i.e., ancillary programs were excluded); (e) Eligible to receive a Partnership Assessment Form (PAF) assessment at intake. The most recent assessment was compared to intake.

Primary Care Physician (PCP) Status (N = 2,922)

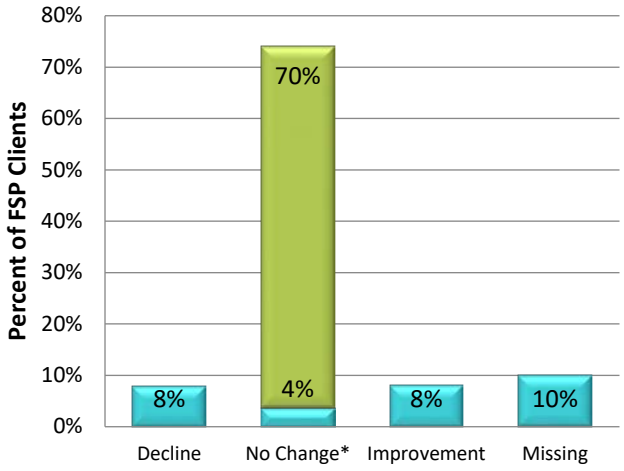
89% of FSP clients gained or maintained a PCP.





School Attendance (N = 2,922)

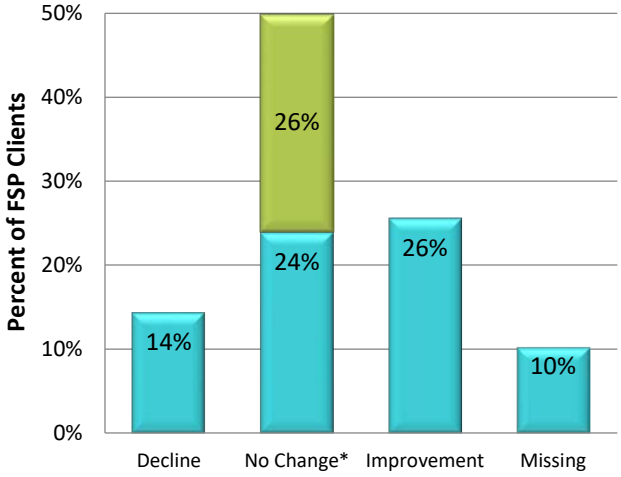
78% of FSP clients either improved (8%) or sustained high (70%) school attendance at follow-up assessment as compared to intake.



**Of the 74% of clients for whom no change was noted, 70% (green portion of bar) had "High" School Attendance Sustained (Clients who had ratings of "Always attends school (never truant)" or "Attends school most of the time" at both the initial assessment and the last quarterly (3M) assessment).*

Academic Performance (N = 2,922)

52% of FSP clients either improved (26%) or sustained high (26%) grades at follow-up assessment as compared to intake.



**Of the 50% of clients for whom no change was noted, 26% (green portion of bar) had "High" Academic Performance Sustained (Clients who had academic ratings of "Very Good" or "Good" at both the initial assessment and the last quarterly (3M) assessment.).*
NOTE: Percentages may not add up to 100% due to rounding.

What Does This Mean?

- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms and reductions in needs, according to client, parent, and clinician report. The CANS-EC data show that a majority of clients ages 0 through 5 also showed reductions in needs between intake and discharge.
- On average, children and youth who received treatment by SUD counselors showed improvement in their risk for substance abuse problems.
- The majority of youth FSP clients had and maintained a PCP during their participation in FSP programs.
- Approximately half of youth FSP clients either improved or maintained excellent school attendance during their participation in FSP programs and nearly 80% either improved or sustained high school attendance.
- Relative to FY 20-21, there was an increase in the proportion of new FSP clients referred through the school system (29% vs 44%). This may be due to the return to in-person learning following COVID-19 school closures.
- **Data may be impacted starting March 2020 due to COVID-19.**

Next Steps

- Continued collaboration between FSP programs and schools to improve or maintain FSP clients' academic performance and school attendance.



For more information on *Live Well San Diego*, please visit www.LiveWellSD.org

The Child & Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California San Diego, San Diego State University, University of San Diego, and University of Southern California. The mission of CASRC is to improve publicly funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders. For more information please contact Amy Chadwick at aechadwick@health.ucsd.edu or 858-966-7703 x247141.

APPENDIX J

ANNUAL SYSTEM-WIDE ASSERTIVE COMMUNITY TREATMENT (ACT) REPORT FY 2021-22



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

The County of San Diego's Full Service Partnership (FSP) programs use a "whatever it takes" model to comprehensively address individual and family needs, foster strong connections to community resources, and focus on resilience and recovery to help individuals achieve their mental health treatment goals. Targeted to help clients with the most serious mental health needs, FSP services are intensive, highly individualized, and aim to help clients achieve long-lasting success and independence.

Assertive Community Treatment (ACT) programs, which include services from a team of psychiatrists, nurses, mental health professionals, employment and housing specialists, peer specialists, and substance abuse specialists, provide medication management, vocational services, substance abuse services, and other services to help FSP clients sustain the highest level of functioning while remaining in the community. Services are provided to clients in their homes, at their workplace, or in other community settings identified as most beneficial to the individual client. Crisis intervention services are also available to clients 24 hours a day, 7 days a week.

Drawing from multiple data sources, this report presents a system-level overview of service use and recovery-oriented treatment outcomes for those who received FSP services from the 19 ACT programs* in San Diego County during fiscal year (FY) 2021-22.

- Demographic data and information about utilization of inpatient and emergency psychiatric services were obtained from the County of San Diego Cerner Community Behavioral Health (CCBH) data system.
- Information related to:
    1. basic needs, such as housing, employment, education, and access to a primary care physician and
    2. emergency service use and placements in restrictive and acute medical settings

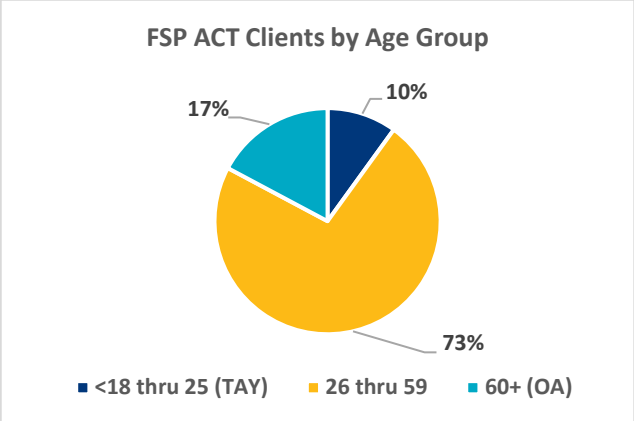
  were retrieved from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) system used by FSP programs across the State of California.
- Recovery outcomes and progress toward recovery were obtained from the County of San Diego's Mental Health Outcomes Management System (mHOMS).

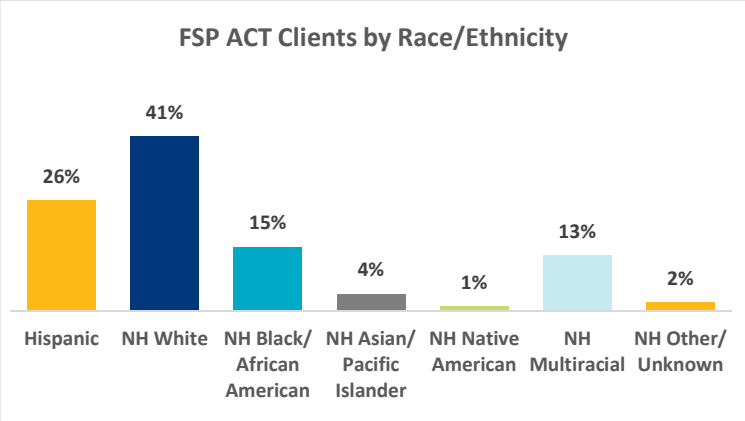
*Data from the following programs are included in this report (program name and sub-unit): CRF Downtown IMPACT (3241, 3244, 3245), Telecare Gateway to Recovery (3312, 3315), Telecare LTC (3331), MHS North Star (3361, 3364), CRF IMPACT (3401, 3404), MHS Center Star (3411, 3413, 3414), CRF Senior IMPACT (3481, 3482), Telecare PROPS AB109 (4192), Telecare MH Collaborative Court (4201, 4203), Telecare Assisted Outpatient Treatment (4211), MHS City Star (4221), MHS Action Central (4242), MHS Action East (4251), Pathways Catalyst (4261, 4264), CRF Adelante (4341), MHS North Coastal (4351), Telecare Vida (4401), Telecare La Luz (4421) and Telecare Tesoro (4411).

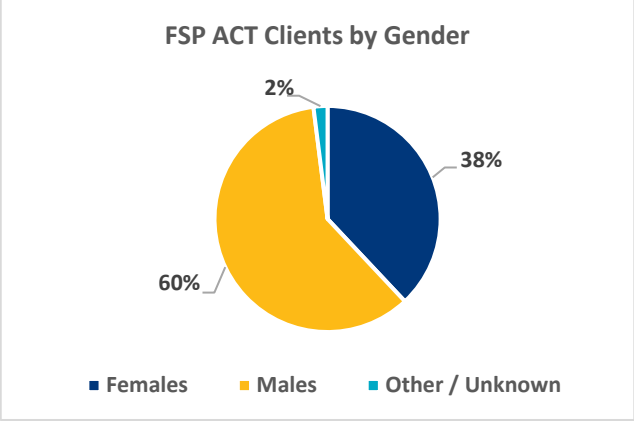
Note: Due to rounding, percentages in this report may not sum to 100%.

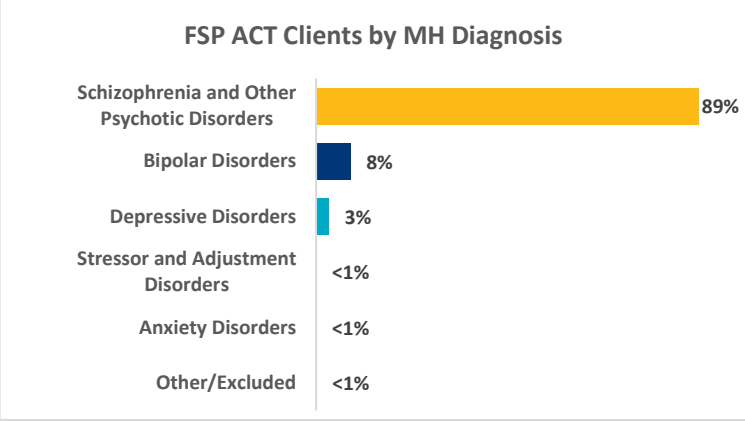
Demographics and Diagnoses

During FY 2021-22, 3,072 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (73%), a majority were male (60%), and the vast majority had a primary mental health diagnosis of schizophrenia or a psychotic disorder (89%). The next most common primary mental health diagnosis among FSP ACT clients served during the fiscal year was bipolar disorders (8%). In addition to their primary mental health diagnosis, 84% of FSP ACT clients served during FY 2021-22 had a history of substance use disorder. Almost half of FSP clients who received services from ACT programs during this period were Non-Hispanic (NH) White (41%), over one-fourth were Hispanic (26%) and nearly one-fifth were NH African American (15%).

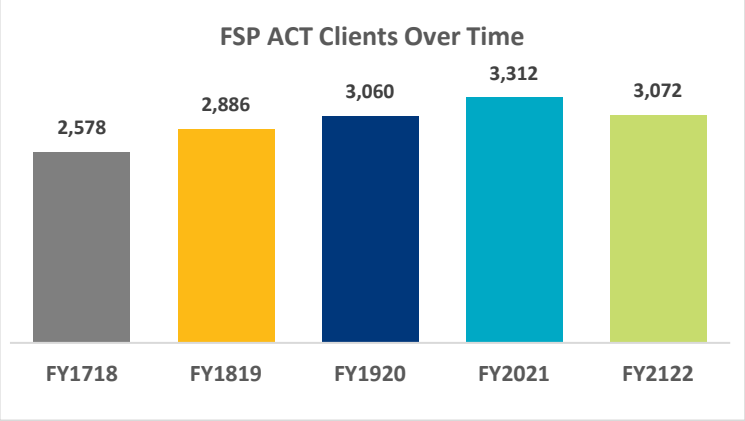








From FY 2017-18 to FY 2021-22, there was nearly 494 additional FSP clients served by ACT teams each year reflecting a 19% increase in the number of FSP clients served by ACT programs since FY 2017-18. In FY 2021-22, there was a 7% decrease in the number of FSP clients served by ACT teams compared to FY 2020-21. Overall, the distribution of the key demographics highlighted above among FSP ACT clients served during FY 2021-22 is similar to the demographics of the clients served by these programs during the previous two fiscal years.



Meeting FSP ACT Clients' Basic Needs*

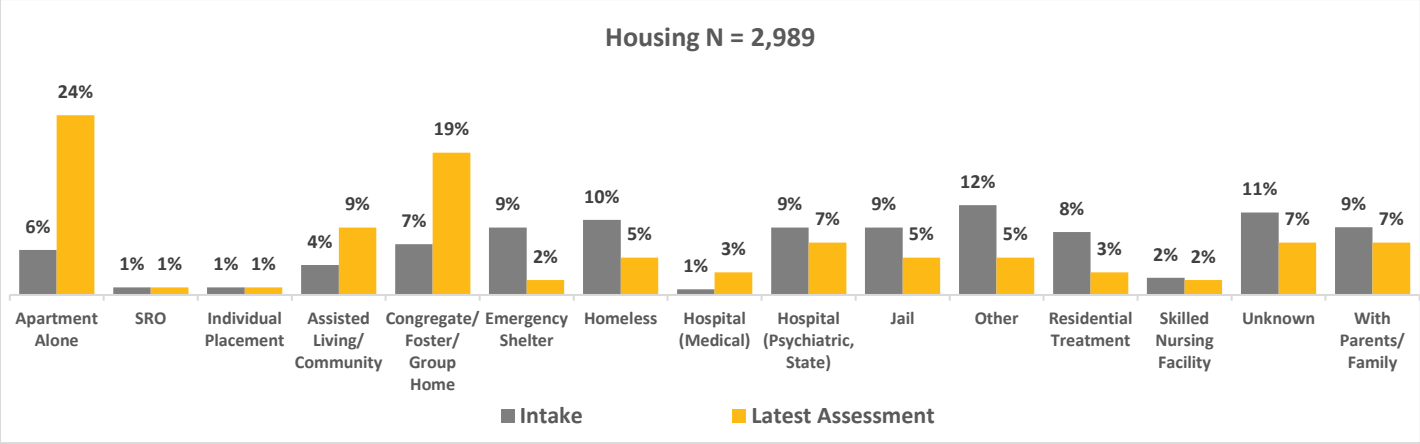
Housing

During FY 2021-22, FSP clients served by ACT programs showed progress in several areas of basic needs. Compared to intake, four times as many clients were living in an apartment alone setting at the time of their latest assessment (6% at intake versus 24% at the latest assessment). Similarly, the proportion of clients living in a congregate, foster, or group home setting almost tripled from intake (7%) to the latest assessment (19%) and the proportion of clients living in an assisted living or community setting more than doubled from intake (4%) to the latest assessment (9%).

Notable decreases in the proportion of clients living in specific housing settings were also observed from intake to latest assessment. The proportion of clients housed in an emergency shelter decreased from 9% to 2%, the proportion of clients reporting a psychiatric hospital as their current living situation decreased from 9% to 7%, and the proportion of homeless clients decreased by half from intake (10%) to latest assessment (5%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment alone** setting more than **quadrupled** from intake (6%) to latest assessment (24%).
- The proportion of **clients** housed in an **emergency shelter decreased** from 9% at intake to 2% at the latest assessment.
- The proportion of **homeless clients decreased** by **one-half** from intake (10%) to latest assessment (5%).



Employment

Many FSP clients served by ACT programs are connected to meaningful vocational opportunities as part of their recovery. Depending on individual need, vocational activities can include volunteer work experience, supported employment in sheltered workshops, and/or competitive paid work.

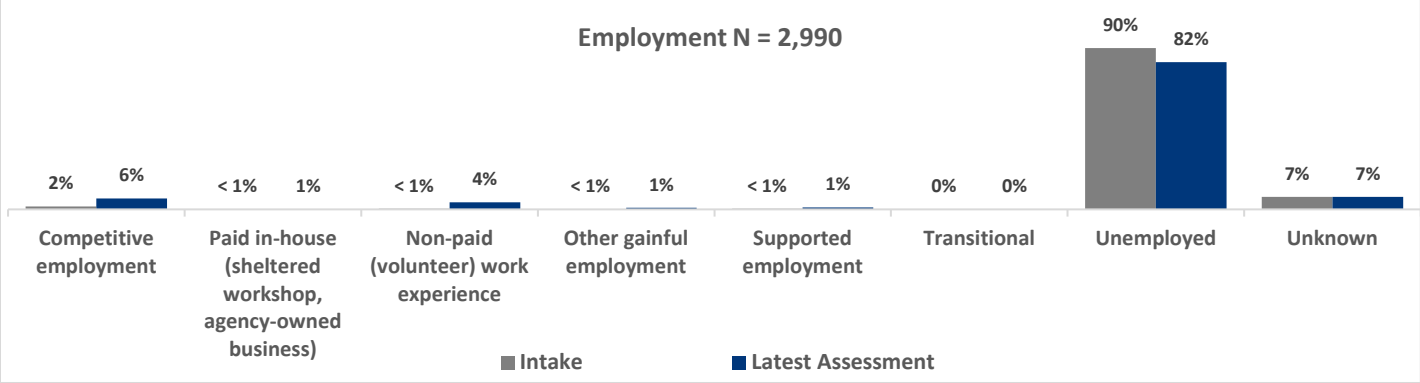
While most clients remained unemployed at the time of the latest assessment (82%), there was a 9% reduction in the number of clients that were unemployed at the latest assessment (2,451 clients) compared to intake (2,704 clients). A notable increase in employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (6 clients at intake compared to 116 clients at the latest assessment). Additionally, there were over three times as many FSP ACT clients employed in competitive settings at the time of the latest assessment (181 clients) compared to the number employed at intake (55 clients). Similarly, there were four times as many FSP ACT clients working in supported employment settings at the time of the latest assessment (16 clients) compared to intake (4 clients).

*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2021-22, as of the 10/2022 DHCS DCR download.

Lastly, while only four clients were employed in another gainful employment setting at intake, 17 clients were employed in this setting at the time of the latest assessment.

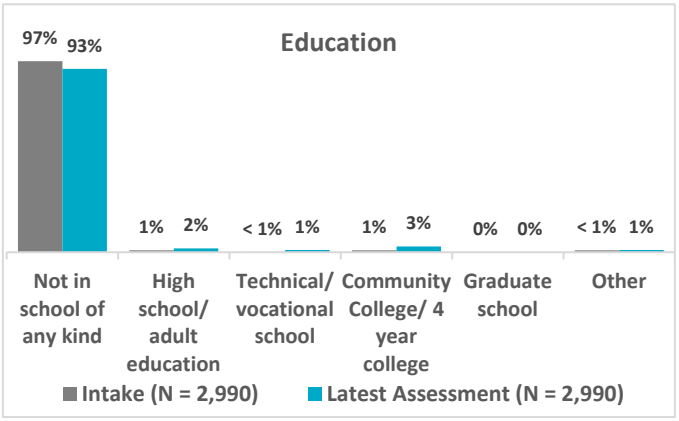
Key Findings: Employment

- There was a 9% **reduction** in the number of clients that were **unemployed** at the latest assessment compared to intake.
- Compared to intake, there were notable **increases** in the number of clients employed in **non-paid** (volunteer), **competitive**, **supported,** and **other gainful** employment settings.



Education

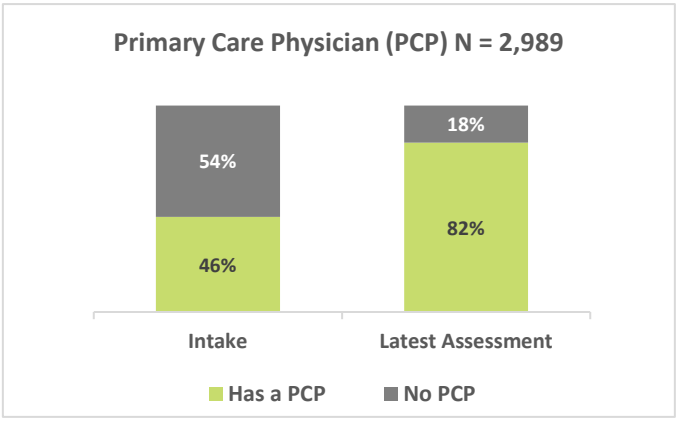
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 2,990 FSP ACT clients with education information available at intake[†], 67 (2%) were enrolled in an educational setting. At the time of the latest assessment, 164 of the 2,990 FSP ACT clients with educational information available (5%) were enrolled in an educational setting[†]. The largest increases from intake to latest assessment were observed in the proportion of clients enrolled in a community or four-year college (1% at intake versus 3% at the latest assessment for both settings) compared to other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2021-22, there was a large increase in the number and proportion of clients who had a primary care physician at the time of the latest assessment compared to intake. Slightly less than half (46%; 1,387 clients) had a primary care physician at intake, while a majority (82%; 2,447 clients) had a primary care physician at the time of their latest assessment.

Overall, changes in basic needs from intake to latest assessment during FY 2021-22 were similar to those observed during previous fiscal years.



[†]Education information was missing for 454 clients at intake, and 371 clients at the time of the latest assessment.

Changes in Service Use and Setting

Use of Inpatient and Emergency Services (Pre/Post)‡

These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as Crisis Stabilization (CS), Urgent Outpatient (UO), Psychiatric Emergency Response Team (PERT) services, Mobile Crisis Response Team (MCRT), Crisis Residential (CR), and services provided at the psychiatric hospital. Overall, utilization of these types of services decreased by more than half (57%) from pre to post assessment during FY 2021-22. While utilization of all types of emergency services decreased from pre to post assessment, there was a greater reduction in the number of CR and psychiatric hospital services compared to the other types of emergency services.

Similar to the reduction in overall emergency service utilization, there was a 46% reduction in the number of unique FSP ACT clients who used emergency services from pre to post assessment with the largest reductions observed among clients receiving CR services (80%) and services at the psychiatric hospital (56%). The number of clients who received a PERT service decreased by 46%, the number of clients who received a CS service decreased by 33%, and the number of clients who received a UO service decreased by 49%, respectively, from pre to post assessment.

A reduction in the overall mean number of emergency services per client was also observed from pre to post assessment (21%). Some of the most notable reductions observed among those receiving services from the CR (24%) and psychiatric hospital LOCs (28%).

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2021-22 were similar to reductions in utilization observed among this population during FY 2019-20 and FY 2020-21. CO was renamed to UO in FY 2018-19 to more accurately reflect the types of services provided at that level of care. MCRT began services right before the beginning of FY 2021-22 resulting in <5 clients being served at pre and 81 clients at post assessment and <5 services being provided at pre and 121 services at post (not shown in table due to services starting to ramp up).

Key Findings: Use of Inpatient and Emergency Services

- Utilization of **all emergency services, except decreased** among FSP ACT clients from pre to post assessment.
- The **greatest reductions** in emergency service utilization were observed in the **CR** and **psychiatric hospital** LOCs.
- A **reduction** in the overall **mean number of emergency services per client** was observed from pre to post assessment.

	# OF SERVICES			# OF CLIENTS*			MEAN # OF SERVICES PER CLIENT		
Type of Emergency Service	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
CS	1,146	959	-16%	529	352	-33%	2.17	2.72	26%
UO†	1,519	674	-56%	657	335	-49%	2.31	2.01	-13%
PERT	1,364	650	-52%	748	401	-46%	1.82	1.62	-11%
Crisis Residential	1,305	201	-85%	704	142	-80%	1.85	1.42	-24%
Psychiatric Hospital	2,981	950	-68%	1,060	466	-56%	2.81	2.04	-28%
Overall	**8,315**	**3,434**	**-59%**	**1,525**	**827**	**-46%**	**5.45**	**4.30**	**-21%**

**The overall number of clients at Pre (n=1,525) and Post (n=827) represent unique clients, many of whom used multiple, various services, while some clients did not use any emergency services.*

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

Note: Clients in this analysis (n=2,457) had an enrollment date ≤ 7/1/2021 and discontinued date (if inactive) > 7/1/2021. Data may include individuals discharged from FSP during the fiscal year but who continued to receive services from a different entity.

†Formerly Crisis Outpatient (CO)

‡Pre period data encompasses the 12-months prior to each client's FSP enrollment and are sourced from the 10/2022 CCBH download. The 10/2022 DHCS DCR download was used to identify active clients, and for Post period data.

Placements in Restrictive and Acute Medical Settings (Pre/Post)[§]

Similar to previous fiscal years, there were overall decreases from pre to post assessment in the mean number of days spent (61% reduction), and number of FSP ACT clients (55% reduction) residing in the following restrictive settings: jail/prison, state psychiatric hospital, and long-term care. The largest reductions observed from pre to post assessment were in the number of days clients spent in a state hospital (88% reduction) and the number of clients who resided in a state hospital (73% reduction). Notable reductions were also observed in the number of days (63% reduction) and the number of clients (49% reduction) residing in long-term care settings from pre to post assessment.

The residential status of individuals receiving FSP services is changed to "Acute Medical Hospital" when admission to a medical hospital setting occurs for a physical health reason such as surgery, pregnancy/birth, cancer, or another illness requiring hospital-based medical care. Data pertaining to placements in acute medical care settings are reported separately in the table below. Compared to pre assessment, there was nearly over a three-and-a-half-time increase (351%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 75% increase in the number of FSP ACT clients in an acute medical hospital setting at post assessment. It is possible that this increase may be partly facilitated by the ACT programs as FSP ACT clients may have delayed seeking necessary medical care during crises prior to enrollment in an ACT program.

In general, during FY 2021-22 the rates of change between pre and post assessment for each type of restrictive setting mirrored the rates observed for these settings during the previous fiscal year. One change from last fiscal year is that the mean number of days per FSP ACT client in the state hospital decreased by 55% from pre to post during FY 2021-22 but decreased by only 8% during FY 2020-21. Also, to note, is the observed 21% increase in the mean number of days per client spent in a jail or prison setting, a trend consistent with the increase observed during FY 2020-21.

Key Findings: Placements in Restrictive and Acute Medical Settings

- Placements in restrictive settings such as **jail/prison,** the **state hospital,** and **long-term care** settings **decreased** among FSP ACT clients from pre to post assessment.
- Placements in **acute medical hospital** settings **increased** among FSP ACT clients from pre to post assessment.
- The mean number of days per client in the **acute medical hospital**, and **jail/prison** settings **increased** from pre to post assessment while the mean number of days per client in **long-term care,** and **state hospital** settings **decreased**.

	# OF DAYS			# OF CLIENTS*			MEAN # OF DAYS PER CLIENT		
Type of setting	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change****
Jail/Prison	51,500	24,631	-52%	459	182	-60%	112.20	135.34	21%
State Hospital	11,236	1,361	-88%	71	19	-73%	158.25	71.63	-55%
Long-Term Care	95,677	35,154	-63%	323	165	-49%	296.21	213.05	-28%
Overall	**158,413**	**61,146**	**-61%**	**797**	**355**	**-55%**	**198.76**	**172.24**	**-13%**
Acute Medical Hospital	4,626	20,871	351%	197	344	75%	23.48	60.67	158%

**The overall number of clients at Pre (n=797) and Post (n=355) represent unique clients who may have been placed in multiple and/or various types of settings.*

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

[§]Data source: DHCS DCR 10/2022 download; 12-month pre-enrollment DCR data rely on client self-report.

Measuring Progress Towards Recovery**

Overall Assessment Means for Assessments 1 and 2

FSP ACT clients' progress toward recovery is measured by two different instruments:

- **Illness Management and Recovery Scale** (IMR), &
- **Recovery Markers Questionnaire** (RMQ).

Clinicians use the IMR scale to rate their clients' progress towards recovery, including the impact of substance use on functioning. The IMR is comprised of 15 individually scored items, and assessment scores can also be reported as an overall score or by three subscale scores:

- Progress towards recovery (**Recovery**),
- Management of symptoms (**Management**), and
- Impairment of functioning through substance use (**Substance**).

Clients can use the 24-item self-rated RMQ tool to rate their own progress towards recovery. Mean IMR and RMQ scores range from 1 to 5, with higher ratings on both assessments' indicative of greater recovery.

The IMR and RMQ scores displayed in the charts to the right compare scores of New FSP ACT clients to those of All FSP ACT clients.

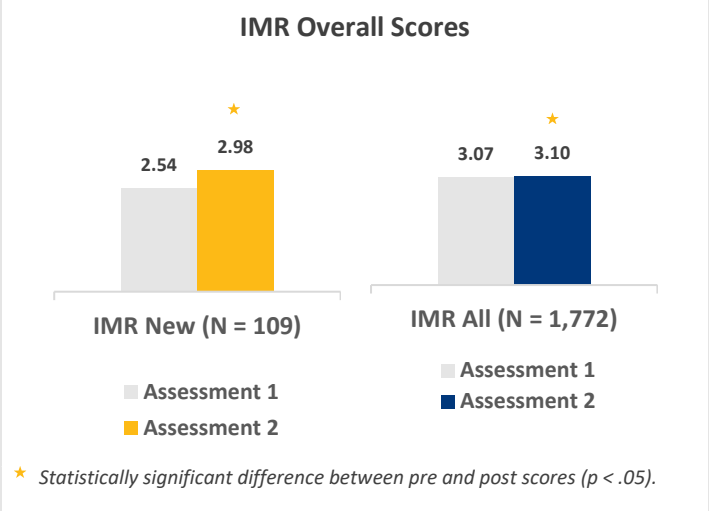
- **New** clients are defined as those who:
  1. began receiving ACT services in 2021 or later,
  2. had two IMR or RMQ assessments during FY 2021-22 (assessments 1 and 2), and
  3. had a first service date within 30 days of their first IMR assessment.
- **All** clients include every FSP ACT client with at least two IMR or RMQ assessments during FY 2021-22 (assessments 1 and 2), regardless of the length of FSP services from ACT programs.

Clients receiving FSP services from ACT programs are generally reassessed on these IMR and RMQ measures every six months to measure progress towards recovery. In general, assessment scores for New clients tend to more directly demonstrate the effect of FSP ACT services on client outcomes because All clients include individuals who may have received services for many years.

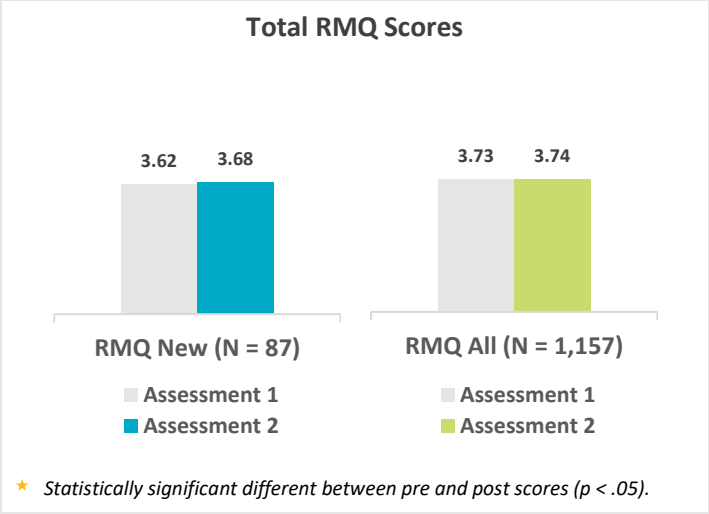
As expected, overall IMR and RMQ assessment 1 mean scores for New clients were lower than assessment 1 mean scores for All clients. For both groups overall IMR assessment 2 mean scores were significantly higher than overall IMR assessment 1 mean scores ($p < .05$).

The mean assessment 1 score from All clients was relatively high compared to mean scores among New clients, suggesting that clients enrolled in ACT services for a longer period of time may have reached a point in their recovery where they are maintaining their current recovery and improvement is no longer expected.

Overall RMQ mean scores were slightly higher at assessment 2, compared to assessment 1 for both New and All clients, but this increase was not statistical significance for both New and All clients. RMQ assessment scores for New and All clients were higher than their IMR scores indicating that both groups of clients rated their progress higher than clinicians did.



★ *Statistically significant difference between pre and post scores ($p < .05$).*



★ *Statistically significant different between pre and post scores ($p < .05$).*

**Outcomes data are sourced from mHOMS FY 2021-22; Data include all mHOMS entries as of 11/8/2022 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2021-22, and who had paired IMR or RMQ assessments 4 to 8 months apart.

IMR Subscale Means for Assessments 1 and 2

Changes in mean scores on each of the three IMR subscales from assessment 1 to assessment 2 were also analyzed for each group of clients (New and All). On average, both New and All FSP ACT clients had significantly higher mean Recovery and Management subscale scores ($p < .05$) at assessment 2 than they did at assessment 1. These data suggest that New and All clients made significant progress towards recovery from assessment 1 to assessment 2.

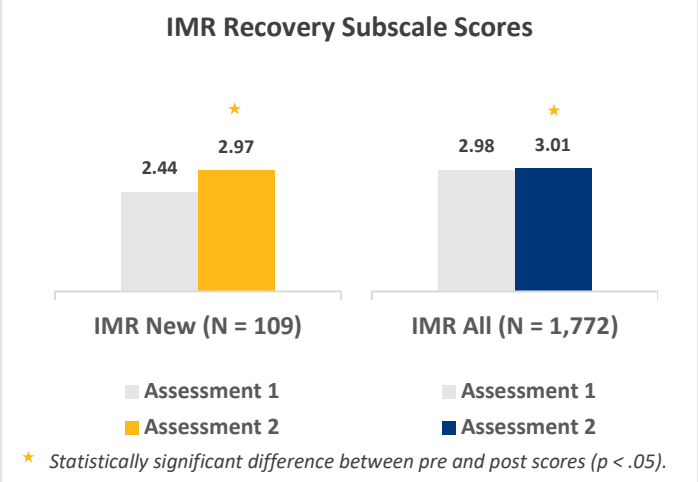
Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or minimal impairment in functioning due to drug or alcohol use as a higher rating is indicative of greater recovery.

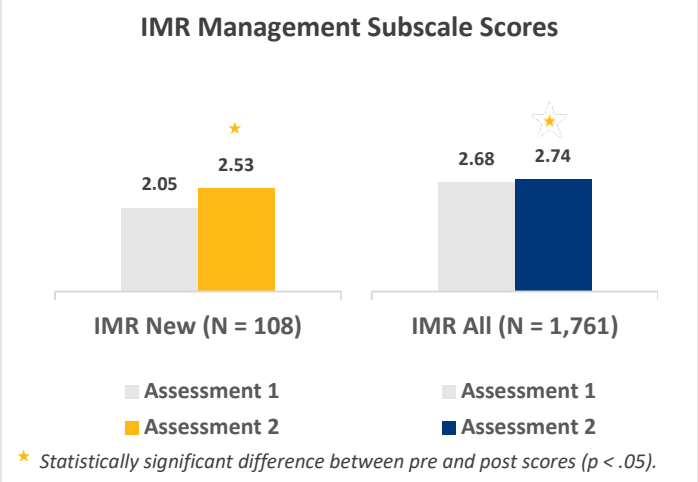
New FSP ACT clients had slightly higher mean Substance Use scores at assessment 2 compared to assessment 1, however this difference in mean scores was not statistically significant.

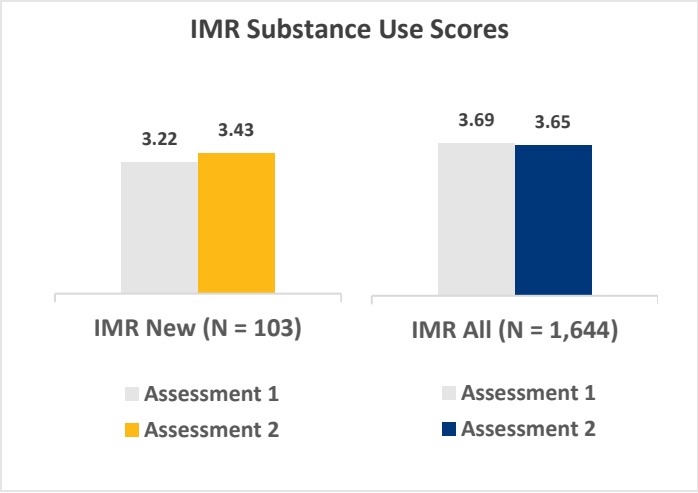
Key Findings: Assessment Outcomes

- Mean **Overall IMR** scores were **significantly higher** at the latest assessment compared to the first assessment for **New and All** clients.
- Mean **Recovery and Management** subscale scores were **significantly higher** at the latest assessment compared to the first assessment for both **New and All** clients.
- Mean **Substance Use** subscale scores were **higher** at assessment 2 compared to the assessment 1 for **New** clients.
- Mean **Substance Use** subscale scores were **slightly lower** at assessment 2 compared to the assessment 1 for **All** clients.
- RMQ ratings suggest that both **New** and **All** clients rated their progress higher than clinicians did.

These findings suggest that drug and alcohol use may be a factor in impairment of functioning among FSP clients new to ACT services but may not be a primary focus of early treatment and may be an area addressed after these clients are in services for a while.

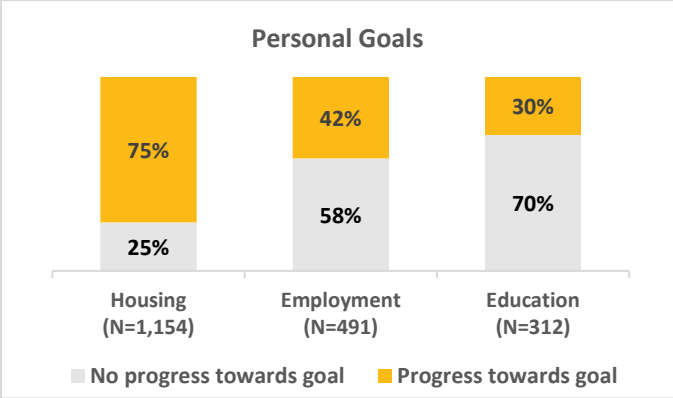






Progress Towards Key Treatment Goals

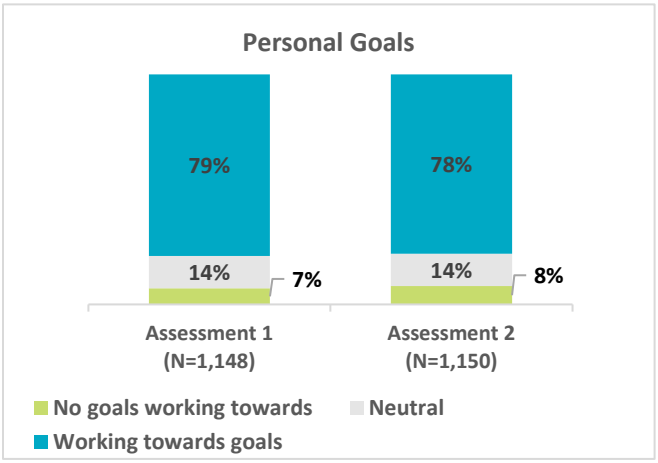
At the time of their follow-up IMR assessments, clinicians also noted client progress towards goals related to housing, education, and employment. Similar to trends observed during FY 2020-21, most FSP ACT clients served during FY 2021-22 with a completed Goal assessment had a goal related to housing (1,154 clients; 85%) on their treatment plan. Of these clients, clinicians reported that 75% made progress towards their individual housing goal at the time of the latest assessment. Fewer FSP ACT clients had goals related to employment (491 clients; 36%) or education (312 clients; 23%) on their treatment plan, compared to the number with housing related goals. Additionally, over two-fifths of clients with goals related to employment (42%) and less than one-third of clients with goals related to education (30%) made progress towards their goals at the time of the most recent assessment. These results may reflect a



"housing first" approach in that obtainment of stable housing may be a primary focus for most FSP ACT clients, while goals related to employment and education may be secondary and an area of focus after stable housing is obtained.

Personal Goals

One of the items in the RMQ assessment asks clients if they have goals which they are working towards achieving. More than three-quarters of FSP ACT clients at assessment 1 (79%) and assessment 2 (78%) agreed or strongly agreed that they had a goal (or goals) they were working towards. At assessment 1 and assessment 2, 14% of clients reported they were "neutral" about working towards goals. There were 88 FSP ACT clients (8%) disagreed or strongly disagreed with the statement that they were working towards achieving goals at the time of the latest assessment. Responses to this RMQ item were unavailable for nine clients at assessments 1 and seven clients at assessment 2 and the chart to the right exclude these clients from percentage calculations.



Level of Care

Completed by clinicians, the Level of Care Utilization System (LOCUS) is a short assessment of a client's current level of care needs and provides a system for assessment of service need for adults. The LOCUS is based on the following six evaluation parameters:

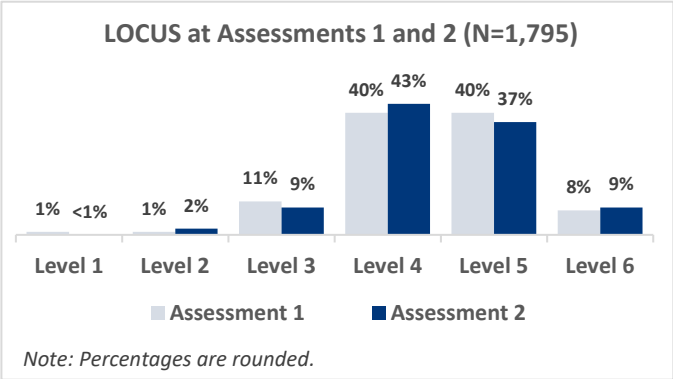
1. risk of harm,
2. functional status,
3. medical, addictive, and psychiatric co-morbidity,
4. recovery environment,
5. treatment and recovery history, and
6. engagement and recovery status.

In the LOCUS, levels of care are viewed as levels of resource intensity. Lower numbered levels correspond with lower intensity resources and services.

LOCUS Resource Levels

	Level of Care Description
Level 1	Recovery maintenance and health maintenance
Level 2	Low intensity community-based services
Level 3	High intensity community-based services
Level 4	Medically monitored non-residential services
Level 5	Medically monitored residential services
Level 6	Medically managed residential services

Similar to LOCUS results from previous fiscal years, the greatest proportion of FSP ACT clients were recommended for medically monitored non-residential services (Level 4) and medically monitored residential services (Level 5) by clinicians at both assessments. A increase in the proportion of clients recommended for medically monitored non-residential services (Level 4) was observed from assessment 1 to assessment 2, and a reduction in proportion of clients recommended for medically monitored residential services (Level 5) was observed between assessments.



Note: Percentages are rounded.

<u>Key Findings</u>: Goals and LOCUS

- **Majority** of FSP ACT clients (85%) had a **housing related goal** on their treatment plan.
- Of the clients with a housing goal on their treatment plan, a **majority** (75%) **made progress** towards that goal by assessment 2.
- **Most** clients (78%) agreed or strongly agreed that they were **working towards a treatment goal** at assessment 2.
- Clients were most likely to be recommended for a **Level 4** or **Level 5** treatment setting at both times points.

Conclusion

With the addition of several new FSP ACT programs within the San Diego County Behavioral Health System of Care during the past few years, there has been increased interest in learning more about the impact of these programs on clients' service use and outcomes. The FSP ACT model aims to serve homeless clients with severe mental illness, as evidenced by the vast majority of clients served during FY 2021-22 with 1) a housing-related goal (85%), 2) a diagnosis of schizophrenia or psychotic disorder (89%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 88% at intake).

Similar to trends reported from previous fiscal years, FSP ACT clients served during FY 2021-22 showed progress in the following areas of basic needs: housing, employment, and having a primary care physician. Notably, the proportion of clients living in an apartment only setting quadrupled from intake (6%) to latest assessment (24%), the proportion housed in an emergency shelter decreased from 9% at intake to 2% at the latest assessment, and the proportion of homeless clients decreased from 10% at intake to 5% at the latest assessment. There was also a 9% reduction in the number of clients unemployed at the latest assessment compared to intake and an 35% increase in the number of clients with a primary care physician at the time of the latest assessment, compared to intake.

Additional success of the FSP ACT model is evident from reductions observed in 1) utilization of inpatient and emergency services, and 2) placements in restrictive settings among clients. For example, overall, utilization of inpatient and emergency services decreased by 57% compared to utilization rates prior to receipt of services from ACT programs. Similarly, placements in restrictive settings, such as jail/prison, state hospital, and long-term care settings, were also reduced from intake to latest assessment, as measured by the number of days FSP ACT clients spent in these settings (61% reduction), and the number of clients housed in these types of settings (55% reduction). Progress towards recovery among FSP ACT clients was also exhibited by 1) significant improvements in clinician-rated IMR scores for New FSP ACT clients and 2) progress towards treatment plan goals for All ACT clients between two assessment time points.

Overall, improvements were observed in several key areas among FSP clients served by ACT programs during FY 2021-22, mirroring improvements observed among this population during previous fiscal years and demonstrating a positive effect of services on the lives of clients served by the ACT programs.

APPENDIX K

HOUSING UPDATE
EXECUTIVE SUMMARY

COUNTY OF SAN DIEGO
Behavioral Health Services

Five Year (2022-2027) Strategic Housing Plan

2022 is a year of opportunity following a seismic shift in how we all think about the importance of home and what it means to be healthy. Now, more than ever, there is a shared understanding of the critical importance of housing and agreement that housing is fundamentally important to being healthy and having a strong platform to achieve goals.

This Five-Year Plan envisions ***Creating Homes With Intention, Purpose, and Collaboration*** and outlines guiding principles and targeted responses that will maximize a range of housing options for people with behavioral health issues (people with serious mental illness/ serious emotional disorders and/or substance use disorder) and limited resources through policy decisions, funding commitments, and programmatic initiatives. The Plan's approach is rooted in principles of equity and inclusion and the goals are driven by the voices of people with lived expertise. The Plan aims to maximize opportunities for community integration as well as choice in housing and services options that best meet individual needs and recovery goals.

>>>



SUMMARIZING THE FIVE-YEAR STRATEGIC HOUSING PLAN

Three key goals have been identified with ten focus areas that call for purposeful action in the first two years in order to recognize the urgent need for housing and maximize the impact of significant new resources.

GOAL #1
Opening More Doors

- ***Focus Area #1*** *Diversity of Housing Options*
- ***Focus Area #2*** *Housing Equity and Supporting Community Integration*
- ***Focus Area #3*** *Priority Populations*
- ***Focus Area #4*** *Geographic Diversity and Regional Distribution of Housing*

GOAL #2
Driving Collaboration Through Active Connectivity

- ***Focus Area #5*** *Effective Collaboration and Integrating Systems*
- ***Focus Area #6*** *Ongoing Pandemic Response*

GOAL #3
Expanding Services Approaches

- ***Focus Area #7*** *Recovery and Retention Supports*
- ***Focus Area #8*** *Flexibility in Service and Housing Models*
- ***Focus Area #9*** *Bring Moving On Opportunities to Scale*
- ***Focus Area #10*** *Increase Wraparound Service Supports*

USE THIS QR CODE TO DOWNLOAD THE FULL REPORT OR LEARN MORE, OR VISIT:
https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa_housing.html

UNDERSTANDING THE CHALLENGES

Corporation for Supportive Housing (CSH) and San Diego National Alliance on Mental Illness (NAMI) designed an input process in partnership with people with lived expertise as well as the Behavioral Health Housing Council and County of San Diego Behavioral Health Services. Throughout the input process, they identified key stakeholders in order to develop and refine the questions and key areas of discussion. An extensive variety of opportunities for participation in the development of the Plan were offered throughout the first half of 2021 in order to engage with a broad range of stakeholders, including:

- **14 Focus Groups with people with lived expertise,**
- **2 focus groups with service and housing providers**
- **Client Surveys (online in English and Spanish; paper copy for in-reach)**
- **13 input/listening Sessions**
- **Online Input Form**

Guided by the BHS multi-sector system of care transformational goals of continuous care and prevention, and providing coordinated resources to keep people connected, stable and healthy, the Housing Council members used all of the valuable feedback to identify the following top three priority goals and corresponding actionable strategies.

GOAL #1 Opening More Doors

The County of San Diego has prioritized the creation of new housing for over two decades, and the inventory of dedicated supportive housing for people with serious mental illness with limited resources has successfully increased from 241 units to 584 units. The need remains high, however, and focused effort needs to continue, especially for very low and extremely low income households; there is a shortfall of 68,959 homes in these income categories. The Housing Council is particularly focused on increasing a diversity of housing options and geographical locations by:

- Maximizing and accelerating unit creation by fully committing the first 3 years of No Place Like Home Funding by February, 2023.
- Maximizing ongoing rent subsidies by aligning with support services, such as Emergency Housing Vouchers.
- Identify opportunities to create “tiny home” villages with wrap-around supports that are not time limited and which have an emphasis on community building, particularly on parcels of land that can’t support larger multifamily housing projects.
- Establish a dedicated flexible housing subsidy pool for people with behavioral health issues.
- Increase inventory of shared housing by exploring feasibility of developed shared housing opportunities, converting more single family homes into co-living or communal living situations, and expanding independent living and recovery residence association member homes by 25%.
- Explore other housing production alternatives and innovative housing types in addition to tiny homes to include, but not limited to 3D printed homes, new prefabricated housing types that meet state and local building code standards, conversion of vacant commercial or industrial buildings to affordable housing. This includes deepening collaboration with Department of Homeless Solutions & Equitable Communities to address system, service & housing needs for people experiencing homelessness who have identified behavioral health needs.
- Expand understanding and implementation of quality in housing and services, including Housing First and Supportive Housing fidelity models which emphasize community integration principles.
- Address systemic disparities by reviewing and incorporating recommendations from the County of San Diego Behavioral Health Equity Index, the San Diego Cultural Competency Plan, and the Ad Hoc Committee Addressing Homelessness among Black San Diegans.

GOAL #2 Driving Collaboration Through Active Connectivity

Stakeholder feedback indicated that purposeful collaboration is needed and also desired among the various industries – health care, mental health care, law enforcement, public defender’s office, district attorney, service providers and more that work every day to assist BHS clients experiencing homelessness to ultimately access housing and keep it. More effective, collaborative working relationships would result in more housing opportunities, and more successful outcomes once people are housed. The Housing Council is focused on supporting:

- Payment reform efforts, including Medi-Cal CalAIM planning, which prioritizes care and provides incentives for collaboration and continuous system improvement instead of cost-based reimbursement which includes burdensome documentation requirements.
- Engage in collaborative data-sharing efforts by seeking out opportunities to align systems and databases with BHS housing planning efforts, building on cross-sectoral referral capacities with housing & service partners.
- Address the digital divide by expanding access to computers and internet access.
- Further develop and promote quality telehealth, phone app based, and 24/7 phone based behavioral health options as well as connections to public health supports (including access to vaccines/boosters).
- Continue to develop services in housing which accommodate for social distancing while maintaining community connection.
- Focus on increasing income and basic supports.

GOAL #3 Expanding Service Approaches

Homeless individuals struggle with a wide range of housing needs, including understanding how to apply for a variety of affordable housing and how to navigate the system once they are able to access affordable housing. Many stakeholders also shared that it is often traumatic to move from homelessness to a new home and BHS clients struggle in making that adjustment. Priorities for Housing Council include:

- Further develop peer based programs to support tenants who are connected to BHS services as they make a transition into housing.
- Identify opportunities to expand services and housing eligibility criteria to more broadly serve people with behavioral health issues through intentional partnerships.
- Expand Moving On opportunities through training and additional housing subsidies.
- Increase BHS client access to Social Security work incentives, Housing Authority “Family Self Sufficiency” programs, and other partner program opportunities that offer financial literacy programs as well as financial incentives to increase earnings and savings.
- Expand employment supports for people accessing housing opportunities.
- Increase the evidence-based and best practice service supports that assist in enhanced access to housing and housing retention, including income and benefit supports, harm reduction strategies, mental health support and linkage to physical health care and housing retention supports.

APPENDIX L

PREVENTION AND EARLY INTERVENTION (PEI) SYSTEM-WIDE SUMMARY

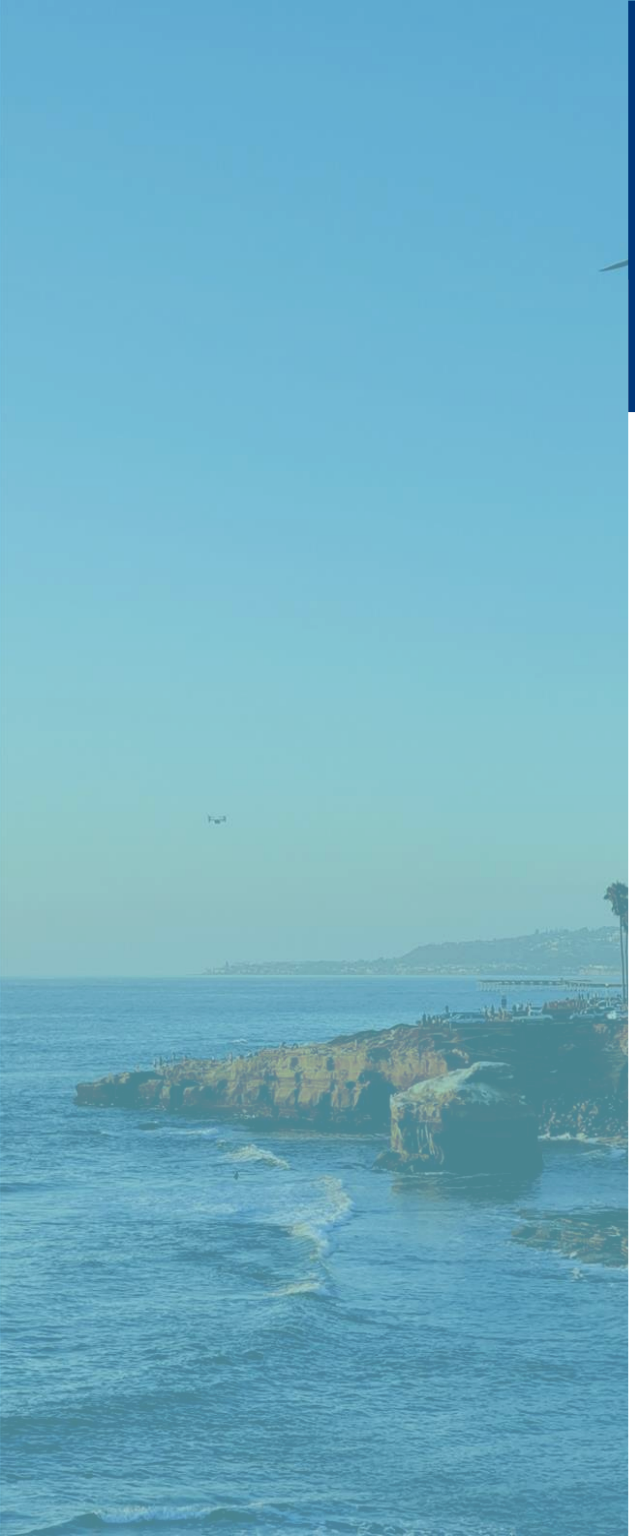
CHILD & FAMILY PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2021-22 ANNUAL REPORT

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

CASRC Child and Adolescent Services Research Center



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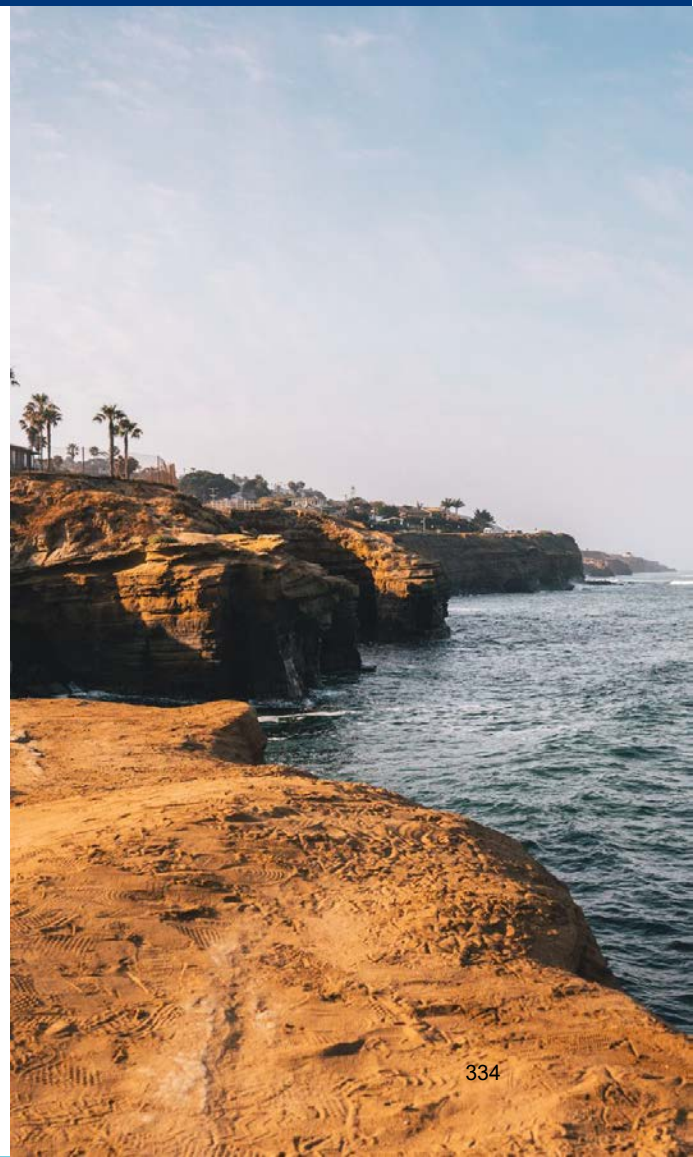
11 Participant Outcomes and Referrals

12 About the Child and Adolescent Services Research Center

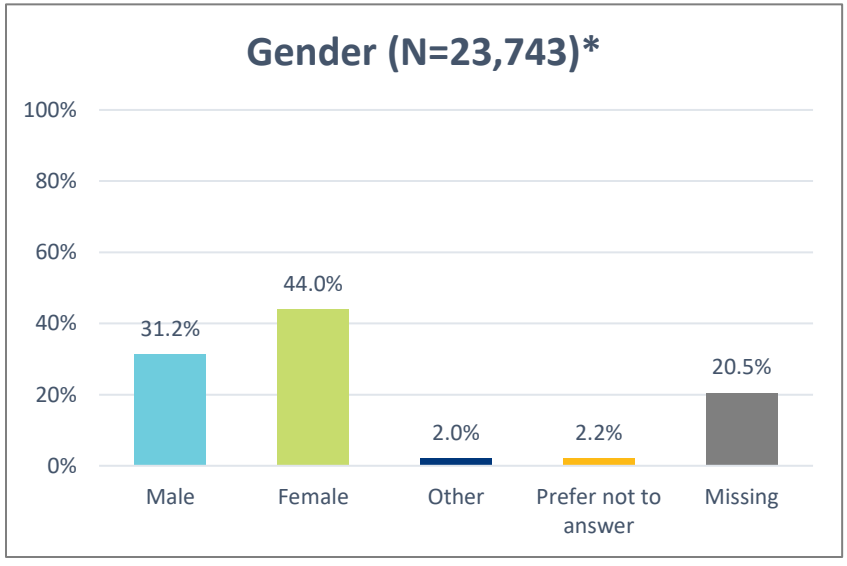
CHILD & FAMILY PEI PROGRAMS: BACKGROUND

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. The County of San Diego has funded contractors to provide PEI programs for youth and their families. The focus of these programs varies widely, from teaching caregivers how to cope with behavior problems in young children to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by a PEI program via outreach efforts, including but not limited to: presentations, community events, and fairs. PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.

DATA: Child and Adolescent PEI Programs
REPORT PERIOD: 7/1/2021-6/30/2022
NUMBER OF PARTICIPANTS WITH DATA IN FY 2021-22: 23,743 Unduplicated*†
**Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators referenced in this report (N=23,743 vs. N=8,040).* *†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.*

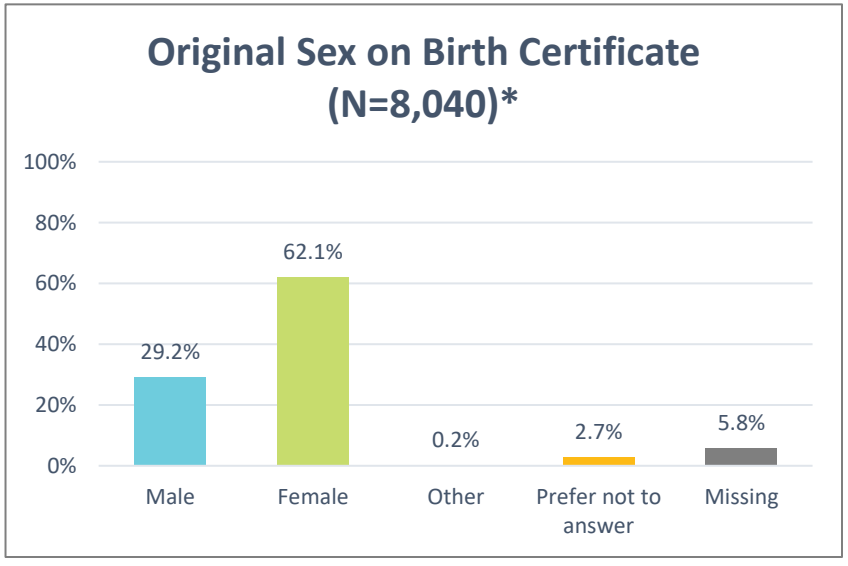


PARTICIPANT DEMOGRAPHICS



Forty-four percent of participants identified as female. Two percent of participants endorsed some other gender identity. Approximately 2% of participants preferred not to answer this question.

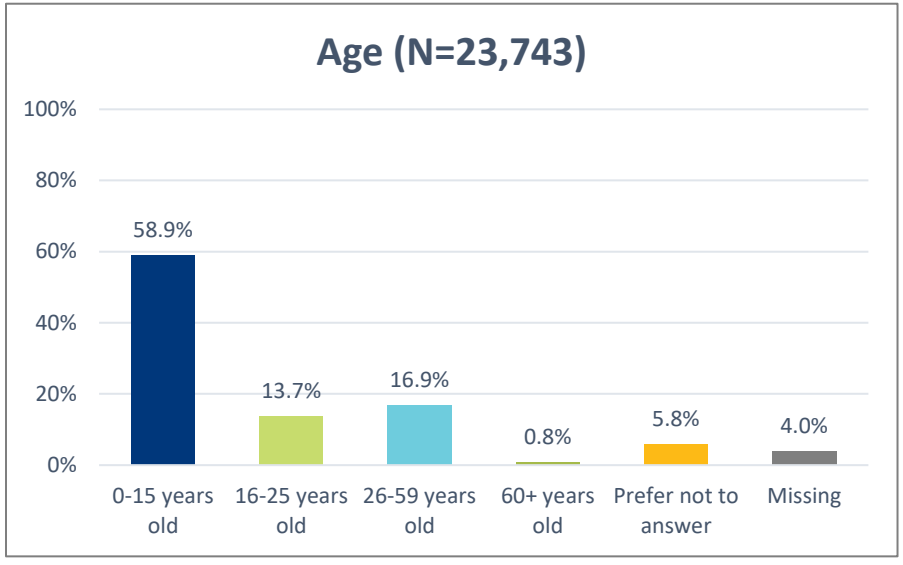
**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*



Sixty-two percent of respondents reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =8,040 vs. N= 23,743).*

PARTICIPANT DEMOGRAPHICS continued



Primary Language (N=8,040)*	Count	%
Arabic	77	1.0%
English	3,601	44.8%
Farsi	38	0.5%
Spanish	3,417	42.5%
Tagalog	25	0.3%
Vietnamese	23	0.3%
Other	254	3.2%
Prefer not to answer	120	1.5%
Missing	485	6.0%

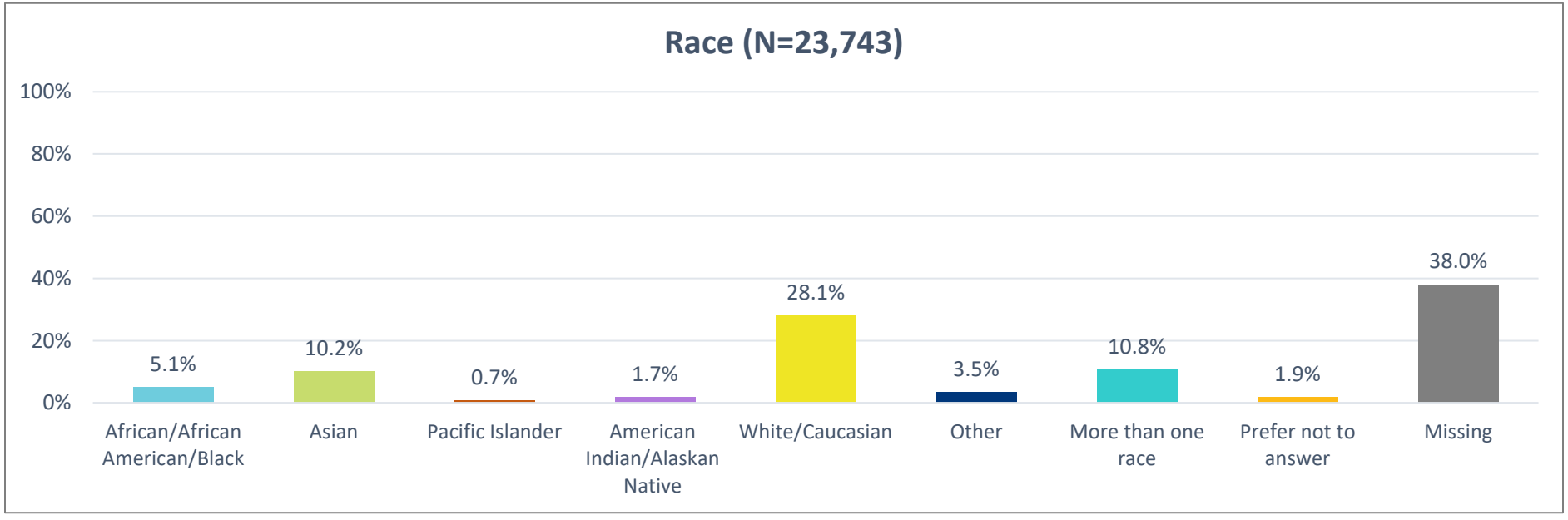
The majority (59%) of participants were 15 or younger. Many participants were older than 18 because several Child & Family PEI programs target caregivers, community members and Transitional Age Youth (TAY).

Note: Percentages may not add up to 100% due to rounding.

Almost 43% of participants identified their primary language as Spanish. About 45% of participants identified their primary language as English.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=8,040 vs N=23,743).*
Note: Percentages may not add up to 100% due to rounding.

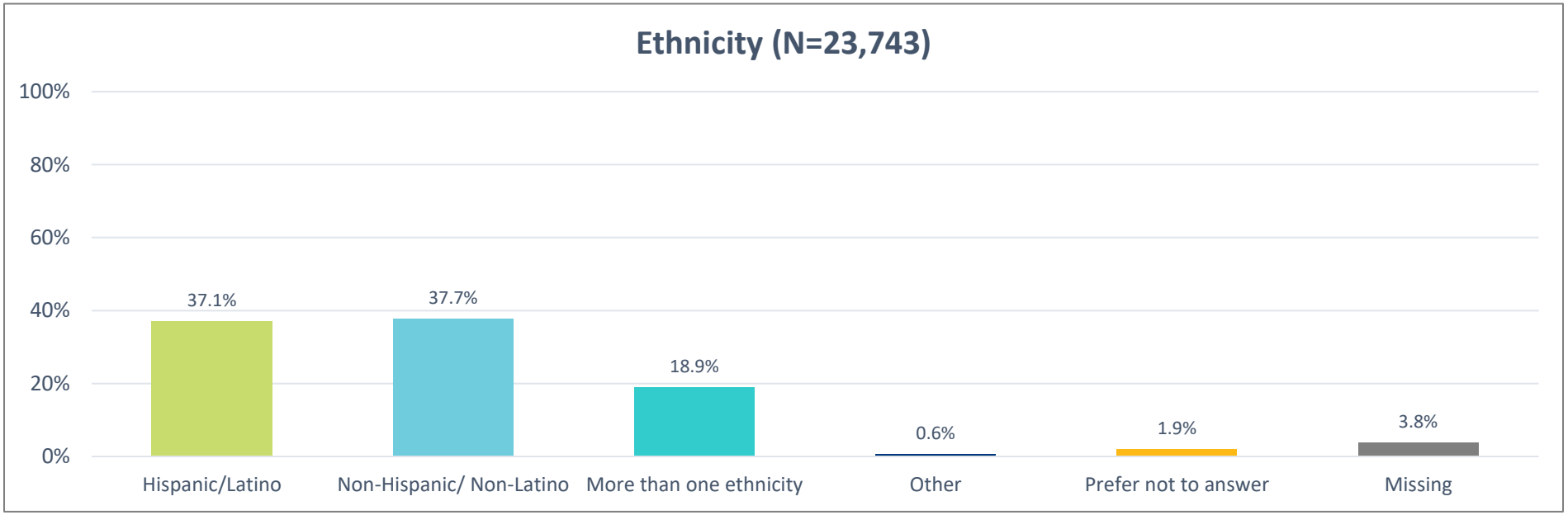
PARTICIPANT DEMOGRAPHICS continued



Twenty-eight percent of participants identified their race as White/Caucasian. Nearly 5% identified as African, African American or Black and approximately 10% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

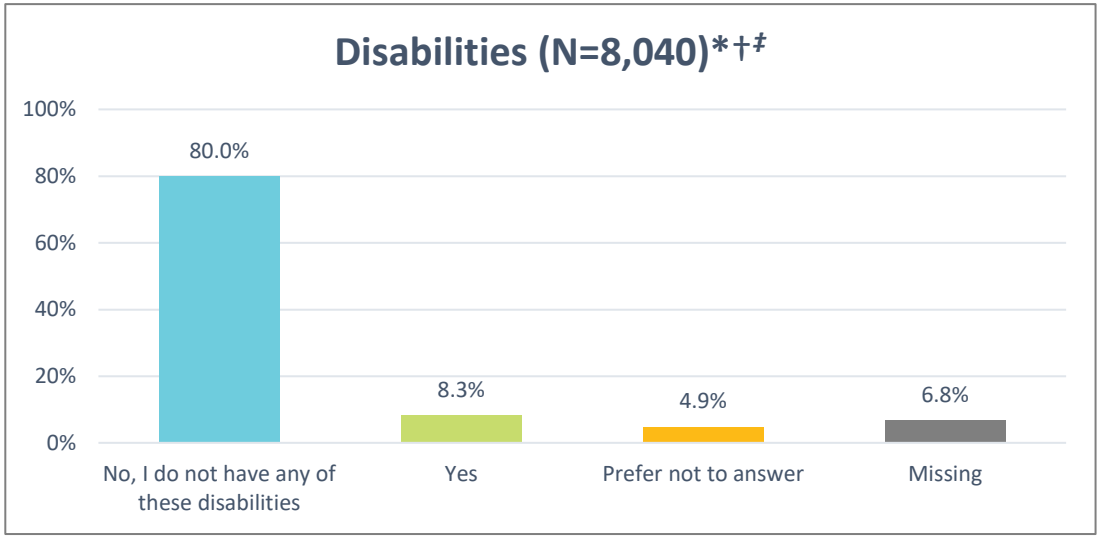
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Thirty-seven percent of participants identified their ethnicity as Hispanic/Latino. Nearly 19% of participants identified as more than one ethnicity.

PARTICIPANT DEMOGRAPHICS continued

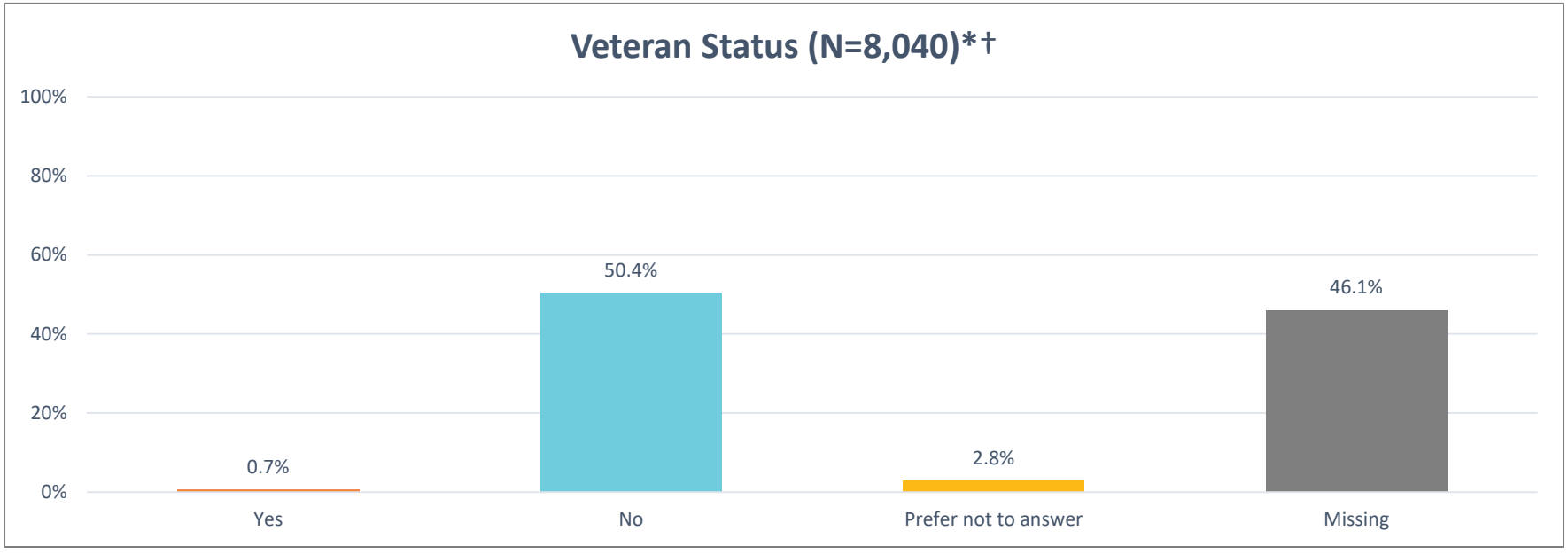


Approximately 8% of participants reported having a disability. Approximately 2% reported having a mental disability (not including a mental illness). Nearly 5% preferred not to answer this question.

Disabilities (N=8,040)*†‡	Count	%
Difficulty seeing	153	1.9%
Difficulty hearing or having speech understood	129	1.6%
Other communication disability	62	0.8%
Mental disability not including a mental illness	180	2.2%
Learning disability	120	1.5%
Developmental disability	34	0.4%
Dementia	<5	<1.0%
Other mental disability not related to mental illness	22	0.3%
Physical/mobility disability	57	0.7%
Chronic health condition/chronic pain	66	0.8%
Other	179	2.2%
Prefer not to answer	393	4.9%
Missing	544	6.8%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability .
‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=8,040 vs N=23,743).
Note: Percentages may not add up to 100% due to rounding.

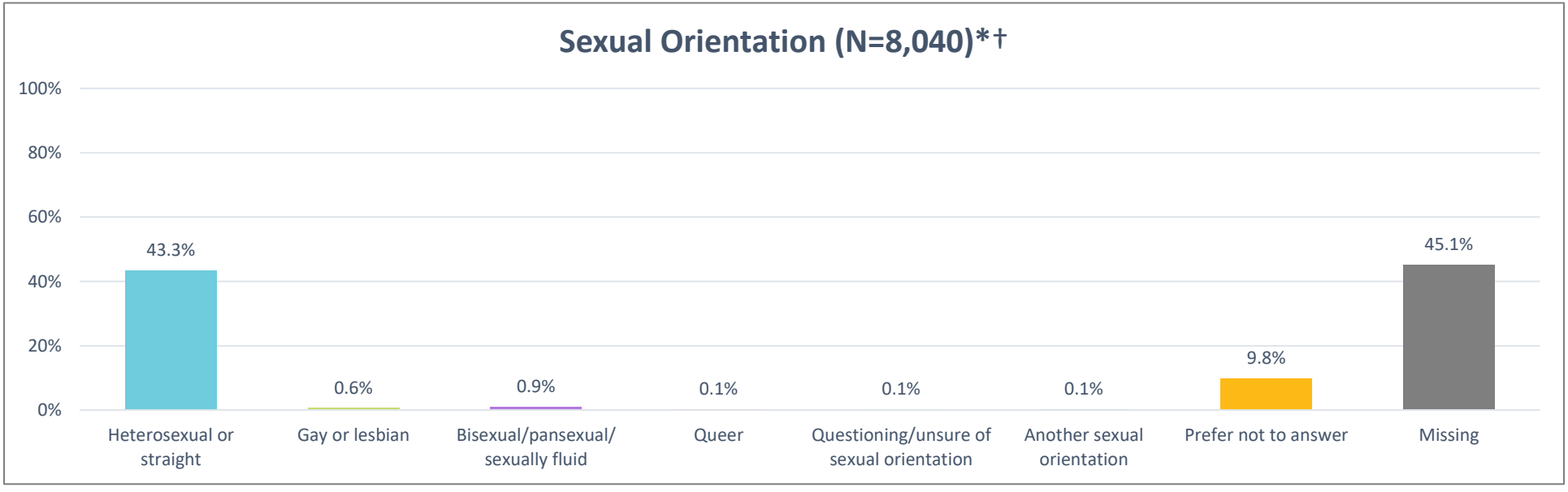
PARTICIPANT DEMOGRAPHICS continued



Fewer than 1% of participants reported that they had served in the military. About 0.5% of participants reported currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=8,040 vs N=23,743).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."

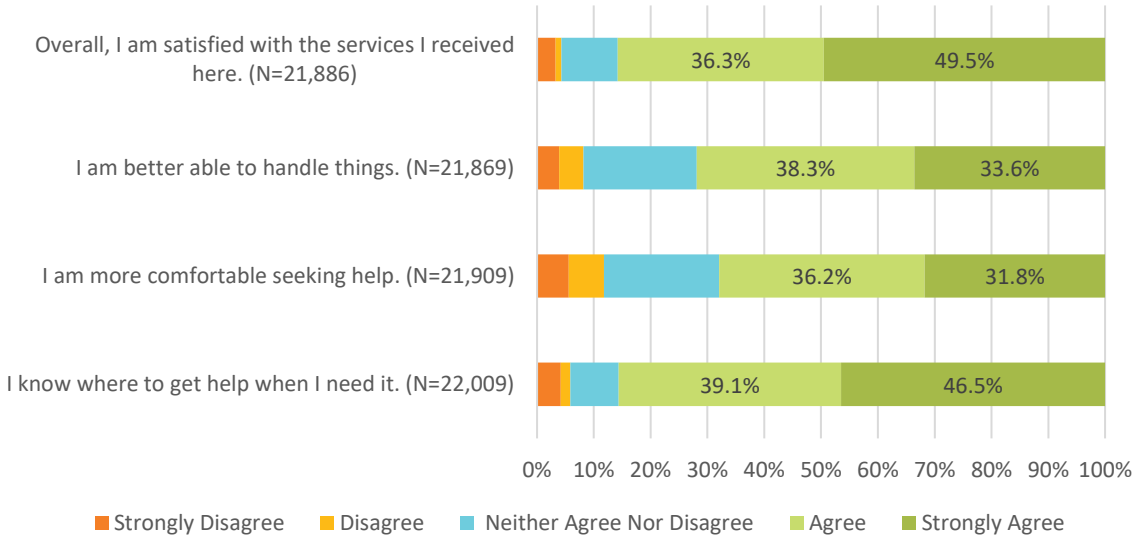
PARTICIPANT DEMOGRAPHICS continued



Approximately 43% percent of the participants identified their sexual orientation as heterosexual or straight. One percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Almost 10% of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=8,040 vs N=23,743).*
†Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."

PARTICIPANT SATISFACTION AND OUTCOMES*†



**Satisfaction and outcome data are not available for all participants.*
† Satisfaction data may include duplicate participants.

Nearly 86% of participants agreed or strongly agreed that they were satisfied with the services they received. Almost 72% of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Sixty-eight percent of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. Nearly 86% of participants agreed or strongly agreed that they knew where to get needed help as a result of the program.

REFERRAL TRACKING SUMMARY*

- In FY 2017-18, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2021-22, a total of 238 participants received a mental health referral, and 142 of these participants received a mental health service as a result of the referral (Linkage Rate = 59.7%)
- A total of 45 participants received a substance use referral, and 43 of these participants received a substance use service as a result of the referral (Linkage Rate = 95.6%)
- The average time between referral and linkage to services was eleven days.

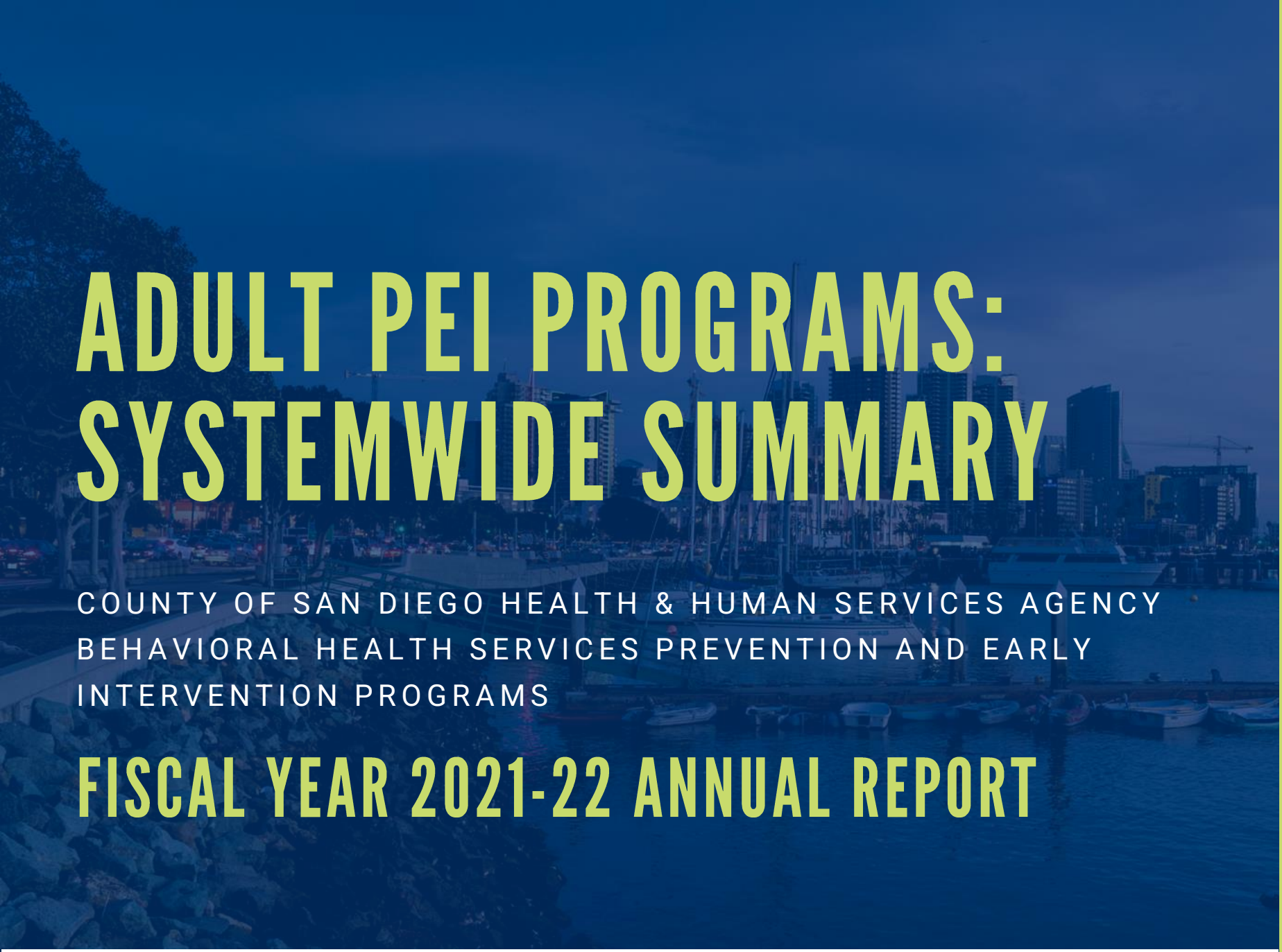
**Not all programs are required to collect referral data.*





CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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.



ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA SAN DIEGO



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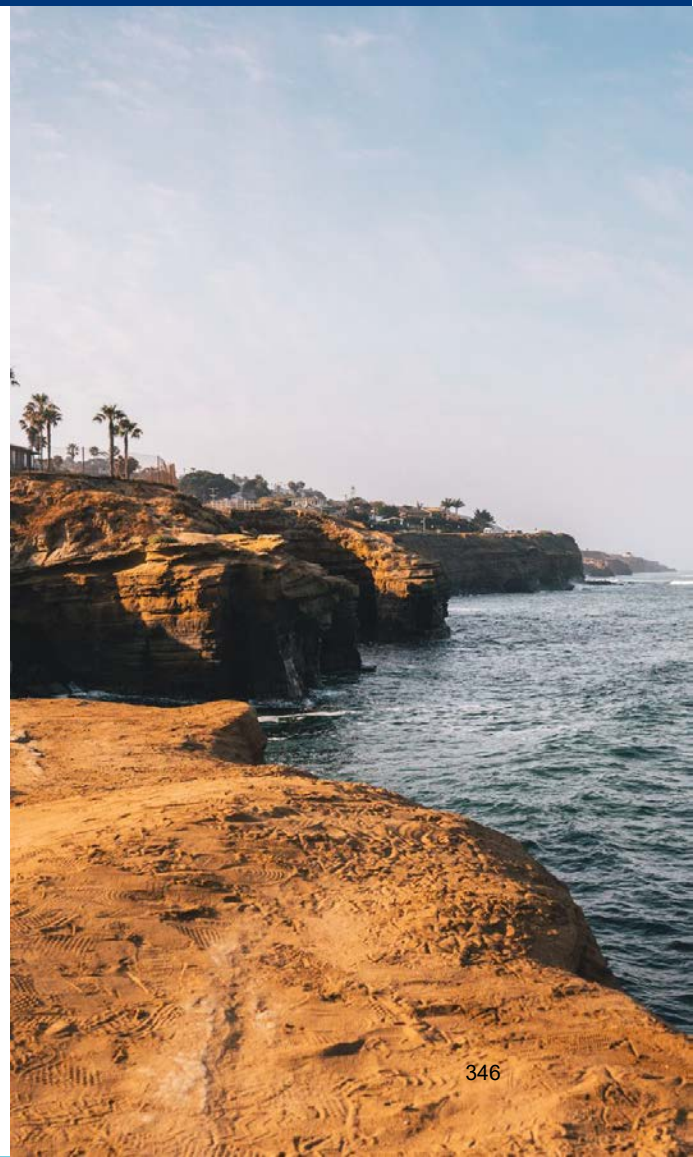
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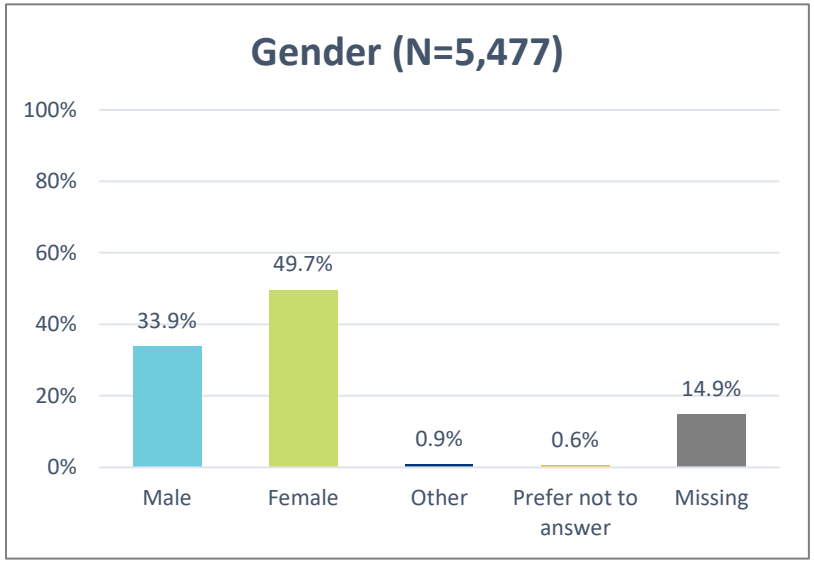
ADULT PEI PROGRAMS: BACKGROUND

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. The County of San Diego has funded contractors to provide PEI for adults. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing depression in Hispanic caregivers of individuals with Alzheimer's disease. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided. PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.

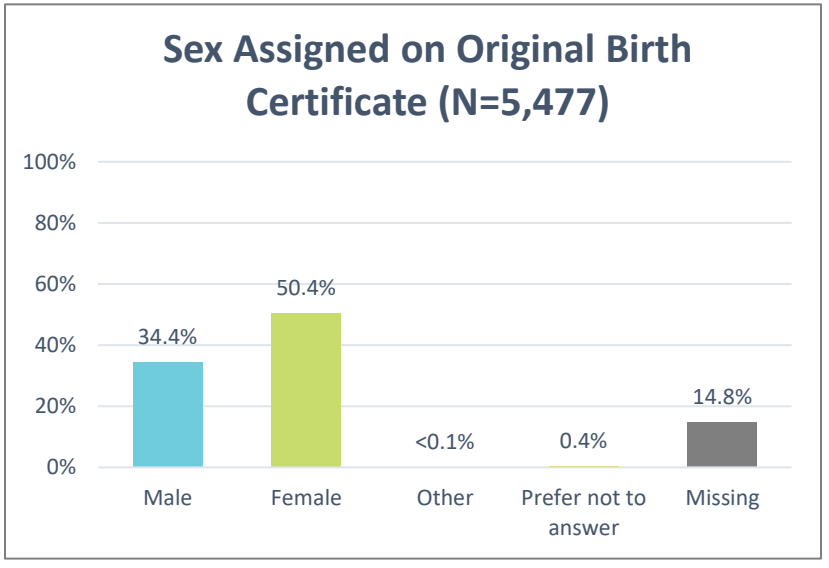
DATA: Adult PEI Programs
REPORT PERIOD: 7/1/2021-6/30/2022
NUMBER OF PARTICIPANTS WITH DATA IN FY 2021-22: 5,477 Unduplicated



PARTICIPANT DEMOGRAPHICS



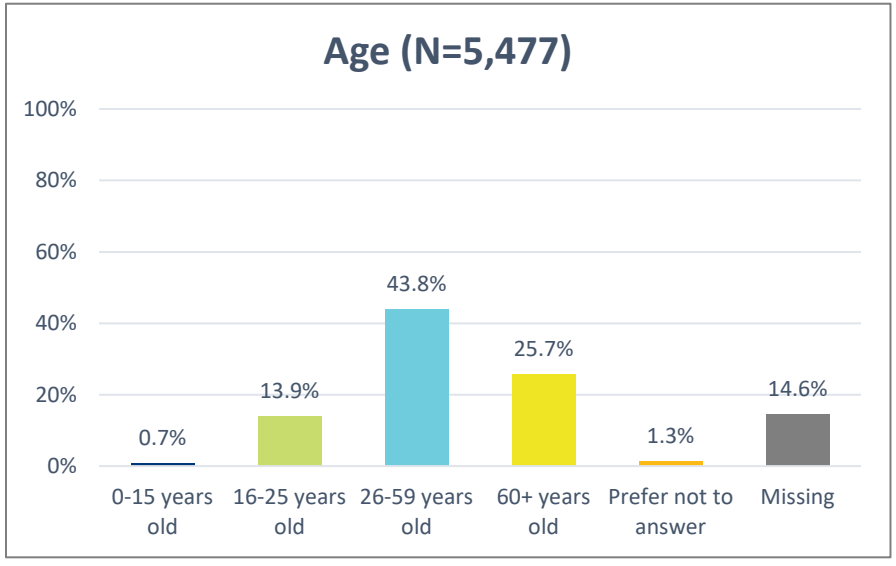
Almost 50% of participants identified as female. Nearly 1% of participants endorsed some other gender identity. Fewer than 1% of participants preferred not to answer this question.



Approximately 50% of participants reported that the sex they were assigned on their original birth certificate was female.

Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



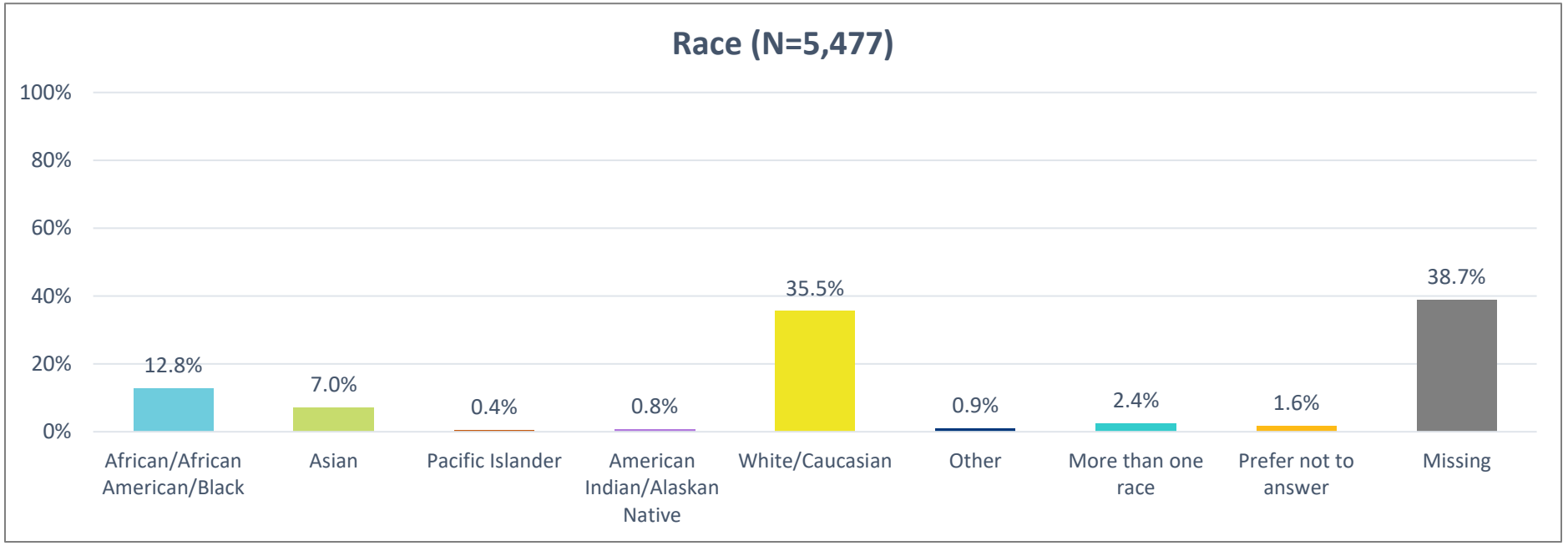
Primary Language (N=5,477)	Count	%
Arabic	124	2.3%
English	3,286	60.0%
Farsi	9	0.2%
Spanish	509	9.3%
Tagalog	58	1.1%
Vietnamese	15	0.3%
Other	670	12.2%
Prefer not to answer	23	0.4%
Missing	783	14.3%

The greatest proportion (44%) of participants were 26-59 years old.

Approximately 9% of participants identified their primary language as Spanish. Sixty percent of participants identified their primary language as English.

Note: Percentages may not add up to 100% due to rounding.

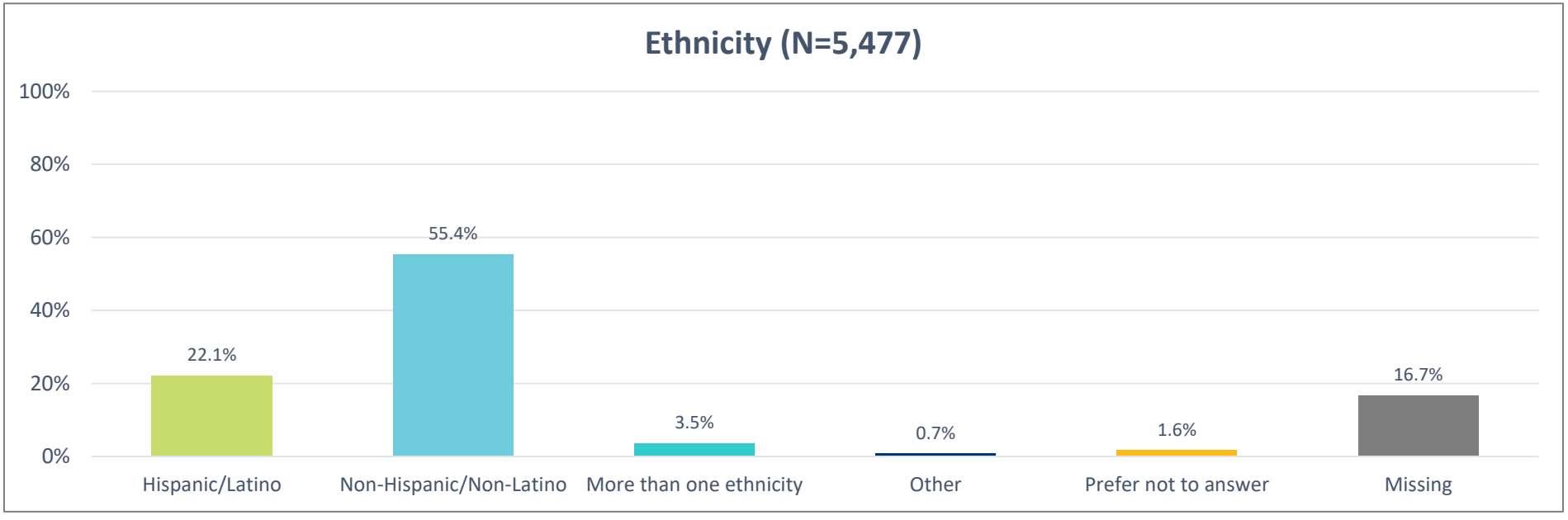
PARTICIPANT DEMOGRAPHICS continued



Nearly 36% of participants identified their race as White/Caucasian. Nearly 13% identified as African, African American or Black and 7% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

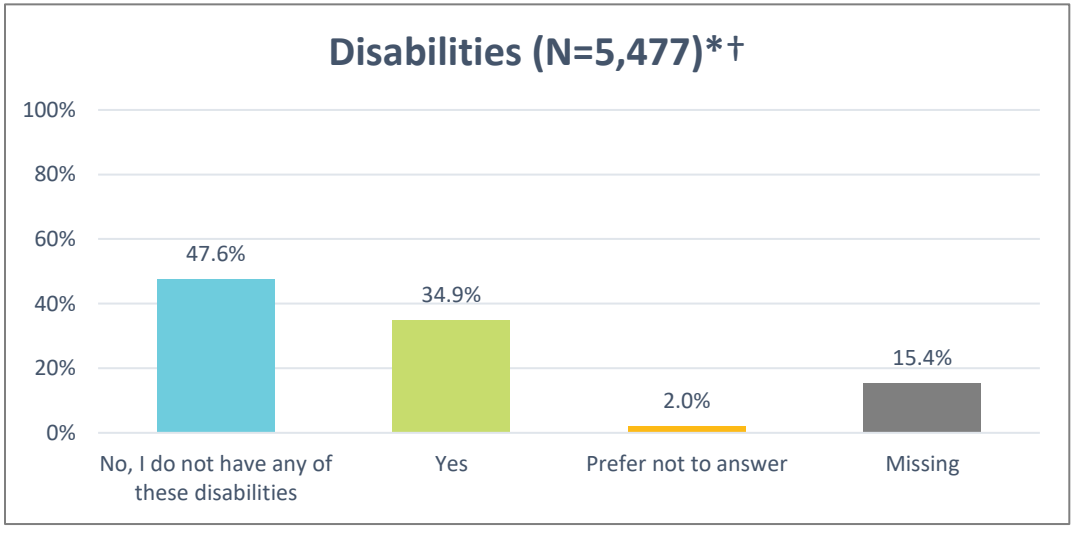
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Twenty-two percent of participants identified their ethnicity as Hispanic/Latino. Nearly 4% of participants identified as more than one ethnicity.

PARTICIPANT DEMOGRAPHICS continued

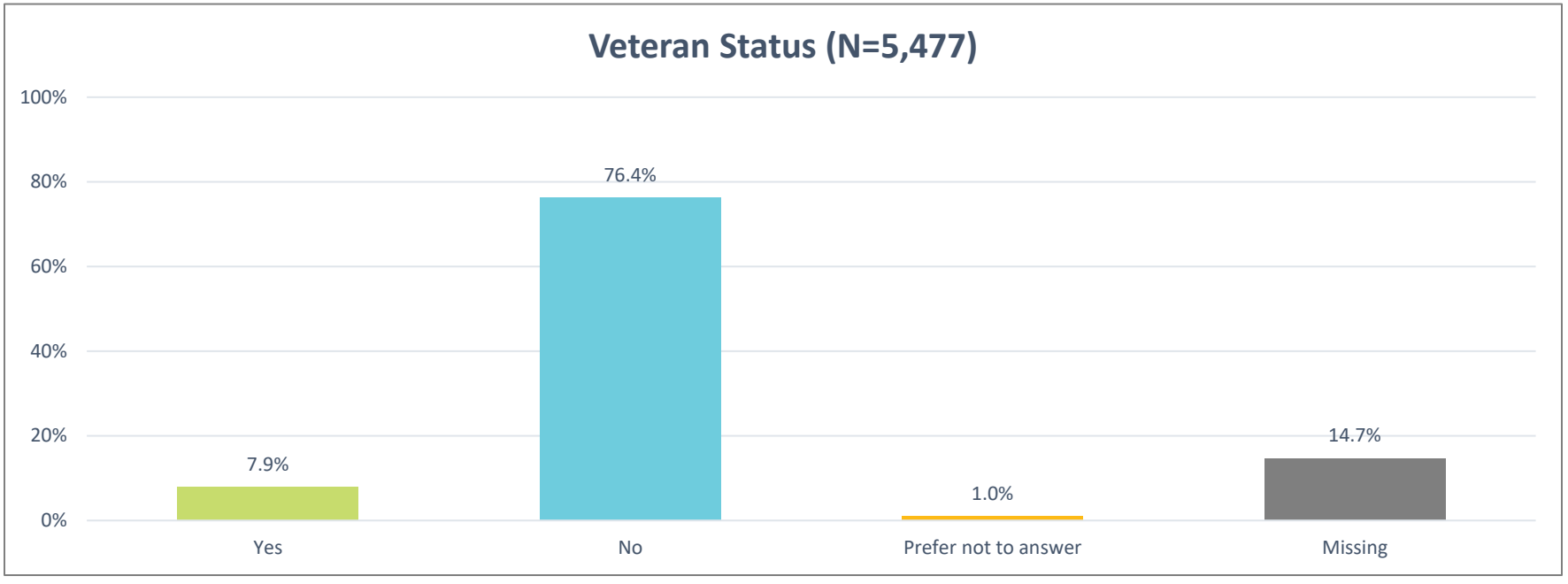


Nearly 35% of participants reported having a disability. Twenty-two percent of participants indicated that they had a chronic health condition or chronic pain. Two percent of participants preferred not to answer this question.

Disabilities (N=5,477)*†	Count	%
Difficulty seeing	185	3.4%
Difficulty hearing or having speech understood	92	1.7%
Other communication disability	12	0.2%
Mental disability not including a mental illness	249	4.5%
Learning disability	105	1.9%
Developmental disability	47	0.9%
Dementia	18	0.3%
Other mental disability not related to mental illness	79	1.4%
Physical/mobility disability	493	9.0%
Chronic health condition/chronic pain	1,200	21.9%
Other	289	5.3%
Prefer not to answer	111	2.0%
Missing	845	15.4%

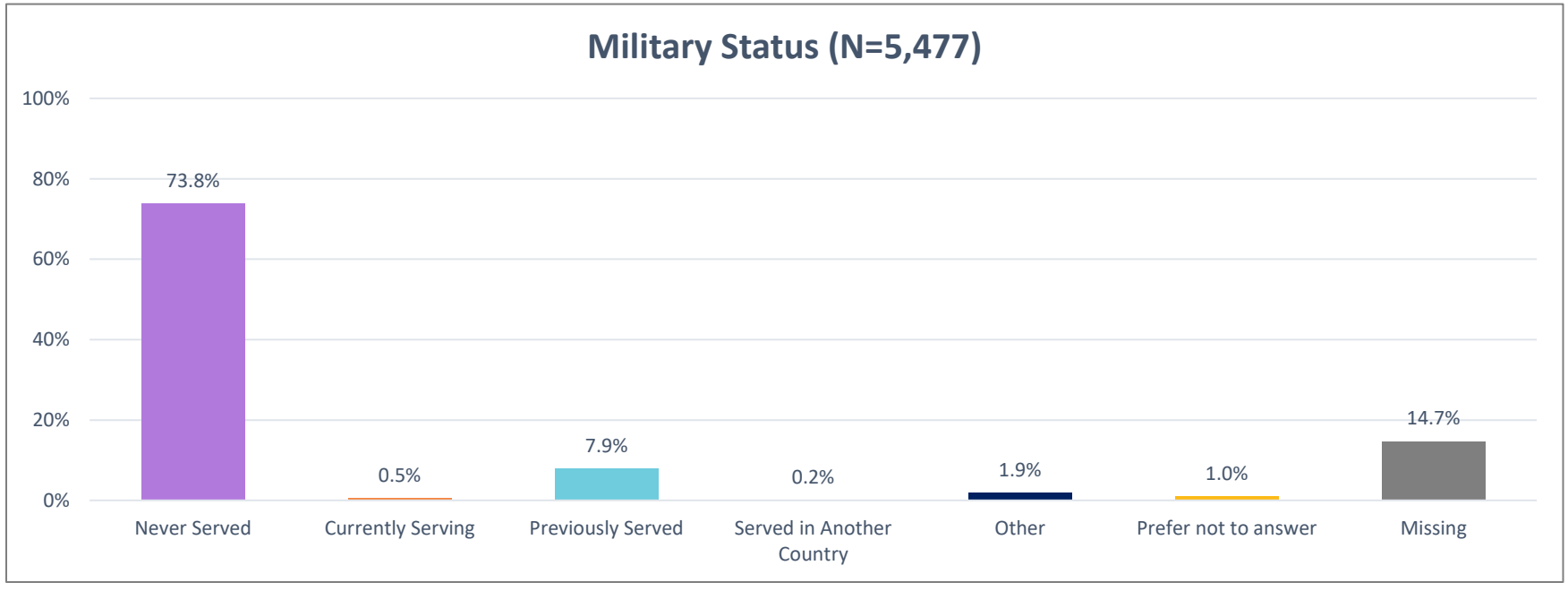
**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability .
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



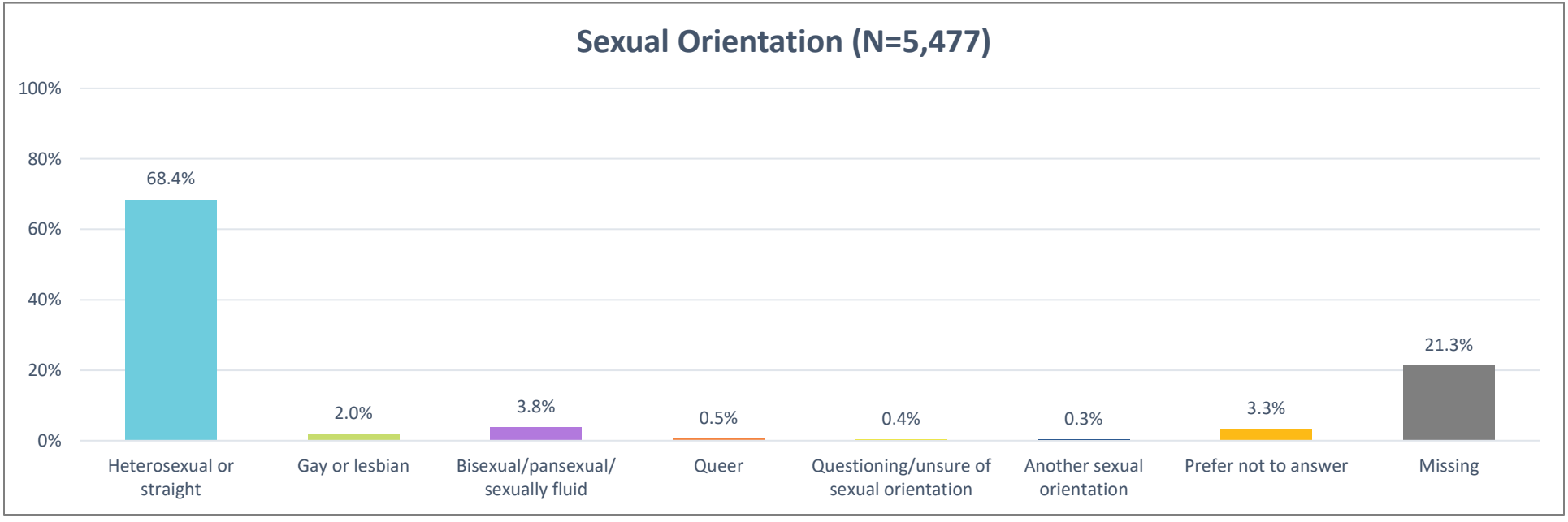
Nearly 8% of participants had served in the military. Additionally, 0.5% of participants reported currently serving in the military (data not shown).

PARTICIPANT DEMOGRAPHICS continued



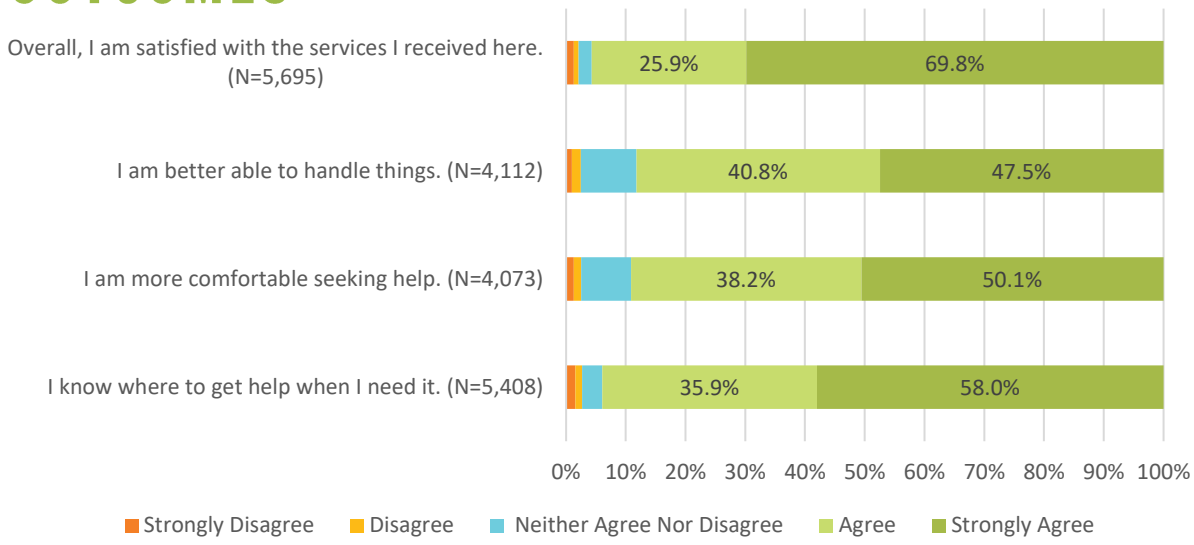
Nearly 74% percent of participants had never served in the military. About 0.5% of participants were currently serving in the military and nearly 8% reported that they had previously served in the military.

PARTICIPANT DEMOGRAPHICS continued



Approximately 68% of participants identified their sexual orientation as heterosexual or straight. Nearly 4% of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Approximately 3% of participants preferred not to answer this question.

PARTICIPANT SATISFACTION AND OUTCOMES*



Satisfaction and outcome data are not available for all participants.

Almost 96% of participants agreed or strongly agreed that they were satisfied with the services they received. Approximately 88% of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Approximately 88% of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. Ninety-four percent of the participants agreed or strongly agreed that they knew where to get needed help as a result of the program.

REFERRAL TRACKING SUMMARY*

- In FY 2017-18, the County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2021-22, a total of 976 participants received a mental health referral, and 240 of these participants received a mental health service as a result of the referral (Linkage Rate = 24.6%)
- A total of 877 participants received a substance use referral, and 393 of these participants received a substance use service as a result of the referral (Linkage Rate = 44.8%)
- The average time between referral and linkage to services was five days.

** Not all PEI programs make referrals.*

HEALTH SERVICES RESEARCH CENTER

The Health Services Research Center (HSRC) at the University of California, San Diego is a non-profit research organization within the Herbert Wertheim School of Public Health and Human Longevity Science. 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.

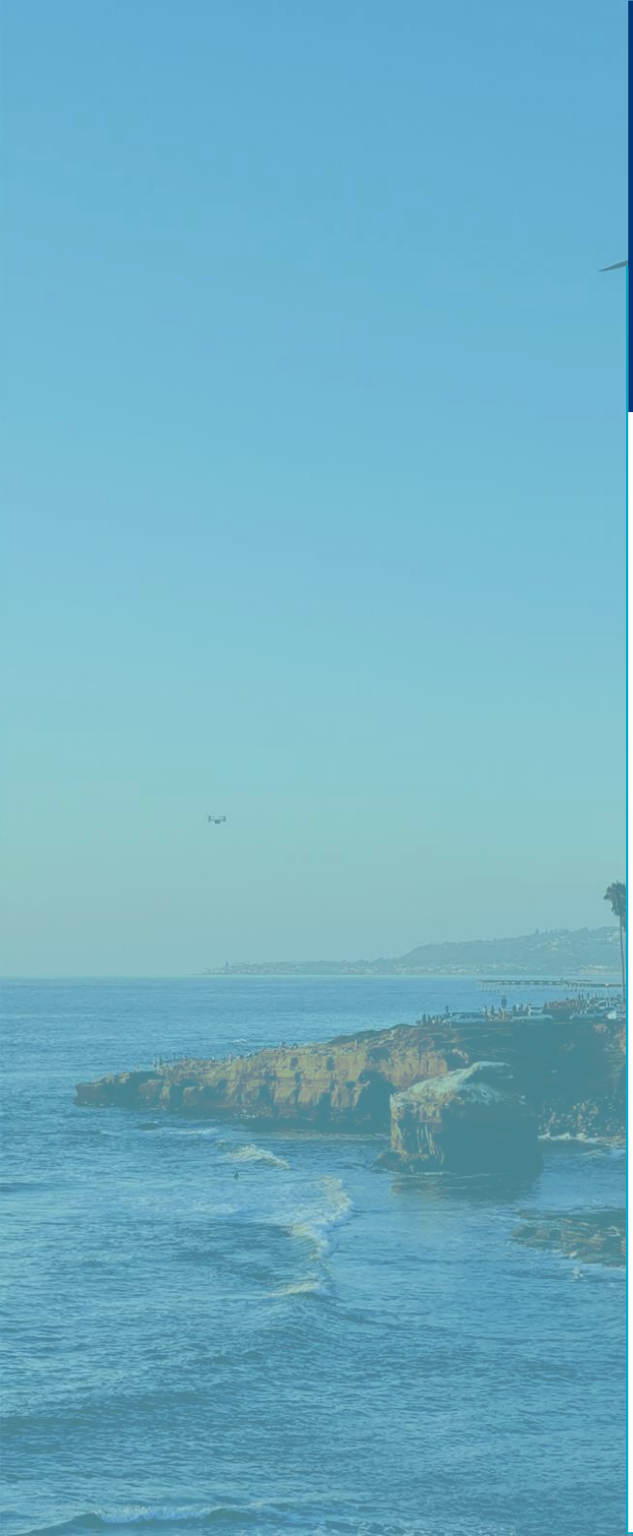




CHILD & ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2021-22 ANNUAL REPORT



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03 Background

04 Systemwide Demographics

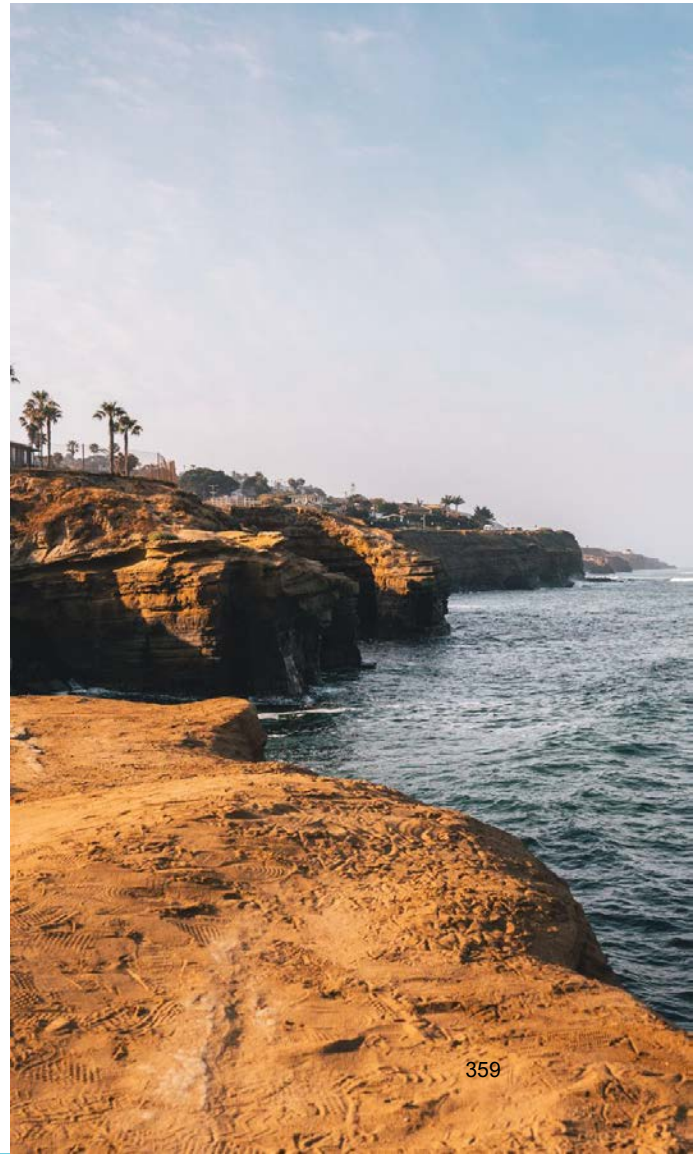
12 Systemwide Outcomes and Referrals

13 About the Research Centers

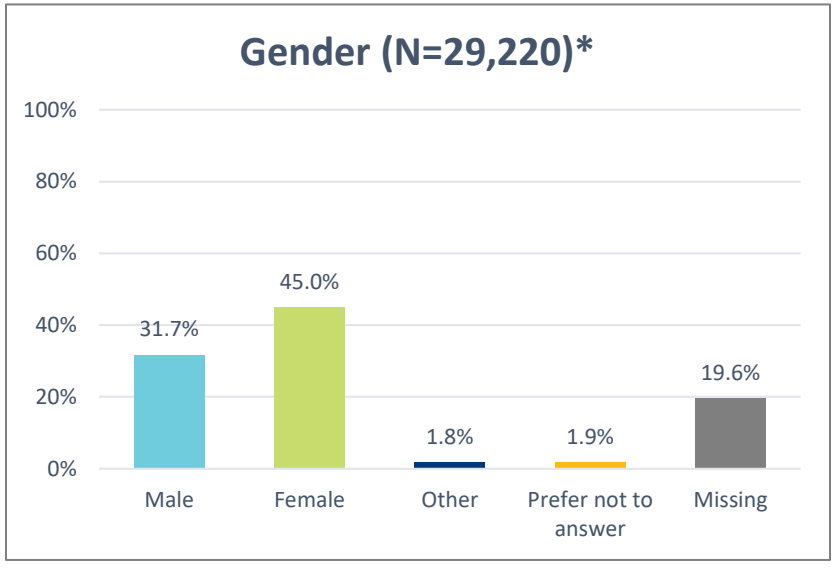
CHILD & ADULT PEI PROGRAMS: BACKGROUND

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. With this funding source, the County of San Diego contracted with providers for PEI programs for adults and older adults, youth and transition age youth (TAY), and their families. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by the program via outreach efforts, including but not limited to: presentations, community events, and fairs. PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.

DATA: Child and Adult PEI Programs
REPORT PERIOD: 7/1/2021-6/30/2022
NUMBER OF PARTICIPANTS WITH DATA IN FY 2021-22: 29,220 Unduplicated*†
**Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators referenced in this report (N=29,220 vs. N=13,517).* *†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.*

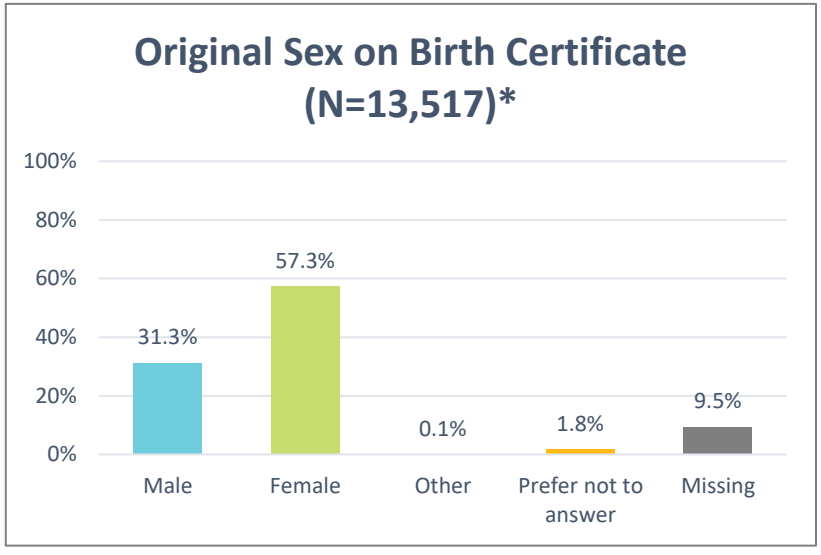


SYSTEMWIDE DEMOGRAPHICS



Forty-five percent of participants identified as female. Nearly 2% of participants endorsed some other gender identity. Nearly 2% of participants preferred not to answer this question.

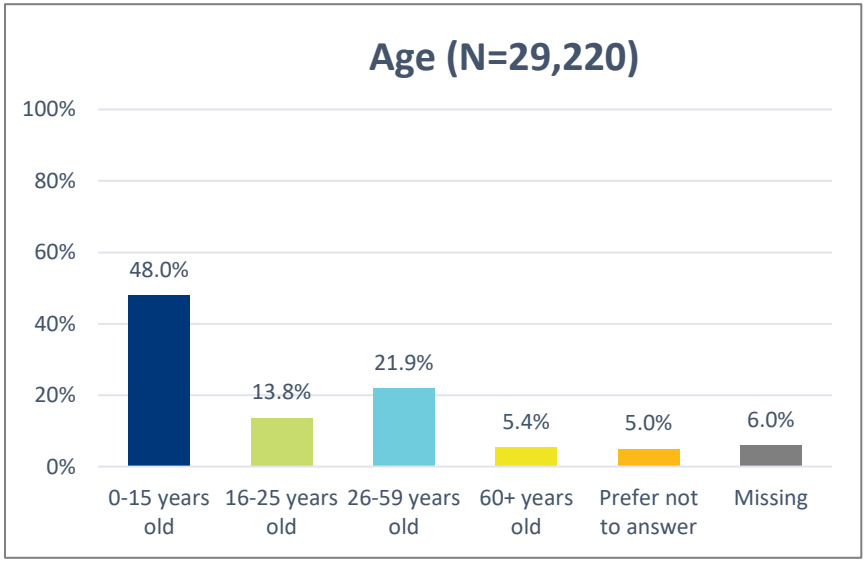
**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*



Approximately 57% of participants reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =13,517 vs. N=29,220).*

SYSTEMWIDE DEMOGRAPHICS continued



Forty-eight percent of participants were 15 or younger. Approximately 22% of participants were between the ages of 26 and 59.

Note: Percentages may not add up to 100% due to rounding.

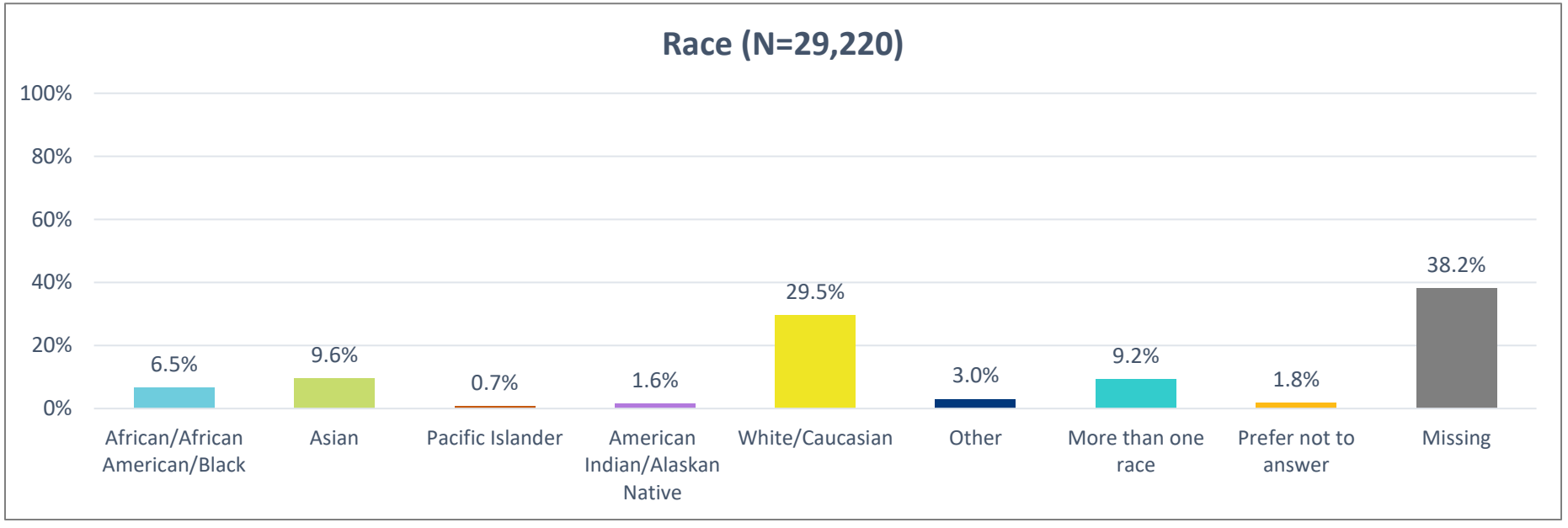
Primary Language (N=13,517)*	Count	%
Arabic	201	1.5%
English	6,887	51.0%
Farsi	47	0.3%
Spanish	3,926	29.0%
Tagalog	83	0.6%
Vietnamese	38	0.3%
Other	924	6.8%
Prefer not to answer	143	1.1%
Missing	1,268	9.4%

Twenty-nine percent of participants identified their primary language as Spanish. Fifty-one percent of participants identified their primary language as English.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,517 vs N=29,220).*

Note: Percentages may not add up to 100% due to rounding.

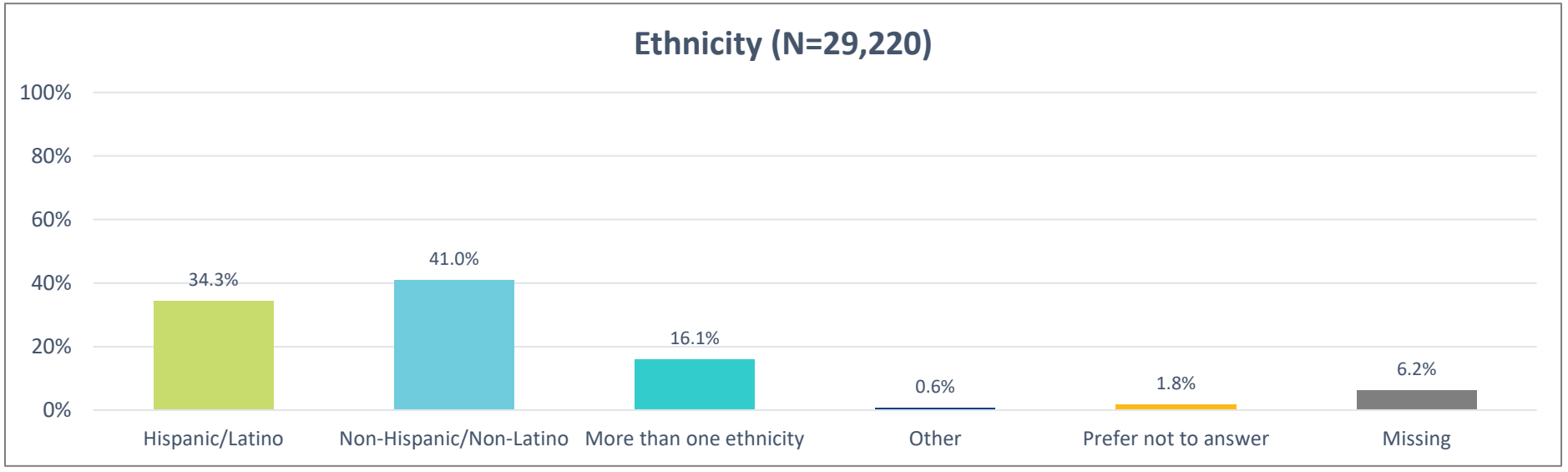
SYSTEMWIDE DEMOGRAPHICS continued



Nearly 30% of participants identified their race as White/Caucasian. Nearly 7% identified as African, African American or Black and approximately 10% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

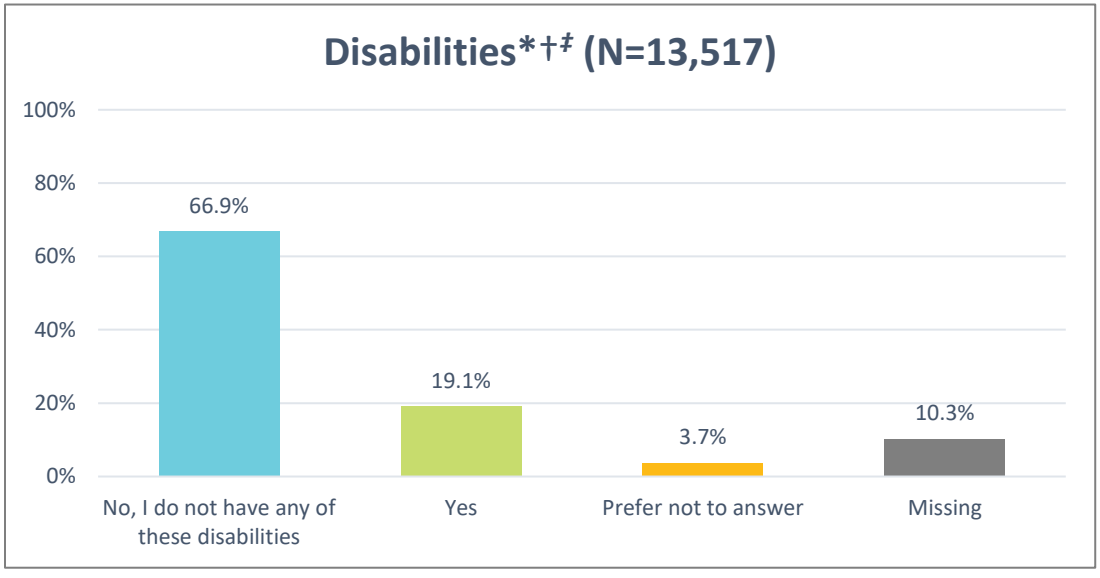
Note: Percentages may not add up to 100% due to rounding.

SYSTEMWIDE DEMOGRAPHICS continued



Approximately 34% of participants identified their ethnicity as Hispanic/Latino. Approximately 16% of participants identified as more than one ethnicity.

SYSTEMWIDE DEMOGRAPHICS continued

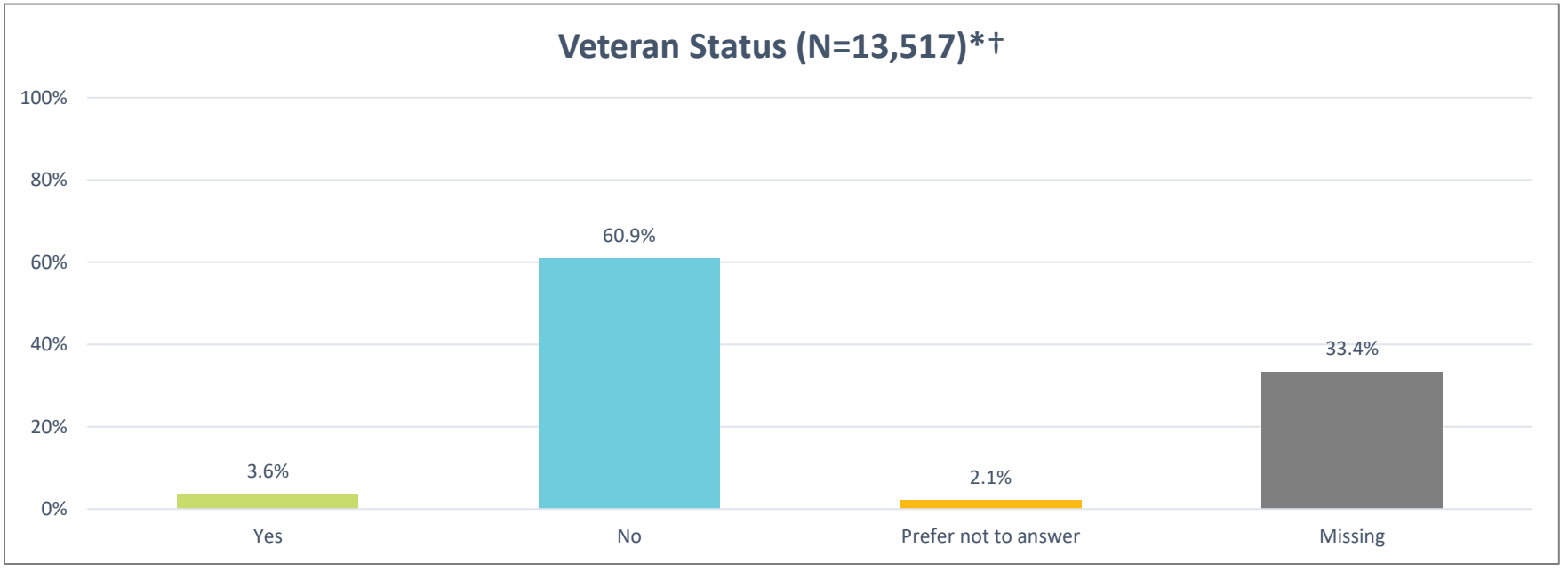


Approximately 19% of participants reported having a disability. Approximately 9% of participants indicated that they had a chronic health condition or chronic pain. Nearly 4% of participants preferred not to answer this question.

Disabilities*†‡ (N=13,517)	Count	%
Difficulty seeing	338	2.5%
Difficulty hearing or having speech understood	221	1.6%
Other communication disability	74	0.5%
Mental disability not including a mental illness	429	3.2%
Learning disability	225	1.7%
Developmental disability	81	0.6%
Dementia	22	0.2%
Other mental disability not related to mental illness	101	0.7%
Physical/mobility disability	550	4.1%
Chronic health condition/chronic pain	1,266	9.4%
Other	468	3.5%
Prefer not to answer	504	3.7%
Missing	1,389	10.3%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability.
‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,517 vs N=29,220).
Note: Percentages may not add up to 100% due to rounding.

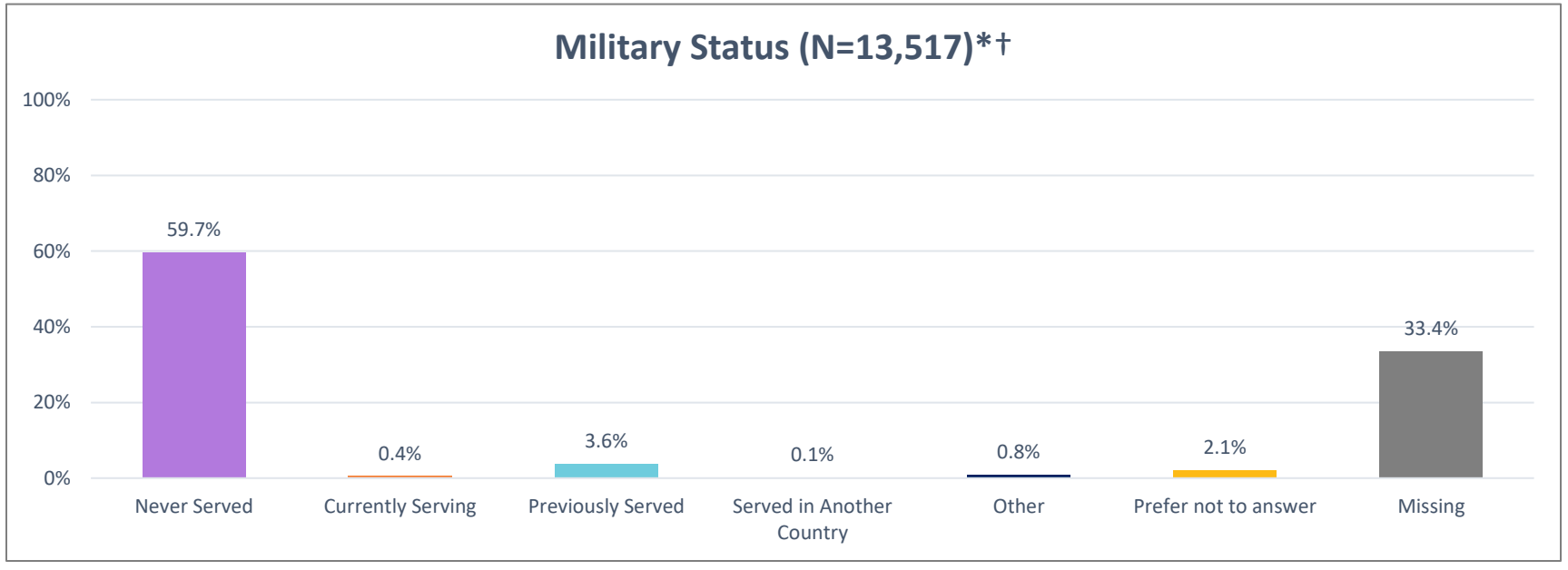
SYSTEMWIDE DEMOGRAPHICS continued



Information on veteran status indicated that nearly 4% of participants had served in the military. Less than 1% of participants reported that they are currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,517 vs N=29,220).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."

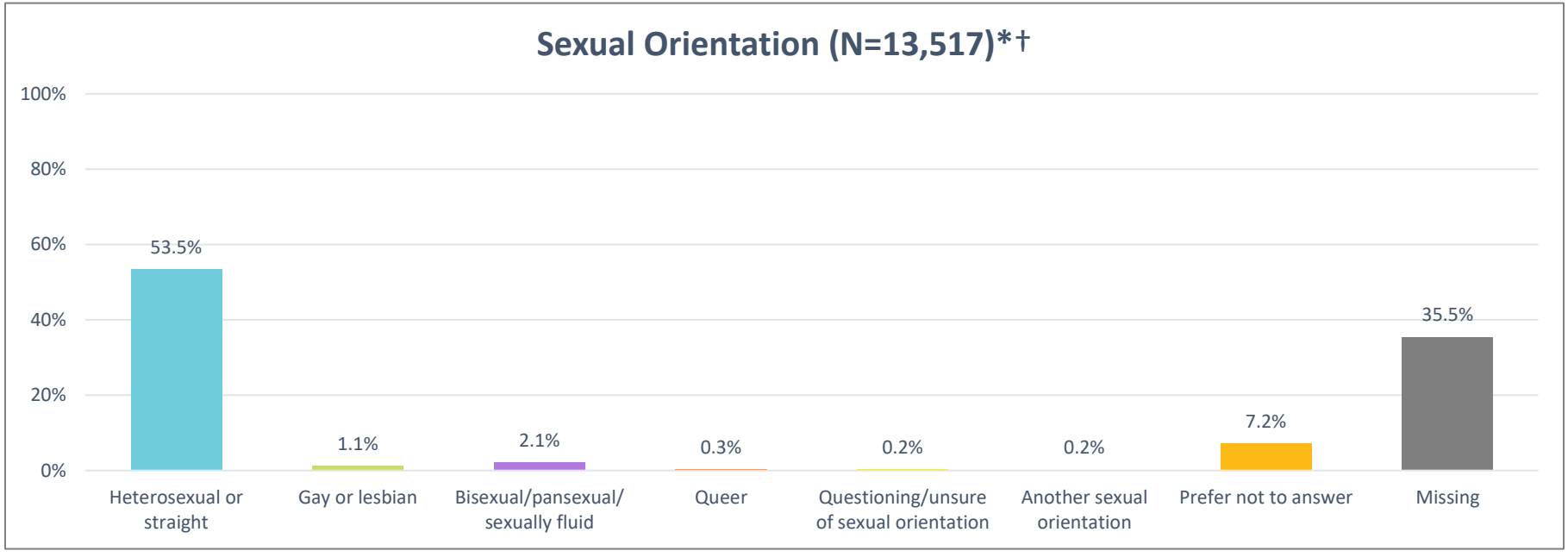
SYSTEMWIDE DEMOGRAPHICS continued



Nearly 60% of participants had never served in the military. Less than 1% of participants indicated that they are currently serving in the military and nearly 4% indicated that they had previously served in the military.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,517 vs N=29,220).*
† Military status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

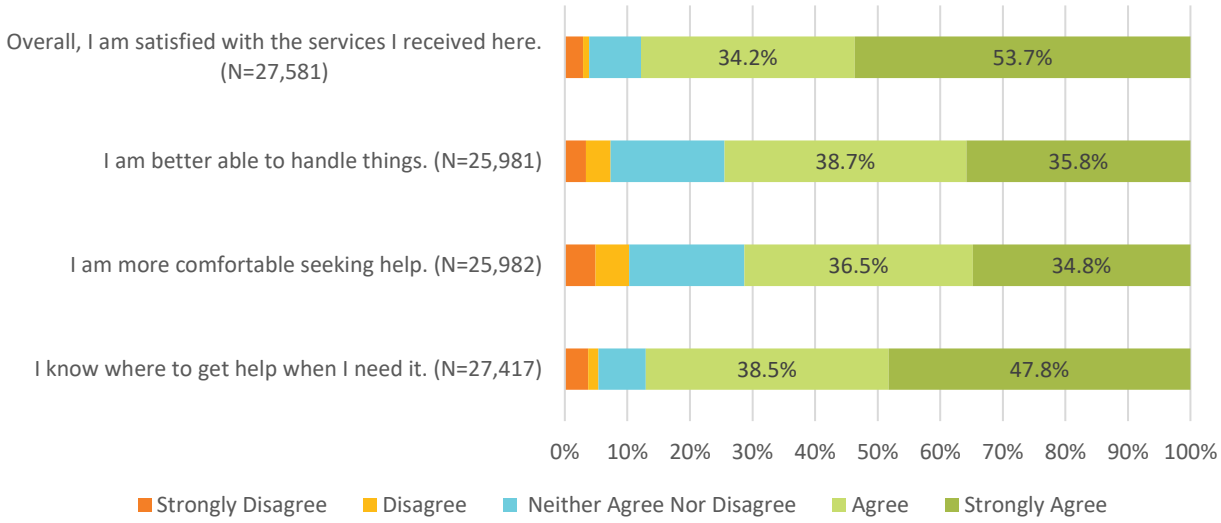
SYSTEMWIDE DEMOGRAPHICS continued



Nearly 54% of participants identified their sexual orientation as heterosexual or straight. Approximately 2% of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Approximately 7% of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,517 vs N=29,220).*
†Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

SYSTEMWIDE SATISFACTION AND OUTCOMES*†



**Satisfaction and outcome data are not available for all participants.*
† Satisfaction data may include duplicate participants.

Nearly 88% of participants agreed or strongly agreed that they were satisfied with the services they received and 86% of participants agreed or strongly agreed that they knew where to get needed help as a result of the program. Seventy-five percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Nearly 71% of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program.

SYSTEMWIDE REFERRAL TRACKING SUMMARY*

- In FY 2017-18, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2021-22, a total of 1,214 participants received a mental health referral, and 382 of these participants received a mental health service as a result of the referral (Linkage Rate = 31.5%)
- A total of 922 participants received a substance use referral, and 436 of these participants received a substance use service as a result of the referral (Linkage Rate = 47.3%)
- The average time between referral and linkage to services was seven days.

**Not all PEI programs make referrals.*



HEALTH SERVICES RESEARCH CENTER

The Health Services Research Center (HSRC) at the University of California, San Diego is a non-profit research organization within the Herbert Wertheim School of Public Health and Human Longevity Science. 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.



CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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 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.

KICKSTART (FB01) PATHWAYS COMMUNITY SERVICES

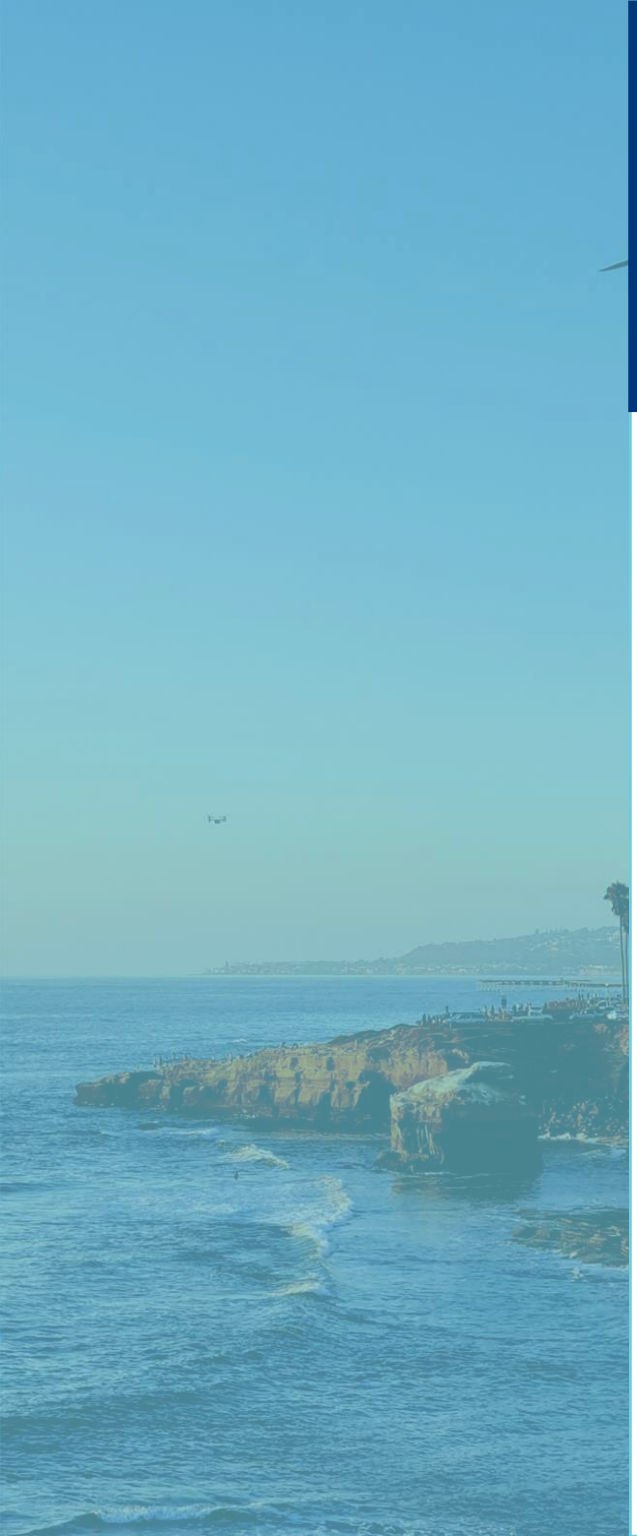
COUNTY OF SAN DIEGO HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES PREVENTION AND EARLY INTERVENTION PROGRAMS

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REGION: Central & North Central – District 4

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

CASRC Child and Adolescent Services Research Center



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BACKGROUND

The purpose of this program is to provide prevention and early intervention services to youth and young adults ages 10-25 who may have clinical high risk (CHR) symptoms of psychosis or have had their first episode of psychosis (FEP). The prevention component of the program focuses on providing psychoeducation and outreach to the community, including other behavioral health providers, school staff, hospital staff, faith-based leaders, and others who may have contact with youth in general community settings. These community leaders are provided education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis. The early intervention component of the program includes a comprehensive assessment (the Structured Interview for Psychosis-Risk Syndromes) to determine the risk for, or the presence of, severe mental illness. This instrument also assesses for emotional dysregulation, physical health needs, stress tolerance, cognitive functioning, substance use issues, and potential safety concerns. Based upon results of the assessment, youth and their families maybe referred and linked to outside community resources to best meet their needs. Youth who screen positive for CHR or FEP symptoms receive an intake into this program and participate in a variety of services: psychoeducation workshops, multi-family groups, and support services including medication/nursing services, occupational therapy, peer support services, and education/employment support. Treatment interventions include individual, family, and group therapy. These services may be provided via telehealth. This report focuses on youth and community demographics and youth outcomes. PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.





MAJOR DATA POINTS

CONTRACTOR: Pathways Community Services	
CONTRACT START DATE: 12/01/2009	DATA COLLECTION START DATE: 05/2010
PROGRAM SERVICES START DATE: 4/1/2010	**REPORT PERIOD: 7/1/2021-6/30/2022**

489

CLIENTS WITH DEMOGRAPHIC DATA IN FY 2021-22 (UNDUPLICATED)

244

COMMUNITY CLIENTS WITH DATA IN FY 2021-22 (UNDUPLICATED)

6,430

COMMUNITY MEMBERS WHO RECEIVED TRAININGS SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE PARTICIPANTS)

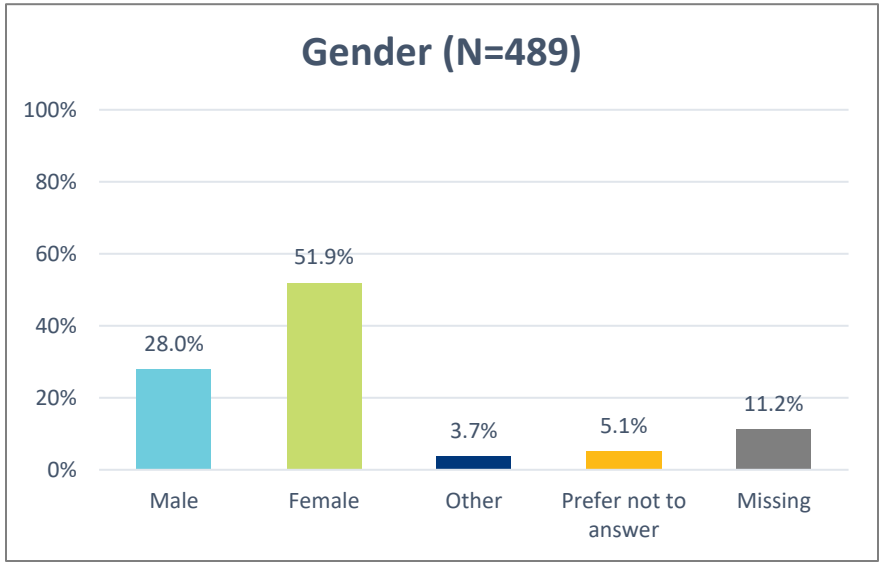
1,718

YOUTH SCREENED SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE YOUTH)

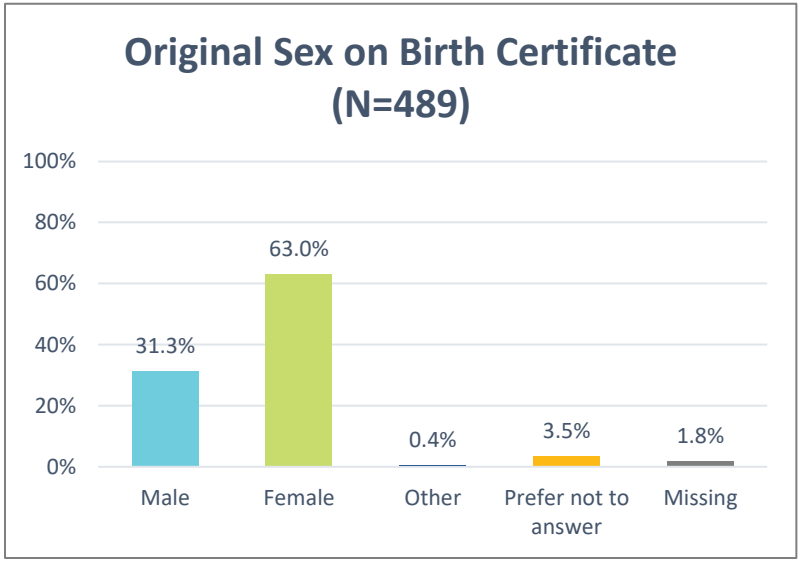
1,038

YOUTH ENROLLED SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE YOUTH)

PARTICIPANT DEMOGRAPHICS



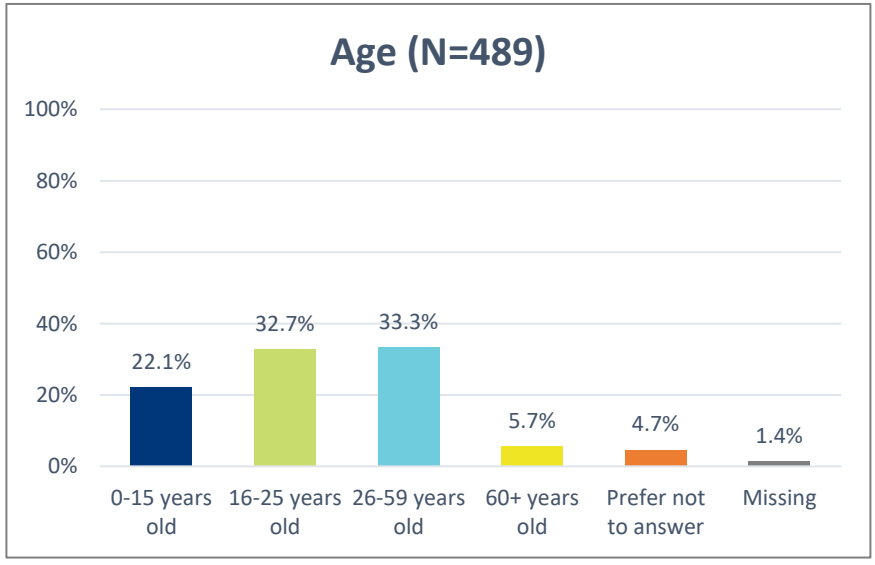
Almost 52% of participants identified as female. Fewer than 4% of participants endorsed some other gender identity. Five percent of participants preferred not to answer this question.



Sixty-three percent of participants reported that the sex they were assigned on their original birth certificate was female.

**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



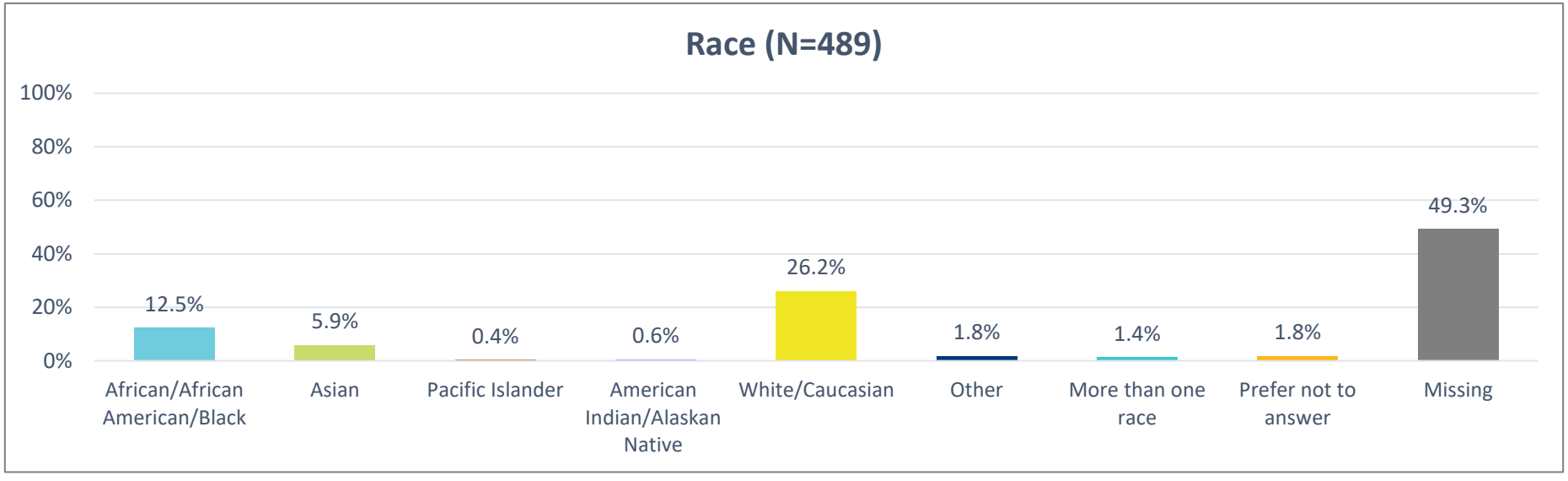
Nearly 33% percent of participants were 16 to 25 years old.

Primary Language (N=489)	Count	%
English	411	84.0%
Spanish	44	9.0%
Tagalog	<5	<1.0%
Other	16	3.3%
Prefer not to answer	<5	<1.0%
Missing	12	2.5%

Nine percent of participants identified their primary language as Spanish. Eighty-four percent of participants identified their primary language as English.

Note: Percentages may not add up to 100% due to rounding.

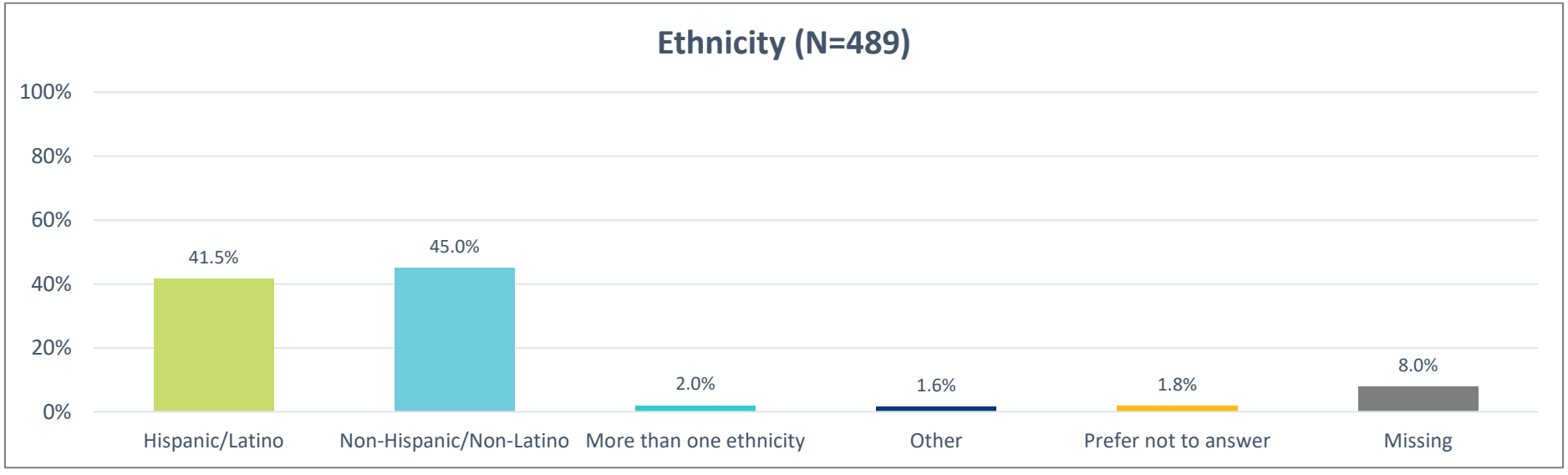
PARTICIPANT DEMOGRAPHICS continued



About 26% of participants identified their race as White/Caucasian. Nearly 13% identified as African, African American or Black and nearly 6% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

Note: Percentages may not add up to 100% due to rounding.

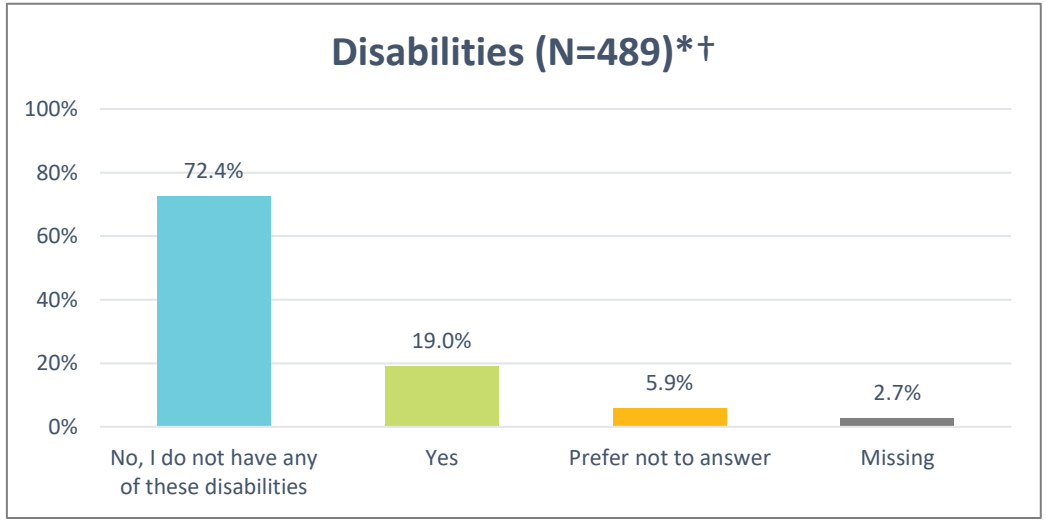
PARTICIPANT DEMOGRAPHICS continued



Nearly 42% of participants identified their ethnicity as Hispanic/Latino.

Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Nineteen percent of participants reported having a disability. Approximately 10% of participants indicated having a mental disability (not including a mental illness). About 6% preferred not to answer this question.

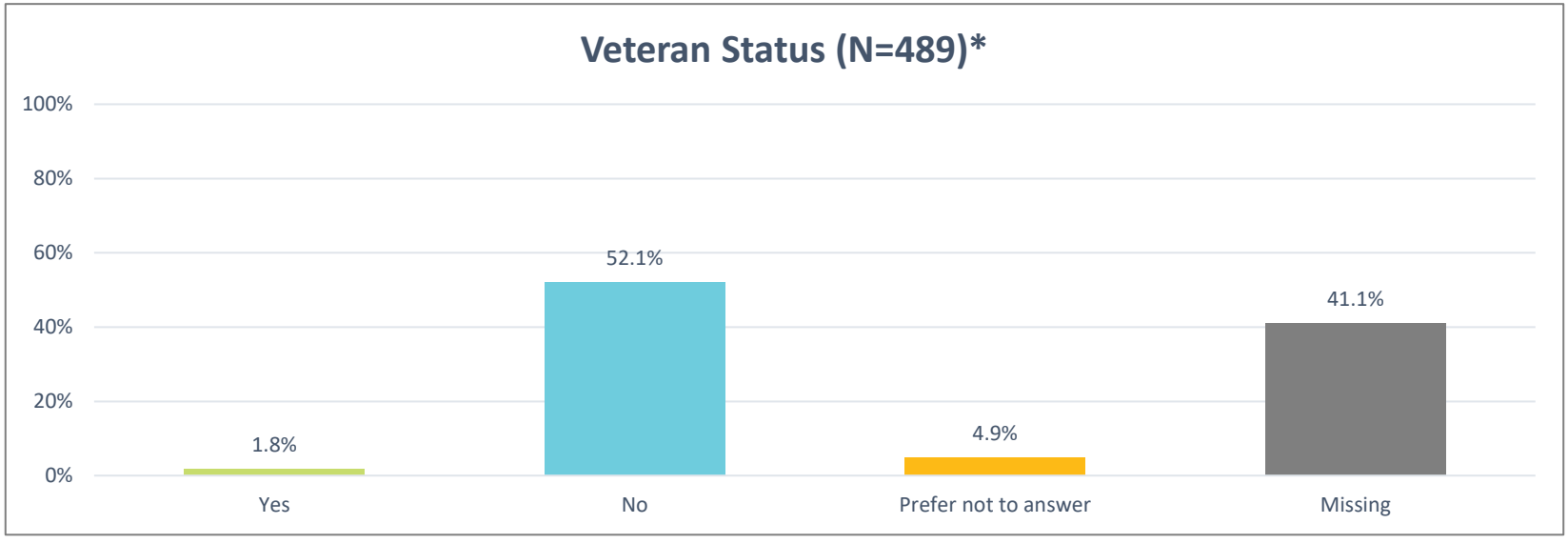
Disabilities (N=489)*†	Count	%
Difficulty seeing	9	1.8%
Difficulty hearing or having speech understood	<5	<1.0%
Other communication disability	<5	<1.0%
Mental disability not including a mental illness	51	10.4%
Learning disability	35	7.2%
Developmental disability	11	2.2%
Dementia	<5	<1.0%
Other mental disability not related to mental illness	<5	<1.0%
Physical/mobility disability	6	1.2%
Chronic health condition/chronic pain	10	2.0%
Other	34	7.0%
Prefer not to answer	29	5.9%
Missing	13	2.7%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*

† The sum of the percentages may exceed 100% because participants can select more than one type of disability .

Note: Percentages may not add up to 100% due to rounding.

