COUNTY OF SAN DIEGO MHSA REPORT FOR STAKEHOLDERS: FISCAL YEAR 2012-13

10/9/2012

A Community Report

This report is written by the County of San Diego Health and Human Services Agency's Behavioral Health Services Division for community stakeholders. It describes the Mental Health Services Act (MHSA) funded programs, provides an implementation progress report for Fiscal Year 2010-11 and an expenditure plan for Fiscal Year 2012-13.

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MHSA Annual Report for Stakeholders: FY 2012-13

MHSA: MAKING A DIFFERENCE

A LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR

Live Well, San Diego! is a 10-year initiative and plan that embodies the Health and Human Services Agency's effort to achieve the County vision for healthy, safe and thriving communities. The initiative advances health and overall wellbeing of the entire region.

Behavioral Health Services' role in the implementation of *Live Well, San Diego!* is to assure healthy communities by providing an array of state-of-the-art behavioral health services to children, youth, families, adults and older adults. Since its approval by voters in 2004, the Mental Health Services Act (MHSA) has provided a unique opportunity to further transform public mental health services in San Diego County. San Diego's behavioral health system transformation has evolved in the past ten years with broad participation of clients, families and youths, advocates, public partners, private providers and the community at large.

Through programs and services funded by MHSA, underserved populations have better access to care and opportunities for an improved quality of life in less restrictive environments. In addition, our prevention and education efforts focus on reducing the stigma of mental illness and co-occurring disorders and increasing access to services. We are committed to significantly increasing client, family and youth participation at the planning, practice, program and policy levels, and in client-operated services.

County of San Diego Behavioral Health Services anchors its delivery in the practice of system of care values and principles, applying a bio-psychosocial rehabilitation and recovery model for services provided to adults that is consistent with the adult and older adult system of care framework. For children's mental health services, the system of care values are consistent with wraparound philosophy and guiding principles. Additionally, integrating treatment for alcohol and other drug substance use and abuse with services addressing mental health is a foundational commitment to the wellness of all clients.

The Behavioral Health Services Division looks forward to continuing to advance the goals of *Live Well, San Diego!* through transforming the public mental health and behavioral health systems with a recovery and resilience focus. This will be accomplished by advancing integrated health care models, utilizing trauma-informed approaches at every level of service, and ensuring that clients and families have the information necessary to make healthy lifestyle decision including: healthy food choices and informed decisions about increasing physical activity and social connectedness.

ALFREDO AGUIRRE, LCSW, Director
Behavioral Health Services
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INTRODUCTION

In July 2010, the County of San Diego Board of Supervisors unanimously adopted a visionary 10-year plan, ***Live Well, San Diego!***, to improve the health and well being of our community. Supporting the County's vision, the plan strategically outlines goals and actions to provide innovative and integrated service delivery to the residents of San Diego County so they can enjoy lives that are Healthy, Safe and Thriving. These three strategic agendas have distinct yet interwoven collection of measurable activities that are categorized within four major pillars:

- Building a Better Service Delivery System
- Supporting Positive Choices
- Pursuing Policy Changes for a Healthy Environment
- Changing the Culture From Within

Mental Health Services Act (MHSA) implementation in San Diego County demonstrates the County's commitment to collaborating with community partners and businesses, aligning internal services to promote healthy, safe and thriving communities for all residents, and putting ***Live Well, San Diego!*** into action.

While adhering to the principles of MHSA and the guiding principles of Behavioral Health Services' Adult/Older Adult and Children's Systems of Care, the MHSA, as implemented in San Diego County, addresses the four major pillars of *Live Well, San Diego!:*

Building a Better Service Delivery System is essential to a healthier community. Integration of physical health, behavioral health and social services is a key component to building a service delivery system that improves quality of care and is responsive to the needs of customers. Access to the right care at the right time is critical to achieving and maintaining the health of an individual. A few examples illustrating strides made towards building a better service delivery system through MHSA include:

- Integration of physical and behavioral health care;
- Improved identification and availability of suicide prevention and mental health resources;
- Reduction of the stigma associated with mental illness and suicide so that individuals are comfortable reaching out and getting help early, and communities are understanding that "home is where recovery begins" for someone with a severe mental illness; and
- Improved coordination of services for high-risk populations.

Supporting Positive Choices is about enabling our community to make the healthy choice be the easy choice. Because the healthy choice is not always the easy choice, it is critical to remove barriers to making the right choice. A few examples of how MHSA funded programs are supporting positive choices are as follows.

- Clubhouses are providing healthy cooking classes and encouraging smoking cessation programs for clients;
- County of San Diego Regional Community Health Promotion and Aging Program Specialists are broadening the reach of education and training by incorporating physical health and behavioral health in their messaging; and
- *It's Up to Us* Stigma and Discrimination Reduction and Suicide Prevention Media Campaign is providing wellness tips through community bulletins.

Pursuing Policy and Environmental Changes is an effort to incorporate health in all policies. By looking at areas such as transportation and planning through a health lens, we are able to create sustainable change in our region that supports healthy living. A few MHSA-funded examples that illustrate this:

- Expand basic prevention education and training to the population at large so they can recognize the signs and symptoms of suicide risk as commonly as they can other health risks like a heart attack or a stroke;
- Expand the definition of "providers" to include those outside of the behavioral health realm, and give them adequate training, education and support; and
- Plan for a healthy environment in the capital facilities projects that will house programs.

Improving the Culture from Within County Government is about the internal County Team. A healthier and more knowledgeable County workforce is a more productive workforce, and in turn, enables employees to better serve all those who use County services. Behavioral Health Services staff participates in:

- A "virtual" walk across the country through a walking challenge;
- Walks for mental health and suicide prevention and recovery activities;
- Annual stigma-reducing events; and
- The development of an internal training for HHSA employees on stigma and discrimination that is associated with mental illness.

COMMUNITY STAKEHOLDER PROCESS

The County of San Diego compiled information through an extensive Community Program Planning process, which included data from the MHSA Gap Analysis and community input from stakeholder-led councils (Children's System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council) and the Mental Health Board in the development of the MHSA Annual Report for Stakeholders: FY 2012-13.

The stakeholder-led councils provide a forum for council representatives and the public to stay informed and involved in the planning and implementation of MHSA programs. The members of these councils received draft materials and presentations on the impact of Assembly Bill 100, which dissolved the California Department of Mental Health and rescinded its role as an approving authority on MHSA plans including the local community planning and approval process. Community input from these councils was collected during the FY 2012-13 planning phase and considered during development of this annual plan. Council members also shared MHSA information with their constituents and other groups involved in behavioral health services and issues. Membership within the Children's, Adult, and Older Adult System of Care Councils and the Housing Council includes consumers and family members, as well as other key stakeholders in the community such as providers, program managers, representatives of consumer and family organizations, advocacy groups, education representatives, and County partners.

The Mental Health Board provided input for the FY 2012-13 funding enhancements for Community Services and Supports as well as Prevention and Early Intervention, reviewed and supported the draft MHSA Annual Report for Stakeholders: FY 2012-13. The Board held a public hearing on June 7, 2012. The Board is comprised of consumers, family members, and clinical professionals from the mental health field representing each of the five County supervisorial districts.

The County's Behavioral Health Services Division is comprised of Mental Health Services and Alcohol and Drug Services (ADS) working together to meet the needs of the community. Throughout the MHSA planning activities, ADS providers offered essential input on the needs for specialized mental health assistance for clients currently receiving treatment in ADS-contracted programs. Additional input was received during numerous community forums, as well as through the ADS Providers Association and monthly ADS Provider meetings. The Alcohol and Drug Advisory Board was provided a presentation where further input was gathered. This Board is comprised of family members, those in recovery and professionals representing each of the five County supervisorial districts.

The Behavioral Health Services Director and MHSA Coordinator presented a draft of this report highlighting some of the accomplishments in FY 2010-11 and areas of proposed program enhancements for FY 2012-13 to the Health Services Advisory Board, a board comprised of individuals in the health services field, such as physicians, hospital partners, academia, and local businesses, also representing each of the five County supervisorial districts.

In addition, the MHSA Planning Team routinely sends updates and communications about planning, meetings, documents and proposed MHSA plan updates to an extensive list of interested parties (e.g., stakeholders, providers, consumers, and family members). Annual update information and input requests were emailed to other stakeholder distribution lists, including the Mental Health Coalition and Mental Health Contractors Association.

The draft annual report was posted on the County's Behavioral Health Services website and with the Clerk of the Board of Supervisors. Community and stakeholder input was also solicited and received via telephone (local and toll-free lines), internet, and email using the County's MHSA Proposition 63 comment/question line.

WHAT IS MHSA?

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provided the first opportunity in many years for the California Department of Mental Health (DMH) to make available increased funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for children (ages 0-18), transition age youth (ages 18-24), adults (ages 25-59), older adults (ages 60 and above) and families. MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. MHSA imposes a 1% income tax on personal annual income in excess of $1 million. MHSA has five program components.

1. **Community Services and Supports (CSS)**

   Most new MHSA programs and strategies are implemented through the CSS component. These programs and strategies are improving access to underserved populations, bringing recovery approaches to current systems, and providing "whatever it takes" services to those most in need. These programs offer: integrated, recovery-oriented mental health treatment; case management and linkage to essential services, housing and vocational support; and self-help.

   The MHSA Housing Program, a function of CSS, finances capital costs associated with development, acquisition, construction and/or rehabilitation of permanent supportive housing for individuals with mental illness and their families. The MHSA Housing Program embodies both the individual and system transformational goals of the MHSA through a unique collaboration among government agencies at the local and state level.

   The largest MHSA component, the CSS expenditure plan for FY 2012-13 is approximately $90.0 million. For additional information about the CSS component, see the Fiscal Year 2012-13 Expenditure Plan section of this report.

2. **Prevention and Early Intervention (PEI)**

   Prevention and early intervention approaches in and of themselves are transformational in the way they restructure the mental health system to a "help-first" approach. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health and co-occurring problems and concerns, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health care and education facilities, community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.

   The FY 2012-13 expenditure plan for PEI is approximately $29.4 million. For additional information about the PEI component, see the Fiscal Year 2012-13 Expenditure Plan section of this report.

3. Innovation

Innovations are defined as novel, creative and/or ingenious mental health approaches that are expected to contribute to learning, and are developed within communities through a process that is inclusive and representative of unserved and underserved individuals. The Innovation component allows counties the opportunity to "try out" new approaches that can inform current and future mental health approaches.

The expenditure plan for innovation programming for FY 2012-13 is approximately $10.9 million. For additional information about the Innovation component, see the Fiscal Year 2012-13 Expenditure Plan section.

4. Workforce Education and Training (WET)

The overall mission of the Workforce Education and Training component is to develop, retain and maintain a sufficient public mental health workforce that is capable of providing client and family driven, culturally competent services that promote wellness, recovery and resilience. WET programs develop training curricula, incorporate cultural competency in all training and education programs, increase mental health career development opportunities, expand postsecondary education capacity, expand loan repayment scholarship programs, create stipend programs, promote distance learning techniques, promote employment of clients and family members in the mental health system, and promote meaningful inclusion of client and family members in all training and education programs.

The FY 2012-13 expenditure plan for WET is approximately $3.8 million. For additional information about the WET component, see the Fiscal Year 2012-13 Expenditure Plan section.

5. Capital Facilities and Technological Needs

Capital Facilities supports the goals and provision of MHSA services through the development of a variety of community-based facilities that support integrated service experiences. Funds may also be used to support an increase in peer-support and consumer-run facilities and the development of community-based, less restrictive settings that will reduce the need for incarceration or institutionalization.

Technological Needs projects demonstrate the ability to serve and support the MHSA objectives through cost effective and efficient improvements to data collection and communications. The goals of the technology projects and enhancements are to: 1) increase client and family empowerment and engagement by providing the tools for secure client and family access to health information through a wide variety of settings; and 2) modernize and transform clinical and administrative information systems to ensure quality of care, parity, efficiency and cost effectiveness.

The budget for the Capital Facilities and Technological Needs component for FY 2012-13 is approximately $12.3 million. For additional information about the Capital Facilities and Technological Needs component, see the Fiscal Year 2012-13 Expenditure Plan section.

FISCAL YEAR 2010-11 IMPLEMENTATION PROGRESS

San Diego County Demographics – 2010 Census

San Diego County covers 4,261 square miles and is nearly the size of the state of Connecticut, with an elevation that goes from sea level to 6,500 feet. The county includes beaches, valleys, deserts, and mountains. With more than three million residents, the county is comprised of 18 cities and 17 unincorporated communities. San Diego County borders Mexico to the south, Orange and Riverside counties to the north, the agricultural communities of Imperial County to the east, and the Pacific Ocean to the west. Its population is ethnically, racially and culturally diverse. In fact, one-third or nearly one million county residents speak a language other than English at home.

Race/Ethnicity	Total	% of Population
Hispanic	991,348	32%
Non-Hispanic	2,103,965	68%
- White (Caucasian)	1,500,047	48%
- Black	146,600	5%
- American Indian	14,098	0%
- Asian	328,058	11%
- Hawaiian & Pacific Islander	13,504	0%
- Other	6,715	0%
- Two or More Races	94,943	3%
All Ethnic Groups	**3,095,313**	**100%**

Addressing Disparities

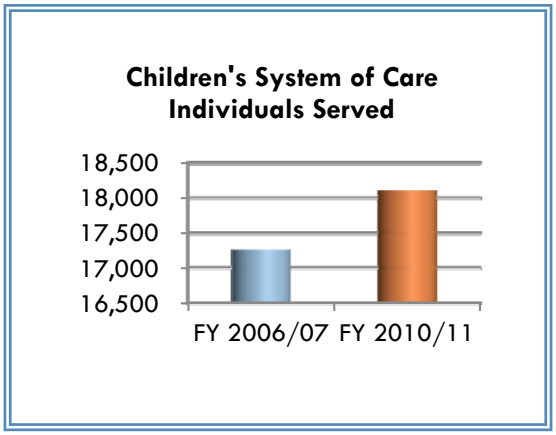
San Diego County Behavioral Health Services continues to develop and monitor the provision of linguistically and culturally appropriate services for the diverse populations of our County, focusing special attention on unserved and underserved communities. Below are highlights that represent some of the contributions our programs have made to address ethnic and racial service disparities and system transformation.

Community Services and Supports (CSS)

SERVING CHILDREN AND THEIR FAMILIES

The total number of individuals served by the children's system of care programs has increased by 5% from Fiscal Year (FY) 2006-07 (17,253) to FY 2010-11 (18,100); 2.5% of that increase came between FY 2009-10 and FY 2010-11. The majority of MHSA funding continues to be used to expand efforts of existing services to reach out to underserved, including, specific ethnic groups, children without insurance, and children already involved with other public services.

Over 30% of MHSA CSS funding has been used for more comprehensive services for underserved children involved with Child Welfare Services and the court system. In the children's mental health population in FY 2010-11, 19% of the clients were involved with Child Welfare Services and 17% received Probation services. School-based service expansion continues to constitute approximately 25% of CSS funding with targeted outreach efforts to underserved special language groups and to uninsured children. New Prevention and Early Intervention (PEI) services have been tailored for the comparatively small population of 0-5 year olds with mental health concerns, with the intent to divert these youngsters from needing future mental health services. Since youth age out of the children's system of care, the capacity of the system to expand may be more limited than the adult system.

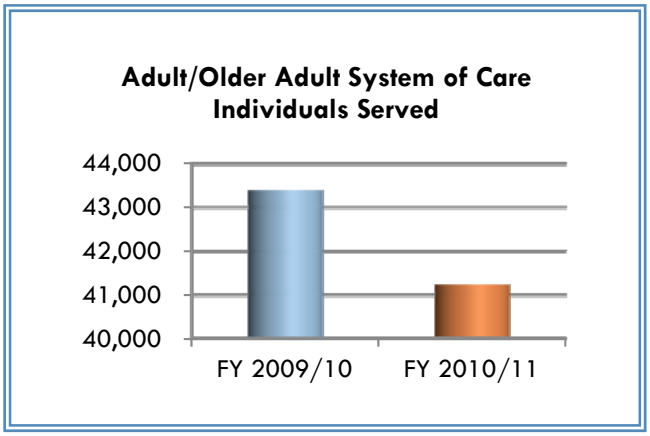


There was a 6% increase in the number of Hispanic children receiving services in FY 2010-11 (9,506) versus 8,936 in FY 2009-10 and a 2% decrease in the number of White children being served. There was also a slight increase in the number of African American and Asian/Pacific Islander children served. The number of Native American children served, however, decreased from 125 served in FY 2009-10 to 109 served in FY 2010-11.

Overall, the increase in the numbers of minority populations served is an indicator that outreach efforts to the underserved populations are meeting with a degree of success. However, expanding avenues of outreach continues as a necessity to bring these numbers closer to the percentages of minorities in the children's population as a whole.

SERVING TRANSITION AGE YOUTH, ADULTS AND OLDER ADULTS

Between FY 2006-07 and FY 2008-09, the growth rate for the adult mental health population had been spurred by the creation of CSS programs, specifically for transition age youth ages 18 through 24 and for older adults (age 60+). Prior to the implementation of MHSA, these age groups had been only peripherally involved in adult programs because of a lack of available funding to tailor programming for their special needs. The number of TAY clients served has increased 22% from FY 2006-07 to FY 2010-11 through MHSA targeted clubhouses, Full Service Partnerships (FSP), TAY counselors at community clinics, combining services that address co-occurring substance abuse and mental health challenges, etc. In FY 2010-11, the County of San Diego delivered mental health services to 6,198 TAY clients; 15% of the total 41,222 clients served. Efforts to reach out to Hispanic TAY have met with some success. The TAY clients served in FY 2010-11 were 42% White and 31% Hispanic, whereas the total adult client population was 50% White and 21% Hispanic.

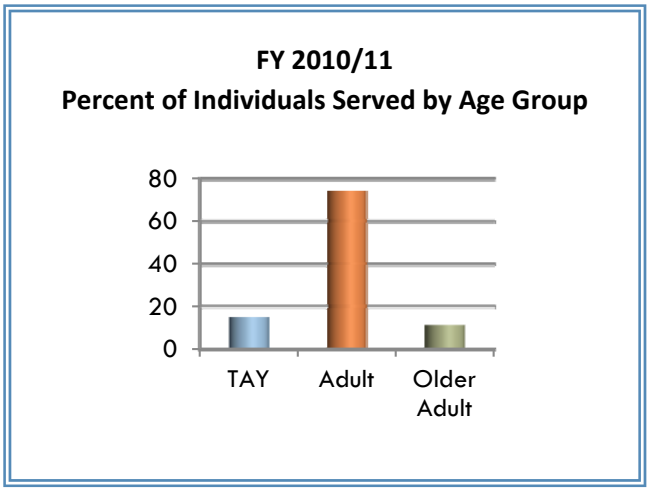


The number of older adult clients served increased 38% from FY 2006-07 to FY 2010-11, primarily as a result of MHSA targeted programming such as mobile outreach, FSP programming and use of promotoras. The County of San Diego provided mental health services to 4,594 individuals age 60 years and older, 11% of the total clients served. The older adult clients were more likely to be White (58%) compared to the overall client population (50%) and less likely to be Hispanic (13% compared to 21% in the total client population.) Outreach efforts to Asian/Pacific Islanders appear to have met with some success - 8% of the Older Adults are in this ethnic group versus 6% in the total client population. The PEI funded *It's Up to Us* anti-stigma campaign with its efforts aimed at specific age groups is expected to help people of all ages become less reluctant to seek services.

The total number of clients served (41,222) by adult and older adult specialty mental health programs decreased by 5% compared to the total clients served in FY 2009-10, when 43,383 clients were served. Two factors are believed to have contributed to this decrease. The PEI programs that began in FY 2010-11 may have provided a successful intervention for some participants, encouraging them to seek mental health assistance before needing to seek higher intensity services from the County. Secondly, in an effort to better integrate mental and physical health care, clients who were felt to be stable on their medications were encouraged to transfer to their local Federally Qualified Health Centers for mental health services.

The client gender in FY 2010-11 was 48% female and 52% male. The clients were slightly more likely to be male compared to the overall population of San Diego County.

The proportion of clients served in each age group has remained stable over the past four



fiscal years. In FY 2010-11, 15% of clients were ages 18-24, 74% were ages 25-59 and 11% were 60 years of age and older. The distribution of client ethnicity and race remained essentially stable from FY 2006-07 to FY 2010-11.

The percentage of clients with English as their preferred language increased to 82% of the mental health adult population from 79% in FY 2009-10. The percentage of clients with Spanish and Arabic language needs remained constant at 7% and 1%, respectively. The percentage of clients with Vietnamese or another Asian language needs rose approximately 1% between FY 2009-10 and FY 2010-11. It should be noted that children who are receiving services may be comfortable with English as their preferred language, but their parents (who are not clients) may still have a need for non-English services.

Community Services and Supports

Providing integrated mental health and other support services to those whose needs are not currently met through other funding sources

Implemented through the Community Services and Supports (CSS) component are the first generation of MHSA programs and strategies that are improving access to underserved populations, bringing recovery approaches to current systems, and providing "whatever it takes" services to those most in need. These programs offer integrated, recovery-oriented mental health treatment, case management and linkage to essential services; housing and vocational support, self-help, and address co-occurring disorders.

CSS contains four service categories:

- Full Service Partnership (FSP)
- Outreach and Engagement (OE)
- General System Development (SD)
- MHSA Housing Program

The following contains a brief description of each of the four service categories as well as program highlights from FY 2010-11. For more demographic information on Full Service Partnership programs, please refer to Appendix B.

Full Service Partnerships

Full Service Partnerships (FSPs) provide all of the mental health services and supports a person wants and needs to reach his or her goal and treatment plan. FSP services comprehensively address client and family needs and "do whatever it takes" to meet those needs, including intensive services and supports and strong connections to community resources with a focus on resilience and recovery.

FSP FOR CHILDREN AND YOUTH (CY-FSP)

These programs serve children, youth, and transition age youth (TAY) up to age 21, who have a diagnosis of a serious emotional disturbance or serious mental illness and their families. Special targeted populations include: indigent/unserved Latinos and Asian/Pacific Islanders; homeless or runaway children and youth; and children and youth who are Medi-Cal eligible, transitioning home or to a home-like setting from residential-based services; and at risk of returning to a higher level of care.

These programs provide an array of full service partnership services including assessment, case management, intensive mental health services and supports, psychiatric services, referrals, linkage with community organizations and co-occurring services. Services are strength based, family oriented, focus on resilience and recovery, and encompass mental health education, outreach, and a range of mental health services as required by the needs of the target populations. These programs offer four targeted approaches.

- Cultural/Language Specific Services are based on principles of community involvement, cultural and linguistic competence, and outreach to underserved Latino and Asian/Pacific Islander children and youth and their families.
- Homeless and Runaway Services focus on conducting outreach and engagement to homeless youth, making connections with homeless-specific community organizations, and linking clients to existing homeless youth outreach workers and community resources.
- Child Welfare Services (CWS) and Probation Department Services provide highly individualized services to maximize the capacity of the family to meet the child's needs, thereby reducing the child's level of care from a group home placement to a home or home-like setting. In addition, Early Periodic Screening Diagnosis and Treatment (EPSDT) services provide medication support for children and adolescents who are full scope Medi-Cal beneficiaries.
- Clinic-Based Services are provided in several locations throughout the County to a diverse range of children, youth, and families. These services are designed to promote access to medical, social, rehabilitative, or other needed community services and supports. Case managers and rehabilitation workers provide mental health rehabilitative services, home visits, and assistance to parents to manage treatment appointments and service plans. Many case managers/rehabilitation workers have bilingual language capacity to serve parents who are often monolingual.

These programs further the goals of the MHSA by providing culturally competent, wraparound services for identified unserved and underserved populations with a focus on family inclusion. Services are designed to address access disparities and reduce stigma associated with mental health services and treatment. The programs also strive to reduce institutionalization and promote integrated service experiences for clients and families.

FY 2010-11 Highlights

- The Cultural Access and Resource Enhancement (CARE) program provided services to 156 unduplicated clients, surpassing the 91 unduplicated client targets for the fiscal year, with a family participation rate of 98%. The flexibility of the program allows services to be provided in the home or other sites chosen by the family. Program staff attended fairs and events within the Central and North Central Regions of San Diego with a strong emphasis on Latino and Asian/Pacific Islander (API) events which resulted in successful contacts and lasting relationships with pediatricians, general practitioners, dentists and other medical professionals who primarily serve the API and Latino communities allowing the program to find medical homes for all of their clients and families if they had none during intake.

  The program conducted 1,757 extensive outreach and education activities to the community which resulted in an increase in API enrollment to the program. A CARE clinician provided an interview on a Vietnamese radio show, TNT Radio Network, which was aired on September 10, 2010. He discussed CARE services, cost of services, parenting difficulties for Vietnamese speaking parents, acculturation, depression in children and services available to the Vietnamese community in San Diego County. Clients and families are also benefiting from "Health and Nutrition" binders created by program staff that contains information on health and nutrition for parents, infants, children and adolescents. The information is provided in English and Spanish and instills the importance of a healthy lifestyle to the clients and family members.

- Harmonium Family/Youth Partner Program supported *Live Well, San Diego!*, the County's strategic health initiative, by encouraging family participation in community events that focus on enhancing the health of their children like visiting produce markets, healthy cooking events where instructions on preparing healthy meals are provided. The program conducted 619 outreach services that involved attending meetings and forums to gather and document community input regarding the services the target community wants and needs.

Seventeen year old "Doug" was referred to Counseling Cove due to his father being incarcerated and his mother being put into a board and care facility for health reasons. Without any parental care, "Doug" entered the San Diego Youth Services (SDYS) Storefront Shelter for teens. "Doug" was raised in a small trailer by his parents who used illegal substances and could not provide basic needs for him. When "Doug" began counseling, he was very depressed, was afraid to interact with others, had very low self-esteem, and was so hopeless about his future that he often thought of suicide. Through the use of program services, he became much more confident in his interactions with others, his self-esteem increased and he become excited about his future. After one year of working with staff, "Doug" graduated high school on time and immediately started college. He started working, received his driver's license and bought his own car. Through SDYS Take Wing Program, "Doug" secured his first apartment and quickly learned to be self-sufficient. After two years with Counseling Cove, he no longer had any depressive symptoms and successfully transitioned out of the program.

FSP FOR AGES 18 THROUGH 65+ (TAOA-FSP)

These programs, which are made up of several services of varying focus, serve unserved or underserved transition age youth ages 18 to 24, adults ages 25-59, and older adults 60 years and above who have a diagnosis of a serious mental illness and may have a co-occurring substance use disorder. These individuals may be homeless or at risk of becoming homeless; living in a locked long-term care or skilled nursing facility; high utilizers of acute inpatient care, medical services, emergency departments, shelters and psychiatric hospitals; and those under the care of institutions or at the risk of institutionalization including criminal justice involvement. These programs also reach out and engage women, African-Americans, Latinos, and Asian/Pacific Islanders with a serious mental illness.

The programs provide a variety of integrated services which may include supported housing (temporary, transitional, and permanent) with a focus of age and developmentally appropriate outreach and engagement, intensive case management 24 hours a day and 7 days a week, wraparound services, community-based outpatient mental health services, rehabilitation and recovery services, supported housing, supported employment and education, dual diagnosis services, peer support services, diversion and reentry services, and other housing options. Some services utilize the Assertive Community Treatment (ACT) model, which is an evidence-based practice that has repeatedly demonstrated effectiveness for people who have a serious mental illness who were not adequately served by the former service system. All services are delivered with cultural competence and are linguistically appropriate. Programs include the following unique components and services.

- Housing Trust Fund, based on the recommendation of the stakeholders in San Diego, sets aside unspent one-time and ongoing housing funds that are used to increase permanent supportive housing opportunities for transition age youth, adults, and older adults in the CSS FSP integrated homeless programs. Funds are set aside in this trust fund to leverage the development of affordable project-based permanent supportive housing units for these low income clients.
- Mental Health Calendar provides mental health services for individuals with a serious mental illness who have been found guilty of a non-violent crime (either misdemeanor or felony) and are awaiting sentencing. Most individuals are repeat offenders who may have received mental health services while incarcerated or in the community and are referred for services via the justice system. The program is delivered by a specialized, multi-agency team that includes Superior Court, District Attorney, Sheriff, Public Defender, Probation, and Behavioral Health Services.
- Residential Integrated Treatment provides 24-hour rehabilitation and recovery services, psycho-education, care coordination, supported employment and education, peer support services, and physical health screening, consultation, linkage, referral and follow up with primary care provider. This program develops community collaborations to provide employment, housing, and other supports for clients transitioning to independent living.
- Case Management is based on the Strength-Based Care Management model that provides treatment, education, and skill building activities for older adults. Outreach, screening and assessments, social skills training, co-occurring services, assistance with activities of daily living, brokerage, and support services are offered.
- Transition Team Services works to reduce psychiatric hospitalization and improve community support through short-term intensive case management services to individuals who have Medi-Cal, no current care coordinator, and are hospitalized at one of San Diego's Medi-Cal psychiatric hospitals.
- High Utilizers of emergency departments, shelters, psychiatric hospitals and those who have had legal and/or justice system involvement are provided intensive services.

These programs were expanded to provide a range of case management and peer-delivered services to persons 18 to 59 of age who are or have been living in institutional care facilities.

The programs advance the MHSA goals to reduce incarceration and institutionalization, to increase meaningful use of time and capabilities, to reduce homelessness and to provide timely access to needed help for unserved and underserved individuals by providing intensive, wraparound services. In addition, these programs advance rehabilitation and recovery practices by assisting clients in their personal recovery via a wellness and resilience focus, as well as in seeking and sustaining employment and educational goals.

FY 2010-11 Highlights

- Intensive Mobile Psychosocial Assertive Community Treatment (IMPACT) was named the Mental Health Program of the Year in 2011 by the County of San Diego Health and Human Services Agency. IMPACT provides Assertive Community Treatment (ACT) services to 224 Central and North Central Region adults with a severe mental illness who have been homeless and who often have co-occurring disorders. Clients have a range of high needs and have demonstrated poor engagement and outcomes in the past. The ACT team members work collaboratively to "do whatever it takes," relying on eight complementary evidence-based and best-practice models including Wellness and Recovery Action Planning (WRAP), full fidelity ACT services, a Housing

First approach, Motivational Interviewing, and others. Once clients are engaged, housed, and psychiatrically and medically stabilized, a vocational specialist is available to work with them. In FY 2010-11, an innovative partnership was established between IMPACT and "Mind Treasures," a non-profit organization that creatively supports financial literacy. Data from the state's Data Collection and Reporting (DCR) system as of June 15, 2011, showed that no IMPACT clients were homeless (although less than 10 clients are in jail, hospital, or an emergency shelter situation), 14% of the clients have some involvement in volunteer or paid employment (compared to 1% upon admission), and 99% of the clients have an identified primary care physician.

- Starting Point, which provides intensive wrap around services 24 hours a day and 7 days a week to help transition age youth in recovery from co-occurring mental health and substance use issues live independently, served 49 unduplicated clients. The program focuses on encouraging each client's recovery and pursuit of a full, productive life by working with the whole person, rather than only focusing on alleviating symptoms. Taking into account this holistic view, treatment at Starting Point addresses the six dimensions of health - physical, social, mental, emotional, spiritual and environmental. The program provides clients with comprehensive, intensive dual diagnosis-enhanced services within a structured, residential treatment program. Clients are supported within the community to accomplish many tasks including visits to the County Recorder, Social Security Administration, and Department of Motor Vehicles offices to get needed documentation.

  During the year, in addition to receiving the above services, clients were also provided transportation and financial support to acquire their GED or High School diplomas through local night school venues. Starting Point provided access to the National Alliance on Mental Illness (NAMI) 12-week Peer-to-Peer course for individuals desiring to become Peer Facilitators. Clients were supported in volunteer work in the community at Friends of Cats Animal Shelter and Father Joe's Villages.

  Residents also participated in community outreach at events such as the County of San Diego's Mental Health Month keynote event, Drumming Out Stigma, and public activities such as beach cleanups and the suicide prevention Save a Life 5K Walk in Balboa Park. Throughout the fiscal year, the program worked to revise their program rules to adopt a more structured philosophy to better serve their intended population. Ample time was spent in training staff and working with clients about the changes to the program and activities resulting in an increased ability for participants to maximize the benefits of the program.

- Catalyst provided Assertive Community Treatment (ACT) to 257 unduplicated transition age youth clients. Catalyst ACT recovery-oriented, strength-based services include mental health services, psychiatric and nursing services, case management, benefits advocacy and management, supportive housing services and rental subsidy assistance, employment and education assistance, peer mentorship and counseling, and treatment for co-occurring disorders. The program conducted ongoing communication and outreach with other community providers and partners such as Child Welfare Services, local crisis stabilization programs and psychiatric hospitals. One of the challenges that Catalyst staff continuously dealt with during FY 2010-11 was being over capacity. The program received a range of two to seven referrals per week, as well as one to two high-priority referrals per week. To mitigate this issue, the program consistently participated in meetings with other ACT team programs, case management programs, and County personnel to address the capacity and referral prioritization issues.

- Behavioral Health Services is a partner in United Way's Project 25 program, a three-year pilot program that provides permanent housing, supportive services and a comprehensive discharge program to at least 25 of the county's chronically homeless and some of the highest utilizers of

public resources. The Gateway, a Full Service Partnership program, was enhanced to provide supportive services to these individuals. These services included outreach and engagement, mental health assessment and treatment, rehabilitation and recovery services, case management, and housing support. Under the County's direction, Gateway staff works in close partnership with St. Vincent de Paul Village, who identifies potential clients and coordinates services delivery.

- Following San Diego Registry Week in September 2010, which documented at-risk homeless individuals in central San Diego, two Full Service Partnership programs - Downtown Impact and Center Star - were expanded to provide services to 50 homeless individuals. These individuals were identified through the Vulnerability Index and often had tri-morbid conditions including physical health conditions, serious mental illness, and substance abuse. The FSPs provided services that include outreach and engagement, mental health assessment and treatment, rehabilitation and recovery services, case management, and housing support.

Outreach & Engagement

Outreach and Engagement (OE) reaches out to people who may need services but are not getting them.

OUTREACH & ENGAGEMENT FOR ALL AGE GROUPS (ALL-OE)

This program serves seriously emotionally disturbed children (age 0-17) and seriously mentally ill transition age youth (ages 18-24), adults (ages 18-59), and older adults (ages 60 and above) who are deaf or hard of hearing or victims of trauma and torture. This program also serves uninsured individuals receiving physical health care at community clinics who are not currently receiving mental health services. Special focus is placed on individuals identified as unserved or underserved by the County of San Diego's Gap Analysis, which includes Native Americans, Latinos, Asians/Pacific Islanders, and African Americans.

This program offers a variety of outreach and engagement, and outpatient mental health services, including care coordination, linkage, and individualized/family-driven services and supports. Clients are provided with necessary linkages to appropriate agencies for psychotropic medication management if necessary, as well as services for co-occurring substance abuse disorders. Targeted services include the following:

- Services for the Deaf and Hard of Hearing reaches out to, and offers specialized counseling for individuals with hearing impairments. The program provides interventions to assist clients and families to achieve a more adaptive level of functioning. Services are provided in communication accessible languages including, but not limited to, American Sign Language.
- Services for Victims of Trauma and Torture reaches out, engages with, and provides specialized interventions for these individuals, as well as training for other providers on working more competently and effectively with victims of trauma and torture.
- Mental Health Services in Community Clinics provides treatment services to uninsured individuals through a master agreement with the Council of Community Clinics for management and authorization of care and general system management. The Council of Community Clinics represents a consortium of community clinics and Indian Health Services providers in San Diego County. The goal of this program is to integrate care between the primary care provider and the mental health provider within the same clinic structure.

These services advance MHSA goals by increasing access to services for unserved and underserved individuals through an integrated system of collaboration with mental health and community providers. The services reduce mental disability and restore functioning for individuals through education, targeted services, and support for enhanced self-sufficiency. In addition, these services provide a range of rehabilitation interventions to assist persons with a serious mental illness achieve a desired quality of life consistent with a bio-psychosocial approach.

FY 2010-11 Highlights

- Survivors of Torture International (SOTI) served 101 unduplicated clients. Specific outreach and education activities included presentations to stakeholders in the community such as the County's Mental Health Board and the Lawyers Club of San Diego, and attendance at the Annual Meeting of the National Consortium of Torture Treatment. Program staff also made presentations to graduate-level nursing classes and sociology classes at local universities. SOTI staff networked directly with the public by staffing tables at venues such as Amnesty International's Annual Human Rights Walk and Chula Vista Presbyterian Church's Annual Social Ministry Fair.
- In 2010, the County of San Diego Behavioral Health Services established regional behavioral and physical health collaboratives in an effort to increase physical and behavioral health integration and provide quality care coordination for clients. The partnerships help address gaps in resources and create an informative network. Since the inception, various concerns and gaps among providers have been addressed, including but not limited to, the need for training and education of primary care providers about mental health clients being treated at primary care sites and the need for mental health staff support and crisis intervention for clients presenting at primary care sites.

  Representatives at these meetings include Behavioral Health Administration, Federally Qualified Health Centers, mental health clinic providers, hospital partners, Health and Human Services Agency (HHSA) staff, HHSA Aging & Independence Services, consumer operated programs, and other community partners. In 2011, programs providing substance abuse services were invited to join. The collaboratives in North Inland, North Coastal, North Central, East, South and Central Regions continue to advance HHSA initiatives such as *Live Well, San Diego!*, primary care integration with behavioral health, Low-Income Health Plan (LIHP) implementation, and also improve program knowledge with the participants.

OUTREACH AND ENGAGEMENT FOR CHILDREN AND YOUTH (CY-OE)

These programs serve children and youth, up to age 18, with a serious emotional disturbance and their families and who are indigent and unserved or underserved. Targeted outreach is made to Latino youth and youth involved in the juvenile justice system and associated community schools and to children and youth with co-occurring disorders.

The programs offer outreach, engagement, assessment, medication management, case management, referral and linkage, co-occurring mental health/substance use treatment, and individual, group, and family therapy. Services are individualized, culturally competent, resilience focused, strength based, and designed to have families and youth actively participate in the development of their treatment plans.

School and home-based services offer evidenced-based services at designated school sites during regular hours. Family services and services after school hours or during school breaks are offered in the

home or office locations. Service providers work closely with school personnel to engage and support youth and their families in defining their vision and purpose, which can then be translated into strength-based goals. Juvenile Court and community school services are designed to assist youth in returning to their home school districts in order to increase academic success. This program is dual-diagnosis capable, able to address substance use and abuse issues.

The programs address MHSA goals by increasing timely access to care for indigent children and youth who would otherwise remain unserved or underserved and by providing client and family-driven, strength-based, culturally competent, and recovery-oriented services in school and community-based settings. The program strives to reduce institutionalization and promote integrated service experiences for clients and families.

FY 2010-11 Highlights

- An important achievement that occurred in FY 2010-11 was around the modification of the delivery of the Incredible Years Parent Training (IYPT) model to make it more available to more families of preschool-aged clients. Prior to the modification, IYPT had been provided in groups at child development centers in the community, in both English and Spanish, in twelve-week increments. While the group model works very well for many families, it does not work well for parents that may have transportation challenges, and parents that care for the needs of their other children or may work various hours. Some parents don't feel comfortable in a group setting or the timing or location of the group may not work in relation to the child's dates of enrollment in the program.

  To provide access to those who were previously unavailable, the program began offering a modified form of IYPT that includes the same teaching strategies - viewing and processing video vignettes, reading and written exercises, and role-plays - but done one on one. Both the program clinicians or promotoras provide this modified version of parent training; and it can be done in the office or at families' homes, depending on need. An added advantage to providing services in the home is that it allows for hands-on parent support in the environment where they struggle with their child's behavior, with immediate feedback. As a result, parents are more involved in their child's services. This partnership works to the obvious benefit of the child.

System Development

System Development (SD) programs improve mental health services and supports for people who receive mental health services.

SYSTEM DEVELOPMENT FOR ALL AGE GROUPS (ALL-SD)

These programs provide services to children, transition age youth (TAY), families, adults, and older adults who are unserved or underserved and have a serious mental illness or serious emotional disturbance. Targeted populations include individuals of Middle Eastern descent, veterans, homeless individuals, Native Americans, children or TAY who are bilingual with a parent or caretaker who is monolingual, adults who are monolingual or not proficient in the English language, and adults who prefer to speak in their native language.

Programs offer a variety of services to individuals of all ages in the community.

- Interpreter Services provides interpretation in multiple languages for clients and families receiving services by a clinician, case manager, psychiatrist, substance abuse counselor or other staff person at a behavioral health program. When services are requested, assigned interpreters travel to the program site to work with the client and care coordinator. In a situation identified as urgent, services are provided within four hours.
- Psychiatric Emergency Response Team (PERT) assists individuals in crisis that come to the attention of law enforcement. PERT seeks to optimize safe outcomes for these individuals through on-scene assessment, crisis intervention, referral, and access to appropriate services. Services are provided by a licensed mental health professional and a specially-trained PERT law enforcement officer. PERT clinicians also provide education and training to the law enforcement community. A PERT clinician also rides with the San Diego Police Homeless Outreach Team to assist with veterans who may be experiencing a crisis.
- Chaldean Services focus on the Middle Eastern community who have not traditionally accessed mental health services due to cultural or language barriers. The goal of this program is to decrease stigma around mental health issues through provision of culturally competent services that increase well being and symptom management. Services are provided by bilingual and bicultural Middle Eastern mental health professionals and include counseling, outreach, education, and training for mental health professionals on Middle Eastern populations and the manifestations of mental disorders in this population. The program collaborates with current mental health providers, Child Welfare Services, Chaldean Catholic Church in El Cajon, Survivors of Torture & Trauma, law enforcement, and Middle Eastern providers of physical and mental health services in private practice.

These programs further the goals of the MHSA through the implementation of rehabilitation principles that are effective in reducing psychiatric hospitalization or incarceration by utilizing the least restrictive level of appropriate care and assisting unserved and underserved persons with a mental illness to become more productive community members. The services ensure timely access to mental health care and address the disparities gap for individuals of diverse multilingual communities. Service providers collaborate with County mental health providers, increasing service integration and coordination across the system.

FY 2010-11 Highlights

- Chaldean and Middle Eastern Social Services provided assertive outreach and engagement, mental health counseling, intake, screening and case management to 83 unduplicated clients. There were also 32 acculturation/welcome groups with 206 youth attending Arabic groups at the following East County Middle and High Schools - Cajon Valley High School, Cajon Valley Middle School, El Cajon High School, El Cajon Middle School, Emerald Middle School and Grossmont High School. There were parenting workshops for the parents whose children were enrolled in acculturation/welcome groups. Also, there were monthly, in-office groups for youth, one for boys and one for girls, addressing anger management and acculturation.

SYSTEM DEVELOPMENT FOR CHILDREN AND YOUTH (CY-SD)

These programs serve children and youth, up to age 18, with serious emotional disturbance and their families. Special outreach is made to unserved and underserved populations including Latinos and Asian/Pacific Islanders, children and youth referred by the Probation Department and Kearny Mesa Juvenile Detention Facility, youth who reside in residential treatment facilities, and children and youth

placed at home, foster care, or small group home at risk of a change in placement (i.e., placement at a higher level of care and therefore at risk of being removed from their home, foster home, or small group home).

- Family and Youth Peer Support and Partner Services hires family members to provide support, education, information, linkage to services, and advocacy for children, youth, and their families. This program offers leadership training opportunities enabling family and youth partners, who have experience with the mental health system, to serve as role models and leaders for the community. Other activities include treatment meetings, care planning, wraparound meetings, intake and assessments, case management, and home visits.
- Crisis Intervention Services aim to prevent escalation, promote management of mental illness, increase safety, and reduce unnecessary and costly utilization of emergency and inpatient services. This program is staffed by one mobile team that provides emergency mental health evaluations, crisis intervention, linkage, and treatment plan development. The program refers and links individuals to services as an alternative/diversion to hospitalization when clinically indicated.
- Screening and Medication Management Services provide short-term stabilization treatment with psychotropic medication, case management, and linkage to on-going treatment. Services include psychiatric evaluation, consultation, assessment, and medication monitoring. The program also offers screening, brief interventions, and referral for clients with co-occurring disorders.
- Early Childhood Services provide family therapy for children ages 0-5. The goal of this program is early treatment intervention in order to increase resilience of the child and family, prepare the child to function in school, and enable the child to interact appropriately with other children. Program staff lead parent groups, parent and child interaction training, trauma intervention, and social skills training for young children.
- Supportive Services and Treatment Program works in conjunction with Child Welfare Services (CWS) and the Department of Probation to provide a full range of rehabilitation options designed to: 1) return children and youth to their family or family-like settings, 2) deter children and youth from being placed in a higher level of care, and 3) stabilize placement. Clients receive case management, assessment, life-skills training, therapeutic support for substance abuse issues, employment support, and specialized treatment. The program also includes a peer mentorship program. Peer mentors serve as a bridge to the adult environment by providing inspiration and hope as youth prepare to leave the San Pasqual Academy.

These programs advance the goals of the MHSA by promoting rehabilitation and recovery for an underserved or unserved group of individuals, increasing client and family participation in service delivery by hiring family members to provide direct service and peer support. Additionally, these programs offer education to decrease stigma associated with mental health services, minimize barriers and increase access to integrated, family-driven services and supports and provide services for clients using the least restrictive environment.

FY 2010-11 Highlights

- The ChildNet program provided services to 131children at 42 different sites around North County. The services were provided child development centers, church preschools, elementary schools, in their homes, or in home-based child care facilities. Thirteen clients transitioned into kindergarten with 10 of the 13 clients successfully meeting goals by discharge. Parents of 58

children discharged received Incredible Years Parent Training with success. The average rate of family participation increased from 73% in the previous year to 83% in FY 2010-11.

- Comprehensive Assessment and Stabilization Services (CASS) offered placement stabilization to 227 unduplicated clients by providing outpatient mental health clinical services to children, adolescents and youth who are severely emotionally disturbed (SED), served by Child Welfare Services (CWS), at risk of change of placement from their home, foster home, small group home, or other home-like setting. CASS provided continuity of care for youth and families during periods when services may otherwise have been disrupted.

- San Pasqual Academy is a residential education campus designed specifically for foster teens. In FY 2010-11, the Academy provided 137 foster teens with a stable, caring home, a quality, individualized education, and the skills needed for independent living. There were 30 young adults in the graduating class of 2011. Three graduates received an Outstanding Citizen Award from the Academy's residential provider, New Alternatives, Inc. for achieving academic excellence, demonstrating leadership skills and giving back to the campus community. Several graduates continued their education in vocational programs, two-year community colleges and four-year universities. Approximately 40 Academy youth are employed or participating in internships on and off campus.

  The Academy's Agriculture Program has been growing since 2004, and has been selling certified, organic produce to local vendors (such as Whole Foods) under the name Dragon Organics. In FY 2010-11, it entered the farmer's market arena with sales at farmer's markets in Scripps Ranch, San Marcos, Escondido and Carlsbad. The Agriculture Program provides an avenue for students to gain academic, work readiness and independent living skills. Youth take farm management classes, participate in harvesting and packaging the produce, work at the local farmers markets and educate their peers on campus about the benefits of eating fresh produce.

- The Caring Helpers program conducted an educational presentation regarding mental illness to 1,181 unduplicated clients. The program also conducted regional education forums, leadership training, and community health fairs for unserved and underserved populations as identified in the County's gap analysis. This program supports the principle of authentic consumer and family/youth participation thereby enabling the community to experience a positive perception of those with mental health issues. In FY 2010-11, the program developed iLEAD, a leadership training, that teaches youth to teach other youth about ending bullying.

- The Juvenile Court Clinic, which provides short-term (up to three months) medication support and stabilization treatment with psychotropic medication and linkage to community-based or private on-going treatment, served 192 clients in FY 2010-11. It also assisted the children and families with support, linkage, and coordination for ongoing behavioral health services as needed. The program provides consultation, reviews and feedback to the Juvenile Court. In FY 2010-11, the program assisted the court with over 1,100 initial reviews. In addition, the program participated in the newly formed Juvenile Mental Health Calendar with screening committee and assisted clients transition into the community.

- Clark Life Skills Program serves the residential mental health clients by offering a life skills curriculum that includes a drug and alcohol component. Advancing *Live Well, San Diego!,* healthy eating is also an important topic of the program and includes organic gardening with chef support.

There was a 7-year-old girl who was hospitalized for several days. CASS was able to work with her and support her family who was unable to drive from Fallbrook to San Diego to visit her and did not understand what was going on (monolingual Spanish family) during this difficult time. CASS continued to coordinate, attend, and actively contribute to interdisciplinary meetings during the hospitalization to plan for her care. All of this would have been non-billable to Medi-Cal, but MHSA funding supported this essential continuity of service.

SYSTEM DEVELOPMENT FOR AGES 18 THROUGH 65+ (TAOA-SD)

These programs consist of various services for the unserved and underserved transition age youth, adults, and older adults with a serious mental illness who may have a co-occurring substance abuse disorder, and their families. Special emphasis is placed on outreach and engagement to African-Americans, Latinos, Asian/Pacific Islanders, Native Americans, women, individuals who are homeless or at risk of homelessness, individuals with a high incidence of emergency and inpatient service utilization, and individuals residing in board and care facilities, emergency shelters, or transitional housing programs.

These programs promote wellness and recovery goals, increase timely access and use of behavioral health services, develop self-sufficiency, and create support networks for clients through the following services.

- Outpatient Bio-psychosocial Rehabilitation clinics provide outreach, engagement, assessment, integrated dual disorders treatment (mental illness and alcohol and other drug substance abuse), rehabilitation and recovery services, employment and education support, and psycho-education classes. Outpatient services have been enhanced to create new levels of care, field capable services, psychiatric-primary care collaboration and increase the walk-in and urgent capacity at clinics.
- Clubhouses are member-run programs that provide opportunities for skill development, social rehabilitation, and symptom management through an array of peer-led educational support groups and community activities. Three clubhouses primarily serve specific ethnic groups: Asian/Pacific Islanders, African-Americans, and Latinos; another is designed specifically for TAY.
- Peer Support and Liaison Services offer peer education delivered by peer counselors. Peers lead classes including Wellness Recovery Action Planning (WRAP) and other best practice curricula.
- Family Education Services offer a series of classes to educate/support families who have relatives with mental illness. This course is taught by families and increases coping skills while encouraging involvement with the mental health system. A 'train-the-trainer' component supports family members willing to become trainers. Classes target English, Spanish, Vietnamese, and Arabic language speakers.

- Supported Employment Services offer job screening, preparation, development, supports, coaching, placements, and employment opportunities. This program uses the SAMHSA evidence-based practice model for supported employment. The goal of this program is to assist individuals in finding and maintaining competitive jobs leading to recovery and independence.
- Patient Advocacy Program provides advocacy services to clients residing in licensed board and care facilities. These services include forming liaisons with staff and residents; providing information on community resources and the rights and responsibilities of residents and staff; conducting site visits; and investigation of client complaints and grievances.
- Mobile Outreach Services provide engagement, mental health/substance abuse screening, benefits information, linkages, and referrals. Services are offered 24 hours a day 7 days a week to isolated seniors in-home and to persons who are homeless, including on-site services in the community.
- Social Security Income (SSI) Support Services provides training and consultation of services for SSI recipients. In their employed role as SSI advocates, consumers assist other consumers through the benefit application process. This service also provides benefits application training and support to advocates on the preparation of a thorough and accurate SSI application.
- Walk-in Centers are voluntary, drop-in assessment centers that provide comprehensive and integrated assessment of mental health/substance abuse, crisis intervention, follow-up appointments, telepsychiatry, and medication management.
- Geriatric Specialist clinicians provide community based outreach services to isolated older adults, including age appropriate assessments of mental health/substance abuse and physical health needs; case management linkage and recovery services delivered onsite or via outreach and home visits. Clinicians also assist transition of stable clients to lower level resources.

These programs further the goals of the MHSA through implementation of rehabilitation principles proven to be effective in reducing psychiatric hospitalizations and assisting unserved and underserved persons with a mental illness to become more productive community members. These services are family and client driven and strive to reduce racial disparities in access to care, decrease the stigma of mental illness and empower peer and family involvement in the service delivery system.

FY 2010-11 Highlights

- Recovery Innovations served 3,744 unduplicated persons, exceeding contractual requirements by 134%, with 98% of clients surveyed saying that Recovery Innovation classes and services were helping them.

  Recovery Innovations also evaluates program success by surveying clients after their sixth visit to determine their level of improvement in domains such as education, employment, recreation, housing, and personal relationships. Based on those surveys through December 2011, 40% reported improved progress on their housing goals, 50% reported improved progress on their employment goals, 65% reported improved progress on developing and maintaining friendships, and 79% of clients improved progress on their education goals.

  The program collaborates with a wide number of advocacy services and service programs to produce an annual Wellness and Recovery Summit. A number of nationally known leaders of the consumer/client empowerment movement are brought to San Diego to speak at the Summit to approximately 400 participants, most of whom are consumers of San Diego County's public mental health system. The 2011 Wellness and Recovery Summit was dedicated to discussing

stigma faced by those having mental illness and ways to reduce that stigma. The day-long summit included a presentation by graduates of the Peer Employment Training on their vision of reducing stigma surrounding mental health challenges. The County of San Diego's *It's Up to Us* stigma reduction/suicide prevention media campaign was presented to the 460 people in attendance.

- The 13 clubhouses in the County of San Diego took action to improve their members' health and well being as a part of the *Live Well, San Diego!* initiative by offering comprehensive and dynamic programs to support people recovering from severe and persistent mental illnesses. Many clubhouse activities specifically target healthy eating and active living, which are important factors in improving the health habits and quality of life of their members.

  With a grant for recovery and wellness materials, the Escondido Clubhouse purchased Nutrition & Fitness Center/Food Education for People with Serious Psychiatric Disabilities, an evidence-based recovery curriculum from the Boston University. Several members reported that they lost weight, had a reduction in their blood pressure, reported their medication working better, were more active, and were sleeping better.

  At the Neighborhood House Association Friendship Clubhouse, members participated in softball tournaments sponsored by the Department of Parks & Recreation's Therapeutic Recreation Services.

  Friend to Friend Clubhouse members living at the Downtown Safe Haven were offered classes such as diabetes management and meditation classes.

  Each Tuesday and Saturday, the Meeting Place provided its members with free fresh vegetables, fruit, eggs, and bread from donations provided by Trader Joe's. This allows members to have healthy food at home that they usually cannot afford.

  Members of the Oasis Clubhouse walked at Chollas Lake on a weekly basis to give members an opportunity to participate in a low impact aerobic workout while enjoying the outdoors.

  The Discovery Clubhouse modified yoga and volleyball by using a chair to address the needs of members with physical limitations. In addition, the clubhouse provided smoking cessation groups once a week to encourage clients to reduce smoking and use of tobacco-related substances and to encourage substituting an alternative means of decreasing anxiety and symptom management independent of smoking.

- In order to promote better and more accessible care around the County, the walk-in outpatient services, which were formerly only available at the County's Walk-In Crisis Clinic at the Emergency Psychiatric Unit (EPU), were decentralized and moved to County and contracted adult and older adult outpatient mental health providers throughout San Diego County on September 1, 2010.

  The redesign increased walk-in and urgent service capacity at the outpatient programs for clients who, in the past, would have been referred to the EPU Walk-In Crisis Clinic to access medication services and urgent, crisis services. During business hours, designated adult and older adult outpatient mental health clinics provided these services to all regions. The intent was to refer the client to the outpatient mental health clinic nearest to their residence. Emergency services remained available after September 1, 2010; and individuals continued to be able to access emergency psychiatric evaluation services at the EPU. However, the EPU is now for emergencies only and does not provide outpatient mental health services, such as medication refills.

Housing Program

The Housing Program finances the capital costs associated with development, acquisition, construction and/or rehabilitation of permanent supportive housing units for individuals with mental illness and their families, especially those who are homeless.

The Department of Mental Health (DMH) and California Housing Finance Agency (CalHFA) Housing Program set aside approximately $33 million for San Diego County to leverage the development of permanent supportive housing units.

The MHSA Enhancement #3 set aside $1 million for ongoing housing support for the full service partnership (FSP) programs. Additionally, $1.7 million of one-time MHSA funds was utilized for housing support in FY 2010-11. These funds are embedded in several programs to facilitate an array of housing needs including short term, transitional and supportive housing.

The MHSA Housing Program is intended to guide the creation of housing opportunities for persons with mental illness in San Diego County, with a focus on developing at least 241 new units for MHSA-eligible clients. Three updates to the Plan have been published since the Plan was adopted, reflecting on both progress and challenges to meeting the goals. The current plan is located on the Network of Care Website (http://sandiego.camhsa.org/housing.aspx). The MHSA Housing Plan was prepared for and reviewed by the Mental Health Housing Council and reflects the input of clients, family members, developers, service providers and County staff.

FY 2010-11 HIGHLIGHTS

- Eleven housing projects with 194 MHSA units were in the development pipeline, representing 80% of the plan's development goal.
- 34th Street Apartments, with five MHSA units, completed construction and occupancy.
- Three developments totaling 58 units had been approved by CalHFA/DMH for funding and two of these projects totaling 48 units have begun construction.
- At the end of the fiscal year, two projects - the Mason and 9th & Broadway - totaling 41 MHSA units, were awaiting approval by CalHFA/DMH. Also at the end of the fiscal year, one development had submitted an application to HCD for local MHSA dollars. The remaining four projects are in various stages of predevelopment.
- For leased, partnership and other units: Mental Health Systems, Inc. and Community Research Foundation secured 50 new sponsor-based subsidies from the San Diego Housing Commission for vulnerable homeless persons with mental illness in the City of San Diego's downtown. The housing subsidies allowed the two full service partnership programs to provide services and permanent supportive housing to an additional 50 homeless individuals with a serious mental illness. In addition, the County partnered with the United Way of San Diego County, the City of San Diego, and local non-profit organizations to provide services for mentally ill homeless individuals who are frequent users of public resources. The HCD prepared to issue a Notice of Funding Availability for project-based Section 8 subsidies in the coming year. This provided an

opportunity for MHSA developments in the county to leverage their capital dollars with much need operating subsidies.

- Improvement in client satisfaction with housing and services: Results from the 2010 focus groups and surveys were shared with the County and operators of full service partnerships and used to improve the delivery of services and housing. The results from the 2011 focus groups indicated higher rates of satisfaction across the board with both housing and services.
- Planning for project lease-up: The County and its technical housing consultant, the Corporation for Supportive Housing (CSH), with input from the FSP programs and the MHSA developers, finalized and adopted the MHSA tenant application and referral process. Additionally, the County and CSH drafted a Memorandum of Agreement that will be used for all MHSA developments. It is an agreement between the County, developers, FSP programs, and property management companies; and it will serve as a guide for the collaborative partnerships of all parties to provide housing and supportive services to MHSA-eligible tenants. In FY 2010-11, the County and CSH established individual project planning committees (or "Crosswalks") for three projects - Townspeople's 34th Street Apartments, Squier/ROEM's Cedar Gateway and Father Joe's Village's 15th and Commercial. The Crosswalk planning model has been successful and will be used as new projects move close to completion and occupancy. The County and CSH have established a "model" planning process that is being replicated in other counties.

The County's goal is to have at least 85% of MHSA FSP clients living in housing. As of July 1, 2011, over 90% of FSP clients were housed; 67% of the clients were living in permanent supportive housing, which was a slight increase over the previous year where 66% of the clients were living in permanent housing. This includes the first five clients to move into developed MHSA units.

FSP Clients Housing Situation as of July 1, 2011

Permanent Housing	**Number**	**Percent of FSP clients**
Developed MHSA Units	5	0%
MHSA Leased Units	259	26%
MHSA Partnership Units/Shelter Plus Care	109	11%
Clients with Project-Based Section 8	79	8%
Clients with Tenant-Based Section 8	36	4%
Clients in Other Affordable housing	41	4%
Clients without Subsidy	149	15%
Total Clients in Permanent Housing	**678**	**67%**
Other Housing		
Clients living with Family/Friends	54	5%
Clients living in Emergency Housing	11	1%
Clients living in Transitional Housing	79	8%
Clients living in Licensed Facilities (Board and Care, Long- Term Care Hospital, Assisted Living, etc.)	159	16%
Other (streets, unknown living situation, etc.)	34	3%
Total Clients in Other Housing Situations	**337**	**33%**
Total FSP Clients	**1015**	**100%**

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Prevention and Early Intervention

Reducing the stigma and discrimination associated with mental illness and providing preventative services to avert mental health crises

The Prevention and Early Intervention (PEI) component of the MHSA supports the design of programs to prevent mental illness from becoming severe and disabling, with an emphasis on improving timely access to services by underserved populations. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, PEI programs and strategies build capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities, community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness. The following are FY 2010-11 highlights. For demographic information, please refer to Appendix B.

Primary & Secondary Prevention: Public Outreach, Education and Support Lines (PS-01)

Countywide public media campaigns aimed at reducing stigma and discrimination around mental illness and increase the knowledge about mental health, supportive housing and suicide prevention via education and outreach is funded through this program. The campaigns also raise awareness of new PEI programs. In addition, this program provides countywide, confidential, peer-staffed support phone lines for youth, adults, and families.

COUNTY OF SAN DIEGO COMMUNITY HEALTH PROMOTION & AGING PROGRAM SPECIALISTS

County of San Diego Regional Community Health Promotion Specialists (HPS) and Aging & Independence Services program staff (AIS) carry out the County's *Live Well, San Diego!* initiative via outreach activities and education presentations throughout San Diego County. The collaboration of the HPS and AIS staff provides an extensive outreach and education in the regions in comparison to the capabilities of the County's Behavioral Health Services Department to reach the general population.

