

# Spring 2025 Mental Health Statistics Improvement Plan Supplemental Report

County of San Diego Behavioral Health Services

December 2025

## Background

As part of the Spring 2025 Mental Health Statistics Improvement Plan (MHSIP) Consumer Satisfaction Survey, adult consumers of the County of San Diego Mental Health (MH) System of Care were asked supplemental questions focused on equitable access to mental health services, cultural responsiveness, and healthcare integration.

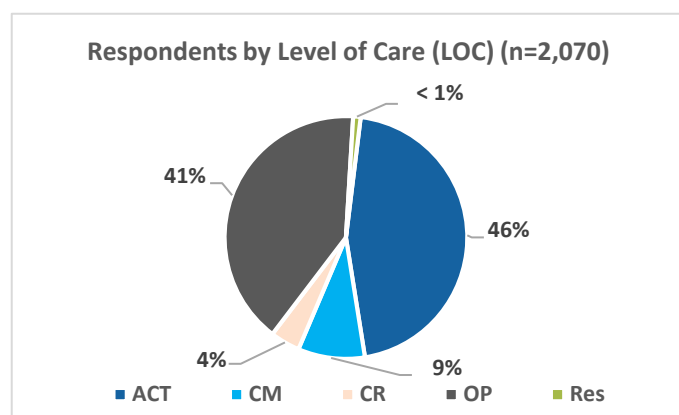
The MHSIP survey was offered to all adult consumers receiving either telehealth or in-person services from San Diego County funded mental health programs during the week of May 19 – 23, 2025. To ensure accessibility across service settings, the County implemented a hybrid administration model, providing both online and paper versions of the survey. A total of 2,240 MHSIP surveys were collected during the Spring 2025 survey period. Among these, 2,070 consumers (92%) completed the supplemental survey items. Findings from the supplemental survey are highlighted in this report.

## Who provided feedback?

The Spring 2025 MHSIP supplemental survey reflects the perspectives of adult consumers receiving services across the Mental Health System of Care. The following sections summarize key characteristics of the respondents.

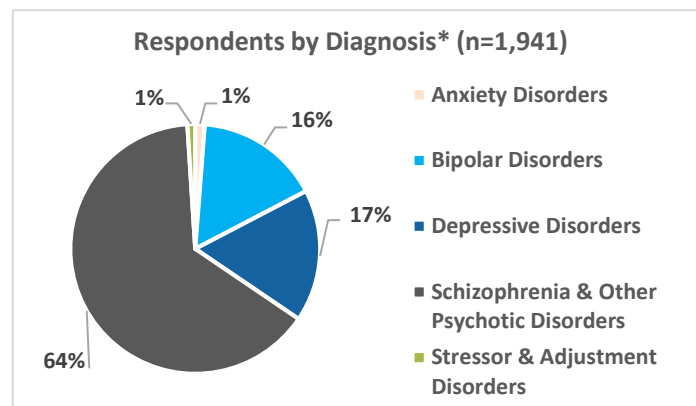
### Level of Care

Nearly half of respondents (46%) were receiving Assertive Community Treatment (ACT) services at the time of the Spring 2025 MHSIP survey and two-fifths (41%) were receiving Outpatient (OP) services. The remaining respondents were receiving Case Management (CM; 9%), Crisis Residential (CR; 4%), or Residential (Res; < 1%) services.



### Primary Diagnosis

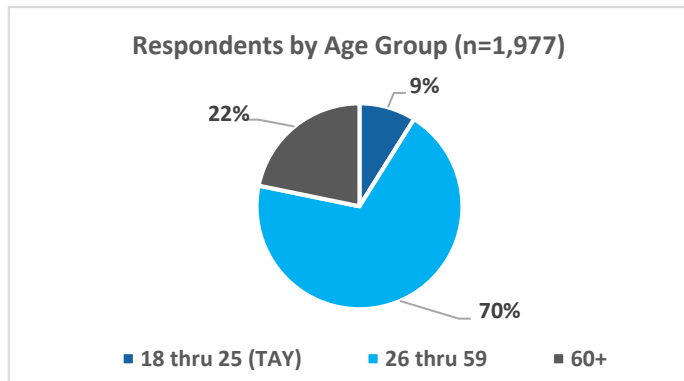
Nearly two-thirds of respondents (64%) had a primary diagnosis of schizophrenia and other psychotic disorders. The next two most common primary diagnoses among respondents were depressive disorders (17%) and bipolar disorders (16%). The remaining respondents had a primary diagnosis of anxiety disorders (1%), or stressor and adjustment disorders (1%).



\*Percentages may not sum to 100% due to rounding.

## Age Group

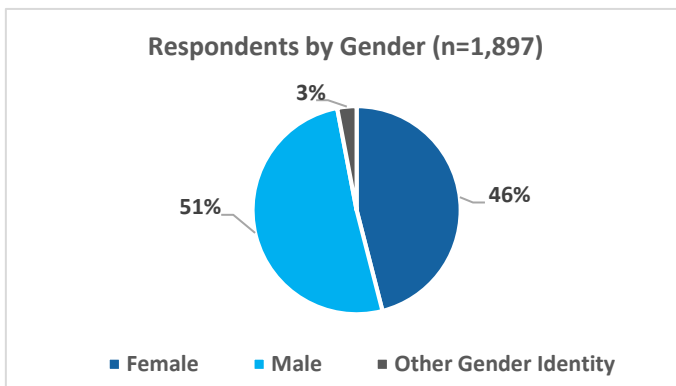
Respondents represented a broad range, with most consumers (70%) were between 26 and 59 years of age. Transition-aged youth (TAY), ages 18-25, represented 9% of the respondents, and adults 60 years or older represent the remaining 22% of respondents.



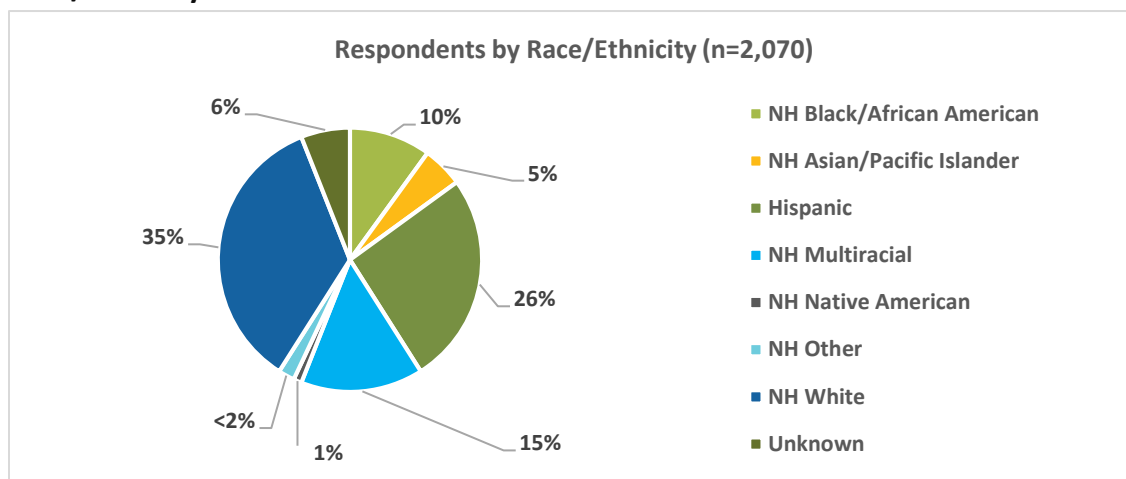
\*Percentages may not sum to 100% due to rounding.