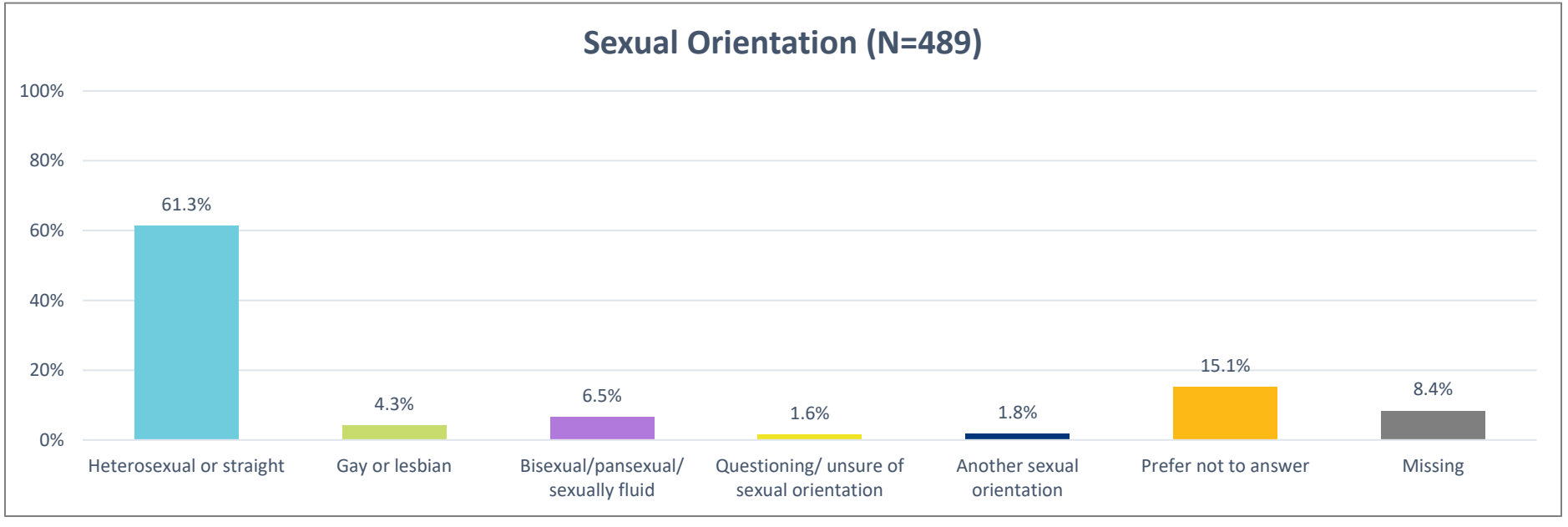
PARTICIPANT DEMOGRAPHICS continued



Fewer than 2% of participants had served in the military.

**Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Approximately 61% of the participants identified their sexual orientation as heterosexual or straight. Nearly 7% identified their sexual orientation as bisexual/pansexual/sexually fluid and 4% identified as gay or lesbian. Approximately 15% of participants preferred not to answer this question.

**Sexual orientation not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

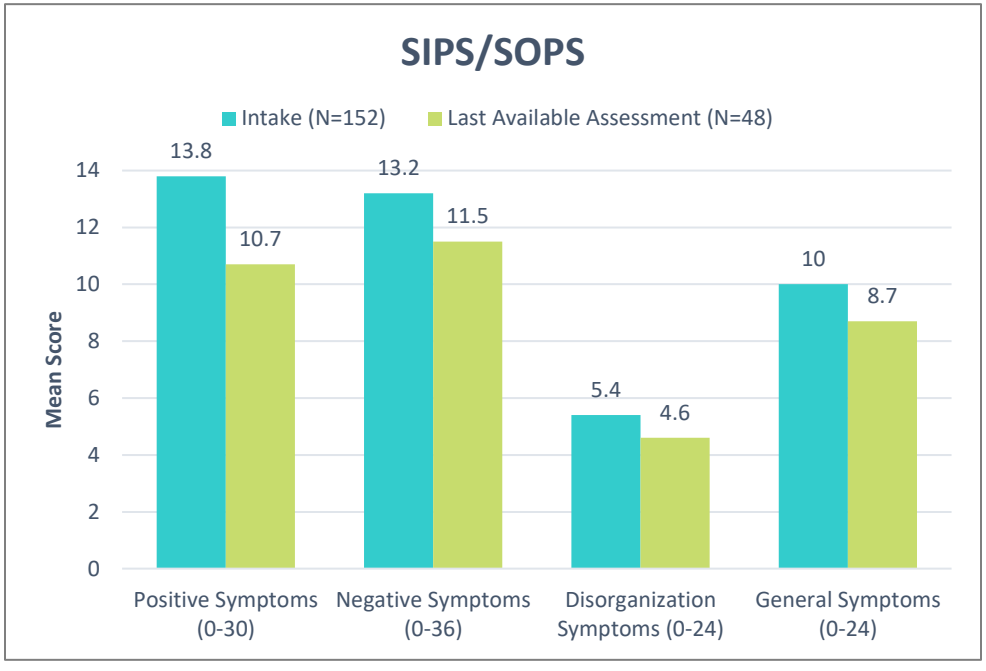
INTAKE: PHONE SCREENS

SYMPTOMS REPORTED AT INITIAL SCREENING	N	%
Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty concentrating), N=223	208	93.3
Changes in perception (auditory, visual, tactile, olfactory abnormalities), N=232	207	89.2
Changes in speech (disorganized communication, tangential speech), N=222	168	75.5
Changes in view (of self, others, or the world in general), N=209	160	76.6
Changes in emotions (depression, mood swings, irritability, flat affect), N=235	224	95.3
Vegetative symptoms (sleep problems, changes in appetite, social isolation), N=235	222	94.5
Family history of mental illness (schizophrenia, bipolar disorder, schizoaffective disorder, psychosis), N=218	146	67.0
Dramatic reduction of overall functioning), N=224	189	84.4

In FY 2021-22, 244 youth were screened for admission into the Kickstart program. The majority of phone screen participants experienced changes in thinking, emotions, and vegetative symptoms. Additionally, approximately 84% of phone screen participants reported experiencing a dramatic reduction in overall functioning.

**Not all youth had complete data for every item on the screener.*

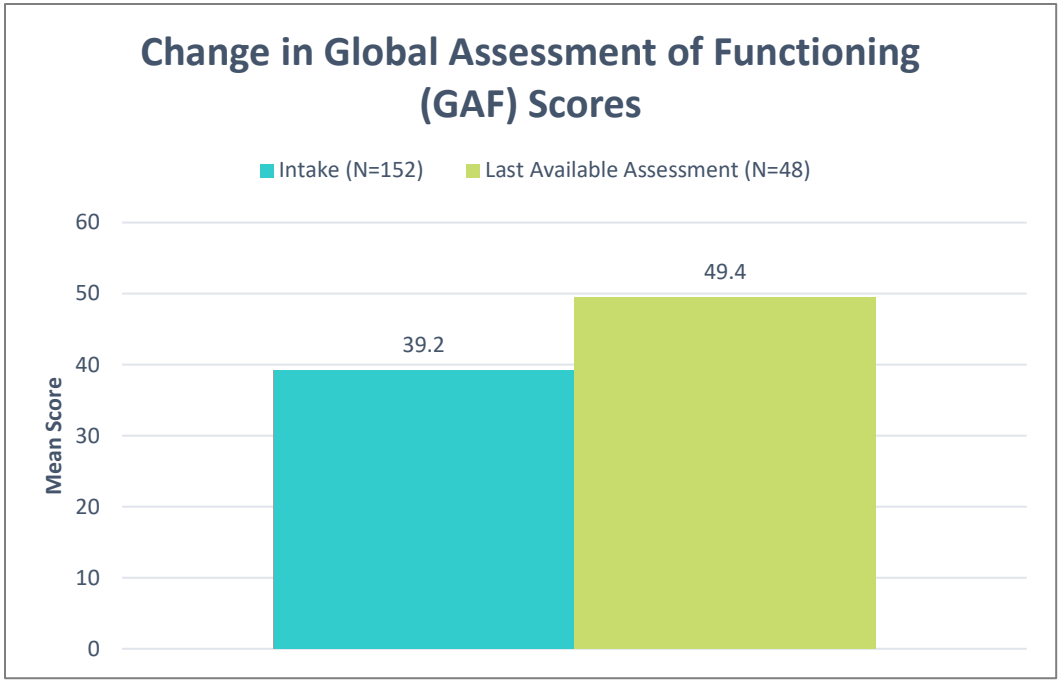
YOUTH OUTCOMES



A higher score on any Structured Interview for Psychosis-Risk Syndromes/Scale of Prodromal Symptoms (SIPS/SOPS) domain indicates higher symptom severity. On average, by the last available assessment, the severity of prodromal symptoms decreased compared to intake. Additional analyses were conducted with participants who had both an intake assessment and at least one other assessment. Participants included in these analyses showed statistically significant improvements ($p<.05$) on the Positive Symptoms, Negative Symptoms and General Symptoms Subscales.

*Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

YOUTH OUTCOMES continued

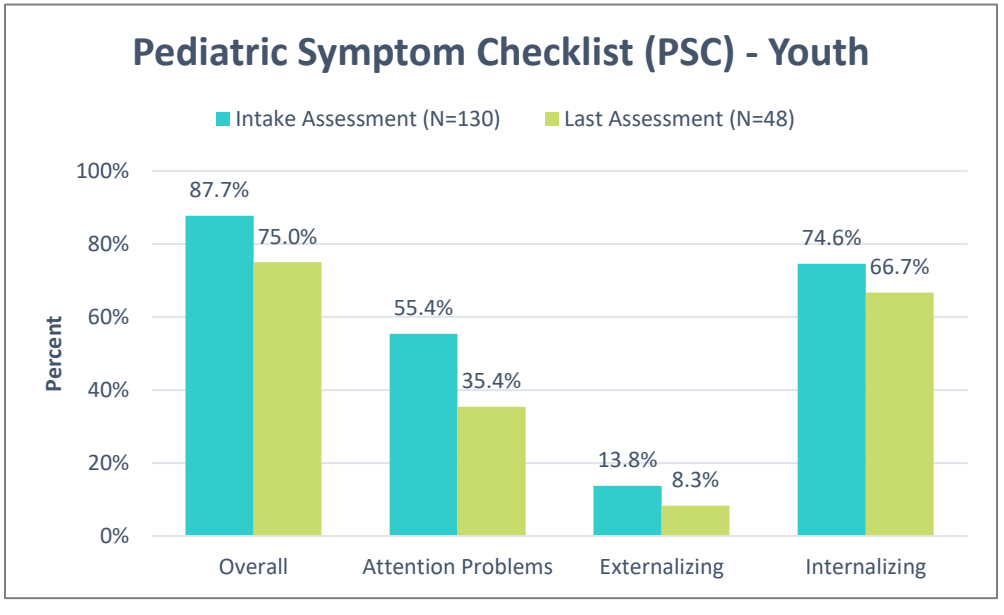


The GAF is scored on a scale of 0-100; a higher score indicates better social and psychological functioning. On average, participants' functioning improved between the intake and the last available assessment. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvements on their GAF Score ($p<.05$).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

YOUTH OUTCOMES continued

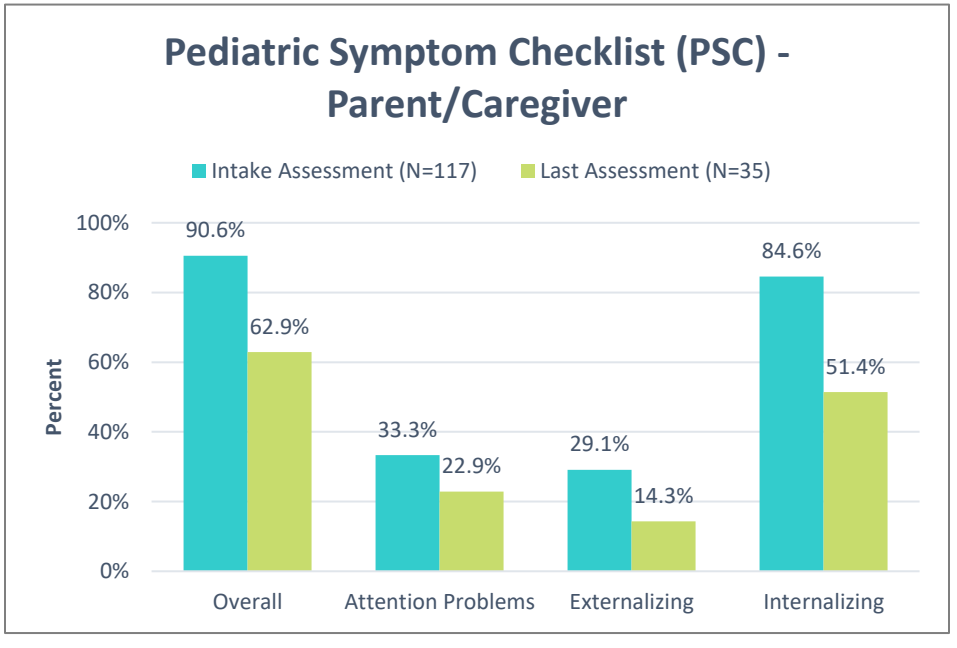
The Pediatric Symptoms Checklist (PSC) is completed by youth participants ages 11 to 18. At intake, nearly 88% percent of youth met the criteria for psychosocial impairment. Seventy-five percent of youth met the criteria for internalizing problems. On average, between the intake and the last assessment, the percent of youth whose scores indicated that they experienced impairment decreased for the total impairment score and all three subscales. For youth who completed both an initial assessment and at least one other assessment, there was a marginally significant ($p<.10$) decrease in impairment related to attention problems.



Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

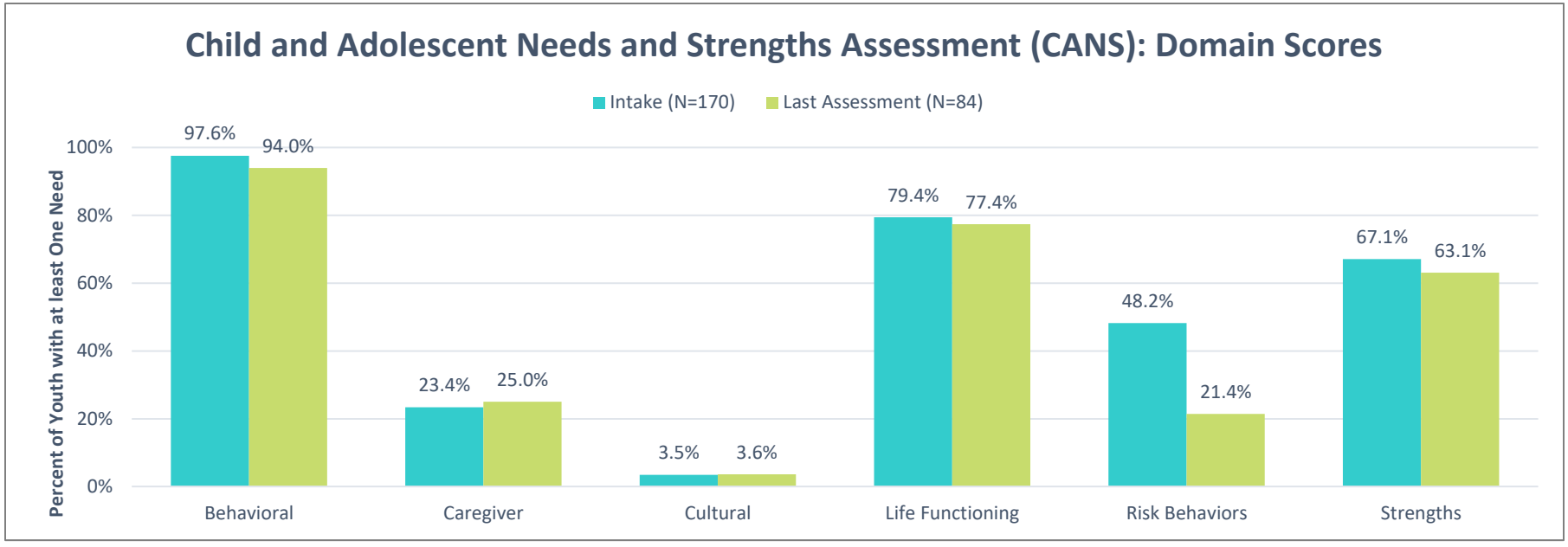
YOUTH OUTCOMES continued

The Pediatric Symptoms Checklist (PSC) is also completed by the parent/caregiver of youth participants ages 18 and younger. At intake, 91% of parents/caregivers indicated that their child met the criteria for experiencing overall psychosocial impairment. Nearly 85% of parents/caregivers reported that their child met the criteria for experiencing internalizing symptoms. On average, between the intake and the last assessment, the percent of parents/caregivers that reported that their child experienced impairment decreased for all subscales. For parents/caregivers who completed both an intake assessment and one additional assessment, there were statistically significant ($p<.05$) decreases in reports of impairment on the internalizing subscale and on the overall impairment score.



Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

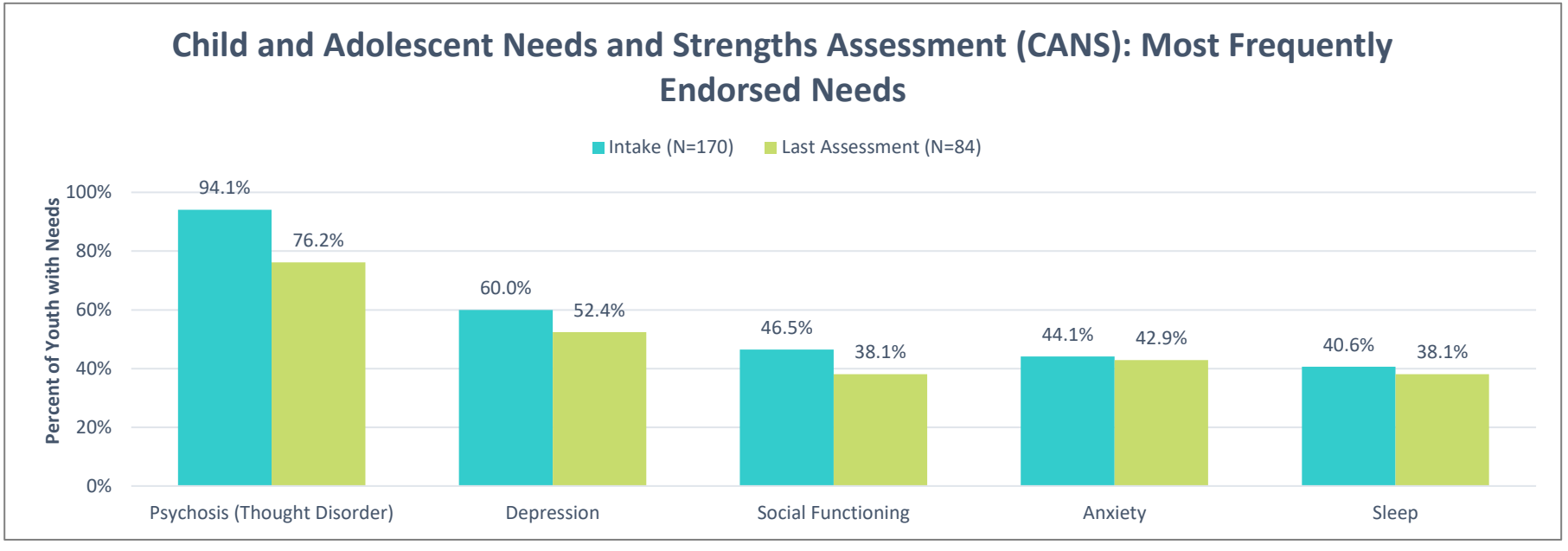
YOUTH OUTCOMES continued



The CANS is a 50-item measure completed by clinicians of youth ages 21 and younger. An analysis of the CANS subscales indicated that at intake 98% of youth participants had at least one behavioral or emotional need and 79% had at least one area of impaired life functioning. Nearly 67% of youth were identified as having at least one strength. With the exception of the strengths subscale, a decrease in the percent of respondents with need indicates improvement. Between intake and the last assessment, there were decreases in the behavioral, life functioning, risk behaviors and strengths subscales. Only the difference in risk behaviors was statistically significant at the $p<.05$ level.

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

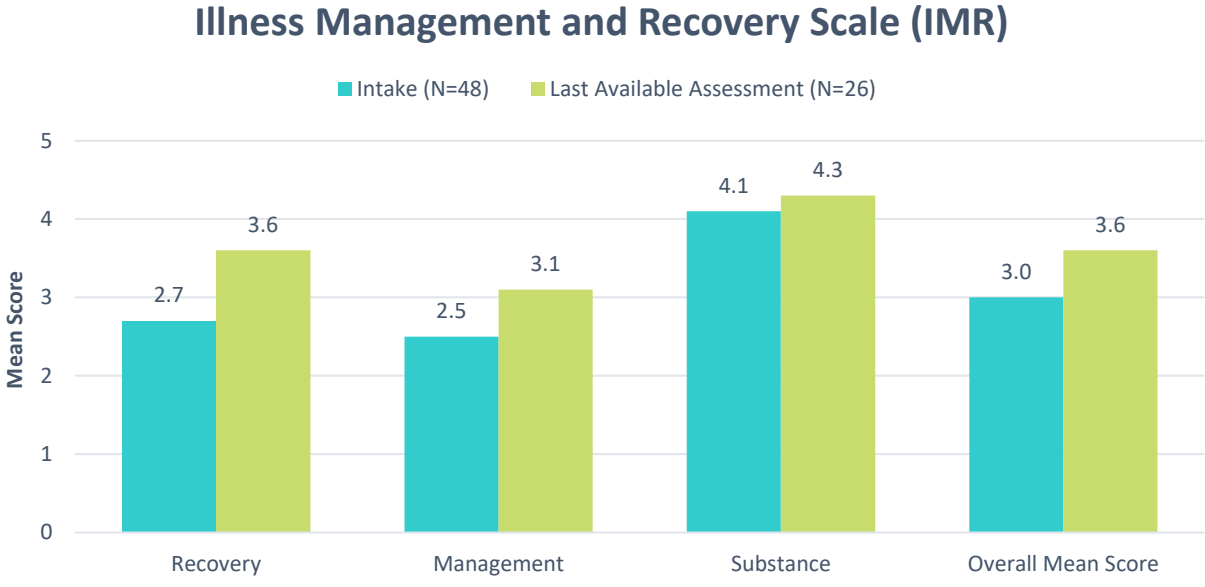
YOUTH OUTCOMES continued



In addition to analyzing the CANS subscales, the individual areas of need can also be evaluated. According to the clinicians' assessments, youth experienced the greatest needs at intake in the areas of psychosis (thought disorder), depression, social functioning, anxiety and sleep. On average, between the intake and the last assessment there were decreases in each of these areas of need. Separate analyses were conducted for youth with both an intake and at least one additional assessment. These analyses indicated statistically significant decreases in the area of psychosis (thought disorder; $p<.05$).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

OUTCOMES FOR YOUTH OVER 18



The IMR assessment is completed by the clinicians of participants 18 and older. Scores range between 1 and 5. An increase on any IMR subscale indicates improvement. On average, participants' overall mean scores improved between the intake and last available assessment. An additional analysis was conducted with participants who had both an intake and a second assessment. Participants included in this analysis showed statistically significant improvements on the Recovery, Management and Overall Subscales ($p<.05$).

The **Recovery Markers Questionnaire (RMQ)** is administered to participants 18 and older. Scoring ranges between 1 and 5. An increase on the RMQ mean score indicates improvement. Participants' scores improved significantly ($p<.05$) between the intake assessment (mean= 3.5; N=44) and the last available assessment (mean = 3.9; N=21).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

FAMILY MEMBER INCREASES IN KNOWLEDGE

Of the 79 caregivers* who attended the family psycho-education group and completed both a pre-test and a post-test, 34 (43%) demonstrated an increase in knowledge of how to support youth with prodromal symptoms. Additionally, 13 caregivers (16%) had a perfect score on both the pre-test and the post-test.

79

CAREGIVERS ATTENDED THE GROUP AND COMPLETED BOTH A PRE-TEST AND A POST-TEST

34

CAREGIVERS DEMONSTRATED AN INCREASE IN KNOWLEDGE OF HOW TO SUPPORT YOUTH WITH PRODROMAL SYMPTOMS

13

CAREGIVERS HAD A PERFECT SCORE ON BOTH THE PRE-TEST AND POST-TEST

*May include duplicate data

COMMUNITY OUTREACH PSYCHO–EDUCATION GROUP

The most endorsed community role among outreach psychoeducation group participants was mental health professional (37%).

Of the 135 community members who attended the outreach trainings and completed both a pre-test and a post-test, 94 (70%) demonstrated an increase in knowledge of risk factors for the development of psychosis and early intervention procedures. Additionally, 14 community members (10%) had a perfect score on both the pre-test and the post-test.

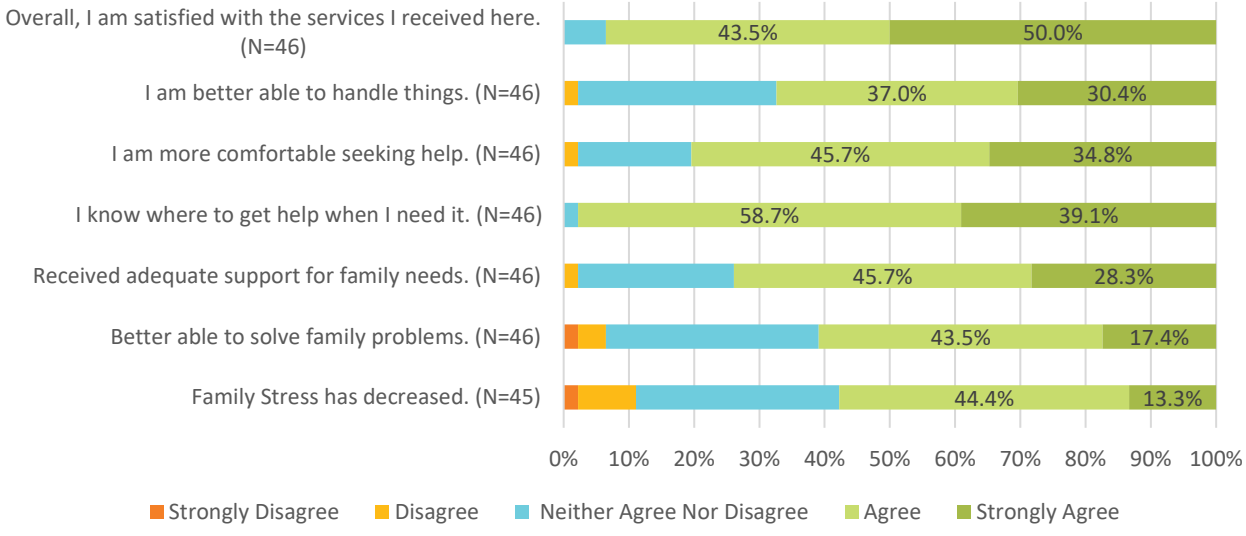
Community Role (N=197)*	N	%
School professional	7	3.6%
Medical professional	10	5.1%
Mental health professional	72	36.5%
Substance abuse counselor	<5	<1.0%
Youth worker	17	8.6%
Multicultural leader	<5	<1.0%
Member of clergy	<5	<1.0%
Employer	<5	<1.0%
Parent	7	3.6%
Member of a community group	16	8.1%
College student	12	6.1%
Missing	71	36.0%

**The sum of the percentages may exceed 100% because participants can identify as more than one role.*

Note: Percentages may not add up to 100% due to rounding.

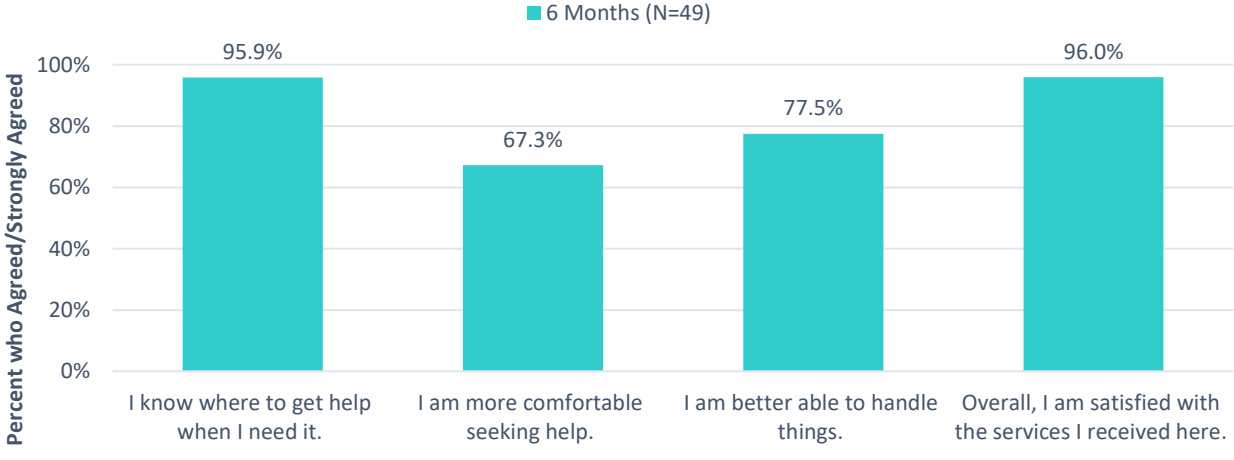
PARTICIPANT SATISFACTION* AND OUTCOMES

Family Satisfaction



Ninety-four percent of caregivers who completed a satisfaction survey agreed or strongly agreed that they were satisfied with the services they received. Approximately 98% agreed or strongly agreed that they knew where to get help as a result of the Kickstart program. Almost 74% agreed or strongly agreed that they received adequate support for their family needs as a result of the Kickstart program.

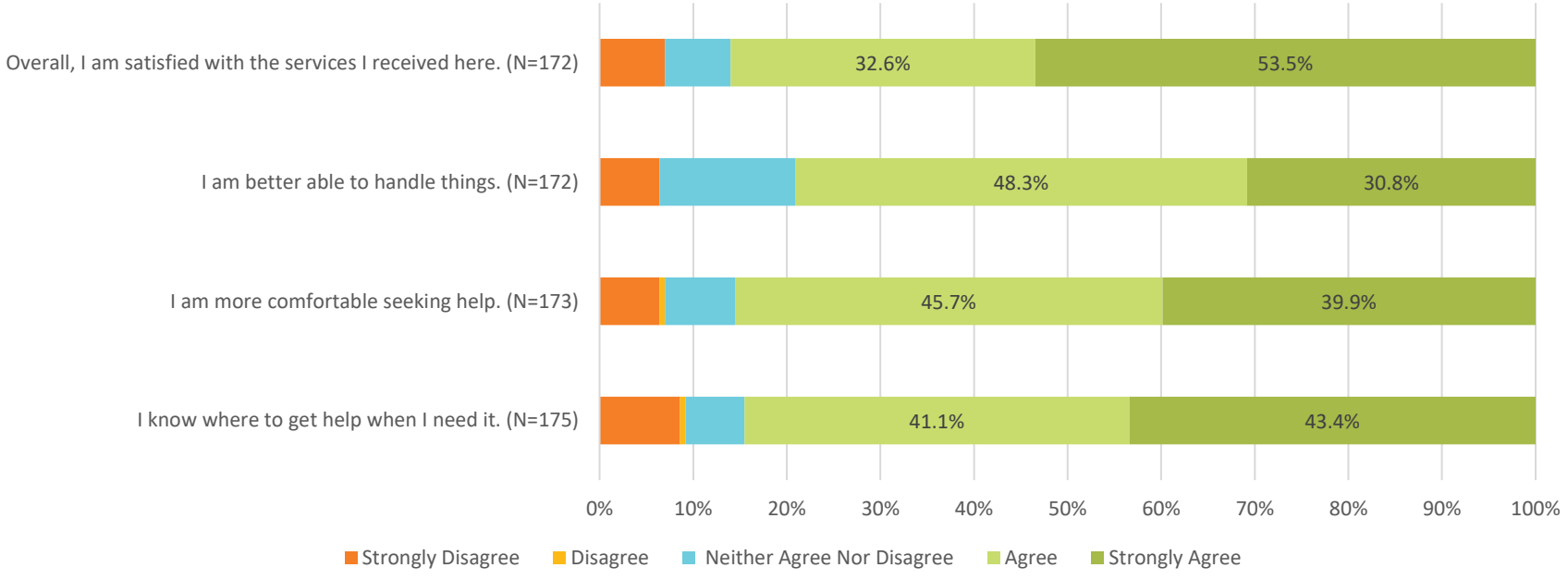
Youth Satisfaction



The majority of youth who responded to satisfaction questions at 6 months agreed or strongly agreed that they were satisfied with the services they received (96%) and that they knew where to get help as a result of the Kickstart program (96%). Youth satisfaction data at discharge are not presented because the sample size was too low to be reliable (N=2).

*Satisfaction data are not available for all participants.

COMMUNITY OUTREACH PARTICIPANT PROGRAM SATISFACTION*



Of the participants who completed an outreach satisfaction assessment, most agreed that they knew where to get help when they needed it as a result of the program (85%). Most also said that they felt more comfortable seeking help after receiving services (86%). Overall, 86% of participants who responded were satisfied with the services they received.

*Satisfaction data are not available for all participants.





CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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 San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly-funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

APPENDIX M

PEI COMPONENTS AND PRIORITIES

Prevention and Early Intervention (PEI) Priority Areas Fiscal Years 2023-24 through 2025-26

Work Plan	Contractor	Name of Program	1-Child Trauma PEI	2-Early Psychosis	3-Youth Outreach	4-Culturally Comp	5-Older Adults
CO-03	National Alliance for Mental Illness, San Diego	Integrated Peer & Family Engagement - Next Steps		x			x
DV-03	Union of Pan-Asian Communities	Community Violence Response Services	x				
DV-04	Home Start	Community Services for Families-East Regions	x				
DV-04	North County Lifeline	Community Services for Families-N Coastal/N Inland	x				
DV-04	Social Advocates for Youth, San Diego	Community Services for Families-Central	x				
DV-04	South Bay Community Services	Community Services for Families-South Region	x				
EC-01	Jewish Family Service of San Diego	Positive Parenting Program (Triple P)	x				
FB-01	Pathways Community Services, LLC	Early Intervention for Prevention of Psychosis - Kickstart		x	x		
NA-01	Southern Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x
NA-01	Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x
NA-01	San Diego American Indian Health Center	Native American Prevention and Early Intervention			x	x	
OA-01	Union of Pan-Asian Communities	Community-Based Services – For Older Adults				x	x
OA-02	Union of Pan-Asian Communities	Home Based Services - Positive Solutions				x	x
OA-06	Southern Caregiver Resource Center	Caregiver Support Services				x	
PS-01	TBD	Recuperative Services and Support Program for Transitional Age Youth			x		
PS-01	City of San Diego	Come Play Outside			x		
SA-01	South Bay Community Services	School Based PEI - South	x				
SA-01	Vista Hill Foundation	School Based PEI - North Inland	x				
SA-01	Palomar Family Centers	School Based PEI - North Coastal	x				
SA-01	San Diego Unified School District	School Based PEI - Central and North Central	x				
SA-01	San Diego Unified School District	School Based PEI - Central and Southeastern	x				
SA-01	San Diego Youth Services	School Based PEI - East	x				
PS-01	National Alliance on Mental Illness, San Diego	Clubhouse Program Services	x				
PS-01	Rescue Agency Public Benefit, LLC	Suicide Prevention and Stigma Reduction Campaign - It's Up to Us				x	
PS-01	County of San Diego - Community Health Promotion Specialists	Community Health Promotion Specialists			x		
PS-01	Mental Health America of San Diego	Mental Health First Aid				x	
PS-01	San Diego Workforce Partnership	Supported Employment Technical Consultant Services				x	
PS-01	Mental Health America of San Diego	ACEs Prevention Parenting Program for Fathers	x			x	
PS-01	Jewish Family Service of San Diego	Breaking Down Barriers				x	
PS-01	National Alliance for Mental Illness, San Diego	Family Peer Support Program				x	
PS-01	Community Health Improvement Partners	Suicide Prevention Action Plan				x	
RC-01	Vista Hill Foundation	Rural Integrated Behavioral Health & Primary Care		x			
RE-01	Community Health Improvement Partners	Independent Living Association (ILA)				x	
SA-02	San Diego Youth Services	School Based Suicide Prevention & Early Intervention - HERE Now			x		
VF-01	Mental Health Systems TURN Behavioral Health Services	Veteran & Family Outreach Education - Courage to Call				x	

PRIORITY AREAS

1 - Childhood Trauma Prevention and Early Intervention
2 - Early Psychosis and Mood Disorder Detection and Intervention
3 - Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
4 - Culturally Competent and Linguistically Appropriate Prevention and Intervention
5 - Strategies Targeting the Mental Health Needs of Older Adults

APPENDIX N

INNOVATIONS REPORTS



ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

INNOVATIONS-18

Annual Report
Year 3 (7/1/2021 - 6/30/2022)

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

v.12.22.2022

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

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The ADAPT program was designed to address unmet needs, improve access to treatment and reduce the negative health outcomes of perinatal mood and anxiety disorders, with a focus on women and families from underserved communities. A key component of the ADAPT program is the partnership with HHSA's Nurse Family Partnership (NFP) and Maternal Child Health (MCH) Home-Visiting programs to provide mental health services to public health nursing participants. ADAPT provides therapeutic treatment, peer support, linkage to community resources and support for the entire family. With the onset of the COVID-19 pandemic, in fiscal year (FY) 2020-21 the ADAPT program transitioned from primarily in-home, in-person services to providing the majority of services via telehealth/video calls. The program has since re-introduced in-person services in the community and is continuing to provide telehealth with reduced reliance on telephone-based services. ADAPT substantially expanded their referral partners during FY 2021-22 to accept eligible referrals (i.e., on Medi-Cal/qualify for Medi-Cal) from persons experiencing peripartum depression and anxiety anywhere in San Diego County.

Primary Findings for FY 2021-22

Increased Overall ADAPT Program Enrollment Serving Racially/Ethnically Diverse Participants

1. A total of 117 persons enrolled in the ADAPT program during FY 2021-22 (97 initial enrollments into Level-1 and 20 initial enrollments into Level-2). Of note, the 97 persons enrolled into Level-1 services during FY 2021-22 represented a 110.9% increase from FY 2020-21 in which 46 persons enrolled into Level-1 services.

2. The increased FY 2021-22 enrollment was the result of: 1) more referrals from the MCH and NFP public health nursing (PHN) programs (n=181) as the COVID-19-related burdens on those programs lessened, and 2) increased referrals (n=80) originating from other community and hospital partners. Total ADAPT enrollment remained less than the initial program goal (i.e., 117 unduplicated persons compared to a target of 300). The effects of the ongoing COVID-19 pandemic, while not as severe as experienced during FY 2020-21, continued to result in lower than initially expected referrals from public health nursing programs.
3. The ADAPT program served a racially and ethnically diverse population with the majority (67.5%) identifying as Hispanic/Latino and approximately 20% indicating that Spanish was their primary language.

Participants Experienced Improvements and Viewed ADAPT Program Favorably

4. As reported through both clinician and participant assessments, ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Additionally, improved sleep and less fatigue were commonly reported along with improvements in other key life domains such as better social relationships and ability to handle daily activities.
5. Participants expressed high levels of satisfaction with ADAPT services and indicated they would recommend ADAPT to family or friends experiencing peripartum depression and anxiety. As one participant stated, “Every mom should have this kind of support - you guys really care and go out of your way to support us.”

ADAPT Program Continued to Evolve to Support Effective and Sustainable Service Delivery

6. The ADAPT team continued to increase the amount of ADAPT services delivered via telehealth with video during FY 2021-22 while also providing more in-person services as conditions of the COVID-19 pandemic allowed (with telephone-based services decreasing). Feedback indicated that many participants preferred a hybrid service delivery model that allowed for the greater convenience and frequency of telehealth services while still having the option for in-person connections as needed. However, some clients expressed a preference for either primarily/exclusively in-person services or primarily/exclusively telehealth services, which highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.
7. To support the potential for long-term sustainability, during FY 2021-22 the ADAPT program completed the process to allow for Medi-Cal insurance reimbursement billing.

ADAPT Program Continued to Foster Community Partnerships

8. Ongoing communication remained critical to effective coordination between ADAPT and PHNs. PHNs continued to express recognition of the value of ADAPT services to their clients and indicated they wish the ADAPT program was available to more of their clients beyond the target population of Medi-Cal recipients, Medi-Cal eligible individuals, and those who are low income and uninsured.

9. The ADAPT program partnered with University of California researchers to pilot test the feasibility and effectiveness of community-based administration of an innovative Sleep and Light Intervention (SALI) to treat peripartum depression. ADAPT clients who voluntarily choose to participate in SALI engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session at a specific time of the day depending upon whether pregnant or postpartum. The study is ongoing with initial results suggesting high levels of feasibility to administer and complete SALI from the perspective of clinicians and participants. Additionally, participants have demonstrated meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors.

Conclusion

During FY 2021-22, the ADAPT program navigated the ongoing impact of the COVID-19 pandemic. While overall enrollment remained below initial goals (due in large part to the impact of the pandemic on PHN referrals), enrollment has increased substantially from FY 2020-21 (from 65 to 117). Continued expansion of referral sources is expected to increase enrollment in future years. Both clinician and participant assessments indicated that ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Other improvements included better social relationships and ability to handle daily activities, as well as better sleep and less fatigue. High levels of satisfaction were reported by participants and echoed by public health nurses, who reported substantial benefits for their ADAPT-enrolled clients.

Primary Recommendations for FY 2022-23

1. Continued emphasis on community outreach to raise awareness of ADAPT program services and increase the number of appropriate referrals.
2. Continued communication and collaboration with PHNs through case consultations, roundtable discussion, and other methods of engagement.
3. Explore opportunities for expanded Medi-Cal reimbursable services to be provided as appropriate to Level-2 participants.
4. Increased efforts to support staffing and workforce needs.
5. Explore potential for developing strategic partnerships to meet client psychiatric/medication management service needs.
6. Review incoming referral process to identify strategies to support efficient and effective workflow.

Program Description

The County of San Diego BHS ADAPT program is funded through the INN component of the MHSA, with services provided by behavioral health clinicians and peer support staff from Vista Hill Foundation, a community-based nonprofit organization. MHSA INN funding for ADAPT services was extended and is now expected to continue through 12/31/2023. ADAPT provides mental health services to clients of HHSA's public health NFP and MCH home visiting programs who have, or are at risk of, perinatal mood or anxiety disorders. NFP is a free, voluntary program that provides at-home nurse visitation services to qualifying first-time mothers prior to their 28th week of pregnancy and continuing through the child's second

birthday, many of whom are low-income. Through NFP, PHNs provide support, education and counseling on health, behavioral and self-sufficiency issues. MCH is also a free, voluntary prevention program that provides at-home nurse visitation to at-risk, pregnant, and postpartum women and their children from birth to five years old. Similar to NFP, PHNs in the MCH program provide support, health and parenting education, address bonding issues, medical, and mental risks.

The ADAPT program was developed in response to concerns about the high prevalence of unmet treatment needs for perinatal anxiety and depression among the women served by the MCH and NFP programs and the desire to prevent the negative consequences often related to perinatal mood disorders, including challenges to the family unit, difficult infant temperament, and emotional and cognitive delays in children of mothers with perinatal mood disorders. ADAPT provides therapeutic treatment, peer support, linkages to community resources, and support for the entire family, as well as other therapeutic interventions including skill building education, group skill building, case management, and facilitating collateral supports. Services are evidence-informed and include care coordination and case consultation. To facilitate better access to care services, the program was designed primarily to provide in-home visiting. As discussed in more detail below, the COVID-19 pandemic required ADAPT to shift their treatment approach from in-person visits to telehealth sessions. A key innovative component of the ADAPT program is the partnership between PHNs, the ADAPT mental health clinicians, and the peer support partners. During the COVID-19 pandemic, new referral partners have been added, and during FY 2021-22 ADAPT began accepting eligible referrals (i.e., on Medi-Cal/qualify for Medi-Cal) from persons experiencing peripartum depression and anxiety anywhere in San Diego County.

The ADAPT program was designed to provide two tiers of services. Level-1 participants meet criteria for Title IX specialty mental health services and peripartum criteria, evidenced in significant functional impairments including but not limited to clinically significant depression and/or anxiety. The persons in Level-1 received ongoing therapy as well as other supportive services. Level-2 participants did not meet full criteria for specialty mental health services but demonstrated impairments in functioning as well as risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors. These participants may have presented with less acute symptoms but were able to demonstrate risk and need for intervention to prevent development of functional impairments and maintain current functioning. Additionally, Level-2 included participants who would meet BHS eligibility for Level-1 services yet were receiving services from another mental health provider or reported not being interested in receiving mental health services at the time of initial assessment. Since ADAPT attempts to enhance the role of fathers/partners in therapeutic interventions as a way to reduce symptoms of maternal and paternal mental health disorders, Level-2 could also include family members of Level-1 participants.

COVID-19 Impact

In FY 2020-21, COVID-19 severely impacted the ability of the ADAPT program to provide in-home assessments and clinical sessions. Initially, services transitioned to telephone. As comfort level and capability with technology increased, the emphasis shifted to telehealth with video as this enabled the participants and service providers to see one another during sessions. As federal- and state-guided COVID-19 precautions became less stringent, ADAPT has reinstated efforts to meet in person with participants. Initially, in-person visits typically occurred in outdoor settings accessible to the participant. Once COVID-19 safety guidelines permitted, providers were able to meet with clients in their homes or other preferred

settings if the participant so desired. Reflecting these broad changes in how services were delivered, during FY 2021-22 in-person services increased but the majority of services were still provided via telehealth with video (see Table 3). A more detailed discussion of ADAPT experiences with providing telehealth services and the impact of COVID-19 on staff is included in other sections of the report.

Participant Characteristics

A brief overview of ADAPT participant characteristics is presented here with a more complete listing in the appendix. As shown in Table 1, a total of 117 unique persons enrolled in the ADAPT program during FY 2021-22 (97 initial enrollments into Level-1 and 20 initial enrollments into Level-2). The 117 people enrolled into ADAPT during FY 2021-22 represented 114 different families with a total of 197 children in the households (including those not yet born at the time of ADAPT program enrollment). Of note, the 97 persons enrolled into Level-1 services during FY 2021-22 represented a 110.9% increase from FY 2020-21 in which 46 persons enrolled into Level-1 services.

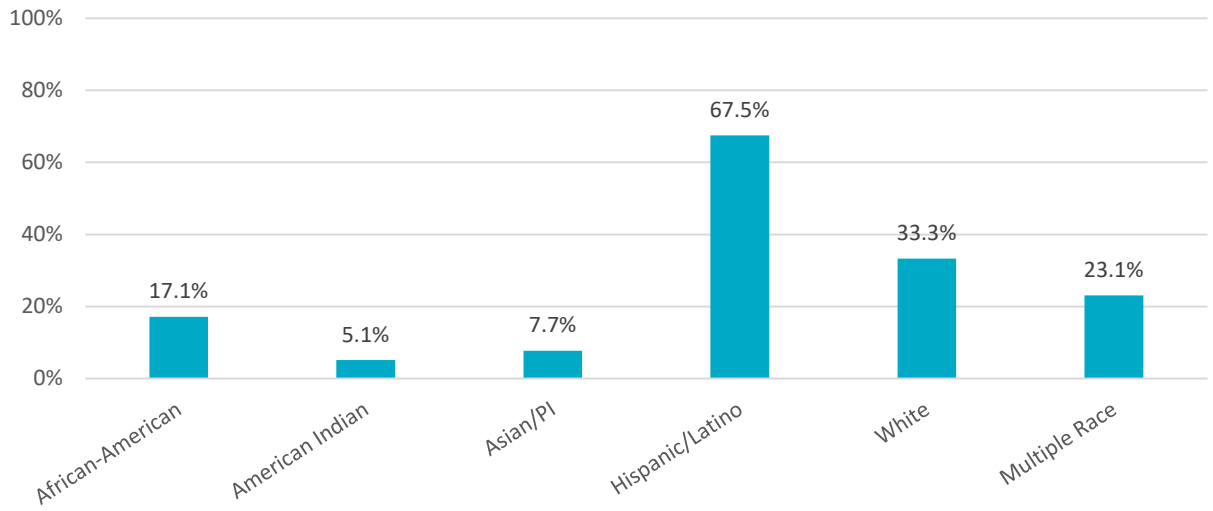
Table 1. ADAPT Program Enrollment for FY 2021-22 (N=117 unique persons)

	FY 2021-22
Enrollment By ADAPT Service Level	**n**
Level-1 services (i.e., ongoing therapy services)	97
Level-2 services (i.e., education and support services)	20
Total unique ADAPT enrollees	**117**

The increased FY 2021-22 enrollment was primarily the result of: 1) more referrals from PHN programs as the COVID-19-related burdens on those programs lessened (i.e., 181 referrals comprised of 124 from MCH and 97 from NFP), and 2) increased referrals originating from other community and hospital partners (i.e., 80 referrals comprised of 64 from Sharp Mary Birch, 9 from Sudden Infant Death Syndrome (SIDS) program, and 7 from other community organizations. Total ADAPT enrollment remained less than the initial program goal (i.e., 117 unduplicated persons compared to a target of 300). The effects of the ongoing COVID-19 pandemic, while not as severe as experienced during FY 2020-21, continued to impact referrals from PHN programs.

Across both service levels, 96.6% of participants identified as female (n=113). The majority indicated English was their primary language (77.8%; n=91), with 19.7% (n=23) selecting Spanish as their primary language (served by Spanish-speaking ADAPT staff). Nearly 90% of participants (88.0%; n=103) identified as heterosexual or straight. Slightly more than 1/3 of ADAPT participants (35.9%) were Transitional Age Youth aged 18-25 and the majority (50.4%) between the ages of 26 and 35. As shown in Figure 1, the ADAPT program served a racially and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (67.5%; n=79).

Figure 1. Race/Ethnicity of ADAPT Participants (N=117)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

ADAPT participants also completed the Adverse Childhood Experiences (ACE) questionnaire at program intake. The ACE is scored from 0 to 10 with higher values signifying more trauma experiences. The ACE seeks to quantify a person's exposure to specific types of childhood trauma at home, with a score of 4 or more considered to be a risk factor for experiencing health and mental health problems as an adult. The mean ACE score among ADAPT participants was 4.3 with approximately half of ADAPT participants (46.7%) having an ACE score of 4.0 or greater. These findings indicate that many of the persons served by ADAPT have experienced substantial levels of childhood trauma that may be affecting their current well-being.

Utilization of Program Services

Level-1 Services

Based on data from the San Diego County BHS electronic health record system, Table 2 describes the number and type of services provided by licensed and license-eligible clinicians on the ADAPT team for persons enrolled in Level-1 during FY 2021-22. The information indicates that on average *during each 30 days enrolled in ADAPT*, participants typically received approximately 4.3 ADAPT services (comprised primarily of an average of 0.6 assessment visits, 2.2 therapy visits, and 0.6 rehabilitation visits per each 30 days enrolled in ADAPT). Therapy visits included both individual and family therapy. While family therapy was rarely utilized as a specific treatment modality, ADAPT services were still anticipated to provide benefits to the overall family unit directly and indirectly through case management and resource support. Of note, ADAPT team members were available to respond to crisis events and did so on less than five occasions during FY 2021-22. This highlights the importance of having a program like ADAPT connected with these persons to address potentially serious situations, while the rarity of such events also suggests that the ADAPT team was generally able to provide support and services that prevented the need for crisis care for almost all ADAPT participants.

Table 2. ADAPT Level-1 Services during FY 2021-22 (N=122)

ADAPT Service Type	Persons with at least one service		Total ADAPT services provided	Average number of services per person, per 30-day period
	n	%		
Any ADAPT service	118	96.7	1,816	4.3
Assessment/Tx. plan development	97	79.5	270	0.6
Therapy (i.e., by licensed clinician)	93	76.2	947	2.2
Rehabilitation (i.e., by peer support or other professional)	48	39.3	237	0.6
Crisis	<5[1]	4.2	<5[1]	<0.1
Case management	59	48.4	172	0.4
Other services (e.g., collateral)	75	61.5	189	0.5

[1] *Exact number masked due to the small number of persons experiencing this event.*

The average time in the ADAPT program was 130.6 days, with a median time of 155 days for the 79 persons who discharged from Level-1 services during FY 2021-22. Approximately 25% of these persons had a relatively short engagement with ADAPT (less than 50 days) and 25% participated in ADAPT for more than 180 days (with maximum program duration of 274 days). Overall, the typical length of time receiving ADAPT services was 5-6 months.

As shown in Table 3, the method used to deliver ADAPT services fundamentally shifted over the years due to the onset of the COVID-19 pandemic. Prior to the pandemic, the majority of ADAPT services were provided face-to-face. During the initial months of the pandemic (i.e., the end of FY 2019-20), services shifted to primarily telephone-based. At that time, since ADAPT had never before offered telehealth with video, only a small number of services were conducted that way. Throughout FY 2020-21, Vista Hill updated policies allowing for telehealth and made efforts to ensure staff were comfortable and equipped with the necessary technological tools. Utilization of telehealth with video has steadily increased from FY 2019-20 to FY 2021-22, (9.4% to 64.7%) reflecting an increased capacity for and comfort of both staff and participants in engaging in this treatment modality (as opposed to conducting remote visits via telephone).

Table 3. Type of ADAPT Service Contact

	FY 2019-20		FY 2020-21		FY 2021-22	
Contact Type	**n**	**%**	**n**	**%**	**n**	**%**
Telehealth with video	150	9.4	720	59.3	1,175	64.7
Telephone	426	26.7	368	30.3	275	15.1
Face to face	1,011	63.5	112	9.2	357	19.7
Other	6	0.4	14	1.2	9	0.5
Total Services	**1,593**	**100**	**1,214**	**100**	**1,816**	**100**

As COVID-19 safety concerns decreased from FY 2020-21 to FY 2021-22, the percentage of face-to-face visits increased (from 9.2% to 19.7%) while telephone visits decreased during the same timeframe (from 30.3% to 15.1%).

Level-2 Services

A total of 30 persons participated in Level-2 services, including 20 enrolled directly into Level-2 and 10 who were enrolled from the prior FY but still active in FY 2021-22. These 30 persons received a total of 296 unique Level-2 ADAPT service contacts during FY 2021-22, which is nearly identical to the 300 Level-2 services provided in FY 2020-21. Level-2 participants received an average of 10.6 ADAPT services (median = 8 services), provided by Peer Support Partners on the ADAPT team. Table 4 highlights the most common types of services provided during Level-2 service contacts, which typically focused on educational/skill-building opportunities or assistance with basic needs. Both staff and participants noted the importance of being able to help address basic needs (e.g., food insecurity, etc.) as this can alleviate a major source of family distress. Additional types of supports provided to some Level-2 ADAPT participants addressed a wide range of other issues including housing assistance, employment services, navigating public benefit or legal issues, or assistance with obtaining needed physical health care.

Table 4. Most Common Types of FY 2021-22 ADAPT Level-2 Service Encounters

	ADAPT Level-2 Service Encounters			
	Total persons (N=30)		Total services (N=296)	
	Number of Persons with service	Percent of persons with service	Number of services	Percent of total services*
Goal Setting Skills	21	70.0	66	22.3
Self-Regulation Skills	18	60.0	111	37.5
Mindfulness Skills	16	53.3	78	26.4
Mental Health Education	15	50.0	31	10.5
Basic Needs	15	50.0	26	8.8
Parenting Skills	9	30.0	18	6.1
Organization Skills	9	30.0	23	7.8
Social Health	9	30.0	21	7.1

** Total may exceed 100% as multiple services could be provided during an encounter.*

For the 26 persons who discharged from Level-2 ADAPT services during FY 2021-22, the average time in the ADAPT program was 117.2 days (median of 103.5 days). Level-2 participation was typically shorter than that for persons receiving Level-1 services with very few requiring services beyond the standard 6-

month program duration. These findings potentially suggest that participation in Level-2 services prevented or reduced the need for engaging in a higher level of care.

Primary Program Outcomes

Due to the small number of Level-2 participants enrolled during FY 2021-22 and their differing service needs, participant outcomes referenced in this section only include the Level-1 participants.

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-report scale developed to identify individuals who may have postpartum depression in outpatient, home-visiting settings, or at the 6-8 week postpartum examination in a physician's office. Individuals indicate which response comes closest to how they have felt over the previous seven days. Each item is scored on a 0 to 3 scale, with higher scores reflecting worse condition/more distress. The maximum score is 30 and scores over 10 are considered to indicate likely depression. The EPDS was administered upon entry into ADAPT and then regularly thereafter as part of clinical/safety assessment and treatment planning (i.e., re-administration of the EPDS was done more frequently than other evaluation measures discussed below due to its direct use as part of treatment and risk assessment/mitigation).

As shown in Table 5, during FY 2021-22 the average EPDS score at intake was 12.2, which reduced to 8.6 at the last EPDS follow-up assessment. This is a statistically significant change in the total EPDS score and reflects an overall reduction in symptoms as reported by ADAPT program participants. A total of 73.5% of all participants demonstrated at least some reduction in depression symptoms at follow-up. A statistically significant reduction of similar magnitude was also identified during FY 2020-21 (i.e., from 12.7 at intake to 8.9 at follow-up).

Additional analyses that compared the FY 2021-22 EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 10.9. This finding suggests that, on average, a reduction in depressive symptoms begins within the first 30 days, followed by continued improvement with further treatment.

Table 5. Change in EPDS Scores from Initial Assessment to Last Follow-up Assessment by FY

	FY 2021-22			FY 2020-21		
		Initial EPDS	Last available EPDS		Initial EPDS	Last available EPDS
EPDS Item *(Note: higher value = worse condition)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
I have been able to laugh and see the funny side of things	98	0.5	0.4*	62	0.7	0.4**
I have looked forward with enjoyment to things	98	0.7	0.4**	62	1.0	0.6**
I have blamed myself unnecessarily when things went wrong	98	1.8	1.3**	62	1.9	1.5**
I have been anxious or worried for no good reason	98	1.9	1.4**	62	2.0	1.5**
I have felt scared or panicky for no very good reason	98	1.3	0.9**	62	1.4	0.8**
Things have been getting on top of me	98	1.8	1.4**	62	1.7	1.3*
I have been so unhappy that I have had difficulty sleeping	98	1.3	1.0*	62	1.3	1.0*
I have felt sad or miserable	98	1.4	1.0**	62	1.4	1.0**
I have been so unhappy that I have been crying	98	1.2	0.7**	62	1.2	0.7**
The thought of harming myself has occurred to me	98	0.2	0.1*	62	0.2	0.1
EPDS Total Score	**98**	**12.2**	**8.6****	**62**	**12.7**	**8.9****
Likely Depression (i.e., score >=10)	**-**	**68 (69.4%)**	**41 (41.8%)**	**-**	**45 (72.6%)**	**27 (43.5%)**

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

While the EPDS total score is generally utilized as an indicator of the extent to which a person is experiencing depressive symptoms, an examination of the individual EPDS items can help identify the specific types of changes experienced. For persons served by ADAPT, changes were evident across all dimensions. The items from FY 2021-22 with the largest changes from intake consisted of reductions in self-blame, anxiousness, and unhappiness (i.e., average EPDS differences of at least 0.5). While not commonly endorsed at intake, it is important to also note that the critical risk item related to thoughts of self-harm decreased significantly at follow-up. The pattern of reductions across the individual items paralleled the changes observed in FY 2020-21. Overall, the findings demonstrated that ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

Illness Management and Recovery Scale-Reduced

To measure clinician perceptions of client recovery and improved illness management, a shortened version of the Illness Management and Recovery-Reduced (IMR-R) scale was completed by ADAPT providers. The IMR-R included 9 of the 15 items from the full IMR that were determined to be most relevant to the ADAPT program services and the focal service population (via review and consensus between representatives from ADAPT, BHS, and the evaluation team). Each item on the scale has a 5-point behaviorally defined response option tailored to that specific domain. Items are rated from 1 to 5, with higher values indicating less impairment/better functioning. The IMR-R was administered upon entry into ADAPT and then at 90-day follow-up intervals, documenting the amount of potential initial impairment and the extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians.

As shown in Table 6, the initial IMR-R ratings varied substantially across the individual items. For FY 2021-22, average ratings for many items were between 2 and 3 which is generally indicative of moderate impairment. Symptom distress was the lowest rated item at 2.2, indicative of fairly high levels of mental health-related distress upon entry to ADAPT. Conversely, medication management and substance abuse were rated as areas of less concern (i.e., intake ratings of 5). This pattern of FY 2021-22 intake IMR-R scores was similar to that observed during FY 2020-21.

Table 6. Change in IMR Scores from Initial Assessment to Last Follow-up Assessment

	FY 2021-22			FY 2020-21		
(Note: higher value = better condition)		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
IMR Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
Progress towards personal goals	62	3.0	3.5**	39	2.4	3.5**
Knowledge about symptoms, treatment, coping strategies, and medication	64	3.0	3.7**	39	2.6	3.6**
Involvement of family and friends in his/her mental health treatment	64	2.8	3.3**	39	3.2	3.4
Symptom distress	64	2.2	3.2**	39	1.9	2.9**
Impairment of functioning	63	2.6	3.4**	39	2.3	3.2**
Coping with mental or emotional illness from day to day	64	2.8	3.7**	39	2.6	3.7**
Effective use of psychotropic medication	4	5.0	5.0	7	3.4	4.3
Impairment of functioning through alcohol use	62	5.0	5.0	39	4.9	4.9
Impairment of functioning through drug use	62	5.0	5.0	39	4.9	5.0
Overall	**64**	**3.3**	**3.9****	**39**	**3.1**	**3.8****

***statistical significance at p < 0.01*

During FY 2021-22 the overall IMR-R score increased from 3.3 to 3.9, indicating a statistically significant change and evidence of clinically meaningful improvements within the participant population. Among the

individual items, medication management and substance use maintained their positive intake levels (i.e., high functioning/less impairment), and many of other items achieved a gain of 0.5 to 1.0. Particularly notable were the ratings of symptom distress, improving from 2.2 to 3.2, indicating clients went from being bothered "quite a bit" by their symptoms at intake to only "somewhat" at follow-up. Consistent with prior year results, the FY 2021-22 IMR-R result indicated the achievement of important improvements to minimize symptom distress and impairment, while also increasing knowledge, coping skills, and progress towards personal goals to help maintain benefits and minimize risks of future recurrence of symptoms.

Wellness Survey Questionnaire

The ADAPT Wellness Survey is a self-report tool administered to participants upon enrollment into ADAPT and then every 90 days thereafter. Survey items were rated on a scale from 1 to 5, with higher values representing the better or more desirable response.

During FY 2021-22, self-reported improvements occurred across multiple dimensions with statistically significant changes occurring for ratings of quality of life, physical health, mental health/mood, satisfaction with social activities/relationships, ability to carry out everyday activities, emotional problems and fatigue (see Table 7). Notably, ratings of hopefulness about the future also improved. The findings from FY 2021-22 were generally similar to those identified during FY 2020-21.

New questions were added in FY 2021-22, and many revealed statistically significant improvements in wellness. Clients reported improvements in sleep, sense of rest, and pain. Additionally, they reported significant improvement in skills and resources in managing conflict with their partner or supportive other.

Table 7. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment

	FY 2021-22			FY 2020-21		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items *(Note: higher value = better condition; Scale of 1 to 5)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
In general, would you say your quality of life is:	65	3.2	3.5**	39	3.3	3.3
In general, how would you rate your physical health?	65	2.9	3.2*	40	2.9	3.0
In general, how would you rate your mental health, including your mood and your ability to think?	65	2.3	3.1**	40	2.5	3.0**
In general, how would you rate your satisfaction with your social activities and relationships?	65	2.5	3.1**	40	2.8	3.0
In general, please rate how well you carry out your usual social activities and roles.	65	3.0	3.4**	40	3.1	3.2
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	65	3.8	4.2*	40	3.8	4.0

Table 7. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment (continued).

Select Wellness Survey Items *(Note: higher value = better condition; Scale of 1 to 5)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	65	2.3	3.2**	40	2.6	2.9
My child(ren) had emotional and/or behavioral problems.	48	3.9	4.0	35	4.7	4.2*
I felt hopeful about the future.	65	3.7	4.0^	40	3.5	4.2**
I felt spiritually connected.	65	3.6	3.8	40	3.1	3.6*
I lived in a home that made me feel safe.	65	4.6	4.7	40	4.5	4.7
I used substances (alcohol, illegal drugs, etc.) too much.	65	4.9	4.9	40	4.9	5.0
How would you rate your fatigue on average?	65	2.8	3.3**	40	2.9	3.1
I get the emotional help and support I need from supportive others.	54	3.6	3.8	N/A		
When I am in distress, I can identify supportive others and may use my supportive others.	54	3.9	4.1	N/A		
Conflict with my partner or supportive others interferes with my ability to respond to everyday life challenges.	54	3.5	3.8	N/A		
I have the skills and resources needed to manage stress stemming from conflict with my partner or supportive other.	54	3.6	4.1**	N/A		
(Note: These items are rated on a scale of 1-10 with higher ratings = worse condition)	**N**	**Mean**	**Mean**			
How would you rate your sleep?	54	5.8	2.6**	N/A		
How would you rate your sense of rest?	54	6.0	2.6**	N/A		
How would you rate your alertness?	54	4.1	2.5	N/A		
How would you rate your pain on average?	65	3.5	2.9**	N/A		

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

ADAPT Participant Feedback Survey

Every 90 days and at discharge, ADAPT participants were asked to rate the extent to which they were achieving specific ADAPT objectives. For FY 2021-22, 93.8% of participants indicated they knew where to get help and 92.3% indicated they were better able to handle things because of participating in ADAPT (see Table 8). Further, ADAPT participants were extremely positive about their experiences. Nearly 100% (98.4%) of participants indicated that services were available at convenient times, they were able to receive all needed services, that staff were sensitive to cultural background, and they were satisfied with ADAPT services. A similar pattern of participant responses was identified during FY 2020-21. These findings, particularly as related to service availability and cultural support, indicate that the ADAPT

program has accomplished the goal of connecting with participants and meeting their needs in a manner which is convenient for and respectful of the participants.

Table 8. ADAPT Participant Feedback Survey

	FY 2021-22 (N=65)	FY 2020-21 (N=43)
ADAPT Participant Feedback Survey Item	**Agree/Strongly Agree**	**Agree/Strongly Agree**
As a result of participating in ADAPT:	**%**	**%**
I know where to get help when I need it.	93.8	97.7
I am more comfortable seeking help.	92.3	97.7
I am better able to handle things.	92.3	86.0
Experiences with ADAPT services:	**%**	**%**
Services were available at times that were good for me.	98.4	100
I was able to get all the services I thought I needed.	98.4	95.3
Staff were sensitive to my cultural background (race, religion, language, etc.).	98.4	100
Overall, I am satisfied with the services I received here.	98.4	95.3

To elicit additional feedback on the program, ADAPT staff asked program participants to engage in a short qualitative survey in June 2022. Participants were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with ADAPT leadership and BHS input. Participants were given a short script explaining the purpose of the survey, and informed that feedback was voluntary, confidential and would not affect services. A total of 18 program participants provided feedback. Given that this information was collected from a sample of persons receiving services at one particular time during the FY, the findings may not reflect the perceptions of all ADAPT participants; however, many of the findings are consistent with data collected in prior years and via other feedback mechanisms such as the ADAPT Participant Feedback Survey administered throughout the year, which increases confidence in their generalizability to the overall ADAPT program. Additionally, it should be noted that the interviews were conducted by ADAPT program staff and therefore could be positively biased.

A little over half of respondents (55%; n=10) indicated that they had not received services and/or medication to help with mental health or substance use related concerns in the five years prior to ADAPT participation. For some clients, the peripartum depression and anxiety symptoms experienced may be their first mental health challenges that rose to the level of needing intervention. For other clients, they may have had difficulty with or discomfort seeking services for symptoms in the past. Regardless of past need or level of usage, participants noted that ADAPT offers timely support and mental health resources. All the respondents (100%) said they would refer a friend or family member to ADAPT. They described

how the program helped them, so it could help others as well. One client stated, “Every mom should have this kind of support - you guys really care and go out of your way to support us.”

The following sections present key themes that emerged from the qualitative participant responses.

The ADAPT Program was Different from Prior Treatment Experiences

Clients shared feedback about ADAPT as compared to services they had received previously. A selection of comments are as follows:

> “For the first time I felt safe and understood by my therapist. I have seen lots of counselors and therapists starting from when I was [younger]. I think my therapist has made the biggest difference because she always listens to me and helps me think of new ways to get better.”
>
> “ADAPT has more quality treatment and I feel more comfortable with ADAPT providers.”
>
> “[ADAPT is] more intensive and tailored to my needs.”

Client Preferences for In-Person and Telehealth Services Vary

When ADAPT began in FY 2019-20, services were primarily provided in person. Due to the onset of COVID-19, there was a rapid shift to remote services (i.e., telephone or telehealth with video). As safety demands of COVID-19 have decreased, clients have had more opportunities for in-person visits when desired. When asked about their preference between the available options (i.e., in-person vs. remote), respondents answered as follows:

- 6 respondents (33%) stated they prefer only/primarily remote services
- 8 respondents (44%) indicated they prefer having both remote and in-person services
- 4 participants (22%) stated they prefer only/primarily in-person services

Reasons for preferring remote services included social anxiety or considering themselves an “introvert.” Others preferred telehealth due to the flexibility and/or other having other obligations (“I have 4 kids and it would be almost impossible for me to do it in person”). Clients who appreciated the choice between in-person and remote services shared, “In-person would be nice to go to but remotely allows me flexibility as a mom” and “I like in-person because it's easier, but also like the online because sometimes I'm really busy.” The four participants who preferred in-person services commented on technological difficulties and the quality of the interaction over video. In this regard, improved capacity to engage successfully in telehealth sessions would likely increase the number of persons who would prefer telehealth as an option to receive ADAPT services.

This feedback highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.

Positive Impact of ADAPT on Clients

100% of survey respondents (n=18) stated that ADAPT has had a positive effect on their life. Impacts included improved communication skills, emotion management, relationships, and better understanding of themselves and/or others. Responses included the following:

> "I don't feel as crazy as I used to because now I have learned about [my disorder] and ways to deal with it. It helped me understand how my childhood impacted me so I can be a better mom than I had. Being part of the program, I was able to apply and enroll to college, find transitional housing for my baby and I, plus I know lots more resources."
>
> "ADAPT helped me to improve and lessen anxiety and have been yelling less at others."
>
> "I truly am so thankful for your support, it is so helpful and has made a big difference. I have been able to work through a lot of anger…"

Other clients mentioned a new awareness of community resources and a sense of feeling heard and supported based on their experiences in ADAPT.

Participant Recommendations

The majority (72.2%; n=13) of the survey respondents offered no recommendations to improve the program and were happy with it as is. Approximately 25% (n=5) suggested that to improve ADAPT, the length of program should be extended. Of note, this recommendation to have services available for more than the standard six months was consistent with feedback provided to the ADAPT program via the Participant Advisory Group (PAG) meetings. Other suggestions were about increasing options for electronic communication, specifically the desire to be able to text their therapist.

Referral Partner Feedback Survey

In June 2022, PHNs and other referral partners were asked to complete a brief online survey to obtain feedback regarding their experiences with the ADAPT program. Survey questions were largely open-ended and served to explore referral partners' understanding of the ADAPT program and elicit recommendations for program improvement. A total of 94 referral partners (e.g., PHNs and other providers) were invited and 15 completed the online survey (response rate of 16.0%). While the low response rate prompts some caution when interpreting the results, the core themes (presented below), are consistent with feedback received in prior years and from other feedback mechanisms such as through the PHN consultations and roundtables. Those who did participate generally had an ongoing relationship with the ADAPT program with almost all (93%; n=14) indicating they had referred at least three clients to ADAPT during FY 2021-22, with 53% (n=8) having referred 6 or more clients. Responding referral partners represented public health programs (47%; n=7), local hospitals and clinics (40%; n=6), and other community agencies (13%; n=2). While the sample sizes were too small for detailed comparisons and conclusions, in general, the feedback was similar between the types of referral partners. Several themes emerged from the referral partners' feedback.

Increased Access to Care

In open-ended responses, 14 out of 15 referral partners mentioned that the ADAPT program has helped to ensure that their patients are connected to appropriate mental health services. Respondents described how "ADAPT has made it easy to refer clients who are in need of peripartum mental health services" and "without this program there isn't much concrete I can do to get them help." ADAPT has improved access to care particularly for depressed individuals, remote clients, and those with public health insurance:

> "When someone is in a state of despair sometimes it's hard for them to follow up on their own to reach out and make the first step."
>
> "Many of our clients have a hard time leaving their homes for many reasons and this offers therapy to them even if they cannot make it to the clinic."
>
> "Moms with Medi-Cal can now get some much-needed counseling and support around PMADs and that was not available before."

Importance of Bilingual Clinicians

Referral partners also highlighted their appreciation of Spanish-speaking clinicians. One survey respondent stated, "ADAPT has been able to assist with my Spanish speaking clients by having bilingual therapists. This is so important and I am so happy to finally have this needed support in my region. Speaking the language is so crucial when you need mental health services."

Desire for Expanded Eligibility

Given the overall success of clients who engage with ADAPT services, in the prior fiscal year (2020-21) many referral partners expressed a desire to have wider eligibility requirements for the program. This theme emerged again in the FY 2021-22 survey, with 33.3% of referral partners mentioning private insurance as a barrier to services. One referral partner remarked, "having only Medi-Cal patients qualify for services is limiting. There are underinsured and insured patients that would benefit from this program."

Ease of Referrals

Well over half of the survey respondents (60%) described how referring clients to ADAPT is an easy and efficient process. One response read:

> "BHS ADAPT has been extremely fast to follow up with a referral, which is something that is really lacking in the mental health field. I also like the fact that they will come to the facility and meet with the [patient], instead of waiting for the [patient] to come to them."

Program Benefits

Referral partners shared that their clients have had positive feedback about ADAPT:

> "The ADAPT program has been a wonderful addition to our program! My clients have all had positive things to say about the services provided."

> "Every single client who has participated in the program has reported to me how helpful the program has been to them. I have had clients with suicidal ideation who have become more stable using coping skills provided by the ADAPT clinician, and will hopefully use the resources provided at closing of the program to continue mental health services."

Additionally, many noted how the presence of the ADAPT program helps them do their job better:

> "It has been great to have a mental health professional focus on the mental health needs of our patients so I can continue with other medical needs for them."

> "It allows us to fulfill our program goal of getting clients linked with ongoing mental health treatment."

> "It helps me so much to be able to provide a mental health option that is available rather than to meet multiple dead ends and long waits for services through other organizations."

All in all, the presence of the ADAPT program in the community has been overwhelmingly positive for the referral partners who participated in this survey.

> "Whereas many outpatient programs in the community have a waitlist ranging from 3 months to 18 months, [ADAPT] has done such a great job of meeting the needs of client and families and not having a waitlist. [ADAPT] has been able to successfully link with clients referred to them and we are so grateful to have a program like this in the community."

Additional Program Activities

Approval for Medi-Cal Billing to Promote Program Sustainability

During FY 2021-22, the ADAPT program completed the extensive process required to allow for Medi-Cal insurance reimbursement billing. The capacity to provide Medi-Cal reimbursable Level-1 treatment services will support the potential for long-term program sustainability. Level-2 services provided to participants who identified as "at risk of perinatal mood and anxiety" were not reimbursable as those individuals did not meet criteria for specialty mental health services (Title IX) although Medi-Cal changes through the Cal-AIM initiative may create opportunities for additional supportive and preventative services to be billable in the future. The potential for Level-2 service to become reimbursable will be explored during FY 2022-23.

ADAPT Participation in UCSD Research to Improve Perinatal Depression Treatment: The Sleep and Light Intervention (SALI) Study

Beginning in FY 2021-22, the ADAPT participants could voluntarily enroll in a pilot study of the SALI for treating peripartum depression. This study was approved by County BHS and administered by ADAPT clinician. SALI is a brief (two-week), non-pharmacological, in-home intervention that utilizes a one-night adjustment in the timing and duration of sleep coupled with two weeks of a 30-minute per day lightbox session at a specific time based upon whether pregnant or postpartum to reset circadian rhythms and reduce perinatal depressive symptoms. This protocol has demonstrated high levels of fast-acting and durable effectiveness at treating perinatal depression in research settings. As part of an effort to move

SALI into community settings, the pilot research study led by Drs. Barbara Parry and David Sommerfeld from the UCSD Department of Psychiatry is designed to test the feasibility, acceptability, and effectiveness of training community providers to deliver SALI. The study is ongoing with initial results indicating it was relatively easy for participants to complete and for ADAPT clinicians to administer the required steps of the SALI intervention. This suggests that SALI is a feasible treatment approach for addressing peripartum depression that can be utilized in community settings. Additionally, participants have demonstrated meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors. The information learned from this study is expected to inform future wide-spread dissemination of SALI to other community care providers and programs that treat perinatal depression.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ADAPT Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ADAPT, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ADAPT Staff Survey was conducted at the end of FY 2021-22. ADAPT program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Of the 12 ADAPT staff invited to participate, all 12 participated for a response rate of 100%. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes.

Program Strengths

Team and Leadership

When asked about strengths of the ADAPT program, nearly every staff member mentioned the quality of the team and leadership. Staff described the team as “highly committed, passionate and empathetic" and highlighted the “collaboration, coordination, compassion, and camaraderie among the team members.” The “commitment and clinical integrity of program leadership and direct service providers” as well as “team environment where we all support each other and work well together” was credited for the success of ADAPT as a program.

Flexibility

The flexibility of the ADAPT program was also noted as a strength. As one staff member described, “we are very reasonable with our intake sessions as far as time frame goes, and we are willing to work around client schedules.” Others mentioned the uniqueness of ADAPT in this respect; the flexibility offered is not typically characteristic of mental health service agencies. For staff, the flexibility to have hybrid work arrangements was viewed favorably. As one staff member stated, “For me personally, work life balance is more achievable by having the flexibility to work remote.”

Accessibility

Since the start of the COVID-19 pandemic, staff have found unique ways to meet with clients while ensuring safety. Appointments are set up via telehealth, outdoors with social distancing, or via the phone.

ADAPT staff arrange times to drop off tangible items such as diapers, formula, and other necessities without face-to-face contact.

Staff credit this accessibility as a key component of program success and contributing factor their ability to reach more participants. Offering both telehealth and in-person services has been beneficial to both staff and clients. One survey respondent remarked that COVID-19 "provided an opportunity to be flexible in how services are delivered and to be able to meet clients where they are at."

Offering bilingual services, both from clinicians and peer partners, was highlighted as another key component of successful client recruitment and retention. Another respondent mentioned the importance of expanding the eligibility criteria for referral into ADAPT. Changes during FY 2021-22 allowed for anyone who met eligibility criteria throughout San Diego County (i.e., Medi-Cal/Medi-Cal eligible with evidence of experiencing peripartum depression or anxiety) to be referred to ADAPT, whereas previously referrals had to come from a select set of approved referral partners.

Program Challenges

Managing Incoming Referrals for ADAPT Services

In the staff survey, participants highlighted the significant time commitment needed to effectively respond to incoming referrals for ADAPT services. These referrals frequently required follow-up communication in order to obtain the information needed for determining ADAPT eligibility. Additionally, for persons not eligible for ADAPT services, the ADAPT team worked to identify and then facilitate connections to other potentially appropriate community resources and services.

In this regard, ADAPT staff endeavored to provide assistance to persons for each referral received, regardless of whether ultimately enrolled into ADAPT. When receiving a substantial number of referrals, staff indicated that they struggled with feeling pulled in multiple directions by needing to serve the existing client caseload while also trying to connect persons ineligible for ADAPT services to other community resources.

Efforts were underway to increase awareness of and relationships with other potential community partners to make it easier to facilitate connections to other resources. Additionally, the ADAPT team will be exploring how best to manage the incoming referral workflow process to allow for the individualized communication, care, and community linkages needed for each referral, even if not ultimately enrolled into ADAPT, while ensuring appropriate allocation of staff resources and time.

Resource Awareness

To assist with the processing of ineligible referrals, staff members noted the need for increased knowledge of community programs.

> "We need more resources and more up to date resources and programs happening in San Diego. I feel like there has to be hundreds of more programs or resources for Clients regarding Childcare and Housing, but it feels like we can't connect to them or find them."

Engagement

As was the case in prior years, efforts by ADAPT staff to keep clients and referral partners engaged in the program have been substantial. Staff reported frequent and consistent communication and scheduling flexibility as two key components in retention. Several staff mentioned the potential benefits of expanding allowable communication methods to include texting and e-mailing clients.

One unique aspect of ADAPT is the inclusion of family members in the treatment process. As the client must approve of included family members, one staff member pointed out that motivational interviewing may be useful in helping the client to identify which family members would be most helpful to engage. Another staff member highlighted the need for explaining "the importance of having family support to our clients when we talk to them about their client plan." In terms of engaging the identified family members, one survey respondent suggested offering family or couples' therapy to provide support and increase motivation to participate.

PHN and ADAPT Program Coordination

The responsibilities of PHNs focused on pandemic-related tasks in FY 2020-21 and has continued that focus into FY 2021-22. ADAPT staff describe challenges in communicating with PHNs. ADAPT staff highlighted communication with PHNs as a challenge and an inhibiting factor in accomplishing the goal of effective referral streams. Several survey respondents mentioned the usefulness of roundtables and meetings with PHNs and how engagement in those activities has the potential to improve working relationships.

Several staff highlighted potential PHN engagement strategies including increased e-mail communication, regularly scheduled meetings, team-building activities. Other suggestions centered around the need for increased education about ADAPT to promote engagement with PHNs and PHN leadership. Staff members suggested the potential benefits of additional messaging to PHNs from PHN leadership about the ADAPT program and the important resource it can be to PHN clients.

Telehealth

While telehealth was mostly appreciated as a benefit to the ADAPT program, the option does come with some challenges. An unstable internet connection can make telehealth sessions difficult and not all clients have ready access to a device. ADAPT staff can facilitate efforts to successfully engage in telehealth services such as helping to find locations with sufficient connectivity and/or "hotspots" if maintain an internet connection is difficult and/or helping clients navigate technological steps for accessing telehealth visits. Where telehealth is not feasible or desirable, ADAPT provided in person services.

ADAPT Staff Recommendations and Additional Feedback

ADAPT staff would like more opportunities for training. Desired types of training included the following:

- EMDR
- Documentation
- Interpersonal Therapy
- Peer Support
- Suicide Prevention
- Peripartum Mental Health
- Medi-Cal Terminology
- Co-occurring Disorders

Several survey respondents shared a desire for more support materials and books, as well as materials to use with clients such as workbooks or other therapeutic aids/tools. Other staff suggested increased administrative support to assist with documentation requirements, and a resource specialist to improve team awareness of other community programs and facilitate processing of ineligible referrals.

A few staff mentioned lack of connections with coworkers/other ADAPT team members as a result of COVID-19 safety practices. One participant mentioned "feeling less supported and missing the full team environment of weekly time all in the office." Despite this challenge, the ADAPT staff overwhelmingly endorsed a positive team climate and "support from program manager and supervisors, support from other staff members, good staff morale."