The following is a summary of the outreach, education activities performed by HPS and AIS staff in each of the regions.

North Regions (North Central, North Coastal, North Inland) Highlights

- HPS actively participated in the Health and Human Services Agency Changing the Culture Within Employee Wellness Committee. The committee focused on mental health and the prevention of chronic disease.
- HPS co-chaired and hosted the San Diego Depression Screening Week (DSW) provider training in October 2010. HPS also developed the provider training packet and materials.

This resulted in screenings at three sites in which 50 individuals were screened for depression during DSW.

South Region Highlights

- HPS have continued a collaboration with the Institute for Public Strategies (IPS) to promote the importance of the overall health and well-being in the south region communities, emphasizing the connection between mental and physical health.
- HPS assisted San Ysidro School District, National City School District and San Diego Unified School District in developing a "Wellness Policy." The wellness policies have mental health and wellness written into the policy language. For example, San Ysidro School District's policy states the school must "provide all students access to credentialed school counselors and psychologists who provide support and assistance in making healthy decisions, managing emotions, and coping with crises."

East Region Highlights

- HPS coordinated art classes with Rancho San Diego Library that featured 110 intergenerational attendees. The intergenerational activity is designed to be a socially and mentally enriching experience for all generations, children, parents, and older adults, paired together to participate in diverse activities.
- HPS co-chaired the 2010 Behavioral Health Depression Screening Week Subcommittee which coordinated 23 sites across the county that resulted in a minimum of 435 individuals screened and hundreds more receiving resources.

Central Regions Highlights

- HPS collaborated with the Community Health Improvement Partner's (CHIP's), Childhood Obesity Initiative (COI) Director, and the COI Chairperson, a pediatrician and expert in eating disorders to educate mental health contractors and healthcare providers about the nexus between mental and physical health, specifically related to eating disorders. As a result, the HPS and pediatrician, along with a nutritionist and psychologist developed an eating disorder workshop which they conducted at the annual national "Meeting of the Minds" conference in November 2011.
- HPS conducted several presentations to Health and Human Services Agency (HHSA) mental health and healthcare providers on the "Animal Abuse/Human Violence Link." The presentations educated providers about the relationship between childhood animal abuse, adult animal abuse, subsequent violence towards people and the impact of trauma. The ultimate goal was to train and certify HHSA Mental Health and Healthcare Providers on a national evidence-based treatment program, and develop a diversion program for youth who would otherwise be sent to Juvenile Hall.

AIS Staff Highlights

- Staff developed a presentation entitled "Good Mental Health is Ageless" which was debuted at the Southern California Council for the Blind Conference and the California Area Agencies on Aging Conference. The presentation was given to dozens of local community groups and

seniors. Some of the attendees noted that the information was presented in an understandable and simple manner. The presentation increases awareness and the importance of good mental health to the aging and disabled communities.

- Staff developed a train-the-trainer module for their "Good Mental Health is Ageless" presentation in order to allow for collaboration with Union of Pan Asian Communities (UPAC) to assist them in outreach to minority clients. These clients served have been historically challenging to reach due to language barriers. The presentation also included a self assessment tool. The training focused on dispelling myths, stigma, prevention and barriers surrounding older adult mental health. The training emphasized the importance of having interpersonal relationships, physical and social activities. The community health staff at the MHSA PEI Elder Multicultural Access and Support Services (EMASS) program received the "train the trainer" training module. The EMASS staff and AIS jointly provided trainings thoughout North County, targeting populations such as, Somali, Hispanic, Filipino and African American.

- Staff collaborated with the media contractor for the *It's Up to Us* campaign specifically advising how to recruit older adults for the media campaign. Staff also provided valuable input on website appeal and print materials relating to older adults.

HOUSING MATTERS MEDIA CAMPAIGN

Housing Matters launched radio, television and print ads highlighting the benefits and importance of supportive housing. The media campaign reached through radio and television broadcasting 84% of adults ages 21-54 and 98% of households. It reached 79% of adults ages 21-54 and 90% of households through cable. Media outlets provided an additional $295,100 in added value. There was an increase of general public awareness of supportive housing by 11% and an increased in acceptance of supportive housing by 7%.

IT'S UP TO US STIGMA & DISCRIMINATION REDUCTION & SUICIDE PREVENTION MEDIA CAMPAIGN

Phase 1 of the campaign began in June 2010 and continued in FY 2010-11. This phase consisted of outreach and education to inform primary care physicians and nurse practitioners about the campaign, prepare them for patient concerns regarding mental health and ensure that they understood how to recognize the signs of mental illness and/or suicide ideation. Phase 2 of the campaign rolled out in September 2010 when the *It's Up to Us* campaign was launched through mass media. This phase focused on stigma reduction and mental health literacy to encourage help seeking and supportive behaviors.

Research-based campaigns that utilize behavior change models can be effective in influencing knowledge, attitude and behavior. Findings from a 6-month follow-up study in March 2011, showed noteworthy changes (compared to the baseline study) in knowledge and behavior in San Diegans that recognized the *It's Up to Us* campaign ads. The 6-month follow-up study showed that 83% of San Diegans recognized the *It's Up to Us* campaign ads and 36% had discussed them with someone else. Sixty percent agreed that the ads helped them recognize symptoms of

mental health problems. As result of seeing the ads, 84% were more likely to be supportive, 83% more likely to be respectful and 75% more likely to feel comfortable talking to a friend or family member about their mental illness. A significantly larger number of San Diegans who saw the campaign ads stated that they knew where to seek help (68% vs. 48%), how to recognize warning signs for suicide (69% vs. 48%) and agreed that people with mental illness should be hired just like other people (66% vs. 52%), and also agreed that they would be willing to socialize (76% v. 64%), work closely (67% vs. 59%) with, and have with a person experiencing mental illness marry into their family (37% vs. 27%).

Since the launch of the campaign on September 13, 2010, until June 30, 2011, there were more than 65,000 unique visitors to the campaign websites and more than 600 calls to the Access & Crisis Line (the County's primary access point for receiving mental health services), all known to be direct results of the campaign.

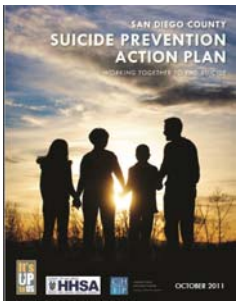
The campaign is recipient of the International Bipolar Foundation's 2010 Hope Award. Part of the success of the *It's Up to Us* campaign can be attributed to the extent to which the campaign has been embraced by community members working in the mental health, stigma reduction, and suicide prevention fields. Regional Community Health Promotion Specialists and Aging Program Specialists distribute campaign materials through their networks countywide. Service providers distribute materials to their clients and integrating them into trainings. The campaign website has been added to other resource guides and outreach materials. As a result, the media campaign messages are reaching community members who receive materials from peers and others they trust. In part, this success can be attributed to a very comprehensive stakeholder interview process, which listened to the community's views and wishes for the media campaign, and further offered them the opportunity to stay actively involved in the campaign design and implementation through an ongoing community input committee. Although this process can add additional time to the early planning phases of a campaign, there is tremendous value when stakeholders view the campaign as "theirs."

Individuals outside of San Diego County are also benefiting from the It's Up to Us campaign. Riverside County has adopted the It's Up to Us campaign to reduce stigma associated with mental illness within their communities.

Campaign ads and material can be found on the campaign website at Up2SD.org.

SUICIDE PREVENTION ACTION PLAN

In 2009, the suicide prevention action planning process was launched. The purpose of the Suicide Prevention Action Plan is to propose strategies that enhance efforts to increase understanding and awareness of suicide, decrease stigma associated with suicide and ultimately reduce the number of suicides in the County.



In FY 2010-11, a needs assessment was conducted to provide local data and evidence to inform individuals, organizations and agencies across the county to take a strategic approach to suicide prevention at the local level. The final strategic report reviewed suicide and intentional injury data, identified resources and gaps in existing suicide prevention efforts, and provided recommendations for moving forward with the action plan. The findings were presented and discussed with over 200 participants at a forum held in January 2011. From January 2011 to June 2011, meetings with community members and stakeholders were held to identify and prioritize suicide prevention strategies. A draft Suicide Prevention Action Plan was submitted to the County at the end of FY 2010-11. The final Action Plan can be found on the *It's Up to Us* website Up2SD.org.

BREAKING DOWN BARRIERS

The purpose of the Breaking Down Barriers program is to increase access to mental health services for persons who come from unserved and underserved, culturally diverse populations. Populations include Latinos, Native Americans, Asian/Pacific Islanders, African Americans, those with disabilities (blind and vision impaired, deaf and hard of hearing, or otherwise physically challenged), gay, lesbian, bi-sexual, and trans-gendered persons, or transitional-age youth and older adults.

As a result, the majority of the participants either "Agreed" or "Strongly Agreed" that because of the outreach and engagement, "I know where to get help when I need it" (96%), "I am more comfortable seeking help" (94%), "I am better able to handle things" (95%). The majority of the participants either "Agreed" or "Strongly Agreed" with the statements, "After the presentation, I feel more knowledgeable about resources available for individuals" (96%), "After the presentation, I feel more comfortable dealing with today's topic" (98%), "The materials given out were helpful" (98%), and, "I feel my questions were answered" (98%).

MOVING FORWARD/SALIR ADELANTE FOTONOVELA

The fotonovela is a small pamphlet akin to comic book format. The goal of the *Moving Forward/Salir Adelante* fotonovela is to educate the Latino community on mental health issues and how and where to access mental health services. Following an inclusive development process, the finalized printed fotonovelas were distributed throughout San Diego County in FY 2011-12. To date, two other California counties have requested permission to reprint the fotonovela for their communities.

ADULT/FAMILY & YOUTH/FAMILY PEER SUPPORT LINES

The Adult/Family and Youth/Family Peer Support Lines provide non-crisis peer phone support and referrals. The lines also provide mental health education. The support lines established a Memorandum of Understanding with the San Diego County Access and Crisis Line (ACL) in FY 2010-11. As part of the agreement, ACL added the program's toll-free numbers to their

brochure. The Family Support Line received and answered a total of 811 calls made during the hours of operation and 17 calls received outside the hours of operation. The Youth Talkline received and answered a total of 183 calls during operating hours and 6 calls outside the hours of operation.

Families as Partners (DV-01)

Families as Partners is a "point of engagement" service in the South Region is a partnership between families, Child Welfare Services, and community service providers establishing a community safety net for the well being of the region's high-risk children and their families. Families as Partners gives immediate provision of services and engagement with community resources and supports families to maintain a safe home and reduce the effects of trauma exposure. All of the participants served have been exposed to domestic violence and/or community violence or are children whose parents are mentally ill or who may have had contact with law enforcement due to a crime or drug related offenses. Referrals come from law enforcement, Child Welfare Services, Domestic Violence Response Team, and/or community-based organizations.

In FY 2010-11, the program strengthened the family and promoted stability by increasing the number of Families as Partners' children who are diverted to prevention services by 20% (from 550 to 660). In June 2011, the program received the National Association of Counties (NACo) award.

Positive Parenting Program (EC-01)

Positive Parenting Program (Triple P) serves Head Start (HS) and Early Head Start (EHS) centers to strengthen the skills of parents, HS/EHS center staff, and educators to promote the development, growth, health, and social competence of young children. Services are designed to benefit the child by working primarily with the parent/caregiver in collaboration with the Head Start staff to promote their education and enhance their ability to work with the child. Staff is also trained to provide ongoing support to the family/caregiver once the Triple P curriculum is completed. The prevention model focuses on reducing the risk for behavioral and emotional problems in young children. Early intervention is done by providing assistance for parents of young children who are beginning to show behavioral or emotional difficulties. The program will serve the Central and North Coastal regions of San Diego.

During FY 2010-11, services were provided to a total of 1,157 unique families with children ages 5 years and below more than doubling their goal of 500 unique families with 99% of the parents evaluated reporting improvement in their parenting skills. Triple P served 26 HS centers, exceeding the minimum target of 15, and worked with four (4) centers with significant military family enrollment. In addition, the program served 57 community sites which exceeded the goal of 6. There were 13 military community seminars conducted, six of which specifically focused on military caregivers in partnership with the Navy Region Southwest Child Development Home Program. There were seminars held in 38 low-income elementary schools, surpassing the 29 low-income schools reported the previous fiscal year.

South Region Trauma Exposed Services (DV-02)

South Region Trauma Exposed Services program works with the Families as Partners program and other community partners in the South Region. The program offers a variety of levels of evidence-based Positive Parenting Program (Triple P) practices to families in the region dealing with issues including

domestic violence, chemical dependency, and abuse/neglect. The goal of the program is to detect any potential issues early allowing referrals to be made and reducing families' enrollment into the Child Welfare System (CWS). Triple P will be enhanced with comprehensive case management and linkage to appropriate community and specialty resources. The program is co-located in CWS South Bay Marina office with a unit from the Families as Partners (DV-01) program.

Alliance for Community Empowerment (DV-03)

Alliance for Community Empowerment (ACE) targets youth, siblings, and families of gang members or those exposed or at risk to exposure of violence. The goals of the program are to increase individual, family, and community resiliency; to reduce the impact of community violence and trauma; and reduce the negative impact of gangs. The program delivers its services through two components: 1) Direct Services to children at risk and their families; and 2) Community Violence Response Team services.

In FY 2010-11, 162 individuals were referred to the direct services component of the program. A total of 347 unduplicated youth and their families were served in the direct services component surpassing their goal of 220 unduplicated youth and their families. A total of 204 unduplicated families were directly served by the Community Violence Response Team, exceeding their goal to directly serve a minimum of 200.

In an effort to meet the needs of the community in FY 2010-11, the ACE Leadership Academy and Teen Empowerment programs continued to increase the number of youth participants. Flyers for the Strengthening Families series were distributed well in advance in order to reach as many potential participants as possible. Gang Awareness for Teens and Parents implemented a community Gang Awareness Assembly at Monroe Clark Middle School located in the City Heights neighborhood of Southeast San Diego. Mobile Response Teams were highly successful in responding to a variety of incidences including one shooting and a continuation of services for several family members of local murder victims. Response Team members also continued to provide family support for court appearances which was a beneficial and much appreciated service to the community. Lastly, ACE recognized the need for a continuum of services and placed a focus on providing quality mentorship for many youth and parents during the summer months.

Kick Start (FB-01)

Kick Start provides services for individuals at-risk for developing or experiencing a first break of a serious mental illness that include outreach, education and intervention. The goal of this program is provide services to individuals experiencing the onset of mental illness and to reduce the potential negative outcomes in the early stages of illness. The target population is youth and TAY up to age 25 in the Central Region. This program was selected for the local evaluation of a PEI program.

In FY 2010-11, 125 presentations providing education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis were provided to over 900 community leaders. In addition, 211 telephone screenings providing an in-depth integrated assessment occurred and 62 clients were enrolled in the program. The program director gave a gatekeeper training to the senior school psychologist with San Diego Unified School District which resulted in an invitation to train all 140 school psychologists in September 2011. Also, Kick Start staff outreached to the following

programs and agencies to set up educational presentations: KPBS; Boys and Girls Clubs at Clairemont, Logan Heights, Mercy and Linda Vista; Mira Mesa Youth Baseball; Rady's Children's Urgent Care Center at City Heights; Arroyo Charter; Second Chance; Comprehensive Health Center; Young Life; Rose and Stein Education Center; The Center for Health and Wellbeing; and The City Beat and Reader magazines.

Dream Weaver Native American Consortium (NA-01)

The Dream Weaver Native American Consortium, which is made up of four Native American health clinics, provides prevention activities and early intervention services to the Native American community within San Diego County. The Consortium casts a broad net to educate and inform community members about prevention and early intervention activities. The services are delivered through the Urban Youth Center, Elder Services/Navigator Program, and the Outreach/Behavioral Health Prevention Education program, with a special focus on suicide prevention by counselors, outreach educators, caseworkers, and elder navigators. The program serves all age groups from children to older adults. Outreach and prevention education activities promote and support community wellness, cultural activities, support groups, and referral services. Emphasis is placed on enhancing individual, family, and community wellness by promoting and increasing awareness and access to cultural events that are known to support resilience. These services include traditional health gatherings, cultural programs that maintain language, knowledge of basket weaving (a local tradition for many tribes), nutrition programs, self-esteem activities, male involvement strategies, positive parenting, exercise programs, and the promotion of overall increased medical and dental health. All of these services will have the goal of preventing the onset of serious mental health problems.

In FY 2010-11, the program provided activities and services to a total of approximately 5,350 community residents. One of the major highlights at the Indian Health Council, Inc. is the Stitch to Wellness program which brings together people who enjoy quilting. Through Stitch to Wellness, individuals were able to get needed therapy, and it is helping to break stigma within the community. Another significant highlight is effective education of staff and community stakeholders regarding multi-generational trauma, adverse childhood experiences and the importance of maintaining wellness. Elders involved with the Elder Navigator Services reported felling more connected, less isolated and more valued due to the interactions with tribal youth.

The San Diego American Indian Health Youth Center provides a unique opportunity to enhance the quality of life for youth through cultural exploration, wellness activities and social interaction. By the end of FY 2010-11, 114 unduplicated youth received prevention services (114% of goal) and 86 unduplicated youth received early intervention services which exceeded their program objectives to provide 34 unduplicated youth with early intervention services. The Youth Center hosted "Native Youth Honoring Our Elders: A Celebration of Wellness," a conference where elders, youth and families participated in prevention activities as well as recreational, cultural and educational activities. More than 400 people participated in the conference.

Elder Multicultural Access and Support Services (OA-01)

The Elder Multicultural Access and Support Services (EMASS) program provides outreach, education, advocacy, peer counseling support and transportation services to older adult Hispanics, African refugees,

African American and Filipino seniors by promotoras (a Latin American approach that uses community peer workers) and community health workers. Much of the program's written materials are provided in threshold languages and in peer education provided to the participants. Promotoras assist participants in understanding documents not in the participants' own languages. The program seeks to identify and prevent mental health issues, reduce inappropriate utilization of services (such as emergency room visits), and increase access to healthcare services. This program also offers transportation assistance to their participants.

During FY 2010-11, the program served 415 individuals in North County, surpassing the goal of serving 400; 300 in the Central Region, surpassing the goal of serving 200; and 200 individuals in the South Region, meeting its goal. In North County, transportation services were provided to 217 unduplicated clients, surpassing its goal of a minimum of 200 unduplicated clients. Additionally, EMASS worked with the International Rescue Committee to assist more than 20 participants begin the process toward U.S. citizenship. To date, at least 10 have completed their paperwork and are awaiting their citizenship exam and interview, and six (6) have already been sworn in as citizens.

Positive Solutions (OA-02)

The Positive Solutions program helps homebound or socially isolated, underserved older adults who are racially, ethnically and culturally diverse, and who are at risk of depression or suicide, redirect their lives to be more social and active, and to rediscover pleasure. The program adapted the evidence-based Program to Encourage Active and Rewarding Lives for Seniors (PEARLS) to help clients recognize symptoms of depression and teach them how to solve problems that contribute to the way they are feeling. Positive Solutions empowers these older adults to actively manage depression and improve their quality of life. Clients work with their counselor to outline goals and tackle solutions. They also plan a fun, physical and social activity for the week.

In FY 2010-11, the program served 814 unduplicated seniors in both the Central Region and North County. According to program evaluation statistics, 86% of seniors who received brief intervention services have shown risk and symptoms reduction, and 44% have at least 50% of symptoms reduction compared to 43% for the original PEARLS study. Based on the client satisfaction survey, 94% expressed overall satisfaction with the program.

Aging Well (OA-03)

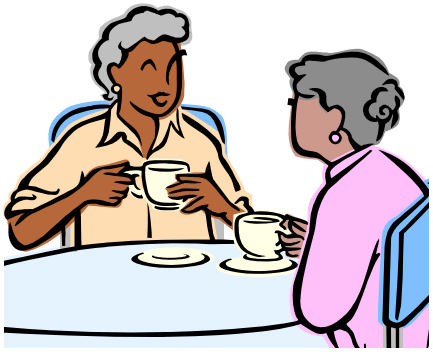
Aging Well delivers age-appropriate, culturally and linguistically appropriate, educational activities and materials about mental health to older adults, family/caregivers, and health and social services providers. Program staff presents lectures and materials at community senior centers, adult day health centers, senior low income housing, and faith-based community organizations.

In FY 2010-11, Aging Well was translated to an eLearning course. The target number to provide aging education was to 500 people. The program trained 330 people, 66% of the goal, with 97% of the participants stating that they increased their knowledge about needs of seniors. Participants were satisfied with the education program and as a result of the training, they knew where to get support and help. Staff is evaluating the program to determine whether modifications in the delivery mechanism and content are needed to maintain the training goals.

REACHing Out (OA-04)

REACHing Out program is a multifaceted, personalized intervention intended to prevent or decrease depression symptoms due to isolation and burden of care in Hispanic caregivers of Alzheimer's patients. The program intervention includes nine home visits, three 30-minute telephone check-ups, and five structured telephone support sessions for caregivers by a trained project staff member.

During FY 2010-11, there were 160 Hispanic caregivers enrolled in the REACHing Out program. All of the caregivers were of Latino origin. A majority were Mexican American/Chicano (82%), with several identifying as Cuban, Dominican, or Other Hispanic. A majority were also female (96%), and under age 60 (69%). The mean age of caregivers was 54.



All of the caregivers responded to an initial assessment and a reassessment about their health after receiving the REACH intervention. At the reassessment, 73% of caregivers reported that they were in "Good" or "Excellent" health, compared with only 56% at the initial assessment. Caregivers were significantly less likely at the reassessment to indicate that their health was standing in the way of doing the things they wanted to do. At reassessment, fewer caregivers were at high-risk for depression than at the initial assessment (28% vs. 59%).

During FY 2010-11, REACHing Out made some design changes by ending a partnership with one of their subcontractors and worked to recruit another partner in the Region. This resulted in working with only one partner agency for several months and this significantly reduced the number of referrals to the program's Care Managers and hence, reduced the number of clients served through Early Intervention activities. This programmatic change, although a challenge in the short term, was necessary to ensure the long term success of the REACH program.

Salud (OA-05)

Salud provides integrated health care for mental and medical conditions to Hispanic older adults. Early intervention includes integrated diabetes/depression care management by a master's level registered nurse, and intervention is delivered in primary care settings.

In FY 2010-11, the program enrolled 142 participants and achieved its goal of reaching persons who might not otherwise receive treatment as almost 90% were not receiving any other mental health services. In addition, patients from San Ysidro Health Clinic have access to a care coordinator who monitors their diabetes and mental health concerns and engages them in Problem Solving Therapy (PST) to help treat their depressive symptoms. The program design supports the development of integrated care for diabetic clients experiencing depression by assigning responsibility for mental health and medical care to one single care provider. In FY 2010-11, 36 clients received PST services.

SmartCare (RC-01)

SmartCare, also known as the Rural Integrated Behavioral Health and Primary Care Services program, includes assessments and short-term interventions in rural community clinics for individuals who may be at

risk for or are in the early stages of mental illness. The program goals are to prevent patients in rural community clinics from developing an increased level of behavioral health issues, severe mental illness, or addiction. The target population includes children, adolescents, transition age youth, adults and older adults in community clinics located in rural areas of San Diego.

In FY 2010-11, the first year of the program, wellness activities reached more than 2,100 rural community members who participated in 143 events. English and Spanish presentations covered topics including nutrition and exercise, mindfulness, meditation and yoga, budgeting, volunteering and job readiness, character education and bullying prevention, as well as anger management and other specific trainings requested from within the rural communities. SmartCare's behavioral health staff actively participated in existing community events such as the Yellow Ribbon Suicide Prevention Walk, National Food Day, various health fairs and fitness programs. Events were strategically held in community centers, schools, senior centers, and Boys and Girls Clubs in an effort to provide outreach in areas where individuals are known to come together for social and educational purposes in a comfortable and familiar environment.

Other community partnerships and collaborations included:

- Sheriff's Department and CASA (Center on Addiction and Substance Abuse) to provide Red Ribbon activities in schools and to assist with Prescription Drug Take Back Day;
- San Diego County's Elder Services to bring the Healthier Living Chronic Disease Self Management Program to the community;
- Lions Club to ensure glasses to Spanish speaking individuals;
- Libraries to create a book exchange to families without transportation; and
- Local hospital and school districts to assist with diabetes/obesity screenings of fifth graders.

The Ramona Patch, a local on-line news source, requested permission to publish the SmartCare blog on their site.

School-Based Program (SA-01)

The School-Based Program provides a family-focused prevention and early intervention plan for school age children and their families in high risk communities with high ratios of Asian/Pacific Islanders and Latinos and socio-economically disadvantaged families in the North and East Regions through its unique design of school and family components. School components served children and their families by providing social-emotional mental health evidence-based prevention and early intervention services. The Positive Behavioral Support (PBS) is implemented through the Building Effective School Together (BEST) and Incredible Years (IY) models; and a family component focused on resiliency is delivered through community outreach specialists. Interventions are coordinated to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress. The aim is to minimize barriers to learning while supporting children in academic and personal success.

In the 2010-11 academic year, the North Region program served 2,020 unduplicated preschool through third graders, exceeding the 1,950 goal, at the four targeted

elementary schools – Rose and Pioneer Elementary in Escondido, and Mission and Laurel Elementary in Oceanside. Combined, there were 92 classrooms served weekly throughout the year, receiving a total of 34 lessons. Of the 624 children screened, 550 children received early social/emotional evidence based practices interventions, with 365 of their parents reporting that 88% of their children decreased the frequency of disruptive behaviors in the home. In addition, 2,941 children participated in BEST, which exceeded the target goal of 2,700 children.

At Mission Elementary, there was more than a 50% decrease in office discipline referrals, with only 106 referrals versus 218 in the 2009-10 academic year, and suspensions decreased by 82%. At Laurel Elementary, there were 78 fewer referrals as compared to the 2009-10 academic year, and a significant 36% reduction of suspensions. Through the family component, community outreach specialists conducted outreach activities on a weekly basis at the four schools to establish familiarity with the program among school families. One barrier that was experienced was difficulty contacting some of the parents of children referred. The program strategized with the school and have collaborated with the principals and teachers to gain access to some of the more challenging and resistant parents.

In the 2010-11 academic year, the East Region program enrolled 937 children (108% of goal) with PBS, 716 children (119% of goal) with IY prevention-based classroom curriculum, 174 children (97% of goal) with IY early intervention group curriculum, 516 parents and adult family members (161% of goal) received program services and 662 community referrals were given out to families in need of additional services.

Suicide Prevention Education Awareness and Knowledge (SA-02)

Suicide Prevention Education Awareness and Knowledge (SPEAK) is a suicide prevention program that serves students through education, outreach, screening and referrals in schools. It includes education to school staff and families. The program goals are to reduce suicides and the negative impact of suicides in schools and to increase education of the community and families. The target population is children, youth, TAY, schools staff, gatekeepers, families and caregivers.

In FY 2010-11, the first implementation year of the program, 318 suicide prevention education presentations were provided at 30 schools and community groups. *Ask for Help*, a suicide prevention presentation for youth, was given to 9,173 students. *Be a Link,* suicide prevention training for gatekeepers, was given to 2,245 San Diego Unified School District staff and 245 parents. A student survey with outcomes through December 2010 demonstrated that 86% of students know where to get help and 66% of students felt comfortable with the notion of getting help.

Courage to Call (VF-01)

The Courage to Call program is a confidential, peer-staffed outreach, education, and training service for the military and veteran community and its service providers. The program goals are to increase awareness of the prevalence of mental illness in this community, reduce mental health risk factors or stressors, and improve access to mental health and PEI services, information and support. The target population includes veterans, active duty military, reservists, National Guard and family members.

During July 16 and 17, 2010, Courage to Call participated in *Stand Down* for homeless veterans, a community-based intervention program designed to help the nation's estimated 200,000 homeless veterans "combat" life on the streets. San Diego has the largest number of homeless veterans nationwide. During this weekend event, Courage to Call made contact with over 200 Veterans and their families and networked with other providers that delivered services to this population. *Stand Down* was featured on the television show *60 Minutes in October 2010*.

The executive branch of the State of California and the federal government have created treatment and support programs intended to benefit veterans suffering from mental health issues stemming from their military service. The mental health problems addressed by these programs include post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), depression, anxiety disorder, and other mental health conditions (referred to collectively as "Military-Related Mental Health Problem(s)" or MRMHP). Some veterans who suffer from MRMHP are defendants in pending criminal cases in the San Diego Superior Court (SDSC).

The Veterans Treatment Review Calendar pilot program (VTRC) utilizes the collaborative approach to establish a comprehensive program that simultaneously responds to veterans' needs and promotes public safety. This approach to the adjudication of veterans with MRMHP promotes accountability through a combined program of judicial supervision, justice partner collaborative efforts, and appropriate treatment and support. The San Diego Superior Court began hearings on February 4, 2011 to divert justice-involved veterans into mental health treatment programs in lieu of incarceration. As of June 30, 2011, twelve veterans were participating in the VTRC, all with mentors, and all have sustained their mental health treatment.

"From Warrior to Soul Mate Weekend Couples Retreats" for active duty and veteran couples are designed to increase marital/relationship satisfaction, communication, and emotional literacy skills, based on a proven, evidence-based model called Practical Application of Intimate Relationship Skills (PAIRS). Active duty and veteran personnel and their families face a variety of unique challenges and, therefore, need access to a variety of interventions at various levels of care. Returning veterans are subject to increased marital discord, divorce rates, and suicidal thoughts associated with distressed relationships. It is not used with extremely troubled marriages, is not for couples experiencing domestic abuse, drug abuse or where there is clear psychosis. The Veterans Affairs Chaplain Service in Augusta, Georgia, has shown significant and impressive results for veterans using the

> *"The Warrior to Soul Mate has saved my marriage from ending in a divorce. This retreat has given me valuable communication skills and relationship skills that I can use to keep a happy and healthy relationship with my husband. Not only does this help my marriage but my young babies will learn this skill from me and hopefully break the cycle of divorce that seems to run in my family. I am so thankful to have had the opportunity to come to this retreat. I could not have afforded this on my own and I gave up on marriage counseling. My relationship with my husband still needs work but now I have hope that we can make it through anything. My dream of growing old with my husband and watching our children grow and thrive with their own relationships have been restored. I want to thank you from the bottom of my heart. Words cannot express the hope and joy I feel with my husband after this retreat. Thanks for all the time and effort put into helping us."*

PAIRS model. From May to September 2010, the VA San Diego Healthcare System piloted this model through four workshops for over 100 couples. The evaluations were extremely positive, with couples who attended each retreat stating that the weekend had saved their relationship from ending. With one-time MHSA funding, the program was designed in the spring of 2011 to reduce the backlog of 80 couples on the VA San Diego Healthcare System's waiting list due to a lack of VA grant funding. As of June 30, 2011, 52 couples attended two weekend retreats held in San Diego. The satisfaction scores were 4.5+ (5 being the highest) and 75% of the couples were active duty military.

Bridge to Recovery (CO-01)

Bridge to Recovery provides screening, brief intervention, education, linkages, and referrals to transition age youth, adults, and older adults. The program also offers peer case management support to clients who need treatment or additional resources. Services are provided on site at the San Diego County Psychiatric Hospital to individuals with low mental health needs and high substance abuse issues. Individuals served at the hospital are indigent, often homeless, highly vulnerable and often disenfranchised.

During FY 2010-11, Bridge to Recovery's work was noted to be the "gold standard" by Substance Abuse and Mental Health Services Administration (SAMHSA) during a site visit by that organization. They also acknowledged the relationship between Bridge to Recovery and the hospital staff was seamless and added to the success of patient care. The Bridge to Recovery featured the Peer Volunteer Program with peers who are graduates of the UCSD Co-occurring Disorders Program. These volunteers engaged new patients by facilitating pre-treatment groups three times a week; and throughout the year they participated in community outreach activities such as Project Homeless Connect, the NAMI Walk and Walk for Recovery events.

> *"Gratitude is not a big enough word to describe Bridge - they got me in here and saved my life. I was brought into the hospital as a 5150 after trying to kill myself and Bridge saved my life."*

Co-Occurring Disorders – Screening by Community Based Alcohol & Drug Services Providers (CO-02)

This program places mental health counselors in thirteen Alcohol and Drug Services (ADS) contracted treatment and recovery programs to identify and screen clients who exhibit mental health concerns prior to their development of a serious mental health diagnosis and to provide prevention and early intervention services.

A "quiet room" was added at the Vista Hill Parent Care Therapeutic Learning Center. The quiet room was integrated as part of therapy during the one-on-one sessions with the children. The quiet room was extremely successful in aiding the child's focus and redirection. The children began to identify and utilize the quiet room as a safe place for retreat when they were feeling anxious, upset or wanted to relax.

During FY 2010-11, the Stepping Stone provided individual psychotherapy to every client in treatment. The program increased client engagement and retention and decreased the client's chances of relapse.

Overall, the program grew and saw a tremendous positive effect on the program culture and dedication of the treatment team. One of the greatest challenges of working with co-occurring disorders is stigma. Clients sometimes come into the program having been stigmatized by loved ones and/or society. The mental health counseling program used individual and group treatment to address the shame and the stigma in clients.

At the Palavra Tree program, approximately 40 to 60 clients were treated every month and 150 service hours were administered monthly. The program used a multi-faceted treatment strategy to impact successful mental health treatment in clients. Many clients are poly-substance users that report using alcohol, methamphetamines, cocaine, ecstasy, etc. The mental health clinicians provided psycho-education, motivational interviews, movement groups and parenting groups as part of the treatment strategy. The PEI clinicians have had significant success with educating parents about the impact of trauma on their lives. Many parents reported a heightened understanding of themselves and their children. They were able to draw parallels between their lives and their children. This factor enabled them to respond in a more empathetic manner. This presentation and subsequent parent meetings have increased the parent's ability to engage in treatment and support their children's recovery. In addition, it has been evident that the infusion of PEI with ADS services has reduced the stigma of mental treatment for families.

Statewide Training, Technical Assistance and Capacity Building

In 2008, the Mental Health Services Oversight and Accountability Commission approved the funding level of $6 million each year for four years for the Statewide PEI Training, Technical Assistance and Capacity Building (or TTACB) that is administered by the counties. San Diego County's allocation is $508,800 annually for four years. Behavioral Health Services initially requested, and subsequently received, this funding in June 2009.

The primary goal of TTACB is to improve the capacity of local partners outside the mental health system (i.e., education, primary health care, law enforcement, older adult services) as well as County staff and partners who work on the development, implementation and evaluation of prevention and early intervention programs that are funded through the County's PEI plan.

Counties can utilize training technical assistance and capacity building methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and the PEI guidelines.

PEI PREVENTION WORKS: A CONVENING OF SOUTHERN CALIFORNIA COUNTIES

San Diego County Behavioral Health Services, in partnership with Southern California Counties, identified the need to increase awareness of prevention and early intervention efforts and share successes and challenges across the southern region. The first activity funded through PEI TTACB, *Prevention Works: A Convening of Southern California Counties,* was held January 26, 2011. Their vision was to create an opportunity where all PEI stakeholders including, but not limited to, administrators, programs, educators, and community members could engage in a focused dialogue related to prevention and early intervention efforts across counties. Over 120 people dedicated to improving the overall health and

wellbeing of unserved or underserved populations came together at the *Prevention Works Convening*. A report was developed which incorporates the shared successes and challenges of implementing specific PEI programs, strategies on data collection and evaluation, and solutions discussed during this event. This tool is available statewide through the California Institute of Mental Health's website.

There are several training, technical assistance and capacity building events in the pipeline with topics including the impact of violence and trauma in communities, a trauma informed approach to mental health training for first responders, supporting community college students, spirituality, cultural competence, and young children.

Innovation

Developing and implementing promising and proven practices to increase access to mental healthcare

The County of San Diego has completed two community program planning efforts, known as cycles, in order to develop innovative programs. After an extensive series of community forums and based on stakeholder input, in December 2009 (Cycle #1), staff developed an Innovation Program and Expenditure Plan that described five initial, new short-term projects with novel and creative mental health practices and approaches. In Fiscal Year 2010-11, utilizing the Mental Health Services Oversight and Accountability Commission's (MHSOAC) *Decision Path for Counties* as a guide for the community planning process, five additional projects were developed (Cycle #2). Of the ten projects, three programs provided services in fiscal year 2010-11. A discussion of each of these and its progress is below.

Additional information about the progress of these programs will be available in the Fiscal Year 2013-14 MHSA Annual Program and Expenditure Plan.

Cycle #1 includes the following projects:

- Wellness and Self-Regulation for Children and Youth (INN-01)
- Peer and Family Engagement (INN-02)
- Physical Health Integration (INN-03)
- Mobility Management in North San Diego County (INN-04)
- Positive Parenting for Men in Recovery (INN-05)

Cycle #2 include the following projects:

- After School Inclusion (INN-06)
- Transition Age and Foster Youth (INN-07)
- Independent Living Facilities (INN-08)
- Health Literacy (INN-09)
- In-Home Outreach Teams (INN-10)

Wellness and Self-Regulation for Children and Youth (INN-01)

The "Wellness Program" integrates therapeutic experience for children in an existing program (e.g., residential or day treatment, school site) that uses a number of innovative activities to address overall mental and physical wellness.

Contracts were awarded in October 2010 for this project. *Project Evolve!,* named by the teen participants, offers an array of alternative, holistic intervention to produce a positive impact on mental and physical health. These interventions strive to help teens improve the quality of their arousal level, mood, physical health, mental health, social functioning, sleeping patterns, and sense of self. The

program focuses on teaching children skills that effectively help them regulate themselves in all areas of their lives.

Project Evolve! focuses on five areas of wellness. These areas are nutrition, fitness, spirituality, meditation/yoga/relaxation, and socialization. Activities in all of these areas are now part of the regular 7 days a week programming. These activities include yoga, tai chi, fitness groups, recreation therapy, nutrition education, horticulture therapy, food preparation, wellness drumming, theater, equine therapy, spirituality and culture groups, trivia Tuesdays, and more.

Family involvement is another component of the Wellness Program. Family night is held once a week. Families, mentors, and other supportive people in the teens' lives are invited to share a meal and an activity. Each activity focuses on an area of wellness. This supports the wellness of the families and also demonstrates how the families can support the teens in their pursuit of their own wellness.

Since its implementation, menus have been revised to include fresh, natural foods and a daily salad bar. The teens are now eating more vegetables and less fried foods. A campus garden was created where the teens plant and tend vegetables and fruit. Since the Wellness Program's implementation, the teens have collectively lost over 1,000 pounds, decreased cholesterol by 300 points, and experience healthy weight change at 40% or higher each month. Healthy weight change is defined by overweight and obese teens losing weight and underweight teens gaining weight.

The teens themselves have expressed their surprise at enjoying healthy foods, feeling healthier and learning new things. By trying new things the teens have discovered that they like activities that they would have never imagined. These activities offer the teens new coping skills. Teens ask to walk in the garden, practice deep breathing, beat on a drum, or exercise when they are feeling frustrated. They were surprised to learn that the attitude of non-violence learned in tai chi can assist them in overcoming their life's challenges. The teens were surprised to discover that broccoli grows right out of the ground and that they can eat a tomato right off the vine.

Residential staff has commented that the kids are stronger and happier than before. School staff report that the teens are more focused in school and that reading levels have improved. The psychiatrist on staff reported that the teens look fit and that the requests for gastrointestinal aides and complaints of gastro problems have decreased significantly.

The staff is also benefiting from the Wellness Program. As they witness and support the Wellness Program they too are becoming more invested in their own health. They are motivated to make change and to be positive role models for the teens. In addition, the Wellness Program's socialization component promotes a process-based structure for the campus. The staff have been trained in techniques that emphasize the strengths of the teens. These techniques teach the staff ways to assist the teens in claiming ownership of their lives and problem solving how to reach their goals and find healing. These techniques are successful in resolving conflict with the teens and decreasing the need for more assertive interventions.

A sampling of lessons learned includes:

- Detailed notes of the client's participation in Wellness groups have provided valuable information in regards to the client's symptoms and progress in treatment. For example, some children escalate very quickly in music groups, but not other relaxation groups like yoga. This is often due

to sensory overload associated with autism spectrum disorders. This information is taken to the treatment team and the expectation for that client in relation to certain groups is modified. Individualizing treatment to meet the client's unique needs is crucial to the success of the program and getting the therapists on board with the program.

- Flexibility to teach in a variety of education modalities is most important for the success of the Wellness Program. The nutrition classes originally were similar to classroom learning. Clients became easily bored, escalated, and defiant. Adjustments were made to be more focused on gardening and healthy cooking, which has continued to teach nutrition, but in a more fun and appropriate way.
- The amount of medications assessed does not appear to accurately represent the client's improvement. Clients will often be on a lower dose of medication upon discharge, or have changed to a more mild medication, but the amount of medications they are on remains the same according to the current output data.

Dance and therapeutic art activities will soon be implemented. The teens are sharing more and more ideas of ways to bring wellness to campus. A comprehensive report will be developed at the end of this program with a thorough discussion of the challenges, barriers and how those barriers were overcome, and the valuable lessons learned.

Peer and Family Engagement (INN-02)

Now called Hope Connections, this peer and family engagement project began in July 2011. Hope Connections consists of integrated teams of transition age youth, adult, older adult and family peer support specialists that provide a number of services to new mental health clients and their family members prior to their first visit to the clinic. One team also serves individuals and their families in the County Emergency Psychiatric Unit.

Team members welcome clients and families to the outpatient mental health clinic emphasizing the hope for recovery and the ability of the client to take an active role in fulfilling personal recovery goals. Every time a new client is referred to an outpatient clinic, they are asked if they would like to involve their family, which may require a field visit. By engaging clients and families prior to their clinical intake, it is anticipated that the entire treatment experience will be cast in a significantly different manner.

Physical Health Integration (INN-03)

With a three-month initial startup, the Physical Health Integration Project, now called ICARE (Integrated Care Resources), began seeing clients in March 2011. ICARE is an innovative pilot project to create person-centered medical homes for a minimum of 600 individuals with a serious mental illness (SMI) in a primary care setting. The goal of the project is to enhance overall mental and physical wellness for individuals with SMI by increasing access to physical health care and reducing stigma. There are two subsets of participants in this project. One group consists of clients that mental health clinical staff identifies as having stable mental health and ready to transfer to a specific health center for comprehensive physical and mental health care. These participants are transferred to one of three primary care clinics that will also provide medication management for the client's mental health needs.

The other group of participants are those who continue to receive mental health treatment at a mental health program and receive physical health care from a specified primary care clinic. Areta Crowell Center serves as the mental health program site. The three primary care clinics participating are in North Park, Logan and City Heights.

Start-up included the building of an exam room within the mental health site, hiring of an alcohol and other drug (AOD) counselor and peer support specialists, participation in the University of Massachusetts' Certificate in Primary Care Behavioral Health Care course, and solidifying efforts in program evaluation tools and measures with a USCD research team.

Notable challenges include:

- Finding a nurse care coordinator that could effectively perform in a mental health setting was a considerable challenge.
- Transitioning clients from mental health site to primary care took longer than expected. To assist in the transfer process, clients who are foreseen as nearing transition criteria are now receiving more information about the process earlier in their treatment. The establishment of the program and, in addition, regular interaction with ICARE staff at the mental health site has built a level of confidence and trust with those who facilitate the transition.

A comprehensive report will be developed at the end of this three-year program with a thorough discussion of the challenges, barriers and how those barriers were overcome, and the valuable lessons learned.

Mobility Management in North San Diego County (INN-04)

The Mobility Management Program began August 2011 and provides peer-based information sharing and support to assist clients with transportation options. A volunteer peer ride share program also enhances client mobility. The program lead coordinates resources and collaborates with the transportation community. Positive changes are anticipated on two levels by participating in this program. First the participants will increase their independence and ability to attend health and social activities in the community. Participants may also form support networks and friendships with the travel buddies, strengthening their social skills and enhancing resilience and hope for recovery. Second, we will learn if coordination of transportation resources and involvement with the transportation community leads to an improved transit system and increase mobility for mental health clients.

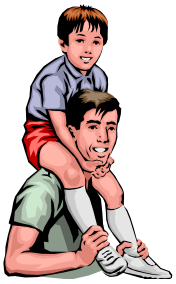
Positive Parenting for Men in Recovery (INN-05)

This program began July 2010 and offers a unique parenting enrichment program for fathers in Alcohol and Other Drug (AOD) treatment programs in order to improve their parenting skills, provide education on mental health, and understand the impact of trauma and violence on their children and families.

Many men receiving treatment for substance abuse suffer from depression, high levels of stress, and loss of self-esteem. Many also have a history of childhood abuse and neglect. An important goal of substance abuse treatment is learning how to maintain healthy relationships. This is directly related to parenting, as a critical skill for parents is learning how to nurture relationships with their children. The knowledge, skills, and ability to provide a healthy environment for children are lost when a parent is

struggling with addiction leading to high rates of child maltreatment. This parenting program for fathers will test the efficacy of an integrated approach that combines education on mental health, wellness and substance abuse with parenting skill building.

Sufficient parenting resources for men in AOD treatment was an unmet need prior to implementation, and having this element now complements AOD treatment and appears to enhance motivation and retention for the men who participate in the program. The parenting component has been very well received by the men who participate. Addressing men separately on the topic of parenting has been an important learning point. For example, many of the participating fathers will be raising children on their own for the first time with the mother being absent and these fathers are learning how to bond and the importance of bonding with their children.



The program has had some challenges. Forming new parenting groups and fostering growing participation have been challenging, as well as raising clients' comfort level around parenting issues, and helping men to be comfortable around other men in group sessions.

The program has been modified to take into consideration men's gender specific needs. For instance, programs have instituted potluck gatherings specific to these groups that are considered a highlight by the clients, integrating food and celebrations into the program and promoting AOD-free pro-social activities.

A comprehensive report will be developed at the end of this program with a thorough discussion of the challenges, barriers and how those barriers were overcome, and the valuable lessons learned.

After School Inclusion (INN-06)

This program is expected to begin September 2012. The essential purpose of this program is to increase access to after-school programs to youth with social-emotional/ behavioral issues who have been prevented from attending, discharged from, or at risk of discharge from inclusive after-school programs. This project will measure the impact on youth, and their families, of the benefit derived from access to existing integrated community-based after-school programs with the goal of leading happier, healthier, less stigmatized lives.

This program promotes early intervention and access to other services for participants by enhancing gatekeepers' (after-school program staff) awareness of how to identify at-risk youth and refer them to appropriate support services.

Transition Age and Foster Youth Program (INN-07)

This innovative program is expected to begin July 2012 and is expected to improve outcomes by incorporating three interactive components: coaching, mentoring and teaching. Within the teaching component, staff will impart specific knowledge of, or skill in, identified areas. Within the coaching component, staff will focus on giving instruction or advice on identified issues and in the mentoring component, the staff strength will be on developing relationships with participants with an aim to increase trust, support and positive influence.

Participants of this program will identify individualized goals and choose activity modules that address those goals. This project expects to reduce the following problems and barriers that were identified by a community planning process:

- TAY lacking self-identity, sense of purpose and passion for future
- Foster/at-risk foster youth, non-engaged TAY are at an elevated risk for mental illness compared to their age peers
- Insufficient preventive programs for TAY
- TAY do not effectively engage in available resources
- Lack of coaching, mentoring or teaching TAY on identifying and developing goals that are directly connected to their passion and motivators.
- Insufficient support resources for at-risk, non-engaged youth and foster TAY

Independent Living Facilities (INN-08)

This innovative program began in July 2012, and creates an Independent Living Facility (ILF) Association with voluntary membership with the mission of promoting the highest quality home environments for adults with a serious mental illness (SMI). The ILF Association's mission statement supports the wellness and recovery of all residents. The project focuses on the following key areas:

- Community Collaboration. ILF Association members will work collaboratively to develop ILF Quality and Ethical standards. Input about the standards shall be solicited from resident clients and their family members. At a minimum, the standards will identify that the wellness and recovery of resident clients will be supported.

- Creation of an ILF Directory. A web-based listing of participating ILFs will be created with the purpose of providing a central resource for hospitals, discharge planners, case managers, family members and consumers. The ILF Directory will identify the facilities adhering to the ILF Quality and Ethical Standards developed.

- Education and Training. Curricula will be created for:

    - Clients – to assist them in areas, including but not limited to, sustaining independence in the community; adjusting to shared living spaces; developing independent living skills (e.g. nutritious cooking, etc.); communicating with ILF operators; awareness of rights as a resident/tenant.

    - ILF Operators – to be educated on topic areas, including but not limited to, residents with SMI; familiarity with mental health programs; appropriate service standards; differences between ILFs, Board and Care (B&C), and Licensed B&C functions; consultations with case managers or care coordinators; appropriate ILF operator-resident relationships; and skills assisting residents sustain wellness, recovery and independence.

- Peer Review and Accountability. A Peer Review Accountability Team will be created to evaluate the implementation of standards and to provide coaching in areas of development. The team will include, at a minimum, a consumer, a family member, and an ILF operator.

This project is expected to create positive impacts for adults particularly in the area of stable housing. Stable housing is an essential initial step in mental health recovery and treatment of mental illness.

Health Literacy (INN-09)

The purpose of this pilot was to increase the quality of service and produce better outcomes by addressing early mortality among those with Serious Mental Illness (SMI) by providing a web-based educational system that is specifically geared toward persons with SMI and their families to increase overall levels of health literacy.

This project is currently being reevaluated. An environmental scan will be conducted to see if this project is still relevant as there are several community initiatives currently addressing health literacy.

In-Home Outreach Teams (INN-10)

This innovative program began in January 2012, and is expected to increase family member satisfaction with the mental health system of care, as well as to reduce the effects of untreated mental illness in individuals with SMI and their families.

The In-Home Outreach Teams (IHOT) program operates 3 regional mobile teams that are clinic-based and provide mobile in-home outreach and engagement services to individuals with SMI and their family members. The IHOT staff, which include a licensed clinician and a case manager, provide in-home assessment, crisis intervention, case management and support services to the individuals with SMI and their family or caretaker, as necessary. Peer and family members are integrated in the IHOT teams and provide services including support services, information and education about mental health services and community resources, linkages to access outpatient mental health care, and other services and resources as needed. A Psychiatric Emergency Response Team clinician will also be available to the regional IHOT teams to link clients for follow up and care coordination of needed services that may include emergency interventions, acute care, alternatives to psychiatric hospitalization such as the Short Term Acute Residential Treatment program, conservatorship and case management services.

Additional linkages and coordination with local emergency departments (ED), psychiatric hospitals and the legal system, to include the jail system, are provided, along with programs such as San Diego County Psychiatric Hospital and Emergency Psychiatric Unit. The IHOT program provides flexible in-home services 24 hours a day and 7 days a week with evenings and weekend program hours.

A longitudinal evaluation will be conducted of the IHOT program to determine the success of the outreach and engagement component, client access to outpatient services, retention of clients in outpatient services, reduction of inappropriate utilization of acute care, EDs and jail system. A cost analysis will also be conducted to assess actual costs and savings to the system of care and the community.

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Workforce Education and Training

Developing and growing the mental healthcare workforce

The MHSA Workforce Education and Training (WET) Plan for the County of San Diego was developed through stakeholder input and a local needs assessment and was approved by the State in July 2009. The plan is focused on increasing the number of well-qualified individuals, and those with lived experience, in the public mental health workforce, with special emphasis on increasing cultural and linguistic diversity to better meet the community's needs and improve access to services. San Diego County's allocation for WET programs is a total of approximately $17.3 million that must be spent by June 30, 2018.

The WET Plan includes multiple programs developed to enhance the public mental health workforce through recruitment and retention of individuals from linguistically and culturally diverse backgrounds. A majority of programs include financial incentives, primarily in the form of stipends and scholarships, to assist individuals from culturally underserved, unserved or underrepresented communities to receive training and/or education for career development in public mental health.

FY 2010-11 was the first year of implementation of the WET Plan. Selected highlights for the year include:

- 11 new WET programs were launched
- 2,230 individuals were directly impacted
- A WET database and outcome tracking mechanism was established
- A countywide WET Collaborative was convened

The following summarizes key FY 2010-11 highlights for programs and activities under the five funding categories of WET: 1) workforce staffing support; 2) training and technical assistance; 3) mental health career pathway programs; 4) residency and internship programs; and 5) financial incentive programs.

Workforce Staffing Support provides funding to plan, administer, and evaluate the workforce programs and trainings in the remaining four funding categories, and includes funding for a Workforce Education and Training Consultant. The consultant's initial role was to develop the San Diego County WET Collaborative, which first convened on August 6, 2010. The Collaborative was created in response to a need identified in the San Diego County MHSA WET Plan for assuring an ongoing "community voice" for promoting and enhancing a public mental health workforce that is culturally and linguistically representative of the community being served. The collaborative has a diverse group of over forty members representing public mental health systems of care, community stakeholders, consumer and family members, employers/providers, education and training programs/universities, and under-represented community groups.

The WET Consultant was also instrumental in initiating a 5-year mental health career longitudinal study which will follow over 1,000 participants of the WET career development programs described below. The purpose of the study is to evaluate the effectiveness of these programs in increasing the recruitment

and retention of a diverse public mental health workforce. In FY 2010-11, surveys were collected on 93% of the 173 students involved in WET programs. Of these students, 67% were non-white, 35% were fluent in a language other than English, and 50% self-identified as having received mental health services for themselves or their family members.

Training and Technical Assistance consists of events and activities to enhance the knowledge and skills of individuals who provide services or otherwise support the public mental health system. Training activities are designed to improve knowledge and skills to assure service delivery is consistent with the fundamental principles of the MHSA.

- The Behavioral Health Education and Training Academy provides the County of San Diego Behavioral Health System with staff development services that increase competency in culture, co-occurring disorders, and the provision of resilience, family focused, and recovery-based services. Services are provided to County and contract staff, consumers, peers, and family members. During FY 2010-11, the Academy provided training to 2,357 people.

Funding to support the Early Childhood Socio-Emotional & Behavior Regulation Intervention Specialist (EC-SEBRIS) Certificate Program was awarded to San Diego State University Research Foundation beginning July 1, 2010. Twenty-three students participated in this year-long certificate program targeted to current and future professionals who are or intend to become early childhood socio-emotional and behavior regulation intervention specialists.

Mental Health Career Pathway Programs include educational, training and counseling programs designed to recruit and prepare individuals for entry into a career in the public mental health system. Programs address training and employment opportunities for under-represented racial/ethnic, cultural and/or linguistic groups, as well as individuals and family members of those who have received mental health services. Listed below are some key highlights of the mental health career pathway programs launched in FY 2010-11.

- **Nursing Partnership for Public Mental Health** provided funding to support the development of curriculum and teaching modalities for a new program at California State University San Marcos, School of Nursing to provide a Master's of Science in Nursing program for an integrated Psychiatric/Mental Health Clinical Nurse Specialist and Psychiatric Nurse Practitioner Program. Program development took place in the first year; students will begin taking core courses in Fall 2011.

- **The Public Mental Health Academy (PMHA)** at San Diego City College provides education and training for entry-level mental health workers to address the serious shortage of mental health service providers, as well as the lack of diversity in the workforce. The primary focus of the PMHA is to develop and sustain a Public Mental Health Work Certificate program that provides workforce development for entry level positions in the mental health field as well as an initial step toward higher academic degrees in the fields of mental health and human services. In the first year of this program, 86 students enrolled, two new courses were developed specifically for the certificate program (Family Support Model and Introduction to Community Psychology), students

participated in practicum experiences at mental health programs, and a campus career fair with a focus on mental health occupations was held in Spring 2011.

- **Consumer/Family Academy** provides expanded training opportunities for consumers and family members through Family Youth Roundtable (FYRT), National Alliance on Mental Illness (NAMI) and Recovery Innovations of California (RICA). Some of the highlights from FY 2010-11 include:
  - 90 individuals completed the Peer to Peer training provided by NAMI; 28 individuals completed NAMI's Family Education training;
  - 74 consumers completed the 75-hour Peer Specialist Training and were provided support to become involved in peer specialist work through RICA; another 25 individuals completed RICA's 35-hour Peer Advocacy Training and received support to become involved in advocacy work;
  - 159 mental health staff completed the Principals to Family/Youth Professional Partnership provided by FYRT to educate administrative and direct service staff regarding the value of incorporating family/youth partners into their programs.

- **Alliant International University's Community Academy** is an innovative program that partners with the Consumer/Family Academy organizations listed above to provide training, employment assistance and other support to consumers and family members with lived experience to help them advance along the pathway to a career in public mental health. Services include academic and peer mentoring, job search assistance, field placement opportunities and support groups. In addition, the university has agreed to provide academic credit for the training programs provided by RICA, NAMI, and FYRT. Eight students enrolled in the program in May 2010; three of them have gained employment since starting the program and five students have enrolled in college.

> *"I joined The Community Academy, offered by Alliant International University and County Mental Health, to continue my training. Through this program, I have been supported as I continue to take certificates through NAMI and RICA and receive advisement, mentorship, field placement, stipend assistance and more. I am excited to be on the pathway to mental health and to help others suffering from mental illness. I have so many opportunities in front of me. I know that I am and will continue to work in public mental health and take advantage of the opportunities in front of me." – Bruce*

- **Health Science High and Middle College Pathway Academy** is a School-Based Pathways/Academy specifically targeted high school students to promote mental health careers and mental health awareness. Health Sciences High School and Middle College (HSHMC) is a public charter high school that provides students an opportunity to explore career opportunities in healthcare through college preparatory curriculum, specialized electives and internship placements. The HSHMC Pathway Academy has developed and implemented a specialized mental health worker career track to serve 50 students per year in a two-year program for 11th and 12th grade students. In addition, curriculum and specialized activities have been developed and offered school-wide to increase mental health awareness and reduce stigma. The mental health career pathway program began in September 2010; 24 12th grade students completed a

one-year pilot program and 26 11th grade students participated in the first year of this program. This program is already having a dramatic impact on the future of the youth.

"My experience with the mental health grant has been extraordinary, shaping my future in ways I have never imagined. In my first year with it, I spent my time with Sharp Mesa Vista, Sharp's leading mental health facility. I had the privilege to work often with the older adult program and make a difference in the geriatric community. From there I moved to observing marriage and family counseling sessions through a program with SDSU's community outreach program. This experience changed my entire view on mental health and put me on the path to applying to UCSD in Psychology. I have been accepted and will be attending in the fall. Finally, I moved to working with San Diego Youth Services adoption program, which has been one of the most amazing experiences I have had with this grant. I have realized that mental health is not the stereotype of caring for 'crazy people,' but to help anyone and everyone in having a full, rich life, one free of the hardships that a heavy mind and soul would give. This grant has done amazing things for me and changed the course of my life." – HSHMC Student

Residency and Internship Programs are specifically directed to address identified shortages in the licensed, direct service provider positions. Listed below are the specific residency and internship programs included in the San Diego County WET Plan.

- **Community Psychiatry (General Community Psychiatry and Child Community Psychiatry) Fellowship** will address the shortage of psychiatrists trained to provide leadership in the public mental health system. FY 2010-11 was spent developing the plan for this program which will be implemented through a partnership with UCSD School of Medicine. The first cohort of psychiatric residents to participate in this program will begin in July 2012.

- **LCSW/MFT Residency/Internship Programs** are designed to increase the number of licensed mental health clinicians in the public mental health system, with an emphasis on ethnic/cultural and linguistic diversity. In addition to student stipends, WET funding provides support for training and clinical supervision needed to obtain licensure. Students receiving stipends and other support through these programs make commitments to work in San Diego County's public mental health system for a specified period of time. Of the 11 masters' students who received stipends in FY 2010-11, the ethnic diversity included 2 African Americans, 6 Latinos and 1 Asian. Five of the students identified as first generation Americans; eight were fluent in Spanish and one was fluent in Tagalog. The following residency/internship programs were launched in FY 2010-11.
    - SDSU LEAD (MFT)
    - SDSU MSW Advanced Standing Program (LCSW)
    - Alliant University (MFT)
    - San Ysidro Health Center (LCSW)
    - SDSU Masters of Rehabilitation Counseling

Financial Incentive Programs have been incorporated into the Residency and Internship programs and the Mental Health Career Pathway programs. Financial incentives are provided to aid in the recruitment and retention of license eligible and culturally, linguistically and/or ethnically diverse public mental health staff to work in the County's and contracted provider organizations' mental health programs.

Masters level stipend recipients are contractually obligated to work in county funded mental health programs for a minimum of two years.

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Capital Facilities and Technological Needs

Improving the infrastructure of California's mental health system

A portion of MHSA funding was specifically set aside for the fifth component, Capital Facilities and Technological Needs, to promote the efficient implementation of the MHSA. The planned use for these funds will produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

Capital Facilities and Technological Needs Component (CFTN) is a unique MHSA component as it incorporates funding for two primary projects: 1) Capital Facilities and 2) Technological Needs. The total one-time funding available to the County of San Diego for this component is $37,346,700. The County of San Diego Mental Health Services received approval by the State that 35% ($13.1 million) of funds support capital facilities with the remaining 65% ($24.3 million) dedicated to technological needs. The CFTN component will help prepare the County of San Diego for healthcare reform activities at the state and federal levels, which include a much greater use of technology to assist with disease management, consumer self-sufficiency, and the seamless transfer of data among providers.

Capital Facilities

The County's use of Capital Facilities funds is expected to move the local mental health system toward the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families. To further the integration goals of *Live Well, San Diego!*, Capital Facilities funds will be used to support a consumer integrated health experience offering mental and other human health and social services.