## Gender Identity

Slightly more male than female consumers completed the supplemental survey (51% and 46% respectively). An additional 3% of respondents reported one of the following gender identities represented as "Other Gender Identity" in the graph: non-binary/genderqueer, questioning/unsure, or another gender identity.



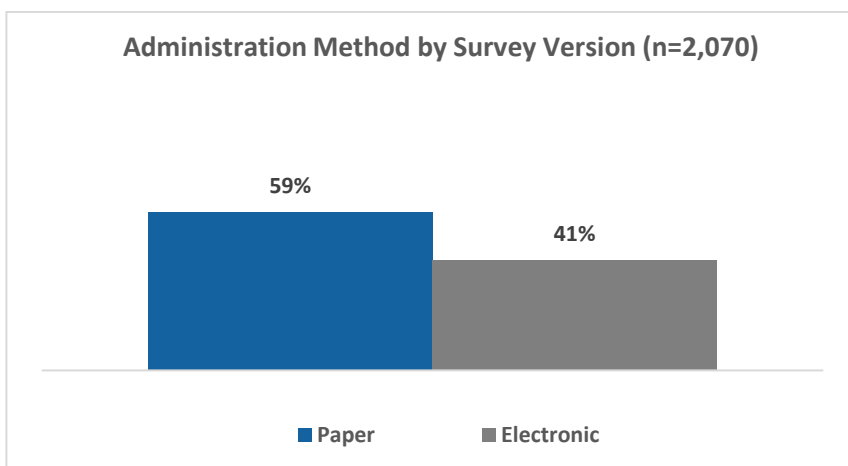
## Race/Ethnicity

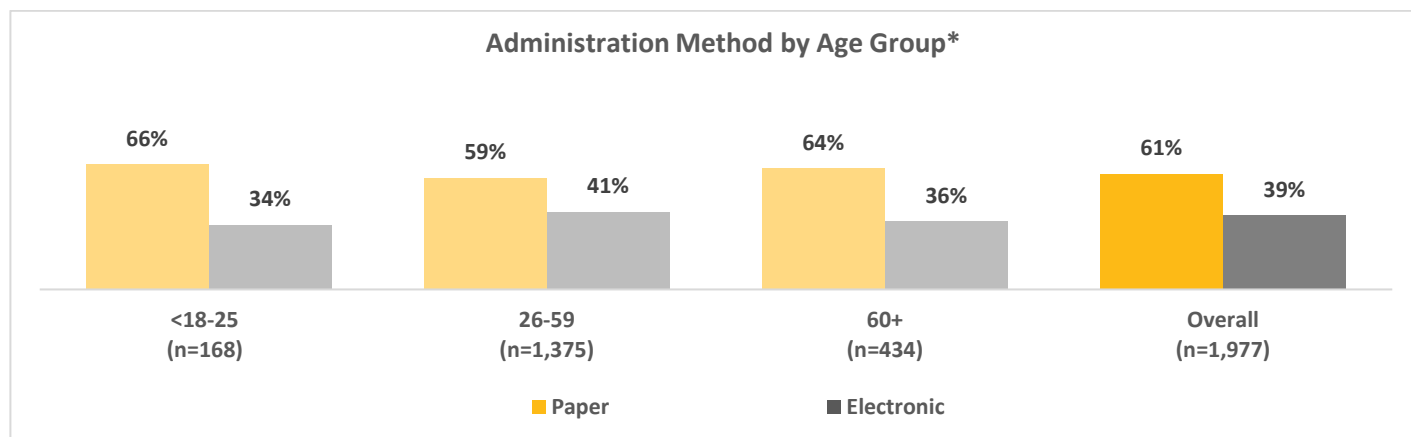


The largest proportion of respondents identified as Non-Hispanic (NH) White (35%), followed by Hispanic (26%), NH Multiracial (15%), and NH Black/ African American (10%).

## Survey Administration Method

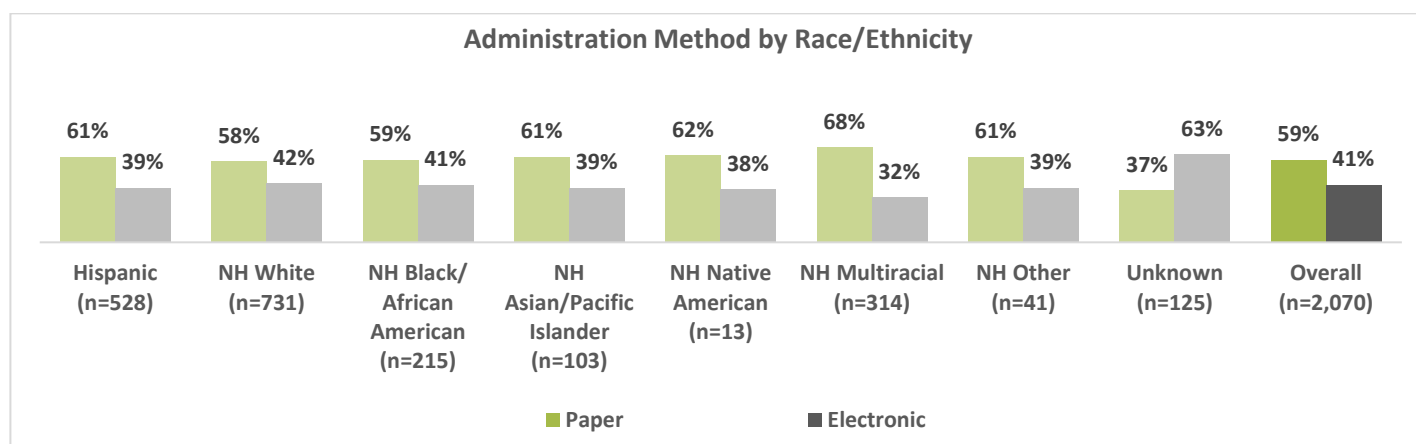
Of the 2,070 clients who answered at least one of the supplemental survey questions related to equity, cultural responsiveness, or healthcare integration, 1,231 (59%) completed the MHSIP survey on paper, while 839 (41%) respondents submitted it electronically. When split by age group, paper administration was more common across all age groups. A higher proportion of TAY and adults aged 60 years old completed paper surveys compared to adults ages 26 to 59.