Changes from Initial Program Design

Allowing Eligible Referrals from Throughout San Diego County

Initially, only PHN programs could send referrals to ADAPT. During FY 2020-21, additional referral partners were added including Sharp Mary Birch, Best Start Birth Center, and the Sudden Infant Death Syndrome (SIDS) program. In FY 2021-22, the options were expanded further to allow referrals from throughout San Diego County. Anyone can refer persons directly to ADAPT, and self-referrals are also accepted. This brought two issues to light: 1) the need for additional community outreach to increase awareness about ADAPT, and 2) the need for effectively communicating who ADAPT can serve (i.e., Medi-Cal/Medi-Cal eligible with evidence of experiencing peripartum depression or anxiety) in order to encourage appropriate referrals.

Program Recommendations

1. Continued emphasis on community outreach to raise awareness of ADAPT program services and increase the number of appropriate referrals.
2. Continued communication and collaboration with PHNs through case consultations, roundtable discussion, and other methods of engagement.
3. Explore opportunities for expanded Medi-Cal reimbursable services to be provided as appropriate to Level-2 participants.
4. Increased efforts to support staffing and workforce needs.
5. Explore potential for developing strategic partnerships to meet client psychiatric/medication management service needs.
6. Review incoming referral process to identify strategies to support efficient and effective workflow.

Conclusion

A total of 117 persons enrolled in the ADAPT program during FY 2021-22 (97 initial enrollments into Level-1 and 20 initial enrollments into Level-2). This Level-1 enrollment represents a 110.9% increase from FY 2020-21, where 46 persons enrolled in Level-1 services. Despite the increased enrollment in FY 2021-22, ADAPT enrollment remained less than the initial program goal of 300 person which was due, at least in part to the continued impact of COVID-19 on public health nursing programs and the resulting lower expected referrals to ADAPT. To support the potential for long-term program sustainability, during FY

2021-22, the ADAPT program completed the process to allow for Medi-Cal insurance reimbursement billing.

The ADAPT program served a racially and ethnically diverse population with the majority identifying as Hispanic/Latino (i.e., 67.5% Hispanic/Latino) and approximately 20% indicating that Spanish was their primary language. As reported through both clinician and participant assessments, ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Additionally, improved sleep and less fatigue were commonly reported along with improvements in other key life domains such better social relationships and ability to handle daily activities.

Participants also expressed high levels of satisfaction with ADAPT services and that they would recommend ADAPT to family or friends experiencing peripartum depression and anxiety. As one participant stated, "Every mom should have this kind of support - you guys really care and go out of your way to support us."

The ADAPT team continued to increase the amount of ADAPT services delivered via telehealth with video during FY 2021-22 while also providing more in-person services as conditions of the COVID-19 pandemic allowed (with telephone-based services decreasing). Feedback indicated that many participants preferred a hybrid service delivery model that allowed for the greater convenience and frequency of telehealth services while still having the option for in-person connections as needed. However, some clients expressed a preference for either primarily/exclusively in-person services or primarily/exclusively telehealth services, which highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.

Ongoing communication remained critical to effective coordination between ADAPT and PHNs. PHNs continued to express recognition of the value of ADAPT services to their clients and indicated they wish the ADAPT program was available to more of their clients beyond the target population of Medi-Cal recipients, Medi-Cal-eligible individuals, and those who are low income and uninsured.

The ADAPT program partnered with UCSD researchers to pilot test the feasibility and effectiveness of community-based administration of the innovative SALI to treat peripartum depression. ADAPT clients who voluntarily choose to participate in SALI engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session at a specific time of the day depending upon whether pregnant or postpartum. The study is ongoing with initial results suggesting high levels of feasibility from the perspective of both participants and clinicians. Additionally, participants have demonstrated meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of Participants who Enrolled during FY 2021-22

Characteristic	Total Participants (N=117)	
Gender	**n**	**%**
Female	113	96.6
Another Gender Identity/Missing/Prefer not to answer	4	3.4
Total	**117**	**100**
Age Group	**n**	**%**
18-25	42	35.9
26-35	59	50.4
>35	16	13.7
Total	**117**	**100**
Primary Language	**n**	**%**
English	91	77.8
Spanish	23	19.7
Other/Missing/Prefer not to answer	3	2.5
Total	**117**	**100**
Race/Ethnicity	**n**	**%**
African American	20	17.1
Asian/Pacific Islander	9	7.7
Latino	79	67.5
Caucasian/white	39	33.3
American Indian	6	5.1
Multi-racial	27	23.1
Total[1]	-	-
Sexual Orientation	**n**	**%**
Heterosexual or straight	103	88.0
Bisexual/Pansexual/Sexually fluid	10	8.5
Another sexual orientation/Missing/Prefer not to answer	4	3.5
Total	**117**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

Appendix (continued).

Military Status	n	%
Never served in the military	115	98.3
Other/Missing/Prefer not to answer	2	1.7
Total	**117**	**100**
Disability	**n**	**%**
Yes, has a disability	19	16.2
No, no disability	97	82.9
Prefer not to answer	1	0.9
Total	**117**	**100**
Type of Disability	**n**	**%**
Learning Disability	6	5.1
Physical Disability/Chronic Health	7	6.0
Other Physical Disability	13	11.1
Other Mental Disability	<5[3]	<4.3
Total[2]	**-**	**-**

[2] Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.

[3] Values were suppressed due to small n size.



BHCONNECT INNOVATIONS-19

Annual Report
Year 3 (7/1/2021 - 6/30/2022)

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

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

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Telemental Health program (commonly known as BHConnect) focuses on persons who have received crisis-oriented psychiatric care services, but are otherwise unconnected to behavioral health treatment services and identified as likely having barriers to accessing traditional outpatient services. The goal is to reduce the recurrence rate for psychiatric crisis services among these persons by offering an alternative method of care that relies primarily on telehealth treatment. BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access. The BHConnect service provider team is comprised of licensed and associate clinicians who provide therapeutic care services, as well as Health Navigators who support the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed. BHConnect provides services to persons of all ages, which are grouped into children, youth and families (CYF) services and adult and older adult (AOA) services for BHS reporting purposes.

Primary Findings for Fiscal Year 2021-22

BHConnect Enrollment, Referrals, and Referral Partners

1. During fiscal year (FY) 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an increase of approximately 30% in total new enrollments from FY 2020-21. Including persons who entered BHConnect during FY 2020-21 and continued to receive services in FY 2021-22, a total of 148 persons (81 CYF and 67 AOA clients) were served by BHConnect in FY 2021-22. BHConnect enrollment increased from the prior year; however, it remained below initial program targets of 250 persons served each year. Efforts will continue during FY 2022-23 to further increase the number of referrals to and enrollees into BHConnect.

2. BHConnect received a total of 256 referrals from community referral partners during FY 2021-22, which represented a 51.5% increase from the prior year (n=169). The growth in referrals was due to receiving substantially more AOA referrals. AOA referrals increased from 38 in FY 2020-21 to 139 in FY 2021-22 (a 265.8% increase), whereas CYF referrals declined slightly from 131 to 117 (a 10.7% decrease).
3. A total of 20 different organizations referred clients to BHConnect. Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 compared to only four organizations achieving this threshold in FY 2020-21.
4. BHConnect prioritized a quick response to client referrals, with the majority of persons (56.0%) enrolled in BHConnect within one day of the initial referral and approximately 75% (74.4%) within three days.
5. As indicated in the referral partner feedback survey, BHConnect was perceived to be an important resource by the growing number of referral partners throughout San Diego County. Key benefits of the BHConnect program identified by referral partners included that BHConnect filled a gap in needed services for persons who may not be interested in traditional outpatient programs by relying primarily on a telehealth model to reduce barriers to accessing services and offering prompt enrollment into services to make connections before participant interest and engagement fades.

BHConnect Program Engagement and Service Delivery Patterns

6. The primary reason for not enrolling in BHConnect was being unable to locate/contact the person (38.8% and 22.2% of AOA and CYF referrals, respectively). For both AOA and CYF referrals, only about 10% of all referrals declined to participate (7.2% and 12.0%, respectively), which suggests a high degree of interest in participating in BHConnect once contact has been initiated. In an effort to increase the number of clients that BHConnect is able to directly engage as part of the referral and recruitment process, during FY 2022-23 BHConnect anticipates re-establishing an onsite presence at select referral partners. This practice of co-locating with potential referral sources was originally part of BHConnect operations, but was terminated after the onset of the COVID-19 pandemic.
7. Persons enrolled in BHConnect as of 6/30/2022 had median service durations of 142.0 days and 155.5 days, respectively, for youth and adults. These findings indicate that BHConnect is frequently able to maintain persons in treatment once they have established an initial therapeutic relationship.
8. CYF clients and AOA clients were provided, respectively, an average of 3.5 and 4.3 BHConnect services per month (i.e., every 30 days enrolled in BHConnect). This represented a 20.7% and 38.7% increase, respectively from the 2.9 and 3.1 total monthly CYF and AOA BHConnect services provided during the prior year. This increase in average monthly service contacts was due primarily to the greater provision of case management and other support services by the Health Navigators in FY 2021-22.

BHConnect Program Outcomes and Participant Perceptions

9. Service utilization patterns indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services as evidenced by fewer inpatient psychiatric hospitalizations and other related services for youth and adults after enrolling in BHConnect.
10. For clients with assessment data at both an intake and a follow-up, many youth and adult clients had improvements in well-being and symptom management identified via clinician and self-reported assessments. However, the target population served by BHConnect (i.e., those with treatment needs

but not engaged in treatment) remained a challenging population to serve with many CYF and AOA clients demonstrating needs for further behavioral health improvements.

11. Based on feedback from BHConnect CYF and AOA clients as well as the caregivers of CYF clients, the BHConnect program was perceived as accomplishing the primary goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services.

BHConnect Participant Telehealth Preferences and Experiences

12. When provided the option, approximately 40% of CYF clients and 50% of AOA clients chose to have an app installed on an existing personal device to participate in BHConnect telehealth services instead of receiving a separate device from BHConnect dedicated to participating in telehealth services.
13. While some technology-based difficulties remained with connectivity and/or device management, among those who provided feedback after their first BHConnect session, less than 10% of CYF and AOA clients and clinicians indicated any issues with audio or video quality and/or the ability to engage in a conversation during the telehealth session.

Conclusion

During FY 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an approximately 30% increase in total new enrollments from FY 2020-21. This increase reflected the efforts by BHConnect to expand the number of community referral partners, particularly for AOA clients, which resulted in a 51.5% increase from the previous year (169 referrals to 256 referrals). While BHConnect enrollment increased from the prior year, it remained below initial program targets of 250 persons served each year. BHConnect continues to build upon and expand their referral partner network as they seek to serve more people FY 2022-23.

A total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 compared to only four organizations reaching this threshold in FY 2020-21. As indicated in the referral partner feedback survey BHConnect was perceived to be an important resource by the growing number of referral partners throughout San Diego County.

Once enrolled in BHConnect and receiving services, CYF and AOA clients frequently engaged with BHConnect for 5-6 months or more with median durations of 142.0 and 155.5 days, respectively for youth and adults still in services as of 6/30/22. An examination of BHS service utilization patterns indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services, as evidenced by fewer inpatient psychiatric hospitalizations and other related services for youth and adults after enrollment. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. However, the target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remains a challenging population to serve with many also demonstrating a need for further behavioral health improvements.

Overall, BHConnect program experienced significant expansion during FY 2021-22 and is expected to continue on a growth trajectory during FY 2022-23. Assessment data, administrative data regarding utilization of crisis and acute care services as well as and client and caregiver feedback indicated that BHConnect program was accomplishing the primary goal of connecting with and assisting a population of

persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services. A potential challenge for the BHConnect program; however, is to continue to demonstrate its uniqueness and specific population niche within the overall behavioral health system of care given that telehealth is now more widely available in other treatment programs due to the changes in service provision strategies brought about in response to the COVID-19 pandemic.

Primary Recommendations for FY 2022-23

1. Continue to develop and expand referral partners in order to identify under-served or vulnerable youth, transitional age youth, adult, and older adult residents of San Diego County who could benefit from the treatment services offered by BHConnect. New partners to include but not limited to: Cal State San Marcos, Adult Protective Services, and Perinatal Care Network.
2. Maintain ongoing and close relations with hospitals to provide on-site warm hand-offs and intakes, and ultimately, increased client engagement with BHConnect. Continue to explore best practices to increase client engagement from the moment referral is received.
3. Finalize internal policies and procedures to implement short-term psychiatric care for AOA clients in order to fill the gap as they are linked to long-term psychiatry. Include therapists and Health Navigators in virtual psychiatric evaluations for added, personalized support to clients.
4. Continue embracing a hybrid-treatment model that caters to the individual needs of BHConnect clients, offering in-home services and increased sessions when clinically indicated, and leveraging engagement strategies such as care packages, Motivational Interviewing, Harm Reduction and trauma-informed, compassion-based approaches.
5. To facilitate program effectiveness and sustainability, continue developing and refining opportunities for Health Navigators to provide creative and engaging case management and rehabilitation services that would be reimbursable through Medi-Cal/Cal-AIM.
6. Continue to provide clinical support and training to all staff on topics that support their effectiveness in working with serious mental illness in telehealth topics/trainings such as: screening, brief intervention and referral to treatment (SBIRT), best practices in suicidality assessment and treatment, psychopharmacology for serious mental illness, trauma grief counseling, virtual-compatible trauma therapies such as Eye Movement and Desensitization Reprocessing (EMDR), crisis management strategies, and creative interventions to maintain engagement with youth in virtual therapy.
7. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care. Continue annual staff training on parenting skills and modalities such as Parent-Child interaction therapy.
8. Refine the screening process by consulting with community stakeholders and internal leadership, refine BHConnect eligibility criteria as needed, educate referral partners on the risks and benefits of telehealth and what would constitute an appropriate referral to BHConnect.
9. Increase ability to address client preferences by including iPads as a device option available for participating in telehealth services.
10. Explore implementation of The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to provide homeless clients with increased linkages to housing resources.

Program Description

The County of San Diego BHS BHConnect program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). MHSA INN funding for BHConnect services was extended and is now expected to continue through 10/31/2023. Services are provided through the Vista Hill community-based organization. BHConnect was developed to increase access and connection to follow-up behavioral health services after a psychiatric emergency in which a San Diego resident utilized a psychiatric hospital, emergency screening, and/or crisis response services.

BHConnect services focus on persons who have received crisis-oriented psychiatric care services, but who are otherwise unconnected to behavioral health treatment services. The goal is to reduce recidivism rates for psychiatric crisis services among these persons by providing specialized supports through telehealth treatment services that reduce barriers to accessing ongoing care. San Diego County residents of all ages are eligible for BHConnect services. Services are culturally and developmentally appropriate and aim to overcome current barriers when clients attempt to connect to care following a psychiatric crisis.

Offering services primarily through a telehealth platform, after an initial onsite evaluation by a case manager, is a key innovative component of the BHConnect program. To facilitate better access to care services, BHConnect either provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access or puts an app on an existing personal device that can be used for participating in the telehealth services if that is preferred by the client instead. Clients receive a full tutorial of how to use the technology, as well as assistance with in-home set up prior to being connected with a behavioral health professional. The BHConnect service provider team is comprised of licensed and associate clinicians who provide therapeutic care services as well as Health Navigators who support the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed.

Participant Characteristics

A brief overview of the BHConnect participant characteristics is presented here with a more complete listing in the report appendix. The BHConnect program provided mental health outpatient treatment services to clients of all ages through both the CYF and AOA BHS service systems. During FY 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an approximately 30% increase in total new enrollments from FY 2020-21. The increase among AOA clients was particularly stark as that increased over 300% from FY 2020-21 when only 18 AOA clients enrolled in BHConnect. Including persons who entered BHConnect during FY 2020-21 and continued to receive services in FY 2021-22, a total of 148 persons (81 CYF and 67 AOA clients) were served by BHConnect. During FY 2021-22, there were similar percentages of CYF clients aged 5-14 (46.4%, n=26) and 15-18 years old (53.6%, n=30). Among AOA clients, Transitional Age Youth (TAY) between the ages of 18-25 comprised 28.3% (n=17) of this group. The majority of both CYF and AOA clients were female (60.7%, n=34 and 56.7%, n=34, respectively).

Referrals for BHConnect Services

BHConnect received a total of 256 referrals from community referral partners during FY 2021-22, which represented a 51.5% increase from the prior year (n=169). The growth in referrals was due to receiving substantially more AOA referrals. AOA referrals increased from 38 in FY 2020-21 to 139 in FY 2021-22 (a 265.8% increase), whereas CYF referrals declined slightly from 131 to 117 (a 10.7% decrease). A total of 10 organizations referred AOA clients to BHConnect with over 40% (42.4%; n=59) originating from Sharp Mesa Vista. Additional primary referrals sources included South East Mental Health Center (n=17), BHS funded In-Home Outreach Team (n=13), Sharp Grossmont (n=13), and San Diego County Psychiatric Hospital (n=9). Overall, approximately 50% (50.3%) of AOA referrals resulted in the person enrolling in BHConnect. The primary reason for not enrolling was being unable to contact the person (38.8% of all referrals).

A total of 10 different organizations referred CYF clients to BHConnect. Consistent with prior years, Rady Children's Hospital was the primary referral source with 70 referrals coming from either the emergency room or behavioral health urgent care. Other prominent CYF referrals sources that emerged during FY 2021-22 included the Crisis Action Connection and SmartCare with 24 and 10 referrals, respectively. The majority of CYF referrals enrolled into BHConnect (58.9%). As with AOA clients, the primary reason for not enrolling into BHConnect was being unable to contact the person (22.2% of all referrals).

Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 as compared to only four organizations achieving this threshold in FY 2020-21.

For both AOA and CYF referrals, only about 10% of all referrals declined to participate (7.2% and 12.0%, respectively), which suggests a high degree of interest in participating in BHConnect once contact has been initiated. In an effort to increase the number of clients that BHConnect is able to directly engage as part of the referral and recruitment process, during FY 2022-23 BHConnect anticipates re-establishing an onsite presence at select referral partners. This practice of co-locating with potential referral sources was originally part of BHConnect operations, but was terminated after the onset of the COVID-19 pandemic.

Utilization of Program Services

BHConnect Services – Duration and Discharge Status

The BHConnect program was very responsive to referrals with 56.0% of persons enrolled within a day of receiving the referral and over 85% (86.4%) of persons enrolled within five days of the original referral to BHConnect.

As shown in Table 1, of the 81 youth and 67 adults who were enrolled in BHConnect services during FY 2021-22, there were 34 youth and 29 adults still active in the program as of 6/30/2022. These persons were typically enrolled for approximately 5-6 months (i.e., median duration of 155.5 days and 142.0 days, respectively). Of the persons who discharged from BHConnect prior to 6/30/2022, the amount of time enrolled in BHConnect was typically shorter, particularly for youth (median of 121.0 and 83.5 days for youth and adults, respectively), but the duration data suggests that the majority of both youth and adults stay connected with the program for at least several months.

Table 1. BHConnect Program Participation Duration and Discharge

	Youth (N=81)		Adult (N=67)	
	Still in program	Discharged	Still in program	Discharged
n (persons)	34	47	29	38
Mean (days)	237.6	182.9	143.4	126.1
Median (days)	155.5	121.0	142.0	83.5

BHConnect Services – Type and Amount

As reported in Table 2, CYF clients and AOA clients were provided, respectively, an average of 3.5 and 4.3 BHConnect services per month (i.e., every 30 days enrolled in BHConnect). This represented a 20.7% and 38.7% increase, respectively from the 2.9 and 3.1 in total monthly CYF and AOA BHConnect services provided during the prior year. For both CYF and AOA BHConnect clients, therapeutic sessions were the primary type of service contact, which represented approximately 55% of all monthly service contacts (57.1% and 58.1%, respectively). Conducting assessments and providing case management services as well as other forms of support such as working with collateral contacts were the other primary forms of interactions. The main difference contributing to the increased total monthly services provided during FY 2021-22 was an increase in these non-therapy, supplemental support service contacts. This is consistent with expectations given that the BHConnect team increased the role of the Health Navigators to provide additional forms of support to CYF and AOA clients during FY 2021-22. A potential growth area for future years would be an increased capacity to provide rehabilitation services by non-licensed clinicians as these were infrequently utilized during FY 2021-22.

Table 2. Average Number of BHConnect Services Provided Per Month during FY 2021-22

	Youth (N=81)	Adults (N=67)
Type of BHConnect Service	Average Number of Services per 30 Days	
Any BHConnect service	3.5	4.3
Psychosocial assessment	0.5	0.7
Therapy	2.0	2.5
Rehabilitation	<0.1	0.1
Case management	0.4	0.8
Other services (e.g., collateral)	0.6	0.3

Primary Program Outcomes

Utilization of BHS Crisis and Acute Oriented Services

An examination of the BHS crisis and acute care service utilization patterns before and after enrolling in BHConnect can help identify the extent to which participation in BHConnect was associated with a reduced need for such services. The following analyses were accomplished by reviewing the electronic health record that documents participation in county-funded BHS crisis and acute care-oriented services

during the 90 days before and after enrolling in BHConnect. To ensure equal 90-day observation periods for all persons, only clients enrolled at least 90 days prior to 6/30/2022 were included in the analysis. Of note, a limitation of these analyses is that they only include BHS-funded services, so any crisis services received outside the BHS system are not reflected. As such, the results presented in Table 3 should be interpreted cautiously as they do not reflect all services received, particularly for the youth population given that many received behavioral health-related care at Rady Children's Hospital Urgent Care.

Table 3. Utilization of BHS Crisis and Acute Oriented Services Before and After Enrolling in BHConnect

	Youth (N=64)				Adult (N=55)			
	90 days before enrolling in BHConnect		90 days after enrolling in BHConnect		90 days before enrolling in BHConnect		90 days after enrolling in BHConnect	
	n	%	n	%	n	%	n	%
Inpatient Psychiatric Hospitalization	13	20.3	<5[1]	<7.8	22	40.0	<5[1]	<9.1
Crisis Residential	0	-	0	-	<5	<9.1	0	-
Crisis Stabilization	16	25.0	<5[1]	<7.8	<5	<9.1	<5[1]	<9.1
Urgent Outpatient	0	-	0	-	5	9.1	5	9.1
PERT[2]	<5[1]	7.8	<5[1]	<7.8	5	9.1	<5[1]	<9.1

[1] *Due to the small number of persons experiencing this service the exact number is masked*
[2] *PERT = Psychiatric Emergency Response Teams*

Overall, the service utilization pattern for both youth and adult BHConnect participants suggested a reduced need for crisis and acute care services after enrolling in BHConnect. This improvement was particularly evident among inpatient psychiatric hospitalizations for adult clients. A total of 40% had at least one inpatient psychiatric hospitalization in the 90 days prior to enrolling in BHConnect, as compared to less than 9.1% during the 90 days after enrolling in BHConnect. While these analyses only include BHS services and may therefore not reflect all crisis services received, the results suggest that participation in BHConnect helped to reduce the need for crisis and acute care services.

Child/Youth Baseline Assessments

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS) assessment is a structured tool used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In BHConnect, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 47 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2021-22 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0-3, with a "2" or "3" indicating a

specific area that could potentially be addressed in the particular service or treatment plan. Table 4 shows the mean number of needs at initial assessment and last available assessment for the domains of child behavioral and emotional needs, life functioning, and risk behaviors. Overall, the findings indicated minimal overall changes from initial assessment.

Table 4. CANS Average Change from Initial Assessment (N=47)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	2.5	2.3
Life Functioning	2.7	3.0
Risk Behaviors	0.7	1.0

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). As shown in Table 5, for each CANS domain, approximately 50-60% of the children and youth served by BHConnect experienced at least one reduction in a need item identified during the initial assessment.

Table 5. Persons with CANS Improvement at Follow-up (N=47)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Behavioral/Emotional	46	27	58.7
Life Functioning	35	19	51.4
Risk Behaviors	24	13	54.2

The percent of persons with an improvement across these three domains was lower than what was reported in the FY 2020-21 Systemwide Annual Report for the overall County of San Diego CYF BHS for discharged clients (i.e., at least one improvement was evident in approximately 75% of discharged clients across each domain). This difference is likely due, in part, to the nature of the population served by BHConnect, which is comprised of youth who have had difficulty engaging in traditional outpatient treatment programs. In this regard, the fact that the majority of the BHConnect population exhibited progress on the CANS suggests that the BHConnect team was successfully able to connect with these children, youth, and their families via telehealth and facilitate improvements in well-being at rates almost as high as those observed across the broader CYF service system.

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 6.

In FY 2021-22, the PSC-35 was administered at initial entry into BHConnect, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 33 caregivers and 32 youth in FY 2021-22 completed both a baseline and follow-up assessment. Table 6 shows that approximately two-thirds of both parents and youth reported PSC total scores (63.6% of parents and 68.8% of youth) at entry into BHConnect that met or exceeded the PSC total score cut point for clinical concerns[1]. At follow-up, this had reduced substantially, particularly among youth, with 50.0% of parents and 40.6% of youth indicating PSC total scores that exceeded the threshold for ongoing clinical concerns. Likewise, an examination of mean score changes showed statistically significant reductions (i.e., improvement) in total PSC scores for both parents and youth. Among the PSC subscales, there were indications of improvements from initial Internalizing scores for both caregivers and youth. With the reduced sample sizes for completed self-report PSC assessments, the findings should be interpreted cautiously as they may not reflect the broader experiences of the full BHConnect youth population; however, the results are generally consistent with prior years, which supports greater confidence in the overall pattern of findings.

Table 6. PSC Average Change from Baseline

	Parent/Caregiver Report (N=33)					Child/Youth Report (N=32)				
Subscales	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Post**
Attention	33	18.2	17.6	4.8	4.7	32	50.0	31.2	6.2	5.3*
Internalizing	33	72.7	41.2	6.1[1]	4.8*	32	78.1	56.2	6.5[1]	4.8**
Externalizing	33	27.3	32.4	4.7	4.5	32	12.5	6.2	3.2	2.5
Total Score	**33**	**63.6**	**50.0**	**32.6[1]**	**28.6[1]***	**32**	**68.8**	**40.6**	**32.2[1]**	**25.4***

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

[1] Score above clinical cutoff. Note: PSC clinical cutoff scores by subscale (higher scores indicate worse condition): Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28

To better understand the extent to which PSC scores changed within the BHConnect client population and to facilitate comparisons with the overall CYF BHS system, analyses were also conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2020-21 Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 7. Distribution of FY 2020-21 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=33)		Child/Youth Report (N=32)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	9	27.3	7	21.9
No improvement (i.e., 0-1 point reduction)	3	9.1	3	9.4
Small improvement (i.e., 2-4 point reduction)	6	18.2	4	12.5
Medium improvement (i.e., 5-8 point reduction)	3	9.1	8	25.0
Large improvement (i.e., 9+ point reduction)	12	36.4	10	31.3

As shown in Table 7, approximately one-third of the parents/caregivers (36.4%) and children/youth (31.3%) in BHConnect reported a large improvement from their initial PSC assessment. Alternatively, 27.3% caregivers and 21.9% of children reported a higher PSC score at follow-up, indicating some increased impairment. These findings suggest substantial variability among BHConnect clients and their self-reported experiences of behavioral health changes. Substantial variability and generally similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2020-21 Systemwide Annual Report. Approximately 45% of caregivers and children/youth reported large improvements and about 20% reported increased impairment from initial PSC assessment. Compared to overall BHS system, BHConnect youth were less likely to report large improvements (i.e., 31.3% compared to 44%); however, the unique composition of the BHConnect population likely contributed to this difference.

Adult Baseline Assessments

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks respondents to answer questions as it is "true for you now."

The total mean score for the 16 adult participants who completed the RMQ at intake and at a follow-up assessment during FY 2021-22 was 3.6 at baseline and 3.8 at follow-up. This change was in the desired direction and statistically significant. An important individual item from the RMQ with a statistically significant and clinically meaningful increase was "I deal more effectively with daily problems," which increased from a 3.1 to 4.4. This difference corresponds to an initial "neutral" response to an "agree"/ "strongly agree" response at follow-up. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2020-21 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, Assertive Community Treatment (ACT), case management, and TAY residential programs) was 3.3 with a follow-up RMQ of 3.7. It appears that BHConnect participants self-report generally similar assessments of their recovery status and outlook on life as do clients in other BHS programs.

Illness Management and Recovery

To measure clinician perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by BHConnect staff. The IMR scale has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement. Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery. A total of 21 participants completed an intake and a follow-up assessment in FY 2021-22 (see Table 8). The mean overall IMR score at intake was 2.7 which increased to 3.5 at last available follow-up. Primary domains where improvements were observed included reductions in substance abuse, effective medication adherence, as well as improved ratings for family involvement.

Table 8. IMR Assessments for BHConnect Adult Clients (N=20)

		Intake	Follow-Up
Individual Assessment Items	**n**	**Mean[1]**	**Mean[1]**
Involvement of family and friends in his/her mental health treatment: How much are family members, friends, boyfriends or girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his or her health treatment?	20	3.1	3.1
Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment?	21	2.0	3.3*
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	21	2.6	3.8*
Using medication effectively: How often does s/he take his/her medication as prescribed?	15	4.3	3.8
IMR Subscales	**n**	**Mean[1]**	**Mean[1]**
Recovery	21	2.5	3.5*
Management	21	1.9	2.9*
Substance Abuse	20	4.2	4.3
Overall IMR	21	2.7	3.5*

**statistically significant at p < 0.05*

[1] *IMR scores range from 1 to 5, where 5 = highest level of recovery*

As reported in the mHOMS Annual Outcomes Report for FY 2020-21 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8, which increased to 3.4 at most recent follow-up. This pattern indicates that BHConnect adult clients have similar levels of impairment and recovery/management skills at program intake as other BHS programs and can achieve similar or greater improvements at follow-up.

BHConnect Participant Feedback

During June and July of 2022, BHConnect staff asked program participants to engage in a short qualitative survey to elicit feedback on the program. Participants were asked a series of questions which had been developed by the University of California San Diego (UCSD) evaluation team in collaboration with BHConnect leadership and BHS input. Participants were given a short script explaining the purpose of the survey, and that feedback was voluntary, confidential, and would not affect services. Of the 25 program participants asked to participate in the survey, four declined and 21 began the survey (nine adult/older adult clients, six youth clients, and six parents/caregivers). One participant discontinued after the first question. Most respondents had been in the program either 3-6 months (35%) or 7-12 months (35%) while smaller groups had been in the program 1-3 months (15%) or more than 12 months (15%).

Given the participation rate relative to the number of clients served by BHConnect during FY 2021-22, a limitation of the findings presented is that they may not reflect the perceptions of the entire BHConnect program participant population. Additionally, it should be noted that the interviews were conducted by BHConnect program staff and therefore could be positively biased.

From the collected data, the following themes emerged:

The BHConnect program model improves service accessibility

1. "This has been so much better for me because I don't have to figure out how to get there(sessions). I don't have to figure out who is going to take care of the kids."
2. "I work full time, and I did not have to take off work for [my child] to do his sessions."
3. "I like that I can go minutes before the session and don't have to ask mom to give me a ride or go on the bus to make it to session."

BHConnect clients prefer the hybrid model over traditional in-person services

1. "Convenience, especially with the price of gas right now."
2. "I like remote services. I don't have to wait a lot. I don't have to work around my schedule that much. This also makes me have more time to schedule my other appointments, since I have physical therapy twice a week, and constant doctor's appointments."
3. "I can stay in familiar surroundings, and comfortable. I'm not around a lot of strange individuals or others. I can be more open with my therapist on the phone."

The BHConnect experience has differed from prior providers

1. "The fact that it's remote, more consistent, more of a team with BHConnect."
2. "The communication the therapist has with me and my son. If I have an issue with [my child] I can call [the therapist] and he will help me with the situation. I would say the constant communication."
3. "I feel like I am getting better care than I have from past providers."

Telehealth may be challenging for young clients

1. "Sometimes I feel that the children don't have that privacy at home. I also feel that some children get distracted in their room, and they are not fully focused on the appointment."
2. "It's been a struggle because my kid is not a phone person."

3. “Telehealth services have a lack of privacy in my home because I have younger kids that might distract my son's therapy appointment.”

Despite potential difficulties of conducting telehealth visits with young clients, 80% of survey respondents reported that BHConnect participation has had a positive effect on their life. Participants mentioned improved relationships and communication, better emotion management, behavior improvements (e.g., following rules at school), and reduced symptoms (e.g., panic attacks). Overall, 100% of survey respondents stated they would recommend BHConnect to a friend or family member.

These findings, combined with the themes found in the open-ended survey responses, indicate that the BHConnect program has accomplished the goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services. Special considerations should be made in the future to accommodate youth clients who may struggle with the logistics of telehealth services.

Telehealth Service Preferences and Experiences

During FY 2021-22, BHConnect clients were allowed to choose between receiving a device from the BHConnect program that would be used exclusively for participating in telehealth services or downloading an app onto a personal device of their choosing that would be utilized for the BHConnect telehealth sessions (previously all clients received a device from BHConnect). Approximately 40% of CYF clients (41.5%) and 50% of AOA clients (49.2%) requested to have an app put on an existing personal device rather than receiving a new device dedicated to only engaging in telehealth services from BHConnect. For those who requested the app to be installed on an existing personal device, the two primary reasons among both CYF and AOA clients for making that choice were: 1) inconvenience of having another duplicative device (i.e., to manage/keep track of), and 2) preferred the familiarity of their own personal device. Among those who opted for a device from BHConnect, the primary reasons for both CYF and AOA clients were: 1) preference of having a separate device dedicated to telehealth services, and 2) financial considerations due to barriers of having adequate personal phone service for telehealth.

At the end of select sessions, BHConnect CYF and AOA clients as well as their clinicians were asked to rate the telehealth session experience on several domains related to the quality of the visit from a technological perspective. Respondents were asked to indicate the extent to which they agreed with each statement on a 5-point scale ranging from strongly disagree to strongly agree. In Table 9, telehealth service feedback from the first BHConnect session is presented.

Table 9. Feedback Regarding the First BHConnect Telehealth Session

	CYF Client Response		CYF Clinician Response		AOA Client Response		AOA Clinician Response	
Amount of Change	**n**	**% Disagree/ Strongly Disagree**	**n**	**% Disagree/ Strongly Disagree**	**n**	**% Disagree/ Strongly Disagree**	**n**	**% Disagree/ Strongly Disagree**
I was able to see clearly	34	5.8	33	9.1	31	3.2	31	3.2
I was able to hear clearly	34	5.9	34	8.8	31	0.0	31	0.
The back-and-forth timing of the conversation was good	34	2.9	34	8.8	31	3.2	31	3.2
There was enough technical assistance	33	0.0	-	-	25	0.0	-	-
I felt comfortable with the equipment used	34	2.9	-	-	31	6.4	-	-

Overall, the results indicated that from the perspective of both clients and clinicians, relatively few (i.e., less than 10%) of the first BHConnect sessions had any issues with the video or audio quality and/or technological disruptions to the conversation between client and clinician. Very few CYF and AOA clients (2.9% and 6.4%, respectively) reported that they were not comfortable using the equipment to conduct their initial telehealth service. These positive perceptions with the telehealth experience were likely particularly important as they helped established "first impressions" regarding engagement in BHConnect services. Analyses of feedback from later sessions indicated that experiences with the technology remained positive and even improved over time.

BHConnect Referral Partner Feedback

During July of 2022, BHConnect providers asked referral partners to engage in a short qualitative survey to elicit feedback on the program. Referral partners were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with BHConnect leadership and BHS input. Referral partners were given a short script explaining the qualitative data collection process, and explained the feedback was voluntary and would be used only to inform recommendations for program improvements. Of the 31 referral partners invited to participate, 19 completed the survey for a response rate of 61%. Given the response rate, a limitation of the findings presented is that they may not fully reflect the perceptions of the BHConnect referral partner population. From the collected data, the following themes emerged from the qualitative data feedback:

BHConnect offers immediate services to clients in need.

1. "BHConnect team is responsive and they connect with patients quickly after the referral is made."
2. "The expediency in getting clients serviced has been of great value."
3. "The referral process is easy and the wait time is reasonable in comparison to other programs where they have a 3-6 month waiting list."

BHConnect reduces barriers to therapy.

1. "BHConnect is the only Medi-Cal based therapy that is available that offers telehealth/phone-based therapy for individuals with severe mental illness. Without the BHConnect program this population would have no other option for therapy besides attempting to return to the clinic model."
2. "Many clients have a difficult time maintaining services at a traditional mental health clinic due to various barriers such as lack of transportation, agoraphobia, and/or significant depression which impacts motivation to leave their house. BHConnect offers a unique way to reduce barriers and provide therapy supports to clients that would be otherwise difficult to connect."
3. "It makes for safer [hospital] discharges with greater chance of patients continuing treatment post discharge."

BHConnect fills a gap in services in the community.

1. "Families tend to sit on other agency wait lists for months and for patients with higher acuity safety concerns, they cannot wait several months before meeting with a therapist."
2. "Many in the community can only see patients on a monthly basis for individual therapy. That is not sufficient for most stepping down from the hospital."
3. "For patients with [serious mental illness], psychotic disorder, it would be extremely difficult to find other referral options."

Referral partners would like follow-up after the referral has been made.

1. "Not sure how many of the referrals follow through or were seen."
2. "Identify a point of contact between programs (BH Connect liaison/Strength Based Case Management Liaison) to ensure coordination of care and successful linkage between the programs. This will make it easier to address concerns, communicate urgent concerns, and better support client needs."

Additional Program Activities

Establishing Additional Referral Partners

As discussed above, the number of referrals, particularly for AOA clients, increased substantially during FY 2021-22. This increase was the result of the ongoing outreach and engagement efforts on the part of BHConnect leadership to increase awareness of BHConnect services throughout the County of San Diego and expand the number of referral partner organizations. Essential to the outreach activities was participation in various service provider related meetings and presentations regarding BHConnect services.

Developing A Partnership to Provide Child and Youth Psychiatric Services

To address any medication management needs of children and youth receiving BHConnect services, a partnership was established with another County BHS "Innovation" program, the Center for Child and Youth Psychiatry (CCYP). By collaborating with CCYP for the provision of psychiatric services (which also relies primarily on a telehealth approach for service delivery), BHConnect was able to better meet the needs of clients.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual BHConnect Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, BHConnect, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual BHConnect Staff Survey was conducted at the end of FY 2021-22. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. All BHConnect staff invited to participate in the survey did so, for a 100% response rate (N=10). Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify the following emergent themes.

Program Strengths

According to annual survey feedback, the flexibility offered by BHConnect is an overwhelming strength of the program. BHConnect staff described their ability to accommodate clients in terms of therapy modality (i.e., offering telehealth when in-person sessions are not possible), scheduling, and location.

One staff member captured the lengths to which the BHConnect team goes to meet the needs of clients:

> "The key strength is the flexibility that [BHConnect] offers clients to receive services despite their living situation, living location, and schedules. It offers them the option to receive services remotely anywhere and anytime for the most part and provides the device that they might not otherwise have to participate in other remote services. BHConnect is a program that meets them where they are at, during a time of significant crisis and an option to get the support they might not otherwise receive in traditional programs and traditional settings. We will drive out anywhere in the county to provide a device, train them on the device, and engage them quickly after experiencing a mental health crisis!"

Staff identified the uniqueness of BHConnect in this respect: "How unique the program is. I might sound repetitive, yet the ability to accommodate clients in our schedule, our flexibility, and that we don't have a set limit of sessions." Another staff member stated, "We are one of the only programs that helps and assists 7-year olds to 70-year olds, and that's very unique for a therapeutic program."

Program Challenges

During the prior FY (2020-21), BHConnect staff identified staff turnover and shortages as one of the biggest challenges to reaching program goals. This theme continued into FY 2021-22. Multiple respondents highlighted the "learning curve" and increased need for training with new staff.

> "The transition from Welcome Home Health [WHH] to FHNs providing support to clients has been a difficult transition. The FHNs required a great deal more training than clinicians on service delivery and how to capture, bill and document the services being delivered under their role. In addition, we had to train the clinicians to consider more case management and rehab."

Staff also mentioned clinician burnout from working with a client population who can be difficult to engage in services.

> "Morale is always a work in progress at BHConnect because our population is chronically unconnected and difficult to engage. Our clients tend to no-show frequently, and this can contribute to clinician burnout or feeling like they are not doing a good job."

BHConnect Participant Engagement and Retention

As a program designed to work with clients who have experienced a mental health-related crisis but were otherwise unconnected to outpatient services, issues with client engagement were anticipated and have been a focus since the beginning.

Staff noted the need for frequent check-ins and contact with clients to maintain participation. One therapist stated, "When clients are affected by stressors such as pandemic, inflation, and life stressors we notice the change in their engagement with services." Health navigator visits, reminder calls and care packages were mentioned as helpful methods to maintain contact between appointments.

Staff also highlighted the importance of program flexibility in maintaining client engagement. The hybrid treatment model offers options for treatment location and modality, and scheduling flexibility is necessary as well:

> "In my experience connecting with the clients in a more 'person to person' approach helped me a lot. Also meeting them where they are. Being flexible, and understanding of their situation is also a key. The program's structure also helped a lot in keeping them connected as we provide them with a lot of opportunities to miss, reschedule or meet more frequently if desired."

BHConnect staff also recognized the need to effectively address co-occurring substance abuse issues with BHConnect participants. Staff mentioned the need for partnerships with substance use treatment programs, to receive further training in assisting this population and/or to refer the clients to those programs when BHConnect cannot effectively serve them. An on-site Alcohol and Other Drug (AOD) counselor was an additional suggestion.

Facilitating Client Referrals

The establishment and maintenance of referral sources has been a necessary goal of BHConnect since its inception. FY 2021-22 ongoing BHConnect outreach efforts included meeting with representatives of potential partner organizations to educate them about BHConnect services and develop processes for identifying and screening potential clients. Additionally, BHConnect gave presentations at multiple community service provider meetings to increase awareness of BHConnect services.

Multiple staff noted the program manager's commendable efforts at outreach and connection with potential referral sources and the resulting increase in referrals. New connections with Rady Children's Hospital Emergency Department, Sharp Mesa Vista and Paradise Valley Hospital are expected to be strong referral partnerships. Respondents mentioned the need for additional adult referral sources, in an effort to fill midday appointments which are historically underutilized. Additionally, continued outreach is recommended to underserved communities "such as Native Americans, Asians, Latino, and African Americans [as well as] at risk-mothers [and] geriatric clients."

Health Navigator Role

During FY 2021-22, the role of Health Navigator was added to the BHConnect service provider team. Prior to FY 2021-22, a separate organization (WHH) provided some health navigation support services to BHConnect clients including device management, crisis intervention/safety planning, appointment scheduling, and reminders/follow-up. This change allowed for greater coordination and integration of health navigation/service engagement activities with the rest of the BHConnect care team.

When asked which key roles/activities should be the focus of Health Navigators as part of their recently enhanced role in BHConnect, most staff mentioned that it would be useful for Health Navigators to focus on case management and rehab activities (e.g., rehab groups). Additionally, staff mentioned that the Health Navigator role should include client engagement activities (e.g., welcome kits/care packages, frequent in-person visits).

Supports, Tools, & Trainings

In the survey, staff were asked to identify supports, tools, and trainings that they would like more of to do their job well. The responses fell into three categories:

1. Additional training to build upon therapeutic skills (i.e., cognitive behavioral therapy, dialectical behavior therapy, training on working with high-risk clients and co-occurring disorders, parenting skills training, and generalized education on evidence-based practices).
2. Organizational & process skills (i.e., treatment session development, note writing).
3. Further training on County protocols.

Additionally, respondents highlighted the desire for reliable technological equipment and support.

Experiences with Telehealth Services

Technical difficulties with both the telehealth platform and devices were reported as the most common challenges when attempting to provide telehealth with video services. Most BHConnect staff recommended utilizing an alternative contact method (e.g., telephone) in case of issues. Additionally, one staff member suggested the following protocol to navigate technology problems:

> "Remind clients to ensure they have good service before logging into their session, and have a plan for if they get disconnected, such as a phone session as an alternative to a video session. I also recommend [to] check for seeing and hearing at the beginning of the session, and throughout as needed, and informing client that they can log off and log back in, or turn their phone off and back on to try to get a better connection."

Impact of COVID-19 on BHConnect Staff

As a result of COVID-19, staff reported that many team members transitioned to working from home and there has been a resulting lack of coworker connection. One staff mentioned they "can go days without seeing staff [in person]" and that "most communication with staff is via e-mail." A therapist stated,

> "I feel that in general something's changed, for example, stress levels, and being more careful/understanding about people's beliefs in the pandemic. More mental health issues on the rise so the frequency and intensity of the job has somewhat changed."

BHConnect staff report utilizing personal protection measures and mental/physical health self-care to manage pandemic-related demands. One staff member noted the need to be "mindful of how hybrid remote work impacts work relationships, team bonding, and communication [as well as] how hybrid remote work can have negative and positive effects on work performance."

Changes from Initial Program Design

During FY 2021-22, BHConnect expanded the options that clients could utilize to connect with BHConnect services. Originally, all clients were issued an electronic device that they would utilize solely for communicating with the BHConnect and WHH team members. BHConnect began to allow clients the option to choose whether they would like to utilize their personal smartphone to receive BHConnect service (and get the relevant programs installed on their phone) or if they would rather receive a device from BHConnect to use for interacting with the care team. When provided the option, approximately 40% of CYF clients and 50% of AOA clients chose to have an app installed on an existing personal device to participate in BHConnect telehealth services instead of receiving a separate device from BHConnect dedicated to participating in telehealth services.

Throughout FY 2021-22 the BHConnect team was refining the relatively new role of the Health Navigator, which was previously outsourced to a separate organization. Primary responsibilities of the Health Navigator include an emphasis on case management and rehab activities (e.g., rehab groups) as well as supporting client engagement activities such as preparing and delivering welcome kits/care packages and connecting with clients on a regular basis.

Program Recommendations

1. Continue to develop and expand referral partners in order to identify under-served or vulnerable youth, transitional age youth, adult, and older adult residents of San Diego County who could benefit from the treatment services offered by BHConnect. New partners to include but not limited to: Cal State San Marcos, Adult Protective Services, and Perinatal Care Network.
2. Maintain ongoing and close relations with hospitals to provide on-site warm hand-offs and intakes, and ultimately, increased client engagement with BHConnect. Continue to explore best practices to increase client engagement from the moment referral is received.
3. Finalize internal policies and procedures to implement short-term psychiatric care for AOA clients in order to fill the gap as they are linked to long-term psychiatry. Include therapists and Health Navigators in virtual psychiatric evaluations for added, personalized support to clients.
4. Continue embracing a hybrid-treatment model that caters to the individual needs of BHConnect clients, offering in-home services and increased sessions when clinically indicated, and leveraging engagement strategies such as care packages, Motivational Interviewing, Harm Reduction and trauma-informed, compassion-based approaches.
5. To facilitate program effectiveness and sustainability, continue providing Health Navigator check-ins and delivery of care packages and resources as clients are discharging from emergency/crisis services, continue incorporating individual and family rehab to augment teletherapy at BHConnect, maintain therapist and Health Navigator close-collaboration through regular virtual warm hand-offs, and offer rehabilitation groups (both virtually and in-person) on topics such as substance use recovery and

money management. Continue developing additional opportunities for Health Navigators to provide support services that are reimbursable through Medi-Cal/Cal-AIM.

6. Continue to provide clinical support and training to all staff on topics that support their effectiveness in working with serious mental illness in telehealth topics/trainings such as: screening, brief intervention and referral to treatment (SBIRT), best practices in suicidality assessment and treatment, psychopharmacology for serious mental illness, trauma grief counseling, virtual-compatible trauma therapies such as Eye Movement and Desensitization Reprocessing (EMDR), crisis management strategies, and creative interventions to maintain engagement with youth in virtual therapy.
7. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care. Continue annual staff training on parenting skills and modalities such as Parent-Child interaction therapy.
8. Refine the screening process by consulting with community stakeholders and internal leadership, refine BHConnect eligibility criteria as needed, educate referral partners on the risks and benefits of telehealth and what would constitute an appropriate referral to BHConnect.
9. Increase ability to address client preferences by including iPads as a device option available for participating in telehealth services.
10. Explore implementation of the VI-SPDAT to provide homeless clients with increased linkages to housing resources.

Conclusion

During FY 2021-22, a total of 116 persons enrolled in BHConnect (56 CYF and 60 AOA clients). This represented an approximately 30% increase in total new enrollments from FY 2020-21. Including persons who entered BHConnect during FY 2020-21 and continued to receive services in FY 2021-22, a total of 148 persons (81 CYF and 67 AOA clients) were served by BHConnect in FY 2021-22. While BHConnect enrollment increased from the prior year, it remained below initial program targets of 250 persons served each year.

As a result of the efforts of the BHConnect program to expand the number of community referral partners, a total of 20 different organizations referred 256 clients to BHConnect in FY 2021-22, which represented a 51.5% increase from the prior year (n=169). The growth in referrals was due to a 265.8% increase in AOA referrals between FY 2020-21 (n=38) and FY 2021-22 (n=139), whereas CYF referrals declined slightly from 131 to 117 (a 10.7% decrease). A total of 12 different organizations (eight AOA and four CYF) referred at least five clients to BHConnect during FY 2021-22 compared to only four organizations reaching this threshold in FY 2020-21.

As indicated in the referral partner feedback survey, BHConnect was perceived to be an important resource by the increasing number of referral partners throughout San Diego County. Referral partners identified the key benefits of BHConnect as filling a gap in needed services for persons who may not be interested in traditional outpatient programs by offering prompt enrollment into services (i.e., before interest or engagement fades) and relying primarily on a telehealth model which reduces barriers to accessing services.

BHConnect prioritized a quick response to client referrals, with the majority of persons (56.0%) enrolled in BHConnect within one day of the initial referral and 74.4% within three days. Once enrolled in the program and receiving services, youth and adults will stay engaged with the program anywhere from a

few weeks to 6 months or more. Of those who were still involved with BHConnect services as of 06/30/2022, the median enrollment duration for youth and adults was 142.0 and 155.5 days, respectively.

CYF clients and AOA clients were provided, respectively, an average of 3.5 and 4.3 BHConnect services per month (i.e., every 30 days enrolled in BHConnect). This represented a 20.7% and 38.7% increase, respectively from the 2.9 and 3.1 total monthly CYF and AOA BHConnect services provided during the prior year. This increase in average monthly service contacts was due primarily to the greater provision of case management and other support services by the Health Navigators in FY 2021-22.

Service utilization patterns indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services as evidenced by fewer inpatient psychiatric hospitalizations and other related services for youth and adults after enrolling in BHConnect. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. However, the target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remains a challenging population to serve with many demonstrating the need for further behavioral health improvements.

Based on feedback from BHConnect youth and adult clients and the caregivers of youth, the BHConnect program was perceived as accomplishing the goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services. A potential challenge for the BHConnect program; however, is to continue to demonstrate its uniqueness and specific population niche within the overall behavioral health system of care given that telehealth is now more widely available in other treatment programs due to the changes in service provision strategies brought about in response to the COVID-19 pandemic.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of Participants who Enrolled during FY 2021-22

Characteristic	Child/Youth (N=56)		Adult (N=60)	
Gender	**n**	**%**	**n**	**%**
Male	18	32.1	25	41.7
Female	34	60.7	34	56.7
Another gender identity/Prefer not to answer	4	7.2	1	1.6
Total	**56**	**100**	**60**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	51	91.1	56	93.3
Other	5	8.9	4	6.7
Total	**56**	**100**	**60**	**100**
Race/Ethnicity[1]	**n**	**%**	**n**	**%**
African American	8	14.3	16	26.7
Asian	-	-	6	10.0
Hispanic/Latino	34	60.7	22	36.7
White	18	32.1	23	38.3
Multiple	10	17.9	8	13.3
Other	7	12.6	1	1.7
Missing/Unknown	-	-	1	1.7
Total[1]	**-**	**-**	**-**	**-**
Sexual Orientation	**n**	**%**	**n**	**%**
Heterosexual or straight	24	42.9	36	60.0
Gay or Lesbian	<5[2]	<8.9	<5[2]	<8.3
Bisexual/Pansexual/Sexually Fluid	9	16.1	8	13.3
Questioning/Unsure	<5[2]	<8.9	<5[2]	<8.3
Missing/Prefer not to answer	19	33.9	9	15.0
Total	**56**	**100**	**60**	**100**
Disability	**n**	**%**	**n**	**%**
Has a disability	13	23.2	24	40.0
Does not have a disability	38	67.9	29	48.3
Declined/Prefer not to answer	5	8.9	7	11.7
Total	**56**	**100**	**60**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

[2] *Values were suppressed due to small n size.*

Appendix (continued).

Characteristic	Child/Youth (N=56)		Adult (N=60)	
Type of Disability[2]	n	%	n	%
Communication (i.e., seeing, hearing)	<5[2]	<8.9	<5[2]	<8.3
Learning Disability	<5[2]	<8.9	11	18.3
Physical Disability	<5[2]	<8.9	9	15.0
Chronic Health	<5[2]	<8.9	8	13.3
Other	<5[2]	<8.9	<5[2]	<8.3
Total	-	-	-	-

[2] *Values were suppressed due to small n size.*

	Child/Youth (N=56)			Adult (N=60)	
Age Group	n	%	Age Group	n	%
5 to 14	26	46.4	**18 to 25**	17	28.3
15 to 18	30	53.6	**26 to 69**	43	71.7
Total	**56**	**100**	**Total**	**60**	**100**



ROAMING OUTPATIENT ACCESS MOBILE (ROAM) INNOVATIONS-20

Final Report

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

v.12.22.2022

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Roaming Outpatient Access Mobile (ROAM) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). ROAM was designed to increase access to and utilization of culturally competent mental health services in rural American Indian communities in San Diego County to decrease the effects of untreated mental health and co-occurring substance abuse conditions. Two organizations, the Indian Health Council (IHC) and Southern Indian Health Council (SIHC), were selected to provide ROAM services. To facilitate access to care and to help treat the typically underserved American Indian population, the ROAM program adopted the use of mobile health units (MHU) to provide effective health services in areas that may be hard to reach as well as offering telehealth and telepsychiatry services to lessen the need for in-person clinic visits. For both the IHC and SIHC ROAM programs, the ongoing effect of the COVID-19 pandemic and the required safety precautions led to periodic suspension of in-person behavioral health service provision, except for crisis situations. This also prevented the consistent use of mobile health units for delivering behavioral health care services.

Primary Findings and Conclusions

ROAM Programs Expanded Access to Behavioral Health Services through Responsiveness to Unique Community Needs and Priorities

1. While both IHC and SIHC operated a ROAM program with the same fundamental mission (i.e., to increase participation in needed behavioral health care by reducing barriers to accessing services) and the same core tools (i.e., MHU, telehealth, and a team of service providers), variations in the areas of expertise of those comprising each ROAM team and the range of unique opportunities and challenges within the communities they served resulted in the development of two similar, but different ROAM programs. An essential component of each ROAM program, particularly when required to strategically adjust to the new realities brought about by the COVID-19 pandemic, was the capacity to flexibly and creatively utilize the tools and resources within the ROAM program to address identified and emerging needs of those they served.

2. Both the IHC and SIHC ROAM programs provided an extensive amount of behavioral health services. IHC provided 2,626 services to 146 persons (average of 18.1 services per person) and SIHC provided 3,404 services to 403 persons (average of 8.4 services per person).

3. Primary services for both programs included the provision of therapeutic care as well as a range of other assessment, psychoeducation, and case management services. While both programs offered psychiatric care to support medication management, over half the participants (51.6%) at SIHC had at least one medication management visit, whereas less than a quarter (22.6%) of participants were served at IHC. With the inclusion of a licensed Alcohol and Other Drug (AOD) counselor on the IHC ROAM team, more than half of IHC participants (56.2%) engaged in at least one substance abuse counseling session, whereas this was not commonly provided by SIHC (only 2% of SIHC clients received the service).

ROAM Programs Provided Important, Accessible Services that Improved Recovery

4. Participant feedback reported that they highly valued ROAM services and noted they likely would not be in services if not for the accessible, trusted, and private ROAM services. ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services in a flexible and private manner, stating that without the program they likely would not be in therapy.

5. While limited outcome data with baseline and follow-up assessments were available, of those persons with such data, reductions in depression symptoms and improved recovery and management of symptoms were identified for many.

Where Feasible, Telehealth Video-Based Sessions were a Promising Approach to Increase Accessibility of Behavioral Health Services

6. Feedback from ROAM staff and participants indicated that where technologically feasible, telehealth with video was an acceptable, and in many instances desirable mode for delivering behavioral health care services for Native community members due to convenience and privacy.

7. Challenges remained for providing telehealth services throughout remote and particularly mountainous regions. Based on the experiences of the ROAM programs, a multi-level model was created (as shown in Figure 1 below), to illustrate and summarize the foundational community-, organizational-, provider- and patient-level factors necessary to support widespread utilization of telehealth services.

Under Challenging Circumstances, Both ROAM Programs Creatively Utilized the MHUs to Provide Services and Increase Awareness of ROAM and Behavioral Health Needs

8. Mechanical and logistical issues delayed and disrupted utilization of the MHUs at times and the COVID-19 pandemic also prevented their use, at least initially, due to safety concerns regarding confined and shared spaces. Even with those challenges, both ROAM programs made creative use of their MHUs to provide behavioral health services throughout the community. When feasible, they also promoted awareness of the ROAM program and provided general behavioral health information via the MHUs through participation in community events. The MHUs were also utilized to address

emerging needs related to the pandemic by assisting with COVID-19 testing and administering vaccines at locations throughout the communities.

9. ROAM staff highlighted the importance of engaging with the local community in order to achieve the goal of expanding access to mental health and substance use treatment services among historically underserved American Indian populations. While the pandemic prevented or substantially altered many types of community events for extended periods of time, when feasible, both IHC and SIHC ensured that ROAM was a visible presence at community festivals, trainings, meetings, and other events to raise awareness about the services available through ROAM as well as increasing education and understanding about mental health and substance use issues more generally. These outreach efforts contributed to the recognition of ROAM as an important community resource.

Future Directions

Between fiscal year (FY) 2018-19 and FY 2021-22, the IHC and SIHC ROAM programs were funded by BHS as part of an MHSA Innovations program to develop and pilot test new services. Based on the experiences, accomplishments, and operational learnings of the IHC and SIHC ROAM programs during this timeframe, both IHC and SIHC decided to continue the ROAM programs indefinitely using non-BHS funding sources such as other federal grants. Feedback from ROAM program staff indicated how ROAM was now perceived as an essential part of the community and a key resource that has been integrated within their existing behavioral health services. Ongoing ROAM program services were expected to closely resemble the types of services provided during the BHS-funded Innovations phase to reflect the unique needs and strengths of each program (i.e., strong emphasis on AOD at IHC and on medication management at SIHC in addition to extensive provision of mental health therapy at both). Additionally, each ROAM program will continue to make flexible use of the MHU and telehealth technologies where feasible to reduce barriers to accessing needed behavioral health services.

Program Description

The HHSA BHS ROAM program was funded through the INN component of the MHSA to develop and pilot-test new services. ROAM was developed to provide fully mobile mental health clinics to American Indians of all ages in the North Inland and East County regions of San Diego. Two organizations, the IHC and SIHC were selected to provide ROAM services. Program planning along with mobile health units design and acquisition began during FY 2018-19 with BHS-funded behavioral health services provided by each of the ROAM clinics from FY 2019-20 through FY 2021-22.

The ROAM teams at both IHC and SIHC included licensed therapists and psychiatrists. The IHC ROAM team also included a licensed AOD counselor; whereas the SIHC ROAM team incorporated a licensed nurse into their care team to help identify and address frequently identified physical health needs. The majority of ROAM staff at both IHC and SIHC identified as American Indian. This representative staffing was part of an effort to provide culturally competent services that were sensitive to the needs of American Indians.

ROAM services were intended to improve access to and utilization of mental health services for American Indian children, transitional age youth (TAY), adults, and older adults residing on tribal reservations and in rural communities in San Diego County. A key eligibility criterion for ROAM services was whether

barriers were identified that would inhibit participation in standard clinic-based outpatient behavioral health care services. ROAM services aimed to decrease behavioral health symptoms and improve level of functioning for participants, while also improving care coordination and access to physical health care. Each ROAM team was staffed with culturally competent licensed and unlicensed professionals who could provide a variety of care services. In addition, the ROAM program used telehealth to decrease burdens for accessing needed services, and as a response to the pandemic, when in-person services were either not possible or not preferred due to concerns about patient and staff safety.

To reduce the stigma often associated with behavioral health concerns and increase awareness of ROAM services in their respective communities, staff from each ROAM program participated in community events and meetings to provide education about behavioral health issues.

Participant Characteristics

A brief overview of the ROAM participant characteristics is presented here with a more complete listing in the report appendix. IHC served a total of 146 persons and SIHC served 403 between 7/1/2019-6/30/2022. In general, the characteristics of the enrollees in both ROAM programs were similar with females comprising a slightly higher percentage of those served at SIHC compared to IHC (57.3% to 50.7%). Of the populations served, 91.1% of IHC and 80.9% of SIHC ROAM clients identified as American Indian, with the majority from both programs indicating they spoke English (93.8% and 98.0%, respectively). , and did not have a disability (37.7% and 73.7%, respectively As shown in Table 1, children (i.e. less than age 16) and transitional age youth (i.e., age 16 to 25) comprised a larger proportion of the population served at SIHC than at IHC.

Table 1. Participant Age

	IHC (N=146)		SIHC (N=403)	
Age	**n**	**%**	**n**	**%**
0 - 15	5	3.4	56	13.9
16-25	15	10.3	79	19.6
26-45	66	45.2	152	37.7
46-65	39	26.7	87	21.6
>65	21	14.4	29	7.2
Total	**146**	**100**	**403**	**100**

Utilization of Program Services

ROAM Behavioral Health Service Provision

A total of 146 persons received 2,626 behavioral health services through IHC ROAM and 403 persons received a total of 3,404 services through SIHC ROAM. While IHC ROAM served fewer persons than SIHC ROAM, those served typically had more service contacts per person than those served at SIHC ROAM (average of 18.1 and 8.6 service contacts, respectively).

As shown in Table 2, one key area of difference between the two programs was the provision of substance abuse counseling, with over half (56.2%) of IHC participants receiving at least one such service compared to the 2.0% of SIHC participants. This difference reflects the composition of the respective ROAM teams and the inclusion of a SUD counselor at IHC. Another key area of difference was that medication management services were received by about twice as many participants at SIHC (51.6%) as compared to IHC (22.6%). Both programs included access to psychiatric care, but expanded access to this type of service was particularly emphasized at SIHC.

Psychoeducation was more commonly reported among IHC participants (38.4% and 8.4%, respectively). Similar percentages of participants from IHC and SIHC received cognitive behavioral therapy (36.3% and 36.5%, respectively). Of note, at both IHC and SIHC, substantial proportion of the clients (19.9% and 30.0%) were specifically reported as receiving trauma-informed therapy. This suggests that prior and/or current traumatic experiences were negatively impacting the lives of many persons served by IHC and SIHC. While there were some differences between the programs, most notably being the emphasis on substance abuse counseling evident at IHC and medication management at SIHC, the overall findings highlight the wide range of service activities that were provided to persons who may have had difficulty accessing needed behavioral health care through traditional outpatient clinic settings.

Table 2. Number and Type of ROAM Service Contact by Program

	IHC				SIHC			
	Total persons (N=146)		Total services (N=2,626)		Total persons (N=403)		Total services (N=3,404)	
	Number of persons with service	Percent of persons with service	Number of services	Percent of total services	Number of persons with service	Percent of persons with service	Number of services	Percent of total services
Assessment	93	63.7	137	5.2	292	72.5	385	11.3
Psychoeducation: Individual	56	38.4	378	14.4	34	8.4	193	5.7
Psychoeducation: Group	<5[1]	<3.4	<5	<0.2	29	7.2	29	0.9
Therapy: Trauma Informed: Individual	29	19.9	364	13.9	121	30.0	538	15.8
Therapy: Cognitive Behavioral: Individual	53	36.3	819	31.2	147	36.5	1,450	42.6
Substance Abuse Counseling	82	56.2	1,015	38.7	8	2.0	21	0.6
Therapy: Cognitive Behavioral: Group	20	13.7	86	3.3	<5[1]	<1.2	5	0.1

[1]*Due to the small number of people receiving this service, (i.e., less than 5), the exact number is masked.*

Table 2. Number and Type of ROAM Service Contact by Program (continued).

	IHC				SIHC			
	Total persons (N=146)		Total services (N=2,626)		Total persons (N=403)		Total services (N=3,404)	
	Number of persons with service	Percent of persons with service	Number of services	Percent of total services	Number of persons with service	Percent of persons with service	Number of services	Percent of total services
Referral to Substance Abuse Counseling	7	4.8	12	0.5	14	3.5	17	0.5
Therapy-Family Involved	<5[1]	<3.4	<5	<0.2	51	12.7	152	4.5
Case Management	9	6.2	18	0.7	74	18.4	208	6.1
Medication Management	33	22.6	220	8.5	208	51.6	1086	31.9
MAT-SUD	-	0	-	0	19	4.7	117	3.4
Other	46	31.5	206	8.1	13	3.2	14	0.4

[1]*Due to the small number of people receiving this service, (i.e., less than 5), the exact number is masked.*

The variety of service activities provided by both ROAM programs were delivered either in-person, over the phone, or via telehealth with video. As shown in Table 3, approximately half of the ROAM services at IHC were provided in-person (50.6%) as compared to 25.5% at SIHC. At IHC 44.3% of the service contacts were provided via telephone with only 5.0% via telehealth with video, whereas at SIHC, telephone-based services represented 26.1% of services contact and telehealth with video comprised almost half of all SIHC services provided (47.8%).

Table 3. Method of Contact

	IHC		SIHC	
Contact Type	**n**	**%**	**n**	**%**
In-Person	1,313	50.6	868	25.5
Telehealth w/video	130	5.0	1,628	47.8
Telephone	1,151	44.3	887	26.1
Other	3	0.1	31	0.9

Based upon feedback from the ROAM programs, the differences in how services were provided by IHC and SIHC were largely the result of two primary factors: 1) conditions of the COVID-19 pandemic, which pushed many services remotely for extended periods of time, and 2) variabilities in technological capabilities across the rural and mountainous communities.

With COVID-19 inhibiting the use of in-person services for long periods of time, SIHC moved rather easily into telehealth during this period due to their high prevalence of psychiatry services. In contrast, the move into telehealth created additional challenges for IHC due to the emphasis on providing substance abuse counseling, which were harder to effectively accomplish remotely, so in-person sessions were utilized whenever feasible.

Another factor in telehealth service utilization were variations in technological capabilities. Technological and internet connectivity difficulties were experienced more acutely across IHC communities which contributed to why only 5% of services were provided via telehealth with video compared to 47.8% at SIHC. Many IHC participants did not have internet connectivity that could support a video-based telehealth session. Where internet services were available, communication disruptions (i.e., dropped calls) and distortions interfered with the health providers ability to consistently engage in the therapeutic discussions with their participants. This prompted a greater reliance on delivering services via phone. Additional difficulties emerged for IHC with integrating information technology systems and the virtual platforms needed to securely conduct telehealth sessions.

Since many services were provided remotely, this allowed participants more flexibility regarding where they were located when receiving ROAM services, with approximately two-thirds of ROAM services provided while the participant was at home (i.e., via phone or telehealth). This highlights the importance of programs such as ROAM that allow services to be accessible and eliminate transportation barriers for many visits. Other locations commonly used by ROAM participants included: 1) the home of friend/family member, 2) the car, 3) work, or 4) while in another inpatient or residential treatment program. The ongoing effects of the COVID-19 pandemic limited the programs' ability to consistently provide ROAM services using the MHU, however, when possible, offering services via the MHU represented another approach used to extend the reach of ROAM into the community and make services as accessible as possible.

Primary Program Outcomes

Patient Health Questionnaire

The Patient Health Questionnaire (PHQ) is a brief, self-report tool used for identifying depression, with higher scores indicating increased severity of depression symptoms. As shown in Table 4, a total of 40 persons at IHC and 65 persons at SIHC completed a PHQ-9 at the time of enrollment into ROAM and completed at least one follow-up assessment. The average intake scores were 9.7 for IHC and 11.2 for SIHC participants, which were generally indicative of moderate depression. However, there was substantial variability in the initial PHQ-9 scores with approximately 35-45% of participants from both programs demonstrating symptoms likely indicative of a depressive disorder.

Table 4. Change in PHQ-9 Scores from Initial Assessment to Last Follow-up Assessment

	IHC (N=40)			SIHC (N=65)		
PHQ-9 Item		**Initial PHQ-9**	**Last available PHQ-9**		**Initial PHQ-9**	**Last available PHQ-9**
Note: higher value = worse condition Scale: 0 ("not at all) to 3 ("nearly every day")	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
Little interest or pleasure	40	1.1	0.9	65	1.4	0.8**
Feeling down	40	1.3	1	62	1.4	1.1**
Trouble sleeping or excessive sleep	40	1.6	1.1	65	1.8	1.2**
Feeling tired	40	1.2	1.2	65	1.6	1.2**
Poor appetite or overeating	40	1.1	0.7	65	1.2	0.6**
Feeling bad about self	40	1.1	0.9	65	1.3	0.9**
Trouble concentrating	40	1.2	0.9	65	1.6	1.1**
Moving or speaking slowly, or being fidgety/restless	40	0.8	0.6	64	0.6	0.3**
Thoughts of being better off dead, or of hurting self	40	0.2	0.2	65	0.3	0.1*
PHQ-9 Total Score	40	**9.7**	**7.8^**	65	**11.2**	**7.4****
MEDIAN	40	**10**	**6.5**	65	**10**	**6**
Likely Depressive Disorder (i.e., at least 4 items scoring 2 or 3)	-	**16 (36.4%)**	**12 (27.3%)**	-	**29 (44.6%)**	**13** (20.0%)**

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) captures recovery as assessed by staff using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

As shown in Table 5, there were 44 persons at IHC and 57 persons at SIHC who had both an intake and follow-up MORS completed from which to conduct a change assessment comparison. The average MORS score upon intake was similar for IHC and SIHC (i.e., 5.3 and 5.0, respectively), which corresponds most closely to "not coping, engaged." The initial MORS score distribution differed to some extent between the two programs; SIHC participants exhibited a broader range of values relative to IHC, demonstrated by a higher proportion of their participants falling in both the lowest and highest MORS ratings categories.

Table 5. Change in MORS Scores from Initial Assessment to Last Follow-up Assessment

		IHC (N=44)				SIHC (N=57)			
		Intake		Follow-Up		Intake		Follow-Up	
Value	MORS Rating Category	n	%	n	%	n	%	n	%
1-4	Extreme risk; High risk, not engaged; High risk, engaged; Not coping, not engaged	4	9.1	4	9.1	23	40.4	4	7.0
5	Not coping, engaged	23	52.3	7	15.9	13	22.8	8	14.0
6	Coping/rehabilitating	14	31.8	21	47.7	12	21.1	24	42.1
7-8	Early recovery; Advanced recovery	3	6.8	12	27.3	9	15.8	21	36.8
	Mean MORS	**5.3**		**6.0****		**5.0**		**6.1****	

***statistical significance at p < 0.01*

As of the last available follow-up assessment completed, the average MORS score increased for both IHC and SIHC participants. Scores were 6.0 and 6.1, respectively, corresponding most closely to "coping/rehabilitating." For both programs, these changes reflected statistically significant and clinically meaningful improvements in recovering and management of symptoms.

ROAM Participant Feedback

ROAM providers asked participants to engage in a short qualitative survey to elicit feedback on the program. Providers were given a short script that explained the qualitative data collection process and that their feedback was completely voluntary and would not impact participation in the program. The 16 ROAM clients who participated were asked a series of questions which had been developed by the evaluation team in collaboration with ROAM leadership and BHS. The following themes emerged from the qualitative data collection effort:

Clients would not be in therapy without ROAM

- "I would feel like there is no help. I wouldn't go and be seen by anybody. I would feel at a loss that there would be no programs to deal with mental health issues."
- "I wouldn't be meeting with anyone. I have tried and it has not been good."
- "I would probably go to the clinic because I needed support. I wouldn't have liked that option though. This has been convenient and private."

Word of mouth and community presence are important for program success

- "I heard from someone I know that you guys were doing telehealth."
- "I was going through difficulties at the time. I saw the bus come out every week and one day I decided to come over. I have anxiety about meeting new people so it helped to have said hello to you (therapist) a few times."
- "Because I knew [the ROAM therapist], I felt comfortable with you and ROAM. Plus, I had no choice I needed some support at the time. Then when I met you I felt even more comfortable because I knew you were cool."

Combination of behavioral health and medical services is helpful

- "I like how ROAM is set up. I can be close to my home and get medical care and therapy. It's convenient and private."
- "I would add (additional medical) services and be more consistent… there are lots of ways to help the community out here."
- "Maybe do more medical services for the elders or people that don't make it to the clinic."

Clients value flexibility in appointment types and locations

- "I liked in-person with ROAM because I was given the option to meet outside. It's hard for me to sit in a room for an hour."
- "If we hadn't started talking on the phone and you hadn't been so nice I never would have started this. The phone helped me with my anxiety. There is no way I would have come and met with you face to face right away."
- "I met with a psychiatrist at another clinic but it was too hard to keep appointments. Transportations was the problem."

Clients appreciate ROAM culturally appropriate and private services

- "The fact that it is Native American culture, and plus you are on the reservation."
- "I don't trust counselors. I felt you were different. It seemed like you actually listened and cared. You weren't trying to be better than me."
- "There is no way I would be getting (behavioral health) services if ROAM didn't come out here. I don't feel comfortable at the clinic because everyone knows your business. This feels private."

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings with ROAM program staff and 2) the Annual ROAM Staff Survey. The stakeholder meetings were held periodically with representatives from BHS, ROAM, and the University of California San Diego (UCSD) evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ROAM Staff Survey was conducted at the end of each FY. IHC and SIHC ROAM program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were

discussed to arrive at a consensus on the key response themes. Information included in the following sections is applicable to both the IHC and SIHC programs unless otherwise indicated.

Favorable Staff Perspectives Regarding the Value of Remote Sessions

Staff from both ROAM programs indicated developing a more favorable view on the role of remote visits (i.e., telephone and telehealth) to provide behavioral health services. Overall, ROAM clinicians thought they were able to accomplish much more in their therapeutic interactions via remote sessions than originally expected. The following observations were provided regarding the change in staff perspectives about utilizing telehealth with video services:

1. Many ROAM clinicians initially had doubts that the Native community would engage in telehealth services regularly. However, after utilizing telehealth they report a significant drop in no-show rates and that Native clients were engaged with services at similar levels to those observed for in-person sessions.
2. ROAM clinicians also had concerns that the lack of person-to-person contact may prevent significant rapport building. However, after extensively utilizing telehealth, clinicians shared that rapport building was effective in most, although not all, telehealth cases.
3. ROAM clinicians thought that technological problems due to remote locations on the reservation would prevent widespread utilization of telehealth services. However, many people living on the reservations were able to find a location where they could engage in a successful telehealth meeting without technical issues, especially after the tribal and organizational investments to expand connectivity options following the onset of the COVID-19 pandemic.

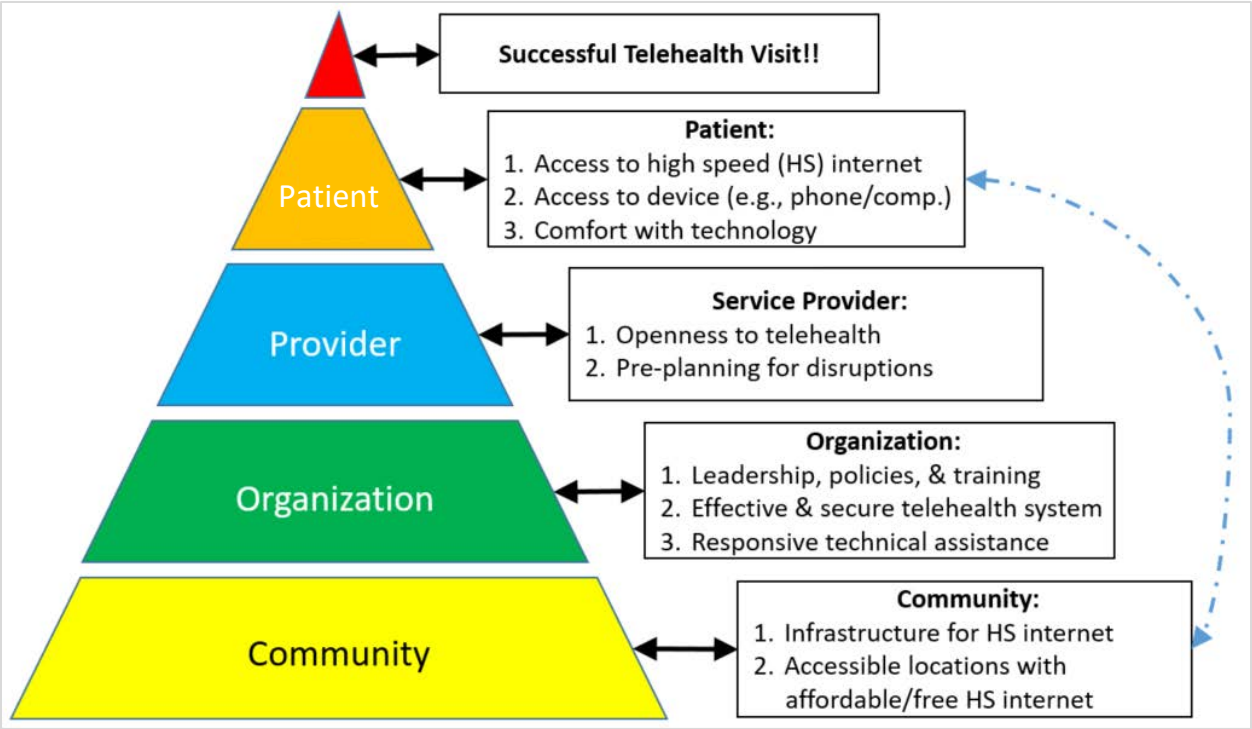
While ROAM staff were generally impressed with what could be accomplished via remote service provision, there was recognition that remote services were not ideal for some persons and that being able to offer at least some in-person services was still essential.

In addition, ROAM staff indicated that the difficulties experienced while trying to comprehensively provide behavioral health care via telehealth services throughout the community helped identify the geographic areas where such services were not feasible (i.e., areas where internet connectivity was nonexistent or not strong enough to support the upload speeds needed to seamlessly conduct video-based telehealth sessions). An increased awareness of the need for improved rural technology infrastructure that can support telehealth services is not unique to the County of San Diego, and ROAM program staff are aware of federal funding sources that will create opportunities for rural and Native communities to enhance the capacity to provide telehealth services. It is expected that these investments will increase the availability of telehealth services for the ROAM programs, particularly for IHC ROAM.

Establishing a Multi-Level Foundation for Successful Delivery of Telehealth Services

Based on the experiences of both ROAM programs and feedback from ROAM participants and staff, the following model was developed to summarize and illustrate the foundational factors needed to successfully deliver telehealth services in the communities served by ROAM. As shown in Figure 1, key foundational elements across multiple levels were identified as necessary to create the context for widespread delivery of telehealth visits.

Figure 1. Multi-Level Foundation for Successful Delivery of Telehealth Services



The overall foundation, upon which everything else is dependent, is community-level infrastructure needed to provide widespread high-speed internet capable of seamlessly and consistently handling video-based interactions between patients and providers. While the goal is for all community members to have their own personal high-speed internet access, or at least have a local friend or family member who does, there are areas where this is not feasible. In that case, locations such as community centers, clinics, etc. should offer secure and free Wi-Fi in private settings so that telehealth options are accessible close to a person's home.

At the organization level, three key factors are needed: 1) organizational support in terms of leadership, provision of staff training, and developing policies and protocols to guide telehealth practice are critical to encourage and champion use of telehealth, especially when it was not initially considered part of standard practices; 2) the adoption of a telehealth platform that integrates well with clinic workflows and data systems; and 3) the importance of a responsive technical assistance team who can help with guiding providers through the telehealth platform and quickly ("real-time" is preferred) address questions and problems that arise when delivering telehealth care.

At the provider level, essential factors are 1) a general openness to trying to provide telehealth care services (which can be greatly facilitated by the organizational-level factors discussed above), as well as 2) pre-emptively developing a plan for how to handle the eventuality that a telehealth visit will get disrupted due to technological issues and communicating that with the patient (e.g., attempting to reconnect via video or switch to a phone call).

At the patient level, two logistical access issues much be addressed: 1) accessibility of high-speed internet and 2) a device capable of accessing the telehealth platform.

As discussed above, community investment into the availability of affordable high-speed internet access is crucial. Additionally, where a patient does not have their own device (e.g., phone, tablet, or computer) or ability to easily access one via friends and family or at a local resource such as community center or clinic, health care organizations should consider providing such a device to patients. A final step, and often one of the easiest, is to ensure (and increase where needed) patient knowledge and comfort with using telehealth technologies (e.g., how to access the internet, start the telehealth session, etc.). Feedback from the ROAM team members indicated that many patients quickly learned how to utilize telehealth technologies, felt comfortable communicating with providers in this manner, and appreciated the flexibility and convenience that it allowed. In this regard, once the multi-level foundation was prepared, successful telehealth visits with patients were feasible and common.

Community Outreach, Education, and Engagement

ROAM staff highlighted the importance of engaging with the local community in order to achieve the goal of expanding access to mental health and substance use treatment services among historically underserved American Indian populations. Staff indicated that positive coordination and communication with community partners led to successful outreach and recruitment. This investment in new and existing relationships resulted in invitations to participate in community and cultural events. While the pandemic prevented or substantially altered many types of community events for extended periods of time, when feasible both IHC and SIHC ensured that ROAM was a visible presence at community festivals, trainings, meetings, and other events to raise awareness about the services available through ROAM as well as increasing education and awareness about mental health and substance use issues more generally. These outreach efforts, coupled with dedicated staff and the inherent flexibility in how services could be offered provided increased accessibility of the ROAM program and acceptability of ROAM as an important community resource. Staff qualitative feedback provided the following related themes:

Connection to the community and culture were key components of ROAM services

- "The program spent the first year building relationships with community organizations on the reservation. This created an increased sense of trust with ROAM which led to more referrals and a greater confidence to seek treatment."
- "[One factor that helped the ROAM program achieve its goals was] open conversation with the Tribal Councils about the availability of the services provided."
- "The communication, perseverance, diligence, passion, intelligence, desire to serve others, dedication [of ROAM staff] to the support of mental health as a whole and serving an underrepresented population in San Diego County."

Services flexibility

- "The adaptability and flexibility of staff to changes of policies and procedures to better ensure clients' needs are met."
- "Adaptability, flexibility, and organization. We are able to meet client needs and adjust to the new requirements and the ever-changing needs of our clientele."

Role of MHU to Support ROAM Operations and Outreach

While the ROAM programs initially stopped utilizing the mobile health units during March 2020 due to the onset of the COVID-19 pandemic and the associated health and safety concerns, SIHC ROAM was able to restart regular "ROAM Bus" mobile health services during FY 2020-21 with adaptations as needed to respond to safety protocols due to the ongoing pandemic. Likewise, IHC ROAM was able to utilize the MHU when conditions allowed. Having access to the MHUs enabled ROAM to expand their reach and provide services to persons who would otherwise have difficulty accessing services, particularly if there was a desire or need for in-person sessions.

Even though the utilization of the mobile health units was affected by the COVID-19 pandemic the ROAM staff from both IHC and SIHC viewed the mobile health units as a particularly important part of the ROAM programs, as can be seen in some example feedback from the staff survey.