In June 2010, County Mental Health Services conducted surveys and held four countywide public forums in an effort to identify the capital facilities needs of mental health clients, consumers, stakeholders and the general public.

The Capital Facilities projects include:

1. The purchase of a permanent, pre-fabricated building to house the Stabilization, Assessment, Transition Team (STAT) that works in conjunction with the County Probation Department to provide services to court-ordered adolescents with mental health needs at Juvenile Hall;
2. Proposed partial demolition of an older County-owned facility in the North Coastal Region and replacement with a new, larger facility to house mental health and other human services, including rehabilitation, wellness and skill development;
3. Proposed purchase and major renovation of an existing facility in the Central Region that will house a multi-service program for young adults (ages 18-24), including wellness, rehabilitation,

skill development, vocational and other human services. There will be collaboration and potential co-location with other HHSA TAY services including foster youth; and,

4. Proposed southeast location of the Central region as a project target offering full integrated health and social services.

Technological Needs

In an effort to identify the technological needs of mental health clients, consumers, stakeholders and the general public, County Mental Health Services conducted two county-wide surveys, with 1,329 respondents. Additionally, there were three regional forums conducted, and four focus groups met under the joint auspices of the Family Youth Roundtable, an independent family- and youth-led organization, and Recovery Innovations of California, a client-operated peer support service.

San Diego County Mental Health Services will be proposing several possible technology projects which will address two MHSA goals:

1. Increase client and family empowerment and engagement by providing the tools for secure client and family access to health information that is culturally and linguistically competent within a wide variety of public and private settings.

2. Modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness.

With start-up funding provided by the MHSA under the Community Services and Supports component, the Mental Health Management Information System (MIS) project plan was approved by the State in August 2010. The implementation phase was completed June 30, 2012, pending full acceptance by the County of San Diego.

In addition to the MIS project, the following seven Technological Needs Projects were approved by the State May 2011.

- Consumer/Family Empowerment (SD-2) - Employs multiple projects to make available resources and tools for secure client and family access to health information.
- Personal Health Record (SD-3) – Implementing the Personal Health Record (PHR) to all Mental Health System of Care providers for clients and family members. A PHR is an individual client health record controlled by the client.
- Appointment Reminder (SD-4) – The Outbound Dialer system will be utilized, with client's permission, by clinics to telephone consumers with appointment reminders.
- Telemedicine Expansion (SD-5) – Expand the utilization of telemedicine video conferencing technology for up to twenty sites. The technology will allow a trained psychiatric professional to communicate with consumers in need of urgent psychiatric consultation/evaluation.
- MIS Enhancements (SD-6) – Expansion of MIS to include Document Management, Doctor's Home Page and Signature Pads. Document Management provides all mental health system of care providers with the ability to electronically scan and store client documents. Doctor's Home Page

allows doctors to prescribe medications quickly and instantly update client treatment plans. Signature Pads are devices that will allow clients to have the ability to sign electronically.

- SpeEd Link (SD-7) – A project that has been reevaluated, and put on hold, due to the transition of services under Educationally Related Mental Health Services.
- Data Exchange Pilot (SD-8) – Linking behavioral health data with primary care health information to build an integrated community health record for clients seen at a community health center or county-contracted program. This project is currently on hold due to many efforts within the Agency to strategically address the need for data exchange between publicly funded programs.

Information about the progress of these projects will be included in the Fiscal Year 2013-14 MHSA Annual Program and Expenditure.

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FISCAL YEAR 2012-13 EXPENDITURE PLAN

The MHSA expenditure for Fiscal Year 2012-13 is approximately $146.4 million. This includes expenditure plans for each of the MHSA components listed below. See Appendix A for detail of MHSA Funding Summary for FY 2012-13.

- Community Services and Supports (CSS) = $90.0 million
- Prevention and Early Intervention (PEI) = $29.4 million
- Innovation (INN) = $10.9 million
- Workforce Education and Training (WET) = $3.8 million
- Capital Facilities and Technological Needs (CFTN) = $12.3 million

Due to under spending prior years' allocated expenditures and initial slow start up of programs resulting from extended procurement processes, approximately $13.2 million of funding was made available and incorporated into selected CSS and PEI programs for enhancements. See Appendix A for a listing of all enhancements and funding summary.

Community Services and Supports

FY 2012-13 Expenditure Plan = $90.0 million

This expenditure plan includes enhancements totaling approximately $7.3 million.

Community Services and Supports provides a full array of services to clients and families through Full Service Partnership (FSP) programs. Full Service Partnership programs use a "whatever it takes" approach to help stabilize the client and provide timely access to needed help for unserved and underserved children, youth and adults of all ages. These individuals have a serious mental illness or are severely emotionally disturbed and may be homeless or at risk of becoming homeless. FSP programs also provide individualized services to children and families through Child Welfare and Probation Department Services, and promote access to medical, social, rehabilitative and other needed services and supports. Programs also provide outreach and engagement activities.

Programs for Children, Youth and Families

Programs for children and youth provide an array of full service partnership services including assessment, case management, intensive mental health services and supports, psychiatric services, referrals, linkage with community organizations and services that address co-occurring mental health issues and substance abuse. Services are strength based, family oriented, focus on resilience and recovery, and encompass mental health education, outreach, and a range of mental health services as required by the needs of the target populations. Some program services are provided in the home or other sites chosen by the family. Below are program highlights from FY 2010-11.

- Cultural/Language Specific Services were implemented based on principles of community involvement, cultural and linguistic competence, and outreach to underserved Hispanic and Asian/Pacific Islander children and youth and their families. Out of the total 529 clients served in FY 2010-11, 48.4% were Hispanic and 7.6% were Asian/Pacific Islander.

- Placement stabilization services were provided through outpatient mental health clinical services to children, adolescents and youth who are severely emotionally disturbed (SED), served by Child Welfare Services (CWS), and at risk of change of placement from their home, foster home, small group home, or other home-like setting.
- In Fiscal Year 2010-11, a total of 1,062 clients received services through FSP Lite programs.

Programs for Adults Ages 18 – 60+

These programs provide a variety of integrated services which may include supported housing (temporary, transitional, and permanent) with a focus of age and developmentally appropriate outreach and engagement, intensive case management 24 hours a day and 7 days a week, wraparound services, community-based outpatient mental health services, rehabilitation and recovery services, supported housing, supported employment and education, dual diagnosis services, peer support services, diversion and reentry services. A sampling of highlights from FY 2010-11 are listed below.

- Following San Diego Registry Week in September 2010, which documented at-risk homeless individuals in central San Diego, full service partnership programs were expanded to provide services to an additional 50 homeless individuals.
- In Fiscal Year 2010-11, FSP clients showed improvement in many areas of basic needs. Significant improvements were seen in movement of people from homelessness (10.9% at intake vs. 2.3% latest) and emergency shelter (9.3% at intake vs. 1.1% latest) into better living arrangements.
- Clubhouses offered comprehensive and dynamic programs to support people recovering from severe and persistent mental illnesses. Many activities targeted healthy eating and active living, which are important factors in improving the health habits and quality of life of their members.

Programs for All Ages

These programs serve families and individuals of all ages by offering a variety of outreach and engagement and outpatient mental health services, including care coordination, linkage, and individualized/family-driven services and supports. Clients are provided with necessary linkages to appropriate agencies for psychotropic medication management if necessary, as well as services for co-occurring substance abuse disorders. Some of the services are provided for specific populations and communities, such as those who have been victims of trauma and torture, the Chaldean and Middle Eastern communities and individuals who are deaf or hard of hearing.

- In FY 2010-11, the County of San Diego Behavioral Health Services Division established regional behavioral and physical health collaboratives in an effort to increase physical and behavioral health integration and provide quality care coordination for clients. The partnerships help address gaps in resources and create an information network so that clients and their families can experience an increase quality of care.
- Family and Youth Peer Support, and Partner Services hired and trained family members to provide support, education, information, linkage to services, and advocacy for children, youth, and their families. This program offered leadership training opportunities enabling family and

youth partners, who have experience with the mental health system, to serve as role models and leaders for the community.

- Geriatric Specialist clinicians provided community based outreach services to isolated older adults, including age appropriate assessments of mental health/substance abuse and physical health needs. Clinicians also assisted in transitioning stable clients to lower level resources.

Prevention and Early Intervention

FY 2012-13 Expenditure Plan = $29.4 million

This expenditure plan includes enhancements totaling approximately $5.9 million.

Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To facilitate accessing supports at the earliest possible signs of mental health problems and concerns, Prevention and Early Intervention (PEI) builds capacity for providing mental health early intervention services at sites where people go for other routine activities (e.g., health providers, education facilities and community organizations). Mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness.

Prevention

Universal prevention programs target the general public or a whole population group that has not been identified on the basis of individual risk. Prevention in mental health involves reducing risk factors or stressors, building protective factors and skills and increasing support. Programs include media campaigns such as *It's Up to Us* (Up2SD.org) and *Housing Matters* (HousingMattersSD.org), which educate the general community and empower individuals to reduce stigma associated with mental illness, suicide prevention education in public schools and throughout the community, and support and talk lines for individuals of all ages. Some highlights from FY 2010-11 are listed below.

- Six months after the launch of the *It's Up to Us* campaign in September 2010, a significantly larger number of San Diegans who saw the ads stated that they knew where to seek help (68% vs. 48%), how to recognize warning signs for suicide (69% vs. 48%) and agreed that people with mental illness should be hired just like other people (66% vs. 52%), and also agreed that they would be willing to socialize (76% v. 64%), work closely with (67% vs. 59%), and have a person experiencing mental illness marry into their family (37% vs. 27%).
- The Moving Forward/Salir Adelante fotonovela educated the Latino community on mental health issues and how and where to access mental health services. Fotonovelas are novels, books, pamphlets or brochures that utilize photos and text to illustrate a message and are useful for sharing information across different language groups. Approximately 140,000 copies of the fotonovela were distributed throughout the county. To date, two other California counties have requested permission to reprint the fotonovela for their communities. Electronic Spanish and English versions of the fotonovela are found on the *It's Up to Us* campaign website Up2SD.org.

Early Intervention

Early intervention programs target individuals or a subgroup whose risk of developing mental illness is significantly higher than average. These programs are typically of short duration and offer relatively low intensity interventions to: those at risk from exposure to community and/or domestic violence; siblings and family of gang members; isolated older adults; veterans, enlisted military, reservists and their families; Native Americans; and those with co-occurring disorders. Following is a sampling of highlights from FY 2010-11.

- Over 1,100 families, which is more than double the program's goal, with children ages five years and below were provided with positive parenting skills. Ninety-nine percent of these parents reported improvement in their parenting skills. The positive parenting program served 26 Head Start centers, exceeding the minimum target of 15, and worked with 4 centers with significant military family enrollment.

- Caregivers of Alzheimer's patients showed remarkable improvement in their health after participating in a program designed to prevent or decrease depression symptoms due to isolation and burden of care. Caregivers responded to an initial assessment and a reassessment after being provided intervention. At the reassessment, 73% of caregivers reported that they were in "Good" or "Excellent" health, compared with only 56% at the initial assessment. At reassessment, fewer caregivers were at high risk for depression than at the initial assessment (28% vs. 59%).

Innovation

FY 2012-13 Expenditure Plan = $10.9 million

Innovation programs are short-term, novel, creative and/or ingenious mental health practices or approaches that contribute to learning. At the conclusion of each program, a comprehensive analysis and report will be produced detailing what has been learned as a result of the program.

The budget includes funding for ten programs that were planned with the community. These are:

1. Wellness and Self-Regulation for Children and Youth
2. Hope Connections (formerly Peer and Family Engagement)
3. Integrated Care Resources (formerly Physical Health Integration)
4. Mobility Management in North San Diego County
5. Positive Parenting for Men in Recovery
6. After School Inclusion
7. Transition Age and Foster Youth
8. Independent Living Facilities
9. Health Literacy
10. In-Home Outreach Teams

Of these ten programs, three provided services in FY 2010-11: Wellness and Self-Regulation for Children and Youth; Integrated Care Resources (began providing services in March, 2011); and Positive Parenting for Men in Recovery. Two programs began providing services in FY 2011-12 and four programs will begin, or have already begun, to provide services in FY 2012-13. The Health Literacy

program is currently being reevaluated to determine its relevancy as there are several community initiatives currently addressing health literacy. Two highlights from the programs implemented in FY 2010-11 are provided below.

- Detailed notes of the youth participation in wellness groups have provided valuable information regarding the clients' symptoms and progress in treatment. For example, some children who responded well in other types of relaxation groups, quickly experienced symptoms of agitation in music groups. This is often due to sensory overload associated with autism spectrum disorders.

- Approximately 50 fathers participating in recovery from substance abuse will be raising children on their own for the first time with the mother being absent. These fathers are learning how to bond, and the importance of bonding, with their children.

Workforce Education and Training

FY 2012-13 Expenditure Plan = $3.8 million

This expenditure plan includes one-time funding of approximately $3.8 million.

Funding provided through the Workforce Education and Training (WET) component is one-time rather than ongoing funding. Total one-time funding for this component is approximately $17.3 million and is to be expended by June 30, 2018. A comprehensive needs assessment as well as robust planning with the community informed the decision for the development of programs. Below is a general description of the programs.

- Training and technical assistance consists of activities that enhance the knowledge and skills of individuals who provide services or support the public mental health system.

- Early Childhood Socio-Emotional & Behavior Regulation Intervention Specialist (EC-SEBRIS) Certificate Program targets current and future professionals who are or intend to become early childhood socio-emotional and behavior-regulation intervention specialists.

- Mental Health Career Pathway programs include educational, training and counseling programs designed to recruit and prepare individuals for entry into a career in the public mental health system. These programs include certification for entry-level mental health workers, nursing partnerships, a consumer and family academy, community academy that supports consumers and family members with lived experience to advance along the pathway, and a high school program that introduces students to the field of public mental health.

- Residency and internship programs are specifically designed to address the shortage of psychiatrists trained to provide leadership in the public mental health system for general and child community psychiatry. Licensed Clinical Social Worker/Marriage Family Therapist residency/internship programs are designed to increase the number of licensed mental health clinicians in the public mental health system, with an emphasis on ethnic/cultural and linguistic diversity.

Capital Facilities and Technological Needs

FY 2012-13 Budget = $12.3 million

Capital Facilities and Technological Needs (CFTN) funding is one-time, rather than ongoing funding. A total of $37.3 million was available for this CFTN component. Approximately $13.1 million (35%) was allocated to Capital Facilities projects and $24.2 million (65%) was allocated to Technological Needs projects. Total one-time funding for this component is to be expended by June 30, 2018. A robust community planning process informed the decision-making process for these projects.

Capital Facilities

The County's use of Capital Facilities funds is expected to move the local mental health system toward the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families. To further the integration goals of *Live Well, San Diego!*, Capital Facilities funds will be used to support a consumer integrated health experience offering mental and other health and social services. The four capital facilities projects are as follows.

1. Juvenile Hall Mental Health Services Office Building
2. North Coastal Health Facility
3. Central Region Health Facility
4. Future project not yet defined

Technological Needs

Technological Needs projects address two MHSA goals: 1) increase client and family empowerment and engagement by providing the tools for secure client and family access to health information that is culturally and linguistically competent within a wide variety of public and private settings; and 2) modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness. The Technological Needs projects include:

1. Consumer/Family Empowerment
2. Personal Health Record
3. Appointment Reminder
4. Telemedicine Expansion
5. Management Information System (MIS) Enhancement/Expansion
6. SpeED Link
7. Data Exchange Pilot
8. MIS

APPENDIX A – MHSA EXPENDITURE PLAN: FISCAL YEAR 2012-13

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MHSA Expenditure Plan: Fiscal Year 2012-13

PROGRAM	Ongoing Program Expenditure	FY 2012-13 Program Enhancement	Annual Program Expenditure for One-Time Funds	Administration	Total Expenditure Plan
Community Services and Supports (CSS)					
Full Service Partnerships for Children and Youth	6,747,818	900,000	0		7,647,818
Outreach and Engagement for Children and Youth	3,354,714	0	0		3,354,714
System Development for Children and Youth	8,464,692	1,605,000	0		10,069,692
Full Service Partnership for Ages 18-65+	26,197,251	2,110,000	0		28,307,251
System Development for Ages 18-65+	22,047,108	2,476,807	0		24,523,915
Outreach and Engagement for All Ages	2,279,784	50,000	0		2,329,784
System Development for All Ages	1,860,000	205,000	0		2,065,000
CSS Admin Cost			0	11,744,727	11,744,727
CSS Total	**70,951,367**	**7,346,807**	**0**	**11,744,727**	**90,042,901**
Prevention and Early Intervention (PEI)					
Education and Support Lines (PS-01)	2,790,132	3,019,813	0		5,809,945
Families as Partners (DV-01)	500,008	0	0		500,008
South Region Trauma Exposed Services (DV-02)	801,907	0	0		801,907
Alliance for Community Empowerment (DV-03)	498,085	120,000	0		618,085
Positive Parenting Program (EC-01)	1,200,000	100,000	0		1,300,000
Kick Start (FB-01)	1,300,000	475,000	0		1,775,000
Dream Weaver Native American Consortium (NA-01)	1,600,000	0	0		1,600,000
Elder Multicultural Access & Support Services (OA-01)	387,153	125,000	0		512,153
Positive Solutions (OA-02)	488,805	125,000	0		613,805
Aging Well (OA-03)	174,925	100,000	0		274,925
Reaching Out (OA-04)	460,380	80,000	0		540,380
Salud (OA-05)	552,595	150,000	0		702,595
SmartCare (RC-01)	1,400,000	150,000	0		1,550,000
School-Based Program (SA-01)	2,800,000	300,000	0		3,100,000
Suicide Prevention Education Awareness and Knowledge (SA-02)	817,596	0	0		817,596
Courage to Call (VF-01)	1,000,000	0	0		1,000,000
Bridge to Recovery (CO-01)	1,500,000	0	0		1,500,000
Co-Occurring Disorders (CO-02)	1,000,000	1,140,000	0		2,140,000
Statewide Training Technical Assistance and Capacity Building (TTACB)	508,800	0	0		508,800
PEI Admin Cost			0	3,773,460	3,773,460
PEI Total	**19,780,386**	**5,884,813**	**0**	**3,773,460**	**29,438,659**

PROGRAM	Ongoing Program Expenditure	FY 2012-13 Program Enhancement	Annual Program Expenditure for One-Time Funds	Administration	Total Expenditure Plan
Innovation (INN)					
Wellness and Self Regulation for Children and Youth	1,500,000	0	0		1,500,000
Peer and Family Engagement	1,600,000	0	0		1,600,000
Physical Health Integration	920,000	0	0		920,000
Mobility Management in North County San Diego	350,000	0	0		350,000
Positive Parenting for Men in Recovery	250,000	0	0		250,000
After School Inclusion	1,139,192	0	0		1,139,192
Transition Age and Foster Youth Program	1,812,706	0	0		1,812,706
Independent Living Facilities	473,593	0	0		473,593
Health Literacy	252,629	0	0		252,629
In-Home Outreach Teams	1,114,098	0	0		1,114,098
INN Admin Cost		0	0	1,411,833	1,411,833
INN Total	**9,412,218**	**0**	**0**	**1,411,833**	**10,824,051**
Workforce Education and Training (WET)					
Workforce Staffing Support	0	0	446,475		446,475
Training and Technical Assistance	0	0	938,484		938,484
Mental Health Career Pathway Programs	0	0	883,187		883,187
Residency and Internship Program	0	0	770,000		770,000
Financial Incentive Program	0	0	400,000		400,000
WET Admin Cost	0	0	0	343,815	343,815
WET Total	**0**	**0**	**3,438,146**	**343,815**	**3,781,961**
Capital Facilities and Technological Needs (CFTN)					
Technological Needs (TN):					
Consumer/Family Empowerment	0	0	93,300		93,300
Personal Health Record	0	0	775,000		775,000
Appointment Reminder	0	0	300,000		300,000
Telemedicine Expansion	0	0	1,675,799		1,675,799
MIS Enhancement/Expansion (Document Management, Doctors' Homepage and Signature Pads)	0	0	941,000		941,000
SpeED Link	0	0	600,000		600,000
Data Exchange Pilot	0	0	1,000,000		1,000,000
MIS	0	0	1,682,795		1,682,795
TN Subtotal	0	0	7,067,894		7,067,894
Capital Facilities (CF): Juvenile Hall, North Coastal, East portion of Central Region Project, and Southeast Facility	0	0	3,621,292		3,621,292
CFTN Admin Cost	0	0	0	1,603,378	1,603,378
CFTN Total	**0**	**0**	**10,689,186**	**1,603,378**	**12,292,564**
TOTAL MHSA EXPENDITURE PLAN: FY 2012-13	**100,143,971**	**13,231,620**	**14,127,332**	**18,877,213**	**146,380,136**

Ongoing Program Expenditure	100,143,971
Annual Program Expenditure for One Time Funds	14,127,332
Administration	18,877,213
Subtotal	**133,148,516**
FY 2012-13 Program Enhancement	13,231,620
Total Expenditure Plan	**146,380,136**

APPENDIX B – FULL SERVICE PARTNERSHIP OUTCOMES REPORT

Included in this section are the following reports:

1. Full Service Partnerships Outcomes Reports for Adult/Older Adults
2. Full Service Partnership - Lites Outcomes Report for Adult/Older Adults
3. Full Service Partnerships Outcomes Report for Children
4. Full Service Partnership - Lites Reports for Children

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Full Service Partnerships OUTCOMES REPORT

FSP Programs
Fiscal Year 2010-11

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Making a Difference in the Lives of Adults & Older Adults with SMI

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

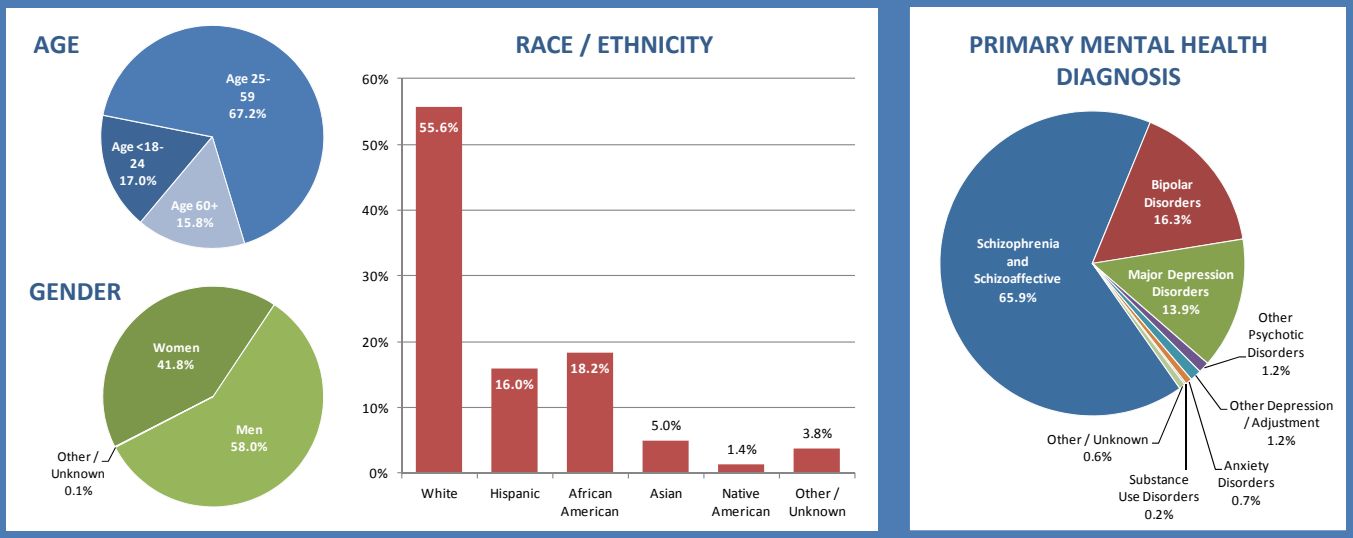
Full fidelity assertive community treatment teams—which include psychiatrists, nurses, mental health professionals, employment specialists, peer specialists, and substance-abuse specialists—provide medication management, vocational services, substance abuse services, and other services to help consumers sustain the highest level of functioning while remaining in the community.

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

In this report we use a variety of data sources to examine recovery outcomes for FSP clients during Fiscal Year 2010-11, focusing on changes in clients':

- Housing, employment, education, and access to medical care from the time of FSP enrollment (intake) to the time of their most recent assessment during FY 2010-11 (latest);
- Use of inpatient and emergency services and placements in restrictive and acute medical settings;
- Scores on clinician and client self-reported recovery measures;
- Progress toward key treatment goals.

1,716 Clients Served in FY 2010-11 — Demographics & Diagnoses

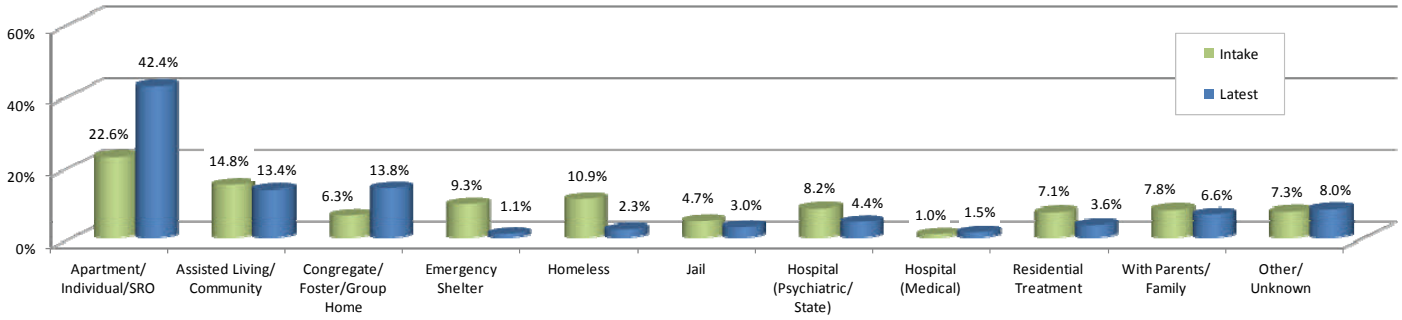


Data source: Anasazi 10/2011 download

MEETING FSP CLIENTS' BASIC NEEDS

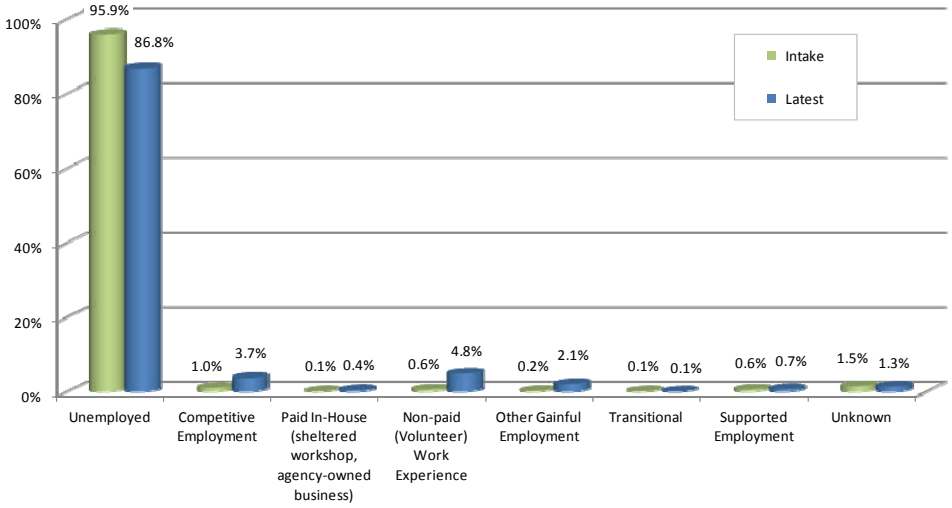
In Fiscal Year 2010-11, FSP clients showed improvement in many areas of basic needs. Significant improvements were seen in movement of people from homelessness (10.9% at intake vs. 2.3% latest) and emergency shelter (9.3% at intake vs. 1.1% latest) into better living arrangements. Significantly larger percentages of clients were able to secure more adequate housing: 42.4% in an apartment or individual living situation and 13.8% in congregate/foster or group homes. About half as many clients were in psychiatric hospital settings (8.2% at intake vs. 4.4% latest).

HOUSING



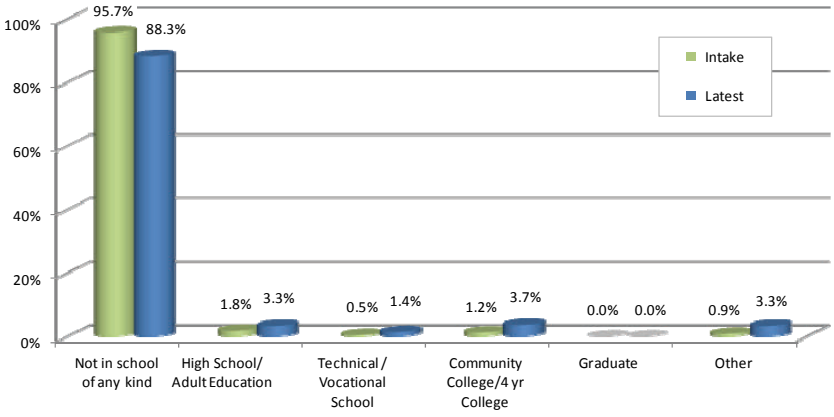
For some clients, involvement in meaningful occupational activities is an important part of recovery. FSPs can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (86.8%), there was an improvement from intake to latest assessment with some clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (from 0.6% to 4.8%) and competitive employment (from 1% to 3.7%).

EMPLOYMENT



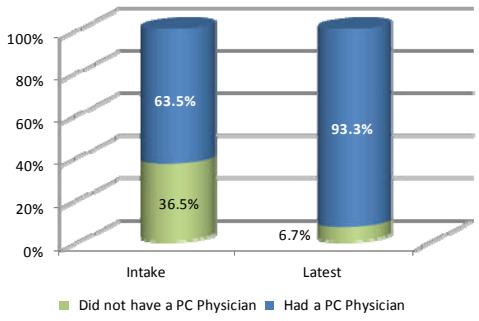
A number of FSP clients became more involved with educational activities, although this is not a goal for all. At intake, 4.4% of clients were enrolled in educational settings vs. 11.7% at the latest assessment.

EDUCATION



At intake, 63.5% of clients reported having access to a primary care physician. In contrast, 93.3% of clients reported having a primary care physician at follow up.

CLIENTS WITH A PRIMARY CARE PHYSICIAN



Data source for all charts on this page: California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/11 download; (N=1,562); Education data missing for 34 (intake) 31 (latest) clients.

CHANGES IN SERVICE USE & SETTING

FSP programs appear to decrease the use of expensive inpatient and emergency services such as Emergency Psychiatric Units (EPU), Psychiatric Emergency Teams, crisis residential, and inpatient psychiatric hospital services. Overall, use of these services declined by 7% as measured by average number of services used, and by 39.3% when considering the number of clients using services. An increase in the number of average services in inpatient psychiatric (14.5%) among fewer clients (29.9%) may indicate that inpatient psychiatric services were being deployed at a higher level of intensity to a smaller, more targeted population of clients most in need of those services. The same pattern, though to a lesser extent, was observed for use of Psychiatric Emergency Teams. Use of EPU and crisis residential services both decreased in terms of average number of services used and number of clients.

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # SERVICES PER CLIENT AMONG USERS		% CLIENTS	
EMERGENCY SERVICE TYPE	# SERVICES	# CLIENTS	# SERVICES	# CLIENTS	MEAN # SERVICES	# CLIENTS	PRE	POST	PRE	POST
EPU	1,042	403	374	153	-5.5%	-62.0%	2.6	2.4	34.2%	13.0%
PERT	286	186	255	163	1.7%	-12.4%	1.5	1.6	15.8%	13.8%
Crisis Residential	436	245	173	112	-13.2%	-54.3%	1.8	1.5	20.8%	9.5%
Psychiatric Hospital	811	321	651	225	14.5%	-29.9%	2.5	2.9	27.3%	19.1%
Overall	**2,575**	**598***	**1,453**	**363***	**-7.0%**	**-39.3%**	**4.3**	**4.0**	**50.8%**	**30.8%**

Data source: Anasazi 10/2011 and InSyst 10/2008 downloads; California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download used to identify active clients.

*The overall numbers of clients pre (598) and post (363) indicate unique clients, many of whom used multiple, various services, whereas some clients used no emergency services.

Clients in this analysis (1,177): had an enrollment date <= 7/1/2010 and discontinued date (if inactive) > 7/1/2010.

FSPs strive to help clients work toward recovery while remaining in the community. In FY 2010-11, there was an overall decrease in both average number of days spent and the number of clients in restrictive settings: jail/prison, state hospital, and long-term care. The data on placement in acute medical settings are considered separately in the table below because medical hospital stays are probably best understood to represent an increase in care coordination and access to care.

- Both the average number of days clients spent in jail or prison, and the number clients who were incarcerated, decreased (by 36.4% and 46.9%, respectively).
- The average number of days clients spent in long term care increased by 10.7%, while the number of clients being placed in long term care decreased by 53.7%. This suggests that fewer clients required long term care but those who did receive long term placement required slightly longer stays.
- Placement in state hospital also decreased, with the average number of days reduced by 42.6% and the number of clients down by 73.3%.
- Both the average number of days and number of clients in acute medical settings increased (by 141.5% and 61.5%, respectively), suggesting that clients' access to medical treatment increased after FSP enrollment.

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

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # DAYS PER CLIENT AMONG USERS		% CLIENTS	
TYPE OF SETTING	# DAYS	# CLIENTS	# DAYS	# CLIENTS	MEAN # DAYS	# CLIENTS	PRE	POST	PRE	POST
Jail/Prison	17,271	179	5,829	95	-36.4%	-46.9%	96.5	61.4	17.1%	9.1%
State Hospital	2,705	30	414	8	-42.6%	-73.3%	90.2	51.8	2.9%	0.8%
Long-Term Care	11,889	67	6,089	31	10.7%	-53.7%	177.4	196.4	6.4%	3.0%
Overall	**31,865**	**260***	**12,332**	**128***	**-21.4%**	**-50.8%**	**122.6**	**96.3**	**24.8%**	**12.2%**
Medical Hospital	897	78	3,500	126	141.5%	61.5%	11.5	27.8	7.4%	12.0%

Data source: California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (N=1,047): had an Enrollment date <= 7/1/2010 and Discontinued date (if inactive) > 7/1/2011; Clients had to be active throughout the FY to be included.

*The overall numbers of clients pre (260) and post (128) indicate unique clients, many of whom used multiple, various services, whereas some clients used no services.

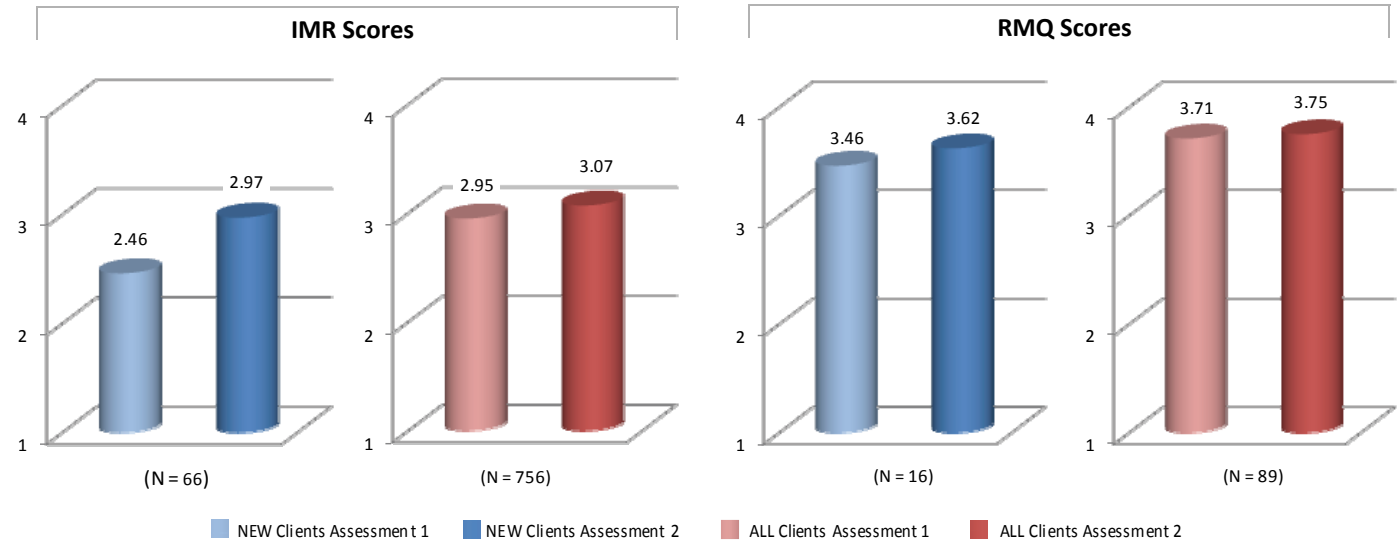
MEASURING PROGRESS TOWARDS RECOVERY

Comparing NEW and ALL FSP Program Clients

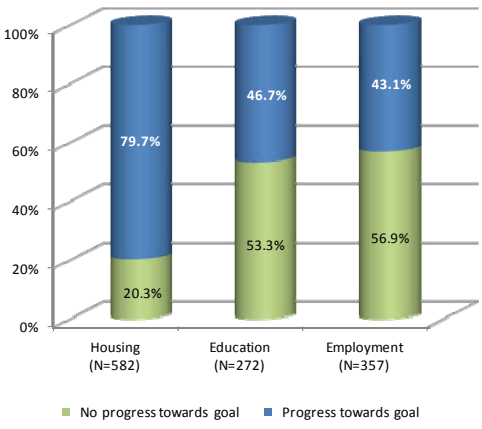
FSP clients' progress toward recovery is measured using two different instruments—the Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ). Clinicians use the IMR scale to rate their clients' progress towards recovery. The IMR has 15 individually scored items; scores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

The FSP client scores displayed in the charts below compare scores of "New Clients" to those of "All Clients." New clients are those who started receiving services in 2010 or later and whose first service date was within 30 days of their first IMR assessment; All Clients includes every client who had both a baseline and follow up IMR assessment, regardless of how long they have received services. Scores for New clients more directly demonstrate the effect of FSP services on client outcomes because All clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP programming.

IMR and RMQ Scores increased for both New and All clients. New clients' IMR scores at intake were lower than All clients' scores but New clients achieved much greater gains between intake and latest assessment. Both New and All clients' RMQ scores were higher than their IMR scores, indicating that both New and All clients tend to rate their progress higher than do clinicians. RMQ scores for New clients showed more progress than RMQ scores for All clients.



MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



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

In their IMR assessments, clinicians also note client progress toward goals related to housing, education, and employment. The chart on the left illustrates progress made by those FSP clients whose treatment plan included one or more of these key goals.

Of those FSP clients with a housing goal on their treatment plan, 79.7% demonstrated progress toward the goal, while 20.3% did not. Of those with an education goal on their treatment plan, 46.7% demonstrated progress, while 53.3% did not demonstrate progress. And of those clients with an employment goal on their treatment plan, 43.1% demonstrated progress toward the goal, while 56.9% did not. Both education and employment are longer-term goals than housing.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

Data source for all charts on this page: HOMS FY 2010-11; Data include all HOMS entries as of 4/5/2012 for clients active in all FSP Programs during FY 2010-11 and who had paired IMR/RMQ assessments within 6 months.

Full Service Partnership-Lites OUTCOMES REPORT

FSP-Lite Programs
Fiscal Year 2010-11

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Making a Difference in the Lives of Adults & Older Adults with SMI

San Diego County Full Service Partnership Lite (FSP-Lite) Programs provide a diverse array of case management and outpatient programs. While offering fewer comprehensive services than FSP programs, they share the same focus on rehabilitation, recovery, and community integration. The goal of the programs is to build on client strengths and assist in the development of abilities and skills that allow clients to become and remain successful in the community, while avoiding the need for more intensive mental health services.

Services offered by most FSP-Lite programs include psychosocial assessments, mental health and substance abuse screening, medication support, individual and group counseling, intensive case management, crisis intervention, care coordination, employment services, and outreach. Some FSP-Lite programs tailor services to selected populations, such as older adults or transition age youth, and some offer specialized services, such as in-home psychotherapy, peer counseling, and neuropsychological assessment.

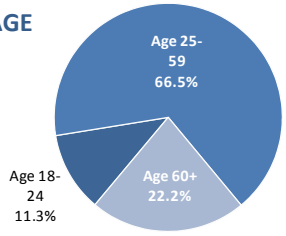
FSP-Lite program staff are multidisciplinary and generally include psychologists, marriage and family therapists, psychiatrists, nurses, social workers, case managers, peer specialists, rehabilitation counselors and master's level psychology interns.

In this report we use a variety of data sources to examine recovery outcomes for FSP-Lite clients during Fiscal Year (FY) 2010-11, focusing on changes in clients':

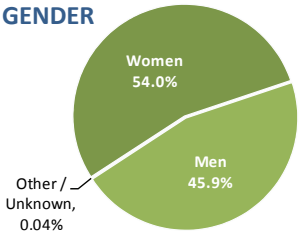
- Housing, employment, education, and access to medical care from the time of FSP-Lite enrollment (intake) to the time of their latest assessment during FY 2010-11;
- Use of inpatient and emergency services and placements in restrictive and acute medical settings;
- Scores on clinician and client self-reported recovery measures;
- Progress toward key treatment goals.

2,275 Clients Served in FY 2010-11 — Demographics & Diagnoses

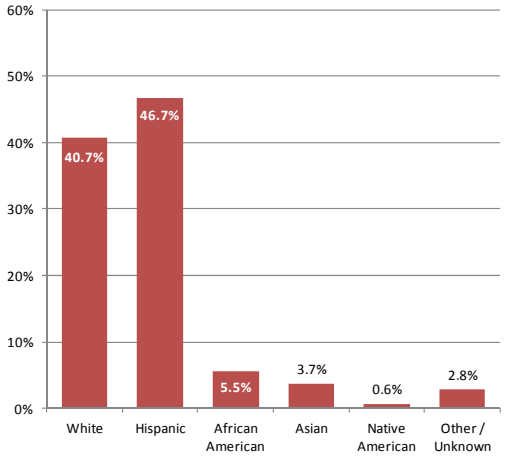
AGE



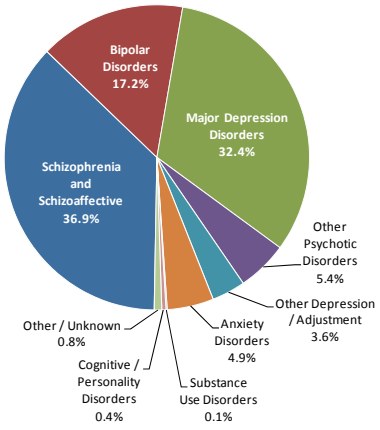
GENDER



RACE / ETHNICITY



PRIMARY MENTAL HEALTH DIAGNOSIS

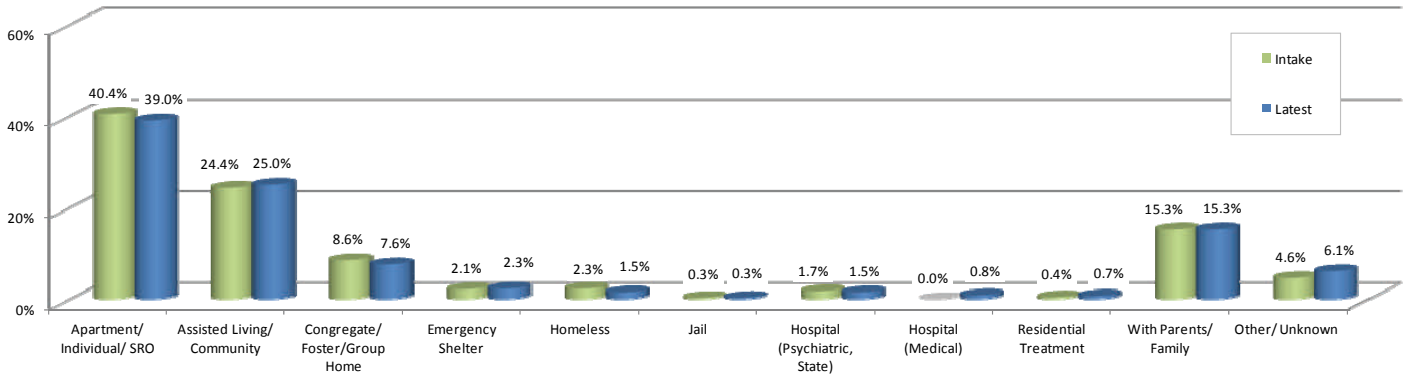


Data source: Anasazi 10/2011 download

MEETING FSP-LITE CLIENTS' BASIC NEEDS

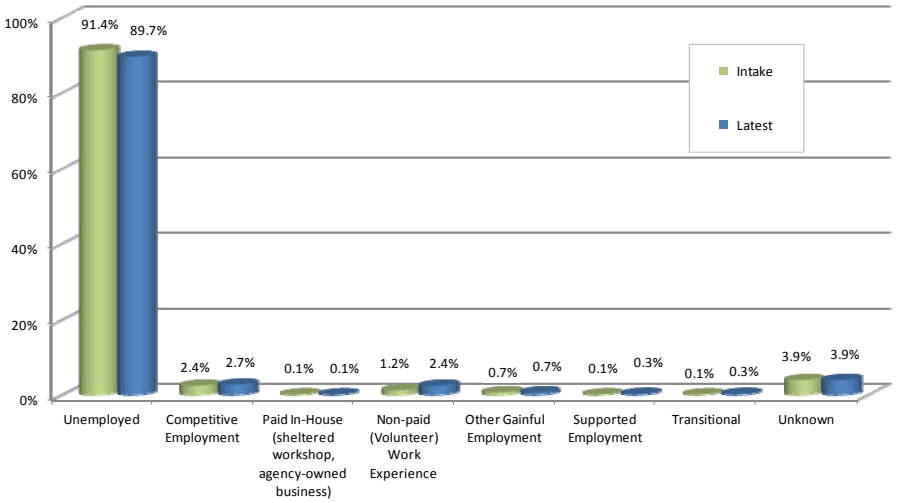
In Fiscal Year 2010-11, clients showed slight gains between intake and latest assessment in some areas of basic needs. Data on clients' residential status show that there were slight decreases in homelessness (2.3% vs. 1.5%) and residence in psychiatric and state hospitals (1.7% vs. 1.5%). There was a slight increase in assisted living in the community (from 24.4% to 25%) and no change in numbers of clients living with parents/family. Clients residing in emergency shelters increased slightly (from 2.1% to 2.3%) while the numbers of clients living independently in apartments or SROs decreased from 40.4% to 39%.

HOUSING



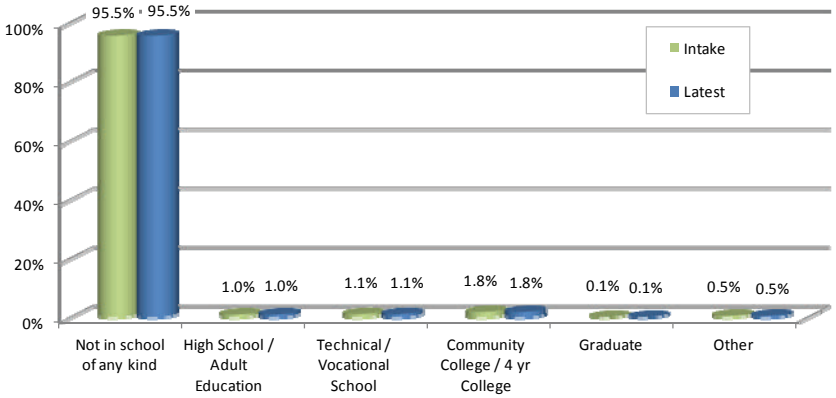
EMPLOYMENT

For some clients, involvement in meaningful occupational activities is an important part of recovery. FSP-Lites can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (89.7%), there was some improvement from intake to latest assessment with clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (1.2% to 2.4%) and competitive employment (from 2.4% to 2.7%).



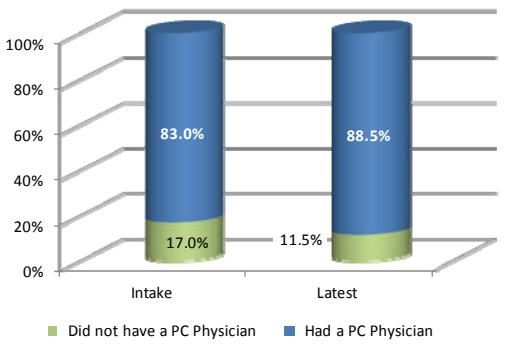
Education is not a goal for most FSP-Lite clients. Involvement in educational activities remained the same for all education categories (1 client who had not been enrolled in school entered community college and another who had been in community college left school).

EDUCATION



Client access to primary care increased slightly, with 83% of clients reporting at intake they had a primary care physician vs. 88.5% reporting access to a primary care physician at follow up.

CLIENTS WITH A PRIMARY CARE PHYSICIAN



Data source for all charts on this page: CA Department of Mental Health Data Collection and Reporting System (DCR) 9/15/11 download; (N=747); Education data missing for 19 clients.

CHANGES IN SERVICE USE & SETTING

FSP-Lite programs appear to decrease the use of expensive inpatient and emergency services such as Emergency Psychiatric Units (EPU), Psychiatric Emergency Teams (PERT), crisis residential, and inpatient psychiatric hospital services. Overall, use of these services declined by 15.6% as measured by mean number of services used, and by 30.2% when considering the number of clients using services. An increase in the mean number of services in psychiatric hospital (5.7%) among fewer clients (34.4%) may indicate that inpatient psychiatric services were being deployed at a slightly higher level of intensity to a smaller, more targeted population of clients most in need of those services. The decreases in number of clients for the remaining 3 service types (EPU, PERT, crisis residential) were all greater than the decreases in mean numbers of those services, indicating that a smaller proportion of clients received higher levels of these emergency services.

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # SERVICES PER CLIENT AMONG USERS		% CLIENTS	
EMERGENCY SERVICE TYPE	# SERVICES	# CLIENTS	# SERVICES	# CLIENTS	MEAN # SERVICES	# CLIENTS	PRE	POST	PRE	POST
EPU	71	49	22	19	-20.1%	-61.2%	1.4	1.2	10.0%	3.9%
PERT	79	56	48	38	-10.5%	-32.1%	1.4	1.3	11.4%	7.8%
Crisis Residential	24	18	21	16	-1.6%	-11.1%	1.3	1.3	3.7%	3.3%
Psychiatric Hospital	111	64	77	42	5.7%	-34.4%	1.7	1.8	13.1%	8.6%
Overall	**285**	**116***	**168**	**81***	**-15.6%**	**-30.2%**	**2.5**	**2.1**	**23.7%**	**16.5%**

Data source: Anasazi 10/2011 and InSyst 10/2008 downloads; California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download used to identify active clients.

*The overall numbers of clients pre (116) and post (81) indicate unique clients, many of whom used multiple, various services, whereas some clients used no emergency services.

Clients in this analysis (N=490): had an enrollment date <= 7/1/2010 and discontinued date (if inactive) > 7/1/2010.

FSP-Lites strive to help clients work toward recovery while remaining in the community. In FY 2010-11, there were significant decreases in the number of clients being placed in all restrictive settings: jail, state hospital, and long-term care. Conversely, the number of mean days spent in restrictive settings increased. The data on placement in acute medical settings are considered separately in the table below.

- Only 1 client spent time incarcerated in FY 2010-11, compared to 8 in the year prior to enrollment. That person had a longer incarceration than clients who were in jail or prison prior to enrollment.
- There were no FSP-Lite clients in FY 2010-11 with state hospital placement, compared to 5 clients with pre-enrollment placement.
- One client experienced long term care placement in FY 2010-11 compared to 9 prior to FSP-Lite enrollment. This client's stay was 232 days longer than the average pre-enrollment stay.
- The number of clients spending time in acute medical settings decreased by 30.3%. Those who did require medical care had longer average stays, suggesting that, while fewer clients sought medical care, those who did had access to more intensive medical treatments if needed.

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

	12 MONTHS PRIOR TO FSP ENROLLMENT (PRE)		FISCAL YEAR 10-11 (POST)		% CHANGE PRE/POST		MEAN # DAYS PER CLIENT AMONG USERS		% CLIENTS	
TYPE OF SETTING	# DAYS	# CLIENTS	# DAYS	# CLIENTS	MEAN # DAYS	# CLIENTS	PRE	POST	PRE	POST
Jail/Prison	331	8	118	1	185.2%	-87.5%	41.4	118.0	2.1%	0.3%
State Hospital	885	5	0	0	NA	NA	177.0	0.0	1.3%	0.0%
Long-Term Care	1,196	9	365	1	174.7%	-88.9%	132.9	365.0	2.4%	0.3%
Overall	**2,412**	**22***	**483**	**2***	**120.3%**	**-90.9%**	**110.0**	**241.5**	**5.5%**	**0.5%**
Medical Hospital	372	33	543	23	109.4%	-30.3%	11.3	23.6	8.6%	6.0%

Data source: California Department of Mental Health Data Collection and Reporting System (DCR) 9/15/2011 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (N=382): had an Enrollment date <= 7/1/2010 and Discontinued date (if inactive) > 7/1/2011; Clients had to be active throughout the FY to be included.

*The overall numbers of clients pre (21) and post (2) indicate unique clients, many of whom used multiple, various services, whereas some clients used no services.

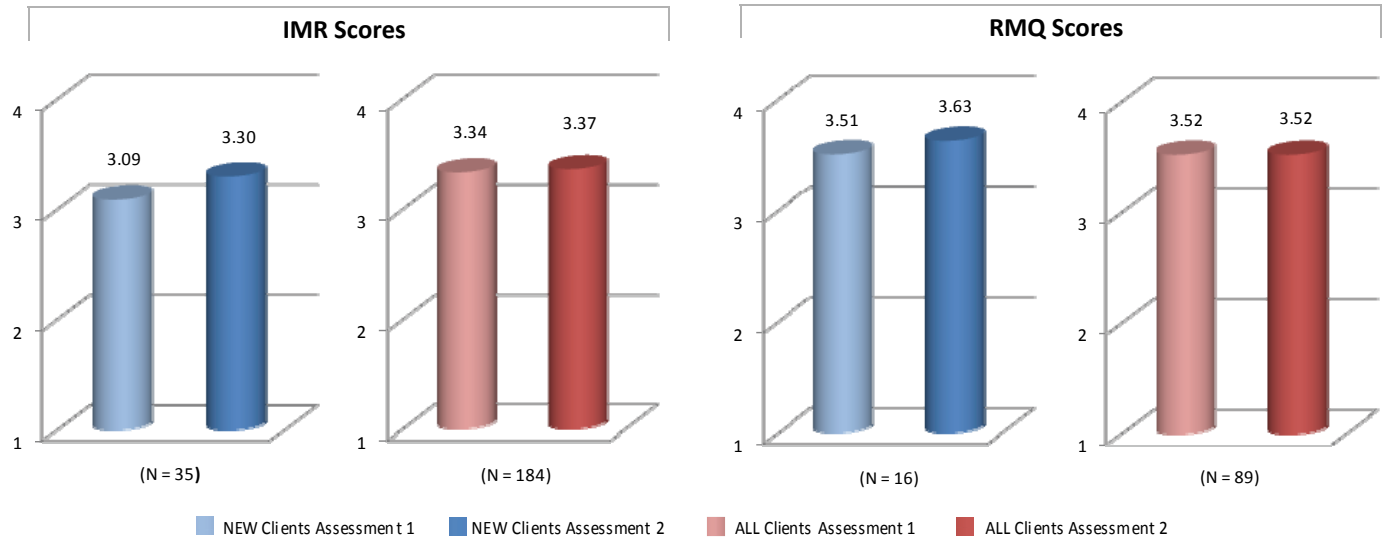
MEASURING PROGRESS TOWARDS RECOVERY

Comparing NEW and ALL FSP-Lite Program Clients

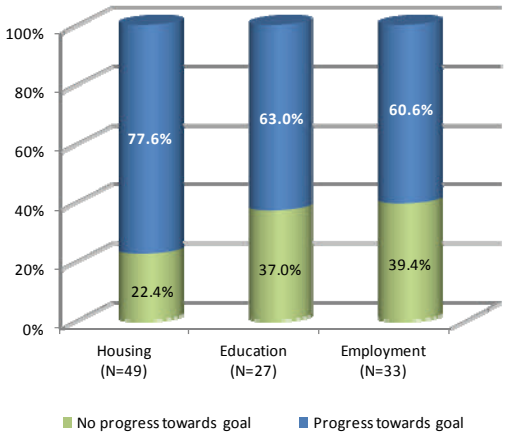
FSP-Lite Clients' progress toward recovery is measured using two different instruments—the Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ). Clinicians use the IMR scale to rate their clients' progress towards recovery. The IMR has 15 individually scored items;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

The FSP-Lite client scores displayed in the charts below compare scores of "New Clients" to those of "All Clients." New clients are those who started receiving services in 2010 or later and whose first service date was within 30 days of their first IMR assessment; All Clients includes every client who had both a baseline and follow up IMR assessment, regardless of how long they have received services. Scores for New clients more directly demonstrate the effect of FSP-Lite services on client outcomes because All clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP-Lite programming.

IMR Scores increased for both New and All clients. New clients' IMR scores at intake were lower than All clients' scores but New clients achieved greater gains between intake and latest assessment. Both New and All clients' RMQ scores were higher than their IMR scores, indicating that both New and All clients tend to rate their progress higher than do clinicians. RMQ scores for New clients showed progress, whereas RMQ scores for All clients showed no change.



MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



All FSP-Lite Clients Whose Treatment Plan Includes Key Progress Goals — Progress at Latest IMR Assessment

In their IMR assessments, clinicians also note client progress toward goals related to housing, education, and employment. The chart on the left illustrates progress made by those FSP-Lite clients whose treatment plan included one or more of these key goals.

Of those FSP-Lite clients with a housing goal on their treatment plan, 77.6% demonstrated progress toward the goal, while 22.4% did not. Of those with an education goal on their treatment plan, 63% demonstrated progress, while 37% did not demonstrate progress. And of those clients with an employment goal on their treatment plan, 60.6% demonstrated progress toward the goal, while 39.4% did not. Both education and employment were longer-term goals than housing.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

Data source for all charts on this page: HOMS FY 2010-11; Data include all HOMS entries as of 4/5/2012 for clients active in all FSP-Lite Programs during FY 2010-11 and who had paired IMR/RMQ assessments within 6 months.

Full Service Partnerships
OUTCOMES REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Children's FSP Summary

Fiscal Year 2010-11

What is This?

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

Why Is This Important?

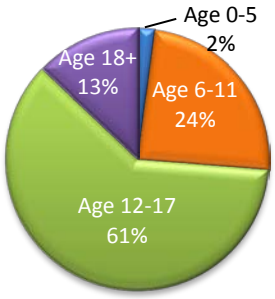
FSP programs support individuals and families, using a "whatever it takes" approach to help stabilize the client. The programs build on client strengths and assist in the development of abilities and skills so clients can become and remain successful. They help clients reach identified goals such as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

Who Are We Serving?

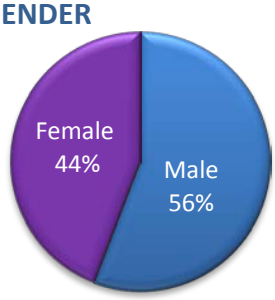
In Fiscal Year (FY) 2010-11, 529 unduplicated clients received services through the original 3 FSP programs, a 19% increase from the number of FSP clients in FY 2009-10 (N=446).

FSP Client Demographics & Diagnoses

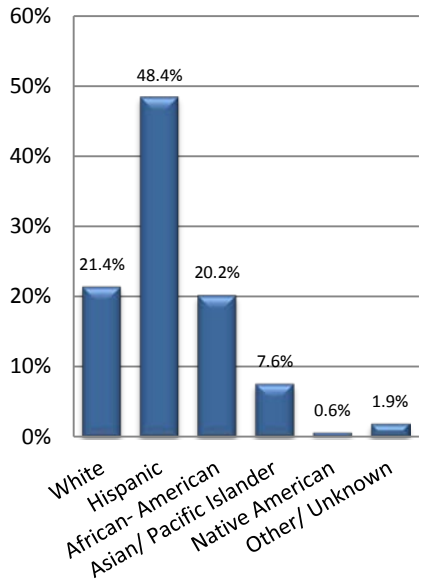
AGE



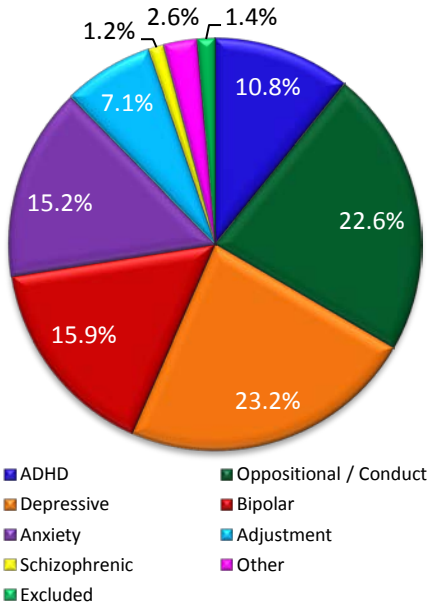
GENDER



RACE/ETHNICITY



PRIMARY DIAGNOSIS



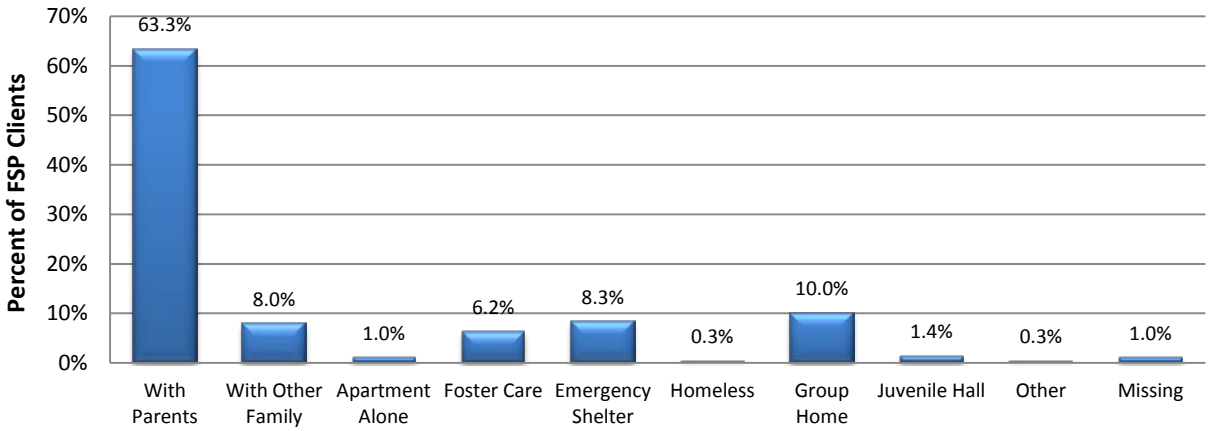
CASRC child and adolescent services research center

Who Are We Serving?