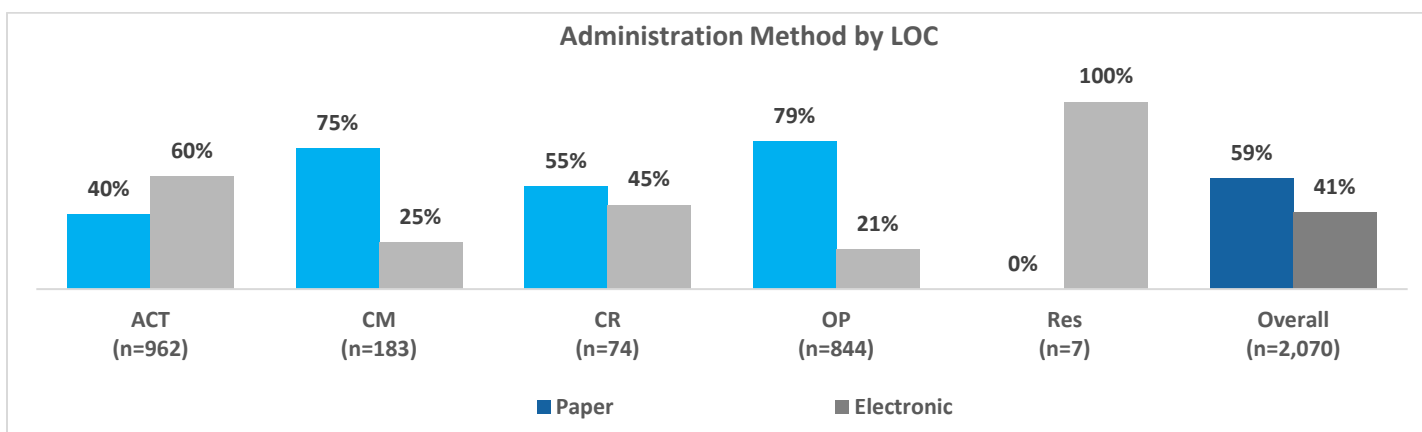


\*Percentages may not sum to 100% due to rounding.

Survey administration method was also examined by racial/ethnic groupings. Across all groups, a greater proportion of clients completed the survey on paper rather than electronically. However, clients whose race/ethnicity was unknown had a higher proportion of electronic surveys completed (electronic 63%; paper 37%).



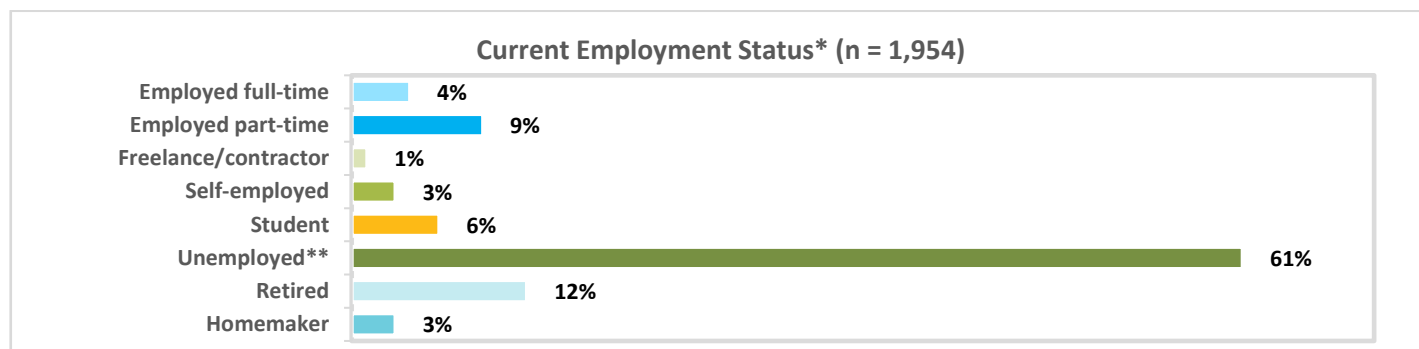
Survey administration method was also assessed by level of care (LOC). Respondents receiving ACT services and RES services were more likely to complete the survey electronically (ACT 60%; RES 100%). In contrast, consumers receiving CM, CR, and OP services predominantly used paper surveys (CM 75%; CR 55%; OP 79%).



## How do clients perceive the impact of their MH diagnosis on their employment?

### Employment Status

Over three-fifths of respondents (1,190 respondents; 61%) reported that they were unemployed. Less than half (45%) of these 1,190 respondents reported that they were looking to rejoin the workforce, while the remaining 55% were not. Nearly one-tenth (9%) of all respondents reported part-time employment, followed by only 3% of respondents reporting full-time employment, and 12% reporting a retired status.

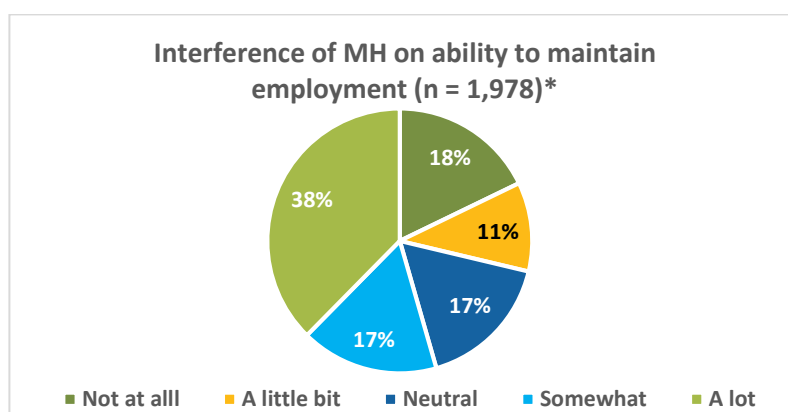


\*Employment status was unavailable for 116 respondents.

\*\*Unemployment is a combination of the “Unemployed and looking to rejoin the workforce” (n=534) and “Unemployed and not looking to rejoin the workforce” (n=656) response options..