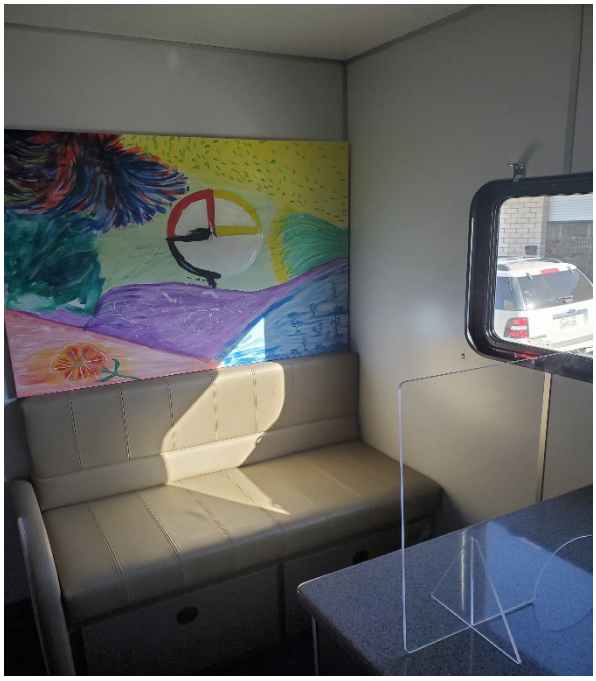
Overall, the ROAM programs endeavored to offer flexibility in location and communication modality to allow participants to engage in services however they preferred and felt safe doing. As such, during a typical day, ROAM clinicians provided services in a variety of physical locations (e.g., at community centers, remote clinics, or on the MHU) and used different methods of communication (e.g., in-person, phone, or telehealth with video) to meet the engagement preferences of ROAM participants.

MHU Flexibility is a strength of the ROAM program

- "This program is excellent for the rural clients/patients without transportation. It aides in providing services in getting the much needed help for them."
- "With the ROAM Bus [i.e., the MHU] acting as a central hub in the community ROAM could potentially expand to include more staff who go out into the community each day to meet needs of community members who cannot make a trip to the clinic."



Photo 1: Outside view of SIHC mobile health unit



Picture 2: Clinician's office



Picture 3: Substance counselor's office

Additionally, both SIHC and IHC reported using their mobile health units to promote awareness of their respective programs in the community via the logos and other information on the units themselves to encourage engagement. The ROAM mobile health units were invited to community events to provide education, behavioral health services, as well as contribute efforts to provide COVID-19 related testing and vaccination services.



Photo 4: Outside view of IHC mobile health unit

Changes from Initial Program Design

The primary changes from initial program design included the adaptations required in response to the ongoing COVID-19 pandemic. The pandemic limited the availability of in-person sessions and increased reliance on remote interactions for both ROAM programs. However, since the ROAM programs were specifically developed to provide a range of options for delivering behavioral health services, the COVID-19-related changes do not represent a completely new approach to service provision. Instead, the adaptations were a shift in emphasis such that remote services via telephone and telehealth have become more common and normalized than initially expected.

In addition, the initial ROAM program design anticipated the use of "cultural brokers" as part of the ROAM staff in order to facilitate connections to and engagement with the American Indian communities intended to be served by the ROAM programs. The decision to utilize organizations already established within these communities (i.e., IHC and SIHC) essentially eliminated the need for maintaining a specific "cultural broker" role on the ROAM teams given that many IHC and SIHC staff identified as American Indians and the organizations had a long history of working with and serving American Indians. In this regard, by embedding the ROAM program within IHC and SIHC, the original goal of promoting engagement with American Indians was achieved without the need for designating specific staff as "cultural brokers."

Conclusion

While both IHC and SIHC operated a ROAM program with the same fundamental mission (i.e., to increase participation in needed behavioral health care by reducing barriers to accessing services) and the same core tools (i.e., MHU, telehealth, and a team of service providers), variations in the areas of expertise of those comprising each ROAM team and the range of unique opportunities and challenges within the communities they served resulted in the development of two similar, but different ROAM programs. An essential component of each ROAM program, particularly when required to strategically adjust to the new realities brought about by the COVID-19 pandemic, was the capacity to flexibly and creatively utilize the tools and resources within the program to address identified and emerging needs of those they served.

Both the IHC and SIHC ROAM programs provided an extensive amount of behavioral health services. IHC provided 2,626 services to 146 persons (average of 18.1 services per person) and SIHC provided 3,404 services to 403 persons (average of 8.4 services per person). Primary services for both programs included the provision of therapeutic care as well as a range of other assessment, psychoeducation, and case management services. While both programs offered psychiatric care to support medication management, this was a primary area of emphasis for SIHC with over half of their participants (51.6%) having at least one medication management visit as compared to 22.6% of the those served by IHC. With the inclusion of a licensed AOD counselor on the IHC ROAM team, more than half of IHC participants (56.2%) engaged in at least once substance abuse counseling session whereas this was not commonly provided by SIHC (only 2% of SIHC clients received the service).

While limited outcome data with baseline and follow-up assessments were available, of those persons with such data, reductions in depression symptoms and improved recovery and management of symptoms were identified for many.

Participant feedback reported that they highly valued ROAM services and noted they likely would not be in services if not for the accessible, trusted, and private ROAM services. ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services in a flexible and private manner, stating that without the program they likely would not be in therapy.

Feedback from ROAM staff and participants indicated that where technologically feasible, telehealth with video was an acceptable, and in many instances desirable, mode for delivering behavioral health care services for Native community members due to convenience and privacy.

Challenges remained for providing telehealth services throughout remote regions. Based on the experiences of the ROAM programs, a multi-level model was created to illustrate and summarize the foundational community-, organizational-, provider- and patient-level factors necessary to support widespread utilization of telehealth services.

Mechanical and logistical issues delayed and disrupted utilization of the MHUs at times and the COVID-19 pandemic also prevented their use, at least initially, due to safety concerns regarding confined and shared spaces. Even with those challenges, both ROAM programs made creative use of their MHUs to provide behavioral health services throughout the community. When feasible, they also promoted awareness of the ROAM program and provided general behavioral health information via the MHUs through participation in community events. The MHUs were also utilized to address emerging needs related to the pandemic by assisting with COVID-19 testing and administering vaccines at locations throughout the communities.

ROAM staff highlighted the importance of engaging with the local community in order to achieve the goal of expanding access to mental health and substance use treatment services among historically underserved American Indian populations. While the pandemic prevented or substantially altered many types of community events for extended periods of time, when feasible, both IHC and SIHC ensured that ROAM was a visible presence at community festivals, trainings, meetings, and other events to raise awareness about the services available through ROAM as well as increasing education and understanding about mental health and substance use issues more generally. These outreach efforts contributed to the recognition of ROAM as an important community resource.

Future Directions

Between FY 2018-19 and FY 2021-22, the IHC and SIHC ROAM programs were funded by BHS as part of an MHSA Innovations initiative to develop and pilot test new services. Based on the experiences, accomplishments, and operational learnings of the IHC and SIHC ROAM programs during this timeframe, both IHC and SIHC decided to continue the ROAM programs indefinitely using their own non-BHS funding sources. Feedback from ROAM program staff indicated how ROAM was now perceived as an essential part of the community and a key resource that has been integrated within their existing behavioral health services. Ongoing ROAM program services were expected to closely resemble the types of services provided during the BHS-funded Innovations phase to reflect the unique needs and strengths of each program (i.e., strong emphasis on AOD at IHC and on medication management at SIHC in addition to extensive provision of mental health therapy at both). Additionally, each ROAM program will continue to make flexible use of the MHU and telehealth technologies where feasible to reduce barriers to accessing needed behavioral health services.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of Participants who Enrolled into ROAM

Characteristic	IHC Participants (N=146)		SIHC Participants (N=403)	
Gender	**n**	**%**	**n**	**%**
Male	70	47.9	170	42.2
Female	74	50.7	231	57.3
Other/Missing/Prefer not to answer	2	1.4	2	0.5
Total	**146**	**100**	**403**	**100**
Age Group	**n**	**%**	**n**	**%**
<16	5	3.4	56	13.9
16-25	15	10.3	79	19.6
26-45	66	45.2	152	37.7
46-65	39	26.7	87	21.6
>65	21	14.4	29	7.2
Total	**146**	**100**	**403**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	137	93.8	395	98.0
Other/Missing/Prefer not to answer	9	6.2	8	2.0
Total	**146**	**100**	**403**	**100**
Race/Ethnicity	**n**	**%**	**n**	**%**
American Indian	133	91.1	326	80.9
Latino	5	3.4	28	6.9
Caucasian	4	2.7	51	12.7
Multi-racial	6	4.1	19	4.7
Other	2	1.2	9	2.2
Missing/Prefer not to answer	8	5.5	8	2.0
Total[1]	-	-	-	-
Sexual Orientation	**n**	**%**	**n**	**%**
Heterosexual or straight	112	76.7	154	38.2
Gay/Lesbian/Bisexual/Pansexual	5	3.4	19	4.8
Prefer not to answer	22	15.1	144	35.7
Missing	7	4.8	86	21.3
Total	**146**	**100**	**403**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

Appendix (continued).

Characteristic	IHC Participants (N=146)		SIHC Participants (N=403)	
Military Status	**n**	**%**	**n**	**%**
Previously served in the military	4	2.7	6	1.5
Never served in the military	98	67.1	301	74.7
NA/less than age 18	6	4.1	81	20.1
Other/Missing/Prefer not to answer	38	26.1	15	3.7
Total	**146**	**100**	**403**	**100**
Disability	**n**	**%**	**n**	**%**
Yes, has a disability	44	30.1	86	21.3
No, does not have a disability	55	37.7	297	73.7
Declined/Prefer not to answer	47	32.2	20	5.0
Total	**146**	**100**	**403**	**100**
Type of Disability	**n**	**%**	**n**	**%**
Communication (e.g., seeing, hearing)	<5	<3.4	7	1.7
Learning/Developmental	<5	<3.4	11	2.7
Dementia/Other Mental	<5	<3.4	5	1.2
Physical	10	6.8	6	6.1
Chronic Health	13	8.9	66	16.4
Other Disability	21	14.4	2	0.5
Total[2]			-	-

[2] *Since participants could select more than one specific non-mental health-related disability, the percentages may total more than the percent who indicated having any disability.*



JUST BE U INNOVATIONS-21

Annual Report
Year 4 (7/1/2021-6/30/2022)

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

v.12.22.2022

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

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Executive Summary

Program Overview

The Just Be U (JBU) program was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY; age 18-25; referred to as "youth" throughout this report) with serious mental illness (SMI) who are homeless or otherwise at risk of homelessness, and repeatedly utilize acute or emergency mental health services but are otherwise unconnected to services. JBU provides short-term housing for youth in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions coupled with occupational therapy (OT) supports to help teach skills needed to accomplish personal goals. Throughout these interactions with youth, JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on youth-centric, whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging youth.

Primary Findings for FY 2021-22

JBU Enrollment and Key Participant Characteristics

1. During FY 2021-22, JBU staff were able to successfully locate and enroll 52 youth who were homeless/at risk of homelessness and receiving crisis services for untreated serious mental illness.
2. The youth served by JBU were a racially/ethnically diverse population with 51.9% of youth identifying as Caucasian, 36.5% as Hispanic/Latino, 21.2% as African American and 13.4% as another race (note: youth could indicate more than one race/ethnicity, so totals exceed 100%).

Improvements in JBU Youth Functioning and Goal Achievement

3. TAY with completed baseline and follow-up assessments on the Milestones of Recovery Scale (MORS) demonstrated statistically significant and meaningful improvements in their symptom management and recovery orientation. Upon entrance into JBU the majority of youth were considered to be "high risk, not engaged" or worse (i.e., MORS score of 2 or less out of 8 recovery levels), whereas at the end

of JBU services, the majority of youth were "coping/rehabilitating" or better (i.e., MORS score of 6 or higher out of 8 recovery levels).

4. OT services were comprehensively incorporated into JBU practices via both individual and group interactions. Structured OT assessments helped youth to identify, develop and take steps to achieve goals commonly related to education, employment, and/or personal growth/skill building. Outcome data indicated TAY were able achieve desired objectives and increased their satisfaction from completing identified tasks.

Participation in Behavioral Health Treatment Services Increased

5. After participating in JBU, TAY typically increased their utilization of BHS outpatient and Assertive Community Team (ACT) program services as evidenced by 40% of youth engaging in outpatient mental health treatment services while enrolled in JBU and 25% connected with ACT services following discharge from the residential phase of JBU.

Participation in Acute/Crisis Behavioral Health Services Diminished While in JBU

6. Participation in JBU was also associated with reduced need for crisis and acute care BHS services while enrolled in JBU (i.e., inpatient psychiatric hospitalizations, crisis stabilization visits, crisis residential admissions, and Psychiatric Emergency Response Team (PERT) interactions).
7. Following discharge from the residential phase of the JBU program, there were signals of some reduction in the number of youths receiving crisis and acute care behavioral health services as compared the period of time before enrolling in JBU. Notably, utilization patterns were higher than while in JBU, which suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants.

JBU Helped Connect Youth to Needed Housing

8. During FY 2021-22 JBU increased their capacity to connect youth to available housing resources by getting approved and trained to administer the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. All JBU youth who completed the VI-SPDAT were identified as needing housing supports, with approximately 85% demonstrating the highest level of need and prioritized for permanent supportive housing. JBU was able to connect 18 youth with housing-related assistance and this is expected to increase during FY 2022-23.

Conclusion

Overall, the findings from FY 2021-22 indicated that the JBU program was able to achieve key objectives of contacting and engaging with their target youth population, creating linkages to appropriate mental health and substance use treatment, and improving the general well-being of the youth who participated in JBU services. However, substantial challenges remain to enable even more youth to experience greater short- and long-term recovery given that many youth have multiple factors inhibiting such gains include co-occurring substance use disorder (SUD), complex physical health needs, and difficulty transitioning to external treatment providers among others.

Primary Recommendations for FY 2022-23

1. To minimize post-JBU relapse of symptoms and utilization of crisis/acute care services, explore potential for longer-term support services by JBU after completing the residential phase and/or developing partnership with long-term care management services tailored to TAY-specific populations.
2. Develop specific partnerships with other provider organizations to allow JBU to have dedicated access to SUD and mental health services via quick referrals and easy onboarding pathways (e.g., like a "fast pass" referral lane) and/or incorporate those services directly into JBU.
3. Explore viability of extending duration of residential phase of JBU to allow a longer period of time for JBU to help youth achieve desired fundamental life changes related to their mental health, housing, and life skills/personal growth.
4. Explore potential for someone with medical expertise on staff in close partnership with JBU to assist with medication management, complex healthcare needs, and navigating insurance challenges.

Program Description

Using County of San Diego BHS Electronic Health Record (EHR) data, BHS personnel identify youth who meet core criteria: age 18-25, multiple acute/crisis-related BHS service contacts, SMI diagnosis, unconnected to behavioral health services, and homeless or at risk of homelessness. After JBU receives the list of eligible names from BHS, intensive outreach efforts are made by JBU staff to locate and contact each youth using available contact information provided by County databases, street searches, and coordination with other County and support agencies. During FY 2020-21, a BHS-approved change was made to allow for "open" referrals as well so that JBU was allowed to enroll youth who were referred from other organizations if they met the core criteria as listed above.

Once eligible youth have been contacted, given an explanation about the program's offerings, and agreed to enroll in the program, JBU provides short-term housing that incorporates support services, integrative medicine, and holistic health care in location. With dormitory-style housing, JBU youth can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same housing unit. During their time in the program youth will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, chiropractic care, and meditation, as well as mindfulness education, nutritional counseling, individual case management, peer support, group outings, and various in-house community-building trainings and events.

The overarching goal of JBU is to engage and stabilize youth by offering short-term housing (typically around 120 days) while providing holistic youth-centric recuperative services. Throughout their residence at JBU, youth are linked with ongoing treatment, housing, and supportive services, thereby improving their mental health and quality of life in the community. Ideally, JBU programming breaks the cycle of homelessness early in the process, avoiding youth hardening in identity as homeless and mentally ill. This has the additional benefit of minimizing the tendency of this population to repeatedly utilize disruptive and financially burdensome levels of emergency and mental health services.

The program's emphasis on community-building, destigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation, self-regulation training, and engagement

with holistic and integrative therapies both attracts and retains this historically difficult-to-reach cohort of the homeless population.

It is particularly salient that the program aims to intervene early in the cycle of homelessness, before youth self-identify as homeless and/or helpless, and before the personal and societal costs escalate and become more intractable. Further, the program's emphasis on destigmatization, community, and well-being provides a model of care and continuity that is characteristic of a well-functioning family, the historical foundation for ensuring safety, growth, and wellness in a well-functioning human society.

Service Changes Due to COVID-19

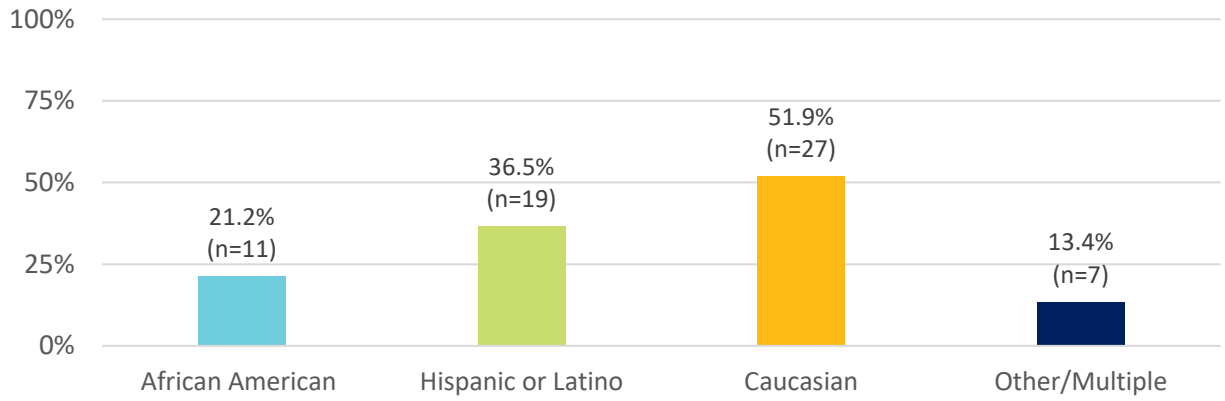
As a residential program serving homeless youth, a population at considerable risk for exposure to disease, JBU implemented several policies and procedures that allowed staff to continue providing in-person services while complying with CDC and San Diego County public health guidelines. These policies and procedures included: holding staff safety procedure trainings, providing quarantine and isolation plans, increasing security and protocols for building entry, posting COVID-19 safety education materials, implementing staff and youth mask requirements and rigorous sanitation procedures, and complying with County public health safety measure. While the basic residential component continued without interruption, JBU has had to periodically suspend or alter the provision of in-person holistic services except those which could be socially distanced or completed via remote technologies (i.e., yoga, fitness, mindfulness, and biofeedback). Public outings to promote education, enrichment, and/or growth with peers continued, but were more limited during FY 2021-22 due to COVID-19. Where possible, activities and events were held outdoors to promote safety among staff and youth. Due to potential exposures to COVID-19 or infections, various JBU staff were required to isolate from JBU youth periodically throughout FY 2021-22, which did create additional burdens and challenges for staff to cover JBU operations amidst staffing disruptions.

Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. Of the 52 youth who enrolled during FY 2021-22, 19 originated from the BHS CO-19 report and 33 were from other referral sources. JBU program eligibility criteria requires that participants are youth between the ages of 18 and 25. Of the 52 youth who enrolled in JBU during FY 2021-22, slightly more than half (n=28; 53.8%) identified as male. All JBU youth (n=52, 100%) spoke English as their primary language. Two-thirds of youth enrolled in JBU had a diagnosis of schizophrenia/psychotic disorders (n=34; 65.4%). Other common diagnoses included bipolar disorders (n=9; 17.3%) and depressive disorders (n=8; 15.4%).

As shown in Figure 1, JBU youth were racially and ethnically diverse. Approximately half (n=27; 51.9%) identified as Caucasian with 36.5% (n=19) identifying as Hispanic/Latino followed by 21.2% identifying as African American.

Figure 1. Race/Ethnicity of Youth Who Enrolled in JBU during FY 2021-22 (N=52)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

Many JBU youth had additional challenges as well as those related to their mental health, including cognitive and sensory differences affecting their ability to process information and engage with certain environments. Many also presented with other complex physical health issues and/or intellectual and developmental disabilities that required support from additional agencies such as the San Diego Regional Center and specialized healthcare providers.

Utilization of Program Services

OT at JBU

Throughout FY 2021-22 there were six OT interns at JBU. Interns were graduate students enrolled in either Masters or Doctorate programs in OT at one of several university partners, including the University of St. Augustine for Health Sciences and San Jose State University. Collectively, they provided over 1,400 hours of service to the JBU program over the course of FY 2021-22. The interns worked under the supervision of Dr. Bianca Doherty, who transitioned from Director of Occupational Therapy to JBU Program Director during FY 2021-22. Christina Lavery, who was, notably, the first OT intern at JBU in 2020, was hired at the end of the fiscal year to support continued OT intern supervision at JBU.

The OT team developed intervention plans with the JBU youth which included individualized long-term and short-term goals related to enhancing participation in activities of: 1) self-care (e.g., grooming and hygiene, community mobility, sleep hygiene, health management), 2) productivity (e.g., work, financial management, school, volunteering), and 3) leisure (e.g., social activities, activities for fun). This OT intervention plan was based on an initial interview with the youth to develop an occupational profile (e.g., client history, strengths, interests, goals, and barriers) as well as standardized and non-standardized assessments to measure client factors impacting performance skills and patterns (e.g., time-use, cognitive, sensory, and goal-focused assessments).

In collaboration with the JBU team, OTs would determine a uniquely tailored service delivery method and outcome measurement approach. The OTs conducted individual client intervention sessions every 1-3 weeks to address identified client needs and goals, as well as running as-needed weekly group interventions addressing topics such as: leisure exploration, social participation, time management and

organization, employment seeking and maintenance, pursuing volunteer opportunities, managing finances, home maintenance, meal preparation, community exploration and engagement, medication management, and self-care.

OTs would conduct observations and activity analyses during a client's transition into the program and their participation in services. These observations served to identify barriers to occupational participation (i.e., being able to do the activities or tasks they want and/or need to do). Youth would review their personal intervention plan with OTs every month and modify as needed. OT services at JBU also provided consultation to the JBU team regarding supporting client with additional needs including cognitive challenges, neurological or sensory differences, physical disabilities, and/or significant mental health challenges. Additionally, the OT team supported participation of JBU youth in program and organization-wide activities, such as the completion of a mural in the downtown Urban Street Angels location (as shown in picture on page 6).



Urban Street Angels mural that JBU youth helped to paint with OT support.

Engagement in JBU Activities

Holistic Services

In FY 2021-22, the primary holistic services provided were: yoga, massage, acupuncture, chiropractic and cryotherapy (i.e., exposure to extreme cold for several minutes in an effort to improve health). Massage therapy was typically the most well-attended service. Approximately 2-6 youth attended each weekly holistic service offering.

Group Outings

JBU youth participated in both major and relatively more minor group outings during FY 2021-22. The major outings included two overnight trips to Harrison Serenity Ranch (HSR) on Mount Palomar. HSR is a working ranch located 55 miles from San Diego. The facility offers recreation, relaxation and wildlife encounter opportunities. These outings were facilitated by the full JBU staff team, while more minor group outings were facilitated primarily by Peer Support with assistance from OT interns and other staff as needed. Examples of these minor outings include trips to the movie theater, makeovers at a salon,

trampoline park, elderly dog rescue "Frosted Faces," the Japanese Friendship Garden at Balboa Park, rollerblading, bowling, the beach, a San Diego Padres baseball game, and hikes. Additionally, some activities focused on engagement were provided in-house such as gardening, embroidery, and mask making.

JBU Services – Duration and Discharge Status

As shown in Table 1, of the 62 youth who received JBU services during FY 2021-22, 54 had discharged and eight were still active in JBU as 6/30/2022. Youth typically received JBU residential care and support services for approximately 75 days, with about one-third (31.5%) needing services for more than 120 days. These data indicated that JBU was generally adhering to the initial goal of operating as a short-term linkage and support program while also allowing somewhat extended (but not long-term) care for youth who needed additional time in the program.

Table 1. JBU Program Participation Duration and Discharge (N=62)

	JBU Youth (N=62)	
	Still in program	**Discharged**
n (persons)	8	54
Mean (days)	73.9	74.1
Median (days)	60.0	63.0

Key Evaluation Findings

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) captures the stage of mental health recovery, as assessed by staff, using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

As shown in Table 2, the results indicated substantial changes in recovery status at follow-up. At intake, only 5% of youth were considered as coping or in recovery, whereas 60% were doing so at follow-up. The number of youth in the "high risk" categories dropped from 12 to 4 (60% to 20%) from intake to follow-up. Overall, the average MORS score increased from 2.9 at intake (corresponds to "high risk, not engaged") to 5.2 at follow-up (corresponds to "not coping, engaged"). This trend was similar to that of FY 2020-21 where overall MORS scores increased from 3.4 to 5.3 from intake to follow-up.

Table 2. MORS Results for JBU Youth with Follow-up during FY 2021-22 (N=20)

		Baseline		Last Follow-Up	
Value	**MORS Category**	**n**	**%**	**n**	**%**
1	Extreme risk	1	5.0	0	0.0
2	High risk, not engaged	11	55.0	1	5.0
3	High risk, engaged	1	5.0	3	15.0
4	Not coping, not engaged	6	30.0	0	0.0
5	Not coping, engaged	0	0.0	4	20.0
6	Coping/rehabilitating	0	0.0	10	50.0
7	Early recovery	1	5.0	2	10.0
8	Advanced recovery	0	0.0	0	0.0
	Mean MORS	**2.9**		**5.2****	

***statistical significance at p < 0.01*

As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2020-21 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.5 at intake and 4.9 at follow-up. The findings from JBU indicate that youth typically entered the program with a lower-than-average MORS score (i.e., more impaired/less engaged in treatment), but had a higher-than-average MORS score at follow-up (i.e., less impaired/more engaged in treatment). The lower-than-average MORS score at intake was consistent with the JBU focal population (i.e., youth with serious mental illness who were not currently in or seeking treatment), with the substantial positive change in MORS score suggesting a high capability of the JBU team to support and connect with youth and get them linked to appropriate levels of treatment.

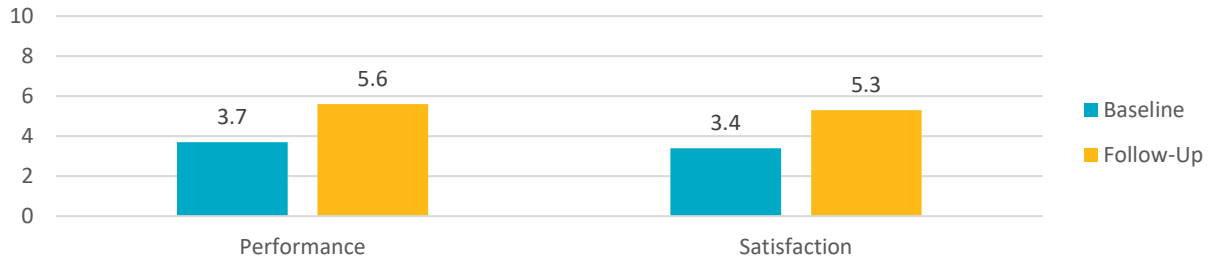
Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is a widely used (e.g., translated into more than 35 languages), individualized, client-centered, evidence-based outcome measure designed to document a client's self-perception of performance in everyday living at multiple time points. The COPM is a standardized instrument, in that there are specific instructions and methods for administering and scoring the test. It is designed as an outcome measure, with a semi-structured interview format and structured scoring method. The COPM asks individuals to identify everyday activities that they want or need to do but are currently unable to do or are dissatisfied in the way they are doing them, across all areas of life, including self-care, leisure, and productivity. The assessment then asks clients to rate these activities on a 1-10 scale for importance, performance, and satisfaction with performance with "1" representing not important/not able to do it/not satisfied at all. Typically, differences of two points or more between the pre- and post-OT intervention scores are considered clinically important.

A total of 16 JBU youth had baseline and follow-up COPM assessments completed during FY 2021-22. Figure 2 shows that that average performance assessment increased from 3.7 to 5.6 at follow-up and the satisfaction score increased from 3.4 to 5.3. Both the performance and satisfaction domains had average change scores of approximately two, indicating clinically important improvements for youth. Of the 16 youth with both baseline and follow-up scores, the majority 56.3% (n=9) had score changes indicating

clinically important changes on performance and 43.8% (n=7) had clinically meaningful improvements regarding task satisfaction. The COPM results indicate that the JBU OT team is able to increase the capabilities of many JBU youth to function successfully in their daily lives; however; the COPM data also reveal that JBU youth have relatively low initial abilities to accomplish their goals and that substantial numbers of youth continue to experience challenges even after working with JBU staff. These findings highlight both the promise of what JBU and the participating youth can accomplish together to improve their lives while also reflecting the difficulties of consistently achieving such objectives.

Figure 2. COPM Mean Scores for JBU Youth with Follow-up during FY 2021-22 (N=16)



OT Facilitated JBU Youth Accomplishments

The JBU OT team regularly met with JBU youth both one-on-one and in groups throughout FY 2021-22. The following information presents an overview of the accomplishments of the OT team generated via a review of notes from the 23 one-on-one sessions conducted with nine participating JBU youth during June 2022 (i.e., the last month of FY 2021-22). As shown in Table 3, work and education were the most common areas that OT staff and JBU youth focused on during their one-on-one sessions (39.1% of sessions for each). Building skills, developing good habits for spending leisure time, and increasing capabilities for handling activities of daily life (e.g., hygiene, financial management, etc.) were each discussed in 34.8% of the sessions. These findings indicate that the OT team helps to address a wide range of individualized needs and goals for the JBU youth, with education and work emerging as primary domains of emphasis.

Table 3. Primary Topic Areas Addressed During June 2022 OT Sessions (N=23)

	Total OT Sessions (N=23)
Primary Area of Emphasis	**% of Sessions Discussed**
Education	39.1
Work	39.1
Skill Building	34.8
Leisure Time	34.8
Activities of Daily Life/Functioning	34.8
Health Management	21.7
Life Transitions	17.4
Social Participation	13.0

A summary of the June 2022 one-on-one OT sessions reviewed the following key areas of impact: education/employment, medical care, and life-skills development.

OT sessions were helpful in preparing youth for next steps in employment. OTs assisted youth in school enrollment and helped spark their interest and investment in finding a future career. This career development was the most frequent focus of the OT sessions. Another focus of OT sessions was medical consistency and self-advocacy. Medical consistency mostly refers to being open to seeking and accepting treatment or medical services, while self-advocacy refers to the ability to speak up for oneself and declare whether they believe something is beneficial to them. Youth also noted improvements in financial competency, comfort level in social skills, self-care through exercise, and ability to identify goals for the future. It appears that OT was especially helpful in guiding youth toward finding leisure activities that provide an outlook for positive coping skills. Lastly, youth were offered assistance in adjusting to bereavement to help deal with loss. Youth frequently cited looking forward to being able to implement these skills upon their completion of the OT session.

Youth Feedback Regarding OT Experiences

JBU youth were asked about their experiences with OT as part of JBU. Responses fell into the following categories:

Participants Enjoy Working with OT Providers

- "The OT interns were enjoyable to be around, easy to talk to. They didn't make you feel bad for coming to them…They wouldn't pressure you to have a conversation. They listened. They'll do activities with you if you need it and it will help you. They don't expect you to do things if you're not comfortable. They would ask me to do things, and if I didn't want to, they might ask me just to try, and then check in after if it helped me and I would realize after that it did. But they were not pressuring me or to continuously do things if it didn't work for me."
- "It helped me get through the program by having some extra support… People from occupational therapy positively impacted my life. They gave me hope that I can succeed and do better and improve my habits. The interns were super nice and positive influence and encouraging. They would help you out whenever you felt down, they were uplifting."
- "I was satisfied on how OTs made everyone engaged in group activity and made everyone have a good time. I liked how the OTS planned engaging group activities (i.e. pill bottles for medication management). We also got to play basketball together in one of our sessions."

OT Offered New Experiences for Participants

- "Helped me spend time with people I wouldn't normally, and helped with my social anxiety... It helped me meet and make more friends."
- "It gets you out of your comfort zone and makes you feel comfortable with being uncomfortable. OT is my favorite group because it makes you get up and get out to do stuff you don't necessarily want to do, which creates a sense of structure."

OT Helped Participants with Goals and Skills

- "[Helped with…] a lot of tasks that I was embarrassed to ever ask anyone for advice on."
- "I like occupational therapy because it actually puts my goals into practice."
- "Going on walks, encouraging me to do better activities instead of just smoking or hanging out all day on the couch e.g. reading manga, getting a job, getting up on time, going to groups/activities, eating (regularly)."
- "It continued to help me after the program as I search for a new job."

OT is Fun

- "Occupational therapy is a way of being in a fun environment and doing fun stuff but also being intimate and focusing on what you need."
- "It is an outlet as well as just having fun and gets you involved with the people around you."

Overall, participant feedback was very positive. One participant summarized, "I hate therapy in general, but OT is different than regular therapy... It's like you're not just sitting there, you're building a connection… it actually helps you figure out what you can do to fix it, instead of just sitting there talking about it."

Increased Connections to Housing and Housing Assistance

To support efforts to connect JBU to housing, during FY 2021-22 the JBU program began administering the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. The VI-SPDAT is a tool used to assess housing needs and risks in order to establish prioritization of housing-related assistance. In the County of San Diego, organizations who are trained to utilize the VI-SPDAT with their clients are then able to enter the resulting information into a centralized data system that assists with matching available housing resources with expressed needs. The VI-SPDAT helps to inform the type of housing intervention or support that may be most beneficial, as well as the order in which individuals should be served. Table 4 presents the VI-SPDAT scores for the 32 youth who had this assessment completed upon enrollment into JBU. The results indicate a high level of housing need among JBU, with almost 85% scoring in the highest priority category with a recommendation for permanent supportive housing. The average score for JBU was 10.1. The substantial need for housing among JBU youth indicated that the JBU program was successfully connecting with the intended focal population given the overall objectives to serve youth with an SMI who are currently homeless or at risk of homelessness.

Table 4. VI-SPDAT Score at Time of Enrollment into JBU (N=32)

Baseline Score (N=32)	n	% of youth at intake
Score of 0 to 3: No Housing Intervention	0	0.0
Score of 4 to 7: Assessment for Rapid Re-Housing	5	15.6
Score of 8+: Assessment for Permanent Supportive Housing/Housing First	27	84.4

While the short-term nature of the JBU program presented challenges in matching youth with housing prior to program discharge, during FY 2021-22 youth were connected to local housing resources directly as a result of the VI-SPDAT scores. This total is expected to increase in future years now that VI-SPDAT assessment has been incorporated into standard intake procedures for the JBU program. In addition, JBU staff were able to successfully connect 18 JBU youth to other housing supports such as assistance with maintaining current living situation, obtaining vouchers to access affordable housing options, and other forms of support to reduce vulnerability to homelessness.

Behavioral Health Service Utilization Patterns

San Diego County BHS Services Utilized Before, During, and After JBU

BHS utilization patterns before, during, and after leaving the residential portion of JBU can help identify the extent to which participation in JBU is associated with a fundamental shift in the mix of service utilization (i.e., increased engagement in treatment and reduced interaction with crisis/acute care). The following analyses were accomplished by reviewing the electronic health record that documents county-funded BHS services provided throughout San Diego County to identify other mental health services received by JBU participants. Given the variable length of time that a youth might be in the residential portion of the JBU program, a standardized metric was created to enable equivalent comparisons for the three time periods of interest. The standardized metric for the "during JBU" period reflects the average amount of services JBU youth would be expected to receive during a 180 day stay with JBU. This metric facilitates comparisons to the 180-day period immediately preceding JBU enrollment and the 180-day period after leaving the residential phase of the JBU program.

The standardized "during JBU" metric was computed by summing the total number of BHS services (by service type) that occurred while the youths were enrolled in JBU and dividing that by the total number of days that all youth were enrolled in JBU. The resulting values represents the average number of each specific BHS service that a JBU youth received per day, which is then multiplied by 180 to generate the estimate of BHS services that JBU youth would receive if they were enrolled in JBU for 180 days. For the 180 days prior to JBU, all BHS services (by service type) were summed and then divided by the total number of JBU clients to generate an estimate of the average number of BHS services received by JBU clients prior to enrolling in JBU. A similar calculation was made for the 180-day period after youth left the residential phase of the JBU program.

The analyses presented in Table 5 include JBU participants who enrolled after 7/1/2020 if they had been discharged at least 180 days before the end of FY 2021-22 to ensure full and equivalent 180-day "post-JBU" observation periods for all persons.

As shown in Table 5, the 66 JBU youth included in these analyses had either no or limited involvement with BHS outpatient treatment services in the 180 days prior to entering JBU (average of 1.1 outpatient sessions across all youth). However, that changed substantially during their time enrolled in JBU as 40.9% of the youth linked to outpatient care and the 180-day average number of outpatient sessions increased to 7.4. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 1.6 sessions per youth. For some, this reduction in outpatient services post-JBU can likely be explained by linkages to the ACT programs that the youth made while in the JBU

program. A quarter of JBU (25.8%) youth had ACT visits post-JBU, with the average of 8.1 sessions compared to less than 0.1 pre-JBU and 1.5 during JBU.

Table 5. BHS Service Utilization Patterns Before, During, and After JBU Participation (N=66)

	180 Days Prior to JBU Enrollment			Standardized 180 Days During JBU Residential Phase			180 Days After Leaving JBU Residential Phase		
	% of youth	# of visits/ episodes	Average per JBU youth	% of youth [1]	# of visits/ episodes[1]	Stdzd. average per JBU youth	% of youth	# of visits/ episodes	Average per JBU youth
Outpatient	12.1	75	1.1	40.9	185	7.4	28.8	107	1.6
ACT	<7.6[2]	<5[2]	<0.1[2]	15.2	38	1.5	25.8	532	8.1
Urgent Outpatient	39.4	51	0.8	42.4	37	1.5	40.9	50	0.8
PERT	28.8	27	0.4	9.1	8	0.3	21.2	25	0.4
Crisis Stabilization	37.9	48	0.7	9.1	11	0.4	25.8	37	0.6
Inpatient Psychiatric Hospitalization	47.0	45	0.7	7.6	5	0.2	34.8	44	0.7
Crisis Residential	36.4	32	0.5	<7.6[2]	6[2]	0.2[2]	22.7	20	0.3

[1]The number of persons and number of visits/episodes during JBU is not comparable to "prior" and "after" JBU since the average length of time in JBU was less than 180 days (mean = 68.4 days). Only the average is comparable across all time periods.

[2]Due to the small number of youths experiencing this service, (i.e., less than 5), the exact number is masked.

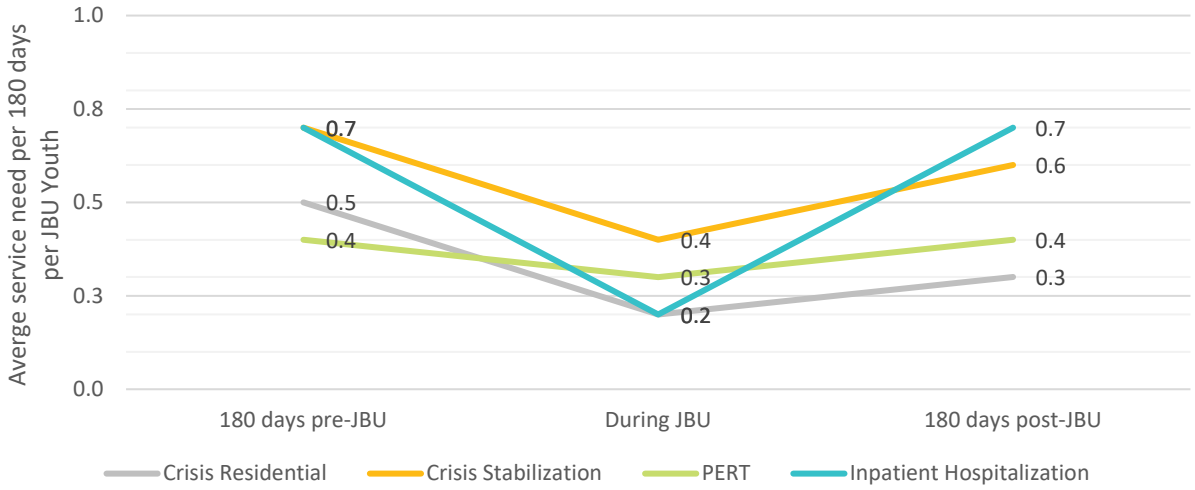
The patterns evident among acute/crisis-oriented type BHS services were more nuanced. Interestingly, the average number of urgent outpatient visits was similar before and after JBU (0.8), but was higher during JBU (1.5). This can likely be explained by the fact that JBU staff facilitated access to needed urgent outpatient care in an effort to avoid situations escalating into the need for a crisis stabilization visit or inpatient hospitalization, both of which occurred much less frequently during JBU than pre-JBU (the percentage of youth needing crisis stabilization dropped from 37.9% to 9.1%, and inpatient hospitalization dropped from 47.0% to 7.6%).

When comparing pre-JBU to post-JBU service utilization, the percentage of youth accessing crisis-oriented BHS services was lower during than after participating in JBU. This was most evident for crisis stabilization services which reduced from 37.9% of youth having at least one crisis stabilization visit during the 180-days before JBU compared to 25.8% in the 180 days after leaving JBU. However, the average number of crisis stabilization visits only reduced slightly before and after JBU (0.7 to 0.6, respectively) since the total number of crisis stabilization visits did not decrease as much (48 to 37, respectively). This pattern was evident among other crisis/acute care services as well (i.e., a reduction in the number of youth who required such services, but minimal reduction in total crisis/acute care services required as those who did access the care did so on multiple occasions).

With the small sample sizes, caution is warranted when interpreting findings, however it is evident that JBU increased engagement with outpatient treatment services and facilitated connections to ACT programs (a preferred discharge destination for many JBU youth). As shown in Figure 3, there was a small

reduction in crisis and acute care behavioral health service utilization from pre-JBU to post-JBU, however the utilization patterns were higher than while in the residential phase of the JBU program.

Figure 3. Visualization of Average Crisis and Acute Care Service Utilization Per JBU Youth Per 180 Days Before, During, and After JBU Residential Phase.



This pattern suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants. This may require exploring the provision of additional services by JBU for a longer period of time and/or more extensive partnerships with other long-term services with a TAY-specific orientation such as case management that can seek to maintain and build upon the gains experienced while in the JBU program.

Additional Program Activities

Moving JBU to a New Location with New Congregate Living Approach

During FY 2021-22, the JBU program moved to a new location within San Diego. This relocation substantially changed the context in which JBU services were provided. Prior to the move in May 2022, JBU residential and support services were provided in a duplex home located in a residential community. The JBU program moved to a new facility in a mixed-use, urban community with the JBU residential and support services provided within a converted motel. While renovations to the new location were ongoing at the end of FY 2021-22, the new living arrangements allowed for 1-2 youth to share an apartment-like studio room with shared programming and dining facilities located in other rooms. Additional onsite recreational space is planned for development in FY 2022-23. Nearby trolley and bus stops substantially increase opportunities for mobility compared to the prior location. Overall, the move was a significant event for the JBU program during FY 2021-22 that resulted in a very different environment for providing JBU services. The goal with this new location is to demonstrate the sustainability of the residential model as well as more closely replicating the type of living situations that JBU youth with be encountering after discharging from the program.

Establishing New Community Partnerships

As a program with a strong emphasis promoting the well-being of youth across many life domains, JBU continued to seek out new community partners to meet the unique needs of JBU youth. With the move to a new location, identifying and establishing new partnerships was particularly salient during FY 2021-22. Examples of community partnerships included the following:

- Oasis Clubhouse – TAY-specific clubhouse with free meals, haircuts, employment support, and social activities.
- Helen Woodward Animal Center – provided Pet Encounter Therapy once per month until move when they could no longer serve us as moved to another city (Chula Vista).
- Mobile Crisis Response Team – utilized when clients experience mental health crisis but were not expressing active thoughts of harming themselves or others (in which case PERT would have been called).
- David's Harp – nonprofit dedicated to engaging homeless youth through music and media production.

Designed and Implemented "Forever Follow Ups" with Former JBU Participants

In collaboration with the University of California San Diego (UCSD) evaluation team, JBU program staff developed and tested an assessment tool to conduct "Forever Follow-ups" with youth who previously participated in the JBU program. While designed to minimize completion burden, the assessment tool gathers information on multiple domains of interest related to the youth's post-JBU experience including: housing, employment, mental health needs/service utilization, and perceptions of JBU among others. The "Forever Follow Ups" were initiated end of FY 2021-22 with data collection efforts expected to continue during FY 2022-23. The results of these follow-ups will be included in future reports and are anticipated to provide greater understanding of the longer-term impact of the JBU program.

App Development

Additional work continued during the early part of FY 2021-22, to create an app that would enable JBU youth to: 1) actively monitor their health and wellness in real-time, 2) access health and wellness educational information, 3) develop and track personal goals, and 4) interact and engage with JBU program staff through either an iOS or Android platform, both while enrolled in the JBU program and potentially afterward during a specified follow-up period of care. However, given the challenges experienced while trying to develop the app and a more complete understanding of the needs, interests, and capabilities of the youth that JBU serves, a decision was made later in FY 2021-22 that the app would not be incorporated into existing JBU services. With the decision to not implement the app within JBU, as of the end of FY 2021-22, BHS was considering whether the app would be beneficial for other programs and therefore warrant additional efforts to make the app fully operational.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual JBU Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, JBU, and the UCSD evaluation team. Primary objectives for these meetings

were to review program operations, evaluation approaches, and outcome data. The Annual JBU Staff Survey was conducted at the end of FY 2021-22. JBU program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. 100% of JBU staff participated in the survey (N=15). Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes.

The main goals identified by JBU staff in FY 2021-22 were the same as FY 2020-21: 1) providing secure housing and 2) supporting youth to stabilize mental health. Staff were asked to identify program strengths and areas for improvement, as well as facilitating and inhibiting factors in goal achievement. The following themes emerged:

Program Strengths

JBU Team

JBU staff identified their team as a primary strength of the program. Staff described coworkers as caring, compassionate, and communicative. One staff member highlighted "the skill set [and] life experiences that the staff can use to support each other and support the youth." Another team member recounted the collaboration of all team members where "through staff meetings each staff would dictate their roles for the week and update their progress," as well as "a solid teamwork ethic and bond" and "an organized plan" for operations. Team members are described as having "passion and drive to help their clients be successful." Staff members shared the following:

- "I genuinely believe [staff] are there with an open heart and compassion to support residents to the best of their abilities."
- "We all get along very well and have all the same goals in mind for the success of the youth and the program."

According to survey responses, this effort is reflected in the overall feel of the program. JBU strives to create a home-like environment for the clients, in an effort to create a "sense of connection and belonging." Staff describe the climate of JBU as "tight-knit," "cohesive," "personable and homey" and "more of a family feeling than just staff and clients."

- "Staff is very open and caring toward the clients. They understand and sympathize for where they came from and what they have experienced. Staff provide the necessary resources for the clients to achieve their goals."

Connections to Outside Providers

Providing secure housing is a primary goal of JBU, as well as connecting clients with mental health services. To do this, JBU staff work hard to build linkages with outside organizations. Several staff describe case managers' hard work to identify and connect with housing and mental health services. "Regular communication" and "connection with our community mental health partner providers" is key to JBU's successful case management efforts. Staff also describe "outreach connections to public defender's office and psychiatric hospitals to receive youth" as well as "connections with therapy and psychiatry, as well as holistic care providers."

As one staff member put it:

- “Connecting [clients] with mental health care is instrumental towards having a solid foundation for themselves and helps prevent repeating the cycle of experiencing homelessness again.”

Client Engagement

The above-described staff characteristics, combined with the ability to link clients with outside providers, helped the JBU program with client engagement and retention in FY 2021-22. When asked to identify the most effective engagement strategies, staff members described:

- “Maintaining a tight knit community between staff. Supporting each other and having each other's backs. Being compassionate and transparent with each other.”
- “Dedicated and persistent staff members at JBU who go the extra mile to ensure their clients are receiving or being connected to the resources they need to be successful.”

Other staff identified client rapport as crucial in maintaining engagement, naming many similar strategies including “creating positive and empathetic relationships”, "making them feel comfortable and supported”, and “building honest, trusting relationships”. One team member described:

- “Successfully connecting/building rapport with youth and meeting them where they are at to build trust allows them to open up about their difficulties/struggles and learn more about what hasn't worked in the past.”

Staff also identified communication about goals as an important component of success:

- “Identifying meaningful goals and connecting those goals to the services provided.”
- “Reminding them of their goals and helping them achieve them.”
- “Continuing to have conversations [about] what they are working towards.”

Additionally, concrete elements for successful retention were named: food, gift cards, engaging outings and recreational activities, as well as individualized incentives/rewards for participation.

OT

The use of OT to assist youth in their goals and treatment plan was cited as a significant strength for the JBU program. OTs aid their clients with vocational and leisure pursuits, social engagements, financial management, medication management, community mobility, among other things. When asked about the potential benefits of OT, most JBU staff mentioned how it helps clients work toward self-sufficiency:

- “OT services provides residents an opportunity to understand and work towards their personal goals. The OT supports residents in gaining autonomy towards their goals by assessing their needs and creating a treatment plan that is specific to each resident.”
- “A lot of the goals that youth have are in relation to self-care/creating a morning routine, finding and obtaining employment, enrolling in school/participation in school, leisure exploration, medication management, financial management, and more. These are all areas that occupational therapy can address during their time at JBU. We also address the development of skills in the areas of time management, planning, safety, judgement, decision making, and problem-solving, which will aid the youth in becoming more independent in preparation for independent living.”

Program Challenges

Relocation to New Community within San Diego

As discussed above, the JBU program moved to a new location during FY 2021-22. The JBU staff identified the move as creating some challenges for meeting program objectives given the need to establish new relationships with a range of behavioral health and other service providers in their new community as well as the added time and efforts required to complete the actual move.

A few staff named effects of this relocation as inhibiting the program's goals in FY 2021-22:

- "Difficulties with site transitions /change in environment (moving from a facility in one city to another)"
- "The move: JBU had to find a new acupuncturist, massage therapist, therapy provider, and psychiatry providers"
- "Staff shortage, temporary transitional periods, uncertain program location"

Client Factors

Client factors are the primary challenges named by JBU staff. Client resistance is identified as a significant inhibiting factor in the success of JBU. Staff describe client resistance due to negative experiences with treatment and/or institutions in the past, or difficulty engaging with services due to the severity of their mental health symptoms.

- "Youth's interest and motivation in participating in provided services can be difficult due to their different mental illnesses. Follow-through and scheduling also pose as difficulties as many of them have challenges with organizing their schedules. Additionally, using public transportation to get to services is difficult for some youth."
- "Youth who have described feeling so traumatized/hurt by the previous mental health/medical care they've received (Not being heard/acknowledged in their care, being forced to take medication they didn't understand, feeling violated or abused) that they are resistant to the idea of services."
- "One of the few challenges that JBU staff face when attempting to help a youth and offer them services, is when the youth isn't open to recovery and refuses the help. In those cases, which are rare, the youth is only in this program for the housing."

According to staff, medication resistance can create particularly serious difficulties in the engagement process: "resistance to medication... creates room for more youth to experience psychosis." In this case, depending on the severity, duration, and willingness/ability of person to engage in relevant treatment, the client may need to receive crisis services or be hospitalized.

Substance use can pose an additional hurdle. In the past, JBU staff reported difficulties in connecting with SUD providers who had availability to admit new clients. This continued to be a theme in FY 2021-22. Staff describe that "rehab centers are consistently full" and state a need for in-house SUD counseling and/or more support from addiction specialists including group therapy and interventions targeting substance use and addiction.

Transportation was a challenge as well. Staff described how some clients struggle with utilizing public transportation and staff are not always available to provide private transit to/from appointments.

Program Duration

A few staff members shared a desire for clients to be able to stay in the program longer. Staff describe how the program duration is "not enough time to affect change." Other relevant statements are as follows:

- "4 months is not long enough for the youth to be stable in their mental health, get housing services, and stable on their medications."
- "I think a big factor that could improve the program is allowing clients to have more than the current allotted time at JBU. This can allow staff members to have more time to create and develop healthy habits and routines with the clients, as well as more time for them to find adequate housing for after the program is completed."
- "There is so much to tackle since homelessness and the experiences that residents are recovering from is so complex that in 3 months, it's difficult to fully support residents."

Telehealth

Telehealth can be a solution for clients who cannot attend appointments in person. However, a reliable internet connection and private space are necessary for successful utilization of telehealth services and these things are not always available.

- "Some youth have felt they do not have a space with enough privacy in order to conduct their Telehealth calls (We have two office spaces with a joint den space, however one has to cross through the den space in order to access staff in the office)."

Additionally, one staff member described how some medical providers "require in-person visits as the youth may be less engaged or inconsistent during their telehealth appointments/attending telehealth appointments."

Changes from Initial Program Design

During FY 2021-22 there were ongoing adaptations to JBU service delivery and community referral partners, particularly following the move to a new location; however, there were no fundamental changes to the types of JBU services provided or to JBU program objectives from the initial program design.

Primary Recommendations for FY 2022-23

1. To minimize post-JBU relapse of symptoms and utilization of crisis/acute care services, explore potential for longer-term support services by JBU after completing the residential phase and/or developing partnership with long-term care management services tailored to TAY-specific populations.
2. Develop specific partnerships with other provider organizations to allow JBU to have dedicated access to SUD and mental health services via quick referrals and easy onboarding pathways (e.g., like a "fast pass" referral lane) and/or incorporate those services directly into JBU.

3. Explore viability of extending duration of residential phase of JBU to allow a longer period of time for JBU to help youth achieve desired fundamental life changes related to their mental health, housing, and life skills/personal growth.
4. Explore potential for someone with medical expertise on staff in close partnership with JBU to assist with medication management, complex healthcare needs, and navigating insurance challenges.

Conclusion

During FY 2021-22, JBU was able to successfully contact and enroll 52 youth who met all eligibility requirements (a level of enrollment similar to prior years). Coupled with having SMI, many of the youth also had substance use and abuse issues or other complex physical health or cognitive development challenges. The youth served by JBU were a racially/ethnically diverse population with 51.9% of youth identifying as Caucasian, 36.5% as Hispanic/Latino, 21.2% as African American and 13.4% as another race (note: youth could indicate more than one race/ethnicity so totals exceed 100%).

JBU staff provided daily encouragement and support throughout the residential phase of the program (commonly about 75-100 days), primarily through extensive OT support services as well as offering group and individual sessions for various holistic services and educational/enrichment activities. While access to external holistic providers was more limited related to the ongoing impact of the COVID-19 pandemic and disruptions due to moving to a new location within San Diego County, JBU staff continued to provide residential care services and facilitated telehealth and in-person connection to outpatient treatment providers. OT sessions while in JBU were perceived favorably by the youth with many demonstrating improvements in the capability to achieve collaboratively identified and individualized goals related to employment, education, life-skills/personal development, constructive use of leisure time and among other life domains.

JBU increased their capacity to connect youth to available housing resources by getting approved and trained to administer the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. All JBU youth who completed the VI-SPDAT were identified as needing housing supports, with approximately 85% demonstrating the highest level of need and prioritized for permanent supportive housing. JBU was able to connect 18 youth with housing related assistance and this is expected to increase during FY 2022-23.

In addition to the emphasis on increasing awareness and practices of wellness among JBU youth, the program was successful at creating linkages to other BHS treatment programs with approximately 40% of youth participating in outpatient care while enrolled in JBU and 25% transitioning to ACT programs after completing the residential phase of JBU. Following discharge from the residential phase of the JBU program, there was a reduction in the number of youths receiving crisis and acute care behavioral health services through the BHS system as compared to the period of time before enrolling in JBU, but utilization patterns were higher than while in JBU. This suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants.

Youth with baseline and follow-up outcome assessment data demonstrated statistically significant and meaningful improvements in their symptom management and recovery orientation. Upon entrance into JBU the majority of youth were considered to be “high risk, not engaged” or worse (i.e., MORS score of 2

or less out of 8 recovery levels), whereas at the end of JBU services, the majority of youth were "coping/rehabilitating" or better (i.e., MORS score of 6 or higher out of 8 recovery levels).

Staff feedback indicated that for youth who were not successfully engaged in JBU services, substance abuse was a primary factor that impeded their efforts. These experiences prompted the JBU program to create additional community connections and develop internal resources to better address substance abuse issues among youth enrolled in the JBU program.

Overall, the findings from FY 2021-22 indicated that the JBU program was able to achieve key objectives of contacting and engaging with their target youth population, creating linkages to appropriate mental health and substance use treatment, and improving the general well-being of the youth who participated in JBU services. However, substantial challenges remain to enable even more youth to experience greater short- and long-term recovery given that many youths have multiple factors inhibiting such gains include co-occurring SUD, complex physical health needs, and difficulty transitioning to external treatment providers among others.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of Participants who Enrolled during FY 2021-22

Characteristic	Total Participants (N=52)	
Gender	**n**	**%**
Male	28	53.8
Female	22	42.4
Another Gender Identity/Missing	2	3.8
Total	**52**	**100**
Age Group	**n**	**%**
18-21	19	36.5
22-25	33	63.5
Total	**52**	**100**
Primary Language	**n**	**%**
English	52	100
Total	**52**	**100**
Race/Ethnicity	**n**	**%**
African American	11	21.2
Hispanic or Latino	19	36.5
Caucasian	27	51.9
Other/Multiple	7	13.4
Total[1]	-	-
Mental Health Diagnosis[2]	**n**	**%**
Depressive Disorder	8	15.4
Schizophrenia or other psychotic disorder	34	65.4
Bipolar Disorder	9	17.3
Other/Missing	1	1.9
Total	**52**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*
[2] *Mental health diagnosis information is obtained from BHS Cerner data system.*

490

Appendix (continued).

Characteristic	Total Participants (N=52)	
Sexual Orientation	**n**	**%**
Heterosexual or straight	5	9.6
Another orientation	4	7.7
Missing/Prefer not to answer	43	82.7
Total	**52**	**100**
Disability	**n**	%
Yes, has a disability	3	5.8
No, does not have a disability	5	9.6
Declined/Prefer not to answer	44	84.6
Total	**52**	**100**
Type of Disability	**n**	%
Learning/Developmental	4	7.7
Physical/Chronic/Other	1	1.9
Total[3]	-	-

[3] *Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.*



THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (CCYP) INNOVATIONS-22

Annual Report
Year 4 (7/1/2021-6/30/2022)

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

v.12.22.2022

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

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Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Center for Child and Youth Psychiatry (CCYP) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). MHSA INN funding for CCYP services will end on 12/31/2022; however, with the successful achievement of program objectives, the BHS has decided that the CCYP program should be incorporated into the existing BHS System of Care as an ongoing service that will be funded through non-INN resources. The CCYP program was designed to provide psychiatric evaluation and treatment to children and youth who have completed behavioral health treatment yet require ongoing and complex medication monitoring that is not viable with their primary care physician (PCP). Additionally, CCYP provides psychiatric care when other County-funded programs experience temporary gaps in their ability to offer timely psychiatric care (e.g., due to psychiatrist departures or leaves of absence). This role of providing services to "ancillary" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere) ensures continuity of care and has become part of standard CCYP operations. During fiscal year (FY) 2021-22 an additional subset of youth enrolled in BHS-funded Short-Term Residential Therapeutic Programs (STRTP) were incorporated into CCYP to obtain medication management services.

CCYP staff include assessment coordinators, a health care coordinator, a nurse, and contracted psychiatrists who provide services both at centrally located clinics and remotely via telepsychiatry. Additionally, the role of transition planner was added during FY 2021-22 primarily to assist families connect with any ongoing medication management (e.g., primary care physicians) or other care services following discharge from CCYP. CCYP is also expected to provide psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. The initial design of CCYP, which already included a reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services.

Primary Findings for FY 2021-22

CCYP Enrollment and Key Participant Characteristics

1. During FY 2021-22, a total of 588 children and youth were served by the CCYP program, including 235 new intake clients and 353 who had enrolled in a prior year (i.e., substantially exceeding the program goal of 500 unique clients served per year). This represented almost 100 more youth served in FY 2021-22 than the 499 served during FY 2020-21.
2. CCYP served a racially and ethnically diverse population with the majority of youth identifying as Hispanic or Latino (59.1%).

CCYP Contributions to Meet Medication Management Needs Throughout BHS System of Care

3. CCYP continued to support other BHS programs that experienced disruptions in their ability to provide psychiatric care services, which ultimately ensures continuity of care for youth. However, this occurred less frequently by the end of FY 2021-22 and overall these ancillary clients represented a much smaller share of new CCYP enrollees in FY 2021-22 (6.4%) than in the prior year (26.4%).
4. A new referral partnership was developed during FY 2021-22 with small BHS-funded STRTPs (i.e., those with 12 beds or less), in which CCYP provided any needed medication management services. A total 35 youth from STRTPs (14.9% of CCYP enrollees) received CCYP services.

Enhanced CCYP Services to Support the Transition of Medication Management to Other Community Providers

5. To ensure that CCYP did not reach full capacity and could continue to enroll new clients, additional attention was focused on identifying long-term stable CCYP clients who appeared to have medication management needs that could now be successfully handled by other services providers such as primary care physicians. During FY 2021-22, this led to the creation of a new role on the CCYP service delivery team, the Transition Planner. The Transition Planner engaged with families to identify and support transitions to appropriate service providers in the community.
6. The Transition Planner aided in nearly doubling the transitions out of CCYP when compared to the prior FY (135 to 278).

Youth Rarely Received Crisis/Acute Care Behavioral Health Services While Enrolled in CCYP

7. BHS crisis/acute care services were rarely accessed during the 180 days prior to enrolling in CCYP or while enrolled in CCYP. This pattern, combined with the lengthy average enrollment, indicates that CCYP was achieving the primary objective of maintaining stability for clients with complex medication management needs.

Improved Well-Being for Many CCYP Youth Even Without a Therapeutic Treatment Component

8. Although therapeutic services are not provided through CCYP, both clinician and caregiver/youth self-report (as documented by the CANS and PSC, respectively) indicated that many youth and family members experienced improvements in their well-being following enrollment in CCYP.
9. In quantitative and qualitative feedback, high percentages of both caregivers and youth indicated that they were satisfied with CCYP services.

Similar Patterns of CCYP Service Utilization and Duration Across CCYP Enrollment Groups

10. Maintenance and ancillary/STRTP clients were estimated to receive 1 - 2 CCYP services per each 30 days of enrollment (1.30 and 1.49, respectively). Approximately half of the service contacts were medication management, for both groups. In the prior FY (2020-21) ancillary clients required almost twice as many psychosocial assessment and collateral service contacts as maintenance clients. This year (2021-22), the numbers were generally equivalent, indicating the workload requirements for Assessment Coordinators are now more similar.
11. CCYP youth typically received services for an extended period of time as evidenced by median durations of 352.0 days and 378.0 days for maintenance and ancillary/STRTP youth who were receiving CCYP services as of 6/30/2022.

Telehealth Services Perceived Favorably by CCYP Psychiatrists and Staff

12. CCYP psychiatrists and other staff indicated favorable views of telehealth services with regard to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information.

Conclusion

During FY 2021-22, CCYP served a total of 586 children and youth (466 maintenance, 85 ancillary clients, and 35 from the new partnership with STRTP). Of these, 235 enrolled in CCYP during FY 2021-22). As in prior years, CCYP continued to serve a racially and ethnically diverse client population with the majority of newly enrolled clients identifying as Hispanic/Latino (59.1%).

In contrast to prior years, in FY 2021-22 CCYP discharged more persons (n=278) than were enrolled (n=235). This number is more than double that of FY 2020-21 (n=135), the result of a strategic decision by the CCYP program to identify and discharge clients who appeared to have medication management needs that could be successfully handled by other service providers (e.g., primary care physicians) to ensure that CCYP continued to have capacity for new clients who needed CCYP services. To facilitate these changes, CCYP created the role of the Transition Planner to engage with families and support discharge to appropriate service providers in the community.

Overall, the pattern of lengthy CCYP program participation coupled with similar or reduced frequency of BHS crisis and acute care services utilized while in CCYP indicated that CCYP achieved the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy. In addition, CCYP fulfilled additional objectives by providing continuity of care for youth who otherwise faced disruptions in access psychiatric medication management at the location where they participated in ongoing therapy. During FY 2021-22, CCYP also became an ongoing partner with STRTPs to meet any medication management needs for youth participating in these programs. CCYP services provided to these ancillary and STRTP youth helped to strengthen the local BHS system of care and minimize potential service delivery gaps.

Primary Recommendations for Future Changes

1. Assess feasibility and potential benefits of incorporating some capacity to deliver short-term therapeutic support services within CCYP.
2. Increase outreach and education to physicians who may be serving medically fragile youth that also have mental health/behavioral medication management needs that could be supported by CCYP.
3. Identify and implement additional strategies for remotely obtaining completed required assessments and other paperwork, particularly for items that traditionally have required a "wet signature."
4. Incorporate additional technical support resources into CCYP services to assist youth and family members with any device and/or connectivity issues that may negatively impact ability to consistently engage in telehealth services.

Program Description

CCYP was developed to provide medication support to select children and youth who have completed behavioral health treatment services, yet require ongoing monitoring of complex psychotropic medications that are essential for their wellness and stability but not easily managed by their PCP. Services are provided through a variety of means, including a centrally located psychiatric clinic and telepsychiatry at satellite clinics and clients' homes. CCYP provides linkages and facilitates access to psychotropic medication, including the administration of long-acting injectable psychotropic medication when indicated and necessary for the child or youth's stability. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full-service clinics, schools, PCPs), and the communities they serve. CCYP also provided psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. A San Diego-based community organization, New Alternatives Incorporated (NAI), was contracted to provide CCYP services including: 1) establishing a team of psychiatrists, assessment coordinators, a nurse, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families.

CCYP is an important county-wide resource that can fulfill the need for temporary access to psychiatric services when other county-funded programs experience a gap in capability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). Providing continuity of psychiatric care in these situations was determined to be an important ongoing benefit that CCYP could contribute to support the overall Children, Youth, and Families (CYF) BHS system of care. Youth who were admitted via this additional service strategy (i.e., ancillary referrals), differed from the traditional maintenance CCYP enrollees in that they continued to receive psychotherapeutic care services from the referring agency while CCYP provided needed medication management support. This required additional communication and coordination between CCYP and the organization providing the therapy services.

During FY 2021-22, a new role was added such that CCYP is responsible for providing medication management services youth enrolled in BHS-funded STRTP with less than 12 beds.

The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to

administrative and institutional barriers, the anticipated partnerships have not been viable so an emphasis on the medically fragile has not been implemented as part of CCYP operations.

MHSA INN funding for CCYP services will end on 12/31/2022; however, with the successful achievement of program objectives, BHS has decided that the CCYP program should be incorporated into the existing BHS System of Care as an ongoing service that will be funded through non-INN resources.

Service Changes Due to COVID-19

The initial design of CCYP, which included a substantial reliance upon telehealth services to provide psychiatric care throughout the entire county, allowed CCYP to adjust to the new practice realities without substantial disruption to ongoing services. Due to the ongoing COVID-19 pandemic, CCYP clients continued to be seen remotely throughout FY 2021-22. If in-person services were needed, individualized arrangements were made as appropriate. One challenge with conducting services exclusively or almost exclusively via telehealth is greater difficulty obtaining completed youth and parent/caregiver assessment tools given the limited amount of in-person interaction.

Participant Characteristics

A total of 235 persons enrolled into the CCYP program during FY 2021-22 (as compared to 258 in FY 2020-21) (see Table 1). Of the 235 enrollees, 185 (78.7%) were considered maintenance enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), 15 (6.4%) were considered ancillary enrollees, and 35 (14.9%) youth enrolled in CCYP services as part of the new partnership with small STRTP programs (i.e., those with 12 beds or less), in which CCYP is responsible for medication management while other forms of treatment and support occur within the STRTP program. A larger proportion of clients who enrolled in CCYP during FY 2021-22 were maintenance enrollees as compared to FY 2020-21 (i.e., 78.7% and 73.6%, respectively).

Table 1. CCYP Program Enrollment for FY 2021-22 (N=235)

Type of CCYP Enrollee	n	%
Maintenance enrollees (i.e., not receiving therapy elsewhere)	185	78.7
Ancillary enrollees (i.e., receiving therapy elsewhere)	15	6.4
STRTP enrollees (i.e., receiving therapy services via STRTPs)	35	14.9
Total CCYP enrollees	**235**	**100**

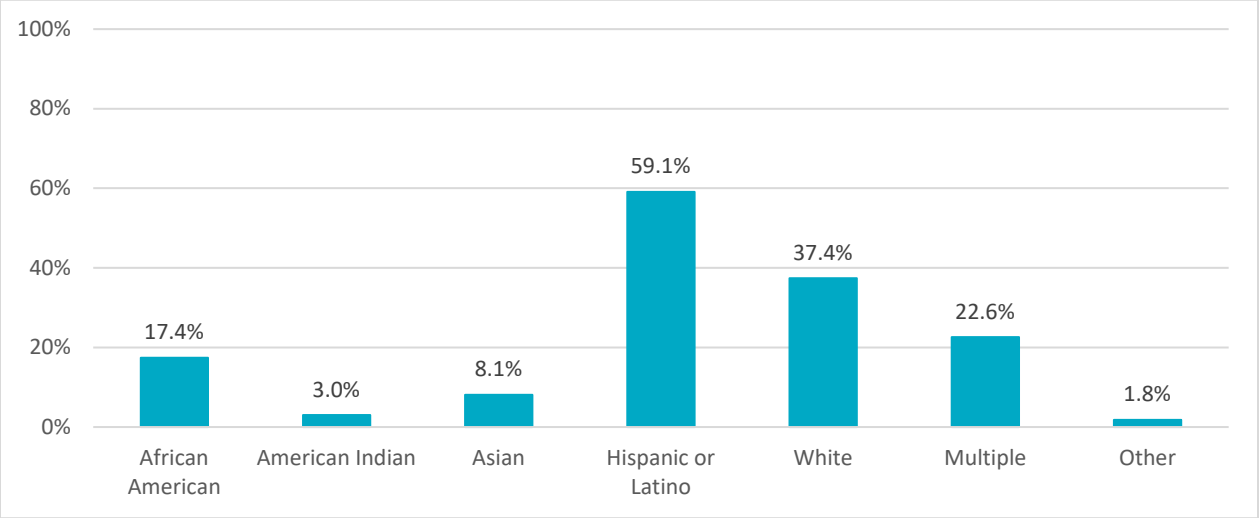
Key characteristics of the 235 persons who enrolled in CCYP during FY 2021-22 (i.e., includes both maintenance and ancillary referrals) are discussed below. A more complete listing of participant characteristics and response options can be found in the appendix. Additional analyses not reported here found similar demographic characteristics between maintenance and ancillary clients.

During FY 2021-22, the majority (77.4%; n=182) of clients enrolled in CCYP were at least 12 years old, with approximately one-fourth of clients age 5 to 11 (22.6%; n=53). More females enrolled than males (49.8%; n=117 and 37.4%; n=88, respectively). Almost half of clients identified as heterosexual (47.2%; n=111),

with 20.4% (n=48) indicating being bisexual, pansexual, or sexually fluid and 20.9% (n=49) declining to select an orientation.

While most clients reported English as their primary language (88.9%; n=209), more than 10% indicated Spanish (10.6%; n=25). As shown in Figure 1, CCYP served a racially and ethnically diverse population. The largest group of participants identified as Hispanic or Latino (59.1%; n=139), followed by White (37.4%; n=88), multiple racial/ethnic backgrounds (22.6%; n=53), African American (17.4%; n=41), and Asian (8.1%; n=19).

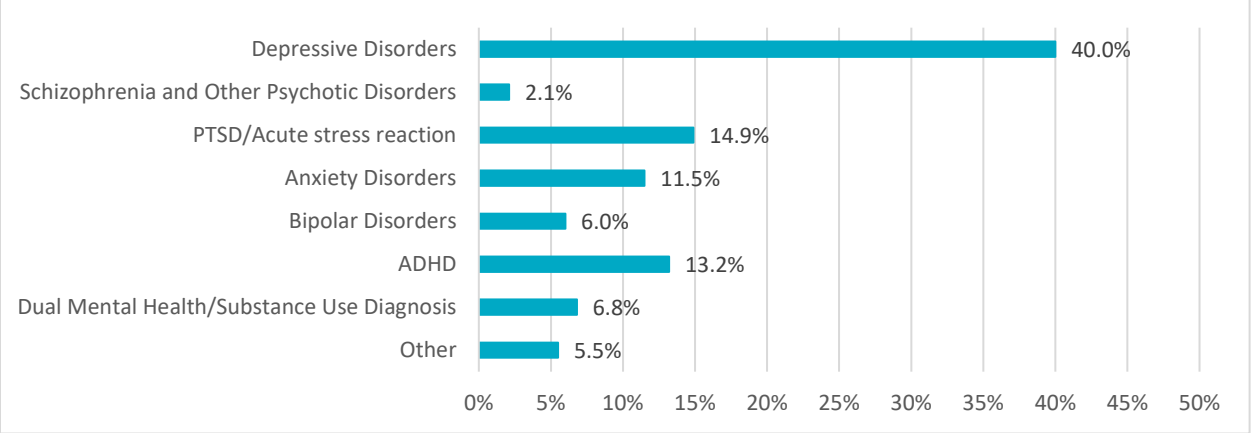
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP during FY 2021-22 (N=235)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

As shown in Figure 2, the youth served by CCYP had a wide range of mental health diagnoses. The most common diagnoses included depression (40.0%; n=94), Post-Traumatic Stress Disorder (PTSD)/Acute Stress Reaction (14.9%; n=35) and attention-deficit/hyperactivity disorder (ADHD) (13.2%; n=31).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP during FY 2021-22 (N=235)



In addition, 5.5% (n=13) of the FY 2021-22 enrollees reported having a non-mental-health-related disability. The most common disability reported among CCYP participants was a learning disability (n=5).

Utilization of Program Services

Program Service Contacts/Service Utilization

During FY 2021-22, the CCYP program served a total of 586 youth (466 maintenance, 85 ancillary youth, and 35 STRTP youth). This total was comprised of the 235 FY 2021-22 enrollees, plus 353 prior year enrollees who were still active during FY 2021-22. The 586 youth served during FY 2021-22 exceeded the original service targets established prior to CCYP implementation (n=500) and represented an increase of almost 100 youth served compared to the previous year (n=499).

For each 30 days enrolled in CCYP, maintenance and ancillary/STRTP youth received between 1 and 2 CCYP services (see Table 2). As reported in Table 2, maintenance clients received an average of 1.30 CCYP services per month (i.e., every 30 days enrolled in CCYP) compared to 1.49 CCYP services for ancillary/STRTP youth. For both groups of CCYP clients, medication management services and nurse consultations represented approximately 50% and 25%, respectively, of average total monthly CCYP services provided. The remaining 25% of contacts were related to psychosocial assessments to track client needs as well as other supportive services such as collateral contacts with other providers. When looking more closely, maintenance clients received an average of 1.30 services while ancillary/STRTP clients received 1.49 services per 30 days of enrollment. This 0.19 difference in average, while small, represents a narrowing of the difference evident in the prior year (0.28 in FY 2020-21). Additionally, whereas in FY 2020-21, the difference in services was due primarily to ancillary clients having a higher average number of monthly psychosocial assessment and other services/collateral contacts, the remaining difference in FY 2021-22 was due to a slightly higher average number of medication management and nursing services per month for ancillary/STRTP clients. This shift highlights successful efforts by CCYP leadership to adjust assessment coordinator task requirements and expectations such that their workload requirements were similar regardless of whether providing services to maintenance or ancillary/STRTP clients.

Table 2. Average Number of CCYP Services Provided Per Month during FY 2021-22 (N=586)

Type of CCYP Service	Mean Number of Services per 30 Days	
	Maintenance (N=466)	Ancillary/STRTP (N=120)
Any CCYP service	1.30	1.49
Psychosocial assessment	0.19	0.18
Medication management	0.68	0.77
Nurse consult	0.31	0.39
Other services (e.g., collateral)	0.12	0.15

Program Duration

To generate a better understanding of typical CCYP participation patterns, the following analyses examine CCYP program duration and discharge status for all FY 2021-22 maintenance and ancillary CCYP clients. Table 3 shows that the average duration for all maintenance clients still participating in CCYP services as of 6/30/2022 was approximately 15 months at 469.5 days. The median duration, which represents the midpoint value (i.e., 50% are shorter and 50% are longer), indicates that half of all CCYP maintenance enrollees had been enrolled in CCYP for more than 352 days. In contrast, ancillary clients still participating

in CCYP services as of 6/30/2022 had shorter mean and median duration values of 392.4 and 378.0 days, respectively.

Table 3. CCYP Duration for Youth Receiving Services During FY 2021-22

	Maintenance (N=466)			Ancillary/STRTP (N=120)		
	n	Mean Number of Days	Median Number of Days	n	Mean Number of Days	Median Number of Days
Open in CCYP as of 6/30/2022	249	469.5	352.0	59	392.4	378.0
Discharged during FY 2021-22	217	490.8	399.0	61	247.7	219.0

Of note, the total number of persons discharged during FY 2021-22 (n=278) represented a more than doubling from the prior year (n=135). This increase in the number of CCYP discharges was purposeful and by design on the part of the CCYP program. As discussed below, the CCYP program added the role of Transition Planner to their service delivery team to help identify cases that may be appropriate for medication management provided by another community-based health provider such as a primary care physician. By adding the Transition Planner and facilitating additional discharges from the CCYP program, CCYP was able to focus more closely on those cases needing the unique psychiatric expertise provided by CCYP and continue to enroll substantial numbers of new clients without reaching program capacity limitations.

BHS Utilization Patterns

BHS Services Utilization Before and During CCYP

To assess the extent to which CCYP was able to support stable mental health among their clients without need for crisis or acute care services, BHS service utilization patterns before and during CCYP enrollment were compared. This was accomplished by using the Cerner administrative database that documents the provision of BHS-funded services throughout San Diego County to identify mental health services received by CCYP clients from other BHS providers. Since the time enrolled in CCYP varies considerably between maintenance and ancillary clients and can be quite lengthy (i.e., frequently more than a year for maintenance clients), a standardized metric was created to enable equivalent comparisons for BHS service utilization before and during CCYP. The standardized metric for the "during CCYP" period reflects the average amount of services youth would be expected to receive during a 180-day period with CCYP. This metric facilitates comparisons to the 180-day period immediately prior to entering CCYP and between maintenance and ancillary clients.

The standardized or average utilization of other BHS services during a 180-day period while enrolled in CCYP was calculated by adding all FY 2021-22 BHS services (by service type) that occurred while clients were enrolled in CCYP and dividing that by the total number of days that all clients were enrolled in CCYP during FY 2021-22. The resulting value represents the average number of BHS services that CCYP clients received per day, which is then multiplied by 180 to generate the estimate of BHS services that CCYP clients would receive during any 180-day period in CCYP. This allows for an equivalent comparison to the average amount of BHS services utilized by youth during the 180 days prior to CCYP.

Table 4. Comparison of BHS Service Utilization Prior to and During CCYP

	Maintenance Clients (N=466)		Ancillary/STRTP Clients (N=120)	
	Average number of BHS services per person, per 180 days			
	Prior to CCYP	In CCYP	Prior to CCYP	In CCYP
Inpatient hospitalization	0.04	0.02	0.13	0.08
Crisis stabilization visits	0.10	0.08	0.35	0.23
PERT/MCRT[1] visits	0.02	0.03	0.12	0.06
Therapeutic behavioral services	2.33	0.15	1.08	0.49
Outpatient sessions (not CCYP)	18.82	1.59	17.53	13.28

[1] *Psychiatric Emergency Response Team (PERT) /Mobile Crisis Response Team (MCRT)*

For the 466 maintenance youth served by CCYP during FY 2021-22 (see Table 4), prior to their CCYP enrollment they utilized crisis/acute care services such as inpatient hospitalizations and crisis stabilization visits relatively rarely (i.e., averaging much less than 1 instance per person in the 180 day period). Further, the average number of instances for these services remained nearly the same from the 180 days pre-enrollment to 180 days in CCYP. This is consistent with CCYP program design in that persons referred to CCYP have been determined to be relatively stable and not in need of ongoing therapy.

An additional component of CCYP concept is that the program provides psychiatric care without requiring participation in therapy. Given this design, the average number of non-CCYP outpatient sessions understandably reduced substantially from 18.82 to 1.59 from the 180 days prior to 180 days during enrollment in the program. Feedback from CCYP staff indicated the non-CCYP outpatient visits that did occur were frequently related to situations where emergent circumstances resulted in the need for a youth to reconnect with a program that offered ongoing therapy. To facilitate the transition, a "warm-handoff" occurred during which a person was simultaneously enrolled in both CCYP and another outpatient treatment program.

A comparison of the behavioral health service utilization patterns of ancillary and maintenance clients prior to CCYP and while enrolled in CCYP reveals some key differences. While still relatively rare events, inpatient hospitalizations, crisis stabilization visits, and Psychiatric Emergency Response Team (PERT) encounters are approximately twice as common in ancillary clients prior to CCYP enrollment and remains higher during CCYP enrollment when compared to maintenance clients. These findings are consistent with the expectation that maintenance clients are determined to be more stable and not in need of ongoing therapeutic services, whereas the ancillary clients are still in active treatment elsewhere and rely on CCYP to provide medication management services to address a temporary disruption in access to psychiatric care. For the same reason, it is not surprising that ancillary clients exhibited a much higher utilization of non-CCYP outpatient treatment services while enrolled in CCYP compared to maintenance clients (13.28 and 1.59, respectively).

Overall, these findings highlight the difference in service needs between the maintenance and ancillary CCYP clients and provide evidence that CCYP was typically able to successfully maintain stable mental health among their participants, particularly among the maintenance client population.

Of note, the findings regarding BHS service utilization before and during CCYP were similar to those reported for FY 2020-21. Identifying this pattern of findings across multiple years, combined with the lengthy CCYP program participation (i.e., often more than a year) indicates that CCYP is consistently able to maintain the stability and well-being of youth by providing regular psychiatric consultation services.

Primary Program Outcomes

Three assessment-based outcome tools are reported in this section of the report. The Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptoms Checklist (PSC) are BHS-required tools to evaluate services provided across all levels and types of care. It is important to note that the primary goal of CCYP is maintaining stability through medication management only; thus, it is not necessarily expected that significant improvements would be seen between initial enrollment into CCYP and later follow-up assessments. Note that only maintenance clients, the primary target population, are included in these analyses (i.e., those who are only receiving CCYP medication management services and not receiving therapy services in other programs).

Child and Adolescent Needs and Strengths

The CANS is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In CCYP, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 333 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2021-22 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a “2” or “3” indicating a specific area that could be potentially addressed in the service or treatment plan (many of these areas are not specifically addressable by the medication management services provided by CCYP). Table 5 shows the mean number of needs at initial assessment and last available assessment for the domains of Child Behavioral and Emotional Needs, Life Functioning, and Risk Behaviors. These findings show statistically significant reductions at the last available follow-up for the Child Behavioral and Emotional Needs domain. These ratings suggest that although only medication management services were provided by CCYP, there were still some areas of need identified at intake that improved while participating in CCYP.