FSP Providers collected client and outcomes data using the DMH Data Collection & Reporting System (DCR). Residential status and risk factors were entered for new clients to three FSP programs in FY 2010-11. Referral sources were also entered; FSP referrals in order of frequency were as follows: social service agency (23%), Juvenile Hall (20%), a family member (19%), the school system (16%), a homeless shelter (8%), self-referral (5%), a mental health facility (5%), or a primary care physician (1%).

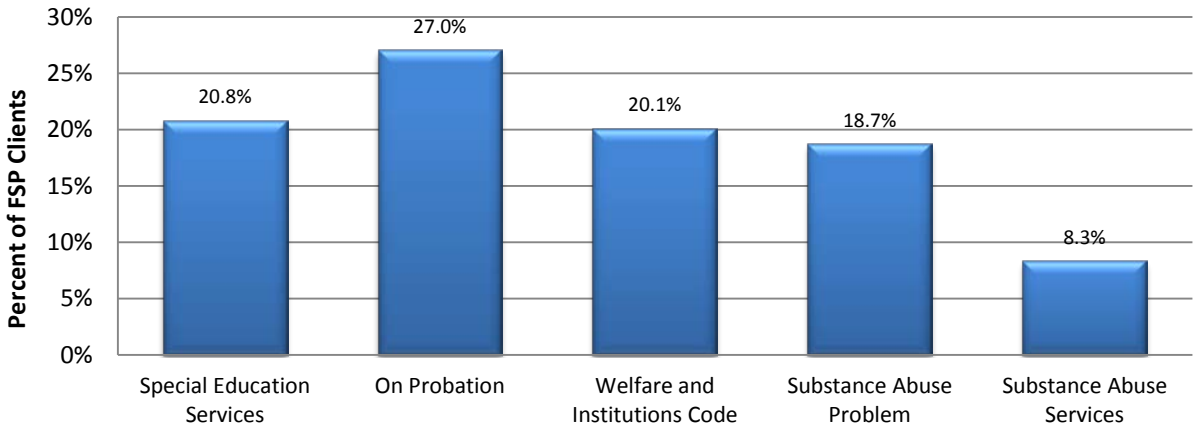
Residential Status at Intake (N=289)

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



Risk Factors at Intake (N=289)

The most prevalent risk factor among youth entering FSP programs was probationary status. Clients may have had more than one risk factor.

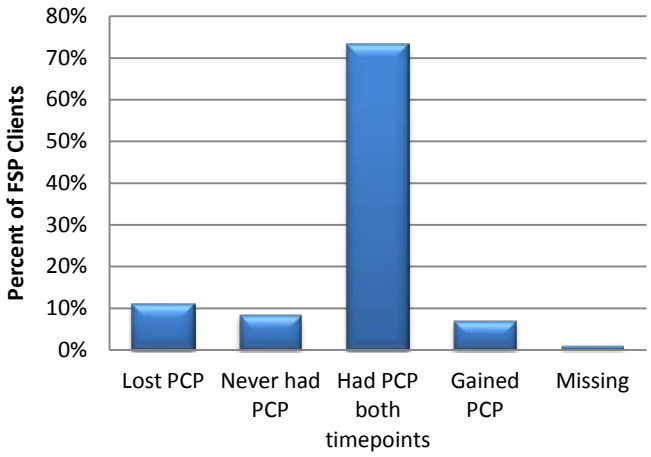


Are Children Getting Better?

FSP Providers also collected client and outcomes data on primary care physician status, school attendance, and academic performance; these were tracked in the DCR for clients with multiple assessments. Analyses of these tracked outcomes were limited to clients with an intake and a 3, 6, 9, or 12 month assessment; the most recent assessment was compared to intake.

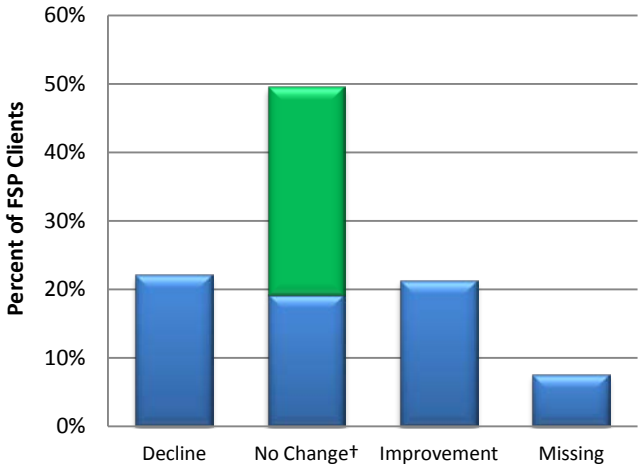
Primary Care Physician (PCP) Status (N=350)

Approximately three-quarters of FSP clients had and maintained a Primary Care Physician.



School Attendance (N=350)

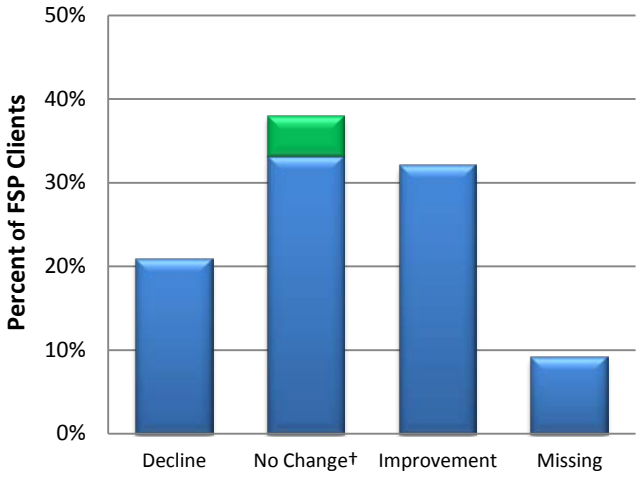
51% of FSP clients either improved or maintained excellent school attendance at follow-up assessment as compared to intake.



†Of the 49% of clients for whom no change was noted, 30% (green portion of bar) had consistently excellent attendance.

Academic Performance (N=350)

37% of FSP clients either improved or maintained excellent grades at follow-up assessment as compared to intake.



†Of the 38% of clients for whom no change was noted, 5% (green portion of bar) had consistently excellent grades.

Forensic Services

In FY 2010-11, 9 FSP clients had an arrest recorded in the DCR. One FSP client was noted to have been on probation.

Inpatient and Emergency Services

Of the 529 unduplicated clients who received services from an FSP program in FY 2010-11, 13 (2.5%) had at least one inpatient (IP) episode and 19 (3.6%) had at least one emergency service unit (ESU) visit.

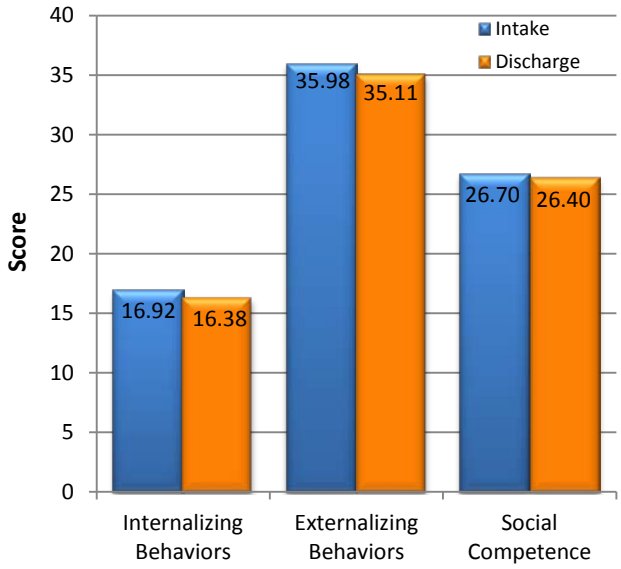
CAMS Scores

The Child and Adolescent Measurement System (CAMS) measures a child's competency, behavior and emotional problems. In FY 2010-11, the CAMS was administered to all parents/caregivers, and to youth ages 11 and older, at Intake, at UM/UR, and at Discharge. The CAMS was not administered in any inpatient settings.

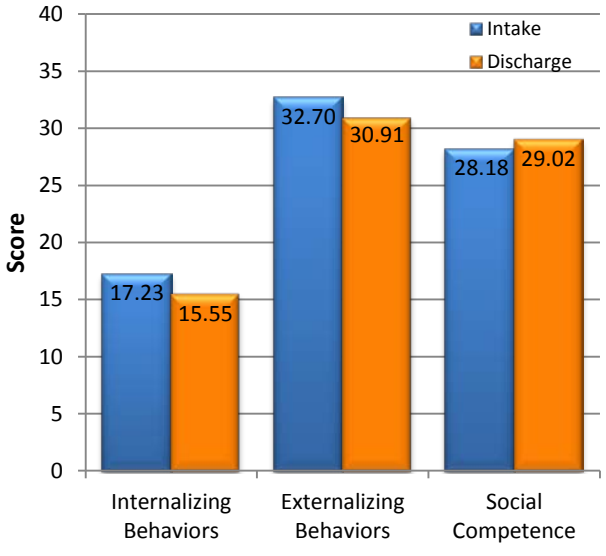
A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered an improvement. An *increase* in the Social Competence (e.g., personal responsibility and participation in activities) score is considered an improvement.

CAMS scores for youth discharged from FSP services in FY 2010-11 who had both Intake and Discharge scores for all three scales were analyzed. These CAMS results (N=133 Parent CAMS and N=56 Youth CAMS) revealed improvement in youth behavior and emotional problems following receipt of FSP services, with youth reporting greater improvement than caregivers. Parents reported a slight decrease in youth social competency, while youth reported a slight increase.

FSP Caregiver CAMS



FSP Youth CAMS



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 the Child & Adolescent Services Research Center (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.

Full Service Partnership Lites OUTCOMES REPORT

Children's FSP Lite Summary

Fiscal Year 2010-11

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

What is This?

Full Service Partnership Lite (FSP Lite) mental health programs were established in January 2010 as part of the Community Services and Supports (CSS) component of MHSA. These programs are geared toward clients who have needs greater than can be met by traditional outpatient programs, but who do not need the service intensity of an original FSP program. The broad variety of services provided may include in-home and community-based case management, rehabilitative services and connections to resources such as physical health services.

Why Is This Important?

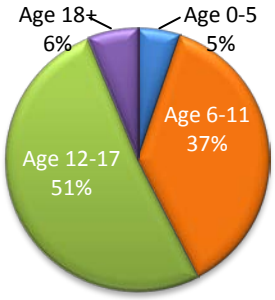
FSP Lite programs wrap around a client, forming a partnership with the family to provide "whatever it takes" to help stabilize the client. The goal of the programs is to build on client strengths and assist in the development of abilities and skills so clients can become and remain successful in the community, while avoiding the need for more intensive mental health services. They assist clients in reaching identified goals such as acquiring a primary care physician, increasing school attendance, and improving academic performance.

Who Are We Serving?

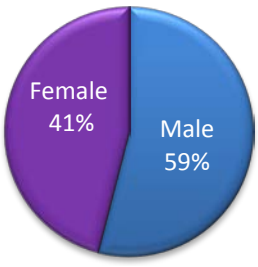
In Fiscal Year (FY) 2010-11, 1,062 unduplicated clients received services through 10 FSP Lite programs.

FSP Lite Client Demographics & Diagnoses

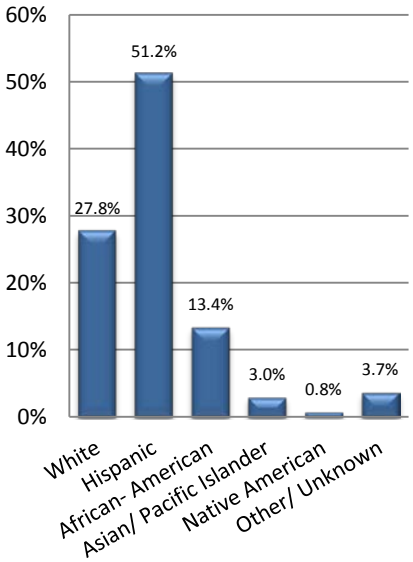
AGE



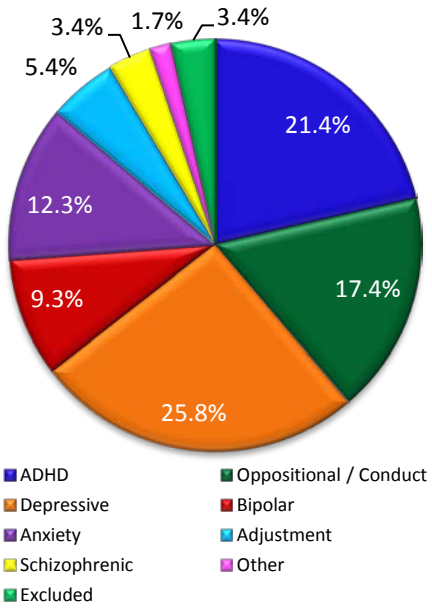
GENDER



RACE/ETHNICITY



PRIMARY DIAGNOSIS



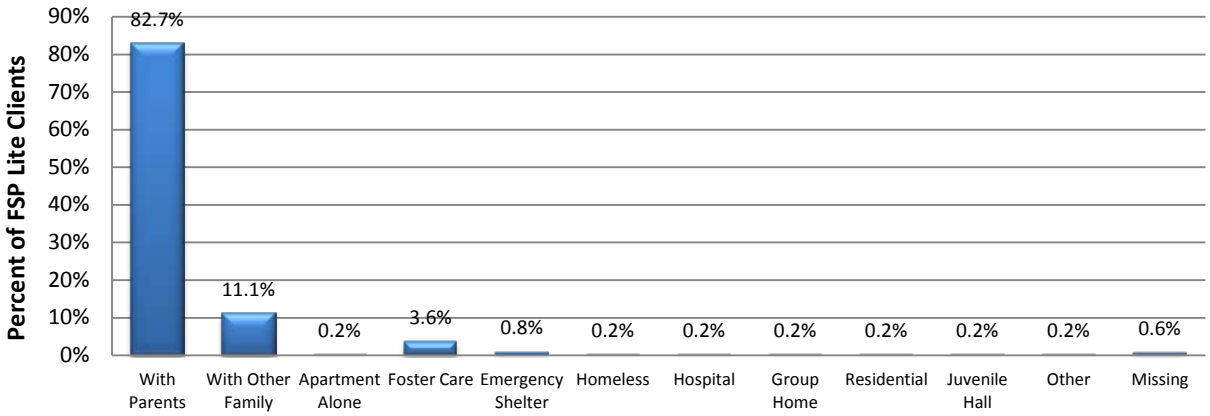
CASRC child and adolescent services research center

Who Are We Serving?

FSP Lite Providers collected client and outcomes data using the DMH Data Collection & Reporting System (DCR). Residential status and risk factors were entered for new clients to ten FSP Lite programs in FY 2010-11. Referral sources were also entered; FSP Lite referrals in order of frequency were as follows: school system (33%), a mental health agency (28%), a family member (21%), an acute psychiatric facility (4%), a primary care physician (4%), self-referral (3%), a social service agency (3%), other unspecified (2%), emergency room (1%), other County agency (1%), or a friend (1%).

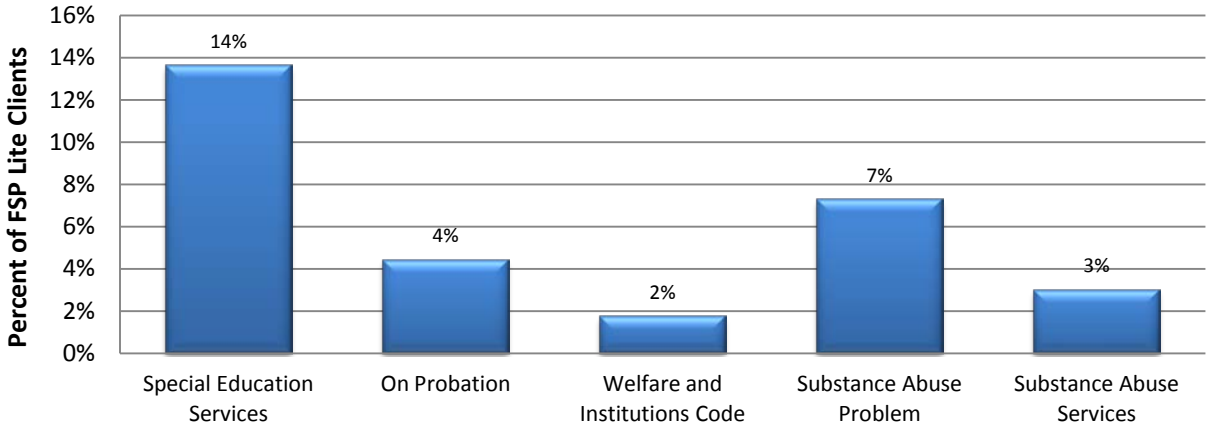
Residential Status at Intake (N=631)

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



Risk Factors at Intake (N=631)

The most prevalent risk factor among youth entering FSP Lite programs was receipt of Special Education services. Clients may have had more than one risk factor.

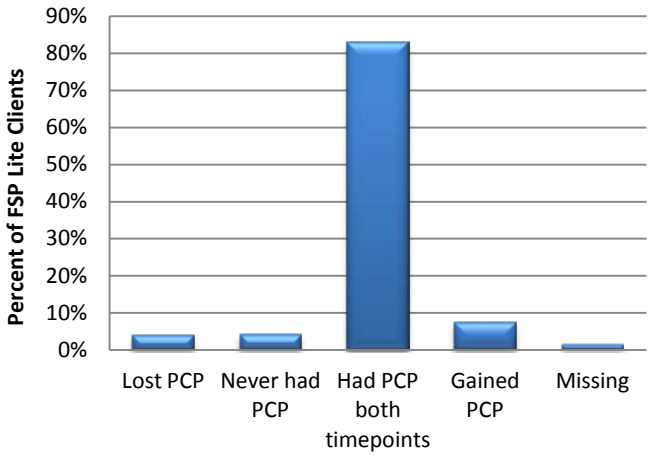


Are Children Getting Better?

FSP Lite Providers also collected client and outcomes data on primary care physician status, school attendance, and academic performance; these were tracked in the DCR for clients with multiple assessments. Analyses of these tracked outcomes were limited to clients with an intake and a 3, 6, 9, or 12 month assessment; the most recent assessment was compared to intake.

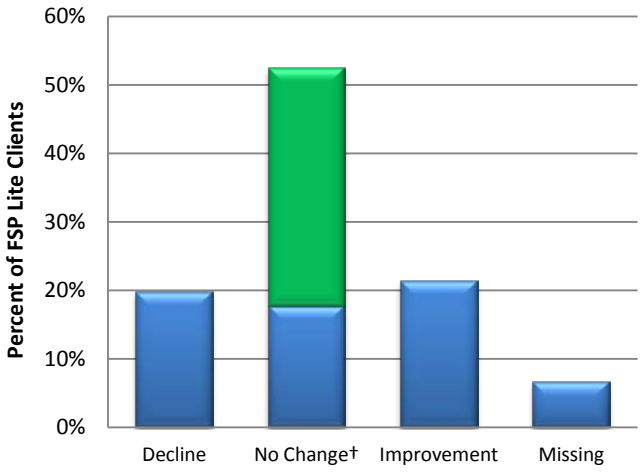
Primary Care Physician (PCP) Status (N=696)

More than 80% of FSP Lite clients had and maintained a Primary Care Physician.



School Attendance (N=696)

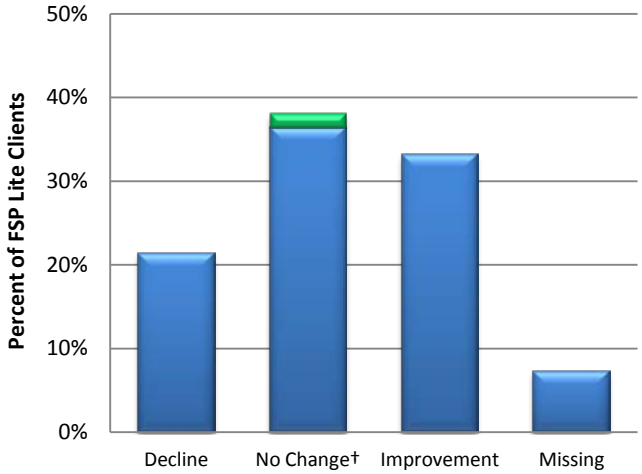
56% of FSP Lite clients either improved or maintained excellent school attendance at follow-up assessment as compared to intake.



†Of the 53% of clients for whom no change was noted, 35% (green portion of bar) had consistently excellent attendance.

Academic Performance (N=696)

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



†Of the 38% of clients for whom no change was noted, 2% (green portion of bar) had consistently excellent grades.

Forensic Services

In FY 2010-11, 8 FSP Lite clients had an arrest recorded in the DMH Data Collection & Reporting System (DCR). No FSP Lite clients were noted to have been on probation.

Inpatient and Emergency Services

Of the 1,062 unduplicated clients who received services from an FSP Lite program in FY 2010-11, 41 (3.9%) had at least one inpatient (IP) episode and 35 (3.3%) had at least one emergency service unit (ESU) visit.

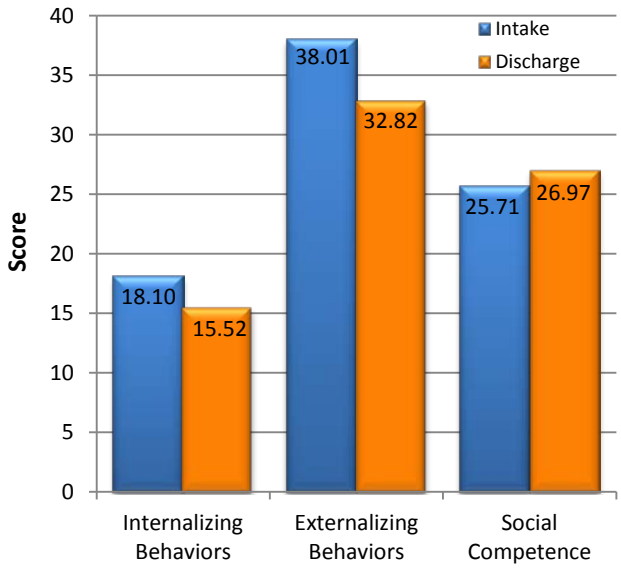
CAMS Scores

The Child and Adolescent Measurement System (CAMS) measures a child's competency, behavior and emotional problems. In FY 2010-11, the CAMS was administered to all parents/caregivers, and to youth ages 11 and older, at Intake, at UM/UR, and at Discharge. The CAMS was not administered in any inpatient settings.

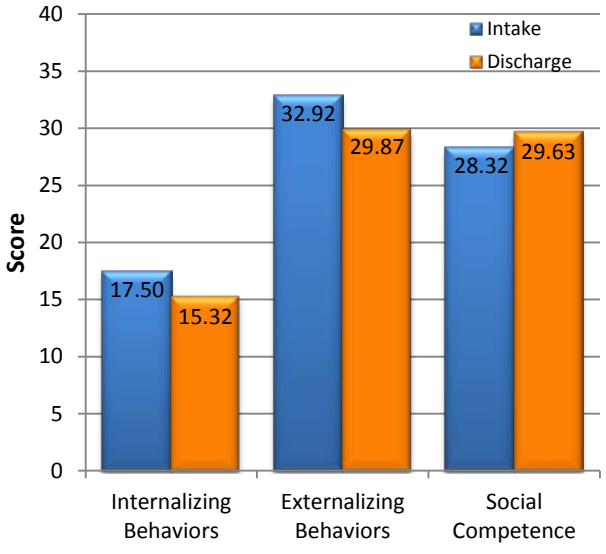
A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered an improvement. An *increase* in the Social Competence (e.g., personal responsibility and participation in activities) score is considered an improvement.

CAMS scores for youth discharged from FSP Lite programs in FY 2010-11 who had both Intake and Discharge scores for all three scales were analyzed. These CAMS results (N=79 Parent CAMS and N=60 Youth CAMS) revealed improvement in youth behavior and emotional problems following receipt of FSP Lite services, as reported by both youth and caregivers.

FSP Lite Caregiver CAMS



FSP Lite Youth CAMS



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 the Child & Adolescent Services Research Center (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 C – PREVENTION AND EARLY INTERVENTION OUTCOMES REPORT

Included in this section are the following reports:

1. Systemwide Report – Child & Adult PEI Programs
2. Systemwide Report – Adult PEI Programs
3. Systemwide Report – Child & Adolescent PEI Programs
4. It's Up to Us (PS01)
5. Peer2Peer Family Supportline (PS01)
6. Peer2Peer Youth Talkline (PS01)
7. Adult/Family Peer Support Line (PS01)
8. Families as Partners (DV01)
9. South Region Trauma Exposed Services (DV02)
10. Alliance for Community Empowerment (DV03)
11. Positive Parenting Program – Triple P (EC01)
12. Kickstart (FB01)
13. Dream Weaver Consortium (NA01)
14. School Based Program – North County (SA01NC): School Age Services
15. School Based Program – North County (SA01NC): Family Community Partnership
16. School Based Program – East County (SA01EC): Family Programs
17. Yellow Ribbon Suicide Prevention (SA02): Caregiver Outcomes
18. Yellow Ribbon Suicide Prevention (SA02): School Staff Outcomes
19. Yellow Ribbon Suicide Prevention (SA02): Student Outcomes
20. Courage to Call (VF-01)
21. Rural Integrated Behavioral Health and Primary Care Services (RC-01)
22. Elder Multicultural Access Support Service (OA-01)
23. Positive Solutions (OA-02)
24. Aging Well (OA-03)
25. REACHing Out (OA-04)
26. Salud
27. Bridge to Recovery (CO-01)
28. Community Based Alcohol and Drug Services (CO-02)

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SAN DIEGO PEI PROGRAMS

SYSTEMWIDE REPORT

SAN DIEGO COUNTY CHILD & ADULT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

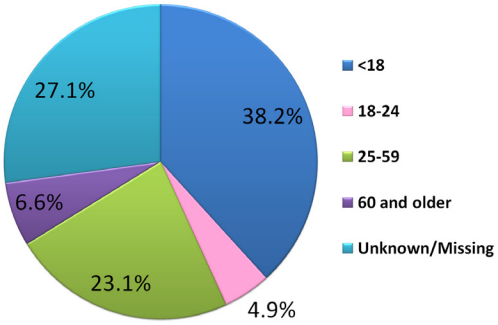
Report completed by the Health Services Research Center (HSRC) and the Child and Adolescent Services Research Center (CASRC)

The Mental Health Services Act Prevention and Early Intervention funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. San Diego County has funded 25 contractors to provide prevention and early intervention (PEI) programs for adults and 10 contractors to provide PEI programs for youth and their families. The focus of these programs vary widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided. This information is summarized in the following report.

DATA:	Child and Adult PEI Programs
REPORT PERIOD:	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	31,728 unduplicated [1,2]
1. Data not available for some participants in the ACE, KickStart, and School-Based East County programs.	
2. Data for all students participating in the Yellow Ribbon Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.	

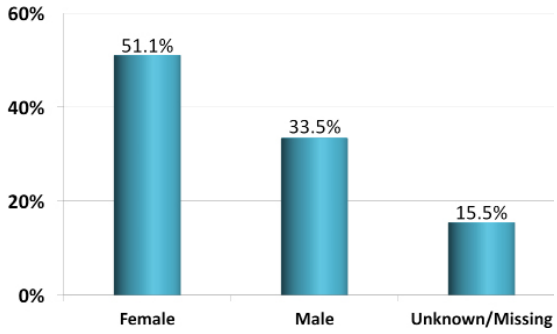
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS*

AGE



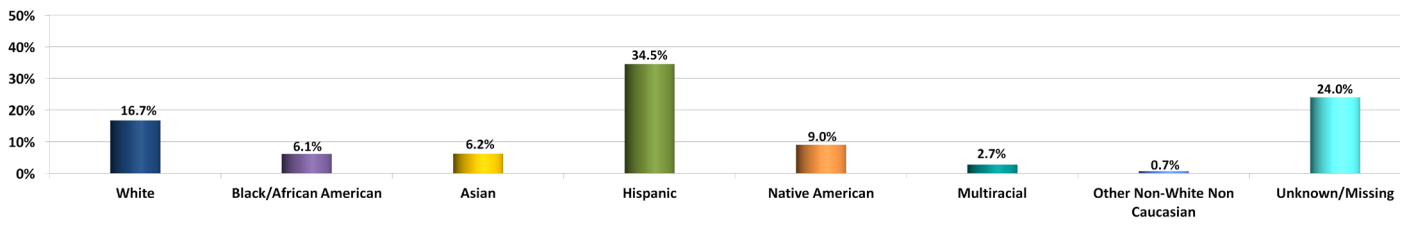
Of the participants who reported their age, the majority were either under 18 or between the ages of 25-59.

GENDER



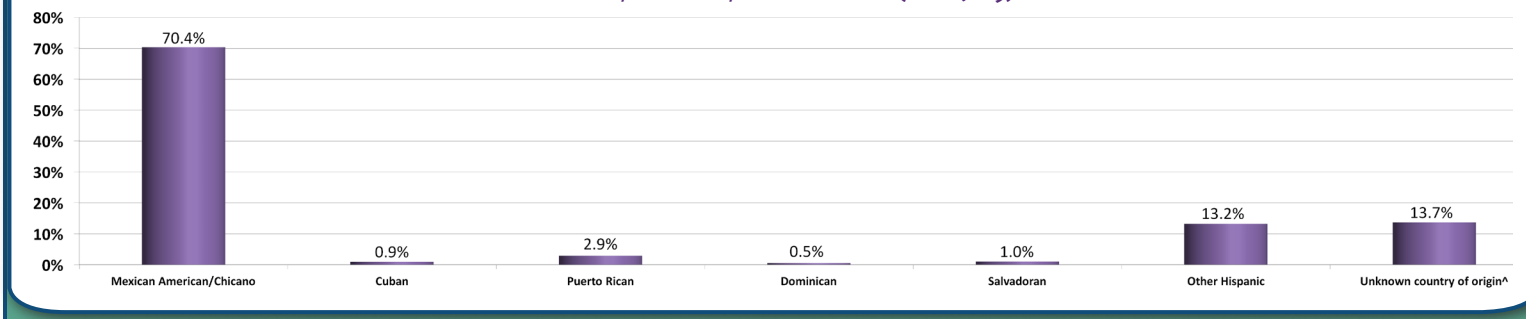
More than half of the participants who received services were female.

RACE/ETHNICITY



Slightly more than one-third of participants who received services identified their ethnic background as Hispanic.

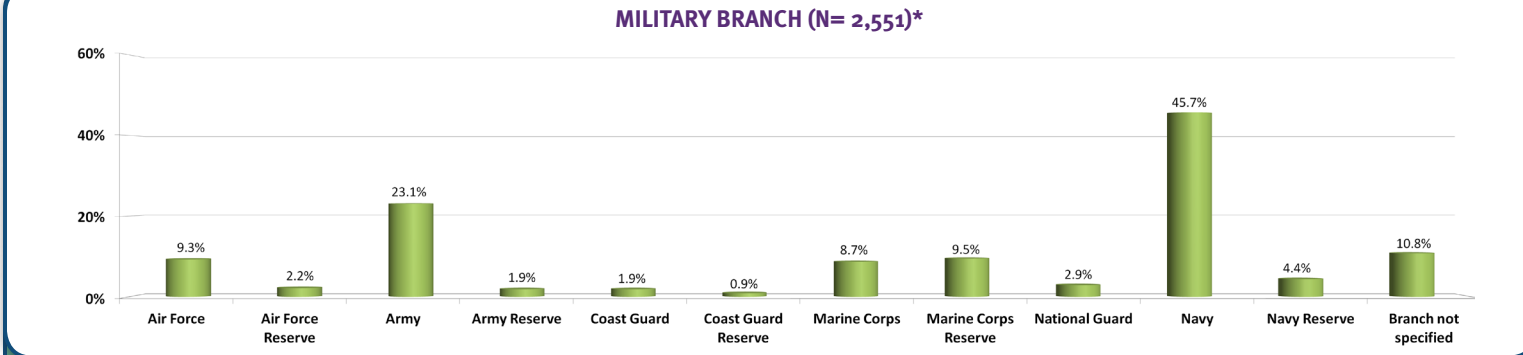
** The percentage of participants with unknown or missing information is high because individuals who called the Adult/Family Peer Support Line, one of the largest PEI programs, often did not report their demographics.*



Of the Hispanic population served, 72% identified their ethnic background as Mexican American/Chicano.

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

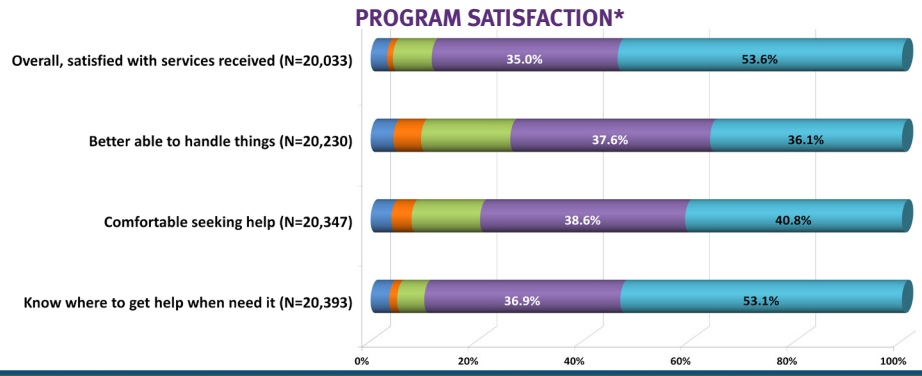
MILITARY SERVICE



In the adult PEI programs, participants were asked about their own military involvement. The children's PEI programs reported whether the children's caregivers had served in the military. Of the 26,418 participants in both systems who reported on military involvement, only 2,551 (10%) stated that either they or their child's caregiver had served in the military. The majority of these individuals served in the Navy (46%) or the Army (23%). The remaining military branches were not highly respresented.

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

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 63% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 89% of the participants who responded were satisfied with the services they received.

*Satisfaction data not available for all participants.

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

ADULT PEI PROGRAMS

SYSTEMWIDE REPORT

SAN DIEGO COUNTY ADULT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

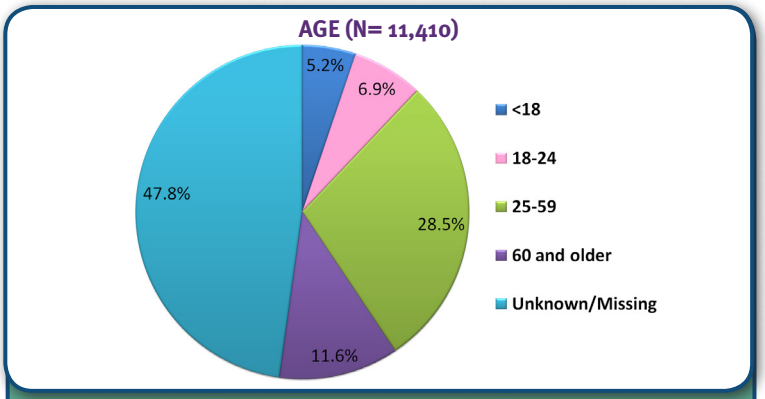
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Report completed by the Health Services Research Center (HSRC)

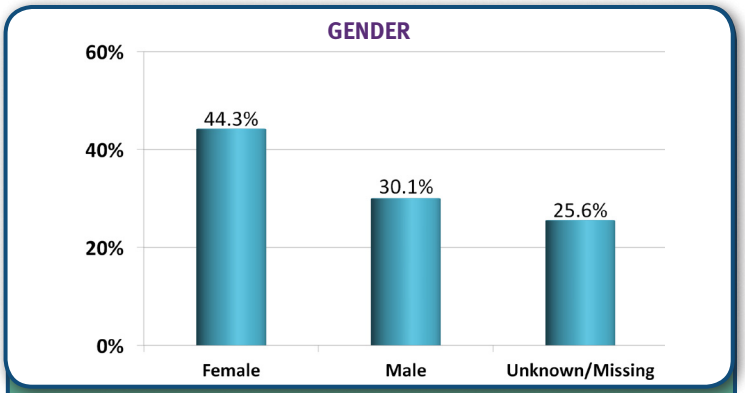
The Mental Health Services Act Prevention and Early Intervention funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. San Diego County has funded 25 contractors to provide prevention and early intervention (PEI) programs for adults. The focus of these programs vary 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. This information is summarized in the following report.

DATA:	Adult PEI Programs
REPORT PERIOD:	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	11,800 unduplicated

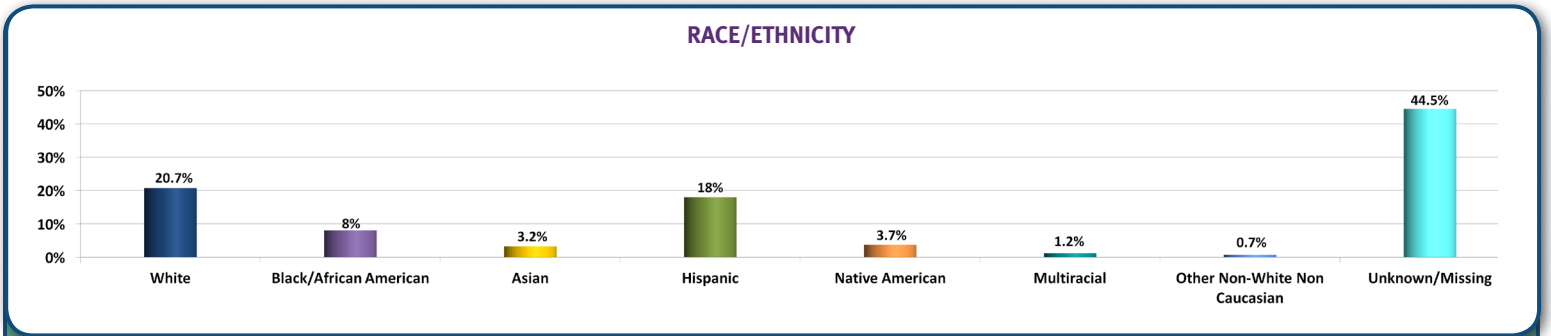
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS*



Of the participants who reported their age, the majority were ages 25-59.

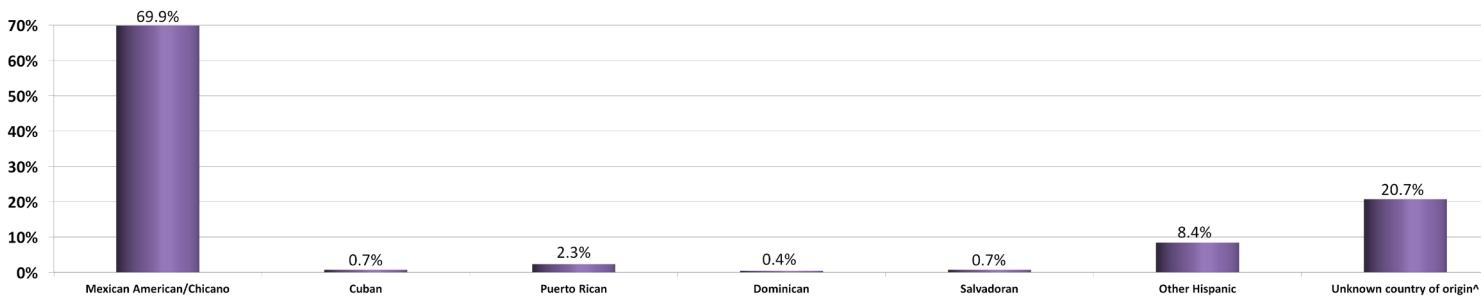


Most of the participants who reported their gender were female.



Most of the participants who reported their racial/ethnic background identified as White or Hispanic.

** The percentage of participants with unknown or missing information is high because individuals who called the Adult/Family Peer Support Line, one of the largest PEI programs, often did not report their demographics.*

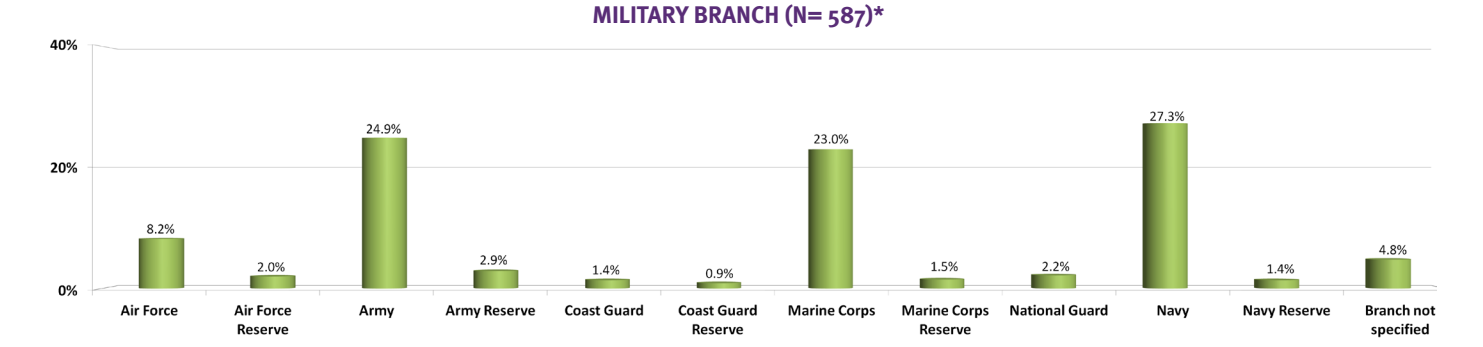


Of the Hispanic population served, 70% identified their ethnic background as Mexican American/Chicano.

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

^Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

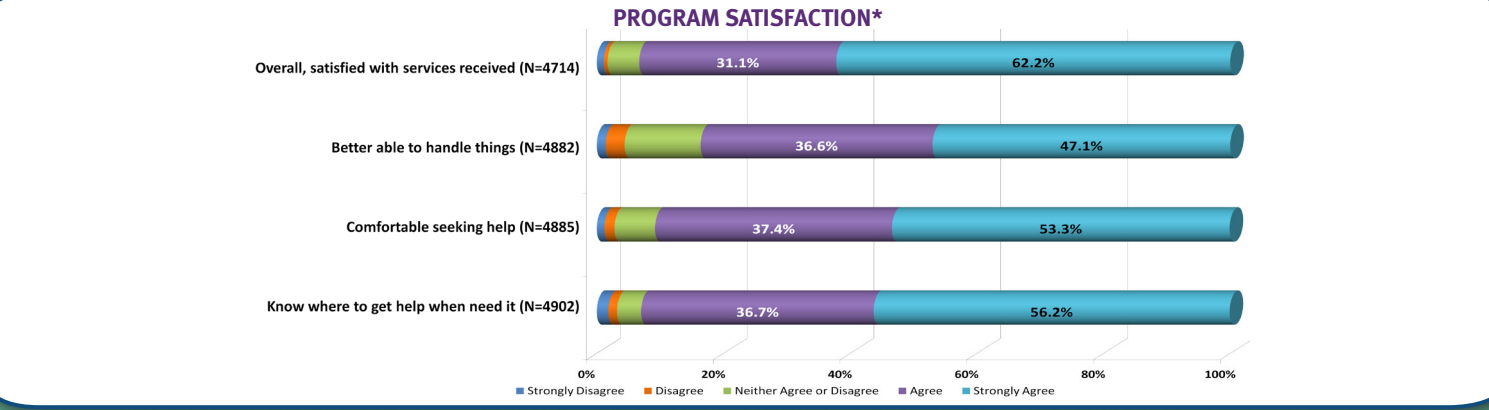
MILITARY SERVICE



Of the 8,727 participants who reported on military involvement, 584 (8%) had served in the military. Of those participants, 27% served in the Navy, 25% served in the Army and 23% served in the Marine Corps. The remaining military branchs were not as highly represented.

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

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 40% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 93% of the participants who responded were satisfied with the services they received.

*Satisfaction data not available for all participants.

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

CHILDREN'S PEI PROGRAMS

SYSTEMWIDE REPORT

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Report completed by the Child and Adolescent Services Research Center (CASRC)

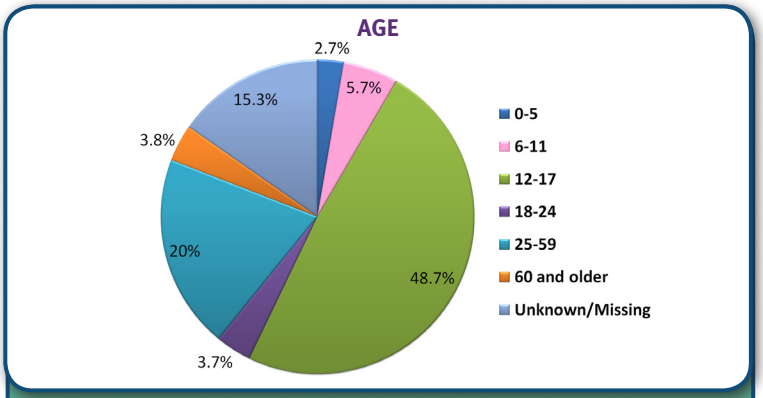
The Mental Health Services Act Prevention and Early Intervention funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. San Diego County has funded 10 contractors to provide prevention and early intervention (PEI) programs for youth and their families. The focus of these programs vary 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. This information is summarized in the following report.

DATA:	Child and Adolescent PEI Programs
REPORT PERIOD:	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	19,928 unduplicated [1,2]

1. Data not available for some participants in the ACE, KickStart and School-Based East County Programs.

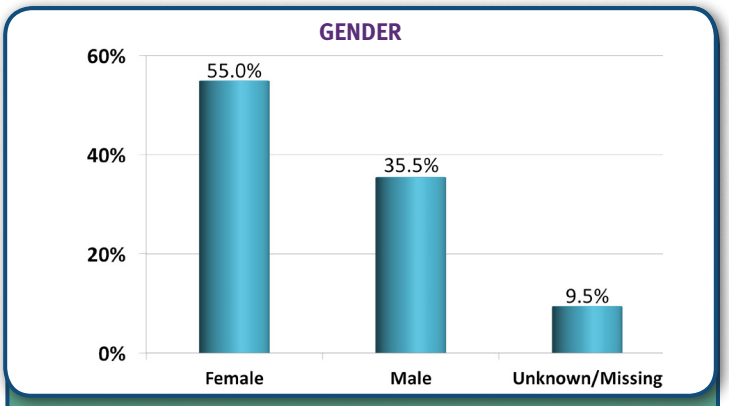
2. Data for all students participating in the Yellow Ribbon Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.

SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

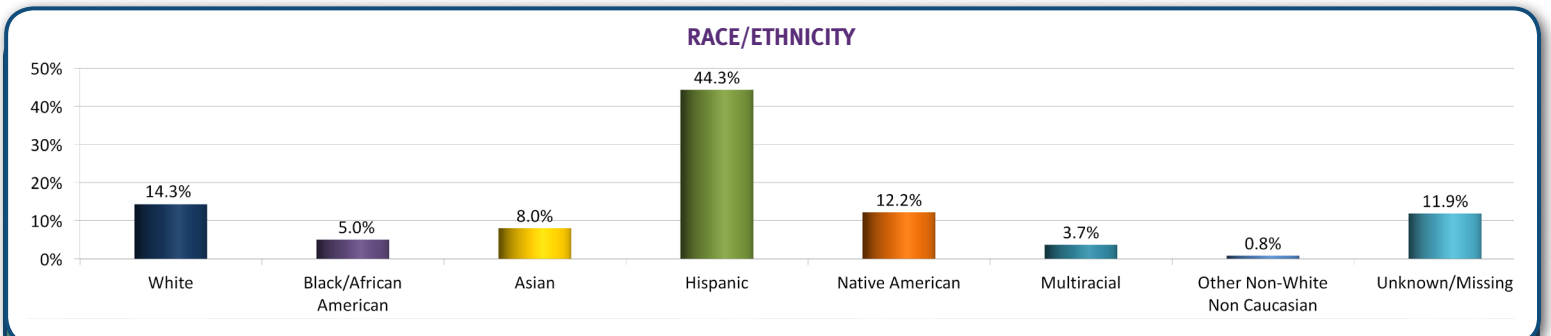


Of the participants who reported their age, the majority were ages 12-17. Some participants were older than 18 because serveral children's PEI programs include caregivers and community members.

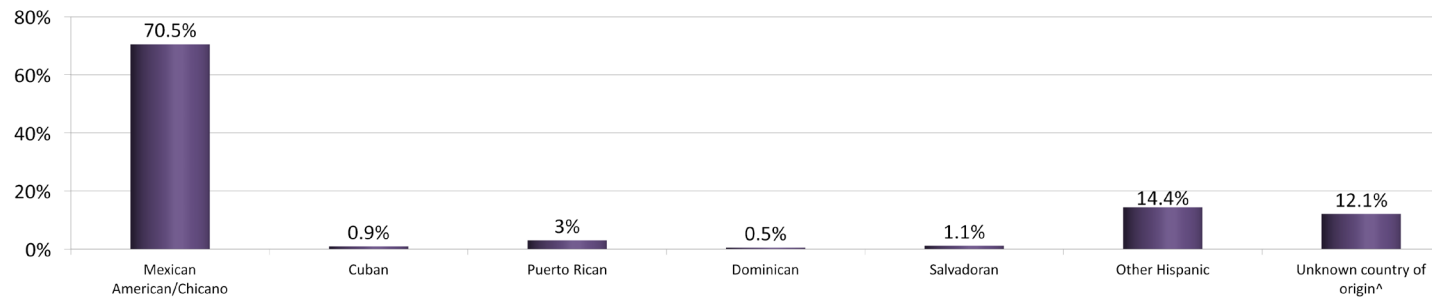
**Many of the individuals who called the Family Support Line, and all of the staff who participated in the Yellow Ribbon Suicide Prevention program, did not report their age.*



The majority of the participants who received services were female.



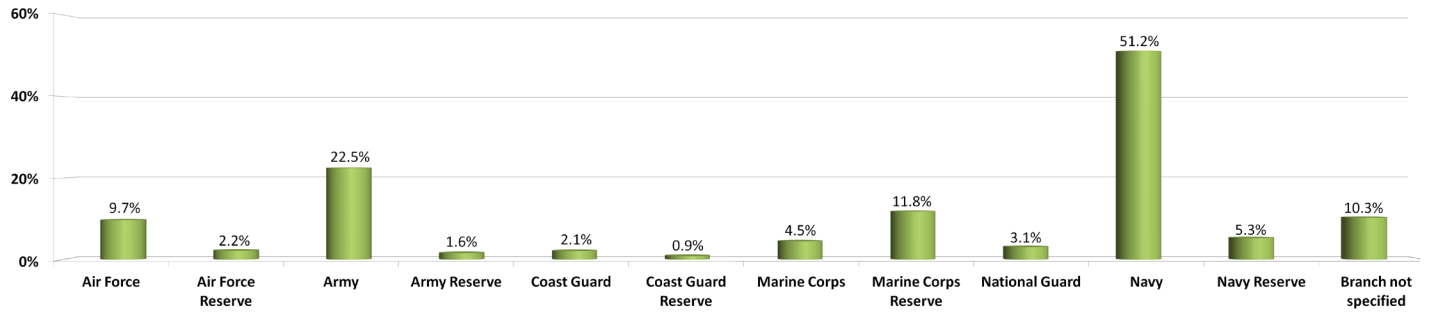
Approximately 44% of participants who received services identified their ethnic background as Hispanic.



Of the Hispanic population served, 71% identified their ethnic background as Mexican American/Chicano.

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

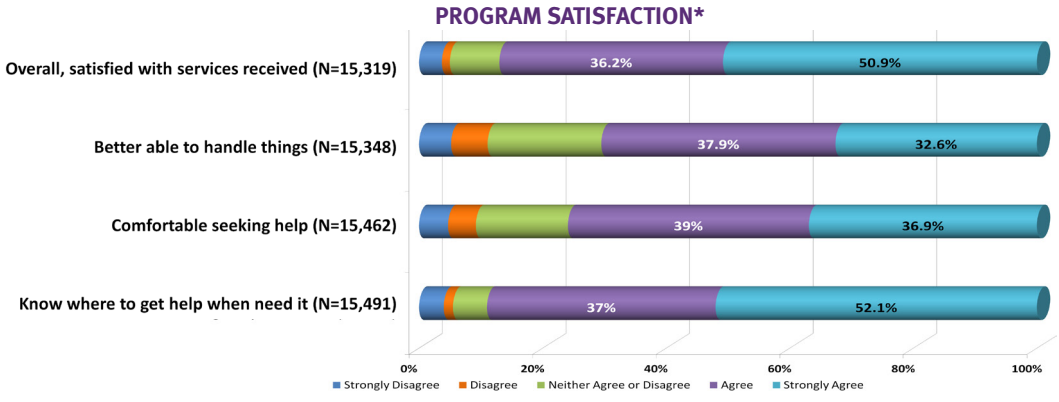
CAREGIVER INVOLVEMENT IN MILITARY SERVICE



Of the 17,691 participants who reported on caregiver involvement in the military,1964 (11%) reported that the youth's caregiver had served in the military. Of these caregivers, 51% served in the Navy and 23% served in the Army. The remaining branches were not as highly respresented.

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

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 77% of the participants.
Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 87% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

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

PREVENTION AND EARLY INTERVENTION REPORT

It's Up to Us

PS01 — All Regions and Districts of San Diego County
Fiscal Year 2010-11

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Public Awareness and Stigma Reduction Campaign

As of spring 2011, the It's Up to Us campaign included six 30-second television and radio commercials, two of each in Spanish and four in English, along with English and Spanish posters and billboards, bus billboards, and bus shelters. These spots encouraged San Diegans to "speak up" and get help, or "listen up" and offer support. Viewers were directed to visit Up2SD.org, or to call an access and crisis line for information about mental illness and treatment resources.

AdEase, a San Diego based advertising, marketing and public relations firm, was contracted to develop the It's Up to Us campaign materials. The first series of materials addressed general mental health stigma and subsequent materials will address additional topics such as suicide and mental health resources. Materials will also be targeted towards specific high-risk populations.

In collaboration with AdEase, Strata Research Inc. (Strata) conducted random digit dialed phone surveys to assess campaign impact. Data to date includes Wave I (a baseline study completed six months prior to campaign launch), and Wave II (a follow-up study completed six months after the campaign launch). Additional Waves of the study will completed annually.

Finally, UCSD's Health Services Research Center (HSRC) was contracted to complete independent direct exposure surveys to determine the specific effects of each component of the campaign. Data will be used to help develop and target specific messages.

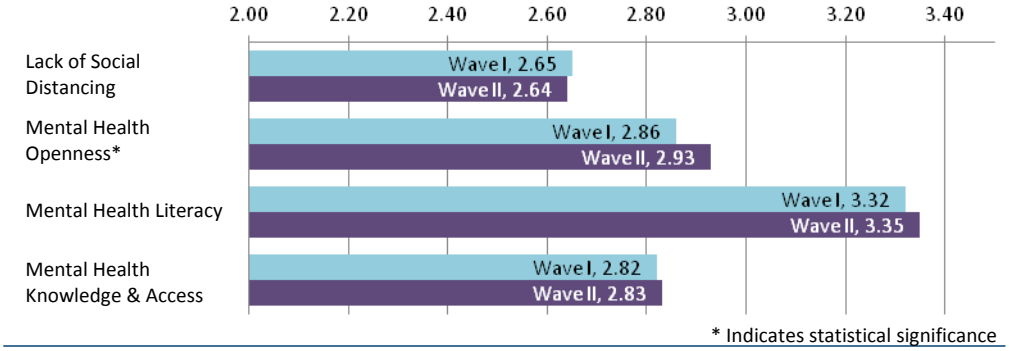
The HHSA implemented this campaign through funding from the Mental Health Services Act (MHSA). Originally passed by voters as proposition 63, the MHSA became state law effective January 1, 2005. The MHSA provides state funding to counties for expanded and innovative mental health programs.

Methods

Wave I of the study, conducted by Strata in April 2010, had 602 respondents and Wave II, conducted in March 2011, had 601 respondents. Each Wave assessed current knowledge of and attitudes towards mental illness.

The HSRC direct exposure study was conducted in March 2011, and had 120 respondents. In this study, participants listened to the audio from each of the It's Up to Us television commercials, and were asked for their reactions to specific components of each.

Data will help attribute specific improvements to the media campaign, as many outside factors can influence responses.



* Indicates statistical significance

Respondents in Wave I and Wave II listened to a scenario about a character with either depression or schizophrenia, and were then asked questions to determine their knowledge of the character's condition, and their feelings towards the character.

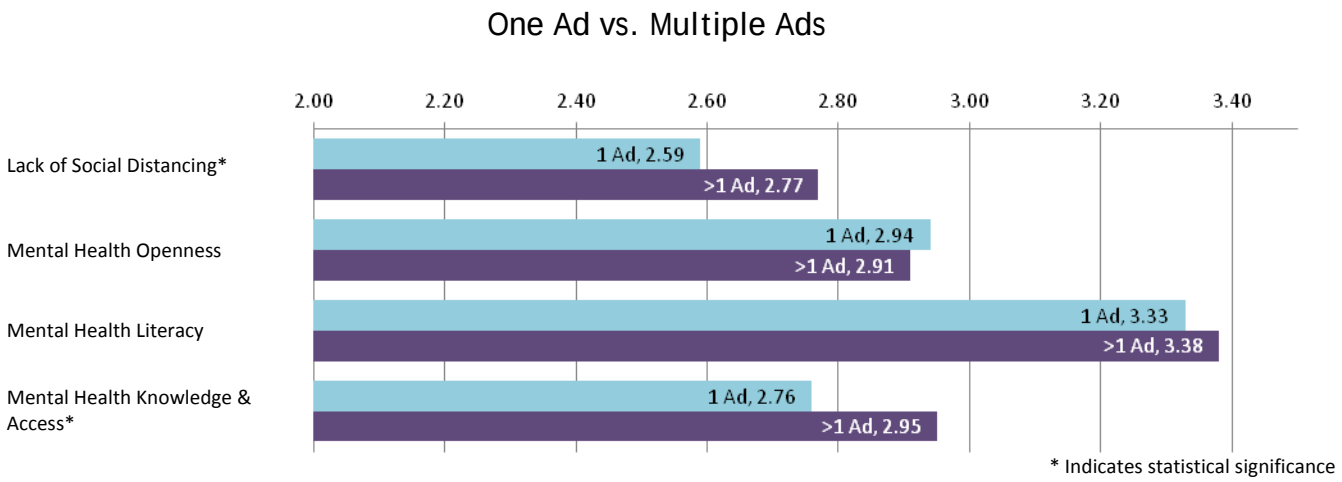
These questions made up the Lack of Social Distancing, Mental Health Openness, Mental Health Literacy, and Mental Health Knowledge & Access scales, which address different aspects of mental health stigma and literacy as well as treatment and recovery. For each of the scales, a higher score represents a more positive result.

From Wave I to Wave II, there was a significant increase in the Mental Health Openness scale for the overall population. This indicates that respondents associated less stigma with discussing mental health problems, and would feel more open to speaking about their personal mental health problems than they did at Wave I.