### Impact of MH Diagnosis on Employment

Nearly two-thirds (65%) of respondents reported that their MH diagnosis interfered with their ability to maintain employment at least a little bit. Notably, 38% reported that their MH diagnosis interfered a lot with their ability to maintain employment, while 17% reported it somewhat interfered, and 11% reported it interfered a little. Another 17% indicated feeling neutral. Just under one-fifth (18%) reported that their MH diagnosis did not interfere with their ability to maintain employment at all.



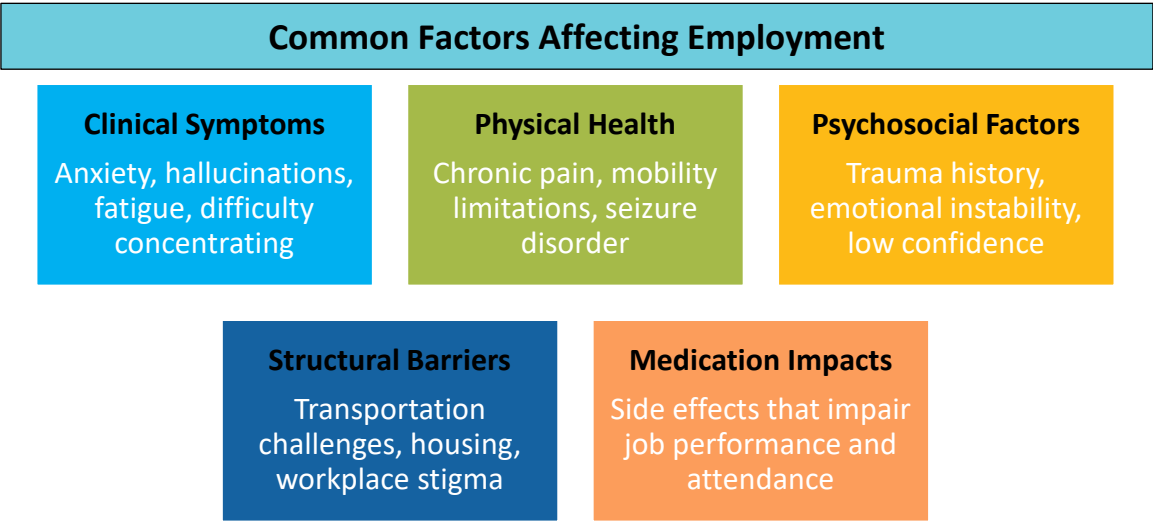
\*Information about the impact of their MH diagnosis on their ability to maintain employment was unavailable for 92 respondents.

### Qualitative Findings: Impact of MH Diagnosis on Employment

A qualitative analysis of open-ended responses provided insights into consumers’ MH diagnosis interfered with their ability to maintain employment. Respondents described five common challenges that limited their participation in the workforce. MH symptoms—including anxiety, disorganized thinking, hallucinations, or significant fatigue—were frequently mentioned as barriers to concentrating, managing workplace stress, and sustaining consistent schedules. These difficulties often disrupted job performance and contributed to periods of job loss.

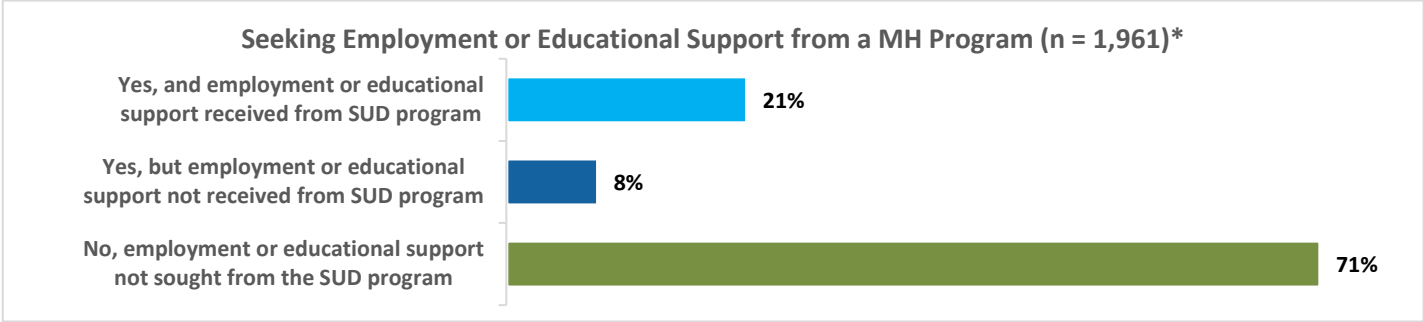
Physical health conditions also played a role. Chronic pain, mobility limitations, and seizure disorders made certain work environment physically demanding or unsafe, compounding their mental health symptoms. Emotional and psychosocial experiences, including trauma histories, grief, and low confidence, affected job readiness and employment stability.

Additionally, consumers identified several structural barriers, including transportation challenges, unstable housing, and insufficient workplace accommodations. Some reported being denied opportunities or fired due to stigma associated with their MH diagnosis. While medication supported functioning for many individuals, others noted that side effects interfered with staying alert or meeting job expectations. Collectively, these responses indicate that interference with employment is shaped by psychosocial factors and social determinants of health.



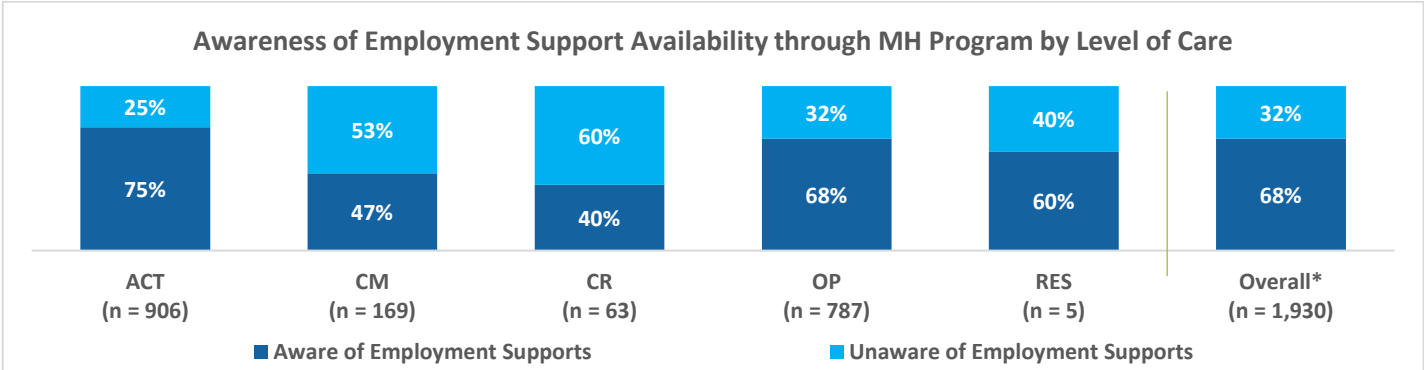
**Seeking Employment or Educational Support from an MH program**

Survey respondents were asked whether they sought employment or educational support as part of their MH treatment program. A majority (71%) indicated that they did not these services, while just over one-fifth (21%) reported that they were seeking and receiving employment or educational support. The remaining 8% of clients indicated that they sought employment or educational services from their MH treatment program but did not receive it.