Table 5. CANS Average Change from Initial Assessment (N=333)

	FY 2021-22 (N=333)	
Key CANS Domains	**Initial Mean Number of Needs**	**Follow-up Mean Number of Needs**
Child Behavioral	1.71	1.35**
Life Functioning	1.10	1.13
Risk Behaviors	0.08	0.08

***statistical significance at p < 0.01*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a ‘2’ or ‘3’ at initial assessment

to a '0' or '1' on the same item at the discharge assessment). As shown in Table 6, for Behavioral and Emotional Needs and Life Functioning domains approximately 60% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment. This reduction in need is close, but slightly less than found in traditional outpatient programs (i.e., approximately 70-75% had at least one improvement for each domain). Given that CCYP does not provide therapeutic services to address specific treatment needs, the findings highlight the importance of consistent medication management and the associated care team such that the majority of the CCYP population with needs at baseline experienced improvements in their overall well-being in these treatment related domains while receiving CCYP services. For Risk Behaviors, only a small number of CCYP clients had such a need, but of those, almost all (94.1%) had a reduction in need in this area at follow-up.

Table 6. Persons with CANS Improvement at FY 2021-22 Follow-up (N=333)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Child Behavioral	264	156	59.1%
Life Functioning	193	115	59.6%
Risk Behaviors	17	16	94.1%

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 5.

In FY 2021-22, the PSC-35 was administered at entry into CCYP, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 139 caregivers and 81 youth completed both an initial and follow-up/discharge PSC assessment. At program entry, 48.2% of parents and 37.0% of youth reported PSC scores that indicated clinical concern (see Table 7). At follow-up, slightly fewer (42.4%) parents reported clinically significant scores, however this limited amount of change is to be expected as there are no therapy services offered as part of the CCYP program. An examination of mean score changes in parent self-report show a small, but statistically significant reduction (i.e., improvement) for both the Attention subscale and the total PSC score. With the reduced sample sizes for completed self-report PSC assessments (as compared to the clinician completed CANS), the findings should be interpreted cautiously as they may not reflect the broader experiences of the full CCYP population.

Table 7. PSC Average Change from Baseline

	Parent/Caregiver Report (N=139)					Child/Youth Report (N=81)				
Subscales	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% of clients above clinical cutoff[1] at baseline**	**% of clients above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**
Attention	139	46.8	29.5	5.9	5.1*	81	30.9	27.2	5.0	4.7
Internalizing	139	36.0	38.1	4.0	3.7	81	35.8	46.9	3.6	4.0
Externalizing	139	26.6	26.6	4.4	4.6	81	7.4	4.9	2.8	2.2
Total Score	**139**	**48.2**	**42.4**	**27.3**	**25.7***	**81**	**37.0**	**34.6**	**23.2**	**21.9**

**statistical significance at p < 0.05*

[1] PSC clinical cutoff scores by subscale (higher scores indicate worse condition): Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28

To better understand the distribution of PSC change scores within the CCYP client population and to facilitate comparisons with the overall CYF BHS system, analyses were conducted that examined the level of change from initial PSC assessment. Consistent with the Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 8. Distribution of FY 2021-22 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=139)		Child/Youth Report (N=81)	
Amount of Change	**n**	**%**	**N**	**%**
Increased impairment (i.e., 1+ point increase)	58	41.7	36	44.4
No improvement (i.e., 0-1 point reduction)	11	8.1	5	6.2
Small improvement (i.e., 2-4 point reduction)	15	10.8	11	13.6
Medium improvement (i.e., 5-8 point reduction)	24	17.3	9	11.1
Large improvement (i.e., 9+ point reduction)	31	22.3	20	24.7

As shown in Table 8, approximately one-third of parents/caregivers (39.6%) and children/youth (35.8%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 41.7% of caregivers and 44.4% of children reported a higher PSC score at follow-up, indicating perceptions of increased impairment. Given that the CCYP population was determined to be relatively stable and not needing ongoing therapy upon entrance into CCYP, this finding of increased impairment likely reflects, at least in part, a "ceiling effect" in that there was not much room for improvement for many youths so it is not surprising that a portion of parents and youth might identify a few additional concerns at a later time point. Overall, these findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes.

Substantial variability and similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2020-21 Systemwide Annual Report. Approximately 40% of caregivers and children/youth reported large improvements while about 20-25% reported increased impairment from initial PSC assessment. While caution is warranted when making any direct comparisons between CYF and CCYP PSC change score analyses, it is not surprising that the CCYP population appears to exhibit lower levels of PSC improvement, given the specific nature of the CCYP population (i.e., demonstrating mental health stability without a perceived need for ongoing therapy), and the fact that the CYF analyses only include persons with completed discharge assessments (i.e., have concluded treatment goals). However, the variability of PSC change scores among CCYP clients is a reminder that there are CCYP clients who may benefit from additional therapeutic support and may require linkage to ongoing behavioral health care outside of CCYP.

Caregiver and Client Perspectives on CCYP Services

A total of 81 caregiver feedback surveys and 61 youth feedback surveys were completed at either the 6-month time point or discharge during FY 2021-22. As shown in Table 9, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (93.8% and 86.9%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on client functioning and help-seeking. More caregivers reported that their child was able to function better in life (87.5%), compared to 81.4% of children/youth. Likewise, 88.8% of caregivers reported knowing where to get help and 88.5% felt comfortable seeking help, compared to 85.0% and 73.4%, respectively, among youth. Most caregivers reported feeling the needs of their family were met by the program (90.1%), while 75.5% of youth reported the same. The above findings should be interpreted with some caution as the number of caregivers and youth who completed a feedback survey is relatively low (i.e., less than 20.0% of all CCYP participants); however, the response patterns are similar to prior years.

Table 9. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=81)**	**Youth (N=61)**
As a result of this program, my child is/I am able to function better.	87.5	81.4
As a result of this program, my child/I know where to get help.	88.8	85.0
As a result of this program, my child is/I am more comfortable seeking help for myself.	88.5	73.4
My child's/my needs were met by this program.	90.1	75.5
Overall, I am satisfied with the services I received here.	93.8	86.9

For the open-ended caregiver and youth feedback survey questions (n=55 caregivers; n=34 youth with codable responses), at least two evaluators reviewed and coded the individual question responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. Across both

caregivers and youth, respondents reported that CCYP was succeeding at providing needed medication management by supportive and responsive staff. When asked about ideas for improving CCYP, most respondents said that CCYP services were helpful and did not have any specific recommendations. Some suggestions mentioned included providing more in-person appointment options and increasing the amount of contact between the program and clients/families.

Additionally, 23 caregivers and clients completed a survey regarding the transition planner position. In general, the survey responses indicated that the transition planner was helpful overall and specifically in providing referrals, information, and resources. The survey responses suggested that the transition planner could be more helpful by increasing their referrals to outside care.

Additional Program Activities

Developing Relationships to Support Transitions From CCYP

CCYP continued to develop partnerships with Children's Primary Care Medical Group (CPCMG) and other primary care physicians throughout San Diego County to facilitate transitions from CCYP service utilization to primary care services with providers able to continue medication management.

Community Outreach and Education

CCYP continued to develop and enhance mechanisms for providing psychoeducation and support to CCYP youth, parents/caregivers, and community members via a monthly newsletter and website (https://www.ccypsd.org/).

Primary Implementation Findings

Findings in this section were derived from two primary data sources: 1) CCYP stakeholder meetings; and 2) the Annual CCYP Staff/Psychiatrist Survey. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of FY 2021-22. CCYP program staff and contracted psychiatrists were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 14 respondents (4 psychiatrists and 10 assessment coordinators/administrators/support staff) from the 15 CCYP staff or contractors invited to participate in the survey (i.e., a 93.3% response rate). For the primary open-ended staff survey questions, at least two evaluators reviewed and coded the individual responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. Secondary open-ended questions were summarized.

Program Strengths

CCYP Staff & Leadership

When asked which factors helped most toward achieving goals in FY 2021-22, staff highlighted the availability of licensed psychiatrists, strong management, and high performing staff. One staff member described "a strong team of psychiatrists, program leadership, [and a] solid team of staff who are

dedicated and loyal" while another highlighted "committed team members working to improve mental health outcomes for kids and families."

Additionally, CCYP added a new role in FY 2021-22. The transition planner meets with families to set the expectation that in many cases the client will eventually be discharged to a primary care physician. Staff highlighted the importance of the transition planner in helping discharges occur to allow new clients to be served.

> "The role of transition planner has been very helpful in initiating the process of discharging clients that no longer meet criteria for the program and therefore referring the client to appropriate level of care."

Outreach and Recruitment

Similar to previous years, outreach and recruitment were not perceived as substantial challenges for the CCYP program. The CCYP program continues to be well-known and accepts referrals from many different organizations & providers (both maintenance and ancillary referrals). In response to the continued substantial demands for youth psychiatric services, additional partnership opportunities were developed in FY 2021-22, such as the formal relationship with BHS-funded STRTP operating throughout San Diego County, in which CCYP would be responsible for medication management while the partner organization continued to provide needed counseling/therapy services.

Client Engagement and Retention

In FY 2021-22, the CCYP program was successful at retaining clients in services as evidenced by lengthy program participation and few program dropouts. A goal for FY 2021-22 was to enhance client engagement strategies, and staff reported using several strategies such as a focus on listening during clinical interactions, providing psychoeducation, day-to-day tips, follow-up outreach, appointment reminders and separate appointments with the caregiver when necessary. Overall, these strategies appeared to have been successful, as CCYP staff overall did not indicate client engagement as a significant concern this year. When asked about how they facilitated client and caregiver engagement in CCYP services, the most common responses were communication with clients/families including appointment reminders, follow-ups, and simply listening, as well as working to set appropriate expectations about the service and education clients and caregivers about medication management.

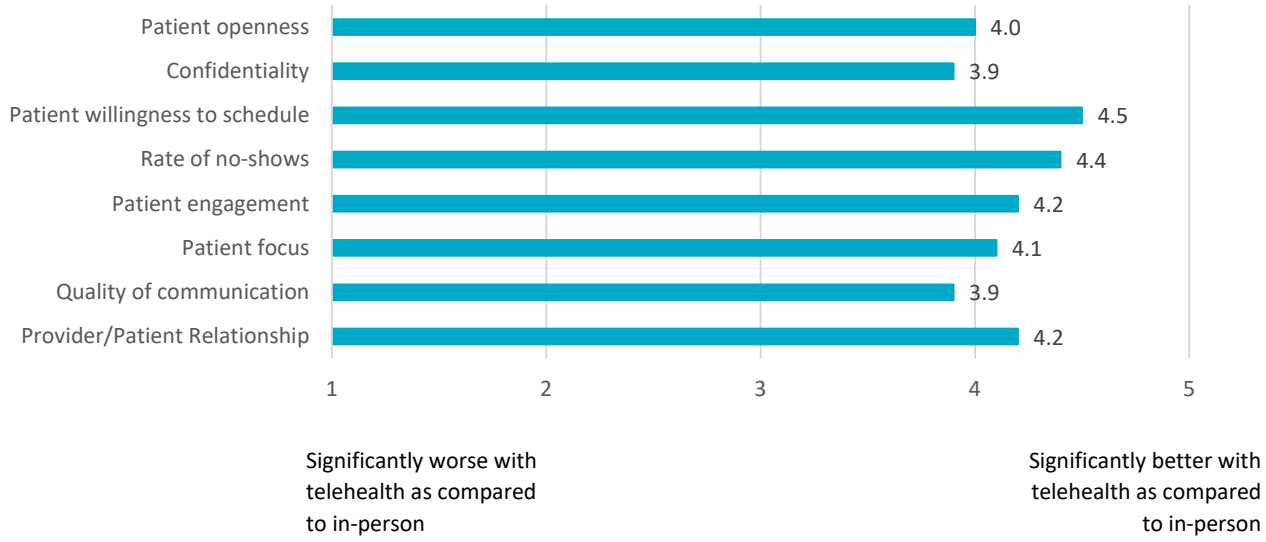
Telehealth

The initial design of CCYP, which already included a reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services. At the beginning of the project, however, telehealth was a relatively novel service modality and there was some uncertainty about the capability of building client rapport when services are not face-to-face. In the FY 2021-22 survey, staff were asked to rate their client interactions: how does telehealth compare to in-person sessions?

On average, staff rated client interactions via telehealth as better than in-person services (see Figure 3). Highest rated items were patient willingness to schedule sessions and the rate of no-shows. Patient openness, provider/patient relationships, patient/client engagement and focus during sessions were all

rated as better with telehealth as compared to in-person sessions. Confidentiality and quality of patient communication were rated the lowest, although still well in favor of telehealth.

Figure 3. Ratings of Interactions with Clients via Telehealth



On a scale of 1 to 5 where 1 = strongly disagree and 5 = strongly agree, staff indicated they like providing telehealth services (4.9) and they feel confident about their ability to provide services via telehealth (4.8). Staff strongly agreed that the agency has done a good job supporting the shift to telehealth services (4.5) and that providing telehealth services should continue to be a high priority (4.8).

> "Clients and parents are pleased that the services are provided via telehealth. This has been very helpful. Clients and families express how they are satisfied with the services."

Program Challenges

Factors that inhibited achieving program goals included high staff turnover and protocol changes that took time to adjust to.

Referrals

In the FY 2021-22 survey, staff scored various aspects of referrals as the most challenging aspects providing CCYP services. On occasion, a CCYP participant may need a referral out for additional therapeutic or social assistance services. The limited availability of other community services, wait lists for other services, and clients not completing their referrals were scored on average as 4.6, 4.5 and 4.0 on a scale of 1 to 5 where 1= not challenging at all and 5 = very challenging. There were some differences in how psychiatrists and non-psychiatrists rated items (see Table 10).

Table 10. Ratings of Service Delivery Challenges by Role

	Psychiatrist Mean Score (n=4)	Non-Psychiatrist Mean Score (n=9)
Limited availability of other community services	5.0	4.4
Waitlists for services clients were referred to	5.0	4.2
Difficulties getting required documentation completed (e.g., BHAs, updated vitals)	2.8	3.8
Forming relationships with community partners	3.8	3.1
Program staff turnover	3.0	3.8
Client attrition/not completing program	2.0	2.4
Clients not actively engaging with CCYP services (i.e., frequent no shows or rescheduling, limited "buy-in")	3.3	3.1
Clients not completing referrals for other services	4.0	4.0

On average, psychiatrists found the following more challenging than non-psychiatrist staff: limited availability of other community services, waitlists for services clients were referred to, and forming relationships with community partners. One survey respondent stated a need for "allowing CCYP to make referrals to programs county-wide in order to assist caregivers and clients that may be struggling to get connected."

Non-psychiatrists found program staff turnover & client attrition more challenging than psychiatrists. Both groups found clients not engaging in services and clients not completing referrals similarly challenging.

Barriers to Telehealth with Video

While overall impressions of telehealth with video were favorable in the FY 2021-22 survey, staff reported that some caregivers are unable to engage in services this way. Staff reported that 5-10% of clients are unable to consistently utilize telehealth with video (i.e., do not have a suitable device or reliable internet) and 5-10% of video sessions experience tech-based difficulties. However, the number of clients who prefer not to use telehealth with video was less than 5%. This discrepancy implies that there are clients willing to and may even prefer telehealth with video but are unable to successfully utilize it. One staff member shared:

> "There may be caregivers that are not familiar with how to connect to the video session. There may be some families where the internet connection may be poor making it difficult to connect to the video session."

Changes from Initial Program Design

1. During FY 2021-22 a Transition Planner was added to the CCYP service delivery team to help with connecting youth and families to relevant post-CCYP services.
2. CCYP began a partnership with the BHS-funded STRTP programs to provide medication management services for youth participating in STRTPs.

Program Recommendations

1. Assess feasibility and potential benefits of incorporating some capacity to deliver short-term therapeutic support services within CCYP.
2. Increase outreach and education to physicians who may be serving medically fragile youth that also have mental health/behavioral medication management needs that could be supported by CCYP.
3. Identify and implement additional strategies for remotely obtaining completed required assessments and other paperwork, particularly for items that traditionally have required a "wet signature."
4. Incorporate additional technical support resources into CCYP services to assist youth and family members with any device and/or connectivity issues that may negatively impact ability to consistently engage in telehealth services.

Conclusion

During FY 2021-22, CCYP served a total of 586 children and youth (466 maintenance, 85 ancillary clients, and 35 from the new partnership with small STRTPs to provide medication management services). Of these, 235 enrolled in CCYP during FY 2021-22). As in prior years, CCYP continued to serve a racially and ethnically diverse client population with the majority of newly enrolled clients identifying as Hispanic/Latino (59.1%).

In contrast to prior years, in FY 2021-22 CCYP discharged more persons (n=278) than were enrolled (n=235). This number is more than double that of FY 2020-21 (n=135), the result of a strategic decision by the CCYP program to identify and discharge clients who appeared to have medication management needs that could be successfully handled by other service providers (e.g., primary care physicians) to ensure that CCYP continued to have capacity for new clients who needed CCYP services. To facilitate these changes, CCYP created the role of the Transition Planner to engage with families and support discharge to appropriate service providers in the community.

Maintenance and ancillary/STRTP clients were estimated to receive 1 - 2 CCYP services per each 30 days of enrollment (1.30 and 1.49, respectively). Approximately half of the service contacts were medication management, for both groups. In the prior FY (2020-21) ancillary clients required almost twice as many psychosocial assessment and collateral service contacts as maintenance clients. This year (2021-22), the numbers were generally equivalent, indicating the workload requirements for Assessment Coordinators are now more similar. These findings highlight successful efforts on the part of CCYP to lessen the additional burden of ancillary clients on Assessment Coordinators.

CCYP clients often received services for a year or more with a median length of stay of 352.0 days for maintenance clients receiving CCYP services of 6/30/2022. While enrolled in CCYP, maintenance clients

utilized crisis or acute care BHS services at a rate similar to or lower than prior to CCYP enrollment. Although therapeutic services are not provided through CCYP, both clinician and caregiver/youth self-report (as documented by the CANS and PSC, respectively) indicated that many youth and family members experienced improvements in their well-being following enrollment in CCYP. Approximately 90% of caregivers and youth indicated that they were satisfied with the services received from CCYP.

The program continued to serve clients during the ongoing COVID-19 pandemic throughout FY 2020-21 without substantial disruption to services due to the planned utilization of telehealth as the main modality for interacting with clients. Staff expressed favorable perspectives regarding the benefits of providing services via telehealth and telehealth services are expected to remain a primary approach for providing services even if in-person services become more available.

MHSA INN funding for CCYP services will end on 12/31/2022; however, with the successful achievement of program objectives, BHS has decided that the CCYP program should be incorporated into the existing BHS System of Care as an ongoing service that will be funded through non-INN resources.

For more information about this Innovation program and/or the report please contact:

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Appendix

Characteristics of Participants who Enrolled during FY 2021-22

Characteristic	Total Participants (N=235)	
Age Group	**n**	**%**
5 to 11	53	22.6
12 to 15	84	35.7
16 to 17	79	33.6
18 to 20	19	8.1
Total	**235**	**100.0**
Gender	**n**	**%**
Male	88	37.4
Female	117	49.8
Transgender	10	4.2
Genderqueer/Gender non-conforming	5	2.1
Questioning/Unsure of gender identity	4	1.7
Another gender identity	8	3.4
Prefer not to answer	3	1.3
Total	**235**	**100.0**
Sex at Birth	**n**	**%**
Male	87	37.0
Female	144	61.3
Prefer not to answer	3	1.7
Total	**235**	**100.0**
Sexual Orientation	**n**	**%**
Heterosexual or straight	111	47.2
Gay or lesbian	11	4.7
Bisexual/Pansexual/Sexually fluid	48	20.4
Questioning/Unsure of sexual orientation	12	5.1
Other sexual orientation	4	1.7
Missing/Prefer Not to Answer	49	20.9
Total	**235**	**100.0**

Appendix

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Other sexual orientation	4	1.7
Missing/Prefer Not to Answer	49	20.9
Total	**235**	**100**

Appendix (continued).

Characteristic	Total Participants (N=235)	
Language	**n**	**%**
English	209	88.9
Spanish	25	10.6
Other	1	0.4
Total	**235**	**100.0**
Race/Ethnicity	**n**	**%**
African American	41	17.4
American Indian	7	3.0
Asian	19	8.1
Hispanic/Latino	139	59.1
White	88	37.4
Multiple	53	22.6
Other	4	1.8
Missing/Prefer not to answer	1	0.4
Total[1]	-	-
Mental Health Diagnosis[2]	**n**	**%**
ADHD	31	13.2
Depressive Disorder	94	40.0
Bipolar Disorder	14	6.0
Anxiety Disorder	27	11.5
PTSD/Acute stress reaction	35	14.9
Schizophrenia or other psychotic disorder	5	2.1
Dual Diagnosis: Mental Health and Substance Use Disorder	16	6.8
Other	13	5.5
Total	**235**	**100.0**
Disability	**n**	**%**
Yes, has a disability	13	5.5
No, does not have a disability	222	94.5
Total	**235**	**100.0**

[1] *Total may exceed 100% since participants could select more than one response.*
[2] *Mental health diagnosis information is obtained from BHS Cerner data system.*

Appendix (continued).

Characteristic	Total Participants (N=235)	
Type of Disability	**n**	%
Hearing	<5[4]	<2.1
Learning	5	33.3
Developmental	<5[4]	<2.1
Physical	<5[4]	<2.1
Chronic/Health	<5[4]	<2.1
Other	<5[4]	<2.1
Total[3]	-	-

[3] *Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.*
[4] *Values were suppressed due to small n size.*

Mental Health Services Act

Collaborative Statewide Early Psychosis Program Evaluation

Annual Innovation Report:

Summary Report of the Activities of the LHCN

Fiscal Year 2021-2022

Draft submitted November 7, 2022

Final version submitted December 9, 2022

Prepared by:

University of California, Davis, San Francisco and San Diego

This report was supported by:



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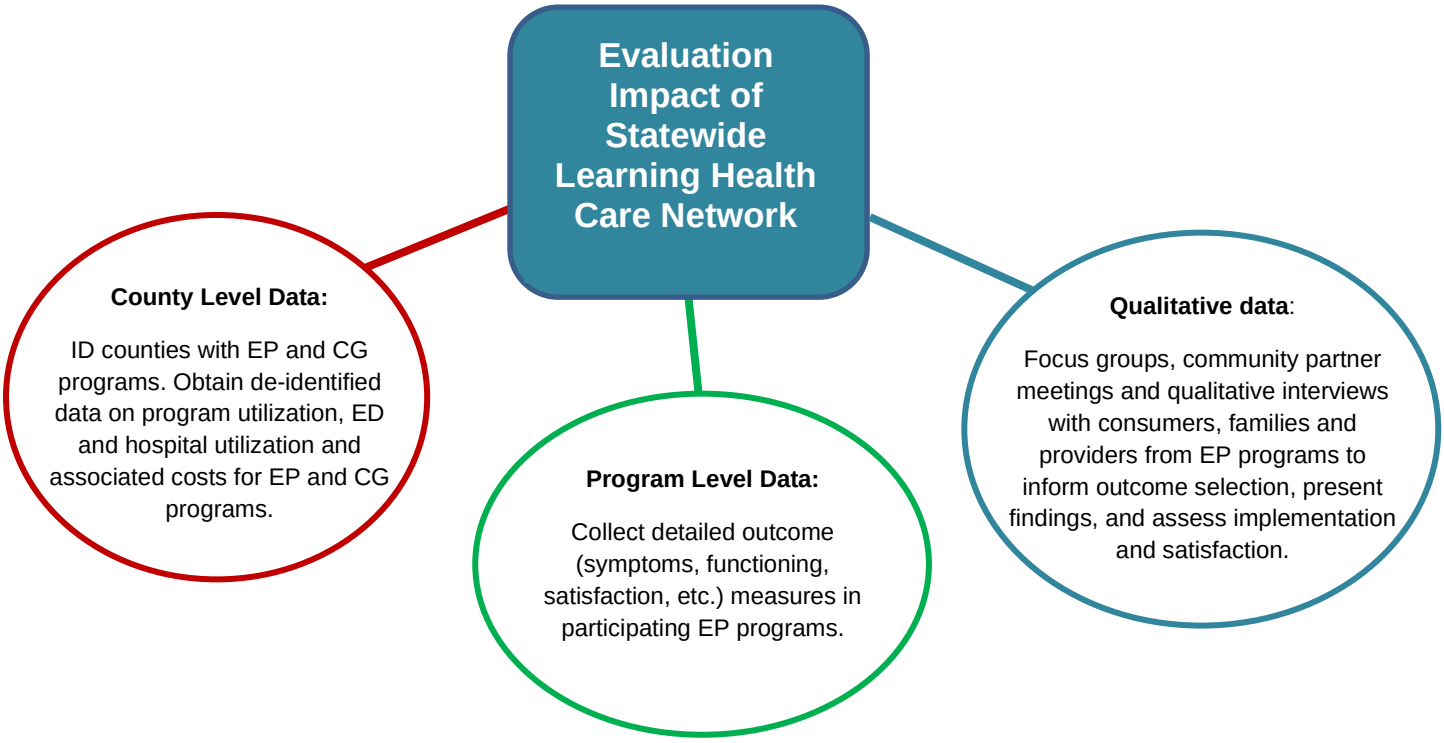
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Background

Multiple California counties in collaboration with the UC Davis Behavioral Health Center of Excellence received approval to use Innovation or other Prop 63 funds to develop infrastructure for a sustainable learning health care network (LHCN) for early psychosis (EP) programs. Of those counties with approved funding, the following counties have processed and executed contracts between their behavioral health services departments and UC Davis: San Diego, Solano, Sonoma, Los Angeles, Orange, Stanislaus, and Napa. One Mind has also contributed $1.5 million in funding to support the project. This Innovation project seeks to demonstrate the utility of the network via a collaborative statewide evaluation to assess the impact of the network and these programs on the consumers and communities that they serve. This project, led by UC Davis in partnership with UC San Francisco, UC San Diego, University of Calgary and multiple California counties, brings consumer-level data to the providers' fingertips for real-time sharing with consumers, and allows programs to learn from each other through a training and technical assistance collaborative. This Statewide EP Evaluation and LHCN propose to 1) increase the quality of mental health services, including measurable outcomes, and 2) introduce a mental health practice or approach that is new to the overall mental health system. The project must comply with the regulatory and funding guidelines for evaluation as stipulated by the applicable Mental Health Services Act (MHSA) funding regulations, contract deliverables, and best practices.

There are three components to the data collected for the LHCN: County Level, Program Level, and Qualitative data (Figure 1). The protocol for collecting each component has been reviewed by an Institutional Review Board (IRB) and approved before commencement of data collection. Further, aspects of the data design has been shaped by the input of community partners, including mental health consumers, family members, and providers.

Figure 1. Three Components of the Evaluation Associated with the Statewide LHCN.



This project was approved for funding using Innovation Funds by the MHSOAC in December of 2018. The California Early Psychosis Learning Health Care Network (LHCN) represents a unique partnership between the

University of California, multiple California counties, and One Mind to build a network of California early psychosis (EP) programs. We leveraged this initial investment to obtain additional funding from the National Institutes of Health (NIH) in 2019, which enabled six university and two county early psychosis programs to join and also linked the California network to a national network of EP programs, including UCSF PATH, UCSD CARE, UCLA Aftercare & CAPPS, Stanford Inspire, San Mateo Felton BEAM UP/(re) MIND, UC Davis EDAPT and SacEDAPT programs. The overarching name of the project, which encompasses the LHCN and the NIH-funded components, is now “EPI-CAL.” In this and future reports, we will refer to the LHCN only when describing components of the project that are specific to the LHCN evaluation (e.g., county data analysis).

Our EPI-CAL team has made significant progress towards our goals outlined in the innovation proposal during the 21/22 fiscal year, which are summarized in the current report.

Executive Summary

The purpose of this document is to provide the EP LHCN Mental Health Services Act (MHSA) Annual Innovation Report to review EP LHCN goals accomplished during FY2021/2022. This report will include summaries and status updates on the infrastructure of the LHCN, steps taken towards implementation, and barriers that have been identified over the course of the last fiscal year. While the counties involved in the EP LHCN may be at different stages in the process, the overarching LHCN is moving forward as planned.

- Prior to beginning activities for the LHCN, UC Davis had to have an executed contract with each of the participating counties so each party could mutually agree to a scope and terms of work. As of June 2022, UC Davis had executed contracts with Solano, San Diego, Los Angeles, Orange, Sonoma, Napa and Stanislaus counties. The Multi-County Collaborative (Colusa, Mono, Nevada) and Lake County LHCN contracts were under review at the time of June 2022. This represents two additional executed contracts (Napa and Stanislaus), and two new contracts under review for the past fiscal year. In addition to existing LHCN counties, Kern County has received approval to join the LHCN in May of 2022. We are working together to execute their contract before officially beginning activities in their county program.
- We have held two LHCN Advisory Committee meetings in the last fiscal year, which was comprised of a county representative from each participating county, a clinical provider from each participating EP program, and consumers and family members who have been or are being served by the participating programs. We will continue to hold Advisory committee meetings on a bi-annual basis and summarize meetings activities in our deliverables and annual reports.
- In the last year, we began fidelity assessments in EPI-CAL/LHCN clinics. We conducted a total of ten fidelity assessments across EPI-CAL clinics, including four LHCN county programs (San Diego, Solano, Orange, and Napa). We have submitted fidelity assessment reports to each program and met with individual program leadership to discuss their fidelity assessment results. We have scheduled fidelity assessments for all remaining participating programs in the LHCN network with an executed contract, with a goal of completing them in the current 22/23 fiscal year.
- In the past year, we continued implementation of the Beehive application in EPI-CAL/LHCN clinics, which has included extensive training and site-specific support. We have refined our training approach and have completed Beehive training in several participating EPI-CAL programs.
- After an initial enrollment period in pilot EP programs, we did an interim analysis of consumer demographics, data sharing preferences, and survey completion. We found that a large majority of consumers (83%) opted in to sharing data for research purposes with UC Davis, and high completion rates of enrollment surveys (80%). We will shift our focus in the future to higher survey completion rates, as we know that while the vast majority of consumers have completed some self-report surveys, not many have completed the full EPI-CAL bundle of surveys for each time point.
- LHCN enrollment progress is summarized in this report through the FY2021/2022. The goal was to have at least 405 individuals enrolled by the end of the FY21/22 . However, the observed rate of enrollment across the LHCN is 145 consumers. Due to the discrepancy in observed and expected

enrollment, we have focused on addressing barriers to enrollment in the current FY and have offered additional support to programs, where feasible. It is important to note that there were an additional 142 consumers who have been registered by the clinic in Beehive, but who have not engaged with Beehive by completing the End User License Agreement (EULA) or starting their surveys. Therefore, one of the points of intervention we have asked programs to focus on in enrolling their registered consumers.

- The needs and preferences of EP programs and the institutions of which they are a part have driven the design of Beehive. In this report, we summarize some of the recent revisions made to Beehive based on our EP program partner feedback. For example, security requirements of counties and institutions have led to increases in the security of Beehive. Feedback from users at EP Programs have identified several aspects of the application that could be improved to increase compatibility with their existing workflows and facilitate implementation of this novel technology.
- We report our preliminary findings from our interviews with EP community partners about the barriers and facilitators to implementing a LHCN into EP treatment programs.
- During the last FY, we have finalized methods for multi-county-integrated evaluation of costs and utilization data. The proposed analysis focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of the LHCN in the EP programs to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via Beehive.
- During the last FY, our team continued to hold meetings with the EP program managers and the county data analysts for each participating LHCN county to identify county-level available data and data transfer methods. We discussed services provided by the EP program, description of consumers served, staffing specifics and billings codes for each service. We also reviewed details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of consumers (i.e., foster care). We have discussed time-periods for which the LHCN team will request data, description of the consumers from EP programs and how similar consumers served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use treatment), and data transfer methods. Our research team has gathered all the information from each program/county and summarized it in a multicounty data table included in this report.
- During the last FY, our team finalized our plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs. One goal of this analysis was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties. Over the last FY, we successfully completed our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources.
- In this report, we provide our preliminary findings on cost and utilization data from a single county. At this time, we did not have enough data to complete a multi-county integrated evaluation of costs and utilization data. However, our progress is summarized and plans for the multi-county analysis is described in this report.

Current Project Goals

The current document summarizes project activities conducted for the LHCN during the FY2021/22. This includes the following project activities:

1. Establish a community partner advisory committee that will meet at least every 6 months. Please note that our team is swiftly moving away from using the term “stakeholder” as it holds a violent connotation for Indigenous communities. We are now using the term “community partner” instead.

2. Schedule for EP program fidelity assessments and provide results from fidelity assessments of EP programs

3. Provide training and implementation of outcomes measurement on app in non-pilot EP programs, detailing training of EP program staff in data collection

4. Outline plan for training EP program staff from non-pilot programs on app implementation and outcomes measurement

5. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation

6. Monitor enrollment and follow up completion rates for LHCN app in all EP programs

7. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

8. Subcontractor to revise dashboard to include feedback from programs and community partners

9. Gather feedback from interviews with EP community partners about experience in EP treatment programs

10. Finalize methods for multi-county-integrated evaluation of costs and utilization data from preliminary multi-county integrated evaluation

11. Identification of county-level available data and data transfer methods, and statistical methods selected for integrated county-level data evaluation

12. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs.

13. Provide findings on cost and utilization data from preliminary multi-county integrated evaluation, identification of problems and solutions for county-level data analysis

1. Establish a community partner advisory committee that will meet at least every 6 months

The Advisory Committee for the LHCN is comprised of a county representative from each participating county, a representative of each participating EP program, and up to five consumers and five family members who have been, or are being served, by EP programs. This committee is co-led by Bonnie Hotz, family advocate from Sacramento County. Recruitment for the Advisory Committee is ongoing, and we have confirmed membership with multiple community partners. These include past consumers, family members, clinic staff and providers. Even though we have already held several Advisory Committee meetings, we continue to distribute flyers to all participating clinics, as their contracts are coming through, to make sure the Advisory Committee is open to all LHCN member clinics. In FY2021/22 , we held Advisory Committee meetings on December 15th, 2021 and June 10th, 2022.

November 15th 2021 Meeting

We held the first Advisory Committee meeting of the fiscal year on November 15th, 2021. The meeting was held remotely due to the COVID-19 pandemic. During the meeting, we introduce two new programs to the LHCN Committee, including Napa and Stanislaus Counties, who recently executed their contract with UC Davis. Dr. Loewy provided a brief update on the county data analysis progress, including reaching a milestone of collecting all initial services data from participating counties. Lindsay Banks then provided an update on the fidelity assessments thus far, as our team has conducted our first assessment with the Kickstart program of

San Diego. Hope Graven, program director of Kickstart, described the fidelity assessment experience from the program perspective.

A large part of the most recent meeting was providing an update on Beehive training progress, including the stage at which each program is at in their training goals and the barriers to implementing Beehive in EP programs thus far. Kali Cowden-Sherwood, a therapist from the Solano SOAR program, gave her perspective on what has been going well and what barriers she has experienced with using Beehive in a clinical setting. Common barriers included the time commitment to getting consumers set up in Beehive, as well as problem solving technical issues with consumers in real time. However, many of these issues are no longer present if the consumer is completing surveys in person on the tablet.

After summarizing training progress in LHCN/EPI-CAL programs, Kathleen Nye also summarized changes that were implemented in Beehive in response to user feedback, such as revising the dashboard layout and modifying clinic-entered survey layout. Upcoming changes to be implemented based on user feedback include lengthening the survey windows and enabling consumers to complete their EULA before their intake date. Dr. Karina Muro then provided an update on Spanish materials available in Beehive, and plans for supporting EP program staff in providing Beehive services in Spanish to consumers and their parents. One of the supports includes a training on Cultural Considerations and Working with Latinx Families that Dr. Muro will lead in December, 2021.

Peer advocates that usually attend the LHCN Advisory Committee meeting were not able to attend this time around. The peer voice is very important to the LHCN progress, so our team will make a greater effort to increase peer partner participation in future Advisory Committee meetings.

June 10th, 2022 Meeting

We held the most recent Advisory Committee meeting on June 10, 2022. The meeting was also held remotely. During the meeting, we discussed recruitment and enrollment progress and challenges. Kathleen Nye gave a general overview of the status of training and enrollment across the LHCN. While many programs are making progress using Beehive (i.e., enrolling consumers and supporting completion of surveys), as many programs have not integrated Beehive into their program to the degree necessary to achieve project aims. We discussed in the meeting that there are many reasons for this. For example, Lindsay Banks presented initial impressions from the barriers and facilitators interviews which have begun at sites who have been using Beehive consistently.

The next part of the meeting consisted of three breakout rooms, facilitated by EPI-CAL research team members, to brainstorm solutions to the challenges identified in the barriers and facilitators interview. The three topics for the breakout rooms were 1) Incorporating Beehive in Care, 2) Consumer Engagement, 3) Training & Beehive Learning Curve. The purpose of these groups was to hear from the EPI-CAL network what solutions they think would work best for them. To this end, each group was asked to identify two to three concrete and actionable solutions to address challenges and barriers associated with each discussion topic.

After the breakout rooms, the final portion of the meeting was devoted to debriefing in a large group discussion. Each breakout group shared their discussion and solutions with the larger group.

The Training & Beehive Learning Curve group shared that hands-on, one-on-one trainings have been helpful to reinforce concepts discussed in the large all-team Beehive core trainings. The group agreed that both live trainings and recordings of those trainings are important to engage different members of the team. Due to the large turnover at most programs, there is a need to retrain staff across multiple programs at regular intervals. One solution for this that was proposed is to offer network-wide trainings for new staff. There was agreement that having materials to reference alongside asynchronous training or to reference after a training is helpful

(e.g., Beehive Resource Guide), and that sites would like more materials to support their usage of Beehive, such as one-page instruction sheets for certain workflows in Beehive. Beehive office hours where individuals can drop-in and ask questions in a group setting was another proposed solution. Finally, group participants agreed it would be helpful to have more guidance on creating increased buy-in for consumers when clinicians are introducing Beehive. Currently, the EPI-CAL team has created scripts and flyers for this purpose, but the group agreed they would like to hear more from the other breakout rooms about additional solutions to this issue.

The Consumer Engagement group included our peer and family partners in attendance at the advisory committee meeting. One solution proposed for providers is understanding that the process for engaging each consumer will be somewhat unique and tailored to that individual. Flexibility is needed. For example, if the day the team planned to introduce Beehive seems to be a day where the consumer is very overwhelmed or symptomatic, the team can choose not to introduce on that day but should try to re-introduce another time. One family partner shared the importance of reminding consumers and families why this information is important in care. Some family members may not understand the relevance of questions about health history, for example. Explaining the relevance of certain questions and domains could increase buy-in. One peer shared the importance of including peers in clinical roles due to the powerful connection that peers can form with consumers. If a peer shares a message about why Beehive is important, that may mean more to a consumer. Similarly, the importance of reminding individuals that this application—and all the questions in it—were developed in collaboration with peers and family members across the state and include the things they thought were important was discussed.

The Incorporating Beehive Into Care group shared details about the barriers they have experienced and possible solutions for each. One challenge is that clinical teams are having trouble integrating Beehive into their existing process. Lack of resources and limited time when teams are short staffed is a huge barrier. Possible solutions for this are: 1) to create a specific policy for adding Beehive into the intake procedure, 2) for leadership to ensure that clinical teams have time set aside for Beehive use and learning, 3) and to consider collecting the minimum necessary information. Another barrier is that use of Beehive is a shift in usual practice, and a possible solution for this is increasing visual reminders about Beehive. One program leader shared that use of Beehive on the tablets was helpful for staff to become more familiar with Beehive. A clinician and supervisor shared that they might benefit from a Beehive flyer which could be a reminder to use Beehive. It was also mentioned from several different attendees that engaging Beehive and using Beehive in-person has been more successful than engaging consumers remotely via telehealth. To conclude the Advisory Committee meeting, Dr. Tara Niendam addressed that the change to practice needed to integrate Beehive into care is difficult, and we are all working hard to make the changes needed. To that end, closing remarks also addressed the need for program leadership to make the space and time for their program staff to learn and use Beehive.

2. Schedule EP program fidelity assessments and provide results from fidelity assessments of EP programs

Each early psychosis clinic undergoes a fidelity assessment to determine their adherence to evidence-based practices for first-episode services using a revised version of the First Episode Psychosis Services Fidelity Scale (FEPS-FS). The FEPS-FS represents a standardized measure of fidelity to EP program best practices (Addington et al., 2016; First Episode Psychosis Services Fidelity Scale: (FEPS-FS 1.0), 2015). The FEPS-FS was developed using an international expert consensus method, focused on six domains: (1) population-level interventions and access, (2) comprehensive assessment and care plan, (3) individual-level intervention, (4)

group-level interventions, (5) service system and models of intervention, and (6) evaluation and quality improvement. The FEPS-FS has been recently revised to meet the agreed upon standards of EP care in the US and allow large-scale fidelity evaluation. Additionally, most programs within EPI-CAL also provide services to individuals with the clinical high-risk syndrome (CHR), for whom evidence-based best practice differs from FEP care in a number of respects. Consequently, to provide a program assessment that most accurately represents the care delivered, alongside the FEP-FS, we will be piloting a new scale under development designed to assess the components of care delivered to individuals with the diagnosis of CHR, known as the CHRP-FS.

Each EP program will participate in an assessment of EP program components using the revised FEPS-FS/CHRPS-FS, which will be completed via web-based teleconference. The fidelity assessment will be used to identify program strengths and possible areas for improvement, which can serve an important driver to improving early psychosis care delivered in EP programs in the LHCN. Additionally, the ability to evaluate the impact of service-level factors on consumer-level outcomes collected by Beehive will provide us with important new insights into what particular components of the EP program of care are associated with improved outcomes in different domains. These findings can then be disseminated across the network (and beyond), further informing care and shaping service delivery.

Assessments are completed in groups of 2-6 programs per quarter, starting in November 2021 until December 2022. Assessments are completed by trained clinical staff with expertise in early psychosis care and supported by evaluation administrative and research staff. Prior to the assessment taking place, the assessors and administrative/research support staff undergo a two-day training to go through the manual and conduct a mock site visit based on real cases. Prior to the evaluation, EP program sites participate in an introductory meeting, in which an overview of the FEPS is provided and the components of the evaluation are discussed. The assessments are conducted in consultation with Don Addington, M.D. from the University of Calgary, author of the FEPS-FS and CHRPS-FS scales.

As of June 30th, 2022 (the time period summarized in this report), EP program fidelity assessments have been initiated or completed for ten EPI-CAL programs: Orange County OC CREW (November 29 - December 3, 2021), San Diego Kickstart (November 1-5, 2021), Aldea SOAR Solano (January 17-21, 2022), San Mateo Felton (April 18, 2022), UCLA CAPPS (April 18-22, 2022), SacEDAPT (May 23-27, 2022), EDAPT (June 6-10, 2022), UCLA Aftercare (June 6-10, 2022), Aldea SOAR Napa (June 13-17, 2022), and UCSD CARE (June 20-24, 2022). The five LACDMH programs are scheduled for the third quarter of 2022 (July, August, September), and Stanislaus LIFE Path program, and Aldea SOAR Sonoma programs are schedule for the fourth quarter of 2022 (October, November, December).

Eight fidelity assessments have been completed using the First Episode Psychosis Service – Fidelity Scale (FEPS-FS) and the Clinical High Risk for Psychosis Service—Fidelity Scale (CHRPS-FS). The FEPS-FS includes 37 items, resulting in a score range from 37 to 185 and the CHRPS-FS includes 32 items, resulting in a score range from 32 to 160. All item scores range from 1 to 5, with an item score of ‘4’ indicating good fidelity, and a score of ‘5’ indicating high fidelity. In the completed assessments, FEPS-FS scores range from 129 to 154 and CHRPS-FS scores range from 108 to 136. Nine assessments are currently in progress with expected completion by the end of the calendar year.

Notably, these tools have been developed as an international standard, so achieving high fidelity scores may be constrained by state, local, or insurance coverage decisions outside of the control of the specific program. With that in mind, frequent low scoring items include population served (all clinics scored 1) and age ranged served (all clinics scored 1).

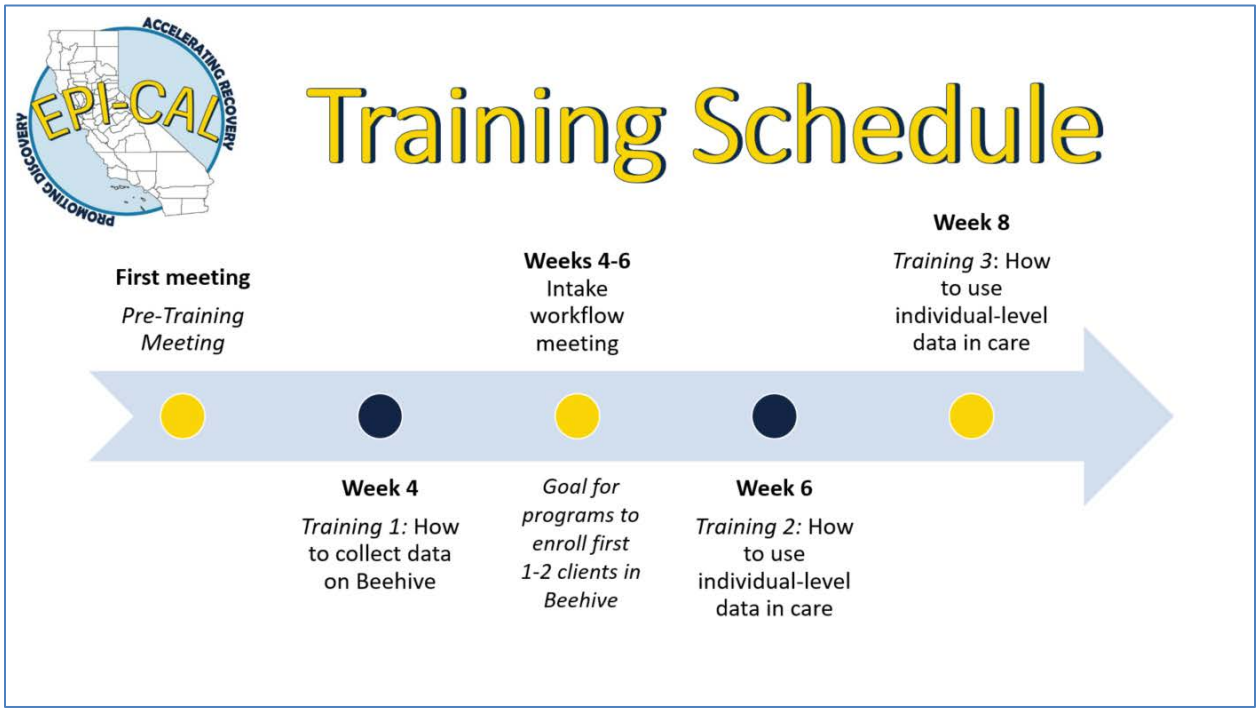
There is notable heterogeneity across programs (FEPS-FS mean score range: 3.36 – 4.16, CHRPS-FS mean score range: 3.48 –4.39). All clinics had over 50% of items at good or high fidelity. Particular heterogeneity can be found in items such as clozapine administration (interquartile range (IQR): 1-5), the delivery of supported employment (IQR: 1-3) and education services (IQR: 1-5), active engagement and outreach (IQR: 1-5), patient retention (IQR: 1-5), the involvement of peers in care (IQR: 1-4), and communication between the CSC team and inpatient services (IQR: 1-4).

3. Provide training and implementation of outcomes measurement on app in non-pilot EP programs, detailing training of EP program staff in data collection

In our original LHCN proposal, we proposed in-person visits to each program to conduct the core training for the Beehive application. However, due to the COVID-19 pandemic, we had to adjust our training plan and conduct the core trainings remotely.

The core trainings begin with a pre-training meeting with leadership at the program to discuss which program staff members would be designated as providers, group analysts, or group and clinic admin in Beehive (roles described below), as well as to cover topics around integrating Beehive into their current data collection system. Next, we conducted a training series consisting of a pre-training meeting with program leadership to introduce the training plan, three training sessions to introduce Beehive to each program (Part 1, Part 2, and Part 3), and an intake-workflow meeting with key clinic staff to understand clinic workflow and brainstorm how to best implement Beehive within their program context.

Figure 2: Beehive Training Schedule



Our remote trainings began with our pilot programs in March 2021. In June 2021, we began to onboard non-pilot programs, starting with the Los Angeles County PIER programs. See table below for all core trainings conducted through June 2022. Note that booster trainings (for entire program or for individuals at the program) have also been conducted in addition to the core trainings and are not included on the table below.

Table 1: EPI-CAL Program Training Completion

Program	Pre-Training	Training 1	Intake Workflow	Training 2	Training 3
UCD SacEDAPT	3/10/2021	3/22/2021	3/10/2021	4/5/2021	6/14/2021
UCD EDAPT	3/10/2021	3/22/2021	3/10/2021	4/5/2021	6/14/2021
Solano SOAR	3/18/2021	3/22/2021	3/29/2021	4/12/2021	6/7/2021
Napa SOAR	7/23/2021	8/19/2021	10/21/2021	10/14/2021	12/2/2021
Sonoma SOAR	8/24/2021	9/29/2021	10/21/2021	10/14/2021	12/2/2021
Kickstart Pathways	3/24/2021	3/31/2021	6/8/2021	4/14/2021	7/28/2021
LAC- IMCES 3	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - IMCES 4	5/10/2021	6/21/2021	8/11/2021	11/10/2021	12/8/2021
LAC - SFVCMHC	5/11/2021	6/18/2021	7/19/2021	11/18/2021	12/9/2021
LAC- The Whole Child	5/13/2021	6/17/2021	7/21/2021	11/23/2021	1/25/2022
LAC- The Help Group	5/14/2021	6/14/2021	8/10/2021	11/29/2021	1/5/2022
OC CREW	7/13/2021	8/12/2021	8/23/2021	10/13/2021	12/8/2021
San Mateo Felton	7/14/2021	10/20/2021	12/9/2021, 4/27/2022, & 5/16/2022	7/13/2022	TBD
UCLA - Aftercare	7/29/21	9/1/2021	2/9/2022	5/13/2022	TBD
UCLA - CAPPS	9/23/2021	11/22/2021	2/1/2022	5/3/2022	TBD
UCSF PATH	9/21/2021	5/6/2022	5/25/2022	7/8/2022	TBD
UCSD CARE	4/7/2022	5/23/2022	7/15/2022	9/30/2022	TBD
Stanislaus LIFE Path	2/23/2022	4/8/2022	5/10/2022	5/31/2022	9/22/2022
Stanford INSPIRE	TBD	TBD	TBD	TBD	TBD
Totals	**18**	**18**	**17**	**14**	**12**

Pre-Training Meeting

The pre-training meeting is conducted between EPI-CAL staff, including the program's assigned point person, program leadership, and a program IT representative. The purpose of this meeting is to introduce the training schedule and gather information to facilitate the first training. For example, the program leadership are invited to Beehive to test network compatibility (e.g., ensure that invite emails are not blocked by institution, ensure that program staff can access web application). The IT representative is engaged as needed to resolve technical issues (e.g., add beehive email address to approved senders list).

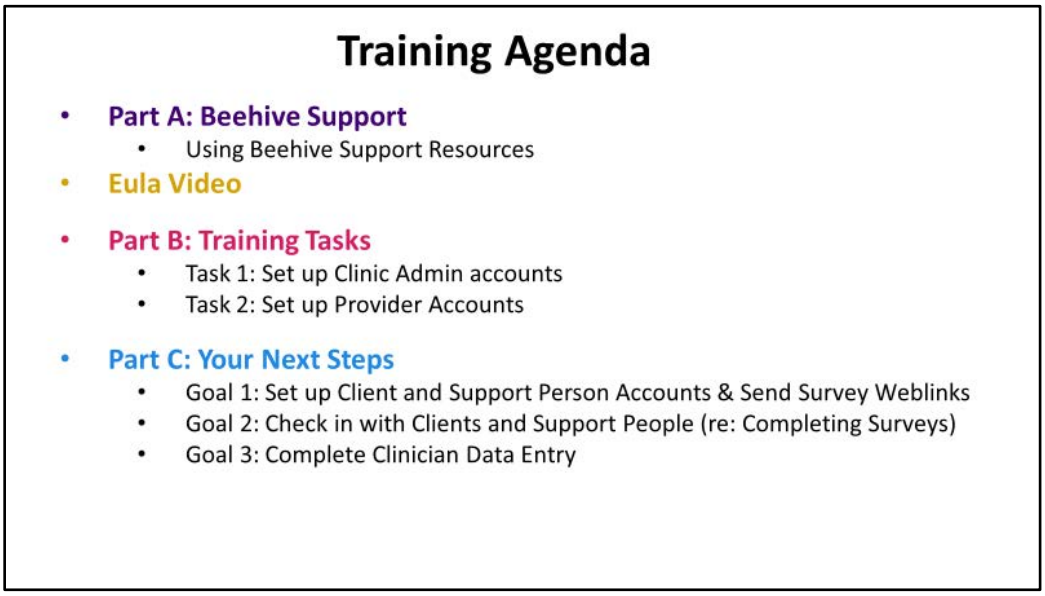
Part 1 Training

The general outline for the first training is as follows:

1. Re-introduction to the EPI-CAL project, including the overarching purpose and goals of data collection via Beehive
2. Presentation on the value of Beehive and data collection
3. Beehive Application training session (see Figure 3)

Presentation- "The Value of Beehive and Data Collection"
An EPI-CAL team member, Leigh Smith, Ph.D., gives a brief presentation that first focuses on how Beehive was developed using input from community partners and providers. Next, she provides a historical example of data collection that led to significant innovation in health care by giving a brief vignette of John Snow's work with the Cholera outbreak in London in 1854. She then draws parallels between Snow's work and how Beehive was designed, focusing on a meaningful connection between providers and community partners, a holistic approach to data collection, and prioritization of record keeping through automation and data consolidation. After, she speaks about Beehive's power to facilitate dialogue between providers and consumers, and within/between clinics, through reports provided by the Beehive team or generated within Beehive. Dr. Smith covers the purpose of participating in a Learning Health Care Network (LHCN), and how valuable information collection can be in informing treatment. Finally, she emphasizes the ability of Beehive's data collection in shaping care by illustrating how over a million points of data can be generated if each of the 18 EPI-CAL clinics enrolled 80% of their consumers and completed the baseline and two follow-up surveys in the first year. If Dr. Smith cannot attend in person, she has a recorded version of this presentation which is shown.

Figure 3: Training Agenda



Part A: Using Beehive Support Resources
We provide all EP program staff with the link to our detailed resource guide, accessed here: https://sites.google.com/view/beehiveguide/home

The resource guide was created so that EP program staff may reference, in detail, how to use the Beehive application and complete the tasks reviewed during the training. This includes: Creating Clinic or Group Admin Account & Inviting them to Beehive, Accepting Beehive Invite & Completing Registration, and Adding a Provider and Inviting them to Beehive. The resource guide also provides information on how to complete the "homework" that was assigned during the first training, including Adding a Consumer & Support Person and Completing Clinician Data Entry.

End User License Agreement (EULA) Video
We show the EULA video to all EP program staff for two reasons: 1) to streamline the registration process for staff during the training (as all users watch this video as part of the registration process), and 2) to orient them to what consumers and families also see when they first access the Beehive system. The EULA video can be

accessed here: https://youtu.be/3E8hiEkIvSQ. The Spanish EULA video is available here: https://youtu.be/UgY7ZUhe-Fk. The EULA video was developed through focus groups with EPI-CAL community partners (consumers, family members and providers) to ensure that core aspects of Beehive (e.g., security, consent and data sharing) were clear to users. The EULA video describes what Beehive is and how it is part of the EPI-CAL project, the purpose of Beehive, how data is shared and stored, and users' options for data sharing. Every new user of Beehive will be presented with the EULA video before making their data sharing choices.

Part B: Training Tasks: Setting up Clinic Admin/Provider Accounts and Registering Consumers
There are three main types of accounts in Beehive; each account is associated with the ability to complete certain actions in the Beehive system in line with that person's job duties:

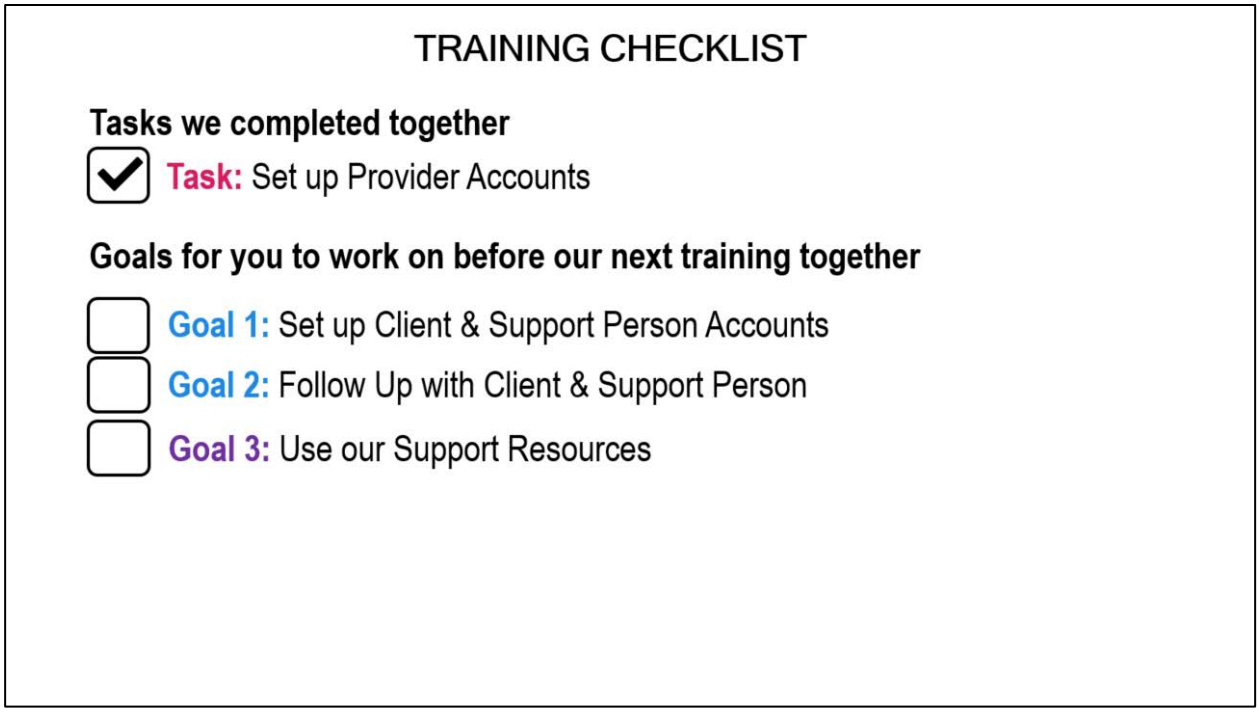
- Group Admin account: For program-level staff members who provide supervision and administrative support across clinics within a particular group – for example, a Group Admin is a person whose position includes oversight of activities at more than one clinic.
- Clinic Admin account: For staff members who provide supervision and administrative support within a specific clinic in a group.
- Provider account: For staff members providing direct services to consumers in a particular clinic, for example therapists, prescribers, and peer support specialists.

There is a general hierarchical structure to the relationship between these account types, such as who can invite new users and who can download data from Beehive.

The first training task is to set up Clinic Admin and Provider accounts in Beehive. For the initial Part 1 trainings, EPI-CAL staff created Group and Clinic Admin accounts prior to the first training meeting and sent those specific users their invitations during the live training (for trainings of non-pilot programs, EPI-CAL staff assist all admin users to register at the pre-training meeting). Once participants with Clinic Admin-level accounts accept their invitations and completed the registration process, EPI-CAL staff guide them through creating provider-level accounts for their staff and inviting those staff to complete registration in Beehive. For programs utilizing a Single Sign-On (SSO) authentication scheme, the EPI-CAL staff also walk them through the process to log in through their institution.

Part C: Next Steps
Once all providers conclude the registration process, EPI-CAL staff demonstrate the process of registering a consumer and their support persons. Next, the survey collection timeline is introduced. Baseline surveys are available for four months after the consumer's intake date. After baseline, follow up surveys are sent, which are due every 6 months from baseline will open two months prior to the due date and close four months after the due date. Next, the process for consumers and primary support persons to complete/request help to complete surveys is shown, along with the steps to manually resend surveys. Participants are then given the goal to register two consumers and their support persons (if applicable) in Beehive, and have the consumers complete their surveys before the next training session (see Figure 4). These consumers can be at any point in treatment when they are enrolled in Beehive. A Beehive consumer introductory script is provided to support the program staff in talking about Beehive to potential participants.

Figure 4: Training Checklist



Intake Workflow Meeting

After the Part 1 Training, EPI-CAL staff, including the program's point person, meet with the program's key staff involved in intakes. The purpose of this meeting is to understand the program's current workflow to facilitate a smooth transition to implementing Beehive. Once EPI-CAL team have a basic understanding of the program's intake process, they ask questions to operationalize how Beehive will be integrated into this process (e.g., "Who will be responsible for registering consumers in Beehive?"). They may offer suggestions or ideas based on what has worked at other programs. The goal of this meeting is to create an initial plan for the program to introduce Beehive into their current workflow. Please see Appendix I for a template of the questions asked at the intake workflow meeting.

Part 2 Training

The second Beehive training focuses on how providers can utilize individual level data in care. The Beehive team introduces the EPI-CAL Core Assessment Battery (CAB), including its domains and how these domains were selected from community partner input. Next, the trainer presents two surveys from the EPI-CAL CAB: the Modified Colorado Symptom Index (MCSI) and the Questionnaire about the Process of Recovery (QPR). Then, the trainer shows participants where to find consumer data in Beehive. The trainer then demonstrates how to present the data visualizations available in Beehive and asks the group what clinical questions or concerns the sample visualizations elicit from them. Participants then participate in small group exercises focused on example data visualizations of the MCSI with the goals of 1) exercising their data comprehension skills and 2) practicing using data to explore a consumer's story.

During small group exercises, an example consumer's MCSI scores are displayed, and participants are prompted to discuss the "story" that could be illustrated by this data set. For example, providers are presented with a graph in which MCSI scores are going up over time (indicating more frequent and/or distressing symptoms; Figure 5A) and then asked to interpret possible situations that could be leading to these data trends for this sample consumer. After providers correctly identify that the example consumer is experiencing an increase in frequency and/or number of symptoms, they are asked how they might use this information in treatment (e.g., modify the consumer's treatment plan to help reduce the frequency of these symptoms,

engage new treatment techniques to reduce these symptoms, request psychiatry consultation to review medication).

Figure 5: MCSI Example Graphs from Beehive

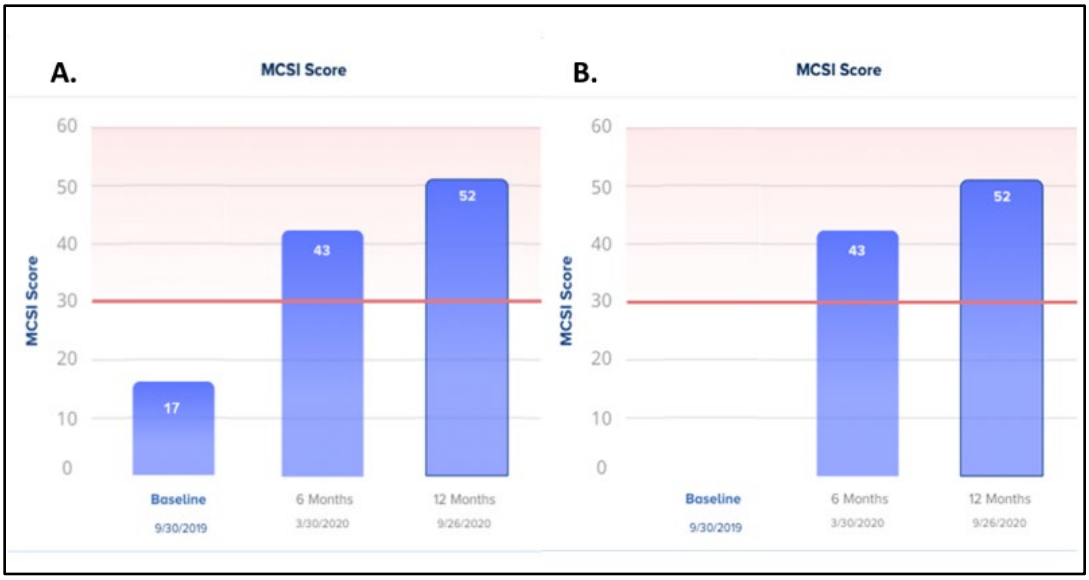


Figure legend: A. Representation of data showing increasing trend in MCSI symptom severity; B. Representation of how missing data (shown here at baseline) impacts the visualization

After these exercises conclude, small groups reconvene back into the larger group, with a member from each group presenting their group's discussion/findings to the rest of the program as a whole. As each small group has different themes and discussions that come up during the exercises, the larger group discussion is meant to help to broaden participants' understanding of data interpretation.

Next, the training details the types of urgent clinical issues that are currently tracked by Beehive, including "Risk to self", "Risk to others", "Risk of homelessness," and "Plan to stop taking medication". These issues were identified during focus groups with EP program community partners as critical moments for intervention during treatment. The training team also explains where each one of these alerts can be triggered within the assessment battery. Importantly, we stress that Urgent Clinical Issues in Beehive are not a replacement for each clinic's standard risk management procedures; instead, Beehive can be used as an additional tool to inform their standard risk management approaches. We also cover how to resolve urgent clinical issues using the responses programmed into Beehive (i.e., "Modified treatment plan", "Conducted risk assessment" or "Sent for emergency care") as appropriate for these alerts.

To conclude the training, the trainer introduces the "Data Use in Care" question pop up and its different response options (see Figures 6 and 7 below). This pop-up appears intermittently when a user leaves a page on Beehive which displays consumer's data. It asks the user whether they reviewed the data with the consumer or family and then asks them how the data impacted treatment. These response options are the same as the response options programmed into the urgent clinical issues – the training team intentionally takes the approach of presenting these two Beehive features together to help maximize participant comprehension. These data will contribute to a data-driven understanding of Beehive's impact (e.g., whether and how staff use data as part of treatment) on the participating programs of the LHCN.

Figure 6: Data Use in Care Question 1

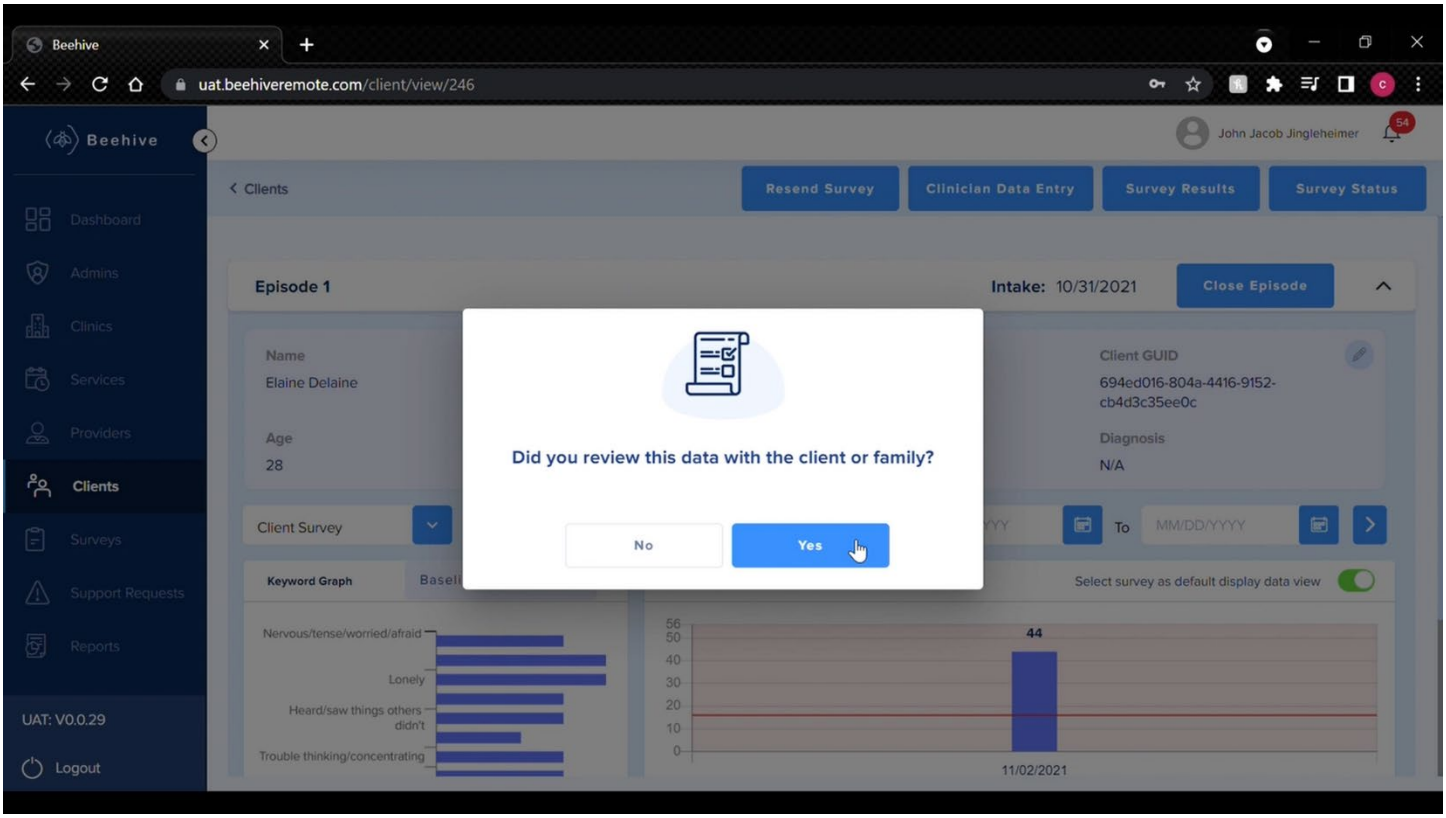
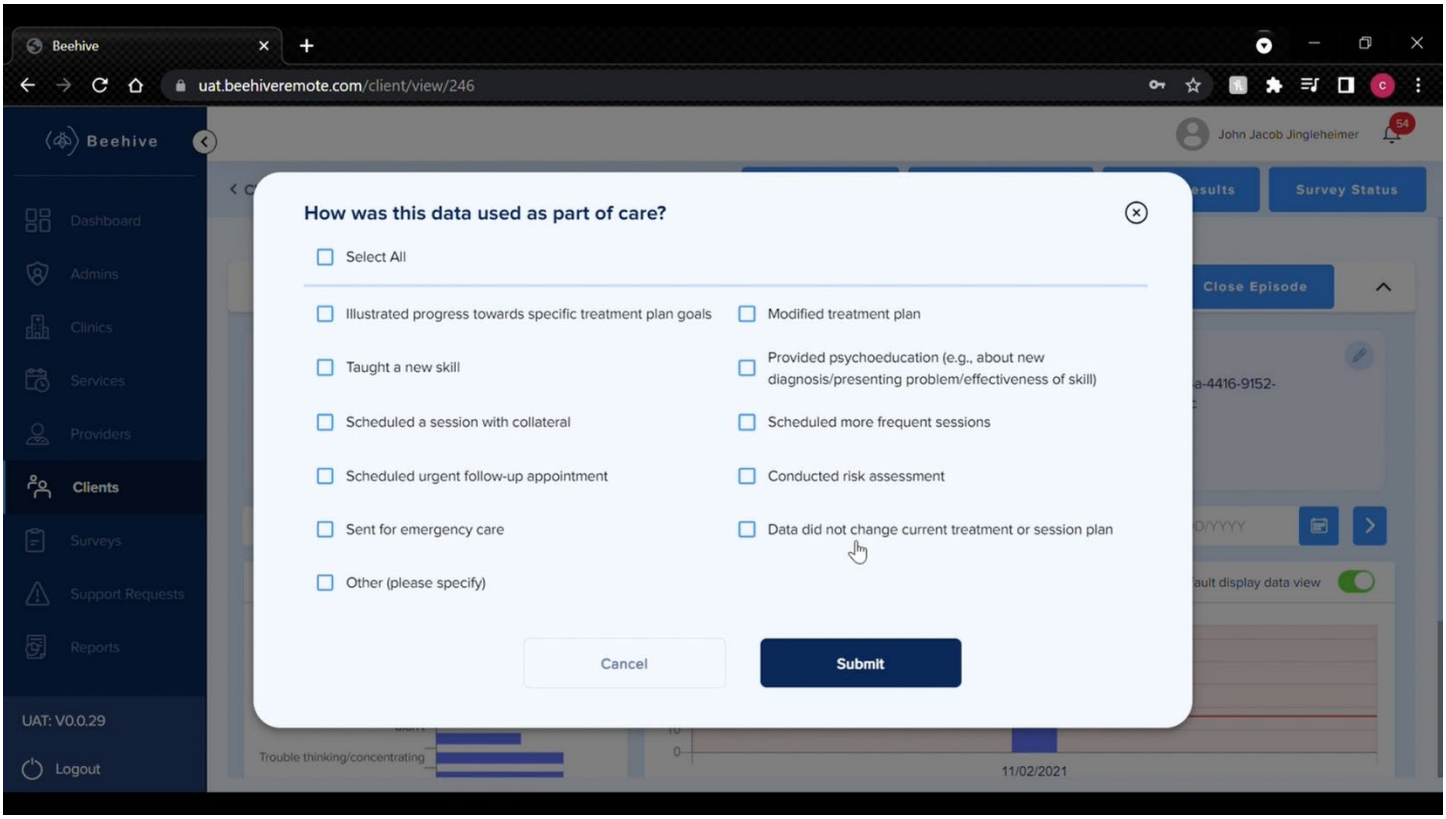


Figure 7: Data Use in Care Question 2



Data-Entry Workflow Meeting

After the Part 2 Training, EPI-CAL staff, including the program's point person, meet with the program leadership. The purpose of this meeting is to help the program create a reasonably sustainable plan for completing clinic-entered data about each consumer's clinical outcomes in Beehive. EPI-CAL team will ask question to understand whether there is an existing data-entry workflow in place as well as which roles on the teams are involved in the process. Once EPI-CAL team have an understanding of the program's existing data-entry workflow, they ask questions to operationalize how Beehive will be integrated into this process (e.g., "Who will be responsible for entering clinic-entered data for consumers?"). They may offer suggestions or ideas based on what has worked at other programs. The goal of this meeting is to support the program to create an initial plan to complete clinic-entered surveys about key consumer outcomes. This should include a plan for which team members will monitor and track completion and which team members will enter the data. Please see Appendix II for a template of the questions that will be asked as part of the data-entry workflow meeting.

This workflow meeting has been added as an iterative update to the core training series based on experience working with initial programs. Our team has identified that programs often need support to operationalize this workflow in their program, so we have added this as a meeting to the core training series. Because this is a recent edition, we have not conducted it at any program yet but are reaching out to programs to schedule.

Part 3 Training

Part 3 training revolves around applying and expanding the data interpreting skills gained in Part 2 training, with actual data from consumers that was collected after the last (Part 2) training. During Part 3 training, participants are oriented on how to input and view Clinic-entered data and how to assign additional surveys to consumers, and how to close and re-open consumer episodes in Beehive.

Part 3 training also familiarizes participants to two more measures included in the Core Assessment Battery: the SCORE-15 and the Burden Assessment Scale (BAS). These measures were selected because they both capture quantifiable scores on domains (family impact and family burden, respectively) that were identified as high priorities by EP community partners during EPI-CAL outcomes focus groups. These measures were chosen for this training as, like the Modified Colorado Symptom Index and Questionnaire on the Process of Recovery covered in Part 2 Training, they are scored measures which are visualized in Beehive.

Next, participants are split into small groups, and given a globally unique identifier (GUID) of a consumer that receives services at their clinic and has completed surveys in Beehive. This is to ensure that each small group has real-world data to interpret. At the beginning of the small group, an EPI-CAL team member orients the group to a worksheet which includes training activities and discussion questions about finding, interpreting, and using consumer data as part of care. As these trainings require participants to examine their consumer's data (i.e., PHI), EPI-CAL training team members are only present for the beginning of the small group exercise to introduce the activity, but they leave prior to any discussion or sharing of PHI. EPI-CAL staff encourage each participant to take an active role within the small group: note taker, screen sharer, delegate to report during large group debrief, etc. Each small group uses the small group worksheet (Appendix III) to guide their time in the small group.

After the small group exercise, participants rejoin the larger group to share their findings. After each small group has presented their findings with the rest of the groups as a whole, the EPI-CAL team facilitates a large group discussion which encourages participants to look for trends and assess what they could mean. After encouraging pattern recognition of common patterns in the data, the training team encourage participants to view their consumer's data through this analytical lens and demonstrate how their treatment plans could benefit from this approach.

Implementation Support After Initial Beehive Trainings

Each program has an EPI-CAL staff point person to provide regular check-ins to provide training and implementation support. The point persons are introduced during pre-training and the Beehive training series. Initially, we request weekly meetings or calls with key program staff (as determined by the program). At these meetings, point persons can help programs troubleshoot issues and support staff with accessing resources and learning to use Beehive.

In addition to regular check-ins with key program staff, point persons may also provide booster trainings to individuals at the program or to groups of program staff. These may be conducted remotely via web conferencing. More recently we have begun to visit sites in-person as initially proposed and planned prior to COVID-19 in-person meeting restrictions.

Point persons will also respond to ad hoc requests from the program for technical support and troubleshooting. For example, if a program experiences a bug or glitch while using Beehive, they are told to contact their point person who can help to troubleshoot or escalate this report.

4. Outline plan for training EP program staff from non-pilot programs on app implementation and outcomes measurement

Our team has learned a great deal from the initial Beehive trainings regarding the most efficient way to approach training for non-pilot EP programs. One of the consistent messages was that the initial trainings were too fast paced for many users. Another major learning opportunity was that we did not have enough time to sufficiently cover all the content we had planned in each session. Therefore, instead of breaking out the initial trainings into two 2-hour sessions, we have revised our training plan to include at least three 2-hour sessions for the introduction to Beehive for non-pilot programs as well as provide a fourth training to cover additional content for admin staff (see Figure 2: Beehive Training Schedule). We will continue to incorporate any changes and feedback from additional trainings into all future trainings, as we view improvement of our training approach as an iterative process. One change we implemented to save time during Part 1 training was to register all admin users (Clinic and Group Admin) during the pre-training meetings so that we only had to register the remaining providers during the first training. This has saved a substantial amount of time in subsequent Part 1 trainings thus far. We have also broken out into small groups to register providers during Part 1 training so several people can be registered in parallel, which has also saved time.

Another important piece of information we learned from these first trainings was the need to meet with each program's IT department ahead of time to make sure that emails/server requests from Beehive are not blocked by their organization's network security protocols. For example, Solano Aldea SOAR had delays in the first training because the emails from Beehive were being quarantined. While we were able to work with IT to unblock these emails, we will meet with IT ahead of time and test the sign-up email process in the pre-training meeting with leadership to avoid the delays during the training in the future. Additionally, meetings with site IT to ensure Beehive's ability to properly communicate with its servers through site networks will be conducted. Thus far, we have modified our pre-training approach with five additional programs in preparation from their training and were able to verify ahead of time that Beehive emails would not be blocked during Beehive training.

We have also identified the need to understand more about each program's intake process so that we may customize our training and support approach to each program's existing clinical workflow. To better understand each program's unique process, we now schedule an additional "Intake Workflow Meeting" with programs between their Part 1 and 2 training to collect information and meet with intake coordinators from each program

to understand data collected during phone screen and intake, and how and where Beehive consumer registration and surveys will fit into their existing process.

Additionally, the team has updated the training material to reflect changes based on each program's needs and how their feedback is incorporated into the application. A multitude of training videos and slides that were accurate earlier in the year have required updating. As the Beehive application continues to evolve, the training team will continue to ensure our training materials will follow.

We have also found that providing more live demonstrations of Beehive features has been helpful during the trainings. Many of the materials that were originally covered in pre-recorded videos during prior trainings are now administered as a live demonstration. Additionally, we provide more information during breakout rooms as we find smaller group sizes to be more amenable for training purposes. Please see Table 1 for an up-to-date list of all Beehive trainings provided thus far through June 30th, 2022.

5. Get preliminary results on program-level data from 2 pilot EP programs, including interviews with EP programs to understand barriers and facilitators to app implementation.

Preliminary results on program-level data from 3 pilot EP programs

After our initial trainings with EDAPT/SacEDAPT and Solano SOAR Aldea programs in March 2021, programs began enrolling consumers into Beehive. Kickstart in San Diego County had also started enrolling consumers in Beehive a few months after the initial launch. Basic demographic information is collected via phone screen and entered into Beehive by clinic staff when initially registering a consumer and their support persons. All consumers had to complete the EULA before being presented with surveys. When consumers complete the EULA, they indicate whether they want to share their data with UC Davis and/or the NIH for research purposes beyond using Beehive for the purpose of their clinical care. Their choices are explained in detail in the EULA video. Our goal is to have 70% of consumers agree to share their data with UC Davis and NIH.

For this annual report, we are reporting on data collected in those three pilot programs up through December 3rd, 2021 for those who agreed to share their data with UC Davis. After that date, we started summarizing enrollment and survey completion rates for all participating programs, which can be found in the section below titled Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs. One hundred and twenty-five consumers were registered in Beehive across the three pilot clinics, and of those, 66 completed their EULA indicating their data sharing permissions. Of those who completed their EULA, 55 consumers agreed to share their data with UC Davis (83%). Therefore, in the current report, we are reporting demographic data for those 55 individuals across three clinics who have registered in Beehive, completed their EULA, and agreed to share data with UC Davis. It is important to note that clinic staff register consumers and invite them to Beehive. Consumers complete their registration and then have the ability to complete surveys. So, if someone has been registered in Beehive, it does not necessarily mean that they have completed any of the outcomes surveys available in Beehive.

Here we report demographic information that is completed at registration, which is a subset of the demographic questions that are asked in Beehive (Table 2). Complete demographic information, including all required PEI fields, are administered via a required consumer-entered Beehive survey. For any cell that has an N less than 5 individuals, this data was masked and both the N and proportion cells were updated with "<5" and "<9%", respectively. If there were 0 individuals who endorsed a response option in the demographic surveys, the category is not represented on Table 2 (e.g., intersex under Sex at Birth); we will continue to add categories to each demographic variable if there are ≥1 individuals in each respective category.