Literacy and Stigma Scales

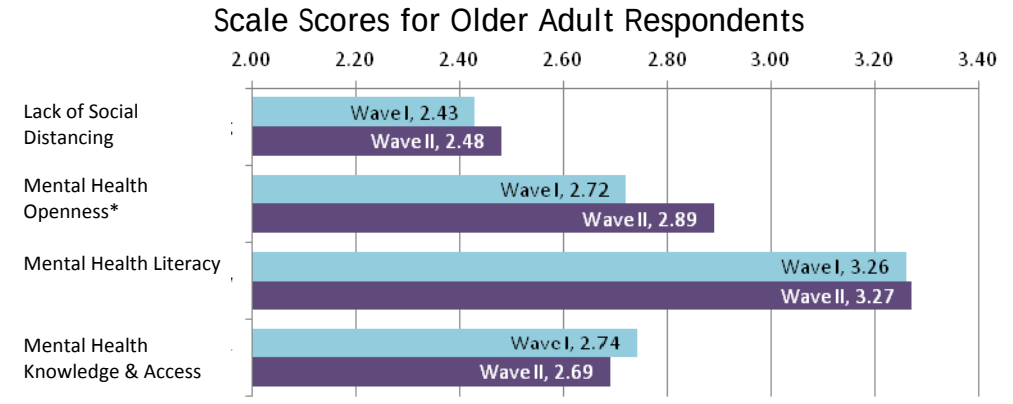
To gauge the effect of viewing multiple It's Up to Us spots, scale scores were compared for respondents with different levels of campaign exposure in Wave II of the study.

- Respondents who saw more than one spot scored significantly higher than those who only saw one spot on the Lack of Social Distancing scale and the Mental Health Knowledge & Access scale.
- Respondents who saw all four spots scored significantly higher than those who saw fewer ads on the Mental Health Openness scale.



Effects on Select Target Populations

Specific components of the It's Up to Us campaign were targeted at different populations within San Diego County, including transition aged youth (TAY), older adults (ages 65+), and Hispanic adults.

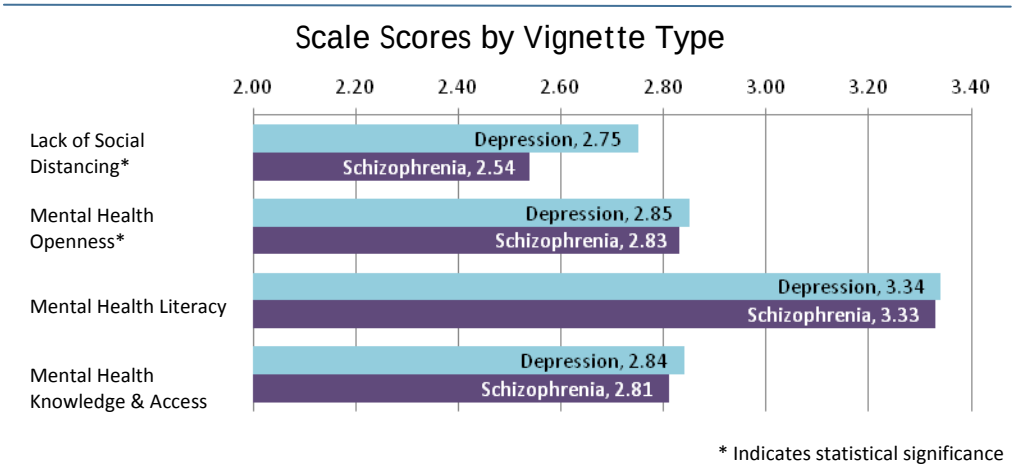


At Wave II, older adults had significantly higher scores on the Mental Health Openness scale than at Wave I. This shows reduced stigma and indicates that they might be more likely to seek help if they are concerned about their mental health. At Wave II, older adults were also more likely to report that they were currently receiving treatment, or had received treatment in the past year than at Wave I.

There were no significant differences in scale scores for Hispanic or TAY respondents.

Vignette Type

Scale scores were also compared for respondents based on which vignette they heard. Overall, respondents' scores on the two stigma scales were significantly higher if they heard the depression vignette than if they heard the schizophrenia vignette. This indicates that there is currently more stigma towards people with schizophrenia than people with depression.



Effects of Viewing Specific Media Spots

Scale scores differences were examined for respondents who had previously viewed each of the spots. Respondents who had seen "Bill & Doug" scored significantly higher on the Lack of Social Distancing, Mental Health Literacy, and Mental Health Knowledge & Access scales. Respondents who had seen "Tyler" or "Older Adults" scored significantly higher on the Lack of Social Distancing and Mental Health Knowledge & Access scales. Respondents who had seen "Coach John" scored significantly higher on the Lack of Social Distancing scale.

Of Hispanic respondents, those who had seen "Luis" scored significantly lower on the Mental Health Openness and Mental Health Knowledge & Access scales. Mean scores are detailed in Table 1 below.

Table 1. Scale scores for respondents who reported that they had previously seen the spot (Yes), or had never seen the spot (No). Only Hispanic respondents were asked whether they had seen the Spanish-language spots (Luis and Pedro).

	Bill & Doug		Tyler		Older Adult		Coach John		Luis		Pedro	
Scale	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Lack of Social Distancing	2.73*	2.61	2.74*	2.61	2.70*	2.61	2.72*	2.62	2.62	2.62	2.59	2.62
Mental Health Openness	2.88	2.95	2.89	2.94	2.92	2.94	2.93	2.93	2.69	2.93*	2.79	2.90
Mental Health Literacy	3.41*	3.32	3.37	3.33	3.35	3.34	3.36	3.34	3.17	3.27	3.21	3.25
Mental Health Knowledge & Access	2.93*	2.79	2.98*	2.78	2.89*	2.78	2.87	2.81	2.69	2.89*	2.70	2.87

* Indicates statistical significance

Treatment History and Community Needs

Respondents were asked about their mental health treatment history. As can be seen in Table 2 below, more respondents reported having received treatment either currently, or in the past at Wave II than at Wave I. However, the same number of respondents reported knowing someone who was currently receiving treatment, which is a non-stigmatizing response. More HSRC respondents indicated that they knew someone currently receiving treatment for mental health problems, that they were currently receiving treatment themselves, or that they had received treatment in the past than respondents in the concurrent Wave II of the Strata survey.

While the Strata survey always asked the treatment questions before questions about the media campaign, HSRC asked them after respondents were exposed to the It's Up to Us spots. The increase in reporting rate could be attributed to a reduction in stigma caused by viewing the spots.

Reports of current and previous treatment for mental health problems were compared for respondents who had, and had not seen the It's Up to Us ads.

- Respondents who had seen at least one of the It's Up to Us ads were significantly more likely to report having ever received treatment for mental health problems than those who did not recognize any of the ads
- Respondents who had seen at least one of the ads were more likely to report having thought about seeking help in the past 6 months and to have sought help in the past 6 months

When looking at only Hispanic respondents, compared to respondents who had not seen the spot:

- Hispanic respondents who had seen "Luis" or "Pedro" were more likely to know someone who is currently getting treatment for mental health problems, and to have personally received treatment in the past
- Hispanic respondents who had seen "Pedro" were also more likely to be currently receiving treatment for a mental health problem

This increase could indicate an increase in help-seeking behavior, however, that cannot account for the finding that respondents were more likely to report receiving treatment more than a year prior, since the campaign was only in place for six months. The change in reporting could also be due to respondents feeling less stigmatized about their treatment history, which would correspond to the increase found on the Mental Health Openness scale.

Table 2. Comparison of reported treatment history for respondents in the HSRC and Strata surveys.

	Strata—Wave I		Strata—Wave II		HSRC—Direct Exposure	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Know anyone receiving MH treatment	47.6%	52.4%	47.8%	52.2%	57%	43%
Currently receiving MH treatment	11.6%	88.4%	14.0%	86.0%	17.5%	82.5%
Previously had MH treatment	14.8%	85.2%	18.0%	82.0%	24.7%	75.3%

Campaign Exposure

With prompting, **59% of respondents recalled at least one It's Up to Us spot**.

The following messages about mental health were most frequently recalled:

- Depression is not a normal part of aging—40%
- Mental health challenges affect 1 in 4 adults—39%
- Mental health is part of your overall health—39%
- One friend reaching out makes all the difference—35%
- It's Up to Us—25%
- Get help—25.8%
- Contact a crisis hotline—25.2%
- Every day people recover from mental illness—24%
- Depression—21.4%
- Suicide Prevention—17.7%

After listening to each spot, respondents answered mental health literacy and acceptance questions to determine which spots had the greatest positive influence (see Table 3).

- Each ad showed increases in literacy and acceptance
- "Tyler" showed the greatest increase in each of the literacy items, and in three of the acceptance items

Table 3. Effects of direct exposure to each of the ads on respondents' mental health literacy and stigmatizing behavior.

	Coach John	Bill & Doug	Older Adults	Tyler
Listening to this ad…		**% Agree or Strongly Agree**		
Helped you recognize symptoms of mental health problems[2]	48.0%	64.5%	75.2%	76.1%
Helped you recognize warning signs of suicide[2]	29.7%	43.8%	37.2%	42.1%
Gave you information on how to get help[2]	75.2%	79.3%	83.5%	83.5%
How did this ad affect your likelihood to…		**% Very much or Somewhat**		
Be as supportive as possible to someone experiencing MI[1]	76.7%	74.1%	83.5%	59.5%
Make an effort to find out more about MI[2]	59.1%	63.8%	65.8%	69.3%
Treat others who have MI with respect[2]	79.3%	73.7%	84.2%	86.1%
Feel comfortable talking to a friend or family member about their MI[2]	67.2%	73.0%	76.3%	78.1%

[1] "Older Adults" had the greatest impact on this item; [2] "Tyler" had the greatest impact on these items.

Wave II Results

Analyses demonstrated a significant impact on residents of San Diego County. **Thirty-six percent of people who viewed a campaign spot had discussed it with someone else.** The spots, which encourage individuals to seek help, resulted in over 500 calls to the ACL lines in the first six months of the campaign.

San Diegans who were exposed to the It's Up to Us campaign:

- Scored significantly higher on the Lack of Social Distancing and Mental Health Knowledge & Access scales indicating reduced stigma and increased knowledge of mental health resources
- Were more comfortable talking to a friend or family member about their mental health
- Were more likely to know how to recognize warning signs for suicide, and where to get help for someone showing warning signs of suicide
- A significantly larger proportion of respondents in Wave II compared to Wave I reported that if they were suffering from a mental illness they would seek help from family or friends, a medical doctor, a counselor or psychologist, a crisis line, a spiritual leader, a website, or an employer.

Results from these early analyses demonstrate specific areas that the media campaign can focus on over the next several years, including specific target populations, and additional mental health topics. Ongoing education about mental health can help dispel some of the myths about mental illness, inform people about available resources, and make people more comfortable seeking help.

The HEALTH SERVICES RESEARCH CENTER at University of California, San Diego is a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Mental Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve client quality of life.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PEER2PEER FAMILY SUPPORTLINE (PS01)

MENTAL HEALTH SYSTEMS INC.

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

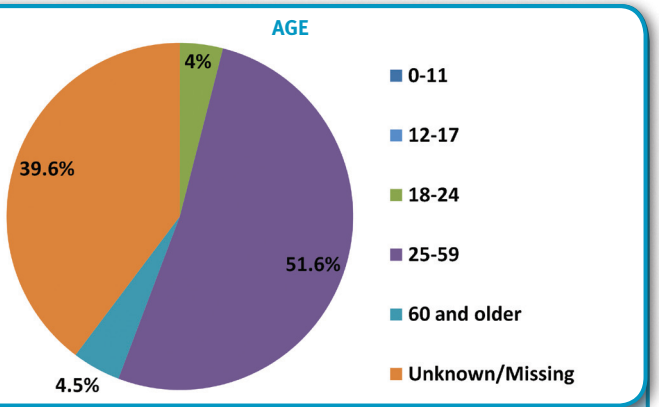
CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

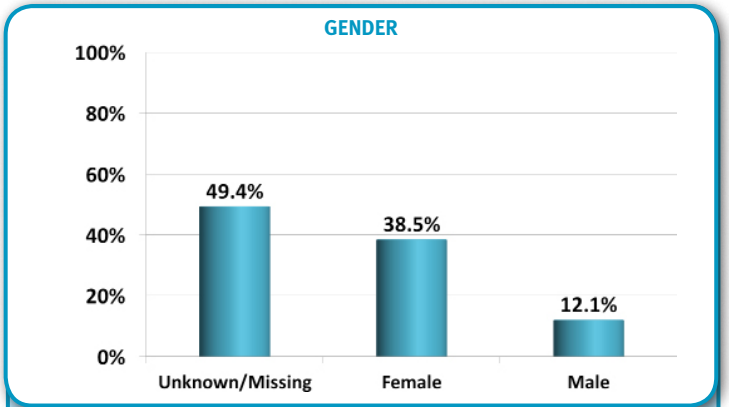
Peer2Peer provides non-crisis, confidential, telephone peer-counseling services to youth and families in San Diego County. The Family Supportline is staffed by caretakers who have children who have been involved with the mental health system. The staff provide culturally-competent information, support, and referrals to needed resources. Services are provided during late afternoons and evenings for a minimum of five days per week. A licensed supervising clinician is available for four hours per week to provide consultation on handling complex phone contacts. *Participant responses to demographics and satisfaction questions were reported to an automated telephone system. Therefore, data for this program are reported in a different manner from other programs.*

CONTRACTOR:	Mental Health Systems Inc.		
CONTRACT START DATE:	5/10/2010	**DATA COLLECTION START DATE:**	7/1/2010
PROGRAM SERVICES START DATE:	5/17/2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	810	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	810

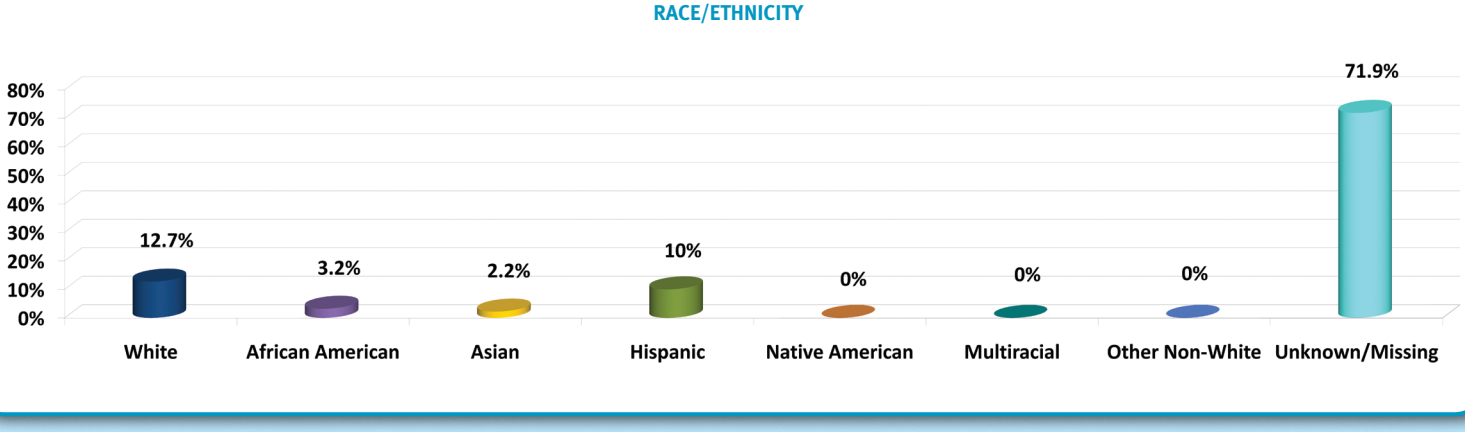
CAREGIVER DEMOGRAPHICS



More than half of the callers were ages 25-59; however, approximately 40% did not report their age.

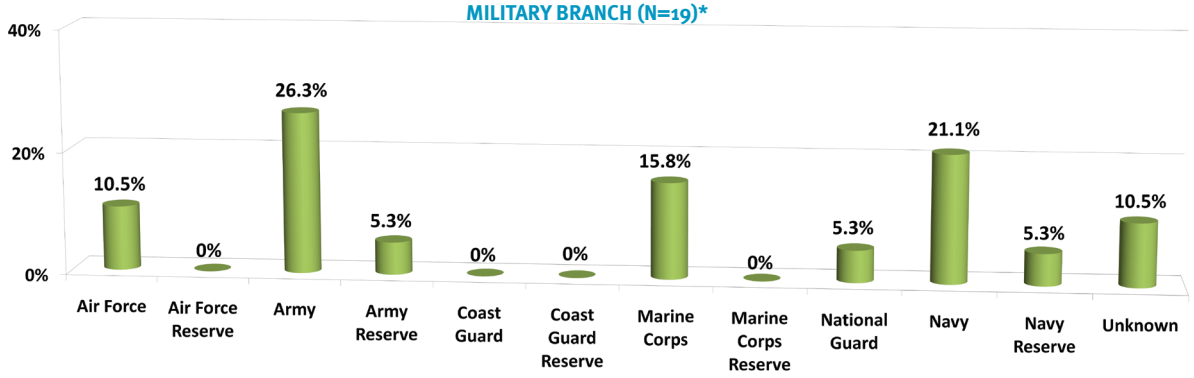


About half of the callers did not report their gender. Approximately 39% of the callers reported they were female; 12% of callers reported they were male.



The majority of the callers (72%) did not identify their ethnic background. Approximately 13% of callers identified their ethnic background as White and 10% of callers identified their ethnic background as Hispanic. Of those identifying as Hispanic, the majority identified as Mexican American.

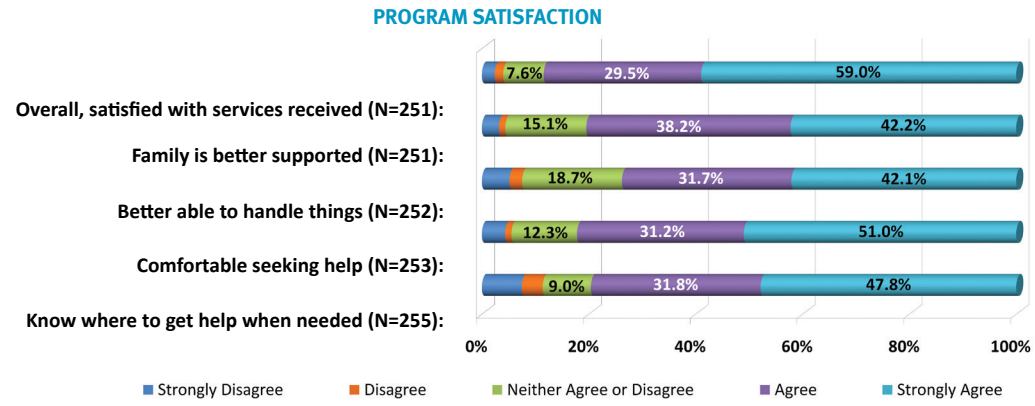
MILITARY SERVICE



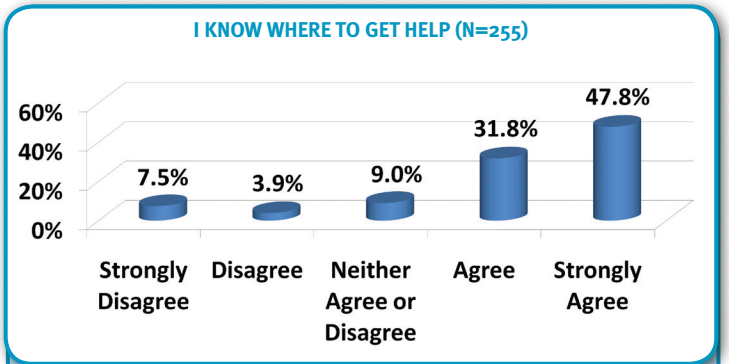
Callers were asked in which branch of the military the youth's caregiver had served. Of the 19 who responded, 5 (26%) reported that the caregivers were in the Army, and 4 (21%) reported that the caregivers were in the Navy.

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

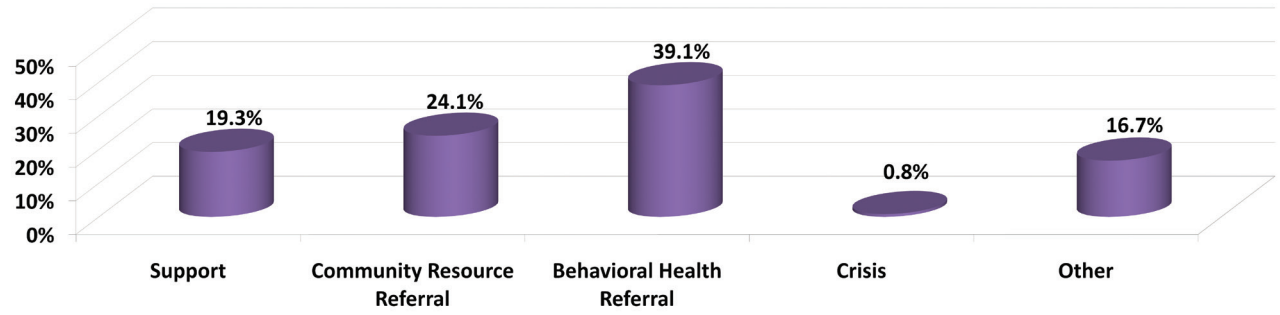
PROGRAM SATISFACTION



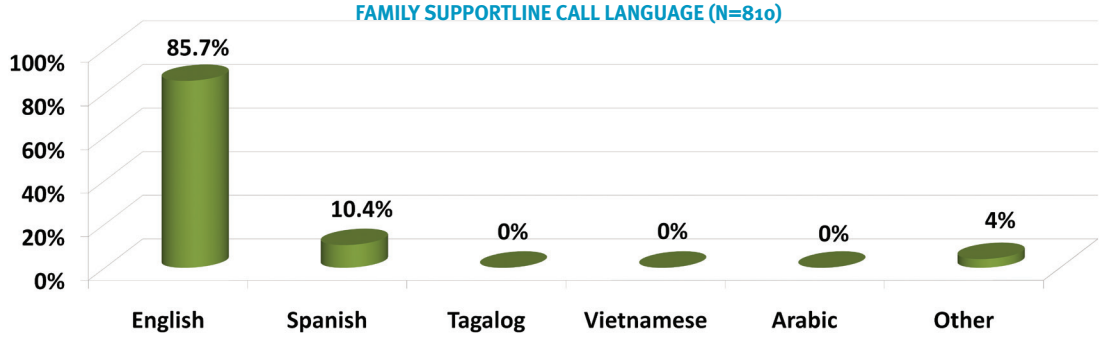
The majority of callers did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 89% of the callers who responded were satisfied with the services received.



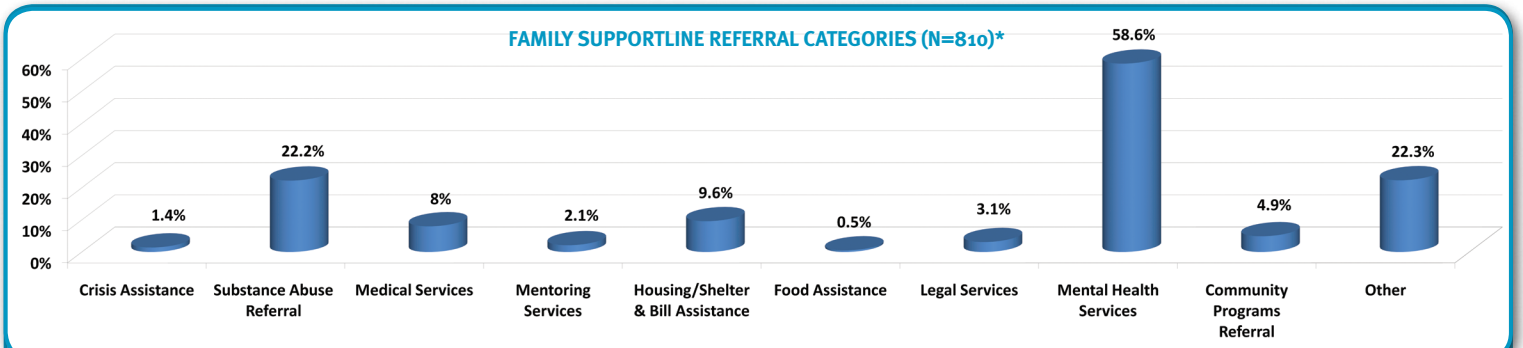
The majority of callers responding to this question reported that they knew where to get help when they needed it. Approximately 11% did not agree with this statement.



The majority (39%) of Family Supportline calls were classified as behavioral health referrals. Additionally, 24% of calls were community resource referrals. The remaining topics were support (19%), crises (1%) and other topics not specified (17%).



The majority (86%) of calls transpired in English. The remaining 10% of calls took place in Spanish.



The majority of callers received referrals for mental health services (59%) and substance abuse services (22%). Approximately 22% received referrals for services other than those categorized above.

**Some callers may receive referrals to more than one type of program so percentages may add up to more than 100% .*

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.

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PEER2PEER YOUTH TALKLINE (PS01)

MENTAL HEALTH SYSTEMS INC.

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

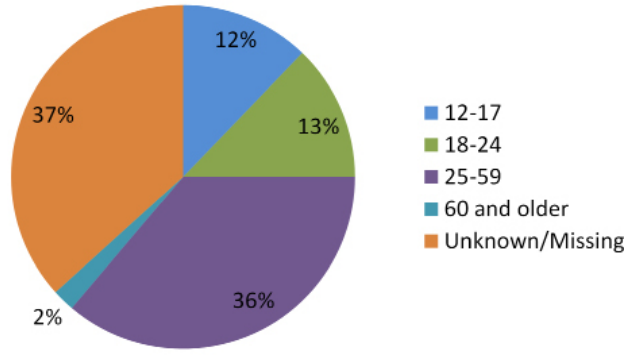
REGION: NORTH CENTRAL- DISTRICT 4

Peer2Peer provides non-crisis, confidential, telephone peer-counseling services to youth and families in San Diego County. The Youth Talkline is staffed by youth who have prior experience with the mental health system. The staff provide culturally-competent information, support, and referrals to needed resources, as well as appropriate services. Services are provided during late afternoons and evenings for a minimum of five days per week. A licensed supervising clinician is available for four hours per week to provide consultation on handling complex phone contacts. *Participant responses to demographics and satisfaction questions were reported to an automated telephone system. Therefore, data for this program are reported in a different manner from other programs.*

CONTRACTOR:	Mental Health Systems Inc.		
CONTRACT START DATE:	5/10/2010	**DATA COLLECTION START DATE:**	7/1/2010
PROGRAM SERVICES START DATE:	5/17/2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	188	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	188

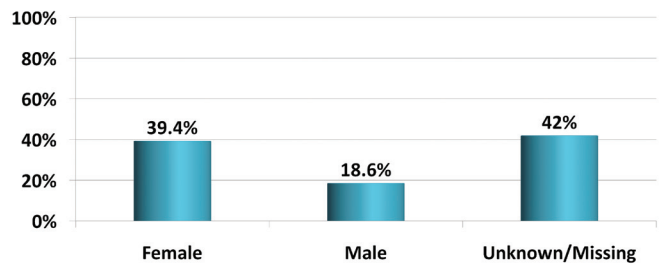
YOUTH DEMOGRAPHICS

AGE



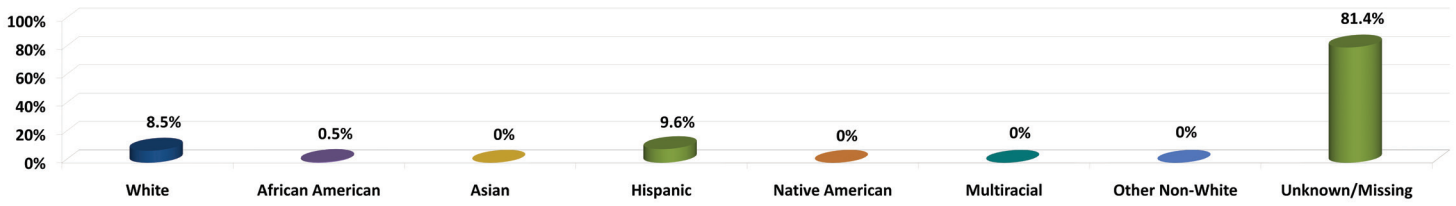
Thirty-seven percent of the population served did not report their age. More than one-third were ages 25-39, and one quarter were adolescents and young adults ages 12-24.

GENDER



Forty-two percent of callers did not report their gender. Almost 40% of the callers receiving services were female; 19% of callers were male.

RACE/ETHNICITY

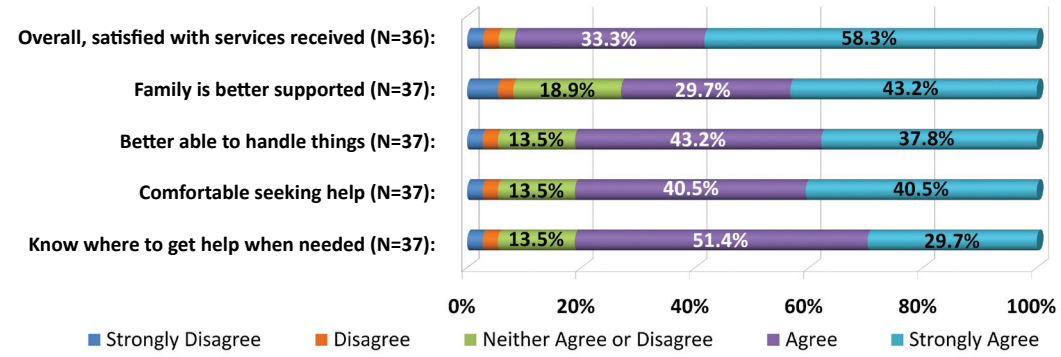


Almost 82% of the callers did not identify their ethnic background. Approximately 10% of the callers identified their ethnic background as Hispanic and 9% of the callers identified their ethnic background as White. Of those identifying as Hispanic, the majority (94%) identified as Mexican American.

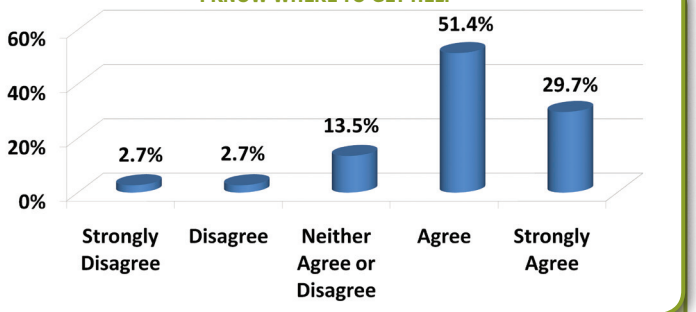
MILITARY SERVICE

Callers were asked in which branch of the military the youth's caregiver had served. Of the 2 who responded, both reported that the caregivers were in the Marine Corps.

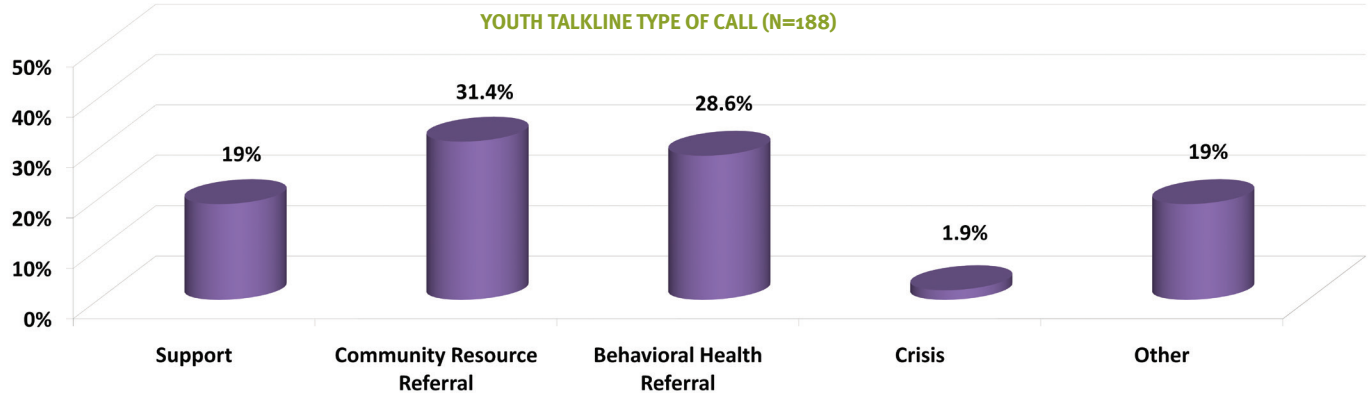
PROGRAM SATISFACTION



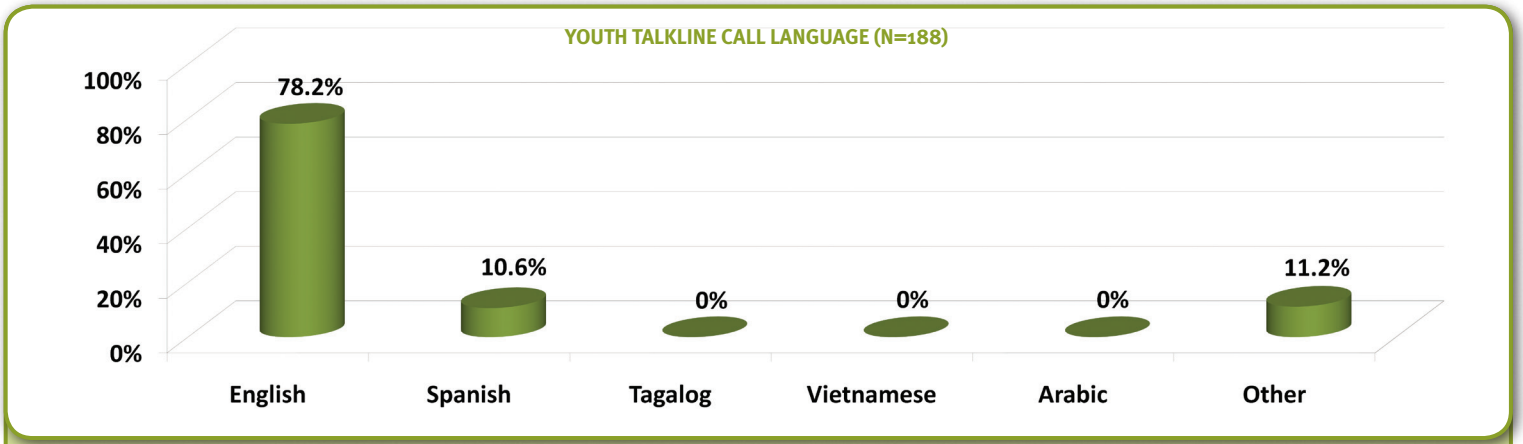
The majority of callers did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the services. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 92% of the callers who responded to these questions were satisfied with the services received.



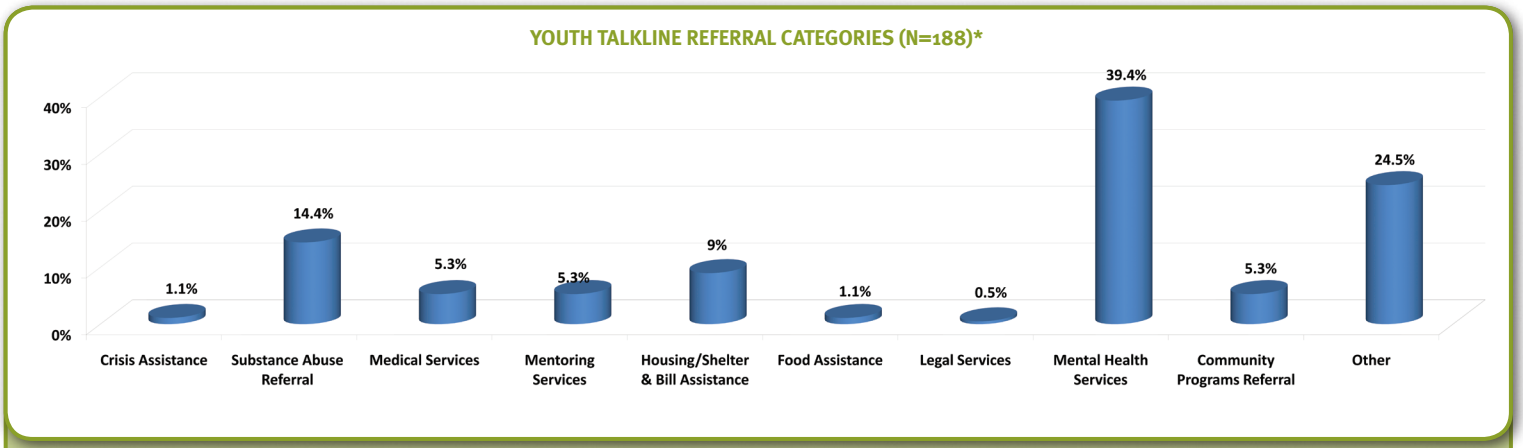
The majority of the callers responding to this question reported that they knew where to get help when they needed it. Approximately 5% did not agree with this statement.



Roughly one-third of Youth Talkline calls were classified as community resource referrals (31%) and behavioral health referrals (29%). The remaining third consisted of calls relating to support, crises, or other topics.



The majority of the calls transpired in English (78%). Eleven percent of the calls took place in Spanish. The call language was not reported for approximately 11% of the calls.



The majority of the callers who received referrals were referred to mental health services (39%). Roughly 25% of callers received referrals for services other than those categorized above.

**Some callers may receive referrals to more than one type of program so percentages may add up to more than 100%.*

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.

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PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Adult/Family Peer Supportline

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

National Alliance of Mental Illness (NAMI)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

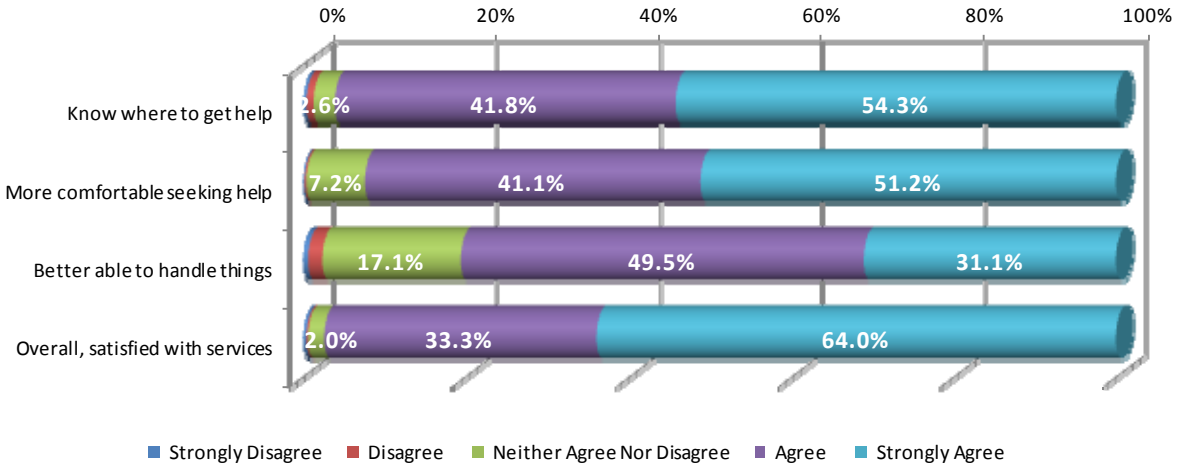
A means of providing outreach and education for PEI occurs via the confidential Adult/Family Peer Supportline supported by the National Alliance on Mental Illness (NAMI) San Diego. NAMI San Diego is part of the grass-roots, non-profit, national NAMI organization founded in 1979 by family members of people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

The supportline is staffed by family members of individuals affected by mental illness who are trained to provide culturally competent support and resources. Individuals calling the NAMI helpline receive information about classes and support groups offered, as well as additional information about mental health related resources. **The NAMI Supportline can be reached at (619) 543-1434**.

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

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

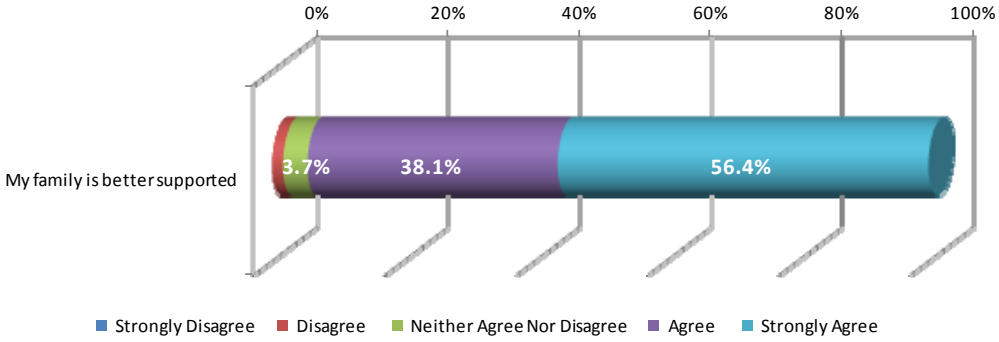
PEI Outcomes and Satisfaction



Participants were asked to assess their improvement in several areas of interest, and their satisfaction with the Adult/Family Peer Supportline. The number of respondents varied for each item. A majority of participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (96.1%), "I am more comfortable seeking help" (92.3%), "I am better able to handle things" (80.6%) and, "Overall, I am satisfied with the services I received here" (97.3%).

Program Specific Outcomes

Individuals who called the Adult/Family Peer Supportline assessed the benefit they received. The number of respondents for this item is lower than the total number of participants. A majority of participants either "Agreed" or "Strongly Agreed" that, "Due to the services I received today, I feel I and/or my family is better supported" (94.5%).

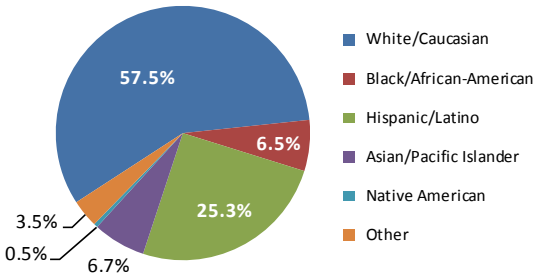


Participant Demographics

During fiscal year 2010-11, Adult/Family Peer Supportline provided services to 3,073 callers. Of those callers who reported their information, the majority were female* (75.9%), Caucasian (57.5%), and between 25 and 59 years old (73.5%). A very small percentage of callers had served in the military (1.5%). Of those consumers for whom data were available, the majority were male* (51.9%) and between 25 and 59 years old (69.7%). Caucasian consumers were the largest racial/ethnic group served (48.6%). Data on specific Hispanic origin, consumer military service or service branch were not collected for this program.

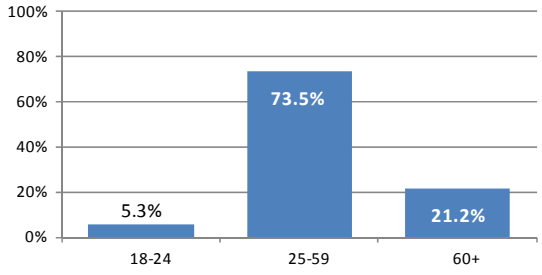
* Gender data were not reported for 490 (15.9%) callers and 2,355 (76.6%) consumers.

Caller Race/Ethnicity



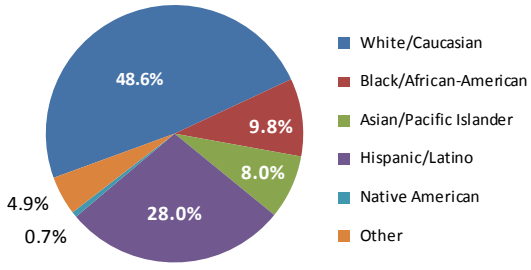
Of those reporting Race/Ethnicity there were no multiracial callers;
2,087 (67.9%) of callers did not provide Race/Ethnicity

Caller Age



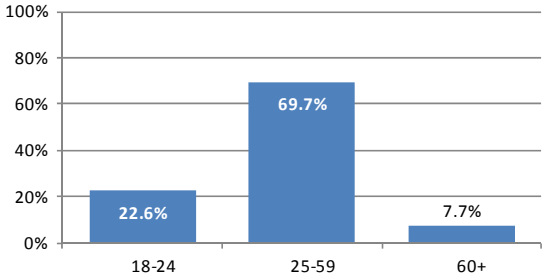
2,282 (74.3%) did not provide Age

Consumer Race/Ethnicity



Of those reporting Race/Ethnicity there were no multiracial consumers;
2,787 (90.7%) did not provide Race/Ethnicity

Consumer Age



2,671 (86.9%) did not provide Age

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

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

FAMILIES AS PARTNERS (DV01)

SOUTH BAY COMMUNITY SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

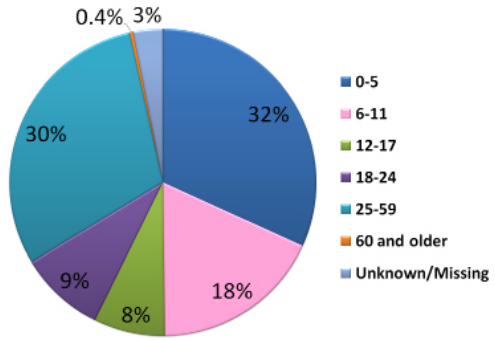
REGION: SOUTH- DISTRICT 4

Families as Partners (FAP) is a San Diego South Region partnership between families, Child Welfare Services, and community service providers. The goal of the partnership is to establish a community safety net for the well-being of the South Region's children and their families who are at risk of becoming involved in the child welfare system. Families are referred from the child welfare hotline, and FAP provides services immediately to help them maintain a safe home and reduce the effects of trauma exposure. FAP clinicians visit families in their homes, conduct thorough assessments of the families' needs and strengths, and help families connect with resources in their community. In some cases, families receive information and support from Parent Peer Partners, parents with former experience with the child welfare system. Families also participate in team decision-making meetings (TDM) with the FAP team, and help develop safety plans for their children.

CONTRACTOR:	South Bay Community Services		
CONTRACT START DATE:	5/1/2009	**DATA COLLECTION START DATE:**	5/1/2009
PROGRAM SERVICES START DATE:	5/1/2009	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	255 unduplicated	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	550 (may include duplicates)

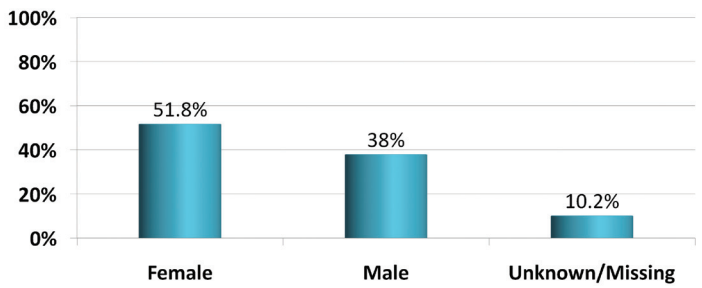
YOUTH AND CAREGIVER DEMOGRAPHICS

AGE



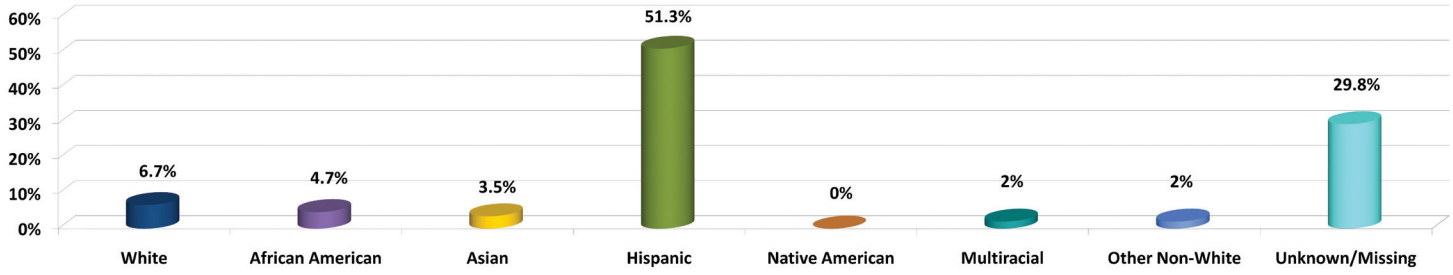
Children and youth ages 0 to 11 comprised 50% of the population served.

GENDER

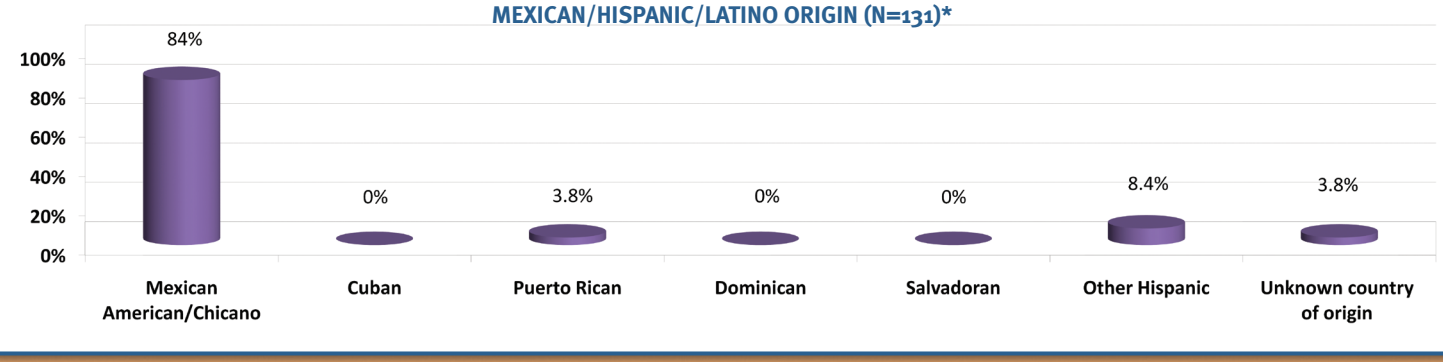


More than half of the participants who received services were female.

RACE/ETHNICITY



More than half of participants who received services identified their ethnic background as Hispanic. However, roughly one-third of all participants served did not report their race.



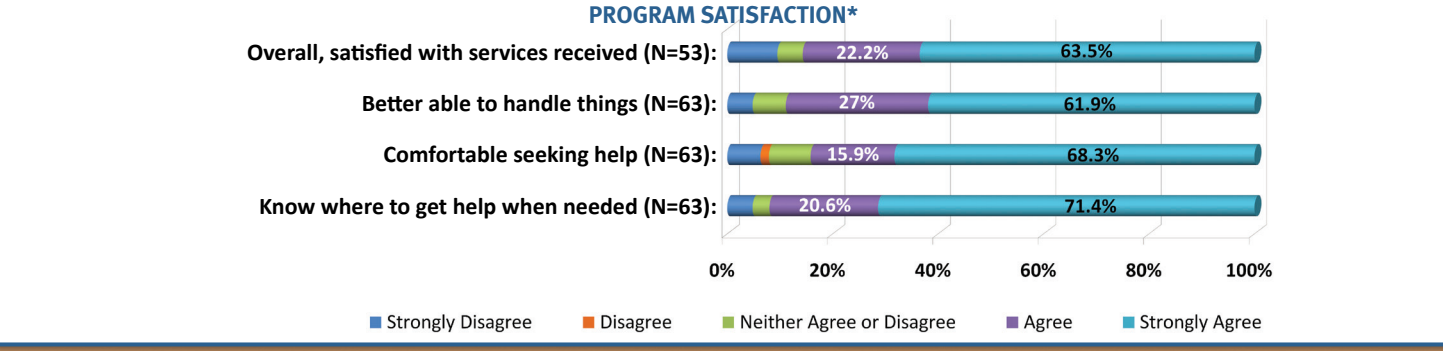
The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

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

MILITARY SERVICE

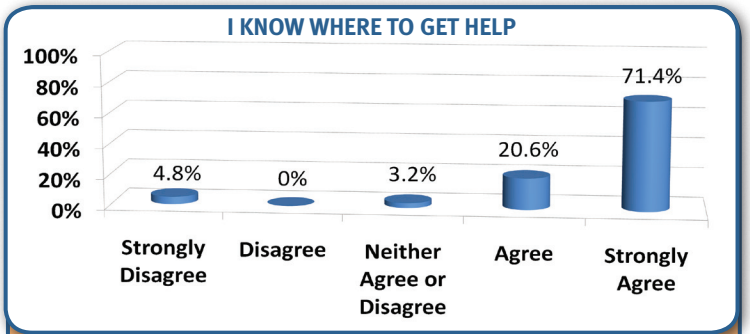
Of the 251 participants who responded to this question, the majority (98%) reported that the youth's caregiver had not served in the military. Of the four caregivers who had served in the military, three served in the Navy and one served in an unspecified branch.

PROGRAM SATISFACTION



The majority of participants did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 86% of the participants who responded were satisfied with the services received.

**Satisfaction data not available for all participants.*



More than 90% of participants who responded to this question reported that they knew where to get help when they needed it.

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.

SOUTH REGION TRAUMA EXPOSED SERVICES (DV02)

FRED FINCH YOUTH CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

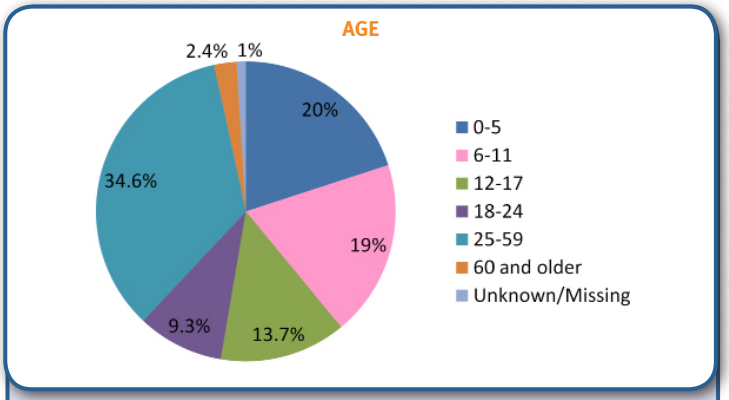
CASRC child and adolescent services research center

REGION: SOUTH - DISTRICT 1

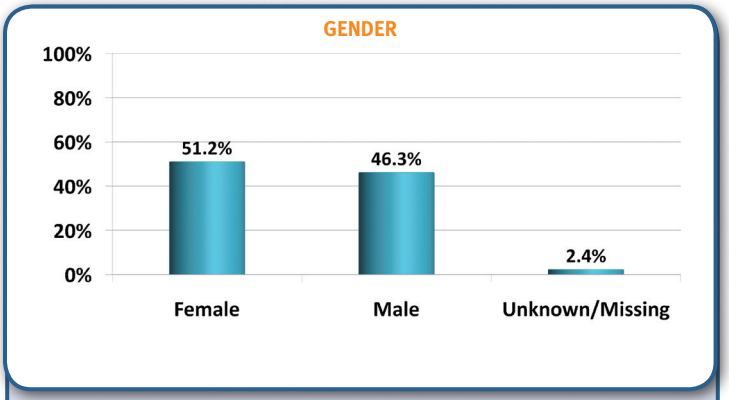
The Fred Finch Youth Center (FFYC) Triple P Positive Parenting Program is an evidence-based, comprehensive prevention and early intervention program to help prevent re-traumatization of children and families who experience contact with the child welfare system. The program serves children and their families that recently had involvement with Child Welfare Services, but do not require voluntary or dependent services. However, Child Welfare Services deems that these families could benefit from parenting and/or support in order to prevent further child welfare involvement. The Triple P Program helps parents develop stronger parenting skills and effectively manage child misbehavior.

CONTRACTOR:	Fred Finch Youth Center		
CONTRACT START DATE:	7/1/2010	**DATA COLLECTION START DATE:**	1/1/2011
PROGRAM SERVICES START DATE:	1/1/2011	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	205 unduplicated	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	205

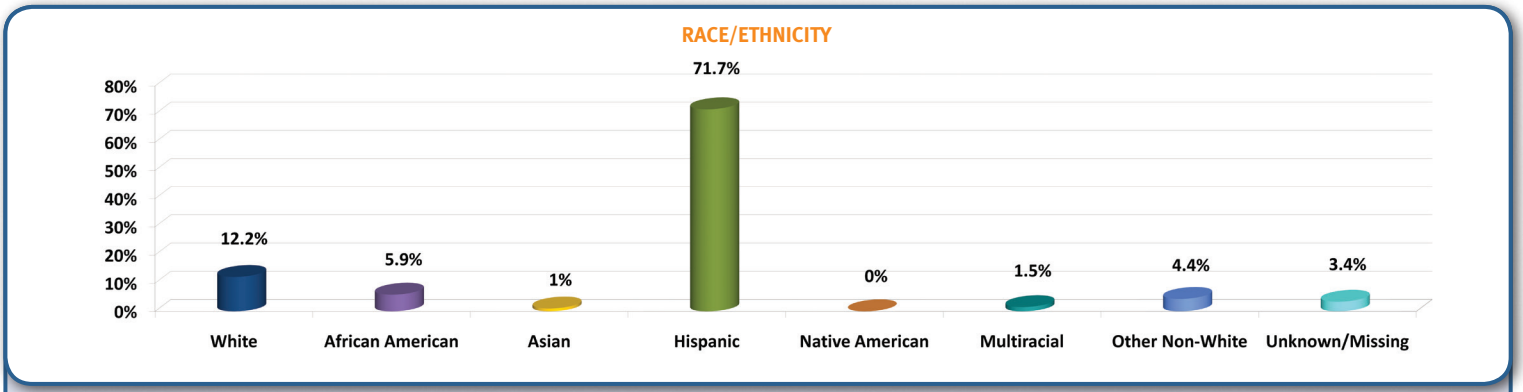
YOUTH AND CAREGIVER DEMOGRAPHICS



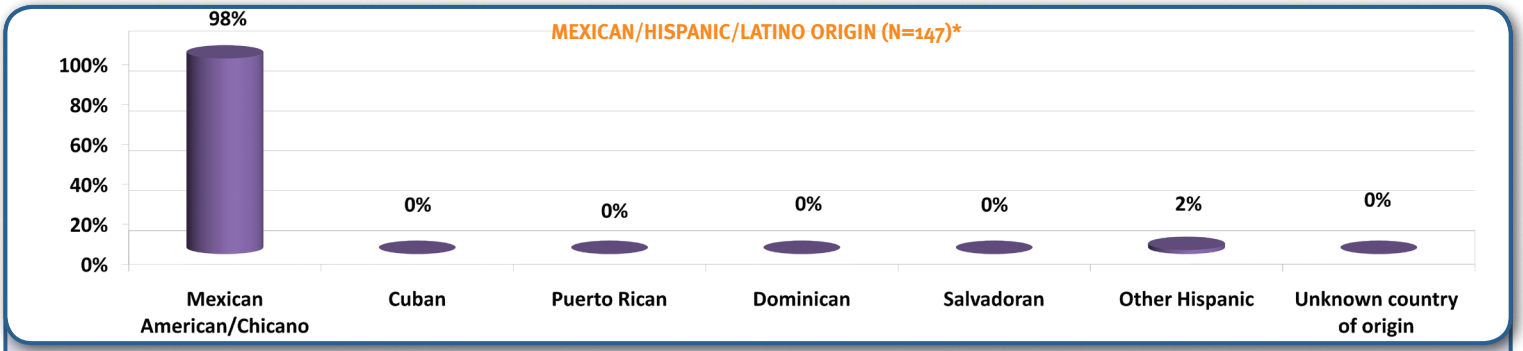
Children and youth ages 0 to 17 comprised more than half of the population served.



The program served slightly more female than male participants.



Over 70% of participants receiving services identified their ethnic background as Hispanic.



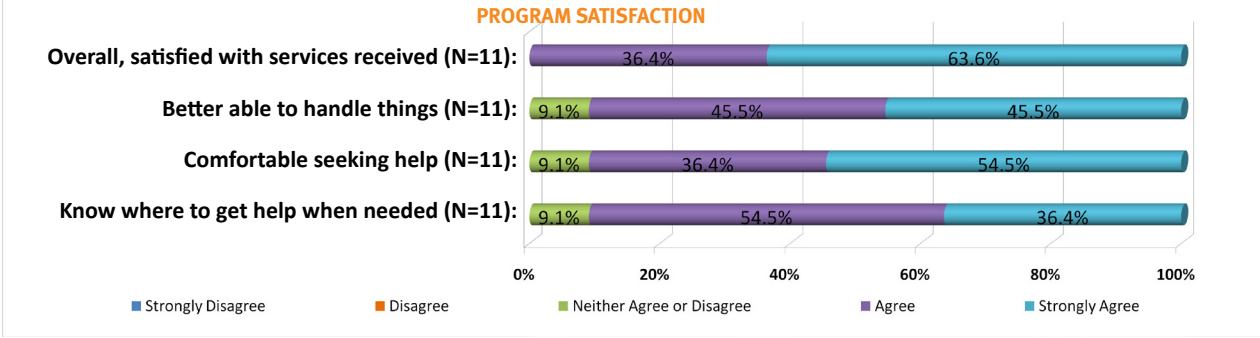
The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

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

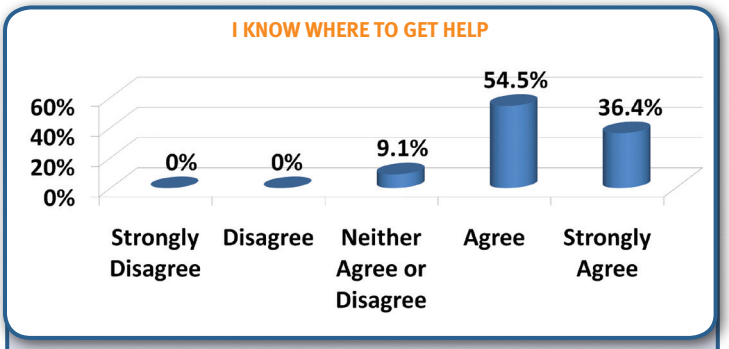
MILITARY SERVICE

Of 204 participants who responded to this question, 99% reported that the youth's caregiver had not served in the military. Of the three caregivers who had served in the military, two served in the Navy and one served in an unspecified branch.