\*Information about seeking employment or educational support from their MH treatment program was unavailable for 109 respondents.

Respondents were also asked about their awareness of employment support services available through their mental health program. Most consumers (68%) indicated that they were aware of this support, while 32% reported they were unaware. When examined by level of care, over half of respondents receiving MH treatment services in a case management or crisis residential program (CM 53%; CR 60%) reported that they were unaware of these employment supports compared to 25% of clients receiving services from an ACT program, 32% of those receiving services from an outpatient providers, and 40% from a residential program.

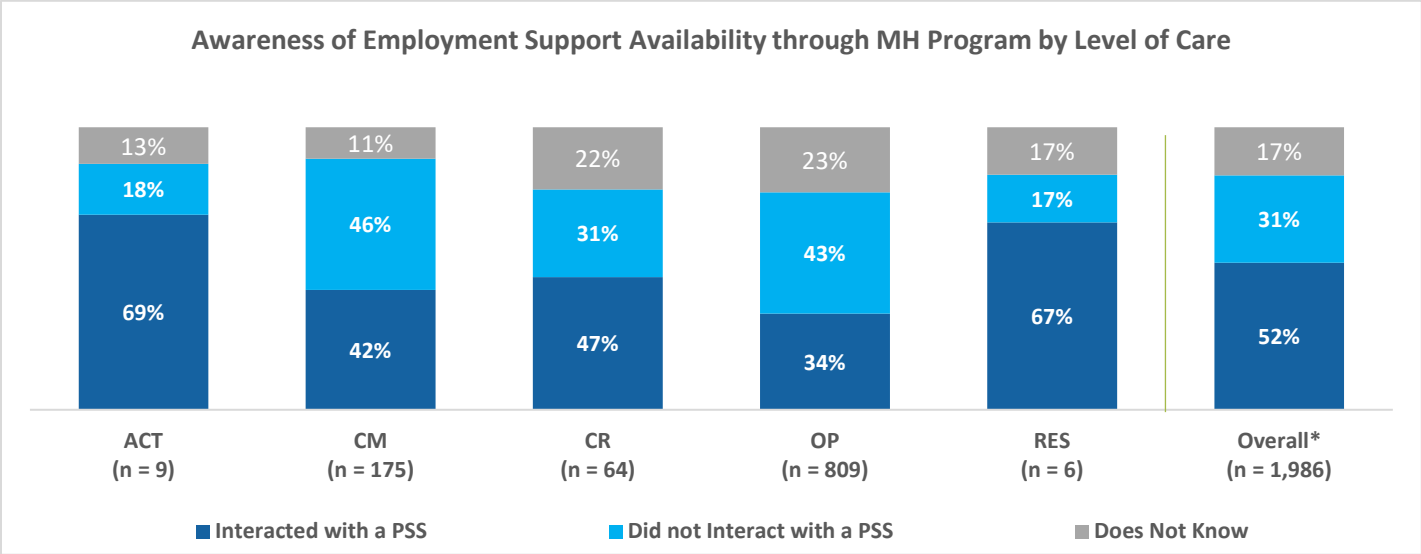


\*Information about awareness of employment support availability from their MH treatment program was unavailable for 140 respondents.

What are clients experiences with Peer Support Partners/Specialists?

The supplemental survey included several questions regarding clients experience with peer support partners/specialists (PSS). A total of 1,986 respondents provided a yes, no, or I don't know response to the question "Have you had any interactions with a peer support specialist at this program?" Over half of the respondents (52%) reported an interaction with a PSS at their MH program while less than one-fifth of the respondents (31%) did not interact with a PSS, and 17% of respondents did not know.

A further analysis by level of care was conducted to better understand the respondents interactions with PSS in their programs. The largest proportion of respondents who reported interacting with a PSS were receiving ACT services (69%). Two-thirds of the respondents interacting with a PSS were receiving RES services (67%). The remaining respondents who interacted with a PSS were receiving CR (47%), CM (42%), or OP (34%) services.



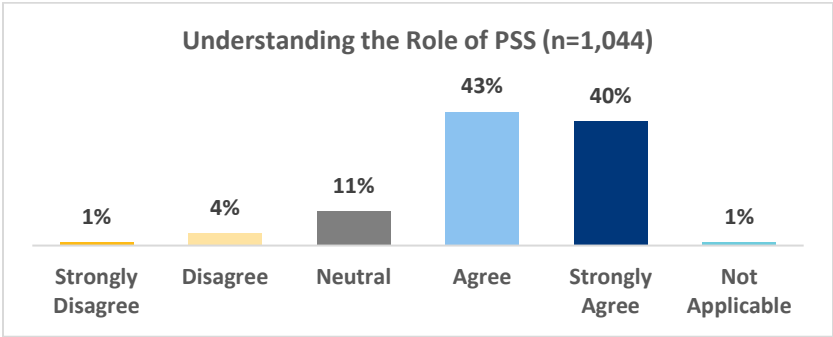
The 1,026 respondents who reported interacting with a PSS were asked to identify the types of support they received within their MH program. Respondents were asked to select all the listed types of help the PSS provided. Table 1 displays the proportion of each type of assistance reported. Most commonly, respondents reported receiving advice or counseling (70%). The next highest proportion of respondents (61%) reported the PSS helped them understand what resources were available, followed by 56% of respondents reporting PSS provided social support or reduced feelings of isolation.

Table 1: "What types of help did the peer support specialist provide?"		Percent of Respondents (n=1,029)
1. Provided advice or counseling (n=723).	<div></div>	70%
2. Helped me understand what resources were available (n=623).	<div></div>	61%
3. Provided social support or reduced feelings of isolation (n=575).	<div></div>	56%
4. Helped me set goals for recovery (n=563).	<div></div>	55%
5. Helped me to fill out paperwork (n=520).	<div></div>	51%
6. Helped me monitor my progress (n=487).	<div></div>	47%

7. Helped me navigate the mental health services system (n=480).	47%
7. Other (n=122).	12%

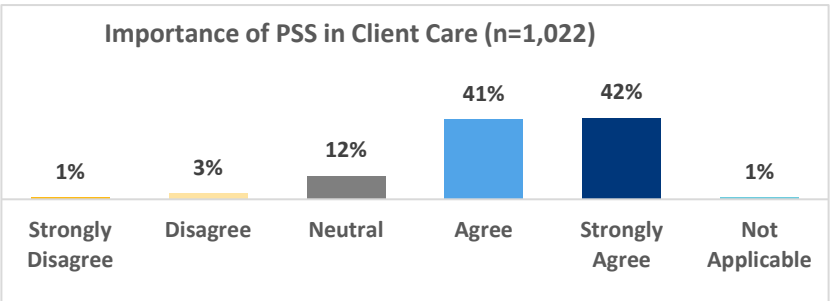
### Understanding the Role of Peer Support Specialists

The majority of respondents (83%) agreed or strongly agreed with the statement, “I understand the role of peer support specialists in my program.” Two-fifths (40%) strongly agreed with the statement. Only 5% of respondents disagreed or strongly disagreed with the statement, while the remaining 11% reported feeling neutral.