Table 2: Preliminary Demographic Data from Beehive Pilot Testing

SacEDAPT, Solano SOAR, and Kickstart Combined Demographics (through 12/3/21)		
Display Language	**N**	**%**
English	55	100%
Age	**N**	**%**
12-17	18	33%
18-23	27	49%
≥24	10	18%
Sex at Birth	**N**	**%**
Female	26	47%
Male	29	53%
Gender	**N**	**%**
Female	21	38%
Male	27	49%
Non-binary	<5	<9%
Questioning or unsure of gender identity	<5	<9%
Prefer not to say	<5	<9%
Pronouns	**N**	**%**
He/Him	27	49%
She/Her	22	40%
They/Them	<5	<9%
N/A	<5	<9%
Race	**N**	**%**
African/African American/Black	13	24%
Asian	<5	<9%
American Indian/Alaskan Native	<5	<9%
Hispanic/Latinx Only	14	25%
White/Caucasian	13	24%
More than one race	8	15%
Other	<5	<9%
Prefer not to say	<5	<9%
Ethnicity	**N**	**%**
No - I do not identify as Hispanic/Latinx	32	58%
Yes - I identify as Hispanic/Latinx	16	29%
Prefer not to say	<5	<9%
Unsure/Don't know	6	11%

Additionally, providers are able to enter a consumer's diagnosis when they register individuals in Beehive, which is reported in Table 2. In the same manner as the table above, cells with less than 5 individuals were masked and both the N and proportion cells were updated with "<5" and "<9%", respectively. For most

diagnostic categories, except Schizoaffective disorder and mood disorders with psychotic features, there were less than 5 individuals per cell. Diagnoses are grouped according to two classes of early psychosis: 1) individuals who are deemed to be at clinical high risk for psychosis (CHR), and 2) individuals who have experienced psychotic level symptoms (First Episode Psychosis, FEP). This reflects the wide range of psychosis diagnoses that are served by the EP clinics represented in this sample.

Table 3 Consumer Diagnoses from Beehive Pilot Testing

Diagnosis	N	%
Clinical High Risk (CHR)		
Attenuated Psychosis Symptoms	<5	<9%
First Episode Psychosis (FEP)		
Substance Induced Psychotic Disorder with onset during intoxication	<5	<9%
Mood disorders with psychotic features	6	11%
Schizoaffective Disorder (Bipolar or Depressive Type Combined)	11	20%
Schizophrenia	<5	<9%
Schizophreniform Disorder	<5	<9%
Unspecified Psychosis	5	9%
CHR or FEP Status Not Confirmed		
Anxiety Disorders	<5	<9%
Missing	25	45%

When consumers finish registration in Beehive, they then have access to Beehive surveys. After registration is complete, Beehive makes three surveys available for completion: Adverse Childhood Experiences (ACES), primary caregiver background, and questions about other lifetime experiences as well as a static demographics information (see EPI-CAL Enrollment Life Questions, see Table 4 and Figure 9). If a consumer is in a survey window (e.g., at intake or six months), Beehive makes available 15 additional surveys that assess various community partner-chosen outcomes including family functioning, education, social relationships, demographics and background, medications, and symptoms (see Table 4). These surveys are presented in different bundles that are grouped based on subject matter and/or timing of the surveys (i.e., whether they receive the survey just at enrollment, or at enrollment and every six months thereafter). EPI-CAL enrollment and required bundles are automatically assigned to every consumer who registers in Beehive. However, each individual clinic also has the option of assigning addition surveys if they choose to do so. The current data only include EPI-CAL enrollment and required bundles.

Table 4 EPI-CAL Enrollment and Required Survey Bundles

Bundle Name	Survey Name	Bundle Timing
EPI-CAL Enrollment Life Questions	EPI-CAL Enrollment Life Questions	Enrollment only
	Adverse Childhood Experiences (ACES)	
	Primary Caregiver Background	
EPI-CAL Experiences Bundle	Life Outlook	

	Questionnaire About the Process of Recovery (QPR)	Every 6 months, including intake
	Modified Colorado Symptom Index (MCSI)	
	Substance Use	
	Legal Involvement and Related	
EPI-CAL Treatment bundle	Intent to Attend and Complete Treatment Scale	Every 6 months, including intake
	End of Survey Questions	
	Hospitalizations	
	Shared Decision Making (SDM)	
	Medications	
EPI-CAL Life Bundle	SCORE-15	Every 6 months, including intake
	Demographics and Background	
	Social Relationships	
	Employment and Related Activities	
	Education	

When enrolled at intake, consumer and identified support persons can be registered in Beehive by clinic staff. Beehive will then prompt them to complete registration, review the EULA, and choose data sharing permissions. Beehive then shows them the surveys that are available for them to complete within each bundle (see Figure 8 below). Respondents can choose which surveys they wish to complete in the order they wish to complete them.

Figure 8: Survey Window Timing

Example Survey Window Timing for a Consumer with Intake on April 1

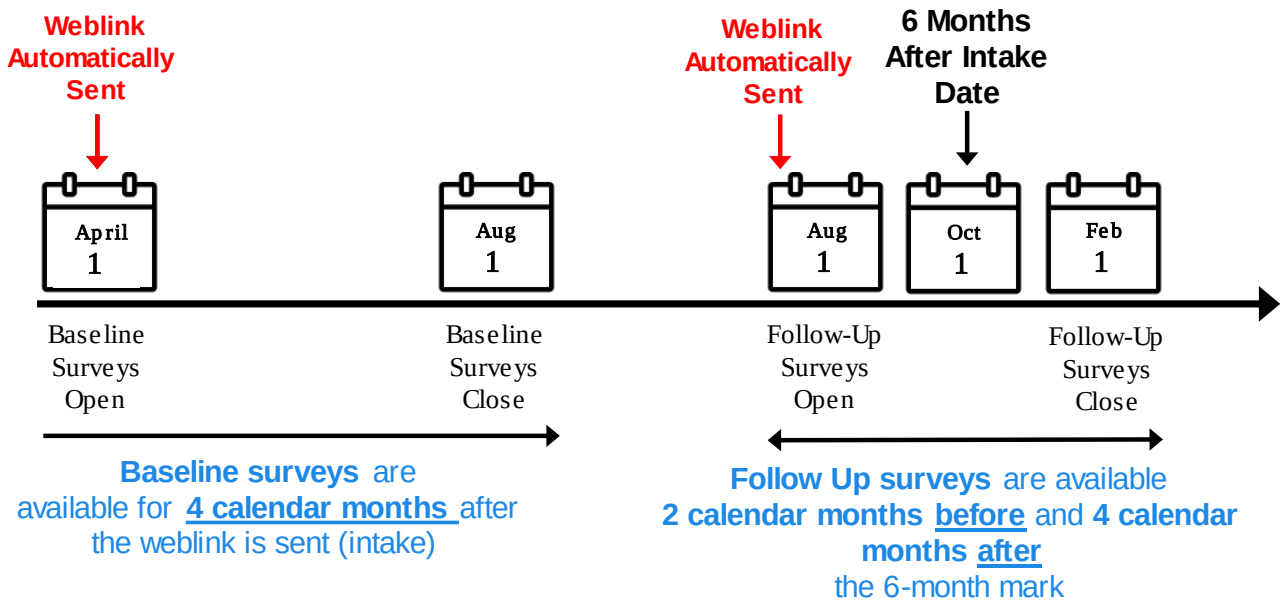
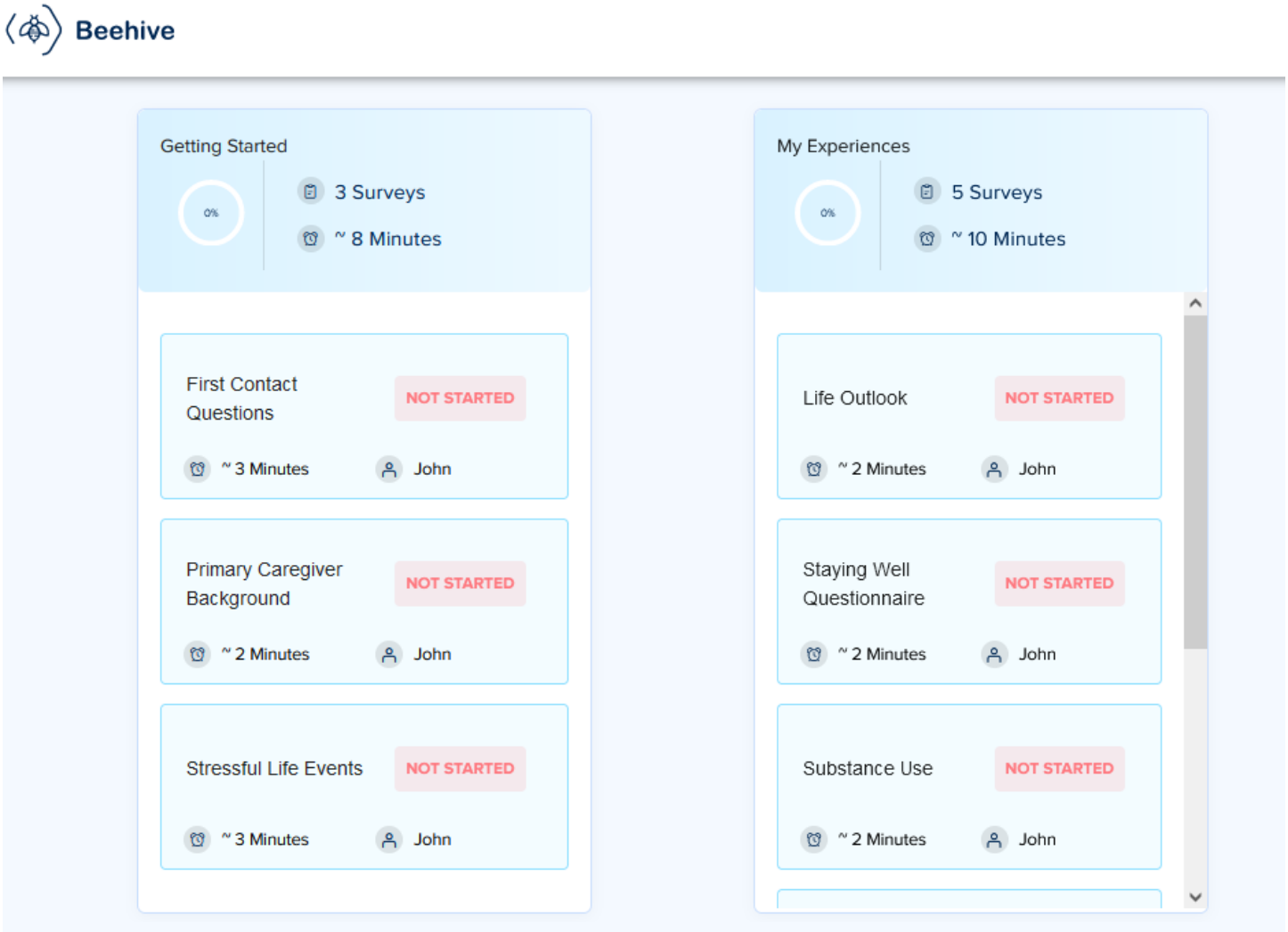


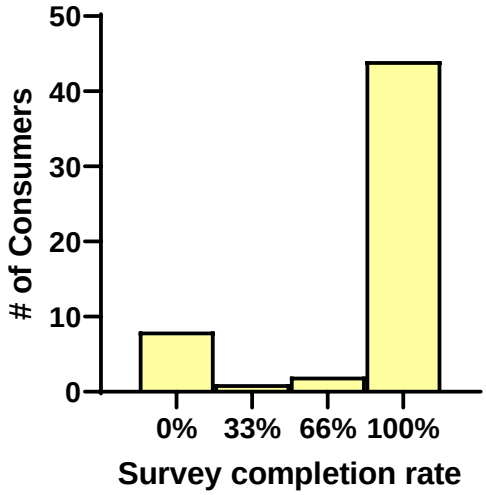
Figure 9: Subset of Surveys Available for Consumer to Complete at Baseline



During the initial phase of Beehive roll out, we asked clinics to enroll consumers and support persons who were already engaged in EP care. When these active consumers are enrolled, Beehive prompts them to complete registration, review the EULA, choose data sharing permissions, and complete enrollment surveys. If they are within the active 6-monthly survey window, they are also able to complete the EPI-CAL required bundles.

At this time, we are reporting the survey completion rate from 55 consumers on the three available enrollment surveys (EPI-CAL Enrollment Life Questions, “Getting Started,” Figure 9) because some consumers were enrolled outside of survey windows and thus were not presented with the remaining 15 surveys. The distribution of survey completion is reported in Figure 10. Survey completion rate ranges from 0-100%, with 80% of individuals completing all three enrollment surveys. The point person at each clinic site will track survey completion and inform clinic staff if there are consumers who are not completing their surveys so that the clinic staff may check in and provide support to ensure survey completion.

Figure 10: Preliminary Survey Completion Rate for Enrollment Surveys



Exploration of barriers and facilitators to implementation of the Beehive system
Results from additional barrier and facilitator interviews in the past fiscal year are summarized below.

6. Monitor enrollment and follow up completion rates for LHCN app in all EP programs

EPI-CAL staff monitor enrollment progress and symptom survey completion for LHCN across all EP programs in LHCN on a weekly basis. The following metrics are monitored and visualized:

- Beehive registrations
- Beehive enrollments (i.e., consumers with a completed EULA)
- Opt-ins for data sharing with UCD and/or NIH for research purposes
- Completion of Modified Colorado Symptom Index (MCSI) at Baseline, 12 month, and 24 months.

Please find the report on recent data for these metrics in the deliverable: Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs in study.

While reviewing these figures each week, the team discusses observed barriers for sites which are enrolling at a rate below the average LHCN enrollment rate. EPI-CAL team will also discuss solutions or interventions to address barriers. This may include developing additional trainings, making changes to Beehive application, reaching out to the program to ask what additional support they may need and brainstorm solutions, etc. Even when barriers are outside the scope of EPI-CAL project, (e.g., program turnover, dedication of program staff efforts), the team will still attempt to understand how we can accommodate the program given their needs at that moment.

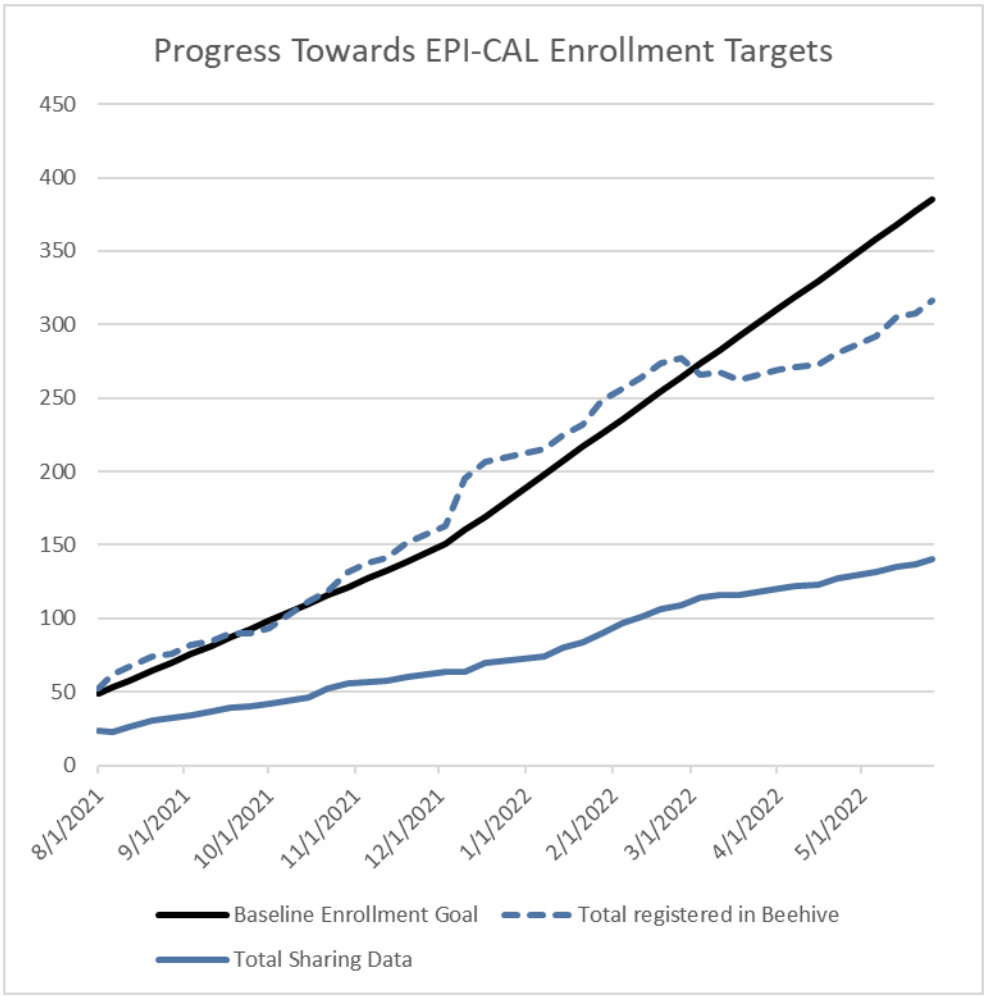
The EPI-CAL team also discusses the facilitators for sites which are enrolling above the average LHCN enrollment rate. EPI-CAL staff develop strategies to disseminate facilitators among all LHCN sites. For example, we noticed that sites who distribute the effort of Beehive implementation across their team, rather than relying on one or two people to carry the weight of implementation, have better rates of enrollment and survey completion. We now strongly recommend this distributed model during our workflow meetings with sites. We have also noticed that sites using the tablet (rather than the weblink) have been more successful in enrolling consumers. We are now encouraging all sites to use the tablet as much as they can.

7. Submit report on LHCN enrollment and follow up completion rates for LHCN software application and dashboard in all EP Programs

LHCN Overview

Figure 11 shows the LHCN Progress towards EPI-CAL Enrollment targets as of June 10, 2022. Consumers are considered enrolled if they have completed the Beehive EULA and agreed to share their data with UC Davis for use in research. If consumers do not allow their data for use in research, but agree to use Beehive as part of clinical care, their data may be used for quality management or quality assurance purposes only. The goal at this point in the project was to have 405 individuals enrolled (endpoint of black line in figure below). The observed rate of enrollment across the LHCN is 145 consumers (solid blue line in figure below). There are an additional 142 consumers who have been registered by the clinic in Beehive (dashed blue line in figure below), but who have not engaged with Beehive by completing the EULA or starting their surveys. We monitor the number of registered individuals because it serves as a proxy for program census (however we know that most clinics do not yet have all active consumers registered) and allows us to see what possible enrollment across the network could be.

Figure 11: LHCN Progress Towards EPI-CAL Enrollment Targets



Figures 12-13 show a site-by-site breakdown of the proportion of individuals who agreed to data sharing with UC Davis for research purposes as of June 10, 2022. Figure 12 shows all registered consumers, regardless of

EULA completion status. Hence this figure shows the room for growth if sites support consumers to complete their EULA in Beehive if those consumers agree to data sharing.

Figure 12: Proportion of Data Sharing with UCD for Research by Site

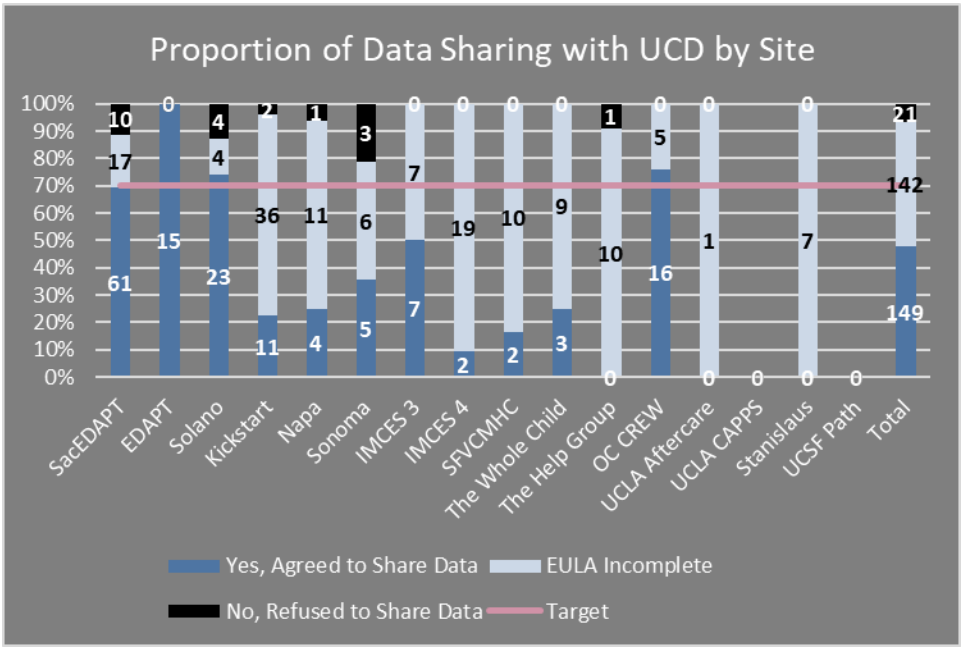


Figure 13 shows the proportion of data sharing choices made by those consumers who have completed their EULA in Beehive. We can see that some sites on this graph do not have a bar at all because they do not have any consumers who have completed the Beehive EULA.

Our goal is that 70% of active consumers at each site agree to use Beehive and share their data for research purposes. When considering all consumers known to EPI-CAL (i.e., all those registered in Beehive), we can see that only a few sites are meeting this metric. However among those individuals who have actually engaged with Beehive and completed the EULA, we are exceeding our target across the network, and at most sites individually as well. We are seeing rates of data sharing closer to 90% when considering all enrolled consumers across the LHCN.

Figure 13: Proportion of Data Sharing with UCD for Research among Completed EULAs

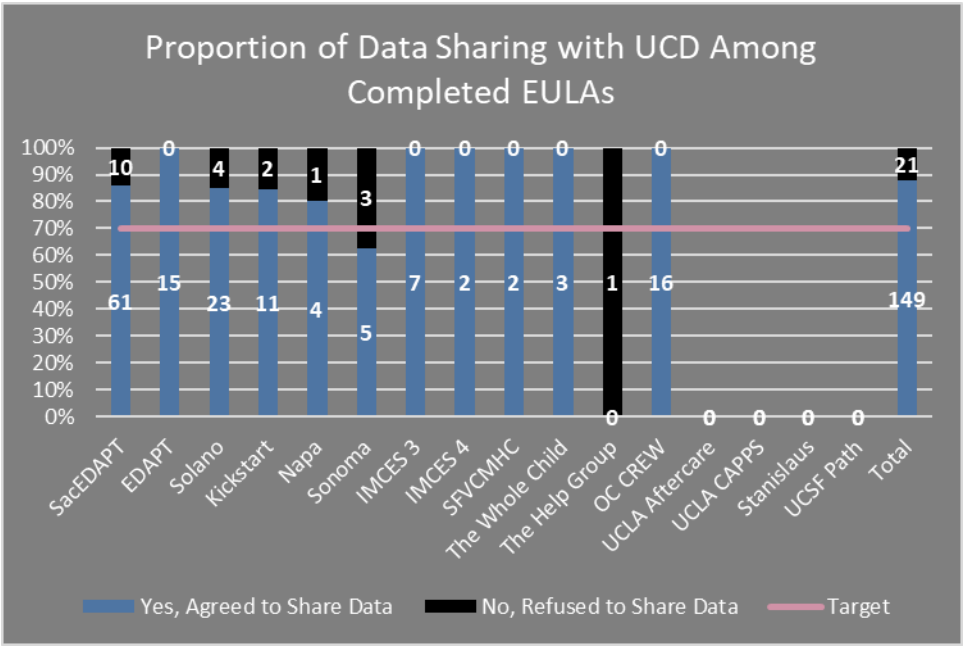
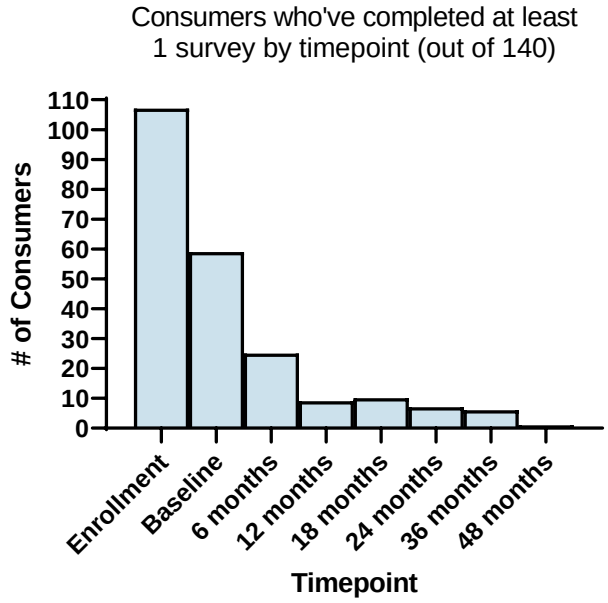


Figure 14 shows network-level survey completion rates by time point as of May 26, 2022. Note that all consumers are able to complete enrollment surveys regardless of when in their treatment they are enrolled. Consumers are not able to complete some survey windows (e.g., baseline) if they are enrolled later in treatment. Some consumers have completed surveys at more than one time point. Seventy-six percent of enrolled consumers (n=107) have completed at least one enrollment survey.

Figure 14: Survey Completion Rates Across EPI-CAL Network



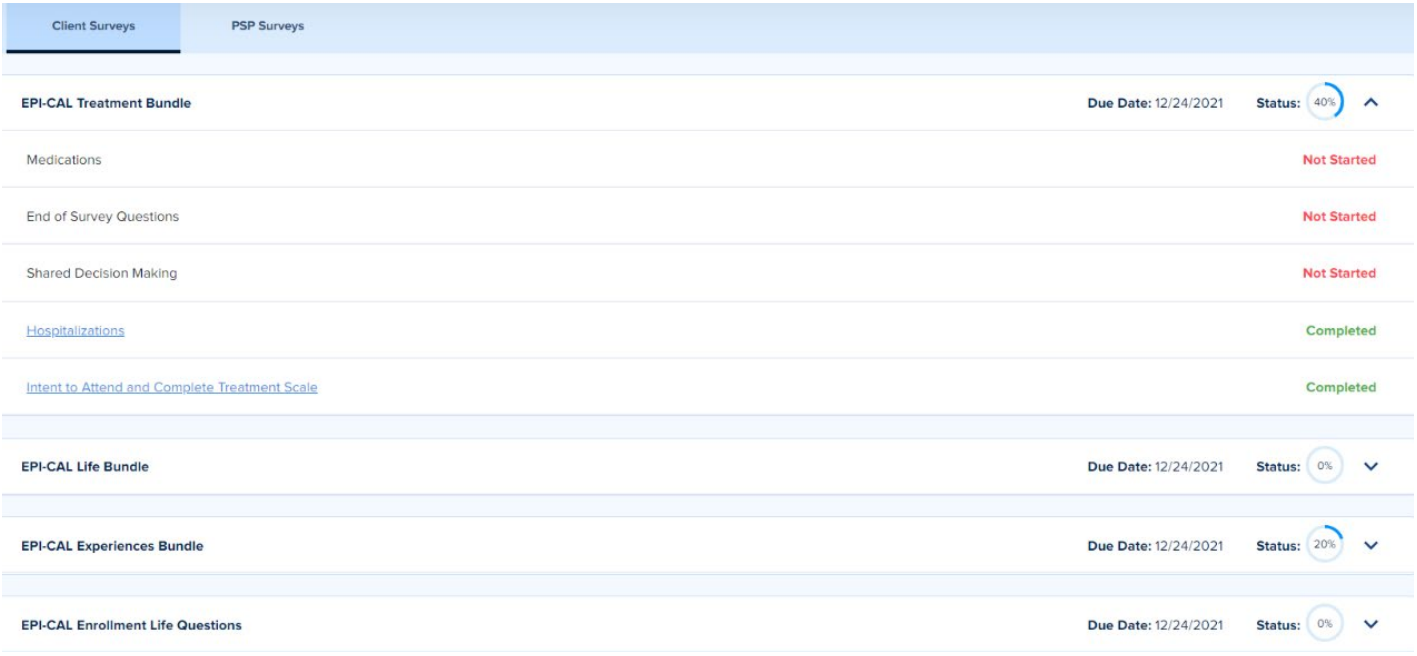
8. Subcontractor to revise dashboard to include feedback from programs and community partners

As Beehive has been designed for EP Programs, the needs and preferences of EP programs and the institutions of which they are a part have driven the design of Beehive. Security requirements of counties and institutions have led to increases in the security of Beehive. Feedback from users at EP Programs has identified several aspects of the application that could be improved to increase compatibility with their existing workflows and facilitate implementation of this novel technology.

Notably, pentesting was conducted by Azacus.io Cybersecurity on the Beehive application as a security requirement for several programs. Penetration testing, or pentesting, is a simulated hack to test the security of a system. Azacus.io conducted pentesting on both the web and iOS applications between June 21, 2021 and July 3, 2021. Azacus.io delivered the results of pentesting to the EPI-CAL team on July 12, 2021. All issues of vulnerability that were identified in the testing were addressed by the developers. On September 10, 2021, Azacus.io completed a retest of the application that proved all identified vulnerabilities had been fixed.

User feedback has also contributed to the development of Beehive. For example, Beehive users at EP programs noted that the process to determine survey progress for an individual consumer using the weblink solution to answer surveys was cumbersome. The EPI-CAL team gathered feedback on this issue and designed a “Survey Status” page in the application which allows the user to view the gestalt of survey completion for both consumers and primary support persons (Figure 15). It also allows the user to drill down into the survey completion for each survey and quickly review survey results by simply clicking on the name of the completed survey. The “survey status” page is a tool for Beehive users at EP programs to monitor survey completion more easily and thus support consumers and support persons to complete both the EPI-CAL battery and any additional program-specific surveys.

Figure 15: Survey Status Screen



Beehive users at beta programs also provided feedback that it was not easy to tell when a consumer had new data to review or to monitor an individual consumer’s survey completion. The EPI-CAL team designed two solutions for this which have since been implemented in Beehive. The first solution was to add an icon to the consumer list on the dashboard which indicates when there is data which has not been reviewed by the consumer’s treatment team lead (green dot on Data icon in Figure 16). The second solution was to make

survey names in dropdowns bolded when they have not yet been reviewed (Figure 17). These features aim to facilitate a clinician's review of their consumers' data by highlighting what remains to be reviewed. Thus far, user feedback from our beta sites has proved invaluable to improving the usability of Beehive in a clinical setting, and we hope to continue to elicit user feedback at non-pilot sites to examine if these changes are sufficient to address previous usability concerns.

Figure 16 : New Data Icon (green dot) on Consumer List, shown in Test Clinic

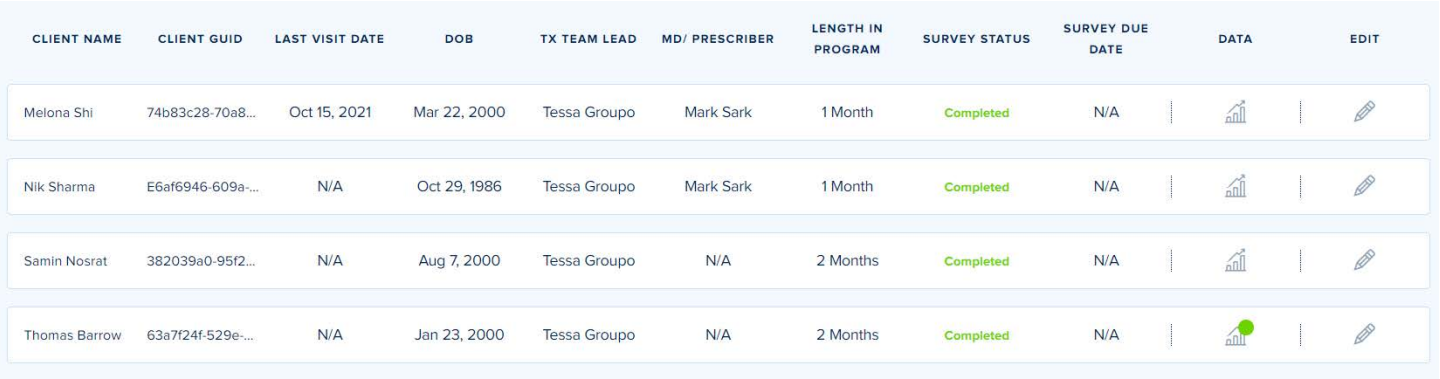
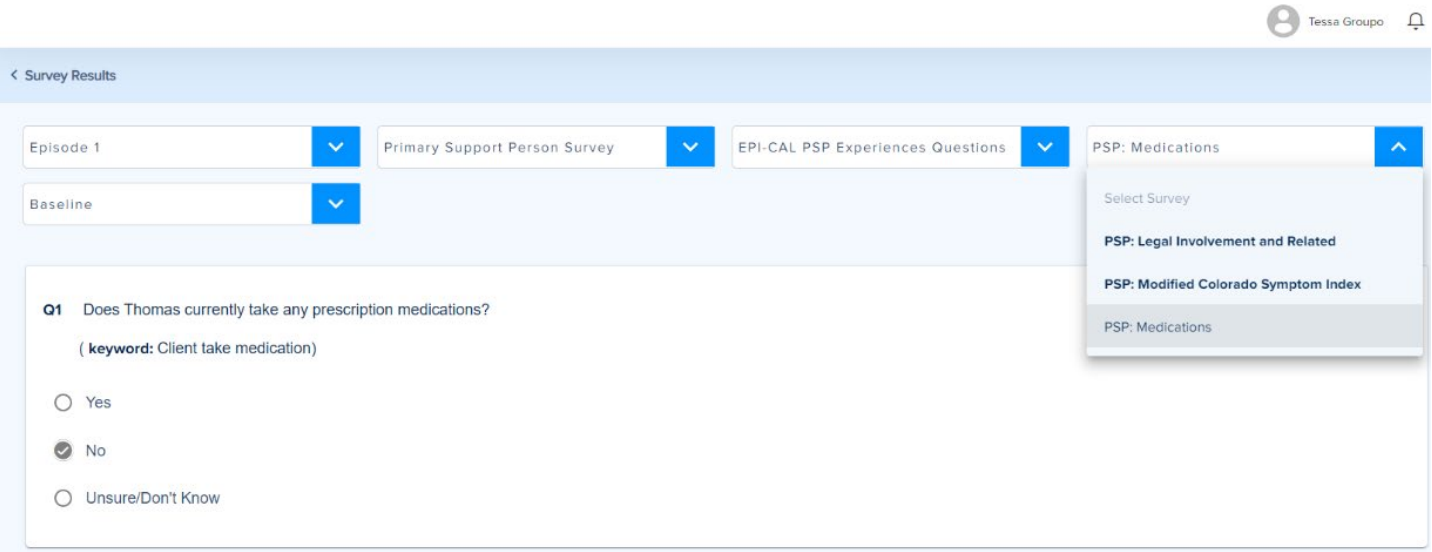


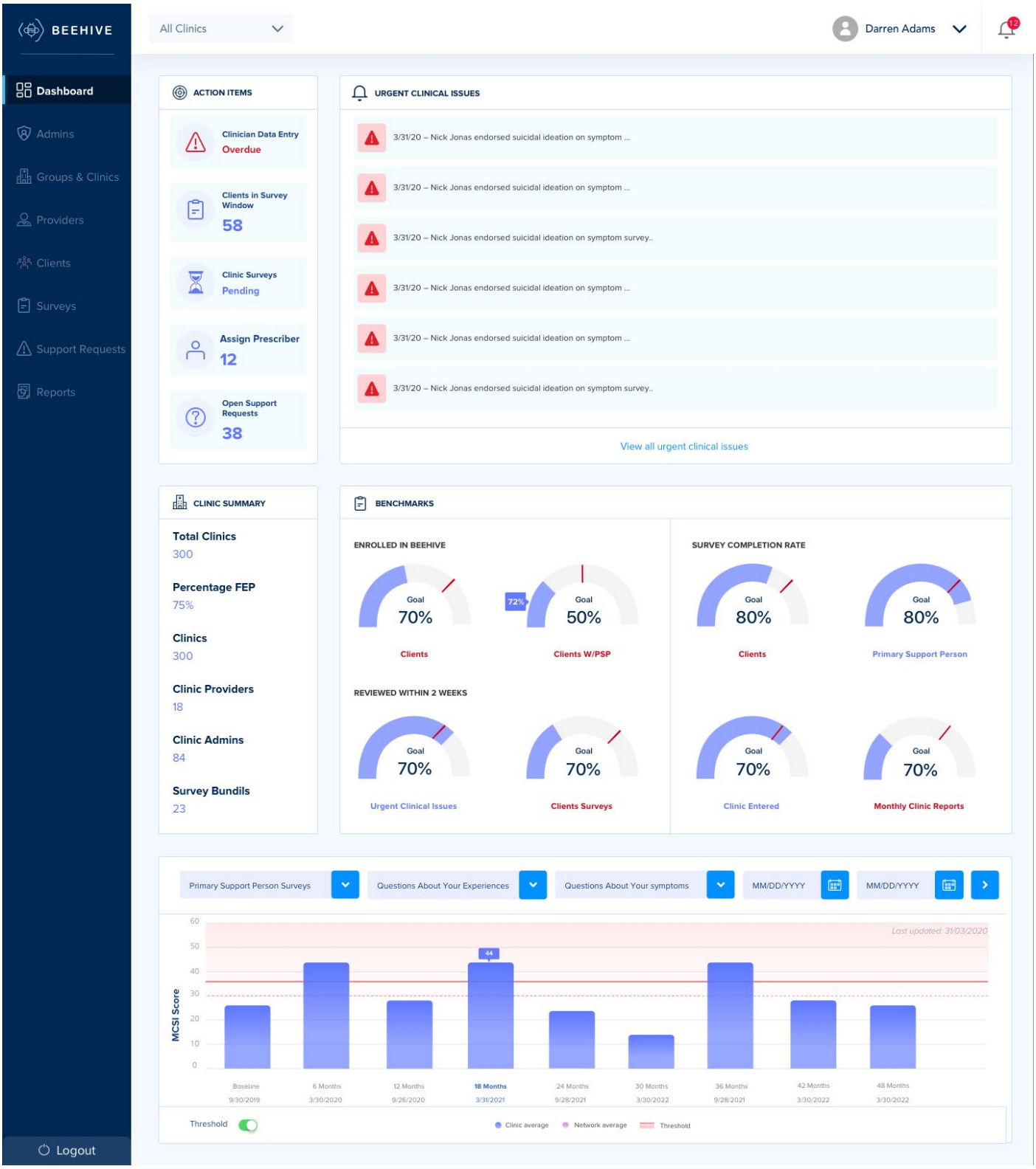
Figure 17 : Newly answered surveys in bold in dropdowns



The Beehive dashboard was also redesigned with input from programs. The goal of the dashboard is to provide users with the information that is of the highest priority for them when using Beehive. However, feedback from beta users indicated that they weren't sure what was most important, and the dashboard seemed busy. With this in mind, the dashboard was redesigned to reduce visual noise. The color scheme was simplified, with red being used sparingly for the most important information. The widgets above the fold of the web page are those that would require the user to act (e.g., urgent clinical issues and action items). Other widgets which are more informational in nature (e.g., benchmarks, clinic summary, and aggregate data widgets) were moved lower. Designs and mock-ups were presented to community partners across programs, including non-pilot programs, for their feedback and approval before implementing in Beehive. EP program community partners said that they liked the placement of the urgent clinical issues widget. They also said they

liked the curved progress bars in the Enrollment widget as they are more visually appealing, compared to straight-bar options that we presented as alternatives. In general, community partners said they thought the information on the new dashboard was easy to digest and their direct feedback was used to update specific design choices in the current dashboard (Figure 18).

Figure 18: Updated Beehive Dashboard



Another common theme of feedback from beta users was that the clinician data-entry was burdensome because it only included one question per page. This design of one question per page was intended to reduce the amount of information presented to consumers completing surveys in Beehive, but clinic users did not have the same needs. Due to the design of Beehive, it is not feasible from a resource perspective to allow more than one question per page. If future modifications in Beehive allow multiple questions to be presented in the clinic user view, we will work to incorporate this change. In the meantime, a new question type, matrix tables, was designed in Beehive so that EP program users could enter multiple data fields per page.

To prioritize community partner preferences and needs, the EPI-CAL team has implemented a system of formally gathering user feedback before planning each sprint series with the developers. A survey was sent out to all beta sites to solicit their feedback to prioritize the issues and ideas they had reported over the beta testing period. Respondents were asked if they were willing to participate in discussions with the Beehive project manager to provide qualitative information to help determine the best method of implementation for prioritized features. The issue prioritized by all respondents who had been using Beehive in their clinic was that survey windows were too short. The Beehive project manager met with individuals from each beta site to discuss their previous workflow around data collection and present possible Beehive solutions around this issue. EPI-CAL staff then used this information to determine the best length for Beehive survey windows moving forward.

Another feature that was adjusted based on community partner feedback is the availability of the EULA video. Several programs have indicated it would be helpful to be able to complete the Beehive EULA process prior to the consumer's intake. We changed Beehive so that the EULA process can be completed up to 15 days in advance of the intake date entered in Beehive.

Moving forward, we will continue to implement this method of gathering community partner feedback before each sprint series. Any program who has completed Beehive core training and begun to use Beehive in their program will be given the opportunity to contribute to the process of prioritizing changes and development to Beehive.

9. Gather feedback from interviews with EP community partners about experience in EP treatment programs.

This section includes the preliminary findings from our interviews with EP community partners about the barriers and facilitators to implementing a Learning Health Care Network into EP treatment programs.

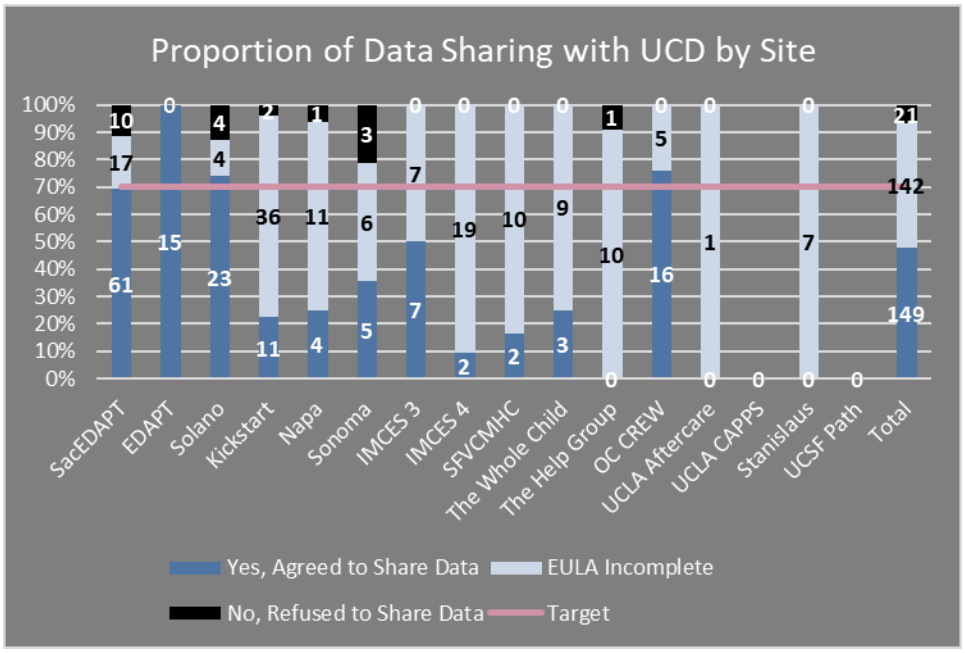
The interview guide was developed by the qualitative lead, with input from the rest of the research team. Once a first draft was completed the interview was submitted to the LHCN advisory group and further modified based on community partner feedback. The interview guide is structured to explore provider experiences related to each component of Beehive implementation, including enrolling consumers into the application, consenting and other steps prior to consumers inputting data, the data inputting process itself, and then incorporating Beehive and the data in care. Finally, provider experiences of training and ongoing support were explored. The aim of the interviews was to understand potential barriers to effective implementation of Beehive at each step of the process, potential solutions either considered or implemented to address these challenges, and facilitators to effective implementation. In keeping with the principles of a Learning Health Care Network, the aim was to disseminate these experiences across the EPI-CAL clinical to encourage cross program learning. Prior to recruitment, the interview guides were reviewed and approved by the UC Davis IRB.

Potential participants were identified through the help of our EPI-CAL clinic point persons. Following identification, the point person would introduce the potential participant to the interviewer via email so that the

interviewer could introduce the study. If the potential participant agreed to take part, a time would be scheduled to go through the consent process, payment form, and if the participant consents, complete the interview all via a zoom call. Interviews lasted one hour, and participants received a $30 gift card or check for participating.

All interviews took place between March 10, 2022 and March 29, 2022 with the exception of one interview that took place on May 3, 2022. Participants were clinical staff at the four specified clinics and identified as having the following roles: Clinical Supervisor, Clinician, Peer, Case Manager, Clinic Coordinator, Bilingual program coordinator, and Director. Nine providers across four clinics (Solano, EDAPT, SacEDAPT, and OC CREW) were interviewed. These sites were selected based on the relatively high degree of engagement with the Beehive platform, as evidenced by Figure 19. The rationale for this selection process was two-fold: 1) at programs in the earlier stage of Beehive implementation, there was a concern that providers may have insufficient exposure to the platform to be able to provide a detailed account of using the tool, and 2) the plan was to initially explore Beehive implementation in sites that have most successfully implemented the platform, allowing for the collection of data that may be helpful to other programs. Going forwards, we aim to expand recruitment of providers across all sites to develop a more comprehensive experience of Beehive implementation across the whole EPI-CAL network.

Figure 19: Proportion of Data Sharing with UCD for Research by Site



Preliminary findings centered on five prominent domains: training, enrollment workflow, clinical utility, the learning curve, and consumer engagement in surveys. Regarding training, preliminary results suggest clinics would like more trainings and refreshers, especially for new hires and when changes to the system happen. Additionally, participants highlighted the importance of hands-on and practice-oriented trainings. Next, participants discussed challenges with the flow of the initial meetings and procedures surrounding enrolling consumers into beehive, consenting, completing the EULA, completing initial surveys and the intake assessment. The most cited problems were technical challenges with the EULA video that were exacerbated by the remote set up due to the COVID-19 pandemic, and not having enough time for consumers to complete initial surveys before their intake assessment. More interviews are needed to understand if recent changes to the application have resolved these issues, and if it is experienced network wide. Some participants elicited concern regarding the current lack of clinical utility in beehive, attributable in part due to the inconsistency of data collection. Next, we have been looking into the learning curve to understanding beehive, which seems to

differ for more experienced clinicians and staff to newer team members. More data is needed to reach saturation for this topic and will be updated in a later report. Lastly, participants have been sharing innovative ways to improve consumer engagement in surveys, such as gift card incentives, making completing a survey a game, and having a case manager or other staff sit with consumers as they complete surveys.

More interviews with staff at additional clinics as well as consumer interviews are needed to fully understand the barriers and facilitators to implementing a LHCN into EP programs. Additionally, it is important to note that Beehive is continuously evolving through feedback, and challenges expressed in March may not be reflective of current progress. These preliminary findings highlight a brief snapshot of experiences for a small group of staff at a particular stage of implementation. We will continue to collect data to get a more cohesive picture.

10. Finalize methods for multi-county-integrated evaluation of costs and utilization data

The proposed analysis is based on pilot work conducted in Sacramento County, scaled to multiple counties (Niendam et al., 2016). It focuses on consumer-level data related to program service utilization, other outpatient services utilization, crisis/ED utilization, and psychiatric hospitalization and costs associated with these utilization domains during two time periods: 1) the three years prior to implementation of project tablet in the Early Psychosis (EP) programs (e.g., Jan 2017 – Dec 2019), to harmonize data across counties and account for potential historical trends, and 2) for the 2.5 year period contemporaneous with the prospective EP program level data collection via the tablet (Jan 2020 - June 2022). Below, we describe the data extraction and analysis plans for the first time period.

Early Psychosis (EP) sample
First, all individuals entering the EP programs January 1, 2017 – December 31, 2019 will be identified using County Electronic Health Record (EHR) data. This list will be cross-referenced with the County EP program(s) to identify those individuals who received treatment versus only eligibility assessment and referral to another service. *We will restrict the comparison to individuals diagnosed with first-episode psychosis (FEP), and not include those at Clinical High-Risk (CHR) for psychosis, due to an inability to reliably identify individuals with CHR in the comparator group.*

Comparator Group (CG) sample
We will compare the utilization and costs of the FEP participants in EP programs to utilization and cost among a group of FEP individuals with similar demographic and clinical characteristics who do not receive care in the EP program during the same timeframe in the same County. FEP individuals meeting the same eligibility criteria for the EP program (e.g., FEP diagnoses, within the same age group) who enter standard care outpatient programs in the County during that same time period will be identified as part of the comparator group (CG). First, we will identify all FEP individuals meeting these criteria receiving any outpatient services who are not served in the EP program. The Comparator Group (CG) was defined as 1) any individual seen in outpatient mental health services between January 1st, 2017 - December 31st, 2019; 2) age as of first date of service during this period: 12 years 0 days – Less than 26 years 0 days; and 3) any primary psychosis diagnosis during this period. We also requested that the counties submit a dataset of prior diagnoses and service utilization for the period of January 1, 2013 – December 31, 2017. This will allow us to correctly identify individuals with “first episode psychosis” (FEP) for our sample. This is defined as individuals who received a psychotic disorder diagnosis within two years of their index service date. The index service date is the first outpatient service associated with a primary psychotic disorder diagnosis in the study period.

Service Utilization

Next, data will be requested from the County EHR on all services received by individuals in the EP programs and all services for members of both groups including 1) any non-EP outpatient services; 2) inpatient services and 3) crisis/ED services. As possible, we will also work with other systems identified by EP programs as having service use data not otherwise captured in the County EHR (e.g., databases of other EP program services; private inpatient hospitalizations not billed to the County; non-billable services, etc.). We have identified these potential additional sources of data in expert interviews with program directors and senior program staff to date and will investigate their availability once groups are defined.

Costs

Costs per unit of service will be assigned to each type of service. We will work with county staff to identify the most accurate source of cost data. This may include internal financial accounting systems, contracts, cost reports, or published rates. We will determine whether to apply a single cost across all services (by type of service) or to apply costs that are county or provider specific. We will include billable and non-billable services. Outcomes will be calculated per month to account for varying lengths of time receiving services during the active study period. Additional details on outcomes and cost data sources are described in Table 5 below.

Table 5. Outcomes, Sources of Outcome Data, and Methods to Determine Costs Associated with Outcomes

Potential Outcomes of Interest	Sources of Data on Relevant Outcomes	Levels of Analysis	Sources of Cost Data associated with Outcomes
COUNTY LEVEL DATA VARIABLES			
Inpatient hospitalization for mental health concerns	• County hospitalization records	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per consumer • Duration of each hospitalization (days) • Total duration of hospitalizations (days) per consumer	• Daily rate paid by County • Daily rate Medi-Cal reimbursement
Emergency Department or Crisis stabilization	• County crisis stabilization unit records	• Number/proportion of individuals with crisis visits per group • Number of visits, per consumer • Duration of each visit (hours) • Total duration (hours) of all visits, per consumer	• Hourly rate paid by County
Outpatient service utilization	• Service unit records by outpatient program from County *Examples:* • Assessment • Case management • Group Rehab • Group Therapy • Individual Rehab • Individual Therapy	• Service type • Number of service units (minutes)	• Contract service unit rates

	• Family Therapy • Plan Development • Medication management • Collateral Services • Crisis Intervention		

Statistical Methods

Multi-County Analysis
The data will be harmonized on demographics, diagnoses, and service types across all participating LHCN counties, for EP and CG groups, then merged into a single dataset for our primary analyses. This combined, multi-county dataset will provide increased statistical power, allowing for a richer set of controls and error structure without compromising efficiency.

Analysis of Sample Characteristics
Student T-tests and Pearson Chi-square (or Fisher's exact) tests will be used to compare unadjusted group differences in demographic characteristics (e.g., age, sex, race, ethnicity, etc.) between the individuals in the EP and CG groups. Both unadjusted and adjusted analyses will be used to examine group differences in clinical characteristics at time of index service such as primary diagnosis, as well as the duration of enrollment.

Analysis of Outpatient Service, Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data
All service data outcomes will be analyzed with a simple empirical equation: the independent variable is regressed on a county-specific fixed effect, an epoch-specific fixed effect, an indicator taking 1 for the EP group and 0 otherwise, a set of interactions between the EP group indicator and each epoch allowing the effect of the EP program to vary over time, and a set of individual-specific controls - measured at intake - consisting of sex, ethnicity, race, and primary language. We will use all demographic variables that were available and harmonized across all counties in time for this preliminary analysis. Standard errors will be always clustered at the individual-level because repeated measures of the same outcome for the same individual are correlated, and we are interested in describing individual-level differences. Further processing of the data will allow the addition of other individual-specific controls and clinic-specific effects to the empirical equation to account for other sources of confounding variation. These will be included in future analyses.

Total outpatient service time (in minutes) of all outpatient services and total minutes of each service type (e.g., medication management, individual therapy, group therapy, rehab services), and time per month will be analyzed by estimating the empirical equation described above with negative binomial regression for count data to determine if outpatient service use differs between the EP and CG samples.

Data related to individuals' use of Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data usage will be examined using multiple measurements based on the study period: 1) a binary indicator for whether the individual had ever been hospitalized; 2) a binary indicator for whether the individual had ever utilized crisis services; 3) number of hospitalizations per month; 4) number of crisis visits per month; and 5) mean duration of hospitalizations (i.e., length of stay [LOS]) in days; 6) mean LOS for Day/Crisis services (hours); 7) total duration of hospitalizations per month; and 8) total duration of Day/crisis services per month. Data for (1) and (2) will be analyzed by estimating the empirical equation described above with multiple logistic regression. Data for (3), (4), (7), and (8) will be analyzed by estimating the empirical equation described above with negative binomial regression for count data. Data for (5) and (6) will be

analyzed by estimating the empirical equation described above with linear regression. These various methods will allow us to determine whether each respective outcome differed between the EP and CG samples.

Data transfer methods
While data transferred between EP program staff and County data analysts within the same County may be identifiable, all information will be de-identified and provided with a unique numeric ID before being submitted to the UCD evaluation team. Data will be shared through an encrypted and password protected SFTP server, which is housed on UCD secure servers. Counties will not have access to any identifiable data from the other counties. Counties receive instructions for uploading their data to the secure SFTP server. Each county is given a unique login and is able to securely login into the SFTP portal and upload their data directly to the UCD servers. Once we receive the data, we confirm with the county that all the information was received.

11. Identification of county-level available data and data transfer methods, and statistical methods selected for integrated county-level data evaluation

One component of the LHCN project is to identify and describe the services and related costs for individuals served by the EP programs in each county. We will also examine services and costs associated with similar individuals served elsewhere in each county. We will harmonize and integrate data across all LHCN counties in order to perform these analyses.

Specifically, in each county we will identify an early psychosis (EP) group consisting of individuals served by the early psychosis program. We will also identify a comparator group (CG), consisting of individuals with EP diagnoses, within the same age group, who enter standard care outpatient programs during that same time period. This analysis focuses on data from Los Angeles, San Diego, Orange, Napa, Stanislaus, and Solano counties. For this component of the project, the evaluation has two phases: 1) the three years prior to the start of this project (e.g., January 1, 2017 – December 31, 2019) to harmonize data across counties and to account for potential historical trends and 2) for the 2.5-year period contemporaneous with the prospective EP program level data collection (January 1, 2020 – June 30, 2022).

For each county, our team held meetings with the EP program managers and the county data analysts. The meeting with the program managers discussed services provided by the EP program, description of consumers served, staffing specifics and billings codes for each service. A follow-up meeting was held with each county to review details of funding sources, staffing levels during certain time-periods and other types of services provided for specific types of consumers (i.e., foster care). Meetings were held with the county data analysts to discuss details about the data the county will be pulling for the LHCN team during the next annual period. The discussion included time-periods for which the LHCN team will request data, description of the consumers from EP programs and how similar consumers served elsewhere in the county will be identified, services provided by each program, other services provided in the county to the EP consumers (i.e., hospitalization, crisis stabilization and substance use treatment), and data transfer methods. We have met with the program managers and data analysts from all LHCN counties with active contracts and have scheduled follow-up meetings with the data analysts as necessary. Our research team has gathered all of the information from each program/county and summarized it in meeting notes and a multicounty data table. For the purposes of this report, we have provided a sample of the data collected from each county (see Table 6).

Table 6. Multicounty Program Services and Billing Information

County	**San Diego**	**Orange**	**Solano**	**Napa**	**Stanislaus**
Program Name	Kickstart	OC CREW	Aldea SOAR	Aldea SOAR	LIFE Path

County	San Diego	Orange	Solano	Napa	Stanislaus
Consumers Served	FEP, CHR	FEP	FEP, CHR	FEP, CHR	FEP, CHR
Census	140-160	42	26	10-15	Current 10-15, cap 40
Length of Services	(+/-) 2 yrs	2 - 4 yrs	(+/-) 2 yrs	(+/-) 2 yrs	2 yrs
Inclusion - Ages	Ages 10-25	Ages 12-25	Ages 12-30	Ages 8-30	Ages 14 - 25
Inclusion - Diagnoses	Any type of psychoses (NOS) but not required, SIPs score of 6	FEP	CHR diagnosis or FEP within 2 yrs	All Psychotic D/Os (within 2 yrs of meeting dx criteria) & CHR diagnosis	Psychotic d/os within 1 year of meeting dx criteria including affective, & CHR diagnosis
Inclusion - Insurance	Medi-Cal, Uninsured	None	Medi-Cal, Uninsured	Medi-Cal, Private, Uninsured	Medi-Cal, Private, Uninsured
Inclusion - Duration of Psychosis	First psychotic symptoms within 2 yrs	First psychosis within 2 yrs	First psychosis within 2 yrs	First psychotic episode within 2 years; Attenuated psychosis of any duration	First episode within 2 years;
Exclusion - Cognition	IQ < 70 - Case by case discretion	IQ < 70	IQ < 70	IQ < 70	IQ < 70, Substance induced psychosis, psychosis due to medical conditions including TBI
Exclusion - Diagnoses	Case by case discretion: Medical diagnosis that better explains symptoms; substance use	No substance use or medical condition that better explains symptoms	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	Substance dependence would not allow to participate in treatment – refer to substance abuse treatment, Head injury or medical condition	
Exclusion - Other	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Not received counseling prior for psychotic disorder in the last 24 months	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative Judgement call: Physically aggressive, sexually inappropriate, safety issues	Qualitative: requires 24 hour care/higher level; staff/peer safety issues

County	San Diego	Orange	Solano	Napa	Stanislaus
Assessments - Billing Codes	10	90899-6 (H2015)	90791	10	10
Assessments - Provider type	Clinicians	Clinician: master's level BHCI, BHCII, psychiatrist	Therapist; clinical supervisor	Therapist	LPHA
Assessments - Notes	Behavioral Health assessment and HRA (high risk assessment)	Code 90899-6 for each of multiple sessions leading up to intake completion; Same code for psychiatrist completing conservatorship evaluation, disability assessment, or eval for med services by telephone		Initial, Annual/ Periodic	Initial, periodic
Targeted case management - Billing Codes	50	90899-1 (T1017)	T1017	50	50
Targeted Case Management - Provider Type	All direct service staff: clinical team, OT, Peer Support or EES. As well as medical team (NP, Psychiatrist, or LVN)	BHCI, BHCII, psychiatrist, Mental Health Specialist, Psychiatrist, Behavioral Health Nurse, Mental Health Worker	Therapist, family partner; Medical director or PNP	Therapist, Family Partner/ Peer Case Manager	Clinician, Behavioral Health specialist
Targeted Case Management - Notes	Monitoring progress toward goals - information gathered from schools and parents	A variety of services can be billed under case management as long as they referred to coordination of care, monitor service delivery and linkage access to community services.	Examples: Therapist discusses consumer with PNP or Family Partner; Therapist or Family Partner discusses consumer need for housing with Caminar; Therapist facilitates consumer's transition to a new service upon	Linkage to Resources; SEE support	Linkages, evaluate other program/resource progress; verify progress

County	San Diego	Orange	Solano	Napa	Stanislaus
			completion of program		
Group Psychotherapy - Billing Codes	35	90849 (H2015)	H2017	31 or 35 (Peer & MFG); Non-Bill (FSG)	38, 36
Group Psychotherapy - Provider Type	Clinician, Peer Support Specialist, Education Employment Specialist, OT	BHCI, BHCII, Mental Health Specialist, Behavioral Health Nurse	Therapist, Family Partner	Therapist, Family Partner/ Peer Case Manager	Clinician, Behavioral Health Specialist, Family Advocate
Group Psychotherapy - Notes	10 different groups offered. Collateral services billed 8-15 to capture other support specialist for any group with multiple facilitators	Group Psych-multifamily	Group rehab	Multi-Family Group, Family Support Group, Peer Group(s) for Adolescents & Adults	Multi-Family Group, Social Skills/Life Skills Group

12. Deliver a plan and timeline for working with counties to support infrastructure to access final round of county-level cost and utilization data for EP and CG programs

Overview

The County Data evaluation of the LHCN project examines the services and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics representing “standard care,” during a concurrent time frame in the same community. The primary goal of this component, submitted December 2021 to the counties in the last report, was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties.

Over the last fiscal year, we successfully completed our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties, as well as our central team, have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, which has delayed project coordination and data extraction.

Over the last fiscal year, we have continued to meet with counties to clarify questions about received cost and utilization data, and to troubleshoot issues related to incomplete or unclear data elements. In these meetings, we requested that each county provide us with contracts and budgets for their EP programs as a way to account for non-billable activities and other unaccounted-for costs of running the program. Further, we worked with counties to obtain actual costs per service, per consumer, rather than reimbursement amounts or fixed costs per unit of service, as these have differed. In our efforts to thoroughly balance EP and CG groups, we decided to request historical data for the EP group from each county and have worked to modify data use agreements as necessary. Finally, we asked each county to provide us with consumers' episode of care end dates for those consumers who may have ended their services since the data was originally extracted.

Summary of preliminary analysis of service utilization data

During the fiscal year, the County Data evaluation team focused on addressing the limitations of the preliminary analysis of service utilization data. This effort is composed of three main activities: 1) improving the harmonization of variables across counties and the detection of episodes of care, 2) addressing missingness in county data, and 3) addressing selection bias into EP programs.

The County Data evaluation team is reviewing CG and EP group data to identify ways to improve the harmonization of data across the counties in the evaluation. This exercise will allow us to fully leverage the diversity of our service-level data. Additionally, we are working closely with county staff to improve how we detect consumer episodes of care in the data. Accurate identification of episodes of care are crucial to accurately measuring service utilization in both the CG and EP groups, improving the credibility and rigor of our estimates of the effects of EP programs.

Subsequent descriptive analyses of county-level service data after the previous analysis revealed substantial variation in the number of variables with missing values across counties, as well as the degree to which data is missing within each county's data. The county data evaluation team is exploring the extent of missingness in the data from each group in each county, as well as the extent to which missingness is correlated with a consumer belonging to the CG group. Once the team has a clear understanding of missing data in our sample, we will explore solutions and determine the extent to which missingness is a limitation of the evaluation.

The preliminary analysis of service utilization data provided comparisons between the CG and EP group adjusted for a small initial set of observable consumer-level characteristics. However, we know consumers are not randomly assigned to the EP group, so even adjusted analyses still suffer from selection bias. This selection bias arises from the likelihood that consumers in the EP group differ systematically from those in the CG group such that they were a priori more likely to have been members of the EP group. For example, many EP programs exclude serious substance use disorders (SUD) on a case-by-case basis, but SUD severity is difficult to discern from the diagnostic data obtained for the comparator group. Hence, a rigorous comparison of the EP and CG groups should correct for this selection bias. To address selection bias, the county data evaluation team is implementing a generalized version of propensity score weighting, using augmented inverse probability weighting (AIPW) with Lasso covariate selection. The principal idea behind this method is to leverage historical data from each consumer to predict the probability we later observe them in the EP group during the study period by modeling selection into the EP group. Each consumer is then "weighted" by the

inverse of this predicted probability, which statistically approximates random assignment of EP care. While powerful, the propensity score weighting method is dependent on the evaluation team's ability to accurately predict the "true" probability a person is observed in the EP group. Lasso, a machine learning technique, allows us to find the best selection model within the available data. The combination of these methods will allow the evaluation team to correct for selection bias to the best of the data's ability. Correcting for selection bias makes the comparison of the EP and CG groups as close to "apples-to-apples" as possible.

In addition to methodological improvements, the county data evaluation team is working with county staff to extract additional data required for the analytic methods. We requested historical data for consumers in our county EP groups to be used in the weighting methodology described above. LA county staff were able to identify previously unavailable service data for 24-hour service categories for all consumers. We are also working closely with Solano county to obtain inpatient service utilization data for the specific CG consumers selected for our comparison. We are also working with two new counties that will contribute data to these combined utilization analyses, Napa and Stanislaus. We have met with both county and program staff to discuss the process for this element of the project and will submit our formal data requests to them shortly.

Cost Analysis

In this report, we present a preliminary analysis comparing the EP and CG groups in San Diego County on service utilization and related costs data. Due to the challenges outlined above, we were not yet able to integrate or analyze cost data from Solano County, Orange County, and Los Angeles County. We are confident that the cost comparison analysis, along with a finalized comparison analysis of service utilization, will be completed for the next deliverable, due December 2022.

Sample and Methods

We identified consumers who initiated services in the San Diego EP program, "Kickstart," from January 1, 2017 to December 31, 2019, and a comparison group of consumers who were using outpatient services during the same time period. We identified Kickstart consumers who first enrolled in the programs between January 1, 2017 and December 31, 2019. We limited the sample to consumers ages 12-25 who did not have a diagnosis of psychosis (ICD-10 codes F20, F22, F23, F25, F28, F29, F31.2, F31.5, F31.64, F32.3 F33.3) greater than two years before enrollment (through October, 2008). We excluded consumers with private insurance, due to an inability to capture all of their services in the public claims system, and consumers who received a diagnosis of intellectual disability (ICD-10 codes F70-F79, ICD-9 codes 317-319), to harmonize the sample with our other counties' exclusion criteria.

We shared a list of Kickstart consumers with program staff who confirmed that these were past or current consumers who had enrolled in services, and were identified as either First Episode Psychosis (FEP) or Clinical High Risk (CHR). FEP consumers have threshold psychosis symptoms defined as having a Psychosis Syndrome on the Structured Interview for Prodromal Syndromes (SIPS), roughly corresponding to a score of 6 for Positive Symptoms on the Scale of Prodromal Symptoms (SOPS). CHR consumers have subthreshold symptoms, defined roughly as having a SOPS score of 3-5.

We identified a comparison group (CG) of consumers with likely FEP ages 12-25 who received an outpatient mental health service in San Diego County between January 1, 2017 and December 31, 2019, and who had a first diagnosis of psychosis (same diagnoses as above) within two years prior to their first service during this time period. We defined the first outpatient service during January 1, 2017 to December 31, 2019 as the index outpatient visit. We similarly excluded consumers with private insurance, consumers who received a diagnosis of intellectual disability, and consumers with a diagnosis of psychosis greater than two years before the index outpatient visit.

We summarized service use over 365 days prior and 365 days following enrollment in Kickstart or the index outpatient visit. Outpatient services included case management, crisis intervention, medication management, and mental health services including rehabilitation and therapy. We defined a visit as a unique day receiving services. We summarized psychiatric admissions including admissions to psychiatric hospitals, admissions to psychiatric units of acute care hospitals, and admissions to crisis residential facilities; and psychiatric emergency services including the emergency psychiatric unit and mobile psychiatric emergency response teams. We also summarized costs of outpatient mental health services covered by Medi-Cal, California's Medicaid program.

We estimated the numbers of services and visits during the year using negative binomial regression models. We estimated the probabilities of having a psychiatric inpatient admission and of using psychiatric emergency services using logistic regression models. We estimated costs using a generalized linear model with a gamma distribution and a log link function. In each model, we included covariates for age, gender, and race/ethnicity (included as indicator variables for Black and Latino), along with indicator variables for FEP and CHR. We calculated standardized estimates for each outcome using the estimated coefficients to generate predicted values for each consumer in the sample as if they were alternately assigned to each group: FEP, CHR, and CG. The standardized mean is the mean of the predicted values across the sample. We calculated standard errors using the non-parametric bootstrap, and significance values using non-parametric permutation.

Results

We identified 301 consumers in the Kickstart program, of whom 104 were FEP and 197 were CHR, and 687 likely FEP consumers in the CG (Table 7). Mean age in the FEP group was 18.3 years (SD=2.8) and the largest percentage of consumers was 15-17 years (N=51, 49%). Mean age was lower among the CHR group (16.5 years, SD=2.8), due to a large percentage of consumers under age 15 (N=63, 32%). Mean age was highest among the CG (19.5 years, SD=4.0), due to a large percentage of consumers ages 21 and over (N=294, 43%). The FEP group had the largest percentage of consumers who were male (N=73, 70%). The distribution of race/ethnicity was similar across the groups.

Table 8 shows the mean number of services in the year prior and year post enrollment for Kickstart consumers and in the year prior and year post the index outpatient visits for CG consumers, as well as the difference in services from pre to post. Service use was highest for the FEP group in both the pre and post periods, followed by CHR and CG. The FEP group also had the greatest increase in services from pre to post (45.7, SE=6.6), followed by CHR (24.0, SE=3.1) and CG (12.3, SE=1.8).

Table 9 shows the mean number of visits in the year prior and year post enrollment or index outpatient visit and the difference between years. Visits were highest for the FEP group in both the pre and post periods, followed by CHR and CG. The FEP group also had the greatest increase in visits from pre to post (32.5 SE=4.2), followed by CHR (17.5, SE=1.9) and CG (8.9, SE=1.1).

Table 10 shows probabilities of psychiatric admission in the pre and post periods and the change in probability of admission from the pre to post period. The CG had the highest probability of admission in the pre period, when 14.4% (SE=1.3) of consumers had admissions. The rate of psychiatric admission was similar among FEP and CG, but slightly lower among the CHR group in the post period. As a result, the FEP group had the greatest increase in probability of admission with an 18.1 (SE=4.7) percentage point increase from pre to post.

Table 11 shows the probabilities of using psychiatric emergency services. The CG had the highest probability of emergency service use in the pre period, when 12.4% (SE=1.5) of consumers used services. The rate of emergency service use was similar among FEP and CG, but slightly lower among the CHR groups in the post

period. As a result, the FEP group had the greatest increase in emergency service use with a 25.3 (SE=4.5) percentage point increase from pre to post.

Table 12 shows Medi-Cal reimbursed outpatient mental health services. Outpatient costs were similar in the year prior to enrollment or index outpatient visit. In the post period, costs were greatest among FEP ($9,711, SE=$910) followed by CHR ($6,334, SE=$451) and CG ($4,620, SE=$272). As a result, outpatient costs increased the most among FEP, followed by CHR and CG.

Summary

Youth consumers enrolled in Kickstart had higher outpatient service use, visits, and costs than a comparable group of adolescent and young adult consumers who were receiving services in standard outpatient programs. Services, visits, and costs were greater for consumers with FEP than consumers who were CHR. We did not find significant differences in psychiatric inpatient or emergency services use in the year following enrollment. However, since Kickstart consumers had lower use of these services in the pre period, they appear to have greater increases in use from the pre to post period.

Table 7: Demographic Characteristics of Youth Consumers of Kickstart and a Comparison Group

	First Episode Psychosis	**Clinical High Risk**	**Comparison Group**	**P-value for difference across groups**
N	104	197	687	
Age N (%)				P<.001
Age <15	9 (9%)	63 (32%)	113 (16%)	
Age 15-17	51 (49%)	88 (45%)	161 (23%)	
Age 18-20	25 (24%)	30 (15%)	119 (17%)	
Age 21- 25	19 (18%)	16 (8%)	294 (43%)	
Gender N (%)				P=.006
Male	73 (70%)	108 (55%)	368 (54%)	
Female	31 (30%)	89 (45%)	319 (46%)	
Race/Ethnicity N (%)				P=.002
Non-Latino White	23 (22%)	39 (20%)	158 (23%)	
Black	14 (13%)	19 (10%)	66 (10%)	
Latino	57 (55%)	118 (60%)	325 (47%)	
Other	4 (4%)	16 (8%)	60 (9%)	
Unknown	6 (6%)	5 (3%)	78 (11%)	

Table 8: Mean Annual Services Use (Individual Visits, Even if Received on the Same Day), Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	19.4 (3.9)	17.8 (2.5)	15.3 (1.4)	<.0001
Post	65.1 (5.5)	41.8 (2.7)	27.6 (1.5)	<.0001
Difference	45.7 (6.6)	24.0 (3.1)	12.3 (1.8)	<.0001

Table 9: Mean Annual Visits, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	12.4 (2.2)	11.5 (1.4)	10.6 (.9)	<.0001
Post	44.9 (3.5)	29.0 (1.7)	19.5 (.9)	<.0001
Difference	32.5 (4.2)	17.5 (1.9)	8.9 (1.1)	<.0001

Table 10: Mean Annual Probability of Psychiatric Inpatient Admission, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	5.4 (2.2)	3.8 (1.4)	14.4 (1.3)	.0002
Post	23.4 (4.3)	17.1 (2.8)	24.8 (1.6)	.095
Difference	18.1 (4.7)	13.3 (3.1)	10.3 (2.1)	<.001

Table 11: Mean Annual Probability of Use of Psychiatric Emergency Services, Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	4.4 (1.9)	6.6 (1.8)	12.4 (1.5)	.011
Post	29.7 (4.3)	18.3 (2.7)	23.1 (1.6)	.075
Difference	25.3 (4.5)	11.7 (3.1)	10.8 (2.0)	.010

Table 12: Mean Annual Costs of Outpatient Services (in USD), Standardized by Demographic Characteristics, in the Year Prior and Year Post Enrollment

	First Episode Psychosis	Clinical High Risk	Comparison Group	P-value for difference across groups
Pre	3606 (785)	3264 (484)	2915 (316)	.490
Post	9711 (910)	6334 (451)	4620 (272)	.001
Difference	6105 (1186)	3070 (640)	1704 (420)	.041

Future Analyses

During the next deliverable period, we will examine service utilization across the entire retrospective period (January 1, 2017 – December 31, 2019) rather than comparing services received during the year prior and the year post program enrollment. In addition, outcomes will be calculated as unique outpatient services accounting for varying durations of active treatment. We will also expand the scope of the cost analysis. Currently, costs are limited to the amounts paid for Medi-Cal reimbursable mental health outpatient services. In the next period, we will consider the costs incurred to the County for all outpatient services, including those services that are not reimbursable by Medi-Cal. We will also consider additional service types including inpatient and crisis residential, and the emergency psychiatric unit and the psychiatric emergency response team.

Although CHR consumers enrolled in the EP program were included as a comparison group in the current analysis, these consumers will be excluded from future planned analyses as they cannot be reliably identified for the comparator group using standard diagnostic codes. We will also refine the exclusion criteria for the CG group based on diagnostic and service utilization history of the EP group as well as utilizing a weighting strategy for included consumers in both groups, as described previously. This will ensure that the CG group only contains consumers most likely to have a first episode of psychosis, allowing for a more accurate comparison between FEP consumers in the EP and CG groups on service utilization and related costs data.

Finally, future analyses will harmonize and integrate service utilization and related cost data from Orange County, Los Angeles County, Solano County, Stanislaus, and Napa counties.

Prospective Data Analysis

Over the last FY, we held a series of meetings with each county (Los Angeles, Orange, San Diego and Solano) to review the prospective data request. In these meetings, we discussed when claims data would become available for service utilization and estimating costs, as well as time needed for data extraction. Data availability ranged from 4-11 months after the service was billed. We also conferred with other LHCN team members about the timelines for program fidelity assessments to be completed and Beehive implementation to obtain consumer-level outcomes. We had originally planned for a prospective 3.5 year period contemporaneous to the EP program-level data collection; however, based on the projected time estimates to receive from the counties, we determined that the 2.5 year period January 1, 2020 – June 30th, 2022 would be best aligned with the goals of this analysis. This period will allow us to obtain service and cost data for all counties Jan 2020 - June 2022, then finish cleaning, harmonizing and integrating data for a preliminary analysis to be completed by December 2023. This aligns with the original preliminary analysis due dates for San Diego, Orange, Los Angeles, Napa, and Stanislaus counties, and is slightly delayed for Solano County, which had a due date for the preliminary analysis of June 2023. We will obtain community partner feedback and complete a final analysis by June 2024 (see Table 13). This aligns with the original plan for Los Angeles, Napa, and Stanislaus Counties, and is slightly delayed for Orange, San Diego, and Solano Counties which had a due date for the final analysis of December 2023. The process of harmonizing and integrating data for the

initial retrospective period has been incredibly useful and will allow us to do the same for the new service period much more quickly. This prospective period would include almost all program fidelity assessments, with the last assessment scheduled for September 2022.

Table 13. Proposed Timeline for Prospective Data Pull

County	Preliminary analysis due date	Length of time required for County to receive data	Data available by this date
Solano	June 2023	3 months	**Sept 2022**
Orange	September 2023	10 – 11 months for charge data	**May 2023**
LA	June 2024	3 months for charge data DHS Hospital data - 6 months other hospitals - 30 days	**Jan 2023**
San Diego	June 2023	3 months - for annual report, so that there will be enough time for clinic to input all data	CCBH data available end of **Oct 2022**, Optum data available December 2023

Due to Covid-related delays in Beehive implementation (e.g., staffing shortages in county programs, leadership and staff turnover, additional efforts associated with engaging consumers remotely), we expect to conduct pilot analyses integrating consumer-level data from Beehive. As described above, enrollment in Beehive has been delayed, providing insufficient statistical power by the end of the award period to conduct comprehensive integrated analyses of consumer-level outcomes with utilization and cost data. However, we plan to discuss the data needs for this analysis in detail with the counties during the next project period in order to complete these analyses in the post award period.

Further, in our meetings with program and county staff, we discussed any changes to the county EHR or billing and claims systems, changes in data elements collected during the new time period, or any other relevant changes to data availability. We met with Solano County on June 2, 2022; Los Angeles County on May 23, 2022; Orange County on May 19, 2022; and held conversations with San Diego County on May 23, 2022.

13. Provide findings on cost and utilization data from preliminary multi-county integrated evaluation, identification of problems and solutions for county-level data analysis

Overview of Deliverable

The County Data evaluation of the LHCN project examines the services and costs associated with individuals treated in Early Psychosis (EP) programs across several California counties in comparison to the services and associated costs for a comparator group (CG) of similar individuals treated in other outpatient clinics representing “standard care,” during a concurrent time frame in the same community. The primary goal of this component was to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California. The secondary goal was to analyze service utilization and costs associated with those services across counties.

For this report, we were able to successfully complete our primary goal and the first part of our secondary goal (service utilization comparison). We were unable to complete the cost comparison analysis due to the complexity of the data required to be harmonized across counties and the variety of data sources. Nearly all programs and counties have been impacted by staff shortages due to unfilled positions and redeployment of staff during the COVID-19 pandemic, which has delayed project coordination and data extraction. In this deliverable, we describe the cost data we have obtained to date, the cost data still needed, and the challenges and solutions relevant to this endeavor.

Description of Early Psychosis Programs Evaluated

Los Angeles County
The Los Angeles Center for Assessment and Prevention of Prodromal States (CAPPS) program is an early psychosis program serving consumers at clinical high risk for psychosis and consumers who have experienced a first episode of psychosis. The majority of assessment and treatment services offered at CAPPS are free of charge to the consumers. There were 6 CAPPS clinics in operation during the study period, January 1, 2017 – December 31, 2019.

Orange County
The Orange County Center for Resiliency, Education, and Wellness (OC CREW) is an early psychosis program serving consumers who have experienced a first episode of psychosis in the last 2 years. OC CREW provides screening and needs assessments, clinical case management, individual counseling and family services, psychiatric care, psychoeducational groups, referrals and linkages to community resources, and community education on “The First Onset of Psychosis.”

San Diego County
San Diego Kickstart is an early psychosis program serving consumers who are at clinical high risk for psychosis and those who have experienced a first episode of psychosis in the last 2 years. Kickstart aims to educate the community, treat youth, and assist families in preventing psychosis.

Solano County
Solano County Aldea provides early psychosis services through the Supportive Outreach and Access to Resources (SOAR) program. They serve consumers who are at clinical high risk for psychosis and those who have experienced a first episode of psychosis in the last 2 years. SOAR provides services based on the model of the UC Davis Early Diagnosis and Preventative Treatment Clinic. Components include community outreach and education, psychiatric medication management, individualized clinical case management, weekly psychoeducation and support groups, bi-monthly family and multi-family support groups, peer advocate support, and employment and education support.

Characteristics of each county program are detailed below in Table 14.

Table 14. EP Program Characteristics

County	**Age Range Served**	**Duration of Services**	**Excluded Diagnoses**
Los Angeles	Prior to March 2019: 16 – 25 March 2019 – present: 12 – 30	2 years	• medication-induced psychosis • psychosis due to a medical condition • intellectual disability
Orange	12 - 25	2 – 4 years	• delusional disorders • affective disorders

			• post-partum psychosis • substance-induced psychosis • substance use disorder • psychosis due to a medical condition • intellectual disability / IQ below 70
San Diego	10 - 25	1.5 years	• psychosis due to a medical condition • intellectual disability
Solano	Prior to June 2017: 12 – 25 June 2017 – present: 12 – 30	2 years	• psychosis due to a medical condition • intellectual disability • substance dependence.

Analytic Approach

This report presents: 1) descriptive analysis of the EP groups in San Diego, Los Angeles, Orange and Solano counties; 2) a preliminary comparison of the service utilization associated with individuals with first-episode psychosis (FEP) treated at the participating EP programs versus service utilization of a comparable group (CG) of individuals seen for usual outpatient care in the same counties, during the same time period; and 3) a description of cost data available to date from each county. The data were harmonized across counties for analysis, in order to obtain a larger sample size than any one county could contribute alone, allowing for more complex and robust statistical modeling with sufficient to detect even small differences between EP and CG groups.

EP Sample Description

All individuals entering the EP programs January 1, 2017 – December 31, 2019 were identified using county EHR data. County data analysts excluded individuals who received services from the EP program prior to January 1, 2017. This list was cross-referenced with the county EP program(s) to identify 1) those individuals who enrolled in the EP program and received treatment, and 2) those who received only eligibility assessment and referral to another service.

The EP programs also identified which consumers were diagnosed with a first episode of psychosis (FEP) and which were diagnosed with a clinical-high-risk for psychosis (CHR) syndrome. Programs differ in whether they serve one or both groups. If the designation was unknown, typically due to lack of program data, individuals were classified as FEP if they had documented psychotic disorder diagnoses (see Appendix IV). For the comparison analysis, the LHCN research team then applied the following additional inclusion criteria to harmonize EP samples across counties: 1) age 12-25, 2) FEP, 3) enrolled in the EP program (not assessed and referred out). None of the EP consumers had a diagnosed intellectual disability. We did not exclude any consumers based on substance use disorders.