PROGRAM SATISFACTION



The majority of participants did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 100% of the participants who responded were satisfied with the services received.



The majority of participants who responded to this question reported that they knew where to get help when they needed it.

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.

ALLIANCE FOR COMMUNITY EMPOWERMENT (DV03)

UNION OF PAN ASIAN COMMUNITIES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

REGION: CENTRAL- DISTRICT 4

The Alliance for Community Empowerment (ACE) provides five different PEI programs that help prevent community violence and support families in San Diego: the Community Violence Response Team, Parent and Youth Gang Awareness groups, Leadership Academy and Strengthening Families program. The Community Violence Response Team provides assistance to individuals who are impacted by acts of violence. The gang awareness groups teach both caregivers and youth about the risk factors for gang involvement, and the Leadership Academy is an on-going intervention designed to help prevent 12-16 youth from participating in gangs. This intervention teaches youth how to improve their decision-making skills and handle peer pressure. The support groups help community members who are grieving the loss of loved ones, many of whom were victims of violence. Finally, the Strenthening Families Program is a researched-based intervention that provides training in parenting, communication, and problem-solving skills to increase families' resilience and reduce the risk of substance abuse, delinquency, and school failure.

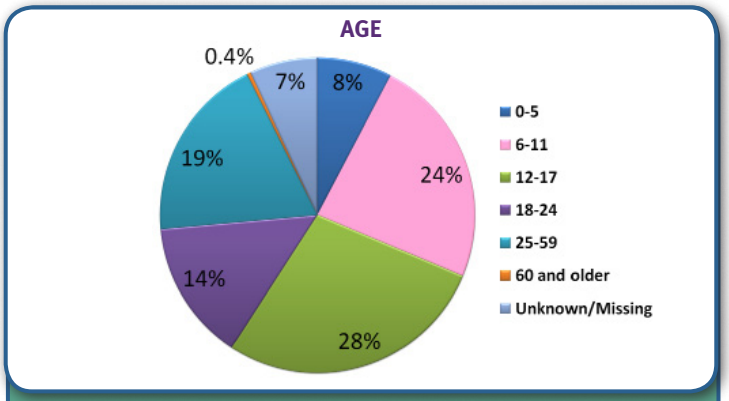
CONTRACTOR:	Union of Pan Asian Communities (UPAC)		
CONTRACT START DATE:	12/1/2009	**DATA COLLECTION START DATE:**	1/4/2010
PROGRAM SERVICES START DATE:	1/4/2010	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	452 unduplicated [1,2]	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	576 unduplicated families[3]

1. Data are limited to information entered into HOMS as of 10/31/2011. Data are not available for the Strengthening Families Program.

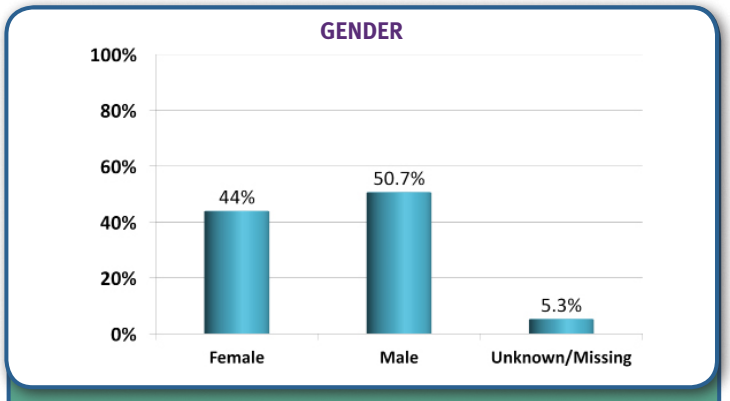
2. Demographics are only available for 284 individuals who received community violence response services.

3. This information comes from the QSR for Q4 FY10-11.

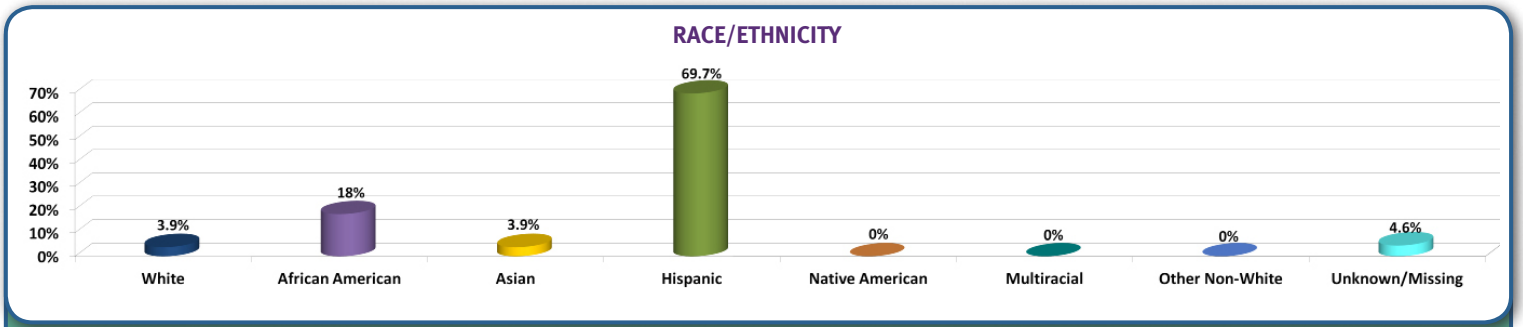
DEMOGRAPHICS OF INDIVIDUALS SERVED BY THE COMMUNITY VIOLENCE RESPONSE TEAM



Children and adolescents ages 0 to 17 comprised 60% of the population served.



Approximately half of the participants who received services were male.



Roughly 70% of participants who received services identified their ethnic background as Hispanic.

REFERRALS TO ACE'S PEI PROGRAMS

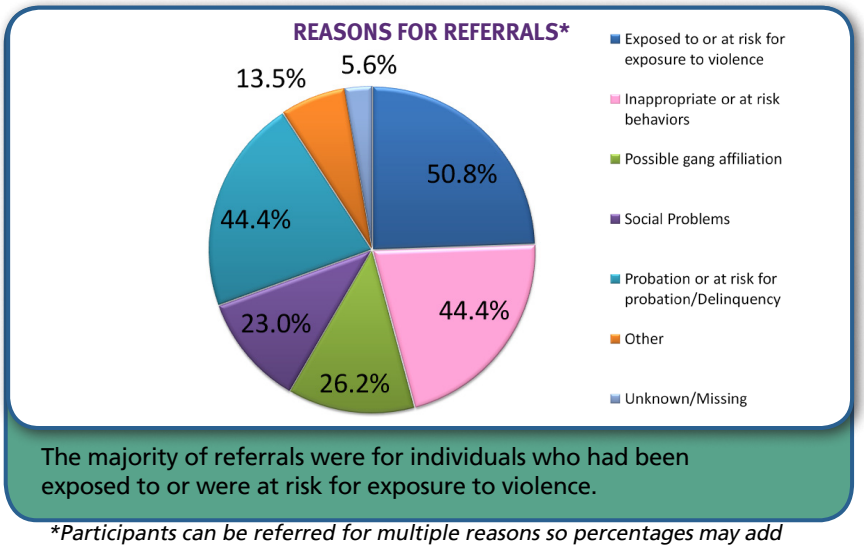
REFERRALS*	N
Number of clients referred to ACE PEI programs	126
Number of referred clients who attended ACE PEI programs	60

** Data not available for all clients.*

GROUP PROGRAMS

ATTENDANCE AT ACE GROUP PROGRAMS	N
Gang Awareness- Parent	91
Gang Awareness- Youth	49
Strengthening Families*	--
Leadership Academy	81
Support Groups	27

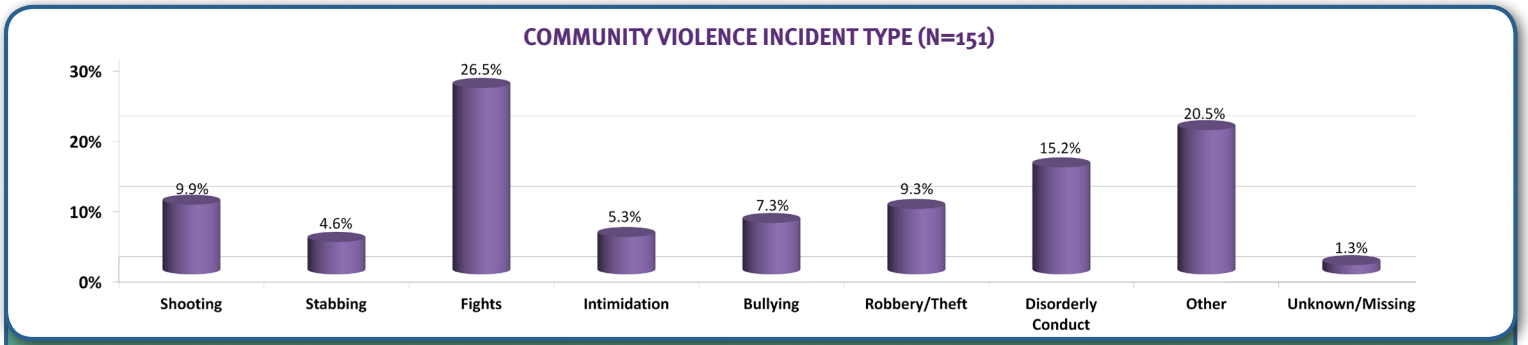
** Data not available.*



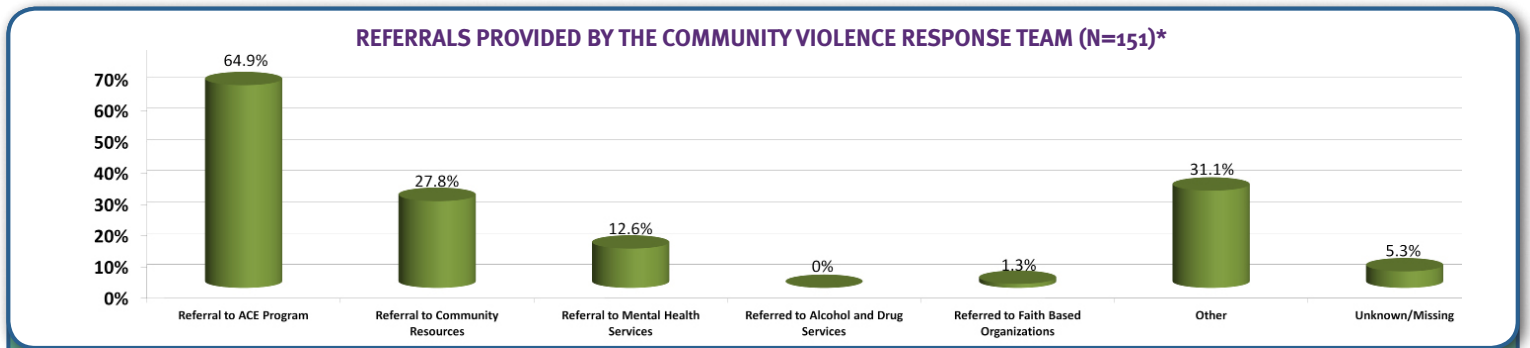
The majority of referrals were for individuals who had been exposed to or were at risk for exposure to violence.

**Participants can be referred for multiple reasons so percentages may add up to more than100%.*

COMMUNITY VIOLENCE RESPONSE TEAM



The most common type of incident the Community Violence Response Team responded to was a fight.



The majority of referrals provided by the community violence response team were referrals to ACE programs.

** Participants can be referred to more than one service so percentages may add up to more than 100%.*

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.

POSITIVE PARENTING PROGRAM—TRIPLE P (EC01)

JEWISH FAMILY SERVICES (JFS)

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

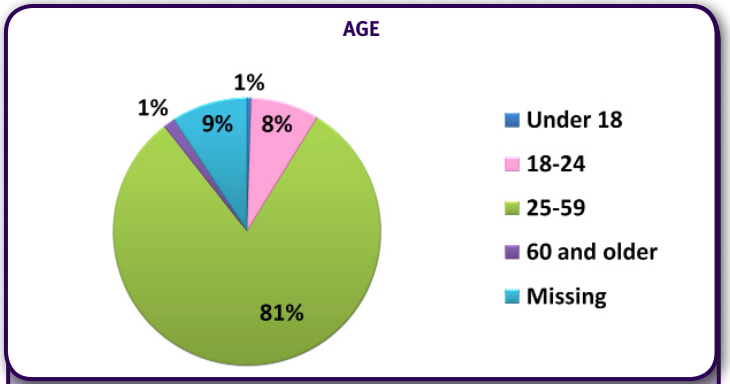
CASRC child and adolescent services research center

REGION: NORTH CENTRAL - DISTRICT 4

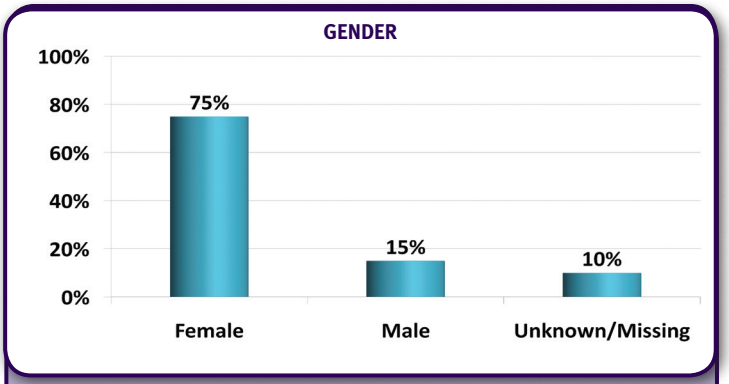
The Triple P – Positive Parenting Program serves Head Start (HS) and Early Head Start (EHS) Centers to strengthen the skills of parents, HS/EHS center staff, and educators in order to promote the development, growth, health, and social competence of young children. Services are designed to benefit the child by teaching caregivers and Head Start staff specific parenting skills and techniques for managing misbehavior. This Triple P program provides both group-based trainings and individual treatment. Staff are also trained to provide ongoing support to the family/caregiver once the Triple P curriculum is completed. This program serves the Central and North Coastal regions of San Diego. This report focuses on parent outcomes.

CONTRACTOR:	Jewish Family Services		
CONTRACT START DATE:	9/1/2009	**DATA COLLECTION START DATE:**	Outcomes: 9/29/2009 PEI Demographics: 1/03/2010
PROGRAM SERVICES START DATE:	9/29/2009	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	1281	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	2545

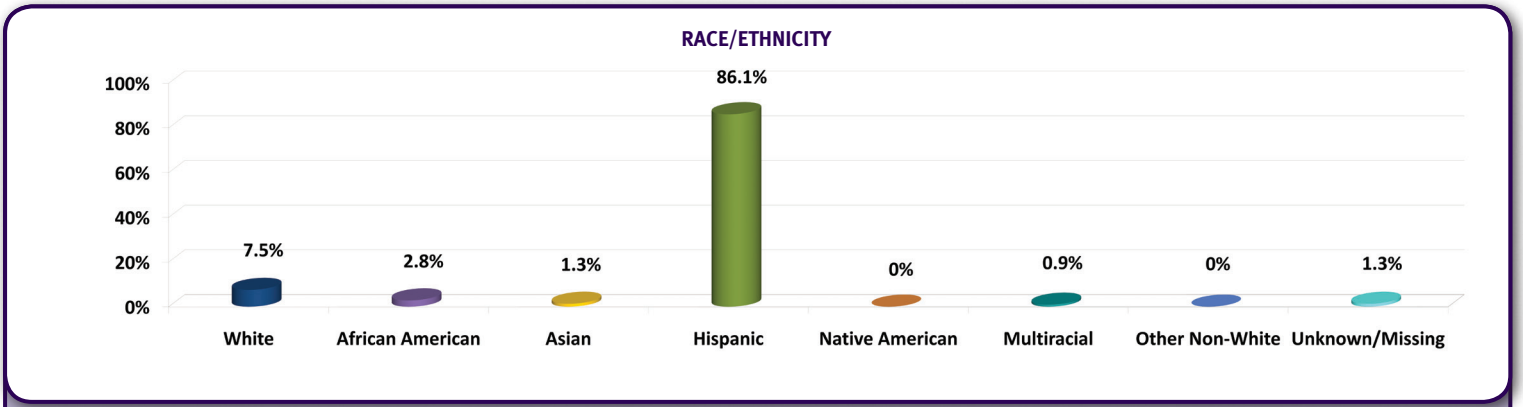
PARENT DEMOGRAPHICS



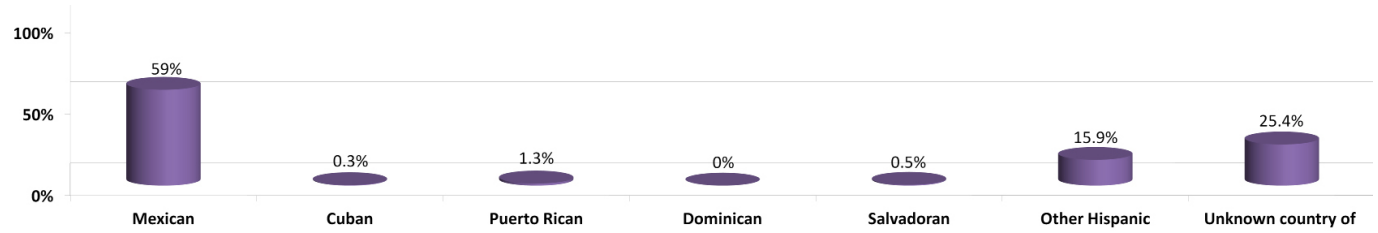
The majority of the adults served were ages 25-59 (81%). Young adults 18-24 comprised 8% of the population served.



Three quarters of the participants who received services were female.



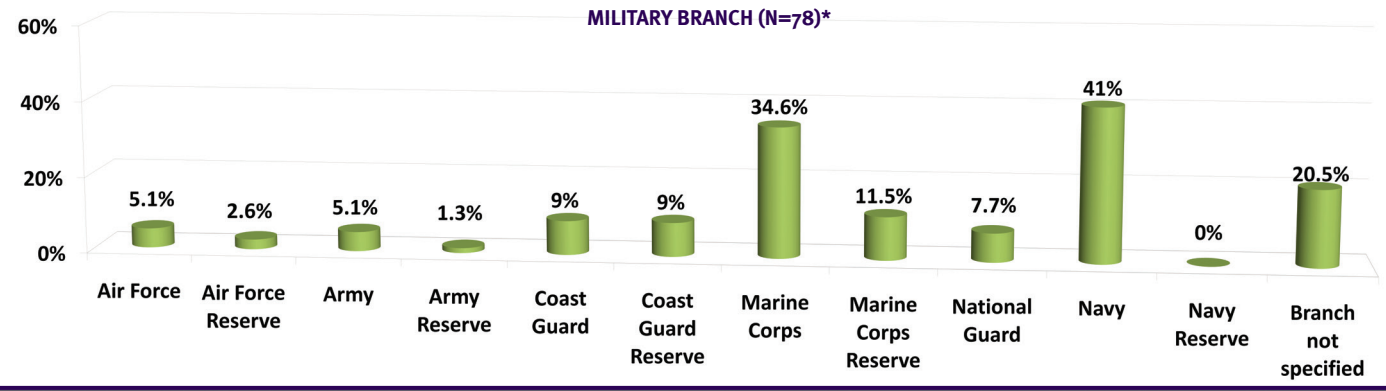
More than 85% of participants who received services identified their ethnic background as Hispanic. Roughly 8% of all participants served identified their ethnic background as White. The remaining racial/ethnic categories were not highly represented.



The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

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

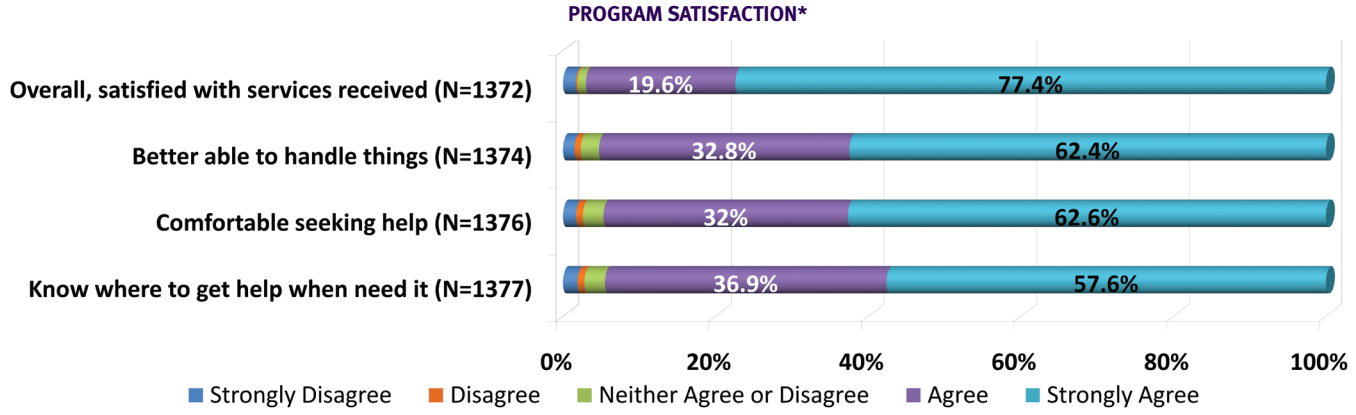
MILITARY SERVICE



Of the 1163 participants who responded to this question, 93% reported that caregivers had not served in the military. Of the 78 clients that reported caregivers had served in the military, 32 (41%) caregivers served in the Navy, 27 (35%) served in the Marine Corps. Sixteen (21%) served in an unspecified branch.

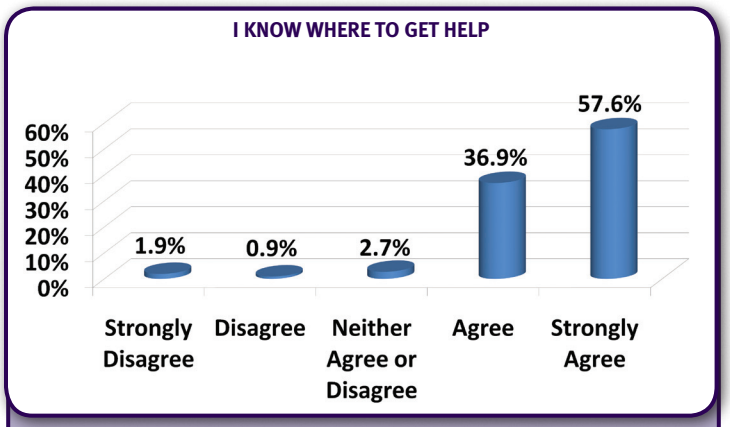
** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Most participants responding to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 97% of the participants were satisfied with the services received.

** Satisfaction data includes duplicated participants.*



The majority of participants responding to this question reported that they knew where to get help when they needed it. Approximately 3% did not agree with this statement.

"I know where to get help when I need it."

PARTICIPATION IN PROGRAM COMPONENTS (N=1411)*	N
Pilot Seminar	420
Community Seminar	312
Head Start/ Early Head Start Seminar	385
Individual	107
Group	187
Total	**1411**

Attendance was greatest at the Pilot Seminars. More than 100 participants received individual treatment.

**Some participants attended more than one component .*

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KICKSTART (FB01)

PROVIDENCE COMMUNITY SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

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CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

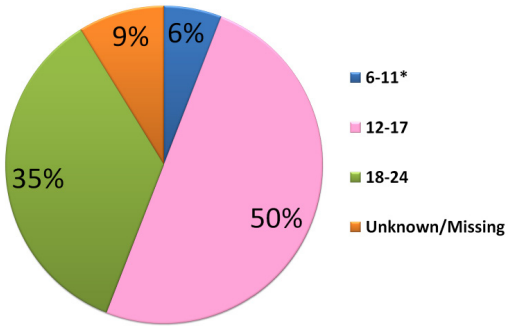
The purpose of this program is to provide prevention and early intervention services to transition-age youth (TAY) who may have prodromal symptoms of psychosis. The prevention component of the program focuses on community leaders who may have contact with TAY in general community settings. These community 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 provides an in-depth integrated assessment for potential mental health and/or substance abuse issues, domestic/community violence, maltreatment, and physical health needs of youth who are identified as being at-risk. TAY and their families are referred and linked for further assessment by a trained clinician. Youth who screen positive for prodromal symptoms receive psycho-education classes, support services, and treatment interventions. This report focuses on the outcomes of the youths.

CONTRACTOR:	Providence Community Services		
CONTRACT START DATE:	12/1/2009	**DATA COLLECTION START DATE:**	May 2010
PROGRAM SERVICES START DATE:	4/1/2010	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	55*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	Community members who received gate-keep trainings: 902 Youth screened: 209 Youth enrolled: 62

**34 participants had demographic and phone screen data. 39 participants had Scale of Prodromal Symptoms (SOPS) assessment data.*

YOUTH DEMOGRAPHICS

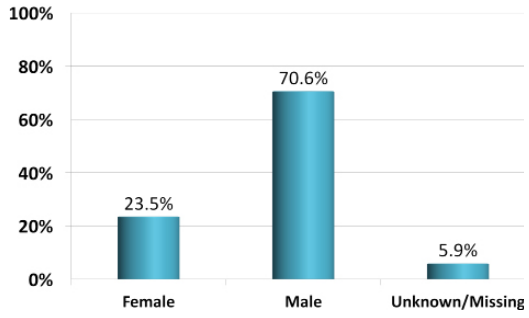
AGE



Adolescents ages 12-17 comprised 50% of the population served while TAY ages 18-24 comprised 35% of the population served.

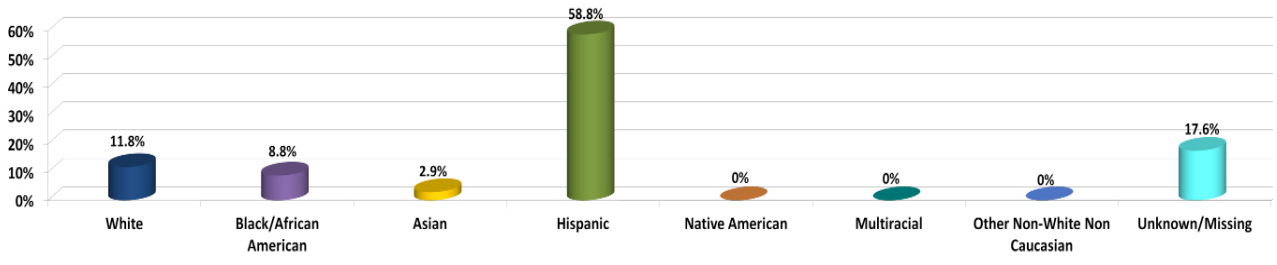
**The two youth in this age-group were screened but referred to other age-appropriate services.*

GENDER

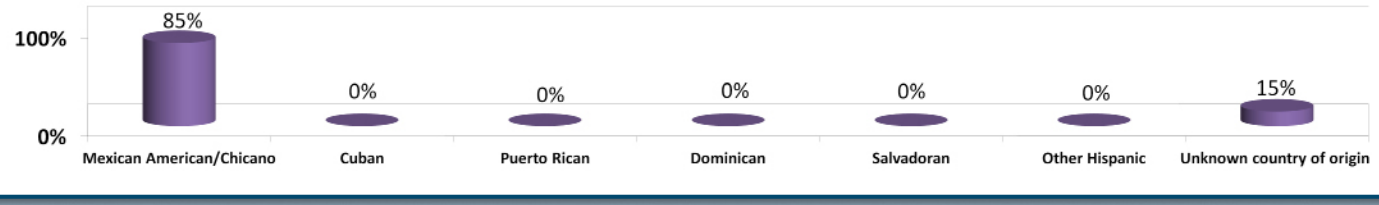


Over 70% of the participants who received services were male.

RACE/ETHNICITY



More than half of the participants who received services identified their ethnic background as Hispanic. Roughly 18% of all participants served did not identify their race.



The majority of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

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

MILITARY SERVICE

Of the 19 participants who responded to this question, 89% indicated that their caregiver had not served in the military. Only two participants reported that their caregiver had served in the military; neither identified the branch in which their caregiver served.

PARTICIPANT SYMPTOMS AT INTAKE

PHONE SCREEN SYMPTOM CHECKLIST*	%
Changes in perception (N=16) (e.g. auditory/visual/tactile/olfactory abnormalities)	81.3
Changes in speech and thinking (N=17) (e.g. odd ideas, suspiciousness, grandiosity, tangential speech)	94.1
Changes in functioning (N=17) (e.g. work/academic difficulties, social isolation)	88.2
Changes in emotions (N=17) (e.g. flat affect, depression, anxiety, mood swings, irritability)	100.0
Vegetative symptoms (N=17) (e.g. sleep difficulties, changes in appetite, somatic complaints)	94.1
Other reported changes (N=15)	40.0

The majority of the youth who were eligible for Kickstart services based on the initial screening had experienced changes in emotions, vegetative symptoms, and changes in speech and thinking.

**Of the 34 phone screens, 17 had missing or incomplete symptom checklists.*

GAF SCORES (RANGE 0–100)	MEAN (STANDARD DEVIATION)
Current GAF (N=37)	59.4 (16.2)
Highest GAF in the past year (N=33)	56.0 (13.5)

The mean current Global Assessment of Functioning (GAF) for participants was 59.4 with a standard deviation of 16.2 on a 0-100 range. The average highest GAF score in the past year was 56.

INITIAL SCALE OF PRODROMAL SYMPTOMS (SOPS) ASSESSMENT (N=39)*	MEAN (STANDARD DEVIATION)
Positive Symptoms Domain (0–30)	7.4 (6.7)
Negative Symptoms Domain (0–36)	10.3 (8.6)
Disorganization Symptoms Domain (0–24)	5.8 (4.7)
General Symptoms Domain (0–24)	5.3 (5.0)

Among the types of symptoms reported by participants, on average, negative symptoms were the most severe.

**Higher scores indicate higher severity*

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DREAM WEAVER CONSORTIUM (NA01)

INDIAN HEALTH COUNCIL

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

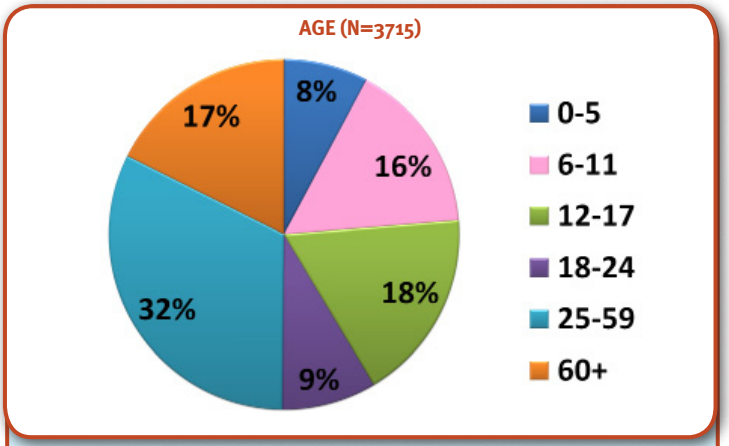
REGION: COUNTY-WIDE

The Dream Weaver Consortium offers four different PEI programs provided by the Urban Youth Center, Indian Health Council, Southern Indian Health Council, and the Sycuan Medical/Dental Center. These providers offer prevention activities that promote community wellness and cultural awareness. Emphasis is placed on increasing awareness and access to cultural events that are known to support resilience. These services include: traditional health gatherings, cultural programs that maintain language, knowledge of basket weaving (a local tradition for many tribes), nutrition programs, self-esteem activities, male involvement strategies, positive parenting, exercise programs, and the promotion of overall increased medical and dental health. All of these services are intended to prevent the onset of serious mental health problems.

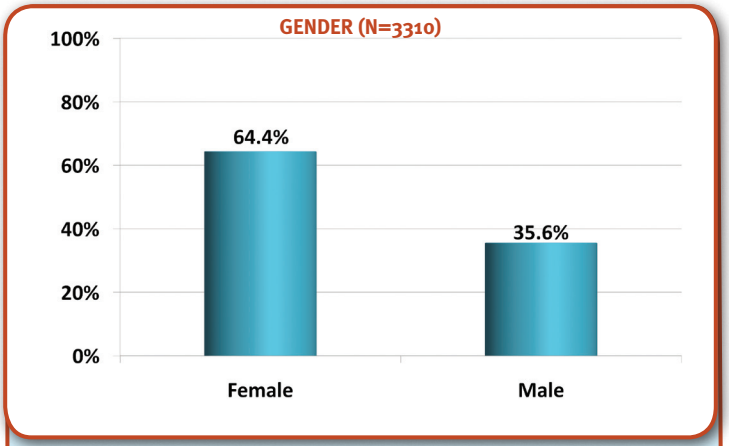
CONTRACTOR:	Indian Health Council		
CONTRACT START DATE:	4/13/2009	**DATA COLLECTION START DATE:**	April 2009
PROGRAM SERVICES START DATE:	April 2009	**REPORT PERIOD:**	7/1/2010—6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	3715 (duplicates Included)*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	7844 (duplicates included)*

** The data presented, excluding satisfaction, were compiled from MSRs because HOMS data was unavailable. Different participant counts were reported for each variable.*

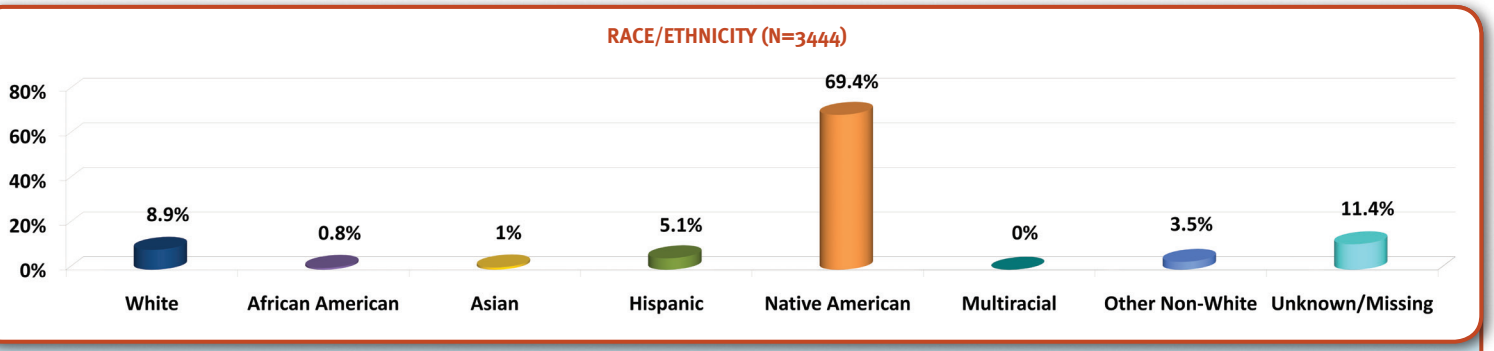
YOUTH AND CAREGIVER DEMOGRAPHICS



Children and youth ages 0 to 17 comprised 42% of the population served. The majority of the adults were ages 25-59 (32%).

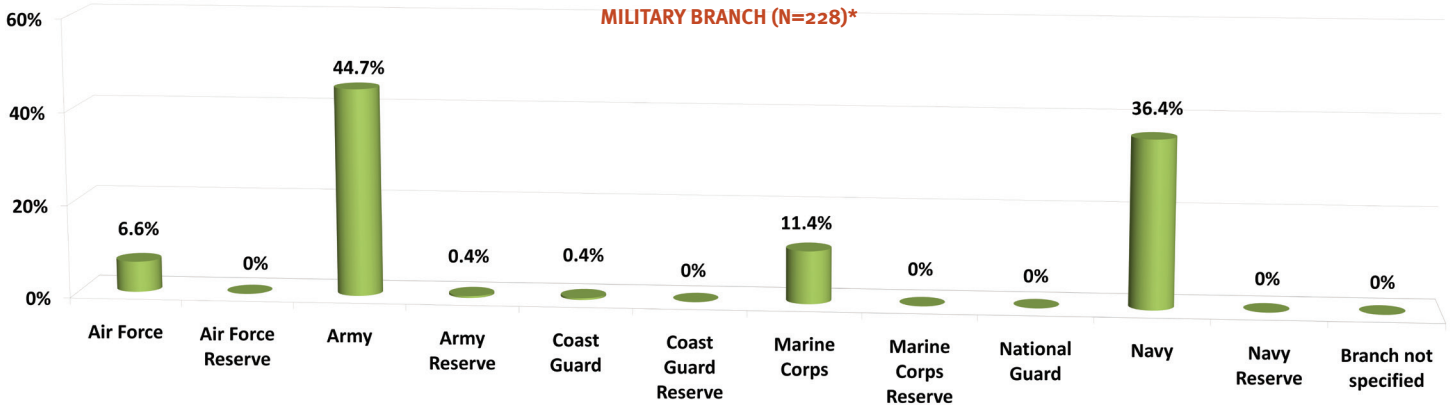


Approximately 64% of the participants who received services were female, while the remaining 36% of participants who received services were male.



Almost 70% of participants who received services identified their ethnic background as Native American.

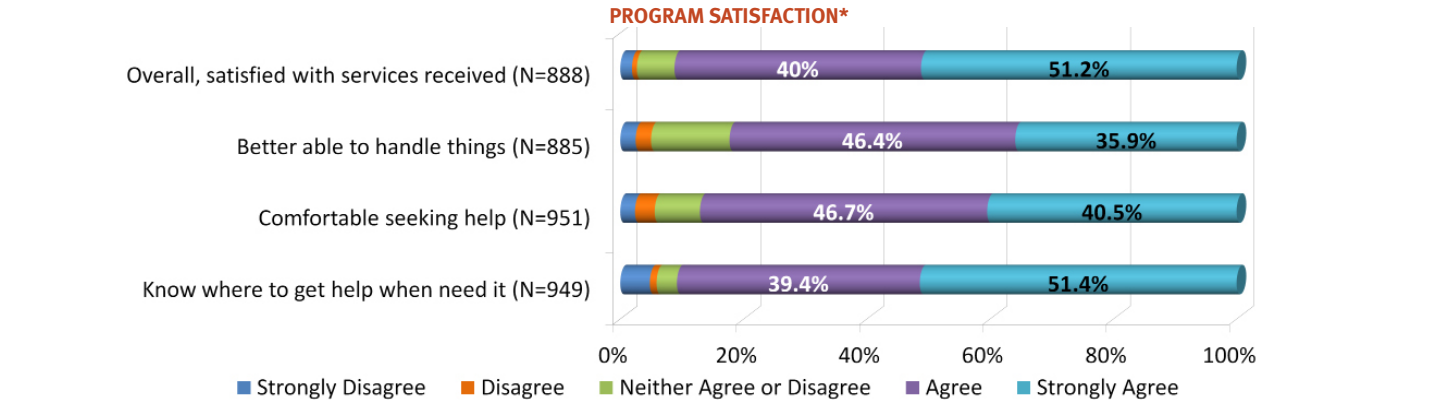
MILITARY SERVICE



Caregivers were asked in which branch of the military they had served. Of the 228 who responded, 102 (45%) served in the Army, 83 (36%) served in the Navy, 26 (11%) served in the Marine Corps and 15 (7%) served in the Air Force.

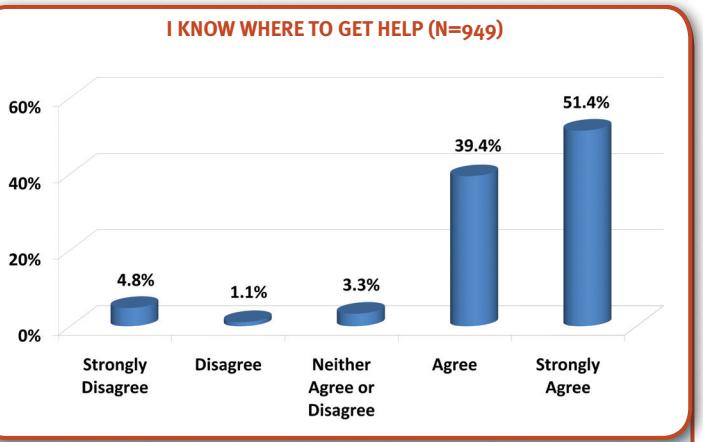
** Participants may have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



The majority of participants did not respond to program satisfaction questions. Of those who did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 91% of the participants who responded to these questions were satisfied with the services received.

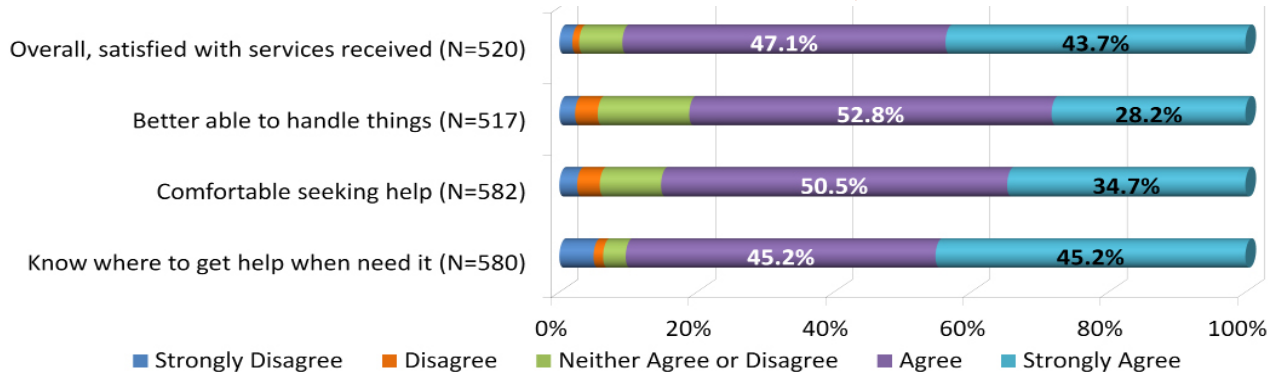
**Satisfaction data not available for all participants.*



The majority of participants responding to this question reported that they knew where to get help when they needed it. Approximately 6% did not agree with this statement.

SATISFACTION BY PROVIDER

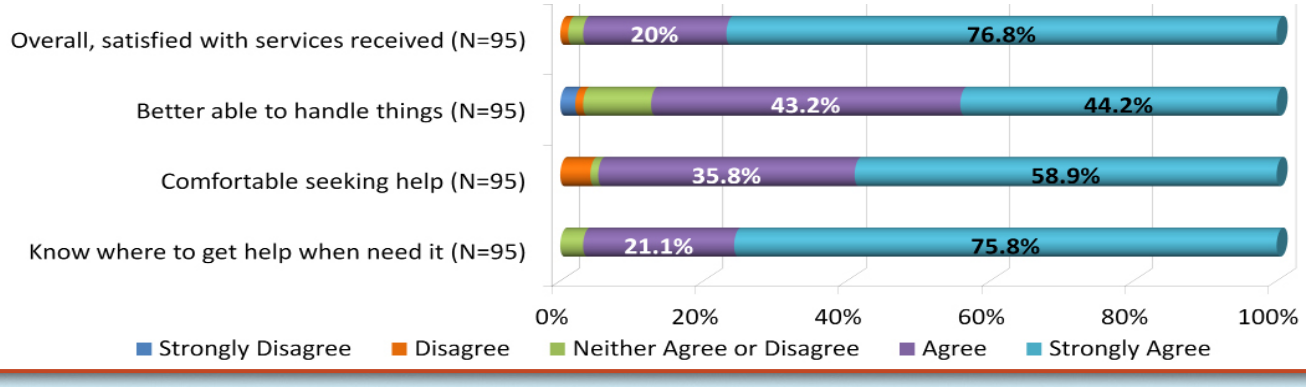
PROGRAM SATISFACTION: INDIAN HEALTH COUNSEL (N=591)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Indian Health Counsel programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 91% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

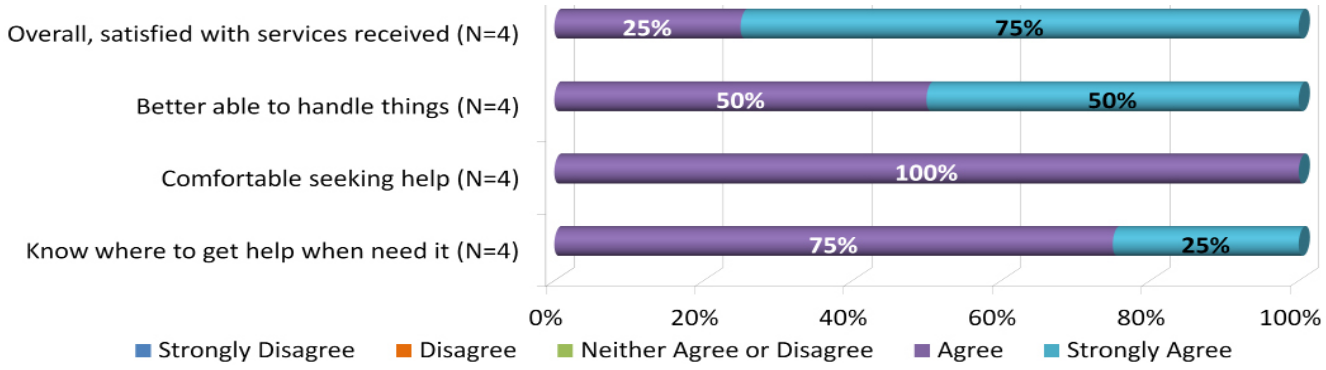
PROGRAM SATISFACTION: SOUTHERN INDIAN HEALTH COUNCIL (N=95)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of Southern Indian Health Council's programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 97% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

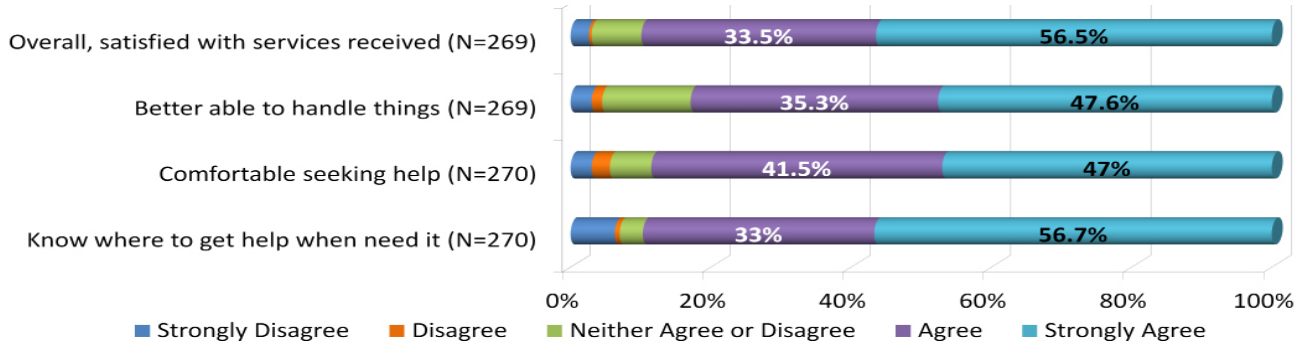
PROGRAM SATISFACTION: SYCUAN MEDICAL/DENTAL CENTER (N=4)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Sycuan Medical/Dental Center programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 100% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

PROGRAM SATISFACTION: URBAN YOUTH CENTER (N=281)*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Urban Youth Center programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 90% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

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SCHOOL BASED PROGRAM-NORTH COUNTY (SA01NC): SCHOOL AGE SERVICES

PALOMAR FAMILY COUNSELING SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

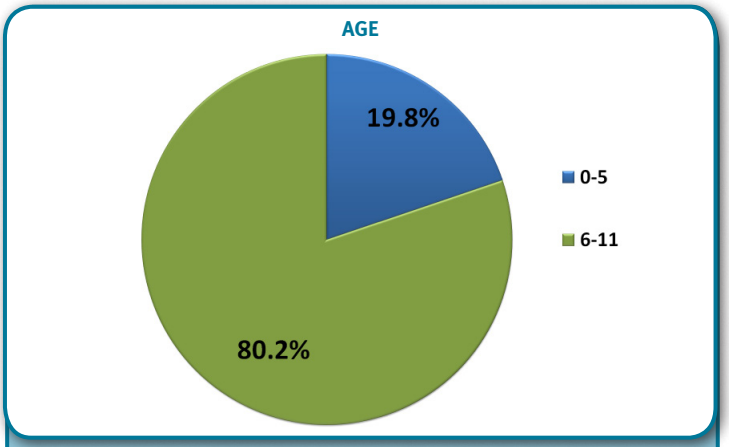
CASRC child and adolescent services research center

REGION: NORTH INLAND- DISTRICT 3

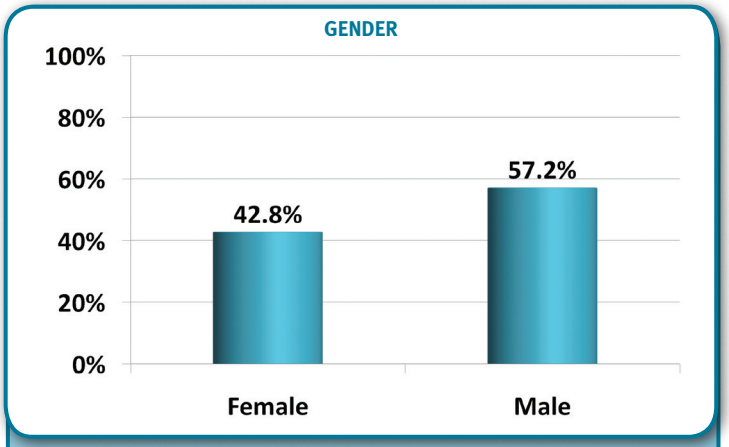
This program provides family-focused prevention and early intervention services for school-age children and their families in Escondido and Oceanside. The program has two components: a school-based component, known as School-Age Services (SAS), and a family-based component. This report focuses on the outcomes of the SAS component. SAS involves the implementation of the BEST Behavior program and the Incredible Years curriculum in preschool through third grades. The aim of the BEST program is to improve the school climate in order to promote positive behavior while the Incredible Years program helps students improve their social and emotional skills. Children are screened for signs of behavioral problems and receive prevention activities tailored to their specific needs.

CONTRACTOR:	Palomar Family Counseling Services		
CONTRACT START DATE:	11/2/2009	**DATA COLLECTION START DATE:**	1/1/2010
PROGRAM SERVICES START DATE:	11/2/2009	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	495	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	504

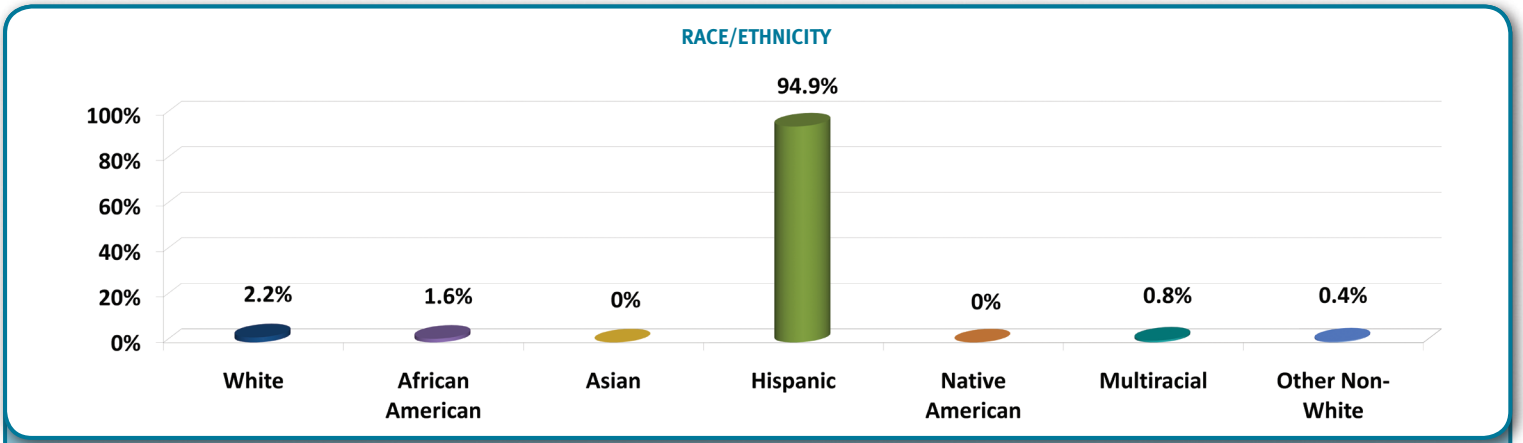
YOUTH DEMOGRAPHICS



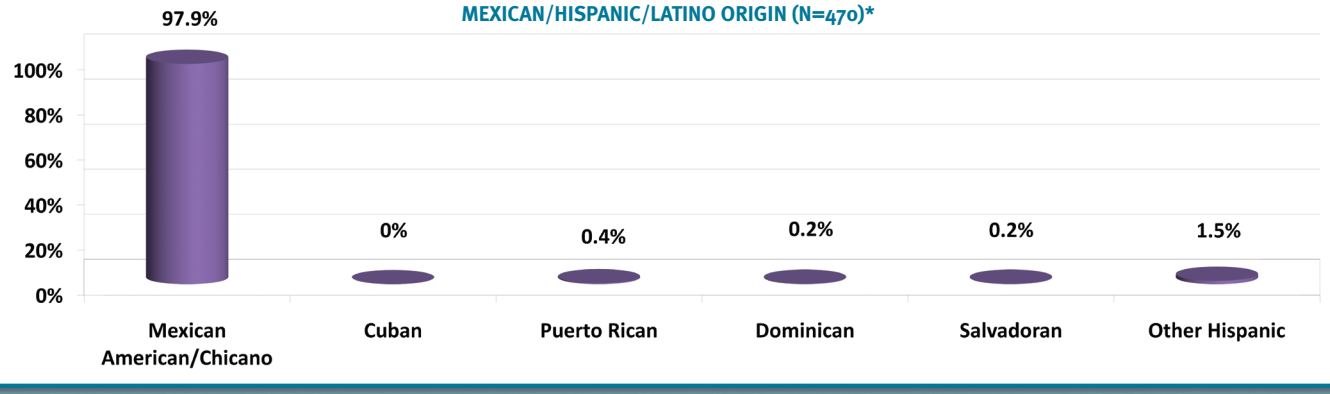
Of the children and youth who received School Age Services, roughly 80% were ages 6-11 while the remaining 20% were between the ages of 0-5. The age breakdown is representative of the youth population that is targeted by this intervention.



Fifty-seven percent of participants who received services were male while the remaining 43% of participants were female.



Approximately 95% of participants who received services were identified as Hispanic. Almost 4% of participants were identified as White or African American. The remaining racial/ethnic categories were not highly represented.



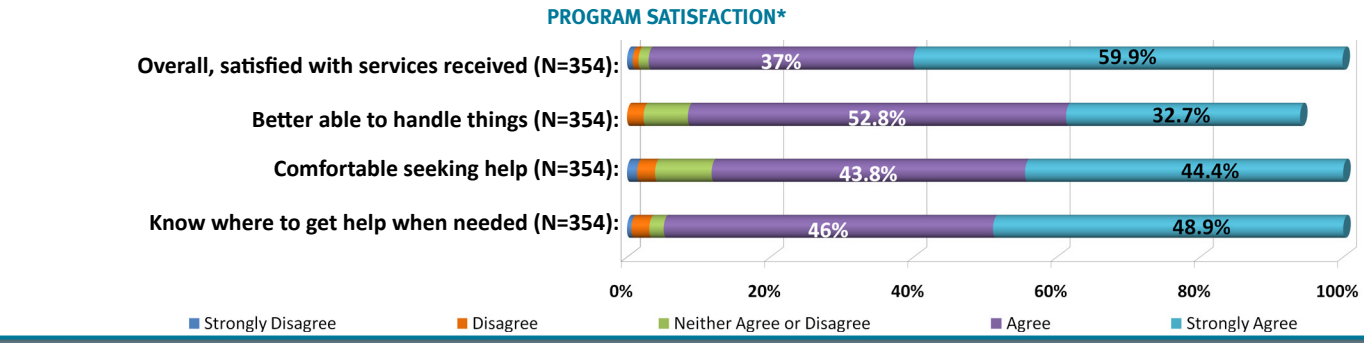
The majority of the Hispanic population served was identified as Mexican American/Chicano.

Participants can be identified as more than one ethnicity so percentages may add up to more than 100%.

MILITARY SERVICE

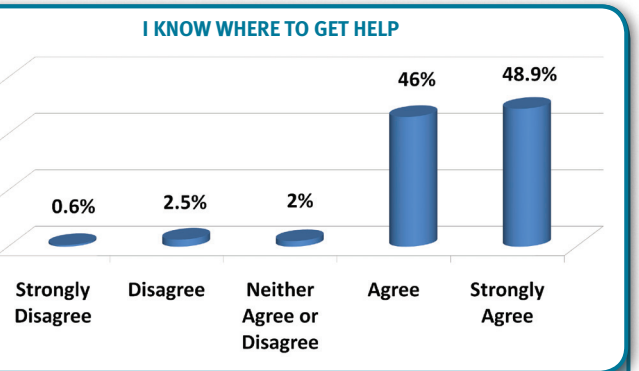
All 495 participants responded to this question. The majority (99%) reported that the child's caregiver had not served in the military. Of the 5 caregivers reported to have served in the military, two caregivers served in the Marine Corps, one served in the Air Force, one served in the Army, and one served in the Navy.

PROGRAM SATISFACTION



The majority of participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the program. Overall, 97% of the participants were satisfied with the services received.

** Satisfaction data not available for all participants.*



The majority of participants who responded to this question reported that they knew where to get help when they needed it. Only 3% did not agree with this statement.

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.

SCHOOL BASED PROGRAM-NORTH COUNTY (SA01NC): FAMILY COMMUNITY PARTNERSHIP

PALOMAR FAMILY COUNSELING SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

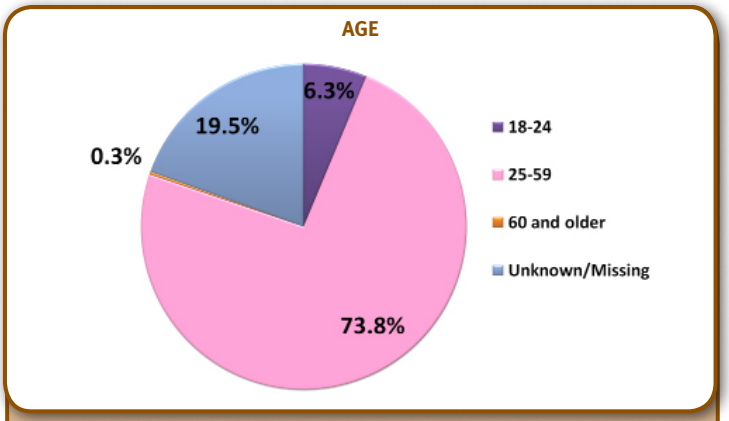
CASRC child and adolescent services research center

REGION: NORTH INLAND- DISTRICT 3

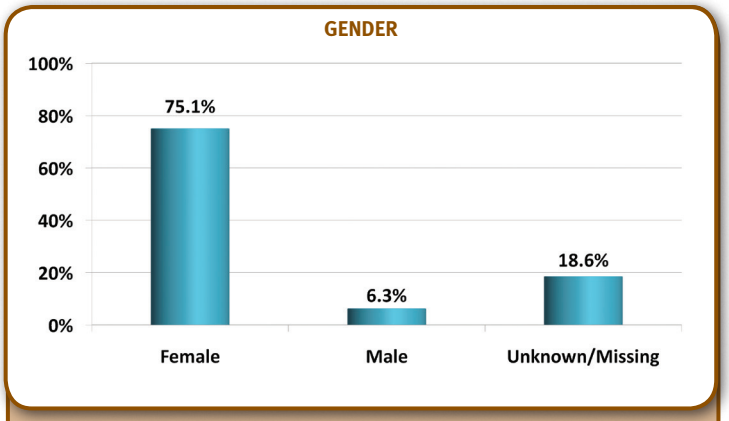
This program provides family-focused prevention and early intervention services for school-age children and their families in Escondido and Oceanside. The program has two components: a school-based component and a family-based component, known as the Family Community Partnership (FCP). This report focuses on the outcomes of the FCP component. FCP provides outreach services to families of the children served in the school-based program. These services are provided by bilingual community outreach specialists who inform parents about ways they can become involved in their child's school, and provide referrals to community resources. FCP also provides group activities for families. The aim of the program is to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress.