### Importance of Peer Support Specialists in Client Care

Similarly, when asked whether “Peer support specialists play an important role in client care in my program,” over four-fifths (83%) agreed or strongly agreed. While 12% reported feeling neutral, and the remaining 5% of respondents disagreed or strongly disagreed with the statement or felt it was not applicable.



Given the high endorsement of PSS, qualitative responses were analyzed to better understand the specific aspects of peer support that clients found beneficial. Across survey responses, three themes emerged:

Rapport and Emotional Connection	Navigational Support	Meaningful Support for Recovery
Frequently described PSS staff as understanding, non-judgemental, patient, and relatable. Many emphasized the value of interacting with someone who had lived experience, noting that it made them feel understood and supported.	Assistance with activities such as WRAP planning, scheduling appointments, and applying for benefits. PSS were viewed as essential in helping clients understand and access the resources available to them.	Respondents shared stories of peers helping them stay motivated, manage symptoms, cope with stress, and maintain sobriety. Some expressed that positive interactions with PSS inspired them to become PSS.

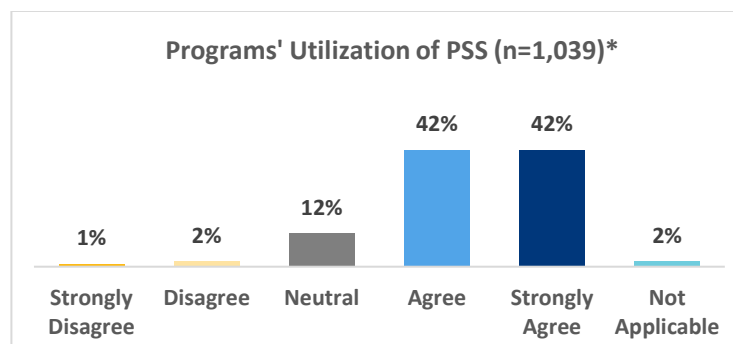
Together, these themes highlight the contribution of PSS to client engagement, recovery, and service navigation. Several respondents also expressed interest in greater availability and expansion of peer services:

- “I would like to see a peer specialist more often.”
- “Their role could be more promoted as a service available to clients very helpful with paperwork + goal settin[g]”
- “There are so many instances, too many to list where they have been valuable. I have had awesome, great spectacular, meaningful interactions over the past few years.”



## Programs' Utilization of Peer Support Specialists

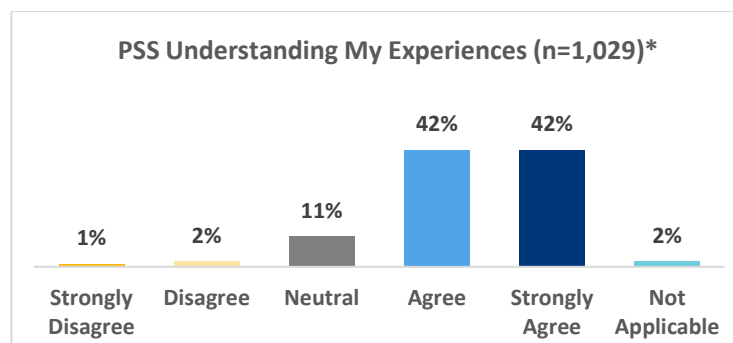
Respondents were also asked how much they agreed or disagreed with the statement, "My program does a good job utilizing peer support specialists in its service delivery to clients." Over four-fifths (84%) of respondents strongly agreed or agreed their program does a good job at utilizing PSS, while more than one-tenth (12%) reported feeling neutral. The remaining 5% of respondents disagreed or strongly disagreed with the statement or felt it was not applicable.



\*Percentages may not sum to 100% due to rounding.

## Peer Support Specialists Understanding My Experiences

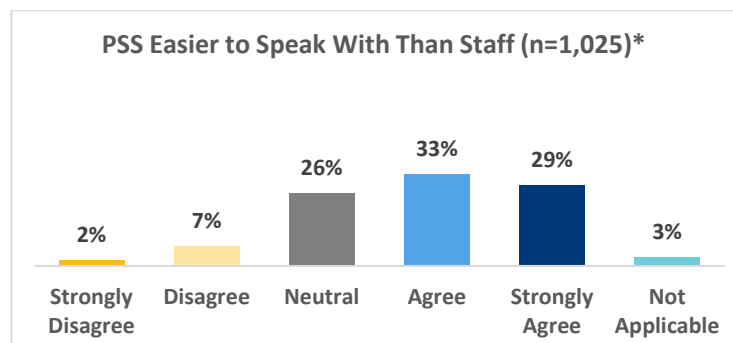
Respondents were also asked how much they agreed or disagreed with the statement, "The peer support specialist understood my experiences." Over four-fifths (84%) of respondents strongly agreed or strongly agreed that the PSS understood their experience, while more than one-tenth (11%) reported feeling neutral. The remaining 5% of respondents disagreed or strongly disagreed with the statement or felt it was not applicable.



\*Percentages may not sum to 100% due to rounding.

## Peer Support Specialists Ability to Speak With Compared to Staff

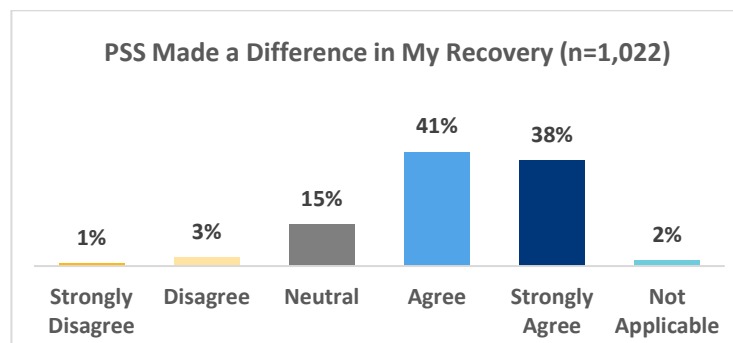
Respondents were also asked how much they agreed or disagreed with the statement, "The peer support specialist was easier to speak with than other clinic staff." Nearly two-thirds (63%) of respondents strongly agreed or agreed that PSS were easier to talk with than program staff, while more than one-fourth (26%) reported feeling neutral. The remaining 12% of respondents disagreed or strongly disagreed with the statement or felt it was not applicable.