Comparator Group (CG) Sample Description

The CG group was defined as individuals served in outpatient behavioral health treatment in each county for a first episode of psychosis during the period January 1, 2017 – December 31, 2019. County data analysts identified individuals from the EHR based on the following inclusion criteria: 1) seen in any mental health service between January 1, 2017 – December 31, 2019; 2) age as of first date of service during the study period from January 1, 2017 – December 31, 2019: 12 yrs 0 days – 25 years 355 days; 3) psychotic disorder diagnosis documented January 1, 2017 – December 31, 2019. The eligible diagnoses were based on the psychotic disorder diagnoses accepted by the EP programs, standardized across counties (diagnosis list in Appendix IV). We requested service data for an extended period of time (January 1, 2013 – December 31,

2019) in order to determine that there was no psychotic disorder diagnosis more than two years prior to their index outpatient service during the active study period. The "index service date" was defined as the first outpatient (non-FSP, when possible) service associated with an eligible diagnosis during the active study period (January 1, 2017 – December 31, 2019)

The LHCN research team then applied the following exclusion criteria to the CG group, in accordance with EP program criteria, to identify a cohort most likely experiencing FEP: 1) diagnosis of intellectual disability; 2) psychotic disorder diagnosis more than 2 years prior to the index service date during the active study period (January 1, 2017 – December 31, 2019); 3) first outpatient service during the active study period was a Full Service Partnership (FSP) OR consumer received FSP service in the two years prior to study period.

Data Sources Included in Analysis

Prior reports described a proposed set of outcomes of interest as well as potential data sources for those outcomes and their associated costs. However, as anticipated, limitations in data availability and data quality resulted in modification of the previously described analytic approach in some areas. Table 4 represents the final set of outcomes used in this analysis. All outcomes and data sources included from the methodology proposed in prior reports, as well as any differences between the proposed analysis and current analysis, are described in this section. Descriptions apply to all counties, except as noted.

Table 15. Outcomes

Finalized Outcomes of Interest	Levels of Analysis
Outpatient Services	• Service type • Number of service units (minutes)
Day Services/Crisis Stabilization	• Number/proportion of individuals with crisis visits per group • Number of visits, per consumer, per month • Duration of visit (hours) • Total duration (hours) of all visits, per consumer, per month
24-hour Services: **Psychiatric inpatient hospitalization, Residential**	• Number/proportion of individuals hospitalized per group • Number of hospitalizations per consumer, per month • Duration of hospitalization (days) • Total duration of hospitalizations (days) per consumer, per month

Description of Included Data Sources

Demographic Data

Consumer demographics were obtained from the EHR system from each county, based on the date of the first EP program or outpatient CG program service, when possible. Table 5 shows dates of demographic data used, by county. Demographic data obtained for the analysis includes age, zip code, race and/or ethnicity, sex, gender identity, sexual orientation, language, education level, currently enrolled in school, employment status, marital status, living arrangement, military service/veteran status, and insurance status. In order to account for differences in how these demographics were coded across counties, we harmonized the variables before integrating them into a single dataset. For example, each county had variations in the way they collected race data for consumers, with some counties having collected more detailed information than others. To

accommodate for the varying levels of data collected and enable analysis across counties, a harmonized race variable was created with six main race categories: White, Black/African American, Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, and Other. Race data from each county was then re-coded to fit into one of these high-level categories (e.g. 'Korean' would be re-coded as 'Asian') to account for the counties with more limited race data. Details regarding when the demographic variables were originally entered into each county EHR system are shown in Table 16 (below), and which variables were available for each county are described in Table 17.

For this analysis, we required "baseline" demographic data, that is, demographics as of the index service date. Due to differences between counties in collection date of demographic data, as well as likelihood of that particular variable changing over time, the final demographic variables used in this analysis were age, sex, and race/ethnicity.

Table 16: Demographic Data – Dates Used

County	Date used for Demographic Data	
	EP	CG
Los Angeles County	Demographics at first date of service in the program	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)
San Diego County	Demographics collected at first date of service in the program	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)
Orange County	Demographics collected at first date of service in the program	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)
Solano County	Demographics at first date of service in the program but can be updated at any time	Demographics at first service during study period (Jan 1, 2017 - Dec 31, 2019)

Table 17: Demographic Data – Availability by County

Data Element	**Availability by County**	**Additional Details**
Year and month of birth (not date)	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	Year and month of birth was not available in the LA CG dataset, but rather, age at first service during the active study period.
Zip code	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	LA provided 9-digit zip code; last 4 digits were removed to be consistent with 5-digit format of other counties.
Race	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	LA collects race and ethnicity data as a combined variable and had to be re-coded into separate variables for harmonization across counties; endorsements of ethnicity only were re-coded as "unknown" for the harmonized race variable. "Multi" category for LA has been rolled up into "other" for harmonized race variable.

Ethnicity	SD - yes	
	OC - yes	2 items - Hispanic ethnicity and self-reported primary and secondary ethnicity
	Solano - yes	
	LA - yes	LA collects race and ethnicity data as a combined variable and had to be re-coded into separate variables for harmonization across counties.
Education level (highest level obtained)	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
Education level (currently enrolled)	SD – yes	No "current education" variable across counties so variable was created using employment status variable (those who endorsed 'student' were coded as being currently enrolled in education)
	OC – no	
	Solano – yes	No "current education" variable across counties so variable was created using employment status variable (those who endorsed student were coded as being currently enrolled in education)
	LA – yes	No "current education" variable across counties so variable was created using employment status variable (those who endorsed student were coded as being currently enrolled in education)
Marital status	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
Primary language	SD - yes	
	OC - yes	
	Solano - yes	
	LA - yes	
Insurance status (i.e., insurance type)	SD - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance.
	OC - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance.
	Solano - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance.
	LA - yes	Three separate harmonized insurance variables were created: 1) Medi-Cal, 2) Medicare, 3) Private insurance. We used the Medi-Cal claim variable from the LA EP services; this was not available for the LA CG datasets.
Employment status	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
	SD - yes	

Living arrangement (housing status)	OC - yes	
	Solano - yes	
	LA - no	Data not available for EP group, included in CG data only.
Sex	SD - yes	
	OC - **no**	
	Solano - yes	
	LA - yes	
Gender identity	SD - yes	
	OC - yes	Variable for gender only, not gender identity. No trans category; only Male and Female. Therefore, some individuals in Male or Female category may be Transgender.
	Solano - yes	
	LA - **no**	
Sexual orientation	SD - yes	Intersex and transgender have been placed in the 'unknown' category as these are not sexual orientations. Deferred has been placed in prefer not to answer.
	OC - yes	
	Solano - yes	
	LA - **no**	
Military service / Veteran status	SD - yes	Indicates some affiliation with the military, does not necessarily indicate military status (e.g. Consumer self-reports that they or an immediate family member have served in the US Military).
	OC - yes	Indicates some affiliation with the military, does not necessarily indicate military status (e.g. Consumer self-reports that they or an immediate family member have served in the US Military).
	Solano - yes	Indicates some affiliation with the military, does not necessarily indicate military status (e.g. Consumer self-reports that they or an immediate family member have served in the US Military).
	LA - **no**	

Psychiatric Diagnoses

Baseline psychiatric diagnoses were obtained from the EHR systems for each county. They were selected as either the first diagnoses within the first 90 days a consumer was served after the index service date or the latest diagnosis before the index service date if no post-90-day diagnosis was found. Index diagnoses for FEP consumers in EP groups, and all CG group consumers were defined as either a primary psychotic disorder diagnosis or mood disorder with psychotic features, with other diagnoses possible for CHR consumers in EP groups (e.g. PTSD, anxiety disorders, autism), using an algorithm described in Appendix IV. As noted previously, classification of FEP and CHR were obtained from the EP programs. Service Dates

As described previously, we defined the index service date for individuals in the EP group as the first date of service at the EP program within the study period (January 1, 2017 – December 31, 2019). The index service date for individuals in the CG group was defined as the first date of outpatient service (non-FSP, when possible) associated with an eligible diagnosis within the study period (January 1, 2017 – December 31, 2019). The "last service date" was defined as the end of the episode of care related to the index service date. If the

episode of care start or end date was outside the active study period, the first or last service within the study period was used, respectively. The “duration of enrollment” was calculated as months between index and last service dates.

A unique feature of EP programs is their limited duration: most programs offer services for a maximum period of approximately 2 years. This focus on early intervention supports transitioning consumers to other services after a specific period of time and/or after treatment goals are met. It also allows new consumers to enter the program as others leave. General outpatient services have no limits on duration of treatment. Therefore, our analyses focus on the first 24 months of treatment for both groups. To account for variation in intensity of services and attrition over time, we defined service periods as index service date to 6 months, 7-12 months, 13-18 months, 19-24 months and 25 months+ (until last service date).

Outpatient Service Data
All contacts related to outpatient mental health services are recorded as part of the reimbursement process via service billing in each county. Clinical staff input all billable and non-billable services into the EHR systems through an electronic progress note that includes the date of service, type of service provided (defined by each county), and the time spent providing the service.

Billable service types examined include: Assessment, Case Management, Collateral, Crisis Intervention, Group Therapy, Individual Therapy, Medication Management, Plan Development, Rehabilitation, Supported Education and Employment services, Therapeutic Behavioral Services, Occupational Therapy, Peer Support, Administrative, Outreach, and Forensic, Lock Out, and Travel/Transportation.

Non-billable services were also compared as work conducted and no-show rates as indicators of engagement (see descriptions of all services in Appendix VI). Availability of service categories by county are detailed in Table 18.

Day Services/Crisis Stabilization Data
Individuals experiencing mental health exacerbation often receive treatment in mental health urgent care or crisis stabilization facilities, which are intended to resolve the mental health crisis and attempt to prevent hospitalization. All Day Services (under 24 hours) and Crisis Stabilization data utilized in the analysis includes: Crisis Stabilization, Day Treatment, and Day Rehabilitation. Data elements used in the analysis include: number of visits per individual in the sample, date of visit, and length of stay (hours).

24-Hour Services/Inpatient Psychiatric Hospitalization Data
Individuals experiencing more severe mental health exacerbation often receive treatment in inpatient psychiatric hospital settings. This includes California Welfare and Institutions Code §5150/§5585 72-hour involuntary psychiatric holds for adults and minors, respectively, and §5250 14-day involuntary psychiatric holds, the duration of which can vary depending on the severity of the individual’s needs, as well as all voluntary stays. All 24-hour services used in this analysis include: Inpatient Hospitalization, Residential Other, and Crisis Residential. We were able to obtain non-comprehensive services data from some private hospitals that bill the county, with the exception of Orange County, which submitted cost data for regional inpatient hospitalization. For 24-hour service data, data elements include number of visits per individual in the sample, dates of hospitalization, and length of stay.

Details regarding which services were available by county are shown in Table 7 below.

Table 18: Availability of services data by county

Broad Service Category	Service Subcategory	Los Angeles	San Diego	Orange	Solano

Outpatient Services (Mode 15)	Assessment	yes	yes	yes	yes
	Case Management	yes	yes	yes	yes
	Collateral	yes	yes	yes	yes
	Crisis Intervention	yes	yes	yes	yes
	Group Therapy	yes	yes	yes	yes
	Individual Therapy	yes	yes	yes	yes
	Medication Management	yes	yes	yes	yes
	Plan Development	yes	yes	**no**	yes
	Rehabilitation	yes	yes	yes	yes
	Supported Education and Employment	yes	**no**	**no**	**no**
	Therapeutic Behavioral Services	yes	**no**	yes	yes
	Occupational Therapy	**no**	**no**	**no**	**no**
	Peer Support	**no**	**no**	**no**	**no**
	Administrative	**no**	yes	yes	yes
	Outreach	**no**	yes	**no**	**no**
	Forensic Services	**no**	yes	**no**	**no**
	No Show	**no**	**no**	**no**	yes
	Lock Out Code	**no**	**no**	**no**	yes
	Transportation	**no**	yes	yes	yes
	Intensive Home-Based Services	yes	yes	yes	yes
	ECT	**no**	yes	**no**	**no**
	Outpatient – other	yes	**no**	**no**	**no**
Day Services (Mode 10)	Crisis Stabilization	**no**	yes	yes	yes
	Urgent Care	**no**	**no**	**no**	**no**
	Day Treatment	yes	yes	**no**	yes
	Day Rehabilitation	**no**	yes	**no**	**no**
	Day Services - other	yes	**no**	**no**	**no**
24-hour Services (Mode 5)	Inpatient Hospital	yes	yes	yes	**no**
	Residential Other	**no**	**no**	yes	yes
	Residential Rehabilitation	**no**	**no**	**no**	**no**
	Skilled Nursing Facility (SNF)	**no**	**no**	**no**	**no**
	Crisis Residential	**no**	yes	yes	yes

Other Mental Health Services

Other mental health services include Substance Use Services for Orange County, and any services that had insufficient information to classify into one of the other three categories. For example, some outpatient services provided by private organizations used codes indicating “Other mental health service” and a provider name. However, there were very few of these, and their impact on the analyses would be negligible. We will explore further during the next project period to see if we can resolve and services in this category.

Description of Unavailable Data Sources

Justice system and Regional Center services were unavailable for all counties. With the exception of Orange County, substance use services could not be obtained, as these records are kept separately from mental health services for privacy protection and require additional data use permissions.

Many consumers have hospital stays in private psychiatric hospitals both within and outside of their county of residence. Some counties track this data in separate databases, but we were unable to obtain and integrate this separate data for the current analysis. Furthermore, due to lack of available psychiatric inpatient beds across California, particularly for children, many consumers are placed out of county and require transportation over extensive distances that may not be adequately captured in our data.

Although the majority of EP consumers are publicly insured (e.g., Medi-Cal), San Diego Kickstart and Solano Aldea SOAR utilize MHSA, insurance contracts, and/or philanthropic funds to serve privately insured consumers. Some of these services are not billed to county systems, therefore, they are not represented in our data. Furthermore, services provided to privately insured consumers by other private providers (e.g., Kaiser Psychiatry) are not represented.

Table 7 summarizes individual subcategories of services that were unavailable for specific counties. This was due to either 1) lack of a specific type of service in that county; 2) service data being unable to specifically denote that service; 3) data for those services needing to be obtained separately and we could not yet do so, or 4) certain non-billed services not being tracked.

Statistical Methods

Multi-County Analysis
After harmonizing the demographics, diagnoses, and service types across all four counties, as well as EP and CG groups, the data were merged into a single dataset for our primary analyses. This combined, multi-county dataset provided increased statistical power, allowing for a richer set of controls and error structure without compromising efficiency.

Analysis of Sample Characteristics
Student T-tests and Pearson Chi-square (or Fisher's exact) tests were used to compare unadjusted group differences in demographic characteristics (e.g., age, sex, race, ethnicity, etc.) between the individuals in the EP and CG groups. Both unadjusted and adjusted analyses were used to examine group differences in clinical characteristics at time of index service such as primary diagnosis, as well as the duration of enrollment.

Analysis of Outpatient Service, Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data
All service data outcomes were analyzed with a simple empirical equation: the independent variable is regressed on a county-specific fixed effect, an epoch-specific fixed effect, an indicator taking 1 for the EP group and 0 otherwise, a set of interactions between the EP group indicator and each epoch allowing the effect of the EP program to vary over time, and a set of individual-specific controls - measured at intake - consisting of sex, ethnicity, race, and primary language. We used all demographic variables that were available and harmonized across all counties in time for this preliminary analysis. Standard errors were always clustered at the individual-level because repeated measures of the same outcome for the same individual are correlated, and we are interested in describing individual-level differences. Further processing of the data will allow the addition of other individual-specific controls and clinic-specific effects to the empirical equation to account for other sources of confounding variation. These will be included in future analyses.

Total outpatient service time (in minutes) of all outpatient services and total minutes of each service type (e.g., medication management, individual therapy, group therapy, rehab services) were analyzed by estimating the

empirical equation described above with negative binomial regression for count data to determine if outpatient service use differs between the EP and CG samples.

Data related to individuals' use of Day Service/Crisis Stabilization, and 24-Hour/ Inpatient Psychiatric Hospitalization Data usage were examined using multiple measurements based on the study period: 1) a binary indicator for whether the individual had ever been hospitalized; 2) a binary indicator for whether the individual had ever utilized crisis services; 3) number of hospitalizations per month; 4) number of crisis visits per month; and 5) mean duration of hospitalizations (i.e., length of stay [LOS]) in days; 6) mean LOS for Day/Crisis services (hours); 7) total duration of hospitalizations per month; and 8) total duration of Day/crisis services per month. Data for (1) and (2) were analyzed by estimating the empirical equation described above with multiple logistic regression. Data for (3), (4), (7), and (8) were analyzed by estimating the empirical equation described above with negative binomial regression for count data. Data for (5) and (6) were analyzed by estimating the empirical equation described above with linear regression. These various methods allowed us to determine whether each respective outcome differed between the EP and CG samples.

Results

The final cohort includes a sample of 506 individuals served by EP programs and 17,092 individuals from the CG group.

Clinical and Demographic Characteristics

Table 10 (Appendix V) summarizes baseline diagnostic and demographic information for the individuals from the EP and CG cohorts.

The EP sample had an average age of 17.0 years (standard deviation [SD] = 3.1 years), 59% of whom identified as male. Of those receiving treatment in the CG group, the mean age was 20.1 (SD=3.8 years), and 61% of them identified as male. The average age of CG individuals was significantly older than the average age of EP individuals in this sample (p<.001). No statistical difference in the distribution of sex was found.

The EP group included a significantly higher number of individuals who identified as Hispanic/Latino (56%) compared to the proportion of individuals from the CG clinics (44%, p<.001). In addition, a higher percentage of EP individuals identified as Caucasian (27%) compared to CG individuals (17%). However, a majority of CG individuals reported Unknown race (54%).

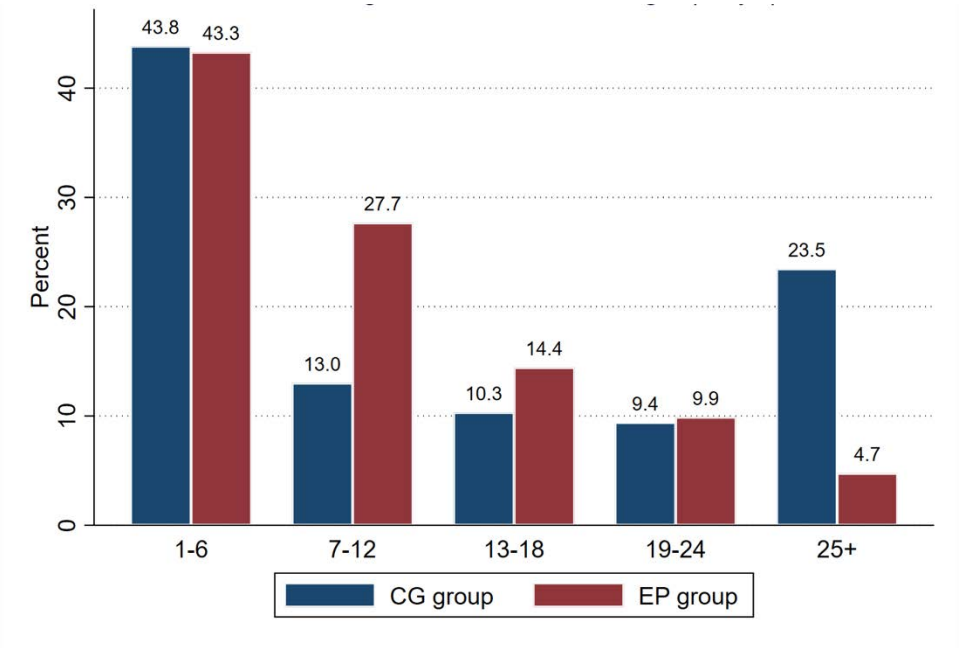
A higher proportion of individuals in the EP group had a Psychosis Spectrum disorder as the primary index diagnostic category compared to the CG group (EP Group: 80%; CG Group: 61%, p<.001). For both groups, Mood Spectrum disorders represented a smaller proportion of the primary diagnoses (EP Group: 6%; CG Group: 21%).

Service Utilization Characteristics

Duration of Enrollment

On average, individuals receiving treatment in both groups tended to remain in treatment for roughly one year (EP group: 11.1 months [SD=9.1], CG group: 12.2 months [SD=12.3]), but average duration of treatment was significantly higher for CG individuals (p<.05).

Figure 20. Percentage of consumers ending treatment within each time period



As shown in Figure 20, a roughly equal proportion of EP and CG individuals ended treatment within the first 6 months (43% and 44%, respectively). A greater proportion of EP individuals ended treatment between 7 and 12 months compared to CG consumers (28% vs. 13%, respectively). However, compared to EP individuals, a larger proportion of CG individuals ended treatment after they had received over 25 months of services (5% vs. 24%, respectively). For more information on differences in enrollment, see Appendix V – Table 20.

Outpatient Service Use

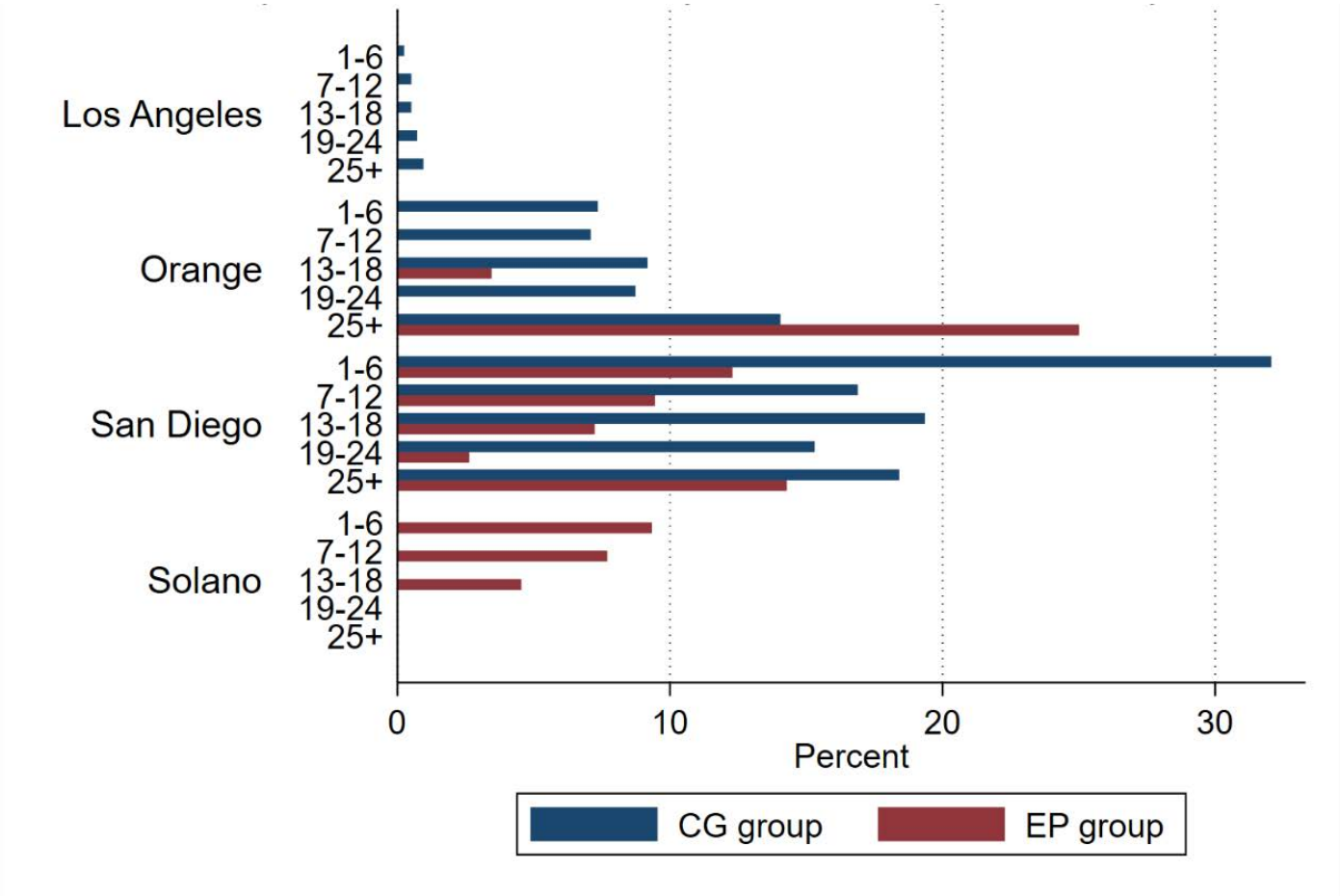
The EP and CG clinics offered similar types of outpatient services, including assessment, case management, collateral, crisis intervention, group therapy, individual therapy, medication support, plan development, and rehabilitation (see Appendix VI Service Code Definitions for descriptions of these services).

In examining the total minutes of outpatient services provided to individuals per month, those served in the EP group received significantly more minutes of service across all time points compared to the CG group ($p<.001$, see Appendix V – Tables 21A and 21B). When specific services are examined individually, the greatest difference is observed between groups in minutes of collateral, per person, per month (EP group: 140 minutes; CG group: 66 minutes) and individual therapy (EP group: 239 minutes; CG group: 188 minutes) per person.

Day Services

The use of day services was rare for both groups, as only 2.0% of EP and 4.7% of CG individuals received these services while enrolled in EP or general outpatient treatment (see Appendix V – Table 22). Calculated as the proportion of individuals with one or more visits, use of day services was greater in the CG group across all time points ($p<.001$). Further, the rate of day service visits was the highest among individuals that had been enrolled in treatment for 25 months or more (EP group: 3.3%; CG group: 5.7%, see Figure 21).

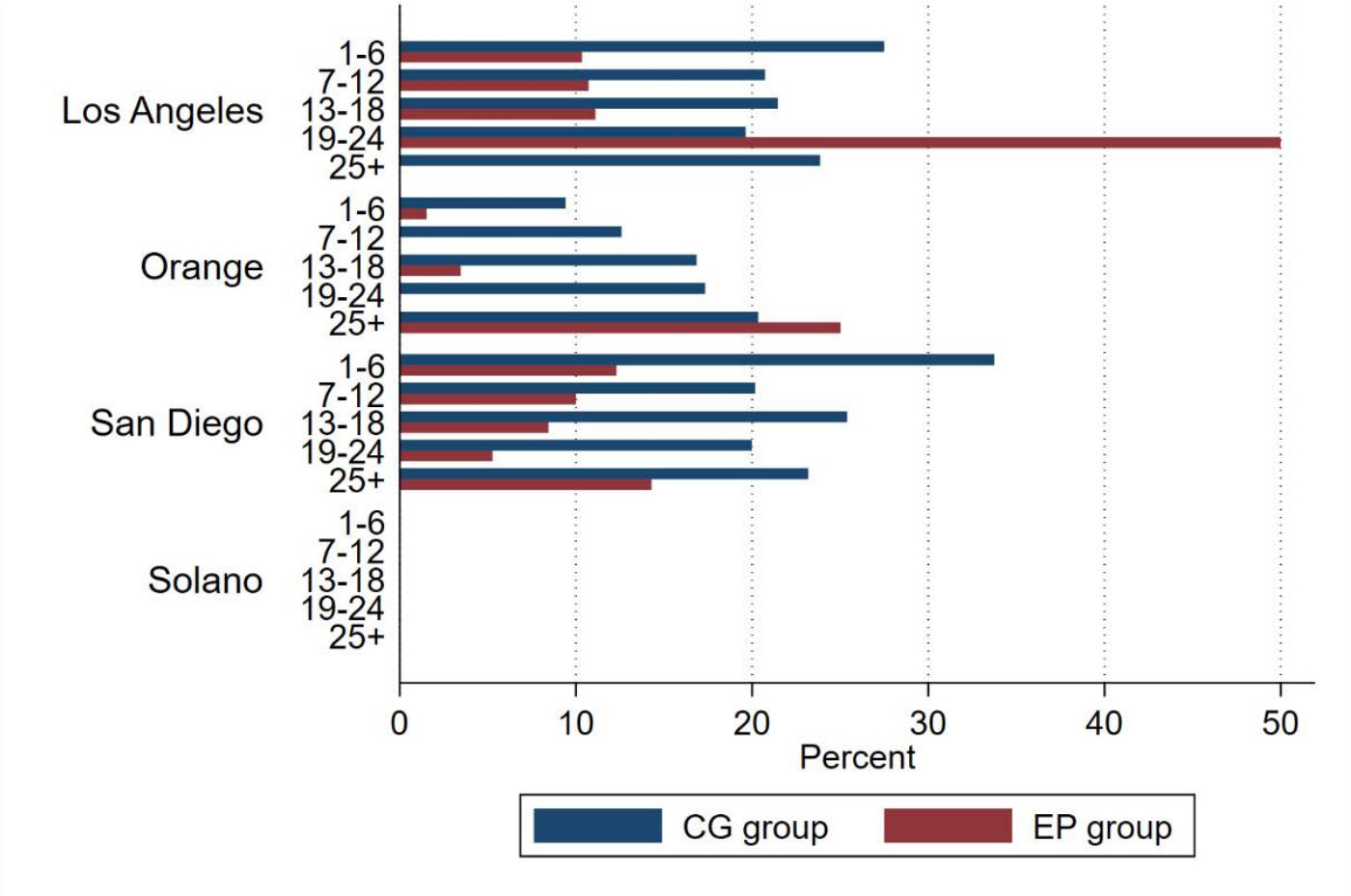
Figure 21. Proportion of consumers with at least one day service visit by time period by county



24-Hour Services/Inpatient Psychiatric Hospitalization Data

A significantly greater proportion of CG individuals experienced at least one 24-hour service or inpatient hospitalization during their enrollment compared to EP individuals (22.4% vs. 8.9%, $p<.001$; see Appendix V – Table 23). As shown in Figure 12, 24-hour services occurred most frequently during the first 6 months of treatment (EP group: 9.4%; CG group: 24.8%) and after 25 months of treatment (EP group: 17.0%; CG group: 23.7%), although we did not test these differences statistically. As noted previously, this data was unavailable for Solano County.

Figure 22. Proportion of consumers with at least one 24-hour service by time period by county



NOTE: Data not available for Solano County

Summary

Across all time periods, the total minutes of outpatient services per month was higher among EP individuals compared to CG individuals. However, the proportion of individuals in the EP group with one or more day services and/or 24-hour services/ inpatient hospitalizations was lower compared to the CG group.

Interpretations

Regarding duration of enrollment in treatment, the EP and CG groups are generally similar, with more EP consumers receiving 7-12 months of service, and the CG group having a substantial proportion of consumers who received longer-term treatment (25+ months), past the standard end-point of EP treatment at 24 months. In both groups, nearly half of the consumers received services for less than 6 months, which may represent challenges in engagement with this population, as well as the mobility of TAY youth, who may also have received services elsewhere.

The groups were both predominantly male, as is often typical in early psychosis clinical samples. There was a slightly older average age in the CG group, and more Hispanic/Latino consumers and Caucasian consumers in the EP group. This may reflect the focus of programs on outreach and staffing availability predominantly in English and Spanish. They identified as predominantly heterosexual across both groups. The results of this preliminary analysis are consistent with the intent of EP programs- to offer more intensive and evidence-based outpatient services in order to reduce the need for higher levels of care and to promote recovery. This is evident in the higher overall outpatient minutes for the EP group. Greater time spent in individual therapy likely

reflects the treatment models of the EP programs, which focus on CBT for psychosis or other similar forms of therapy. EP programs make a concerted effort to involve families of these transition age youth, reflected in the results of more collateral services than the CG group.

Similarly, the significantly greater proportion of CG individuals who had inpatient hospitalizations during the study period may demonstrate the effectiveness of early intervention in reducing hospitalization rates. Day services were so rare in both groups that we only analyzed the proportion of individuals with at least one service. Overall, these group differences are quite promising, although at this time, we cannot rule out differences in severity and needs between the EP and CG groups at baseline that could partly or fully explain the service utilization differences. As noted previously, access to hospitalization data may have been limited (e.g., by treatment outside county); however, these issues should have affected the EP and CG groups in a county similarly.

Limitations and Future Analyses

The primary goal of the current deliverable was to demonstrate the availability of service utilization and cost data that can be accessed and integrated across counties. Through this process, we identified a number of issues that require additional clarification for the final analysis. We will focus on these issues during the next project period:

Defining CG consumers

Identifying an equivalent comparison group relies upon identifying similar individuals to EP consumers. Given the lack of the CHR syndrome as a formal DSM or ICD diagnosis, we are unable to identify CHRs for comparison. Restricting our analysis to “first episode” psychosis, we were able to exclude CG individuals with recorded psychotic disorder diagnoses for more than 2 years prior to out active service period (the most common eligibility requirement for the EP programs). However, this does not rule out individuals who had psychosis but were not accurately diagnosed as such in health records. Due to factors such as the complexity of early psychosis diagnoses, lack of information about symptoms over time, and provider hesitance related to stigma about psychosis and serious mental illness, FEP consumers are often only diagnosed with a psychotic disorder in records after a substantial period of time with psychosis. Less stigmatizing disorders such as bipolar disorder, or those that represent only current symptoms, such as substance-induced psychosis are often used instead. Further, consumers who recently entered the county system, but were treated for psychosis outside the county prior to the service period, may not be appropriately excluded. Finally, as we explore comparisons of baseline characteristics of EP and CG consumers, we may use propensity score matching or a similar method in our final analysis.

Defining CG services

We attempted to compare services in specialized EP programs to usual outpatient care, or “treatment as usual.” These services vary greatly across counties and across child and adult systems of care, so that we may have inadvertently included other specialized programs that offer more intensive services as well. Finally, consumers were not randomized to treatment, so there may be systematic biases that influence whether consumers received services at the EP program or elsewhere that we cannot see in the data we obtained. We excluded CG consumers who were treated in FSPs for this reason, but we were only able to accurately identify all FSP programs in our data in San Diego and Orange Counties. This will be a focus of our work during the next project period.

Inpatient services

Our preliminary analysis only includes inpatient data for county hospitals and some private hospitals that bill the counties. Some counties maintain separate databases of inpatient hospitalizations, which we expect to receive in time for the final analysis.

Private insurance services
Some EP programs serve all residents of the county, regardless of insurance. This may include individuals who have private insurance, and therefore services outside the EP program would be within a private insurance or HMO network, which cannot be included in these data. We will work with programs and counties to make sure we are accurately identifying these individuals and may need to exclude them form the final analysis.

Non-billable services
In future analyses, we plan to analyze no-show and cancellation rates as measures of treatment engagement.

Missing service categories
Although there were very few services that could not be categorized, we will follow up to obtain additional information about either subcategories for which we have no services in a county or specific services that lack sufficient detail. We will also investigate additional sources of data to determine whether more day services and 24 hour services can be integrated into our dataset. We may limit the analysis where there remain discrepancies in availability of specific service types by county or by group.

Demographic factors
Due to time constraints, we were only able to fully harmonize and analyze a subset of demographic variables. For the next deliverable, we will examine the relationship of more demographic factors to our outcomes, including: sexual orientation, language, education level, employment status, marital status, housing status, military service/veteran status, foster care status, insurance status and zip code. We will also determine which values represent true "baseline" characteristics, and which may be outcomes, recorded at later time points in treatment.

Fiscal year
In the next period we will explore fiscal year as a factor impacting outcomes, given changes over time in both service categorization and reimbursement.

Description of Sources of Cost Data
The costs associated with each service type were requested from each county. For the purposes of this report, we will describe the cost data obtained thus far. Comparison of costs associated with service utilization in the EP and CG groups will be analyzed once all cost data have been received by the study team. Potential sources of cost data were identified for specific service types, as described in Table 9, below.

Table 9. Sources of Cost Data by Service Type

Service Type	Included Sources of Cost Data
Outpatient	Contract service unit rates
Day/Crisis Stabilization	Hourly rate paid by County
24-hour: Inpatient, Residential	Daily rate paid by County Daily rate Medi-Cal reimbursement Harmonized Average Statewide Rate

Los Angeles and Orange County were able to submit their cost data to the study team prior to the completion of this report. San Diego County provided several tables of cost rates for services; however, after review of the

submitted data, a revised cost data request was sent to the county seeking final costs attached to each service. Because final cost data from San Diego County are still pending, the present report describes the data sources that were received. Solano County also experienced delays in obtaining and submitting their cost data. Delays included more complex data sources and lack of IT support staff available to the county data analysts to be able to pull the requested data. Final details of specific cost data sources for San Diego and Solano County will also be included in the next deliverable.

Los Angeles County
Outpatient Service Use: Los Angeles County costs rates were attached to each service and included all service types. For outpatient services each cost rate was the total cost of the service and the service unit (recorded in minutes).

Day Services/Crisis Stabilization Data: Costs related to day services included total cost of the service and the service unit (recorded in minutes).

24-Hour Services/Inpatient Psychiatric Hospitalization Data: Costs related to 24-hour services include inpatient county hospitals, Fee-for-Service hospitals and County contracted providers. These costs include total cost of the service and cost per service unit (recorded in days).

Orange County

Outpatient Service Use: Costs related to outpatient service use were based on contract service rates. Each outpatient service included a service unit rate and number of service units (in minutes).

Day Services/Crisis Stabilization Data: Costs related to day services/crisis stabilization were based on contract service rates which included a service unit rate and number of service units (in minutes).

24-Hour Services/Inpatient Psychiatric Hospitalization Data: Costs related to 24-hour services were day rates which varied by contract. Inpatient/hospital stays include negotiated bed day rate for each HCA contracted acute inpatient facility. These rates are different from the general regional rates set by DHCS. Skilled Nursing Facility (SNF)/IMD rates were averaged and include a bed day rate. Crisis Residential rates include a day rate and charge for the medical services by the minute.

San Diego County
Outpatient Service Use: County interim cost rates for outpatient services per service unit (15 minutes, bill in one-minute increments). Published reimbursable cost rates and actual reimbursable cost rates for EP community services, including case management, mental health services, medication support, and crisis intervention.

Day Services/Crisis Stabilization Data: County interim rates for day services/crisis stabilization per service unit (in hours).

24-Hour Services/Inpatient Psychiatric Hospitalization Data: County interim rates per service unit (in days) for inpatient/hospital stays, crisis residential, and therapeutic foster care. Contracted inpatient hospital rates for adult and adolescent services, effective February 1, 2020. Regional rate, effective July 1, 2021, for non-contracted inpatient hospitals.

Statewide Sources of Cost Data
Across California, psychiatric inpatient beds are often unavailable, particularly for minors. Patients are placed at both county-run and private hospitals, in or out of county. Each county negotiates different day rates with each hospital. Due to this variability, we will use multiple sources of data to develop averaged rates statewide.

We will apply these cost rates to inpatient service utilization for both the EP and CG groups, across counties. Once we are able to review the day rates for residential services in each county, we may use the same harmonization method.

Discussion and Next Steps

Discussion

Over this last FY, the team has continued to work hard to meet each of the goals that were set to out for the project period. It should be noted that the LHCN represents one of the first collaborative university-county partnerships between the University of California, Davis, San Diego and San Francisco with multiple California counties to implement and expand an integrated Innovation project. Through this endeavor, all parties hope to have a larger impact on mental health services than any one county can create on their own. While the project has experienced some delays and many barriers due to the global COVID-19 pandemic, we are confident that we are making excellent progress at meeting our goals and catching up with the original planned timeline.

We have completed Beehive training with all of the original LHCN counties and are in the midst of training our newest LHCN county program, Stanislaus LIFE Path. We are continuing to collect data on the core outcomes battery for the EPI-CAL project with 18 programs. Based on feedback from users in these programs, we have continued to work with Beehive developers to make modifications to the application, such as extending survey windows, as well as modify our training approach based on constructive feedback from programs.

We have completed several fidelity assessments, and plan to complete those for all of our programs within the next few months. The next annual report will summarize the results from all participating programs.

As noted previously, we were able to successfully complete our primary goal for the retrospective county data analysis, to provide a preliminary demonstration of the proposed method for accessing data regarding EP programs and CG groups across California, and the first part of our secondary goal, to analyze service utilization and costs associated with those services across counties. However, we are still gathering additional data to inform a final analysis of the 2017-2019 period, which we expect to complete by December 2022.

While we were not able to integrate the cost data for all counties, we have described our cost analysis for San Diego County in section 9 above. We have obtained some cost data and are working with our county partners to obtain the remaining information. We are confident that the cost comparison analysis will be completed for the December 2022 deliverable.

Next Steps

In the next project period, we will continue to conduct fidelity assessments with EPI-CAL programs and meet with county and program leadership to provide detailed feedback on fidelity results. We will also continue and complete training of EP programs from both the LHCN and larger EPI-CAL network, especially as new programs join. As implementation of Beehive continues, we will elicit feedback from EP programs how to improve both the training process and Beehive itself via feedback surveys, regular check-ins from point people, and qualitative interviews. Our goal is to continue to improve Beehive in an iterative process and to incorporate community partner feedback so that Beehive be a useful data collection and visualization tool for the programs using it. We are also working with sites to understand why enrollments are not matching the original projections and to support them to increase the degree to which they are integrating Beehive into their standard practice.

Over the next project period, the LHCN team expects to receive and review data for both EP program and CG consumers and their service utilization data from Napa and Stanislaus counties for the retrospective data period January 1st, 2017 – December 31st, 2019. Upon receiving the data, we will review the submitted datasets and problem-solve with counties regarding any missing data elements, particularly other mental

health services received by EP program consumers, which may need to be retrieved from different sources. We will harmonize these data with the prior counties' and integrate them into the final dataset. We will also be requesting all related cost data for the services received by consumers in the EP programs and CG groups from Napa and Stanislaus counties.

In addition, for all counties participating in the county data component of the LHCN, meetings will be scheduled over the next several months with each county to review the details of the EP and CG retrospective data pulls, the cost data, and to problem-solve any issues that arise. We will then conduct the statistical analyses for individual counties and across the integrated dataset. In anticipation of the prospective data analysis, we have met with each county to discuss the timeline for obtaining their data and details of what will be included in the data pull. We will submit the formal data extraction requests in writing in July 2022, after we complete meetings with all relevant parties.

Another major goal of the next project period is to develop the final analysis plan for all LHCN data, with a particular focus on the consumer outcomes data collected via Beehive. This will integrate results from the fidelity assessments.

Appendix I: Intake Workflow Meeting Template

Our goal for this meeting: understand your intake workflow to help make transition to using Beehive at intakes smoother. Today we are focusing on how to integrate Beehive into your workflow, but remember (once Beehive is approved for use), you can also register existing consumers.

Questions

a. Current Intake process
    i. What is program's general intake workflow?
        1. Do you do phone screenings before scheduling an intake? (review template of phone screen to compare with Beehive registration fields)
        2. Do you currently have consumers complete surveys/paperwork with the intake appointment?
            i. Treatment consent, research consent, ROIs?
            ii. How are surveys administered?
            iii. When surveys they sent (e.g., prior to intake date, morning of intake date)?
        3. At what stage in the process do you register consumers into the Electronic Health Record
        4. How do you complete assessments or other paperwork for people who are in need of interpretive services?
b. Integration of Beehive
    i. At what stage in the workflow would Beehive registration fit best?/When would you register consumers into Beehive (takes about 15 minutes)
        1. In advance (Web app)? Is all of the information in registration already gathered? (see phone screen)
        2. Day of (tablet)?
    ii. Which staff member(s) will complete registration?
    iii. When would consumer complete the intake surveys (EPI-CAL battery takes about 45 minutes)?
        1. Do clinicians plan to use survey data as part of their intake assessment?
        2. Consider prioritization of surveys required for intake assessment
    iv. Which staff member(s) will orient consumer to EULA/surveys on intake day?

(As needed) demonstration of registration process

Appendix II: Data-Entry Workflow Meeting

1. **Questions to Understand Current Clinic Data** *(can skip if already asked at Intake Workflow meeting)*

    2. Is clinic already using a data-entry platform?
        i. If so what? (excel, EMR, redcap, in-house platform (ex. MHOMS)
        ii. Who designs the surveys on that platform?
        iii. Do you first enter data on a CRF prior to entry in this system?
    3. What roles on team currently complete data-entry? (QM, Clinic Coordinator, Clinicians)
    4. How do you access/view data after it is entered?
    5. Does your program have dedicated staff to analyze data?

2. **Questions about Integration of Beehive for Survey Completion**

    a. Who will be responsible for each of these items (one person? Each clinician for their caseload? Leadership?):
        i. Following up with consumers about completing their surveys?
        ii. Entering clinician-entered data for each consumer?
        iii. Monitoring urgent clinical issues? (our recommendation is that each clinician monitors their caseload)
    b. What level of support do you want with tracking survey completion (consumers & clinicians) and urgent clinical issues?
    c. Are there other surveys that your clinic wants to collect through Beehive?
        i. Standardized measures that are already built in: PSC-35, CATS-Guardian report
        ii. Other measures can also be entered-- our team needs to review first to ensure that we can design the surveys in Beehive
    d. Who is assessing COMPASS & GFS/GFR? Who is monitoring ACES to determine if additional survey should be assigned?
        i. We will want to make sure that they have completed the trainings for these trainings

Demonstration on how to access clinician-entered data, view survey status page (for consumer & PSP) as necessary

Appendix III: Beehive Part 3 Training Small-Group Worksheet

Beehive Part 3 Training Small Group

Identify a group note-taker and a person who will report back to the larger group

Survey 1 *(Identify a member of your group to screen share survey 1)*

1. Find one of the 3 measures we have introduced to you in trainings: **Modified Colorado Symptom Index** (MCSI), **Questionnaire on the Process of Recovery** (QPR), or **SCORE Index of Family Functioning and Change** (SCORE-15). Next answer the following questions about that survey:
    a. What is the global score?
    b. Is there a clinical threshold?
    c. Is there score severity shading? In which direction? What does that mean?
    d. Is the global score above or below the threshold? What does that mean?
    e. Which is the highest rated individual item(s)? What does that mean?
    f. Which is the lowest rated individual item(s)? What does that mean?

-
2. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?
    c. What questions do you have after viewing these surveys?

Survey 2-3 *(Identify a new member of your group to screen share survey(s) 2-3)*

3. Reference the Table of Contents for the EPI-CAL battery (next page). Find one to two additional surveys that you are interested in or that might answer the questions you have from the first survey.
    a. Is there a global score? (i.e. is this survey visualized?). If yes,
        i. Is there a clinical threshold?
        ii. Is there score severity shading? In which direction? What does that mean?
        iii. Is the global score above or below the threshold? What does that mean?
        iv. Which is the highest rated individual item(s)? What does that mean?
        v. Which is the lowest rated individual item(s)? What does that mean?
    b. If there is no visualization, remember you can view the survey responses by clicking the "survey results" button at the top left of the page

-
4. Discussion Questions
    a. How might you use this information in care?
    b. Are the survey responses consistent with your knowledge of the consumer's experiences?

-
- Additional Discussion Questions
5. Does either survey help you understand the other survey better?
6. Think about the different roles in the clinic and how they might use this data differently
    a. How might a family advocate or peer partner use this information compared to a clinician?
    b. How might a prescriber use this information compared to a case manager?

Appendix IV. Algorithm Used to Determine Index FEP Diagnoses

1. If present, the psychotic disorders listed below will always be the index diagnosis:

    - F20.0 Paranoid schizophrenia (ICD 9: 295.12)
    - F20.3 Undifferentiated schizophrenia (ICD 9: 295.15)
    - F20.81 Schizophreniform disorder (ICD 9: 295.21)
    - F20.9 Schizophrenia (ICD 9: 295.23)
    - F22 Delusional disorders (ICD 9: 295.25)
    - F23 Brief psychotic disorder (ICD 9: 295.30)
    - F25.0 Schizoaffective disorder, bipolar type (ICD 9: 295.32)
    - F25.1 Schizoaffective disorder (ICD 9: 295.33)
    - F25.9 Schizoaffective disorder, unspecified (ICD 9: 295.35)
    - F28 Other psychotic disorder not due to a substance or known physiological condition (ICD 9: 295.40)
    - F29 Unspecified psychosis not due to a substance or known physiological condition (ICD 9: 295.41)

2. If no psychotic disorder is present, these mood disorders with psychotic features will be the index diagnosis

    - F31.64 Bipolar disorder, current episode mixed, severe, with psychotic features (ICD 9: 295.82)
    - F31.5 Bipolar disorder, current episode depressed, severe, with psychotic features (ICD 9: 295.73)
    - F31.2 Bipolar disorder, current episode manic severe with psychotic features (ICD 9: 295.64)
    - F33.3 Major depression with psychotic features (ICD 9: 296.20)
    - F32.3 Major depressive disorder, single episode, severe with psychotic features (ICD 9: 296.06)

Appendix V. Cost and Utilization Data From Preliminary Multi-County Integrated Evaluation

Demographic Characteristics

Table 18. Demographics of Individuals included in Analysis

	Early Psychosis (N=506)		Comparator Group (N=17,092)			
	n	%	n	%	X^2	p-value
Sex						
Male	300	59%	10,345	61%	2.04	0.564
Female	206	41%	6,672	39%		
Other	-	0%	46	<1%		
Unknown	-	0%	7	<1%		
Gender Identity						
Male	288	57%	9,783	60%	407.99	<.001
Female	185	37%	6,391	39%		
Transgender	3	<1%	61	<1%		
Other	10	2%	33	<1%		
Prefer not to Answer	2	<1%	11	<1%		
Unknown	15	3%	6	<1%		
Sexual Orientation						
Heterosexual	232	69%	2,624	68%	51.40	<.001
Gay/ Lesbian	9	3%	86	2%		
Bisexual	31	9%	109	3%		
Other	16	5%	116	3%		
Prefer not to Answer	17	5%	324	8%		
Unknown	32	9%	577	15%		
Ethnicity						
No - Not Hispanic/Latino	205	41%	9,426	55%	62.57	<.001
Yes - Hispanic/Latino	285	56%	7,507	44%		
Unknown	16	3%	153	1%		
Race						
White	137	27%	2,894	17%	356.83	<.001
Black/African American	67	13%	2,791	16%		
Asian	32	6%	627	4%		
American Indian/Native Alaskan	4	1%	114	1%		
Native Hawaiian/Other Pacific Islander	4	1%	114	1%		
Other	140	28%	1,328	8%		
Unknown	122	24%	9,208	54%		
Language						
English	448	89%	14,361	89%	1.42	.702
Spanish	47	9%	1,463	9%		

Other	8	2%	292	2%		
Unknown	1	<1%	93	1%		
Education level						
Grade K-4	-	0%	739	9%	92.67	<.001
Grade 5 (completed elementary school)	41	12%	982	12%		
Grade 8 (completed middle school)	209	58%	3,027	38%		
Grade 12 (completed high school)	48	13%	856	11%		
Some college	32	9%	1,196	15%		
Completed college	2	1%	67	1%		
Graduate degree	2	1%	51	1%		
Prefer not to Answer	-	0%	14	<1%		
Unknown	24	7%	1,039	13%		
Employment Status						
Employed full time	8	2%	163	2%	51.83	<.001
Employed part time	30	7%	234	3%		
Student	280	65%	4,776	57%		
Unemployed, seeking employment	17	4%	311	4%		
Unemployed, not seeking employment	40	9%	1,551	18%		
Other	32	7%	596	7%		
Unknown	27	6%	782	9%		
Marital Status						
Single/ never married	396	97%	7,663	90%	22.39	<.001
Married	-	0%	95	1%		
Other	-	0%	46	1%		
Unknown	12	3%	698	8%		
Living Arrangement						
House/ apartment (No support required)	289	78%	3,634	63%	125.37	<.001
House/ apartment (Support required)	56	15%	346	6%		
Foster care	2	1%	91	2%		
Residential treatment	4	1%	271	5%		
Inpatient psychiatric hospital	-	0%	7	<1%		
Homeless	8	2%	785	14%		
Jail/ prison/ correctional facility/ juvenile hall	-	0%	198	3%		
Other	3	1%	134	2%		
Unknown	11	3%	325	6%		
Military Service/Veteran Status						
No	403	99%	4,612	99%	2.02	.155
Yes	5	1%	29	1%		
Diagnosis Category						
Psychosis Spectrum	405	80%	10,346	61%	84.47	<.001

Mood Spectrum	30	6%	3,618	21%		
Other	69	14%	2,646	16%		
Unknown	2	<1%	482	3%		

Table 19. Age of Individuals included in Analysis

	Early Psychosis		Comparator Group				
	Mean	**SD**	**Mean**	**SD**	***t***	***df***	**p-value**
Age	17.0	3.1	20.1	3.8	18.41	17596	<.001

Table 20. Proportion of Individuals Ending Treatment within each Time Period

	Early Psychosis		Comparator Group			
	n	**%**	**n**	**%**	**X^2**	**p-value**
≤6 months	219	43%	7,493	44%	162.14	<.001
7 to 12 months	140	28%	2,221	13%		
13 to 18 months	73	14%	1,762	10%		
19 to 24 months	50	10%	1,606	9%		
>25 months	24	5%	4,010	24%		
Total	506	100%	17,092	100%		

Service Utilization Characteristics

Outpatient Service Use

Table 21A. Total Minutes of Outpatient Services per Individual per Month

	Early Psychosis		Comparator Group			
	Mean	**95% CI**	**Mean**	**95% CI**	***z***	***p*-value**
Total minutes of outpatient services (per month)	452	417 - 488	296	290 - 302	8.63	<.001

Table 21B. Total Minutes of Outpatient Services per Individual per Month by Time Period

	Early Psychosis		Comparator Group			
	Mean	**95% CI**	**Mean**	**95% CI**	***z***	***p*-value**
≤6 months	537	493 - 582	287	281 - 292	11.11	<.001
7 to 12 months	455	403 - 508	305	297 - 314	5.58	<.001
13 to 18 months	433	375 - 491	313	302 - 323	4.02	<.001
19 to 24 months	321	261 - 380	299	288 - 309	0.71	.48
>25 months	297	218 - 377	285	274 - 297	0.29	.77

Table 21C. Total Minutes of Outpatient Services per Individual per Month by Service Type and Time Period

		Early Psychosis		Comparator Group			
		Total Minutes of Service per Individual per Month		**Total Minutes of Service per Individual per Month**			
		Mean	**95% CI**	**Mean**	**95% CI**	***z***	***p*-value**
Service date from enrollment	**Service Type**						
<6 months	**Assessment**	90	82 - 97	69	68 - 70	5.51	<.01
	Case Management	89	72 - 106	81	77 - 84	0.93	.35
	Collateral	139	121 - 157	62	60 - 65	8.44	<.01
	Crisis Intervention	66	49 - 83	125	121 - 128	-6.79	<.01
	Group Therapy	75	60 - 89	95	84 - 106	-2.37	.02
	Individual Therapy	238	215 - 260	171	165 - 176	6.00	<.01
	Medication Support	73	67 - 79	64	62 - 65	3.08	<.01
	Plan Development	47	42 - 52	48	46 - 50	-0.30	.76
	Rehabilitation	98	84 - 113	66	59 - 73	4.14	<.01

7-12 months	**Assessment**	44	36 - 53	59	56 - 63	-3.55	<.01
	Case Management	93	68 - 119	100	95 - 106	-0.52	.61
	Collateral	157	132 - 182	72	68 - 75	6.64	<.01
	Crisis Intervention	64	35 - 93	92	86 - 98	-1.86	.06
	Group Therapy	64	51 - 78	110	96 - 124	-4.94	<.01
	Individual Therapy	258	225 - 291	201	193 - 209	3.39	<.01
	Medication Support	64	57 - 71	55	54 - 57	2.34	.02
	Plan Development	39	31 - 46	53	50 - 56	-3.56	<.01
	Rehabilitation	106	89 - 122	79	68 - 89	2.59	.01
13-18 months	**Assessment**	50	37 - 64	60	57 - 63	-1.40	.16
	Case Management	69	50 - 88	105	99 - 111	-3.60	<.01
	Collateral	137	110 - 164	70	66 - 74	4.82	<.01
	Crisis Intervention	89	34 - 144	92	86 - 98	-0.10	.92
	Group Therapy	63	40 - 86	129	106 - 152	-4.12	<.01
	Individual Therapy	232	199 - 264	202	193 - 211	1.79	.07
	Medication Support	63	52 - 74	59	57 - 61	0.67	.50
	Plan Development	50	32 - 68	54	51 - 57	-0.43	.67
	Rehabilitation	108	84 - 132	80	69 - 92	1.94	.05
>19-24 months	**Assessment**	52	33 - 70	58	55 - 61	-0.66	.51
	Case Management	40	29 - 52	105	98 - 111	-9.59	<.01
	Collateral	132	92 - 172	67	63 - 72	3.15	<.01
	Crisis Intervention	58	50 - 66	81	74 - 87	-4.53	<.01
	Group Therapy	85	33 - 137	141	114 - 168	-1.88	.06

	Individual Therapy	222	181 - 264	198	189 - 208	1.13	.26
	Medication Support	68	53 - 83	59	57 - 61	1.18	.24
	Plan Development	44	22 - 66	49	46 - 52	-0.46	.65
	Rehabilitation	68	46 - 91	68	58 - 78	0.02	.98
25+ months	**Assessment**	57	30 - 84	46	43 - 48	0.82	.41
	Case Management	62	37 - 87	91	85 - 97	-2.21	.03
	Collateral	118	70 - 166	59	55 - 64	2.42	.02
	Crisis Intervention	66	-9 - 140	65	59 - 71	0.01	.00
	Group Therapy	97	85 - 109	124	100 - 147	-1.87	.06
	Individual Therapy	232	177 - 288	184	174 - 193	1.70	.09
	Medication Support	64	40 - 87	57	54 - 60	0.57	.57
	Plan Development	95	14 - 177	43	40 - 46	1.26	.21
	Rehabilitation	47	13 - 80	52	44 - 60	-0.29	.77

Day Service Use

Table 22. Day Services – Proportion of Individuals with One or More Visits

	Early Psychosis		Comparator Group			
Visit date from enrollment	**%**	**95% CI**	**%**	**95% CI**	***z***	***p*-value**
≤6 months	2.4%	0.017 - 0.032	5.0%	0.047 - 0.054	-6.24	<.001
7 to 12 months	1.8%	0.010 - 0.026	4.0%	0.036 - 0.044	-4.67	<.001
13 to 18 months	1.5%	0.004 - 0.025	4.7%	0.041 - 0.052	-5.43	<.001
19 to 24 months	0.4%	-0.003 - 0.011	4.2%	0.037 - 0.048	-8.33	<.001

>25 months	3.3%	-0.006 - 0.071	5.7%	0.050 - 0.064	-1.22	.222
Across All Time Periods	2.0%	0.014 - 0.026	4.7%	0.044 - 0.050	-7.93	<.001

24-Hour Service/Inpatient Hospitalization

Table 23. 24-Hour/ Inpatient Hospitalization Services – Proportion of Individuals with One or More Visits

	Early Psychosis		Comparator Group			
Visit date from enrollment	**%**	**95% CI**	**%**	**95% CI**	***z***	***p*-value**
≤6 months	9.4%	0.067 - 0.121	24.8%	0.242 - 0.255	-10.83	<.001
7 to 12 months	7.7%	0.044 - 0.109	19.5%	0.186 - 0.204	-7.00	<.001
13 to 18 months	7.1%	0.026 - 0.116	21.4%	0.204 - 0.225	-6.10	<.001
19 to 24 months	5.4%	-0.005 - 0.114	19.5%	0.184 - 0.207	-4.57	<.001
>25 months	17.0%	-0.014 - 0.353	23.7%	0.191 - 0.216	-0.72	.472
Across All Time Periods	8.9%	0.061 - 0.118	22.4%	0.224 - 0.250	-9.03	<.001

Appendix VI. Service Code Definitions

These definitions are based upon the Medi-Cal Billing Manual published in September 2019 by the State of California—Health and Human Services Agency Department of Health Care Services, Mental Health Services Division.

Medication Support
Psychiatric medication-related services provided by nurse or physician including obtaining informed consent linked to providing Medication Support Services activities; instructions in the use, risks and benefits of and alternatives for medication; and plan development related to Medication Support Services. This may include services to consumer, family and caregivers.

Assessment
A service activity designed to evaluate the current status of a consumer's mental, emotional, or behavioral health. Assessment includes but is not limited to the following: mental status determination, analysis of consumer's clinical history; analysis of relevant cultural issues and history and diagnosis. The Server may be gathering information from a variety of sources. Interactive complexity includes the need to manage high reactivity, emotions or behavior of participants that interferes/complicates implementation or delivery of treatment services. It also may include mandated reporting such as in situations involving abuse or neglect. May include the use of play equipment, other physical devices, and interpreter or translator services.

Collateral
A service activity to a significant support person in the consumer's life for the purpose of meeting the needs of the consumer in achieving the goals of the consumer plan. May include but is not limited to consultation and training of the significant support person(s) to assist in better understanding of mental illness. The consumer may or may not be present for this service activity.

Plan Development
A service activity that consists of development of consumer plans, approval of consumer plans, and/or monitoring of a consumer’s progress. Includes team meetings for these purposes. Whenever possible, consumer should be present for these activities.

Rehabilitation
Individual: A service activity provided to a consumer and may include the following: counseling, assistance in improving, maintaining, or restoring an individual's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. If family or others are present, the focus of the session shall be on the consumer’s individual goals.

Group
A service activity provided to a group of individuals and may include the following: counseling, assistance in improving, maintaining, or restoring an individual's functional skills, daily living skills, social and leisure skills, grooming and personal hygiene skills, meal preparation skills, and support resources; and/or medication education. This may include consumers with family (can be foster family) for example multi-family groups, consumers with consumers, or consumers with others.

Individual Therapy
Psychotherapy conducted with a consumer: includes insight-oriented, behavior modifying and/or supportive psychotherapy. If family or others are present, the focus of the session shall be on the consumer’s individual goals.

Group Session/Group Therapy
Psychotherapy conducted with a group of individuals. Interactions among members are considered to be insight-oriented, behavior modifying and/or supportive. This may include consumers with family (can be foster family) for example multi-family groups, consumers with consumers, or consumers with others.

Case Management/Brokerage (CMB)
Case management services provided to assist the consumer to access needed housing, medical, educational, social, prevocational, vocational, rehabilitative, alcohol or drug treatment, or other needed community services. Includes targeted case management services of monitoring the beneficiary's progress toward consumer plan goals and placement services.

Crisis Intervention
Response to an unplanned event enabling consumer to cope with a crisis while maintaining his/her status as a functioning community member to the greatest extent possible. Includes related components such as assessment, evaluation, collateral contacts and therapy. Crisis Intervention is only provided to the consumer or the consumer with family present.

Non-Billable Codes
No-Show (Missed Visit)

Cancelled by Consumer

Cancelled by Program

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APPENDIX O

GLOSSARY OF ACRONYMS

Glossary of Acronyms

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
BHAB – Behavioral Health Advisory Board
BHS – County of San Diego Health and Human Services Agency, Behavioral Health Services
BIPOC – black, indigenous, and people of color
BPSR – Bio Psycho Social Rehabilitation
CalMHSA – California Mental Health Services Authority
CalWORKs – California Work Opportunity and Responsibility to Kids
CASRC – Child and Adolescent Research Center
CCRT – Cultural Competency Resource Team
CFTN – Capital Facilities and Technological Needs
C-HRT – Community Harm Reduction Team
CHFFA – California Health Facility Financing Authority
CHW – Community Health Workers
CWS – Child Welfare Services
CLAS – Culturally and Linguistically Appropriate Services
CREST – Cognitive Rehabilitative and Exposure Sorting Therapy
CSEC – Commercially Sexually Exploited Children
CPP – Community Planning Process
CSU – Crisis Stabilization Unit
CSS – Community Services and Supports
CYF – Children, Youth, and Families
DMC/ODS – Drug Medi-Cal Organized Delivery System
EMASS – Elder Multicultural Access and Support Services
ESU – Emergency Screening Unit
FSP – Full Service Partnership
FY – Fiscal Year
HHSA – Health and Human Services Agency
HCDS – Housing and Community Development Services
HOW – Homeless Outreach Workers
HSRC – Health Services Research Center
ICM – Institutional Case Management
IHOT – In-Home Outreach Team
ILA – Independent Living Association
IMAR – Illness Management Recovery
INN – Innovation
LGBTQIA+ – Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, intersex, asexual, and more
MDT – Multidisciplinary Team
MHFA – Mental Health First Aid
MHSA – Mental Health Services Act
MHSOAC – Mental Health Services Oversight and Accountability Commission
MORS – Milestones of Recovery Scale
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
PSC – Peer Specialist Coaches
POFA – Project One for All
QI – Quality Improvement
RER – Revenue and Expenditure Report
ReST – Recuperative Services Treatment
ROAM – Roaming Outpatient Access Mobile Services
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
SMI – Serious Mental Illness
SSI – Supplemental Security Income
START – Short-Term Acute Residential Treatment
SUD – substance use disorder
TAOA – Transition Age Youth, Adults and Older Adults
TAY – Transition Age Youth
TN – Technological Needs
UCSD – University of California, San Diego
WET – Workforce Education and Training
WIC – California Welfare and Institutions Code
WRAP – Wellness Recovery Action Plan

APPENDIX P

GLOSSARY OF TERMS

Glossary of Terms

Aftercare: a program of outpatient treatment and support services provided for individuals discharged from an institution, such as a hospital or mental health facility, to help maintain improvement, prevent relapse, and aid adjustment of the individual to the community. Aftercare may also refer to inpatient services provided for convalescent patients, such as those who are recovering from surgery.

Assertive Community Treatment (ACT): a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address every aspect of their life, whether it is medication, therapy, social support, employment, or housing.

CalAIM: (California Advancing and Innovating Medi-Cal) is a multi-year initiative by the California Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi- Cal members through broad delivery system, program, and payment reform across the Medi-Cal program.

Case Management: a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

Cognitive Training: a term that reflects the theory that cognitive abilities can be maintained or improved by exercising the brain, in an analogy to the way physical fitness is improved by exercising the body.

Complex Behavioral Health Conditions: can include serious mental illness (e.g., schizophrenia, bipolar disorder, or major depressive disorder) or other mental health conditions, with or without co-occurring substance use disorders that, individually or in combination, have an impact on one or more functional abilities. Functional limitations can impede an individual's ability to live independently at home and engage in the community.

Crisis Intervention: is the brief 'first-aid' use of psychotherapy or counseling to persons who have undergone a highly disruptive experience, such as an unexpected bereavement or a disaster. Crisis intervention may prevent more serious consequences of the experience, such as posttraumatic stress disorder. It is also a psychological intervention provided on a short-term, emergency basis for individuals experiencing mental health crises, such as an acute psychotic episode or attempted.

Culturally Appropriate: community interventions that are defined as meeting each of the following characteristics: (a) The intervention is based on the cultural values of the group, (b) the strategies that make up the intervention reflect the subjective culture (attitudes, expectancies, norms) of the group, and (c) the components that make up the strategies reflect the behavioral preferences and expectations of the group's member.

Family Engagement: a family-centered and strengths-based approach to making decisions, setting goals, and achieving desired outcomes for children and families. It encourages and empowers families to be their own champions, working toward goals that they have helped to develop based on their specific family strengths, resources, and need.

Family Groups: a therapeutic method that treats a family as a system rather than concentrating on individual family members. The various approaches may be psychodynamic, behavioral, systemic, or structural, but all regard the interpersonal dynamics within the family as more important than individual intrapsychic factors.

Full Service Partnership (FSP): a collaborative relationship between the County of San Diego and the client, and when appropriate the client's family, through which the client may access a full spectrum of community services to achieve identified goals.

Outreach: an activity of providing services to any populations who might not otherwise have access to those services. In addition to delivering services, outreach has an educational role, raising the awareness of existing services.

Peer Support: counseling or support by an individual who has experience and/or status equal to that of the client.

Personal Health Record (PHR): an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorized, in a private, secure, and confidential environment. A PHR includes health information managed by the individual. The clinician's record of patient encounter, a paper- chart or electronic medical record (EHR) is managed by the clinician and/or health care institution.

Primary Care: basic or general health care a patient receives when he or she first seeks assistance from a health care system provided by licensed general practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians.

Psychiatric Assessments: evaluations based on present problems and symptoms, of an individual's biological, mental, and social functioning, which may or may not result in a diagnosis of a mental illness.

Serious Emotional Disturbance (SED): a condition that affects persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): a condition that affects persons who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation.

Stigma: includes prejudicial attitudes and discriminating behavior directed towards individuals with mental health problems or the internalizing by the mental health sufferer of their perception of discrimination.

Strengths Based Approach: a specific method of working with and resolving problems experienced by the presenting person. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person's resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems.

Substance Use Disorder (SUD): recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Suicide Prevention: an umbrella term used for the collective efforts of local community-based organizations, health professionals and related professionals to reduce the incidence of suicide; reduce factors that increase the risk for suicidal thoughts and behaviors; and increase the factors that help strengthen, support, and protect individuals from suicide.

Supplemental Security Income benefits (SSI): pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. SSI is a federal income supplement program funded by general taxes. It is designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

Supportive Housing: an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities.

Trauma Informed Care: a style of care that accounts for the widespread impact of trauma and the understanding of potential paths for recovery. It includes the recognition of the signs and symptoms of trauma in clients, families, staff, and others. Organizations that are trauma informed fully integrate knowledge about trauma into policies, procedures, and practices and actively avoid re-traumatization.

Warning signs: behaviors that may be signs that someone is thinking about suicide, examples include:

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated, behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

APPENDIX Q

STAKEHOLDER COMMENTS

MHSA - Three Year Plan

30-Day Public Notice Feedback Summary

Date	Source/ID		Response
4/4/23	Survey/1	"I will be brief. Far too much funding is wasted in programs that never reach the most mentally ill/homeless population. There needs to be more LICENSED housing for the severely mentally ill. The ILFs are not a safe or successful option for anyone but the operator. There are few homes that have any knowledge of mental illness let alone provide quality food and cleanliness. We also need more IMD's like Crestwood and Alpine to stabilize those who sadly get stepped over on the street or locked up and waste away in jails due to incompetency to stand trail. Far too much money is spent on programs serving those who are able to work and have the mental capacity. These funds should be ear tagged for the severely mentally ill first. In addition we need more Crisis Houses with the capacity to house clients for a month allowing to transition to drug rehabs or suitable living options. We need more DETOX FACILITIES! There is an increase in homeless because there is an increase in drug use and this will continue until you stop creating useless programs and start providing easily accessible treatment for addiction. An addict isn't going to make phone calls for beds and wait a couple of weeks. We have FAR too many mentally ill incarcerated in our jail due to failure of mental health in this community. I am exhausted like most parents who have dealt with all these sad situations for many years. We need full wrap housing as a step down from locked facilities. This housing should provide the psychological component of recovery beyond what a hospital provides, treating the individual not just writing scripts for the disease. Allowing the mentally ill to decompensate so they can be scrapped off the sidewalk and placed on a hold is not the answer and it is inhumane. Parents like myself are angry, tired and frustrated with the false promises. You need to listen to families. Faith based programs like ECTLC that sweep people off the street should be regulated. They take in mentally ill people and do not encourage them to contact their programs/caseworkers OR take medication. We can't pray away Schizophrenia. They utilize a lockdown of 30 days without access to Act Programs or psychiatrists. Bottom line summary here: 1) We need more DETOX facilities for the County that serve the mentally ill 2) We need more Crisis Centers for the Mentally Ill 3) We need LICENSED housing for the mentally ill 4) We need more IMD facilities 5) We need to build treatment facilities that provide: housing-therapy-life skills-and encourage confidence Thank you	Noted
4/4/23	Survey/2	"I am concerned that Older Adults/Seniors are NOT listed/identified as a priority population with the boom in this population expected in the next decade. In terms of access to services we need better trained, qualified mental health case managers in the field doing home visits at a more frequent rate, in order to prevent mental health crises and reduce risks for homelessness, and to sustain housing. Telehealth case managers receive very low pay and are considered entry level and this group requires a better trained more highly skilled group of case managers in	Noted

Date	Source/ID		Response
		order to be effective with this population and they should not be capped on the number of home visits per client. They should be able to serve their clients based on individual care plans based on needs, which change when client is stable, with the option to increase visits based on circumstances and need. There needs to be better flexibility in this program to meet client needs. We also need to invest more in case management/boots on the ground for outreach, meeting the population where they are. Online and 2-1-1 results in high barrier to access. When people are struggling with mental illness executive functioning can be diminished, and it helps to have high-touch human guidance to guide people toward the resources needed for stability: Home visits, help with phone calls, providing transportation to DMV, Social Security, etc; transportation to medical appointments and helping them keep track of follow ups like prescriptions and follow up appointments. Invest more in your field case managers in all of your initiatives. In addition, you need more case managers in the field helping clients not only apply to Medi Cal and Cal Fresh and other fed and county benefits but also helping them gather and submit proofs that are required to obtain the benefit. For example, MSSP only accepts people AFTER they have Medi Cal. PACE only accepts people AFTER they have Medi Cal."	
4/20/23	Survey/3	"It's exciting to see that the County is taking measures to retain/recruit individuals in the BH workforce. I hope to see opportunities for County Contracted staff working with clients with substance use disorders being considered. Wage increases are greatly needed, and this would be an excellent starting point in retaining/recruiting efforts. I'm in favor of having student loans forgiven after 5 years in the BH field, however, I'm concerned that County Contracted Programs are not included. Also, making this forgiveness available only to those making $50,000 or more excludes most professionals in this field. Thank you, and I appreciate your time. Cynthia"	Noted. This comment pertains to the Innovation Project
4/21/23	Survey/4	"The most important takeaways are- why are County Contracted Staff left out of literally everything?! These are the contractors that the well-staffed county relies on for services in EVERY area of this field. These are non-profits, paying rent for their locations and figuring out how to pay a competitive wage. Personally, I am an SUD counselor working with a non-profit contractor. I could make $10 more hourly if I switched to a private for profit rehab. Me and my coworkers do this because with we believe in it. Younger generations or even my generation (millennial) act like I am crazy to take a job paying so little, so far from home, in such a “bad” neighborhood. They don’t take these jobs, even if mental health is their career tract. They work sales jobs, HR jobs, or other much higher paying jobs in the private sector- we lose valuable employees at every single contractor I have worked at to the private sector. High turnover is the highest expense for any business when you realize it. A revolving door of staff told that this is “stepping stone position” is very harmful to clients/participants. We quickly find out these jobs are a stepping stone to what? If my supervisor and program manager are unhappy and overburdened with constant changes then why would I want their position? My plan is to get my MSW and always planned on working in the system - but sadly I have learned that if I want to do things like have a family or house I will need to get	Noted. This comment pertains to the Innovation Project public behavioral health field.

Date	Source/ID		Response
		licensed and into private practice and work both jobs, something many directors and program managers already do (leading them to place less focus on the program they manage —> more turnover). Or I have the option to move to another state. We need a LIVABLE wage that reflects the COST OF LIVING. You leave these contractors ripe for unionization just FYI. This is from my director: Overall, I am so happy to see that the County is looking at how to retain and recruit BH workforce. I am hoping that these opportunities are for both County and County Contracted staff. I am also hoping that it is for working with clients with mental health and a substance use disorder. Loan Forgiveness- this seems like a great opportunity to have a student loan forgiven after 5 years in the BH field. I am concerned that it seems to be for 1900 individuals only in County BH workforce and does not include County Contracted Programs. I am also concerned that it is for only staff making $50,000 or more which excludes some line staff. This program should allow for at least a 3 months grace period if someone is on medical leave during the 5 year repayment plan. Upskilling- seems like a great idea and I like that it includes County and County Contracted Staff. Tiered Loan and Home Ownership Incentive- again I think it should include both County and County Contracted Staff. I think the description is a little confusing and vague. I really think the numbers should be highest in this category because this will really bring BH staff to the field. It is a little confusing if this is only for people that received a loan and completed the 5 years? Is this only for County BH staff? If so, that does not seem equitable."	
05/02/23	Survey/5	"It is essential that the Program and Expenditure plan include an explicit and intentional focus on the behavioral health needs of children/youth and their families. If we do not more effectively engage with children and youth earlier on in their lives, we will continue to see the overwhelming demand for severe/intensive behavioral services for adults. This problem cannot be addressed in silos, and also requires a very intentional focus on QUALITY of care, and patient outcomes. Thank you for your work on this, Sarah"	Noted.
05/04/23	Survey/6	"Although veterans are identified as a priority target population in the Program and Expenditure Plan, the plan does not adequately address the need to fund veteran specific programs and services. Veteran Service Organizations bring millions of dollars in Federal funding to the region annually, helping to alleviate the burden the County and State would otherwise carry. Still, these funds only cover between 70 and 80 percent of what it actually costs to provide critical housing, mental health, and supportive services to this vulnerable population. Each year across California, millions in MHSA dollars go unspent despite pleas from veteran service organizations seeking to step in and do the work. We urge the County of San Diego, the Department of Behavioral Health Services, and the Health and Human Services Agency to increase funding to support programs providing care to veterans. Local government has an obligation to care for all of its citizens. The responsibility of caring for our veterans should not lie solely with the federal government especially in a place like San Diego where nearly 250,000 veterans reside. Providing this critical support to local agencies aligns perfectly with the regional plan to end veteran homelessness. Decreased access to quality mental health care and	Noted.

Date	Source/ID		Response
		support are known barriers to maintaining housing. BHS can choose to support community-based mental health clinics that serve veterans. BHS can choose to fund innovative approaches to serving veterans. One way to do this would be to create veteran specific Full-Service Partnership programs (FSP). Local veteran service organizations cannot do this work alone. As we collectively work towards modernizing the behavioral health system statewide, we cannot leave our nations heroes behind. Thank you! Respectfully submitted by the leadership of Veterans Village of San Diego."	
05/04/23	Survey/7	I still maintain the need for a critical evaluation and reworking the Behavioral Health Advisory Board (BHAB) and its duty to review and approve the Behavioral Health Services (BHS) non-existent public Community Program Planning (CPP) processes and documenting their plans and budget. Our BHS has not acknowledged their duty to create a plan for our CPP activities. They consistently refuse to articulate a line-item budget for CPP activities. They have also been consistently resistant to have a meaningful dialog with the BHAB or knowledgeable stakeholders such as myself about how we can collaborate. This reticence is causing harm and we are missing crucial opportunities to modernize our BHS, especially in light of significant historical inequities many of our residents experience to this day. I blog at https://BHABrehab.com. Thank you.	Noted.
05/04/23	Survey/8	"Supporting the education, training, and retention of a mental health workforce trained to work in early childhood is crucial for promoting the optimal development and well-being of young children. Research has shown that early intervention for mental health concerns in infancy and early childhood can lead to better outcomes in a range of areas, including academic achievement, social-emotional development, and long-term mental health. To support the development and training of the mental health workforce, it's important to provide access to funds for training clinics employing trainees and associates/interns under the supervision of licensed clinicians, to reimburse county-funded services while providing increased reimbursement and/or stipends for supervision costs. Historically, institutions employing trainees or interns/associates were not allowed to bill insurance or Medi-Cal. This has greatly hindered the number of training positions. Additionally, reimbursement rates rarely cover the cost of supervision and liability. Providing enhanced reimbursement rates for agencies employing trainees and associates would alleviate the strain on the training pipeline that currently serves as a barrier to workforce development. However, it is not enough to simply open up funding. Supervision and training of clinicians should be done by agencies and/or institutions that have a proven track record for quality training and supervision and who assess the outcomes of their training models. Simply increasing the number of positions does not ensure the quality of the workforce or ensure clinicians enter the workforce well-trained and at a lower risk of burnout. Therefore, vetting must be done to ensure that the training and supervision being provided are of the highest quality. Investing in early childhood mental health and the training of the mental health workforce is crucial, as it can help to prevent the preschool-to-prison pipeline by identifying and addressing mental health needs in young children early on. Waitlists of 6 months to a year for young children to receive mental health services are unacceptable and highlight the urgent need for a highly trained workforce to address the mental health needs of young children. By supporting early childhood mental health consultation as a prevention program and workforce development mechanism, we can work towards building a more equitable and healthy society for all."	Noted.

Date	Source/ID		Response
05/04/23	Survey/9	"The County must begin funding Infant and Early Childhood Mental Health consultation. Infant and early childhood mental health consultation is an evidence-based prevention program that has been shown to have positive outcomes for children and families. Here are some of the outcomes and benefits of infant and early childhood mental health consultation: Improved social-emotional development: Infant and early childhood mental health consultation promotes healthy social-emotional development in young children by helping parents, caregivers, and early childhood educators to understand and support their emotional and behavioral needs. Early identification and treatment of mental health problems: Infant and early childhood mental health consultation helps to identify mental health problems in young children early on, before they become more severe and harder to treat. This can help to prevent more serious mental health problems later in life. Increased access to mental health services: Infant and early childhood mental health consultation provides access to mental health services for children and families who may not otherwise be able to access them. This can help to reduce health disparities and improve health outcomes for children and families. Improved parenting and caregiving skills: Infant and early childhood mental health consultation provides parents, caregivers, and early childhood educators with the skills and knowledge they need to support the social-emotional development of young children. Reduced healthcare costs: By identifying and addressing mental health problems early on, infant and early childhood mental health consultation can help to reduce healthcare costs by preventing more serious mental health problems later in life. Given these outcomes and benefits, county, state, and federal healthcare funders should fund infant and early childhood mental health consultation. By doing so, they can help to improve the mental health and well-being of young children and families, reduce healthcare costs, and promote equity and access to care. Funding for infant and early childhood mental health consultation can take the form of grants, contracts, or reimbursements for services provided by mental health professionals. Below are just a few examples of statewide models of early childhood mental health consultation. There are many more programs across the United States that provide similar services to promote healthy social-emotional development in young children. Minnesota: The Minnesota Department of Human Services provides Early Childhood Mental Health Consultation services to child care providers, Head Start programs, and other early childhood programs to support healthy social-emotional development in young children. More information can be found at: https://mn.gov/dhs/partners-and-providers/policies-procedures/child-care-manual/early-learning-and-care/early-childhood-mental-health-consultation.jsp New York: The New York State Office of Mental Health provides Early Childhood Consultation Partnership services to early childhood programs and families to promote healthy social-emotional development in young children. More information can be found at: https://omh.ny.gov/omhweb/ecp/ Michigan: The Michigan Department of Health and Human Services provides Infant Mental Health Consultation services to promote healthy social-emotional development in young children and support the mental health of families. More	Noted

Date	Source/ID		Response
		information can be found at: https://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_4845_79588---,00.html Connecticut: Connecticut's Early Childhood Consultation Partnership provides consultation and support to early childhood programs and families to promote healthy social-emotional development in young children. Found at: https://www.ct.gov/oec/cwp/view.asp?a=4542&q=545838 For local resources and additional information contact the Center for Excellence in Early Development at SDSU or the YMCA"	
5/4/23	Survey/10	Very concerned that this proposal does not include specific carve out and targeted funding for children 0-5 years of age and their care giver workforce. With all that we know about the importance for early intervention, I am shocked and dismayed that this proposal does little to nothing to improve the 6 month to year long wait list for our youngest children's referrals and assessments. Families and children cannot wait this long for referrals and this proposal should address this. Additionally, the child care educators need specific carve outs and support as essential workforce that serve our youngest children. Specific support for community based organizations is essential to support early intervention and should be included in this plan.	Noted
5/4/23	BHAB/1	Constituent spoke about the budget spending, and the public is frustrated. He wanted to make sure that BHS is engaging stakeholders more vigorously in the Community Planning Process.	Noted
5/4/23	BHAB/2	Constituent spoke about how she has been in the BHS system for 30 years. She is appointed to the Peer Council; more input is needed from the Peer Council into what is being proposed. Mariposa Clubhouse feels like a clinic and not a clubhouse. Upset that BHS use to have 14 clubhouses, but now 6 only. Her colleagues are not satisfied with what happened to the clubhouse facilities. These facilities now look like clinics; Clubhouses must be a place that provides comfort to people and where people can socialize.	Noted
5/4/23	BHAB/3	Constituent stated she feels there are some gaps. She indicated a few points as written by her friend which included supporting SB 43 regarding 5150, modifying HIPAA, ensure mental health history in state mental database, provide case manager following 30 day hold, and creating long term therapeutic housing after psych release among others.	Noted