CONTRACTOR:	Palomar Family Counseling Services		
CONTRACT START DATE:	11/2/2009	**DATA COLLECTION START DATE:**	1/1/2010
PROGRAM SERVICES START DATE:	11/2/2009	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	978	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	978

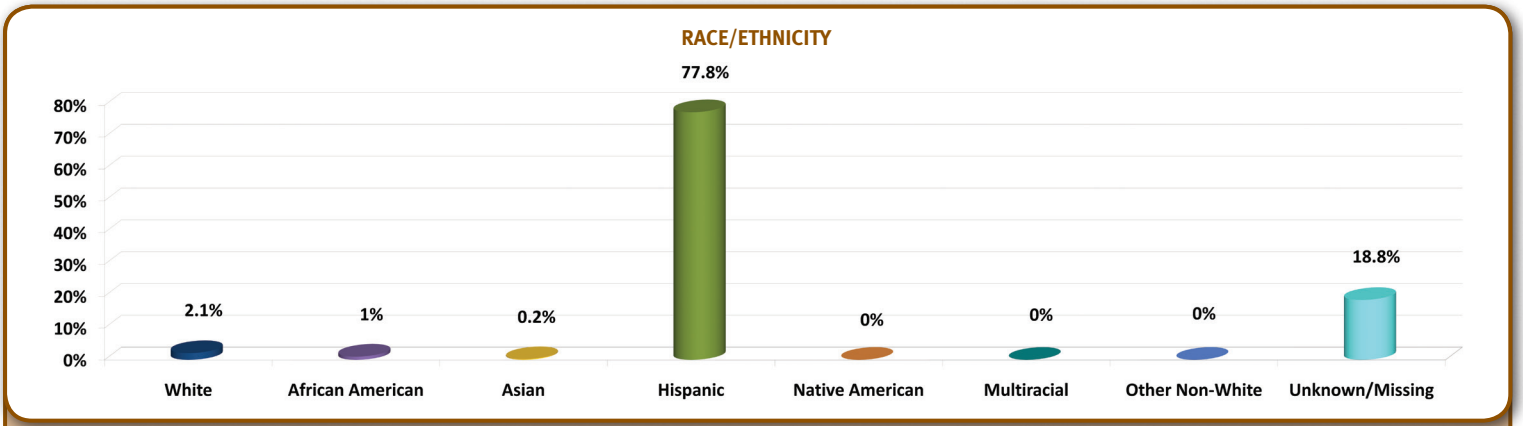
CAREGIVER DEMOGRAPHICS



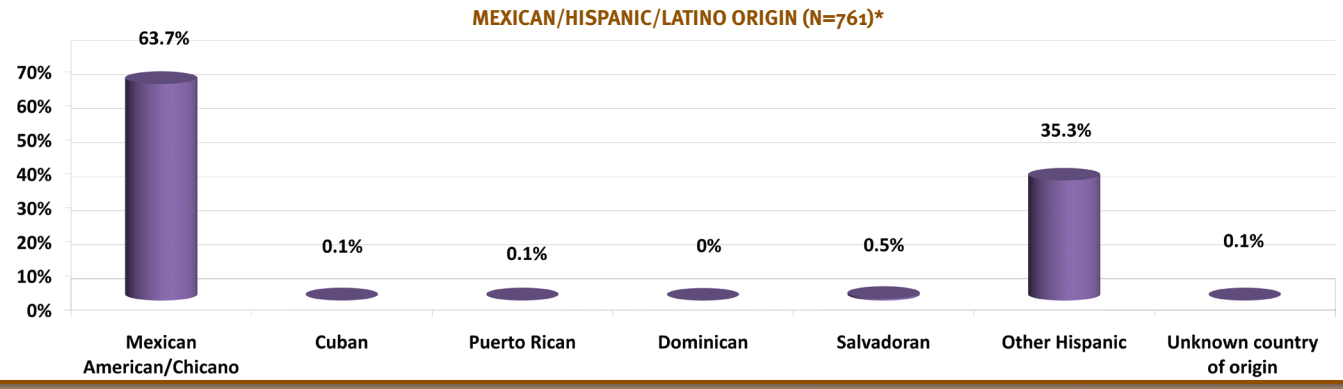
Nearly three-quarters of the caregivers who received Family Community Partnership Services were ages 25-59. Age was not reported for 20% of the participants.



Over 75% of caregivers who received services were female; gender was not reported for 19% of the participants.



Approximately 78% of caregivers who received services identified their racial/ethnic background as Hispanic. Race/ethnicity was not reported for 19% of participants.



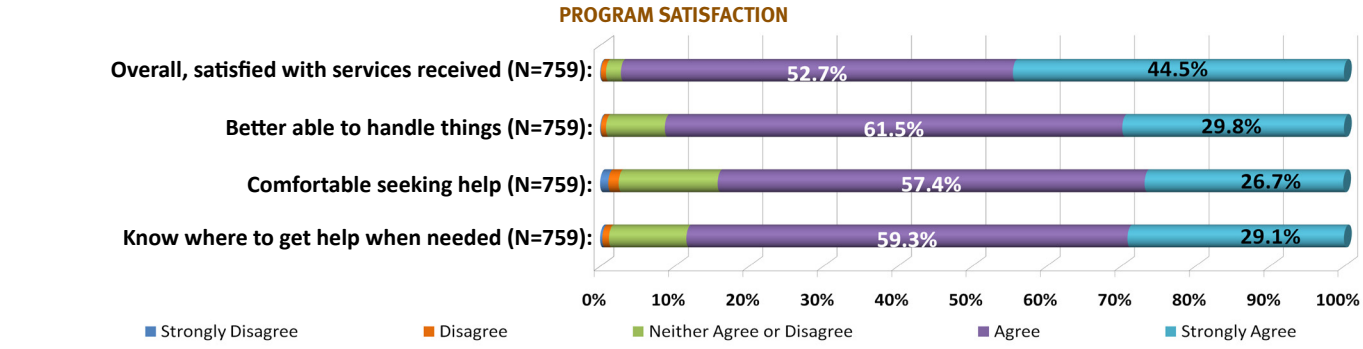
The majority of the Hispanic population served reported their ethnic background as Mexican American/Chicano.

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

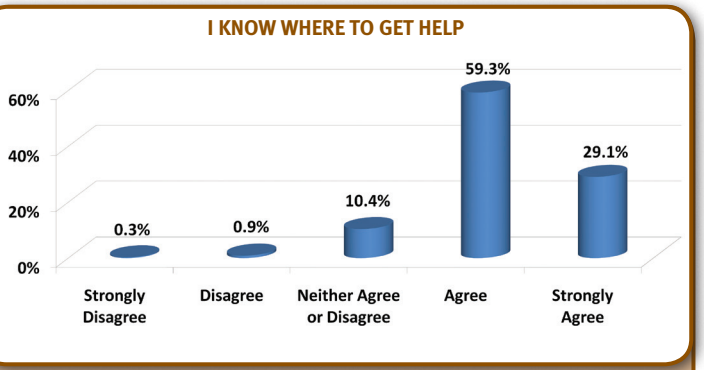
MILITARY DEMOGRAPHICS

Of 792 caregivers who responded to this question, the majority (99%) reported that they had not served in the military. Of the seven caregivers who said they had served in the military, four reported serving in the Army, one served in the Army Reserve, one served in the Marine Corps and one served in an unspecified branch.

PROGRAM SATISFACTION



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the program. Overall, 97% of the caregivers were satisfied with the services received.



The majority of participants responding to this question reported that they knew where to get help when they needed it. However the percent of participants that stongly agreed with this statement was lower than the percent who marked strongly agree in other PEI programs.

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SCHOOL BASED PROGRAM-EAST COUNTY (SA01EC): FAMILY PROGRAMS

SAN DIEGO YOUTH SERVICES

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

This program provides family-focused prevention and early intervention services for children who attend La Mesa Dale and Avondale elementary schools and their families. The program has two components: a school-based component and a family-based component. The family component includes parenting support groups, which use the Incredible Years curriculum, and culturally appropriate family-based activities that promote health and wellness. These interventions are designed to increase resiliency and protective factors for children by improving child/parent social and emotional skills and reducing parental stress. *This report focuses solely on the family component. For information about the school component, please see the annual report completed by Duerr Evaluation Resources.*

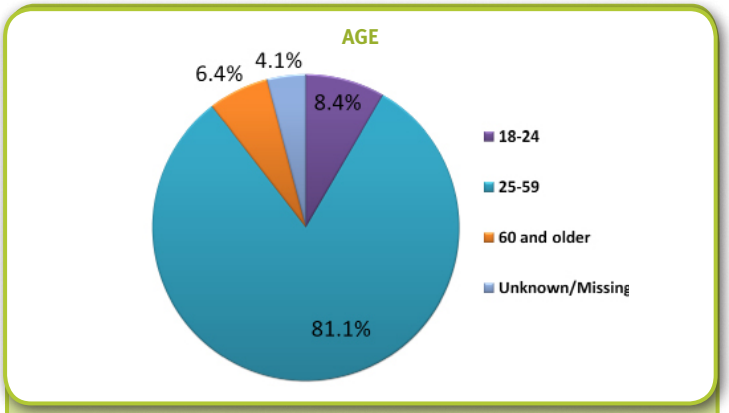
CONTRACTOR:	San Diego Youth Services		
CONTRACT START DATE:	7/1/2010	**DATA COLLECTION START DATE:**	1/10/2011
PROGRAM SERVICES START DATE:	9/27/2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	440 unduplicated	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	440

PROGRAM ATTENDANCE

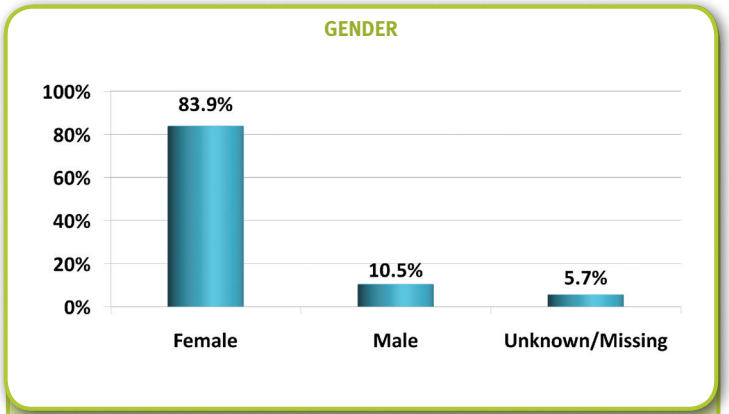
PROGRAM ATTENDANCE*	N	PERCENT
AVONDALE: PARENTING SUPPORT GROUP	54	12.3
AVONDALE: FAMILY PREVENTION EVENT	242	55
LA MESA: PARENTING SUPPORT GROUP	48	10.9
LA MESA: FAMILY PREVENTION EVENT	152	34.5
UNKNOWN LOCATION OR TYPE	27	6.1

**Numbers and percentages may add up to more than the total/ 100% because parents may have attended more than one location or type of activity.*

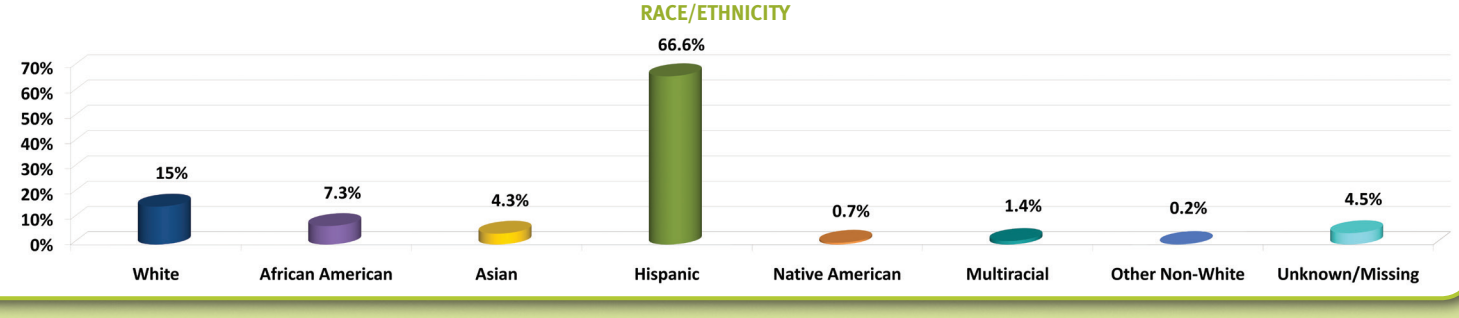
CAREGIVER DEMOGRAPHICS



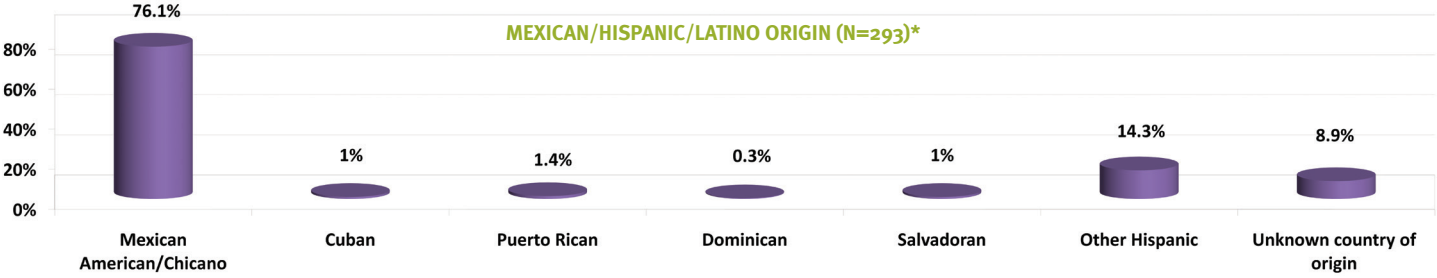
The majority of caregivers who participated in the family interventions (90%) were between the ages of 18-59. The age breakdown is representative of the adult population that is targeted by this part of the intervention.



Nearly 84% of caregivers who participated in the family interventions were female.



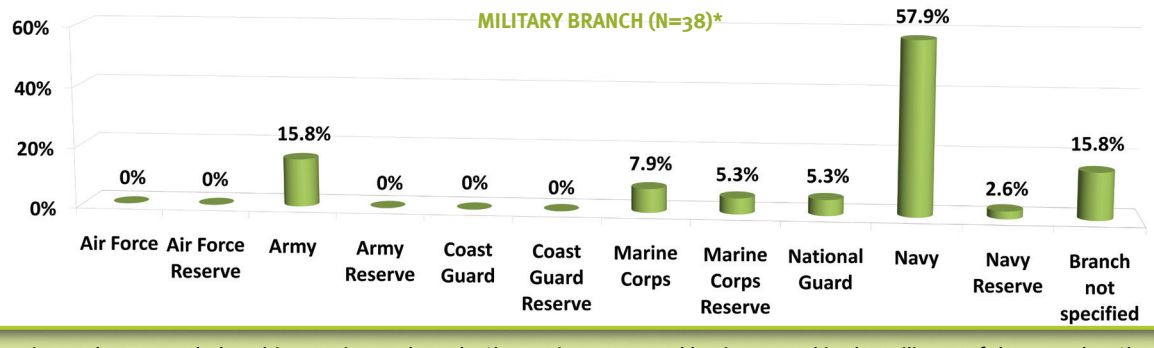
Two-thirds of caregivers who participated in the family interventions identified their racial/ethnic background as Hispanic.



The majority of the Hispanic population served reported their ethnic background as Mexican American/Chicano.

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

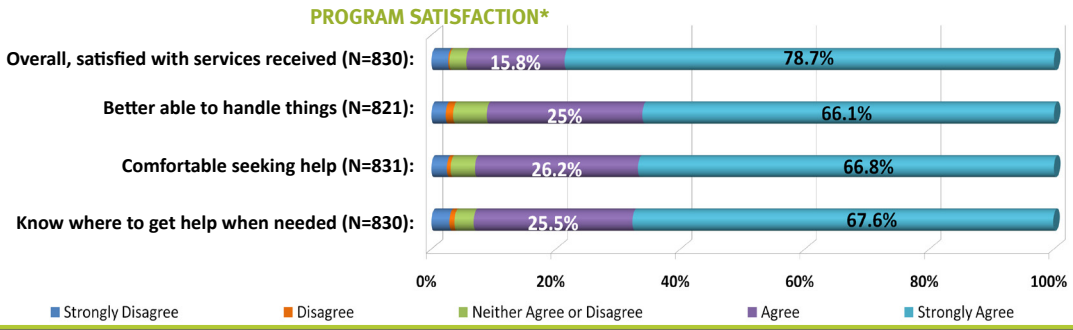
MILITARY SERVICE



Of the 404 caregivers who responded to this question, only 38 (9%) caregivers reported having served in the military. Of these, 22 (58%) served in the Navy, 6 (16%) served in the Army, and 3 (8%) served in the Marine Corps.

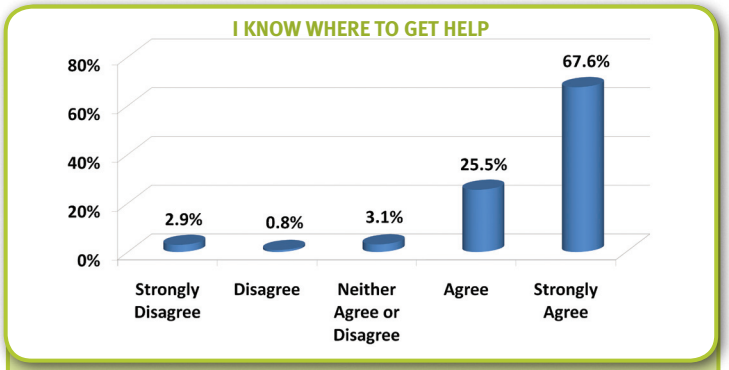
** Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION

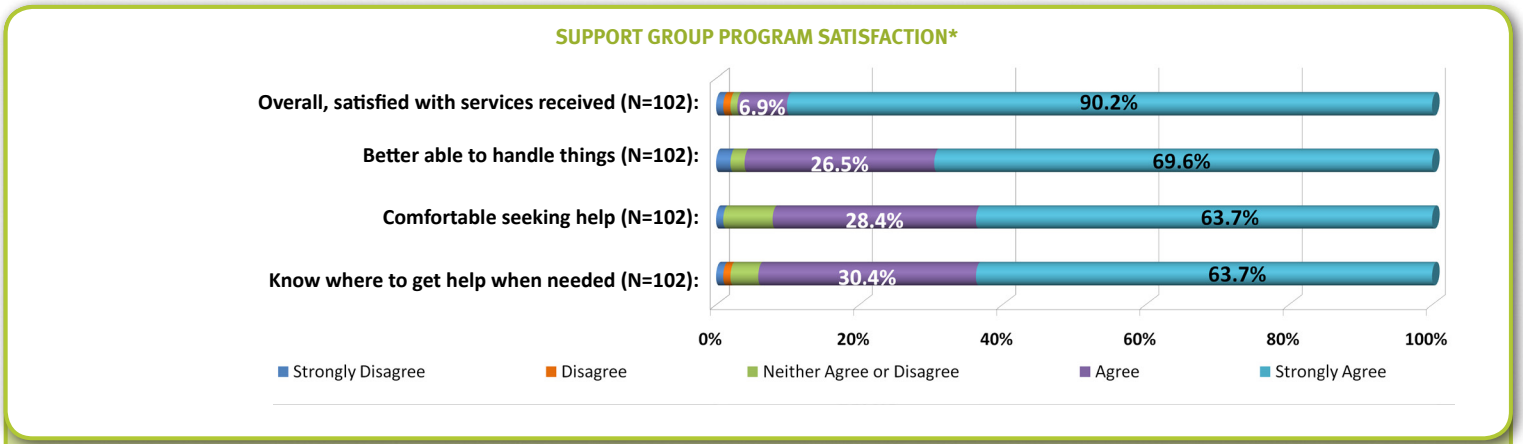


The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the program. Overall, 95% of the caregivers were satisfied with the services received.

** Satisfaction data includes duplicated participants.*

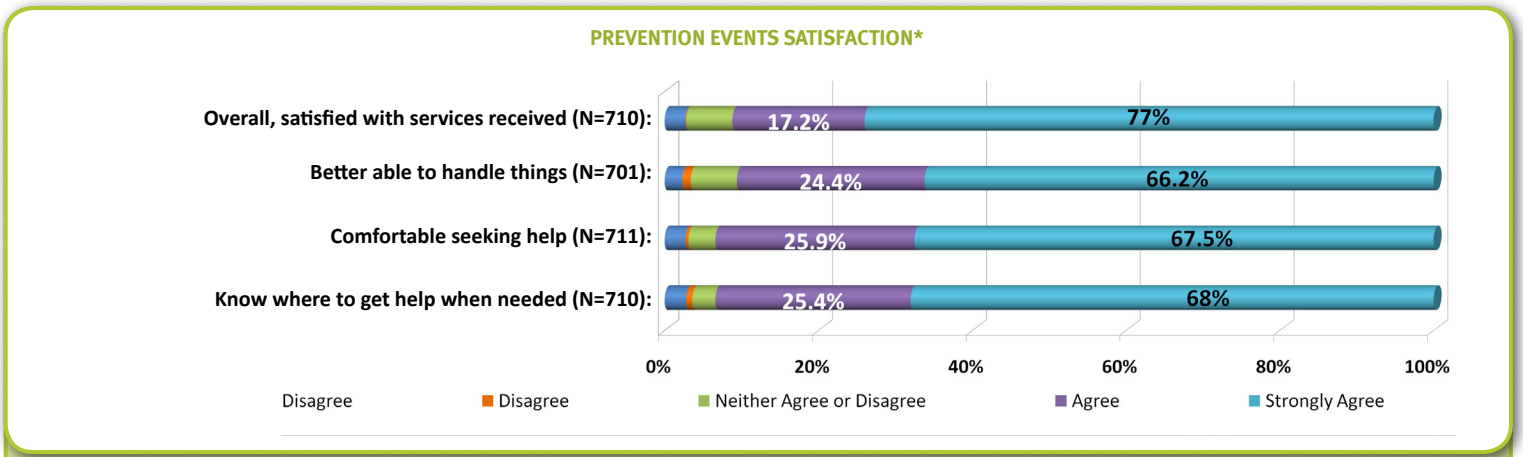


The majority of caregivers responding to this question reported that they knew where to get help when they needed it. Only 4% did not agree with this statement.



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the support groups. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the group program. Overall, 97% of the caregivers were satisfied with the services received in the support groups.

** Satisfaction data includes duplicated participants.*



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the prevention events. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the events. Overall, 94% of the caregivers were satisfied with the services received.

** Satisfaction data includes duplicated participants.*

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YELLOW RIBBON SUICIDE PREVENTION (SA02): CAREGIVER OUTCOMES

MENTAL HEALTH RESOURCE CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

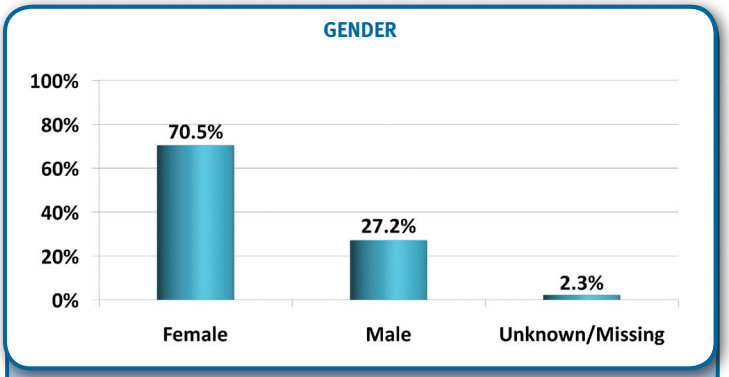
REGION: NORTH CENTRAL- DISTRICT 4

The School-Based Suicide Prevention program serves children, youth and transition-age youth (TAY) in school settings. This program provides presentations on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and parents. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013.

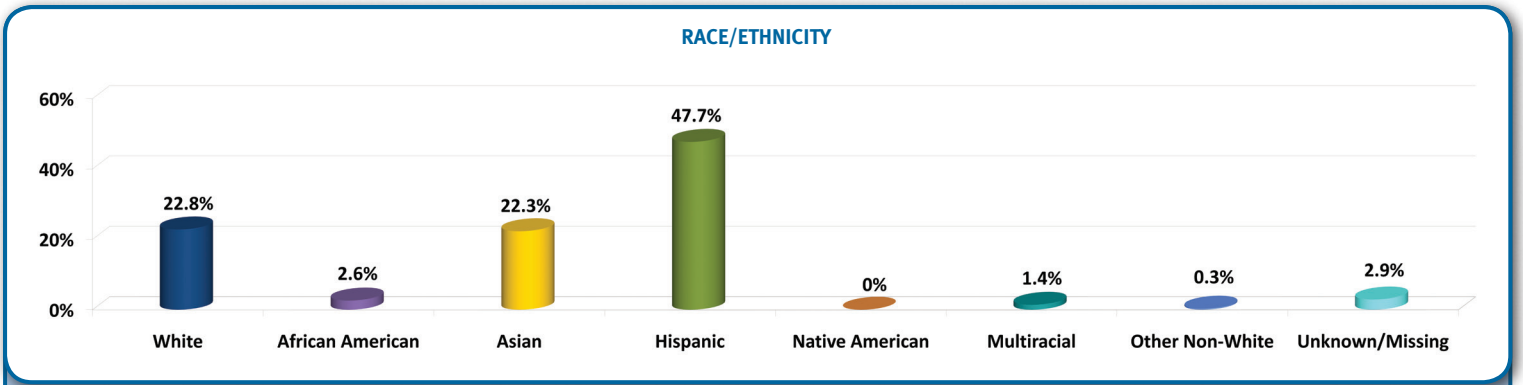
CONTRACTOR:	Mental Health Resource Center		
CONTRACT START DATE:	November 2009	**DATA COLLECTION START DATE:**	October 2010
PROGRAM SERVICES START DATE:	August 2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	346*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	387

**Data not available for all participants.*

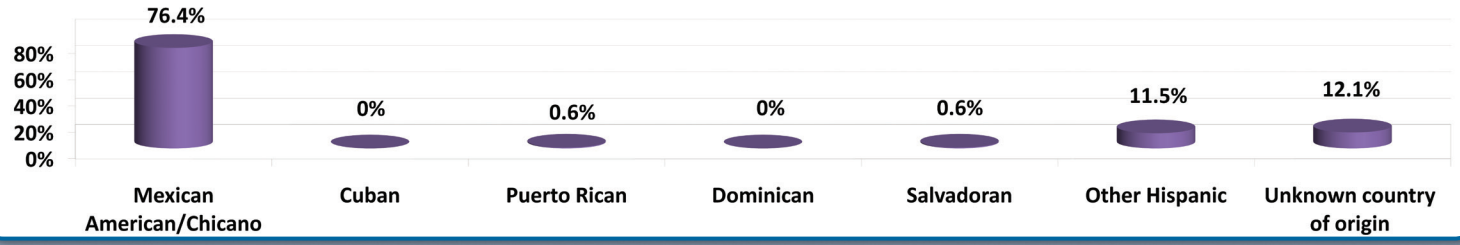
CAREGIVER DEMOGRAPHICS



The majority of the caregivers in the sample were female.



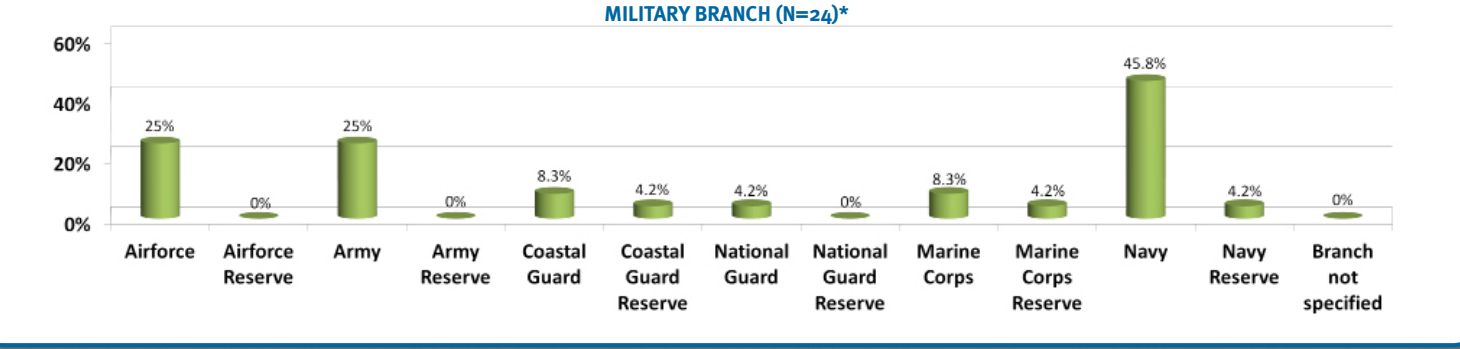
Almost half of the caregivers in the sample identified their ethnic background as Hispanic. Nearly one-quarter of the caregivers identified their ethnic background as White. A similar proportion of caregivers identified their ethnic background as Asian. The remaining racial/ethnic backgrounds were not highly represented.



The majority of the caregivers in the sample of Hispanic origin identified their ethnic background as Mexican American/Chicano.

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

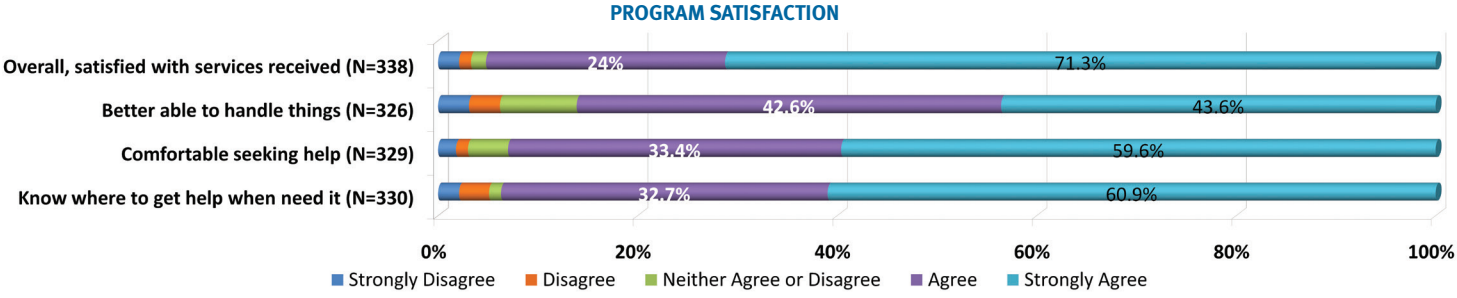
MILITARY SERVICE



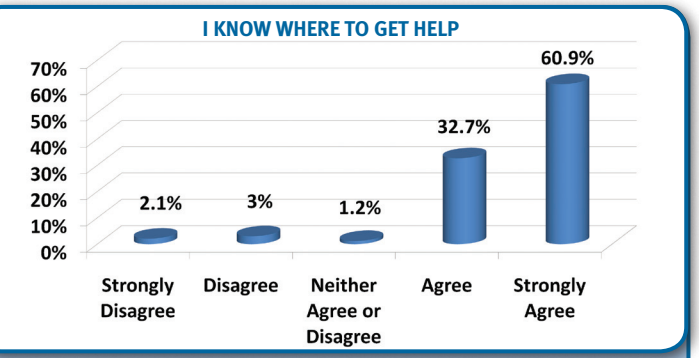
Of 319 caregivers that responded to this question, the majority (92%) reported that they had not served in the military. Of the 24 caregivers that reported they have served in the military, 11 (46%) served in the Navy. Six (25%) caregivers served in the Air Force and 6 (25%) served in the Army. The remaining military branches were not highly represented.

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

PROGRAM SATISFACTION



Most caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 95% of the caregivers were satisfied with the services received.

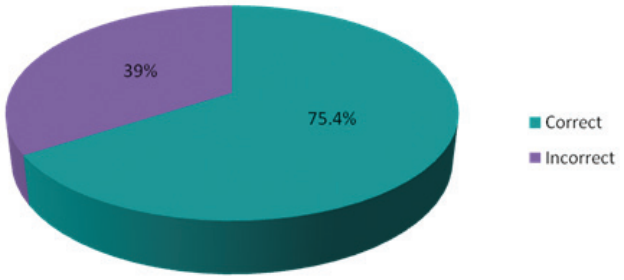


The majority of caregivers responding to this question reported that they knew where to get help when they needed it. Approximately 5% did not agree with this statement.

"I know where to get help when I need it."

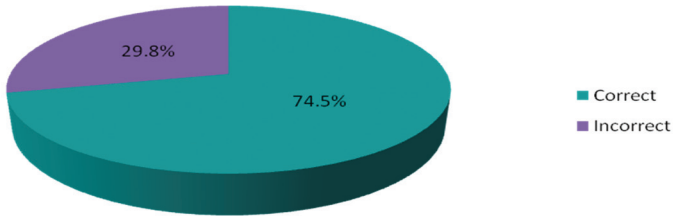
PROGRAM SPECIFIC OUTCOMES

PERCENT OF CAREGIVERS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



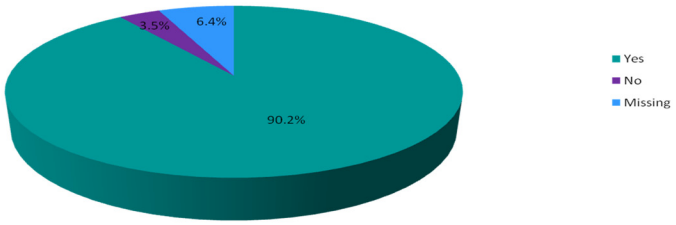
Approximately, 75% of caregivers correctly identified the warning signs of suicide after the presentation.

PERCENT OF CAREGIVERS WHO CORRECTLY IDENTIFIED THE PROTOCOL STEPS ON THE ASK 4 HELP CARD.



Following the presentation, approximately, 75% of caregivers correctly identified the protocol steps on the Ask 4 Help card.

IF A STUDENT CAME TO ME BECAUSE THEY WERE DEPRESSED OR HAVING SUICIDAL THOUGHTS, I WOULD KNOW WHO TO REFER THE STUDENT TO FOR HELP.



Following the presentation, 90% of the caregivers reported that if a student came to them because they were depressed or were having suicidal thoughts, they would know who to refer them to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
Referrals that were made after the presentations	*66 out of 169*
Referrals from Schools that did not receive presentations FY2010-2011	95 (36%)
One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.	

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YELLOW RIBBON SUICIDE PREVENTION (SA02): SCHOOL STAFF OUTCOMES

MENTAL HEALTH RESOURCE CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

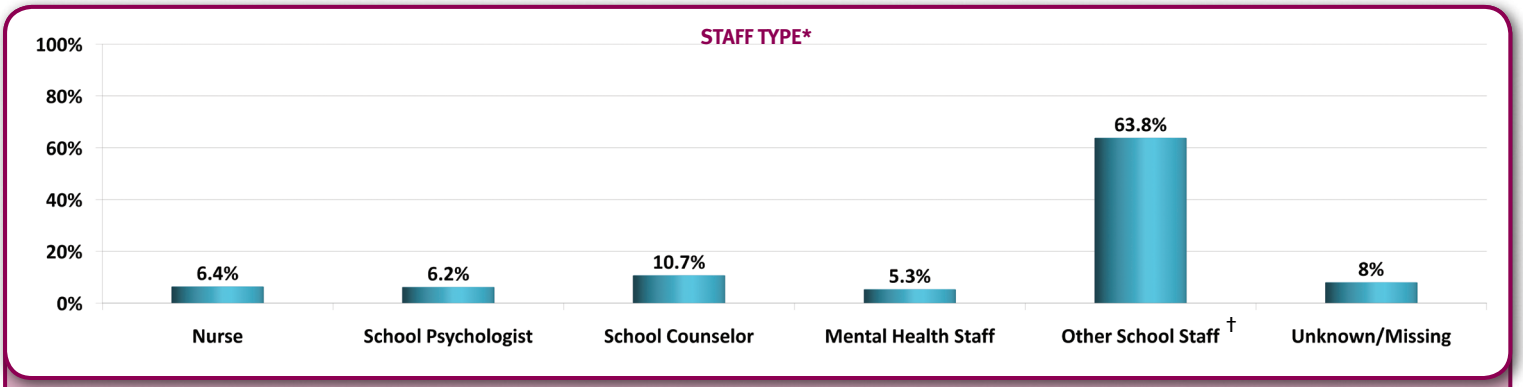
REGION: NORTH CENTRAL- DISTRICT 4

The School-Based Suicide Prevention program serves children, youth and transition-age youth (TAY) in school settings. This program provides presentations on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and parents. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013.

CONTRACTOR:	Mental Health Resource Center		
CONTRACT START DATE:	November 2009	**DATA COLLECTION START DATE:**	October 2010
PROGRAM SERVICES START DATE:	August 2010	**REPORT PERIOD:**	7/1/2010-6/30/2010
NUMBER OF PARTICIPANTS WITH DATA:	1953*	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	2381

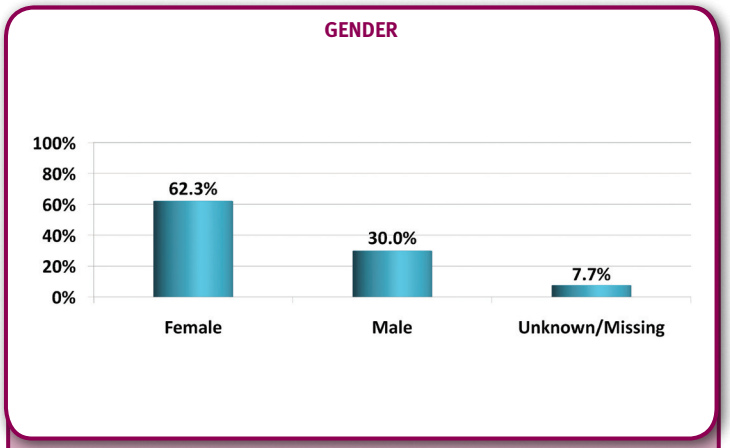
**Data not available for all participants.*

STAFF DEMOGRAPHICS

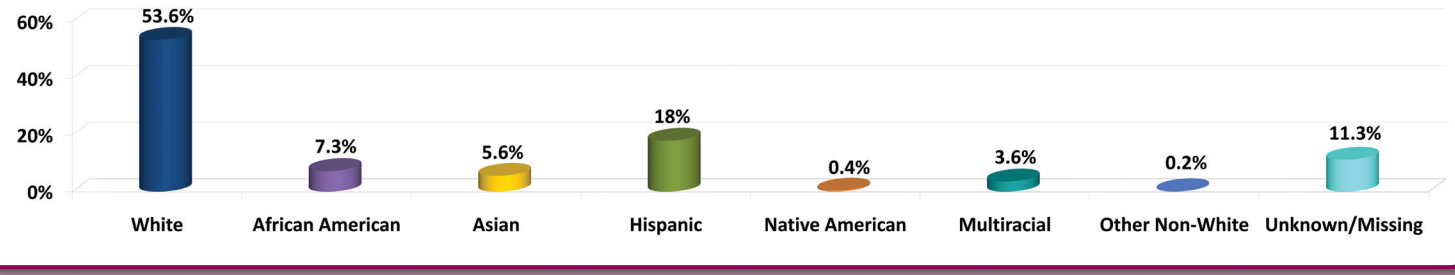


The majority (64%) of staff in the sample were not physical or mental health care providers.

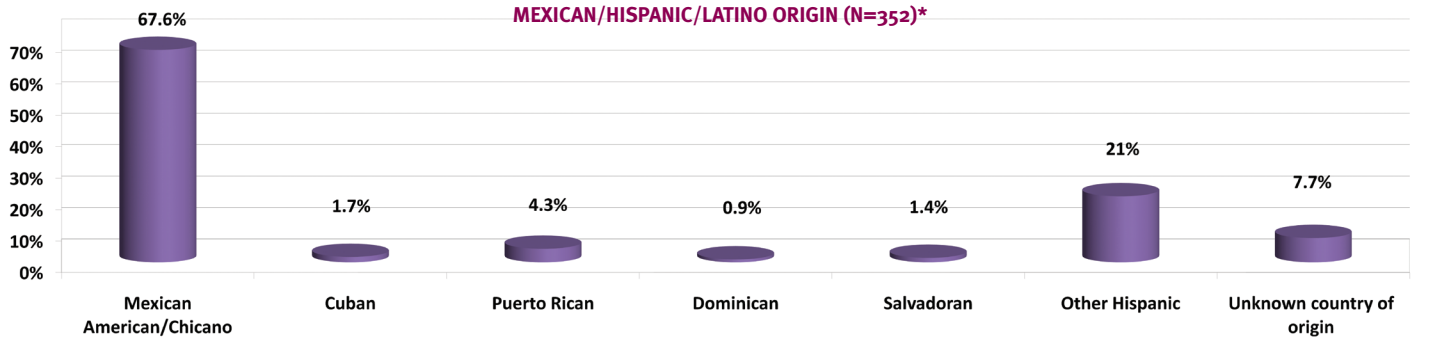
**Staff can self-identify as serving in more than one position so percentages may add up to more than 100%.*
† The majority of staff in this category are teachers.



Over 60% of the staff were female.



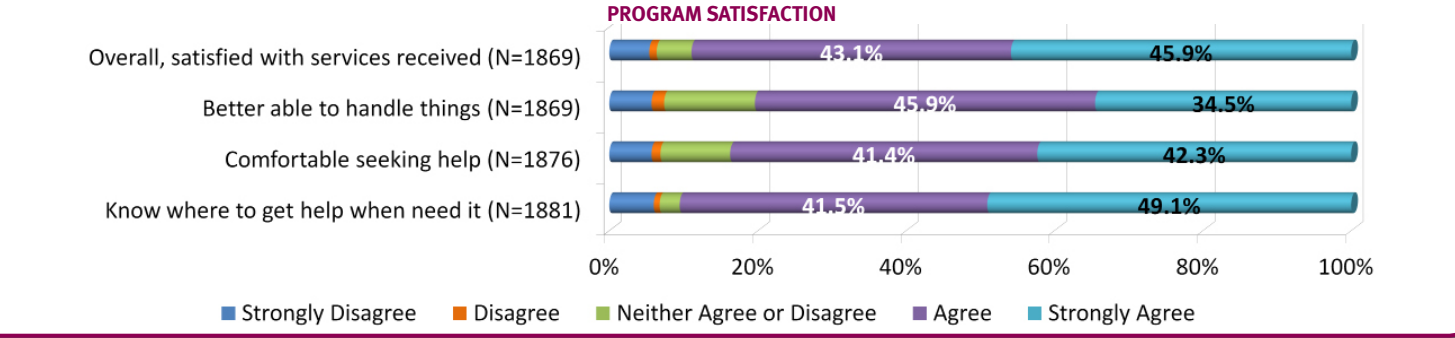
More than half of the staff identified their ethnic background as White, and 18% of staff identified their ethnic background as Hispanic. Approximately 11% of staff did not identify their racial/ethnic background.



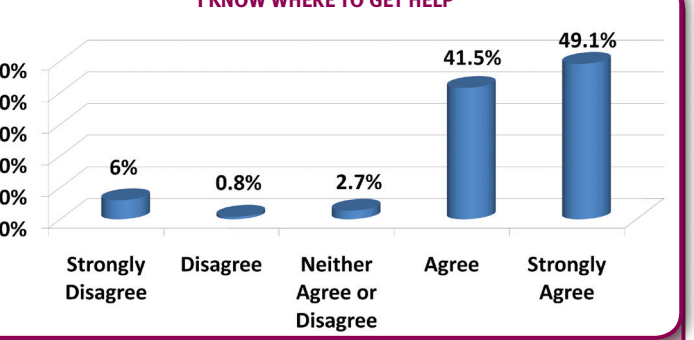
The majority of the Hispanic population in the sample identified their ethnic background as Mexican American/Chicano.

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

PROGRAM SATISFACTION



Most staff who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 89% of the staff were satisfied with the services received.

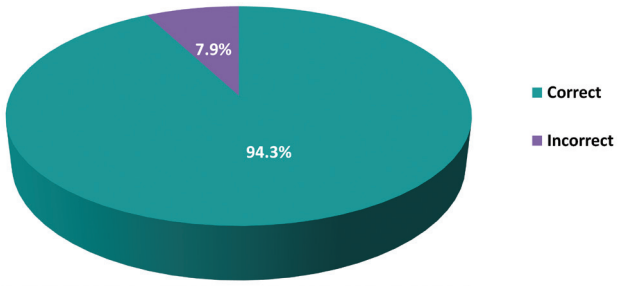


The majority of the staff responding to this question reported that they knew where to get help when they needed it. Approximately 7% did not agree with this statement.

"I know where to get help when I need it."

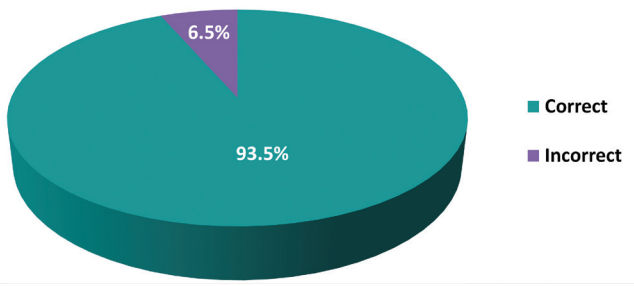
PROGRAM SPECIFIC QUESTIONS

PERCENT OF STAFF WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



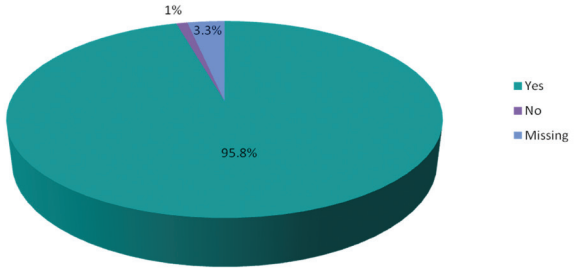
Following the presentation, approximately 94% of staff correctly identified the warning signs of suicidal ideation/behavior.

PERCENT OF STAFF WHO CORRECTLY IDENTIFIED THE PROTOCOL STEPS ON THE ASK 4 HELP CARD.



Following the presentation, approximately 94% of staff correctly identified the protocol steps on the Ask 4 Help card.

IF A STUDENT CAME TO ME BECAUSE THEY WERE DEPRESSED OR HAVING SUICIDAL THOUGHTS, I WOULD KNOW WHO TO REFER THE STUDENT TO FOR HELP.



Following the presentation, approximately 96% of the staff reported that if a student came to them because they were depressed or were having suicidal thoughts, they would know who to refer them to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY 2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
Referrals that were made after the presentations	*66 out of 169*
Referrals from schools that did not receive presentations	95 (36%)

One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.

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.

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YELLOW RIBBON SUICIDE PREVENTION (SA02): STUDENT OUTCOMES

MENTAL HEALTH RESOURCE CENTER

SAN DIEGO COUNTY CHILD & ADOLESCENT PREVENTION & EARLY INTERVENTION PROGRAMS

FISCAL YEAR 2010—2011 ANNUAL REPORT

Live Well, San Diego!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

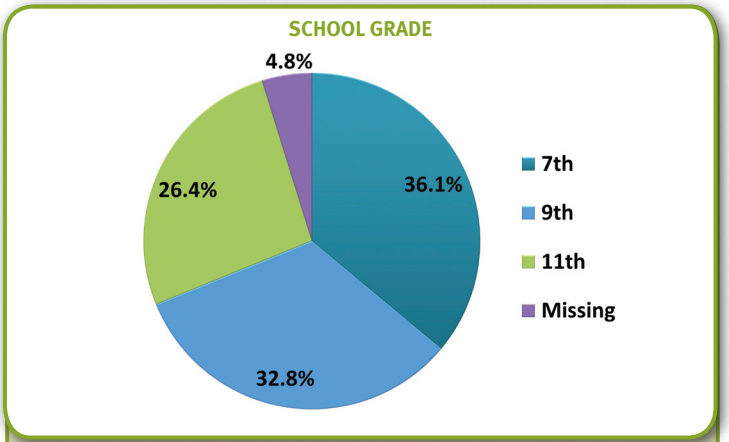
CASRC child and adolescent services research center

REGION: NORTH CENTRAL- DISTRICT 4

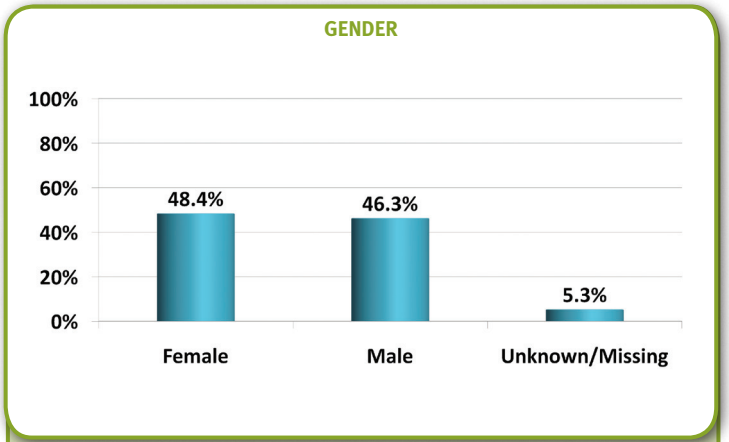
The School-Based Suicide Prevention program serves children, youth and transition-age youth (TAY) in school settings. This program provides presentations on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and parents. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013. Due to the large number of students served, CASRC collects data on a representative sample of 25% of the youth who attend the presentations.

CONTRACTOR:	Mental Health Resource Center		
CONTRACT START DATE:	November 2009	**DATA COLLECTION START DATE:**	October 2010
PROGRAM SERVICES START DATE:	August 2010	**REPORT PERIOD:**	7/1/2010-6/30/2011
NUMBER OF PARTICIPANTS WITH DATA:	3470	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION:**	8944

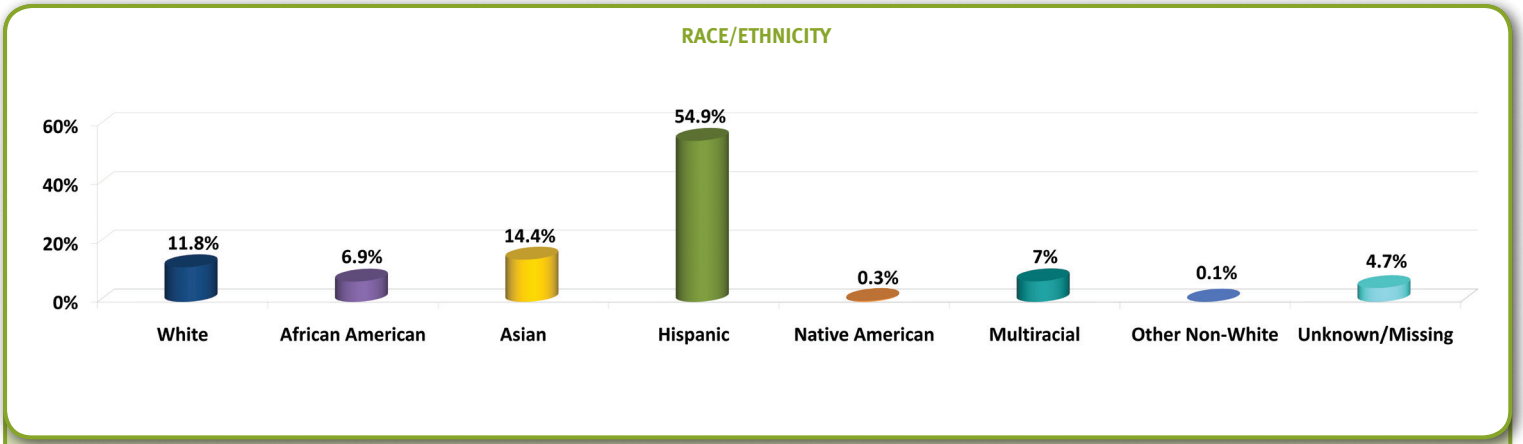
STUDENT DEMOGRAPHICS



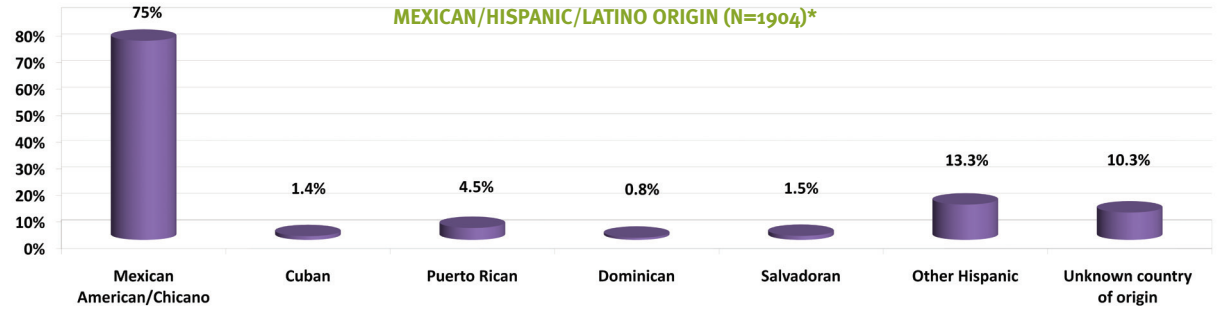
The sample population used for the analysis contained slightly more 7th graders (36%) than 9th (33%) and 11th graders (26%).



The sample population was comprised of slightly more females than males.



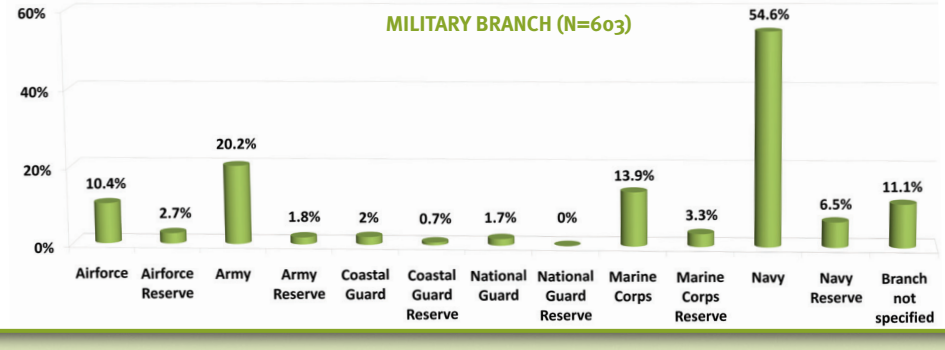
More than half of the students in the sample identified their ethnic background as Hispanic. Almost 15% of students identified their ethnic background as Asian.



The majority of the Hispanic population in the sample identified their ethnic background as Mexican American/Chicano.

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

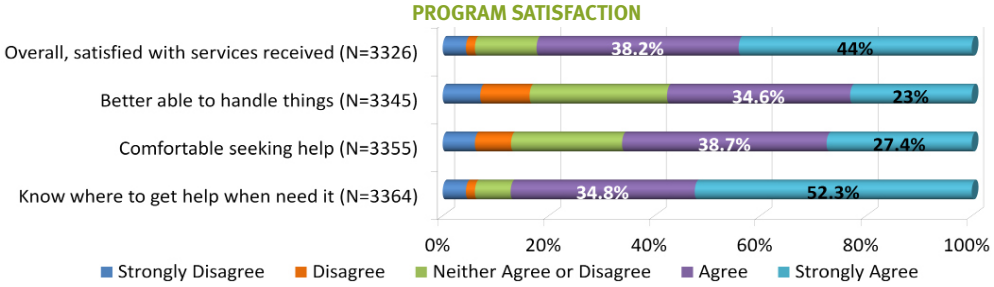
MILITARY SERVICE



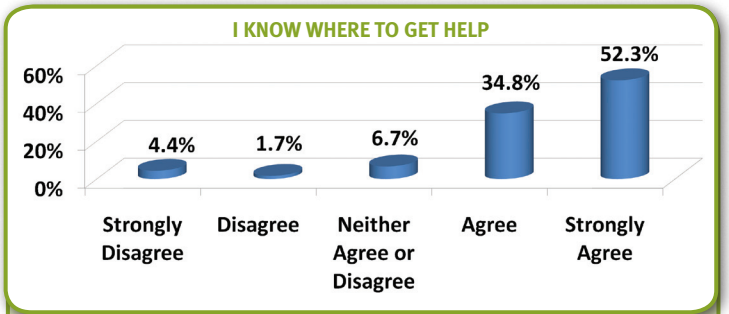
Of the 2674 students who responded to this question, 77% reported that their caregivers had not served in the military. Of the 603 students who reported that their caregiver has served in the military, 329 (55%) reported their caregivers have served in the Navy and 122 (20%) reported that their caregiver served in the Army. Additionally, 84 (14%) students reported their caregivers served in the Marine Corps and 63 (10%) students reported their caregiver served in the Air Force. The remaining military branches were not highly represented.

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

PROGRAM SATISFACTION



Most students in the sample who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 82% of the students in the sample were satisfied with the services received.

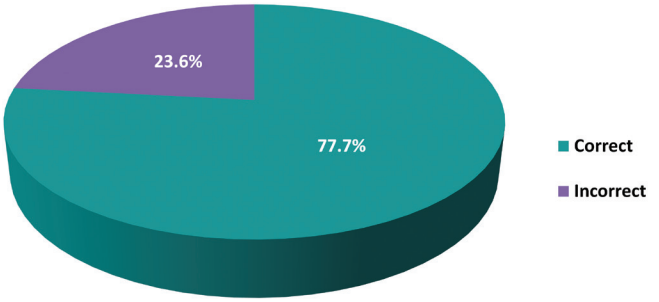


The majority of students in the sample responding to this question reported that they knew where to get help when they needed it. Approximately 6% did not agree with this statement.

"I know where to get help when I need it."

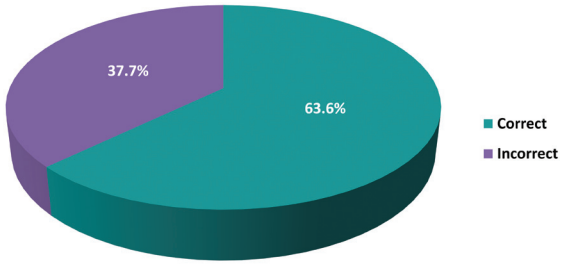
PROGRAM SPECIFIC OUTCOMES

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE.



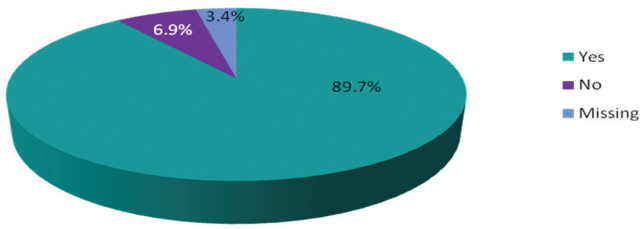
Following the presentation, approximately 78% of students in the sample correctly identified the warning signs of suicidal ideation/ behavior.

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED THE STEPS TO TAKE IF A FRIEND SAYS HE/SHE IS CONSIDERING SUICIDE.



Following the presentation, approximately 64% of students in the sample correctly identified the steps to take if a friend is considering suicide.

IF I FELT DEPRESSED OR WAS HAVING SUICIDAL THOUGHTS, I KNOW WHO TO GO TO FOR HELP:



Following the presentation, roughly 88% of students in the sample reported that if they were depressed or were having suicidal thoughts, they would know who to go to for help.

SUICIDE RISK REFERRALS	N
Referrals from FY2009-2010	130
Referrals from FY2010-2011	264
Referrals from schools that received presentations FY2010-2011	169 (64%)
Referrals that were made before the presentations	*103 out of 169*
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Referrals from schools that did not receive presentations FY2010-2011	95 (36%)

One of the goals of this PEI program is to increase the identification of students who are at risk for suicidal ideation and behavior. A greater number of students were identified in 2010-2011 (the year the PEI program began) than in 2009-2010.

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.

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PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Courage to Call

VF01—Central, East, South, North Coastal, North Inland, and North Central Regions, Districts 1-5
Mental Health Systems, Inc.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

The Prevention and Early Intervention (PEI) Veterans and their Families program (VF01) focuses on populations not served, or whose needs are not met by traditional veteran and active duty military service providers. The potential target population of this PEI program is in excess of 1,000,000, roughly 1/3 of San Diego County. Specifically, the VF01 program provides education to VMRGF on relevant mental health topics, and peer counseling to reduce mental health risk factors or stressors. Education and training is also offered to providers serving the VMRGF community (behavioral and primary health care providers, businesses, faith-based organizations, schools and colleges/universities, law enforcement, and justice system) to improve understanding of the military culture and improve recognition of mental health issues unique or relevant to the VMRGF.

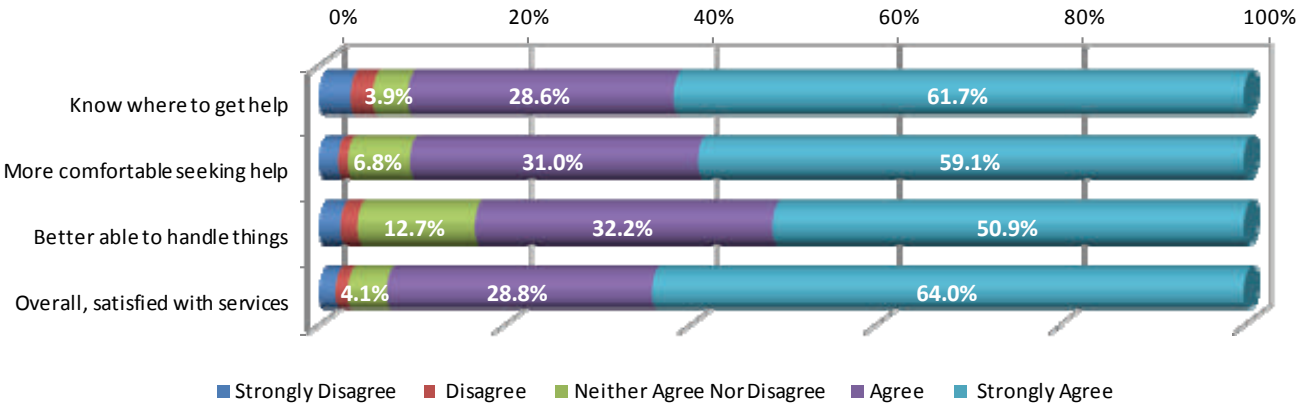
The VF01 program also provides free comprehensive information 24 hours a day, 7 days a week to VMRGF, outside of military channels, via the Courage to Call telephone helpline. The helpline is staffed with veterans who provide mental health information, self screening tools and appropriate resources,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

Courage to Call staff follow up with all callers to ensure that individuals are able to access the services they need. During the follow-up call, individuals are asked to participate in a short survey regarding their satisfaction with the Courage to Call helpline. The data presented in this report reflect only those 390 callers who agreed to participate in the survey during Fiscal Year 2010-11.