\*Percentages may not sum to 100% due to rounding.

## Peer Support Specialists Made a Difference in My Recovery

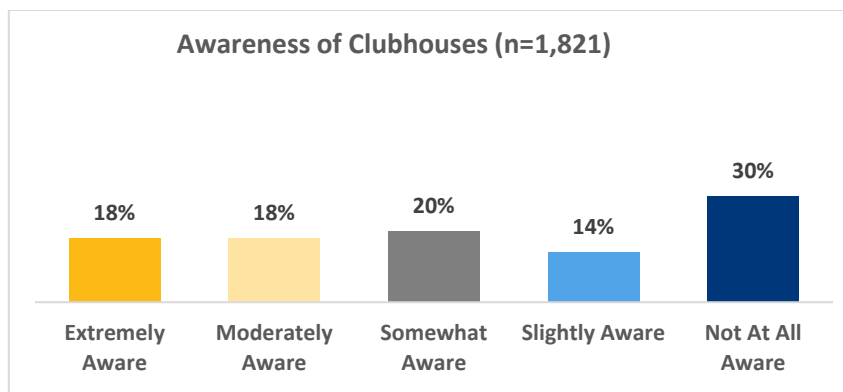
Respondents were also asked how much they agreed or disagreed with the statement, "The peer support specialist made a difference in my recovery." Four-fifths (80%) of respondents strongly agreed or agreed that they received poorer services than other clients, while more than one-tenth (15%) reported feeling neutral. The remaining 6% of respondents agreed or strongly agreed with the statement or felt it was not applicable.



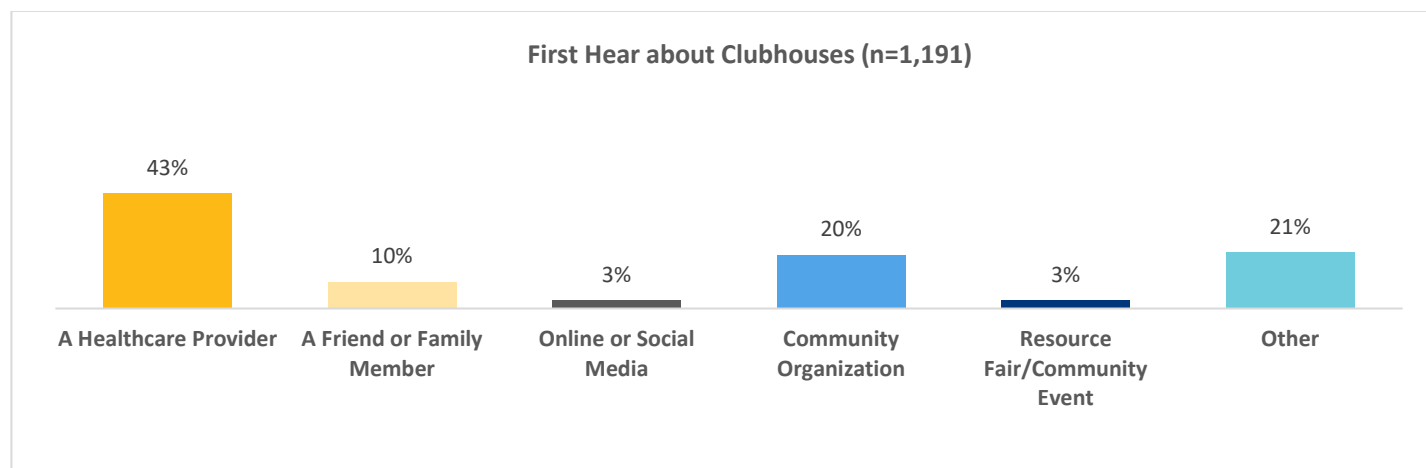


## What are clients experiences with Clubhouses?

Respondents were asked, “How aware are you of the Clubhouses available in San Diego County and the support they offer?” Nearly one-third of the respondents (30%) reported not being aware at all of the Clubhouses and the support they offer. The remaining respondents reported varying levels of awareness: extremely aware (18%), moderately aware (18%), somewhat aware (20%), and slightly aware (14%).

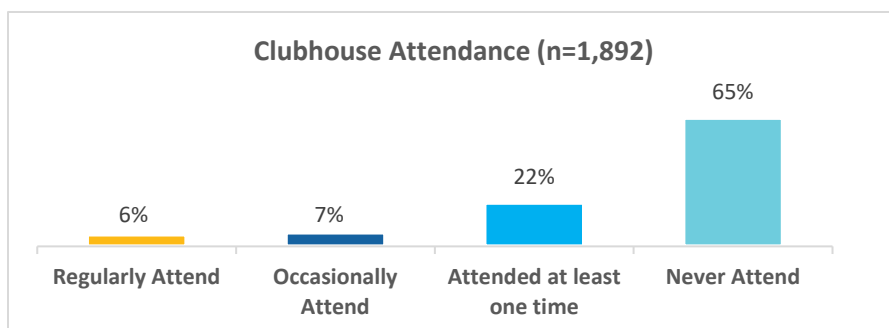


Among the 1,274 respondents who indicated any level of awareness of a Clubhouse in the previous question, were further asked, “Where did you first hear about Clubhouses?” Over two-fifths (43%) reported hearing about Clubhouses from a healthcare providers. Over one-fifth (21%) of the respondents reported first hearing about Clubhouses from another source, while 20% of respondents reported hearing about Clubhouses from community organizations.



## Clubhouse Participation

Respondents were asked whether they had ever attended or received services from a Clubhouse. Of the 1,892 who responded to the question “Have you ever attended or received services from a Clubhouse?” Nearly two-thirds of the respondents (65%) had never attended a Clubhouse while 35% reported attending in some capacity.



Based on their response, individuals were directed to a set of follow-up questions about their Clubhouse experience.

- ❖ 670 respondents who reported attending a Clubhouse was asked which services they received
- ❖ 1,222 respondents who had never attended a Clubhouse were asked to identify reasons for non-attendance

## Services Received at Clubhouses

Respondents who had attended a Clubhouse could select multiple services from ten listed options. Table 2 displays the proportion of respondents that endorsed each service received by attending. The highest proportion of respondents (58%) reported receiving social and recreational activities from attending a Clubhouse. The next highest proportions of respondents reported receiving mentorship and peer support (41%), along with music and activities (37%).

**Table 2: Services Received at a Clubhouse\***

	Percent of Respondents (n=635)
1. Social and recreational activities (n=371).	58%
2. Mentorship and peer support (n=259).	41%
3. Music and at activities (n=235).	37%
4. Wellness resources or classes (n=221).	35%
5. Job skills and development (n=163).	26%
6. Assistance with SSI and SSDI benefits (n=141).	22%
7. Housing assistance (n=104).	16%
8. Employment support and job assistance (n=97).	15%
9. Education assistance (n=91).	14%
10. Other (n=83).	13%

\*Percentage is based on the total proportion of respondents who endorsed each option. Multiple responses were permitted for each respondent.

## Reasons for Not Attending a Clubhouse

Respondents who had never attended a Clubhouse was asked to select one or more reasons for non-participation. Table 3 displays the proportion of respondents that endorsed each reason for not attending a Clubhouse. The highest proportion of respondents (50%) endorsed the reason they did not attend a Clubhouse was because they did not know enough about them. The next highest proportion of respondents (21%) endorsed preferring other forms of support, followed by 18% of respondents endorsing they do not need the services as reasons for not attending a Clubhouse.

**Table 3: Reasons for Not Attending a Clubhouse\***

	Percent of Respondents (n=1,745)
1. I don't know enough about them (n=542).	50%
2. I prefer other forms of support (n=225).	21%
3. I don't need the services (n=195).	18%
4. Transportation is a barrier (n=164).	15%
5. Other (n=148).	14%
6. I'm not sure if I qualify (n=122).	11%

\*Percentage is based on the total percentage of respondents who endorsed each option. Multiple responses are permitted for each respondent.

## Client Identified Strengths and Areas for Improvement

In addition to structured survey items, open-ended responses were analyzed to better understand how clients perceive Clubhouse programs as well as opportunities for improvement. The themes below reflect the most commonly identified aspects of Clubhouse environments that support client recovery, along with areas where clients suggested enhancements to better meet their needs.

What Clubhouses Do Well	Suggested Improvements
<b>Welcoming Environment</b> Respondents described Clubhouses as friendly, safe and supportive places where they felt accepted and comfortable engaging with others.	<b>More structured programming</b> Clients expressed interest in clearer expectations, consistent schedules, and more organization.
<b>Social Connection and Reduced Isolation</b> Many valued opportunities to build friendships, feel less alone, and connect with peers in recovery.	<b>Expanded activity options</b> Some respondents wanted more advanced, “higher-functioning” activities or skill building opportunities that better meet their current needs.
<b>Recovery Support</b> Clients highlighted support with job readiness, symptom management, coping strategies, and peer encouragement as key benefits.	<b>Inclusion Across Age Groups</b> Older adults reported that some activities felt geared toward younger participants and expressed a desire for age-appropriate programming.
<b>Meaningful activities</b> Art, music, recreation, and group programming were frequently described as enjoyable, engaging, and meaningful to clients’ recovery.	<b>Improved transportation and mobility access</b> Limited transportation options and mobility-related barriers were reported as significant obstacles to regular participation

## Key Findings

- ❖ A total of 2,070 clients who received services from the County of San Diego Mental Health System of Care providers during the week of May 19 – 23, 2025, responded to at least one question on the MHSIP 2025 Supplemental survey.
- ❖ Most respondents (70%) were between the ages of 26 and 59 years of age and identified as male (51%).
- ❖ The racial/ethnic groups that respondents most often identified with were NH White (35%) and Hispanic (26%).
- ❖ Over two-fifths of respondents (46%) were served by ACT treatment providers during the survey period, followed by 41% of respondents being served by outpatient providers.
- ❖ The majority of the respondents (59%) submitted the paper version of the survey, while 41% of respondents submitted a survey electronically.
- ❖ Over three-fifths of respondents (1,190 respondents; 61%) reported that they were unemployed. Less than half (45%) of the 1,190 respondents reported that they were looking to rejoin the workforce, while the remaining 55% were not.

- ❖ Nearly two-thirds (65%) of respondents reported that their MH diagnosis interfered with their ability to maintain employment at least a little bit.
- ❖ A majority (71%) of respondents indicated that they did not seek employment or educational support from their MH treatment program, while more than one-fifth (21%) reported seeking and receiving this support.
- ❖ Over half of the respondents (52%) reported an interaction with a PSS at their MH program while less than one-fifth of the respondents (31%) did not interact with a PSS, and 17% of respondents did not know.
- ❖ The largest proportion of respondents who reported interacting with a PSS were receiving ACT services (69%). Two-thirds of the respondents interacting with a PSS were receiving RES services (67%). The remaining respondents who interacted with a PSS were receiving CR (47%), CM (42%), or OP (34%) services.
- ❖ Overall, the highest proportion of respondents (70%) endorsed that the PSS provided advice or counseling. The next highest proportion of respondents (61%) endorsed the PSS helped them understand what resources were available, followed by 56% of respondents endorsing PSS provided social support or reduced feelings of isolation.
- ❖ Over four-fifths of respondents either agreed or strongly agreed that understand the role of PSS, PSS play an important role in their care, their program does a good job utilizing the PSS in their service delivery, the PSS understood my experiences, and the PSS made a difference in my recovery.
- ❖ Nearly one-third of the respondents (30%) reported not being aware at all of the Clubhouses and the support they offer. The remaining respondents reported varying levels of awareness: extremely aware (18%), moderately aware (18%), somewhat aware (20%), and slightly aware (14%).
- ❖ Over two-fifths (43%) of respondents first heard about the Clubhouses from a healthcare providers. Over one-fifth (21%) of the respondents reported first hearing about Clubhouses from another source, while 20% of respondents reported hearing about Clubhouses from community organizations.
- ❖ Nearly two-thirds of the respondents (65%) had never attended a Clubhouse while over one-thirds of the respondents (35%) had attended a Clubhouse to some capacity.
- ❖ Respondents who had attended a Clubhouse could select multiple services from ten listed options. The highest proportion of respondents (58%) reported receiving social and recreational activities from attending a Clubhouse. The next highest proportions of respondents reported receiving mentorship and peer support (41%), along with music and activities (37%).
- ❖ Respondents who had never attended a Clubhouse was asked to select one or more reasons for non-participation. Table 3 displays the proportion of respondents that endorsed each reason for not attending a Clubhouse. The highest proportion of respondents (50%) endorsed the reason they did not attend a Clubhouse was because they did not know enough about them. The next highest proportion of respondents (21%) endorsed preferring other forms of support, followed by 18% of respondents endorsing they do not need the services as reasons for not attending a Clubhouse.