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

Mental Health Advisory Team (MHAT) IV Brief developed by Pentagon (2006)

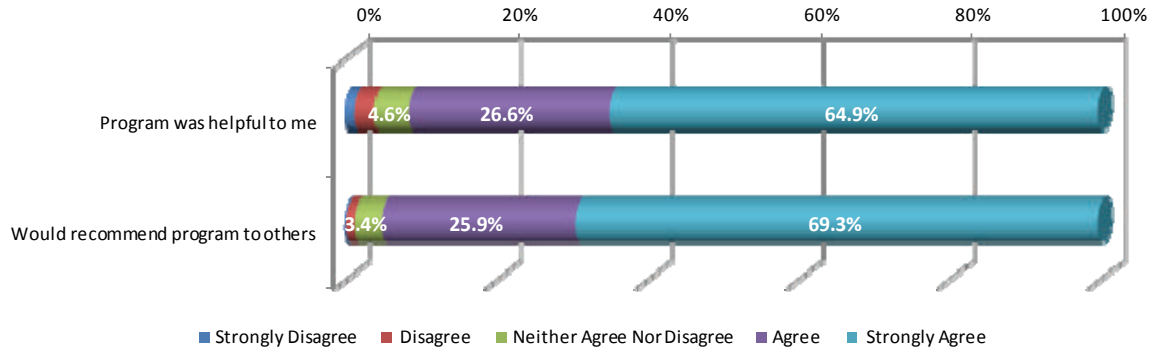
PEI Outcomes and Satisfaction



Participants were asked to assess both their improvement in several areas and their satisfaction with the Courage to Call program. These items were given only to those participants who completed the intervention, and the number of respondents varied for each item. A majority of participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (90.3%), "I am more comfortable seeking help" (90.1%), "I am better able to handle things" (83.1%), and "Overall, I am satisfied with the services I received here" (92.8%).

Program Specific Outcomes

Courage to Call participants also assessed the benefit they received from the helpline program. These items were again only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of participants either "Agreed" or "Strongly Agreed" that, "This program was helpful to me" (91.5%) and, "I would recommend this program to others" (95.2%). Most participants contacted the services that the program recommended (78.0%), and would use the program again (97.7%).

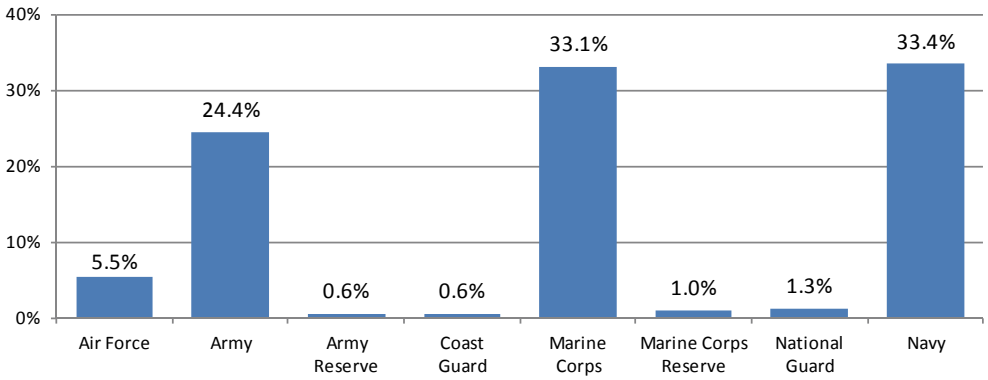


Participant Demographics

The majority of Courage to Call participants in Fiscal Year 2010-11 who responded to the survey were male (75.8%), Caucasian (52.5%), and between 40 and 64 years old (55.1%).

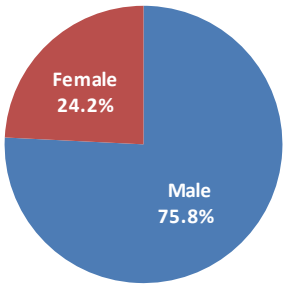
A large majority of participants had served in the military (79%), with most serving in the Navy (33.4%), the Marine Corps (33.1%), or the Army (24.4%).

Branch of Military Service



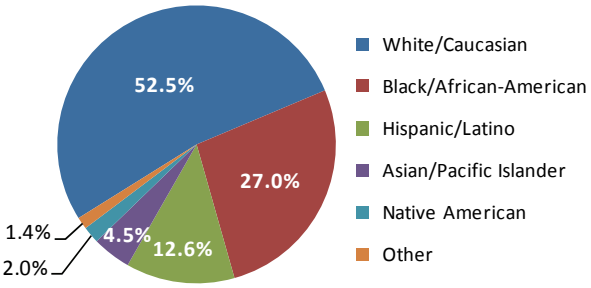
3 (1%) did not provide branch of military; Total Military Service responses may not match the number of "Yes" responses due to service in multiple branches and/or "unknown"/"not reported" responses.

Gender



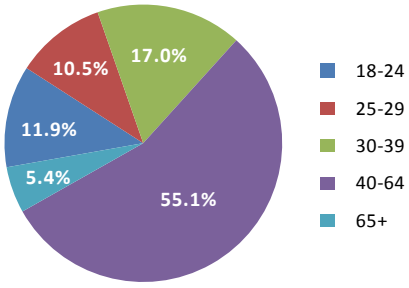
14 (3.6%) did not provide Gender

Race/Ethnicity



There were no multiracial consumers; 34 (8.7%) did not provide Race/Ethnicity

Age



Age was collected in the categories shown; 20 (5.1%) did not provide Age

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

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Rural Integrated Behavioral Health and Primary Care Services

RC01— North Inland Region, Districts 2, 5
Vista Hill

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

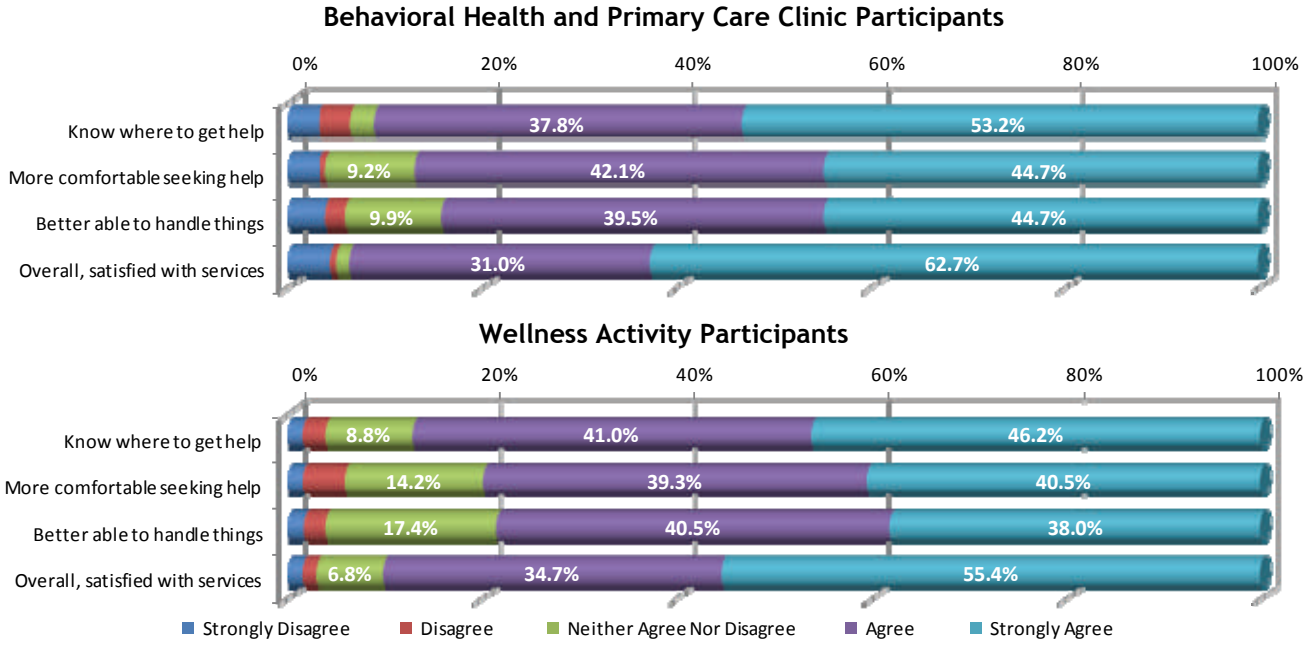
The RC01 program, part of the Prevention and Early Intervention (PEI) plan, is a fully integrated, behavioral health/primary care service for children, adolescents, transition age youth, adults, and older adults in three rural community clinics in San Diego County. The program offers services to help prevent community clinic patients from developing increased severity of behavioral health issues, severe mental illness, or addiction by addressing behavioral health needs early.

Clinic patients are screened for priority risk factors including mental health, alcohol and drug use; domestic violence; elder abuse; and problem gambling. Children and parents are screened for risk factors related to family stress and transitions. A portion of the patients screened may be identified as needing treatment services. Patients receive needed services within the clinics, or are linked to regional treatment providers with support from a liaison to traditional mental health, as well as drug and alcohol services.

Additionally, partnerships have been developed with community-based agencies in rural areas and schools to provide mental health wellness education activities for community members. Community partners include Senior Centers and self help groups such as Alcoholics Anonymous (AA).

Program Satisfaction

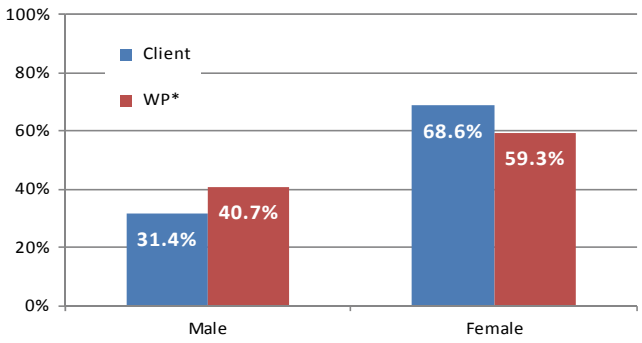
Behavioral Health consumers and Primary Care Clinic patients who received services through the Rural Integrated Care program and members of the community who participated in Wellness Activities through the Rural Integrated Care program were asked to assess the perceived benefits of each program. These items were only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of both the clinic participants (C) and the Wellness Activity participants (WP) "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (C-91.0%; WP-87.2%), "I am more comfortable seeking help" (C-86.8%; WP-79.8%), "I am better able to handle things" (C-84.2%; WP-78.5%), and "Overall, I am satisfied with the services I received here" (C-93.7%; WP-90.1%).



Participant Demographics

During fiscal year 2010-11, Rural Integrated Behavioral Health and Primary Care Services served 662 participants, and had 2,144 community members participate in their Wellness Activities. The majority of participants were female (68.6%), Caucasian (51.5%) or Hispanic (42.9%), and aged 25-59 (58.0%). A majority of Hispanic participants were Mexican American/Chicano (90.8%). A majority of the Wellness Activity (WP) participants were female (59.3%), Caucasian (44.2%) or Hispanic (35.3%), and under 24 years old (59.2%). Of the Hispanic participants, a majority were Mexican American/ Chicano (88.6%). A small proportion of both Clinic and Wellness Activity participants had served in the military (1.8% and 0.7% respectively).

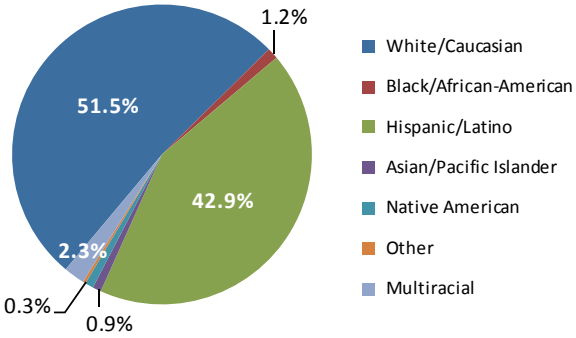
Gender of All Participants



* 25 (1.2%) of Wellness Activity Participants did not report Gender

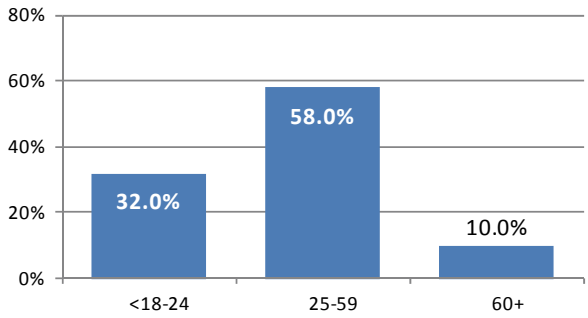
BEHAVIORAL HEALTH AND PRIMARY CARE CLINIC PARTICIPANTS

Race/Ethnicity



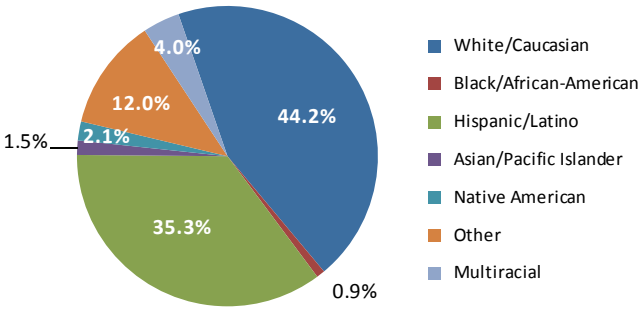
4 (.6%) did not report Race/Ethnicity

Age



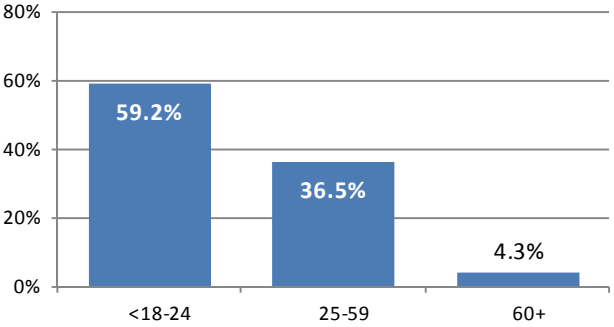
WELLNESS ACTIVITY PARTICIPANTS

Race/Ethnicity



388 (18.1%) did not report Race/Ethnicity

Age



72 (3.4%) did not report Age

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

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Elder Multicultural Access and Support Services

OA01 – Central and North Inland
Regions, Districts 1, 2, 5
Union of Pan Asian Communities

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Background Information

The Prevention and Early Intervention (PEI) Elder Multicultural Access and Support Services (EMASS) program provides multicultural outreach, education, advocacy, peer support, and transportation services to older Latinos/Hispanics, Filipinos, African refugees (Somali), and African American adults. This program is implemented by the Union of Pan Asian Communities (UPAC), in partnership with the National Alliance on Mental Illness (NAMI) of San Diego County, and the Somali Family Services of San Diego. Utilizing the "Promotoras Model," an identified best practice model to outreach underserved and un-served communities, EMASS offers educational/support sessions about medications management, grief, and mental health.

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

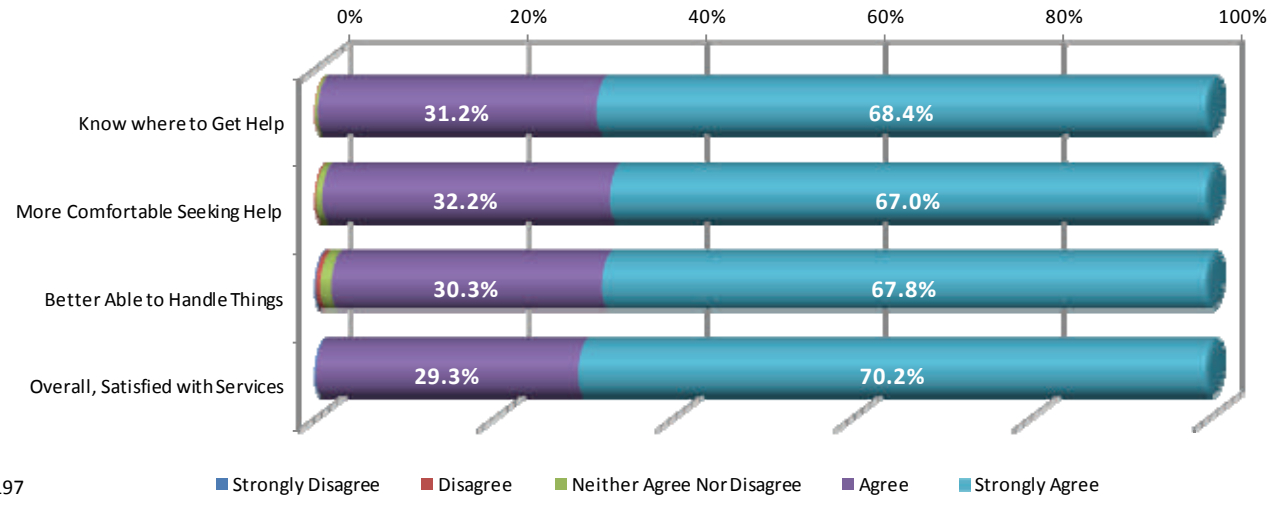
In January and February 2011, Health Services Research Center conducted focus groups to explore the extent to which EMASS program services impact participants' knowledge, mental and physical health, and quality of life. Individuals from each of the major ethnic groups served by EMASS were invited to share their experiences and opinions. The four focus groups were conducted in three San Diego regions, including North County, Central San Diego, and South Bay. Each focus group session was one hour in length and included six to ten individuals, for a total of 33 participants. The Latino and Somali focus groups were conducted in participants' native languages, Spanish and Somali, respectively.

The common themes, expressed across groups, and some representative quotes are noted on the following pages. Reported demographics and satisfaction data are inclusive of all participants in EMASS during fiscal year 2010-11.

"We ask every person who is associated with this program if they can enlarge the program."

– Somali focus group

Program Satisfaction of All EMASS Participants in Fiscal Year 2010-11*



* n = 1,197

Participants reported that some of the EMASS activities have helped to increase their knowledge about mental health, and to aid in prevention/early intervention in mental health problems for themselves, or others.

"[EMASS] gave us so much information that I did not know about healthcare, using Medicare services, when you should use services, and how to take your medications."

– African American focus group

"We have lectures, and these lectures are very helpful to us. They help us in our mental state. There was a time the speaker talked about helping ourselves. At our age we might have dementia or Alzheimer's disease and we might not have known that we have them."

- Filipino focus group

"They teach one more or less what one can eat to help prevent dementia...I think this is very helpful. This is a learning experience that is appreciated. I am thankful I have learned this; that they have taught me about nutrition, about everything."

Latino focus group

"The other thing we benefited from in these workshops was how to notice when some person is suffering mental sickness. We were taught the symptoms."

– Somali focus group

Participants identified that EMASS helped alleviate their mental health issues, specifically depression and anxiety.

"It [EMASS] helps for my depression. When I am at home, I just remember what we did and I laugh about something that I saw or about what we did. And that is very good to think about, and to think that it is almost Friday again when I can come to enjoy myself."

– Latino focus group

"I love the exercise program. It has helped me so much because I was depressed because I lost my house. The exercise and laughing workshops make me feel so good, I feel restored and relaxed… I have had therapy with psychologists and all that, but I think this has helped me more."

– Latino focus group

"For me, before I joined the workshops of EMASS, I was stressed and up all night. But as soon as I took these lessons, I began to walk daily. To walk, walk, walk. I got a lot more healthy. And the best benefit of these workshops and seminars is health. My health totally changed from before."

– Somali Focus Group

[Participant speaking about husband] *"…They are telling us how to cope with the problem. And then how we can deal with depression, because he has depression, also. We learned how to come out of the depression, and it helps a lot to have somebody going to our house."*

– Filipino focus group

"I am very appreciative to have participated in this program because I used to suffer from extreme anxiety. And here, I have learned to relax. They have shown me how to relax. All of this has helped me tremendously, and now I feel that I am a new person."

– Latino focus group

Participants reported that, in addition to alleviation of mental health symptoms, they have experienced an improvement in their physical health symptoms and quality of life.

"*The best thing I get from EMASS, is that they encourage me to walk daily. I also suffer from diabetes. The first days I was doing 15 or 20 minutes, now I am doing one and a half or maybe two hours daily. So, my health totally changed. There were times I was feeling more dizziness, more headaches, more stress . As soon as I got this advice I started walking every afternoon or evening and I got a lot of help. I am better than before thanks to EMASS."*

– Somali focus group

"All this has helped me very much and now I feel that I am another person. Also, these exercises that we do here, mainly breathing exercises, have helped me to control my high blood pressure and now I can control it on my own. Before, the ambulance would come for me, or my friend would take me to emergency. Now, I control my symptoms myself."

– Latino focus group

"I am not a dance person, but they teach us salsa, tango, all the steps. It really helps us not only with our mental sickness but also physical stress."

– Filipino focus group

"I feel very well because all this is relaxing to me, and I'm not stuck at home thinking that I will have another attack, another stroke. I had a stroke before. I was told to not stay at home alone thinking about it, but all I could think about was 'I am going to have another one', and that was going to make things worse."

– Latino focus group

"It's definitely a program that's needed… I don't know what you're looking at as far as your assessment, but I think the impact is greater than this room represents, because people are aging, they're living, and it helps with our quality of life."

– African American focus group

Many participants expressed that social isolation and lack of social opportunities were a major problem in their lives before becoming involved with EMASS.

"Before we came to EMASS, my wife and I were sort of confined to our home. When we came to EMASS we made new acquaintances, we made friends, Filipino, as well as Latinos. We just enjoy the commonality, the companionship and not just worrying about our sickness."

– Filipino focus group

"EMASS is good especially for people who have just come from their native countries and they're new here. It's a good place to mingle with other people from other cultures and learn from each other. There is a lot to learn from different cultures, so they learn to be more appreciative of one another, to be more tolerant. They get to understand why these people behave this way, or what these people eat, and so on. They exchange information, languages, they learn languages also, so it's a good socialization venue. I hope it will be expanded to benefit more people, so there'll be more outreach."

– Filipino Focus Group

"This [computer workshop] has helped to clear my mind. And the knowledge that I can do something more than be stuck at home has helped. I like to learn because it helps my health and I don't have to be alone in my house."

– Latino focus group

"I've attended some of their gatherings for the holidays … and what was really interesting was that on those occasions they would go around and each culture shared some of the things about their culture so it was very enlightening, very informative. I'm sure that some of the other observers that were there probably never had a clue about what some of other cultures do during those holiday events, so it was really enlightening. I thought it was probably just really awesome for the people that were attending to live a lifetime and never realize what other cultures were doing."

– African American focus group

"We get something that we never had before. For example, we Somali always think, back home, they [women] never socialize with men. So they come here, they socialize. They communicate with each other; they get out of the house. They feel better now. We benefit a lot."

- Somali focus group

"Right now, activities are only once a week. Is there a possibility that it could be increased? Twice? More than once."

– Filipino focus group

Across all groups, participants expressed appreciation of the staff and satisfaction with the program.

"They assist with whatever we need. Every place we need to go, they drive us. They translate for us when we need. When we need to talk to a person, they help us. They do a lot of things."

– Somali focus group

"My last thought is that if I encounter a senior like me, I will tell them about EMASS because I would like them to experience what I am experiencing now."

– Filipino focus group

"I think this program is well worthwhile. From one to ten, I'd give it twelve because it's really helpful to a lot of people less fortunate. Some people are in dire need of things and this program is really helpful to all of those people, including me. Thank you."

– African American focus group

"I like very much the kindness of everyone. You arrive and you feel at home. You feel confidence, because they give you confidence. When you arrive, you see cheerful, friendly people. They take care of you well, and that to me is wonderful."

– Latino focus group

"We like the program very much. We hope that this program continues for a long time and that they don't take it away from us. We hope that they can show us more things to learn."

– Latino focus group

Specific concerns and suggestions for improvement were offered by some participants.

"In order to see each other, we go to 50th street. We stand beside the road, beside the street. We Somalis, elders, we discuss there. Why? Because we do not have a place to sit, to see each other, to discuss. We would like to have, if EMASS could lend it to us, a hall where we can unite, discuss, sit down… Because it is not comfortable to stand beside the road and discuss. It's not good for us. We need it! Now when we leave here, right now, a few minutes after, we will go and stand beside the street. Everyone passing by. It's not good for us!"

– Somali focus group

"More lectures on other topics. Just other topics that would be useful to others."

– Filipino focus group

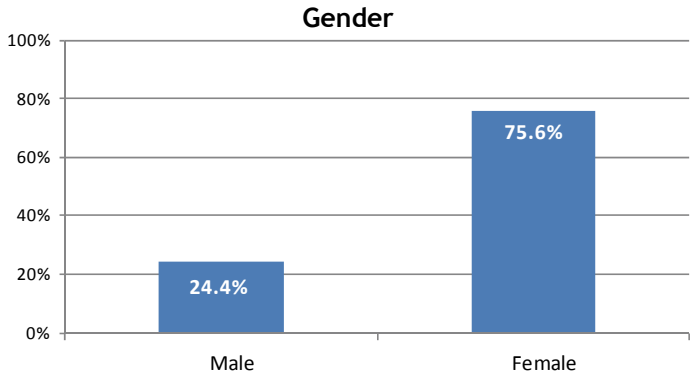
"Yoga and the laughter workshop have helped me. And I would like them to continue giving us more exercise workshops and computer classes. I would like it if the program advanced, because we have very good coordinators."

- Latino focus group

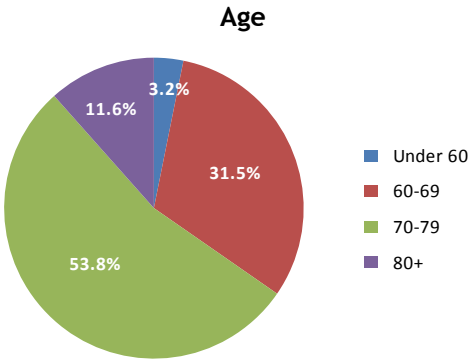
"More help with transportation would be good for those of us who do not have a car, and who sometimes have doctors' appointments. I do not know if we could have that service? I take the bus, and sometimes I get lost when I have to take another bus. It is very problematic getting to my appointments when they send me to a new doctor, and I don't know how to get there."

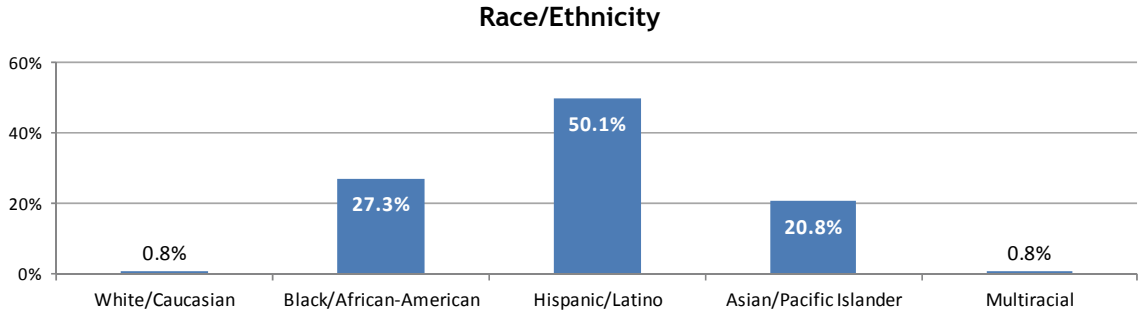
– Latino focus group

Demographics of All EMASS Participants in Fiscal Year 2010-11



1 (.2%) did not provide Gender





1 (0.2%) did not provide Race/Ethnicity

236 (93.7%) Mexican American/Chicano

Overall Messages from the Groups

- Being able to participate in enjoyable activities with others was seen as one of the greatest benefits of EMASS across groups.
- EMASS activities made participants feel less isolated and confined to their homes.
- Participants made friends from other cultures and cited EMASS as a valuable tool to learn and become more tolerant.
- EMASS activities increased participants' knowledge about mental health problems, and enabled them to help themselves and others.
- Activities that encourage participants to be more active were effective at alleviating both mental health issues and physical health symptoms, improving overall quality of life.
- None of the focus group participants expressed overall negative impressions of the EMASS program/ services.
- Overall, participants liked the staff and were satisfied with the program.

Conclusions

The information gathered through these focus groups allows for greater understanding of the impact EMASS has on the health and lives of ethnic minority, older adults in San Diego County. Focus groups were selected to measure the impact of this program in order to effectively capture the variety of participants' experience of services.

Overall, focus group participants were appreciative of the opportunity to share their experiences, and to contribute towards the progress of the EMASS program. Although these groups were not representative of all older adults in San Diego, or of all individuals involved in the EMASS program, the opinions obtained provide a valuable perspective on the needs of these underserved populations. This information will provide the foundation for future program development and advancement.

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Positive Solutions

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

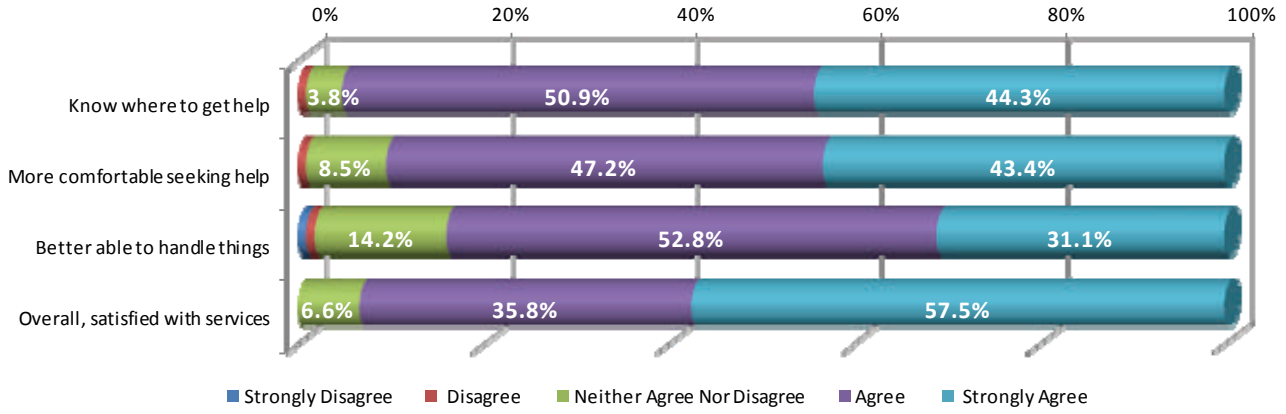
In San Diego County, in the year 2000, almost 15% of the total population was aged 60 and over. San Diego County older adults have a higher risk of committing suicide than any other age group. According to data from the Centers for Disease Control, the suicide rate among older adults in San Diego has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

The goals of the Positive Solutions (OA02) program, part of the Prevention and Early Intervention (PEI) plan, are to increase knowledge of the signs of depression and suicide risk, provide education and support to reduce stigma, and to promote linkage with services and supports. The target population includes racially, ethnically and culturally diverse older adults who are underserved in the public mental health system, and are at risk for depression, medication misuse, and substance abuse. This program provides services that address needs of at-risk homebound seniors for prevention and early intervention, and those less likely to seek traditional mental health services.

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

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

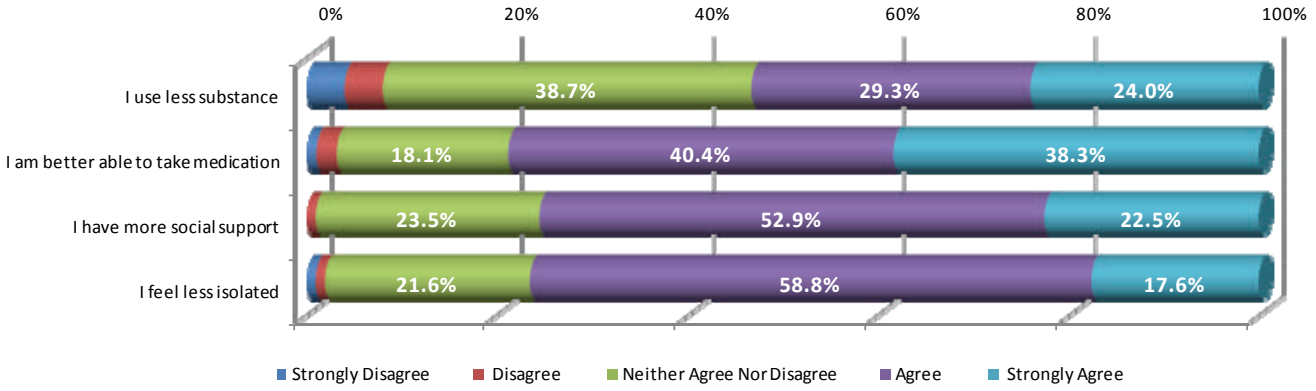
PEI Outcomes and Satisfaction



Participants were asked to assess both their improvement in several areas and their satisfaction with the Positive Solutions program. These items were only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of the participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (95.2%), "I am more comfortable seeking help" (90.6%), "I am better able to handle things" (83.9%), and "Overall, I am satisfied with the services I received here" (93.3%).

Program Specific Outcomes

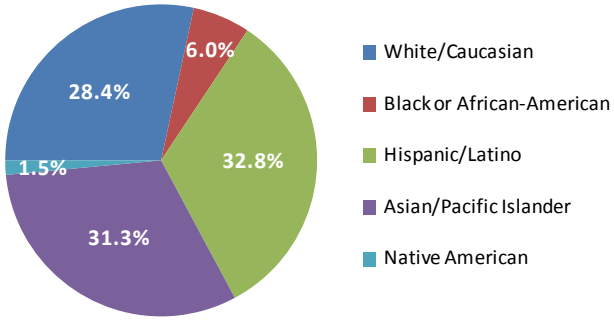
Positive Solutions participants also assessed the benefit they received from the program. These items were again only given to participants who completed the intervention, and the number of respondents varied for each item. Just over half of participants "Agreed" or "Strongly Agreed" that, "I use less substance" (53.3%). A larger majority of the participants either "Agreed" or "Strongly Agreed" that because of Positive Solutions, "I am better able to take prescription medication as prescribed" (78.7%), "I have more social support" (75.4%), and, "I feel less isolated" (76.4%).



Participant Demographics

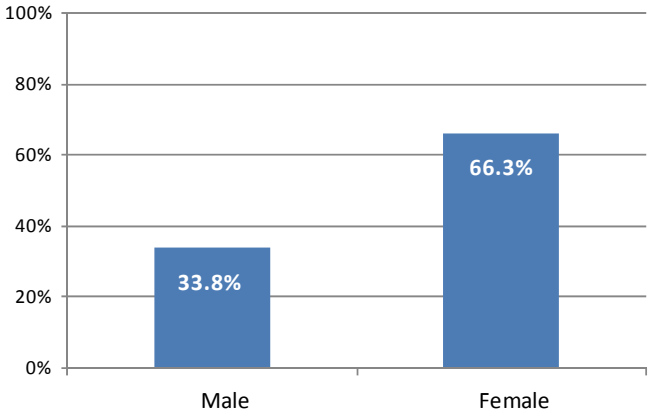
During fiscal year 2010-11, Positive Solutions provided services to 107 participants. The majority of the participants were female (66.3%), Hispanic/Latino (32.8%) or Asian/ Pacific Islander (31.3%), and between 60 and 69 years old (52.8%). A large proportion of the Hispanic participants were Mexican American/Chicano (86.7%). A small percentage of participants had served in the military (7.5%), all in the Army.

Race/Ethnicity



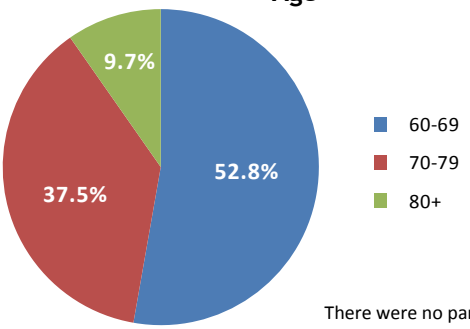
There were no multiracial or Other participants; 40 (37.4%) did not provide Race/Ethnicity

Gender



27 (25.2%) did not provide Gender

Age



There were no participants under 60; 35 (32.7%) did not provide Age

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Aging Well

OA03 – North Central Region, District 4
University of California, San Diego

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

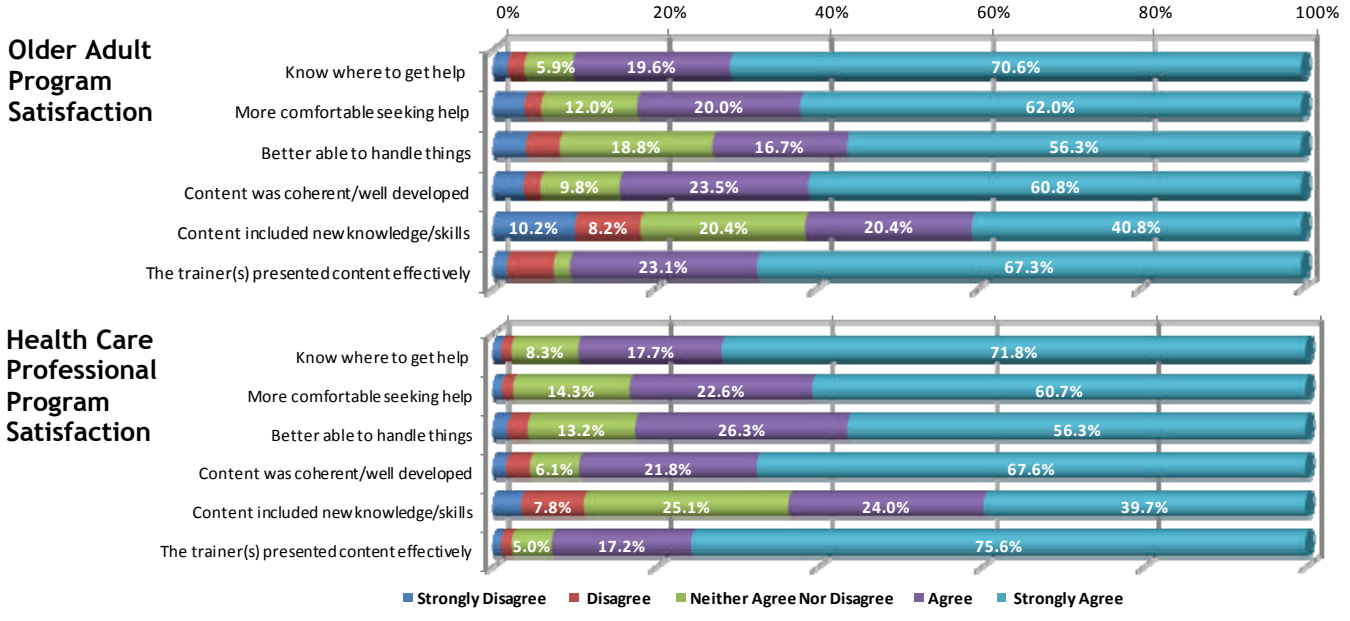
Aging Well is a San Diego County Prevention and Early Intervention (PEI) program designed to inform the community about older adult mental health. Aging Well was implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to avert the onset of mental illness or to provide early intervention to help decrease its severity.

Aging Well was developed by the University of California, San Diego Extension, and updated by the Behavioral Health Education & Training Academy (BHETA). This program aims to increase awareness, knowledge and skills addressing aging, wellness, behavioral issues, mental illness prevention, mental health promotion, stigma, depression, and suicide in older adults. Program staff conduct no-charge, culturally sensitive educational activities at senior centers, adult day health centers, senior low income housing, libraries, faith-based community organizations and educational campuses. Targeted populations include:

- Older adults who are at risk of developing mental illness and/or other conditions;
- Family members, caregivers, and other people that provide support to older adults;
- Primary care providers, allied professionals (MD, NP, PA, RN, SW), and hospital and emergency room staff; and
- Other support staff (employees of in-home support services, skilled nursing and assisted living facilities, churches, and housing complexes).

Program Satisfaction

Older adult participants and health care professionals were asked to assess the perceived benefits of the Aging Well training intervention in which they participated. These items were only given to those older adults participants and health care professionals who completed an Aging Well educational intervention, and the number of respondents varied for each item. Large majorities of both the older adults (OA) and the professionals (P) "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (OA-90.2%; P-89.5%), "I am more comfortable seeking help" (OA-82.0%; P-83.3%), "The content was coherent and well developed" (OA-84.3%; P-89.4%) and, "The trainer(s) presented the content of the training effectively" (OA-90.4%; P-92.8%). Professionals reported a higher degree than older adults of perceiving themselves as, "Better able to handle things" due to the intervention (OA-72.9%*; P-82.6%). And smaller majorities of both groups "Agreed" or "Strongly Agreed" that, "The content included knowledge and/or skills that are new to me" (OA-61.2%; P-63.7%), indicating a possible need for adjusting the training content to better serve the needs of each group.



Program Impact

All Aging Well participants were asked to rate their level of knowledge on several topics related to mental health and aging before they attended educational trainings:

- The role of depression in aging
- The interplay of substance abuse in elders
- Suicide rates in the elderly
- Your role in early identification and intervention

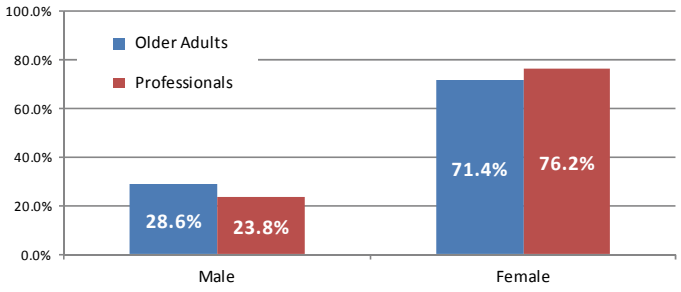
Participants were then asked to evaluate the impact of the educational training on their understanding of those same topics. Responses were on a Likert scale ranging from "No Understanding" to "Full Understanding."

All participants reported having a significantly greater understanding of each of the topics after receiving the training. These questionnaire items were only given to participants who completed the training, and the number of respondents varied for each item.

Participant Demographics

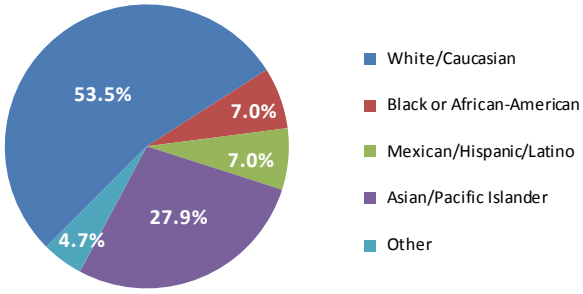
During fiscal year 2010-11, BHETA trained 200 participants in the Aging Well program. The majority of older adult participants in the program were female (71.4%) and Caucasian (53.5%). Participants who were health care professionals were also majority female (76.2%) and Caucasian (53.5%). Older adult participants over 60 comprised 82.6% of the non-professional participants. The majority of health care professionals were 25-59 years old (61.9%). A small proportion of older adult participants and health care professionals had served in the military (14.3% and 15.0%, respectively).

Gender of All Participants



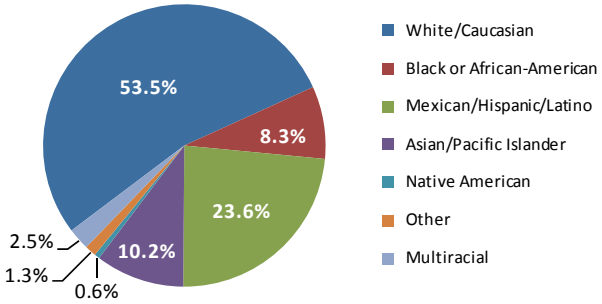
10 (19.2%) Older Adults, 36 (19.7%) Professionals did not provide Gender

Race/Ethnicity of Older Adult Participants



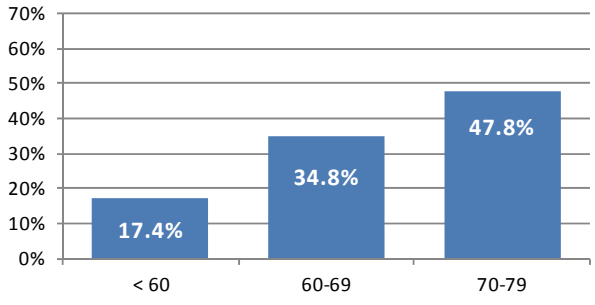
9 (17.3%) did not provide Race/Ethnicity

Race/Ethnicity of Health Care Professionals



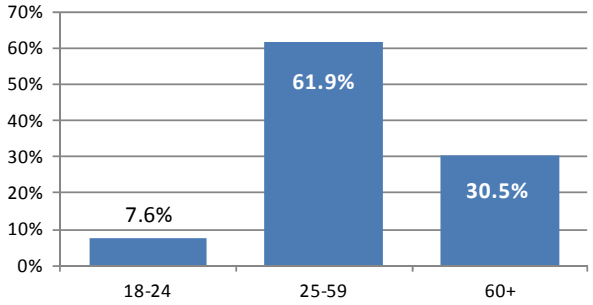
26 (14.2%) did not provide Race/Ethnicity

Age of Older Adult Participants



29 (55.8%) did not provide Age

Age of Health Care Professionals



65 (35.5%) did not provide Age

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

REACHing Out: Resources for Enhancing Alzheimer's Caregiver Health

OA04 – South Region, District 4
Southern Caregiver Resource Center

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

To combat the physical and emotional strain put on caregivers of AD patients, the National Institutes of Health granted funding to several universities to develop interventions for helping family caregivers. This initiative started in 1995, and created the Resources for Enhancing Alzheimer's Caregiver Health (REACH). This evidence-based, multi-component intervention provides resources and emotional support to caregivers of AD patients to prevent or decrease symptoms of depression due to isolation and the burden of care. Many types of existing home and community based interventions were tested across the country, and the most successful methods became the model for the REACH programs.

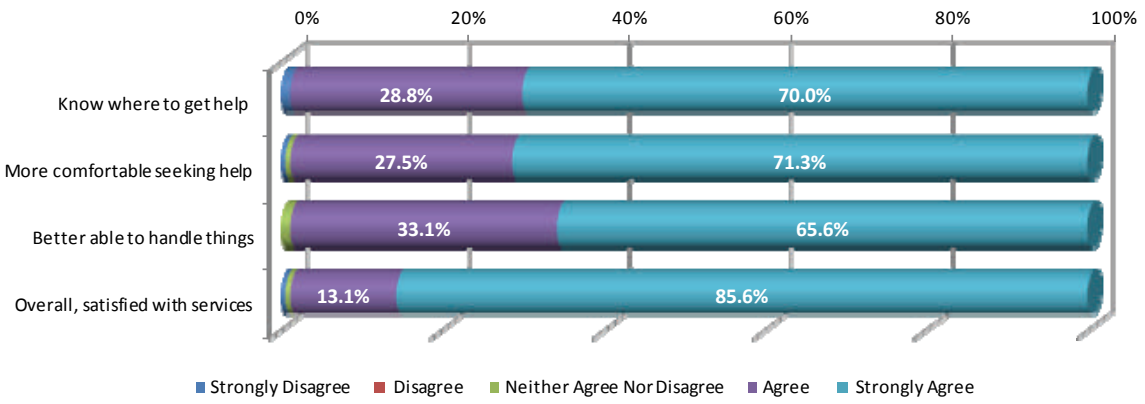
To improve the quality of life for the growing population of AD patients and caregivers, the County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services contracted with Southern Caregiver Resource Center to implement the REACHing Out program, as part of the Prevention and Early Intervention (PEI) Plan.

Research has demonstrated that the health outcomes for Hispanic caregivers are worse than other groups, due to the disproportionate share of AD care that is performed by family members, and a reluctance to utilize formal care. With the large Hispanic population in San Diego County, Southern Caregiver Resource Center tailored the program to address the specific needs of this population. The programs emphasize behavior management, communication, stress management, and relaxation techniques.

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

Program Satisfaction

Caregivers were asked to assess the perceived benefits of the REACH intervention. These items were only given to caregivers who completed the intervention; 160 caregivers responded to each of the items. Almost all of the caregivers (98.8%) "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" and, "I am more comfortable seeking help." Almost all caregivers (98.7%) also reported that, "I am better able to handle things" and, "Overall, I am satisfied with the services I received here."



Program Impact

Caregivers were asked to complete several questions regarding their own health at both an assessment and a reassessment after receiving the REACH intervention.*

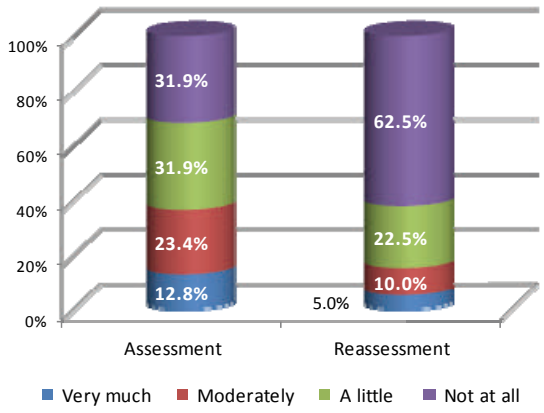
At the reassessment, 72.7% of caregivers reported that they were in "Good" or "Excellent" health, compared with only 56.2% at the initial assessment.

Caregivers were significantly less likely at the reassessment to indicate that their health was standing in the way of doing the things they wanted to do.

Mental health was also assessed using the CES-D, a validated measure of depression. At reassessment, fewer caregivers were at high-risk for depression based on CES-D score than at the initial assessment (28.2% vs. 58.7%).

* These numbers reflect only those 48 caregivers who completed both the assessment and reassessment.

Health Standing in the Way



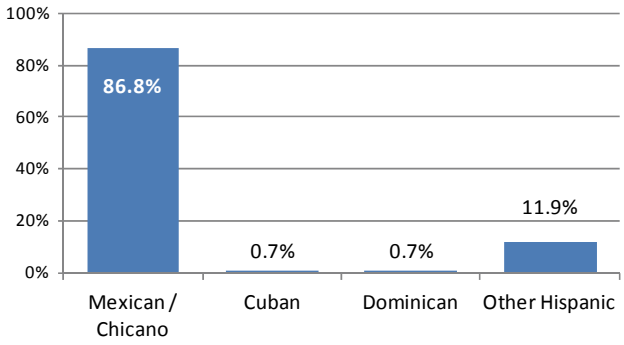
Southern Caregiver Resource Center, 2011 data

Demographics of REACH Participant Caregivers

During the fiscal year 2010-11, Southern Caregiver Resource Center enrolled 160 Hispanic caregivers into the REACHing Out program.

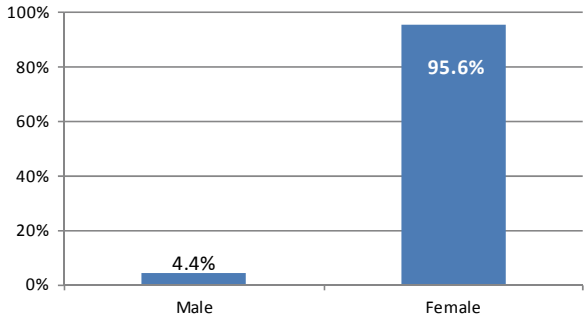
All of the caregivers were of Mexican/Hispanic/Latino origin. A majority were Mexican American/Chicano (86.8%), with several identifying as Cuban, Dominican, or Other Hispanic. There were no Puerto Rican or Salvadoran caregivers. A majority were also female (95.6%), and under 60 (68.9%). The mean age of caregivers was 54.4 years.

Caregiver Ethnicity



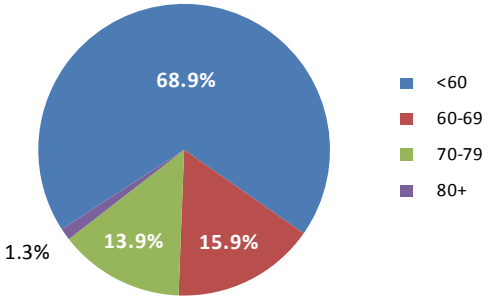
9 (5.6%) did not provide Ethnicity

Caregiver Gender



2 (1.3%) did not provide Gender

Caregiver Age



9 (5.6%) did not provide Age

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

SALUD

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

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

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

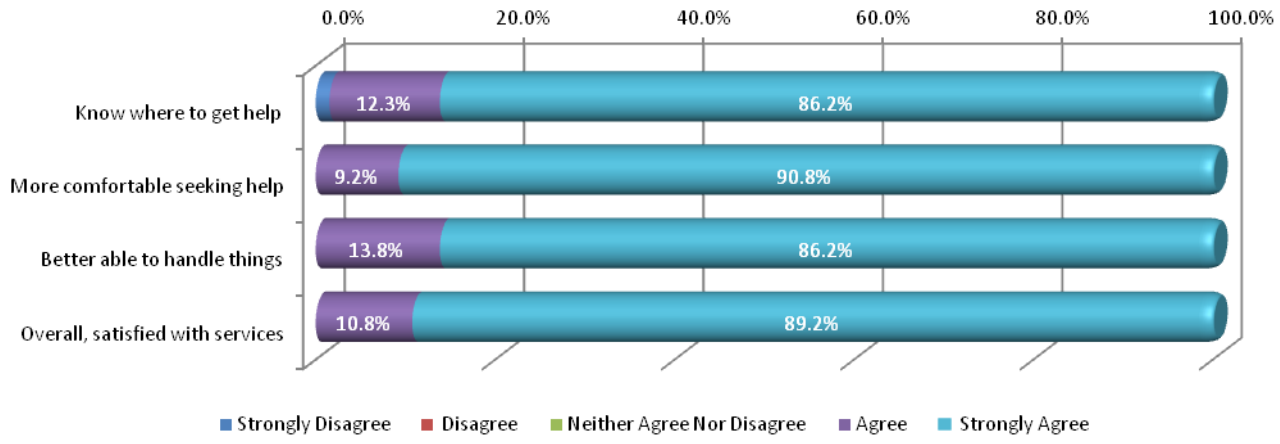
All SALUD program participants take part in the Diabetes Self-Management Program (DSMP), an evidence-based practice treatment approach designed to provide patients with the knowledge and skills needed to better manage their diabetes through six weekly group workshops. Participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.

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

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

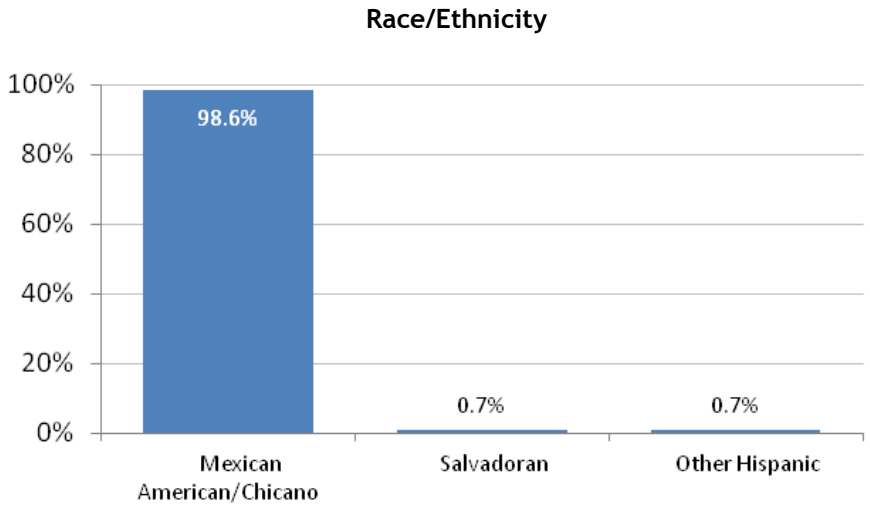
Program Satisfaction

Upon completing the SALUD program, participants are asked to assess the perceived benefits of the program. Of the 142 enrolled participants, 65 have completed the program and the assessment. A majority of these participants "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (98.5%). All of the participants who completed the assessment either "Agreed" or "Strongly Agreed" that because of the intervention, "I am more comfortable seeking help," "I am better able to handle things," and, "Overall, I am satisfied with the services I received here."

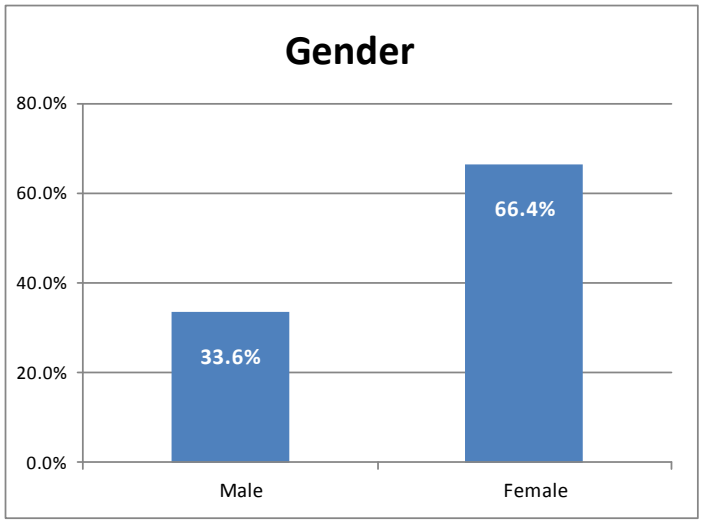


Participant Demographics

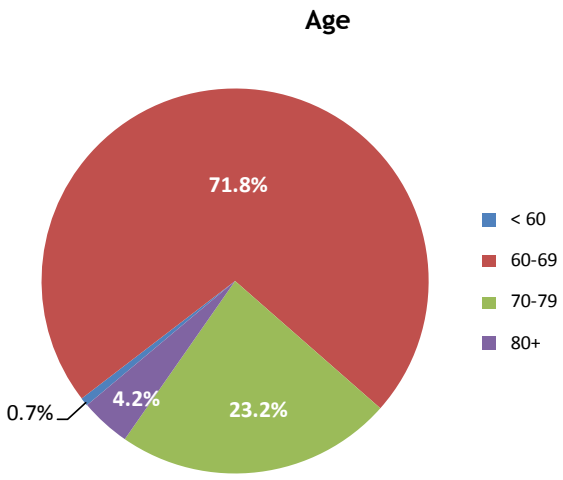
During fiscal year 2010-11, San Ysidro Health Center, North County Health Services, and the University of California, San Diego provided services to 142 participants through the SALUD program. The SALUD program is designed to target the Hispanic population in San Diego County. All of the participants identified themselves as Mexican/Hispanic/Latino, with no other Races/Ethnicities represented. Almost all of the participants were Mexican American/Chicano (98.6%), and none were Cuban, Puerto Rican, or Dominican.



The majority of the participants in the program were female (66.4%), and aged 60-69 (71.8%). The mean age of the participants was 66.8. A small proportion of the participants had served in the military (3.5%), all of them either in the Army, Air Force, or Air Force Reserve.



2 (1.4%) did not provide Gender



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PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Bridge to Recovery

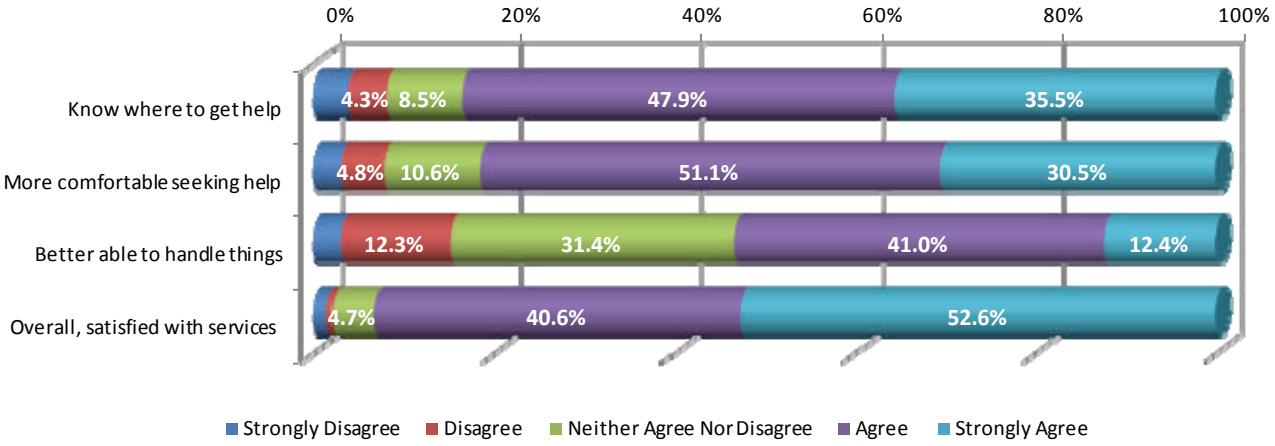
CO01 – North Central Region, District 1
University of California, San Diego

In fiscal year 2010-11, 3,683 adults (ages 25-59), 812 transition age youth (TAY) ages 18-24, and 243 older adults (ages 60+) were served in the San Diego County Psychiatric Hospital's (SDCPH) Crisis Recovery Unit (CRU), the County-run Emergency Psychiatric Unit (EPU), and the County's Crisis (Walk-in) Clinic. Of those receiving services, 66% had co-occurring disorders.

The goal of the Bridge to Recovery program, part of the Prevention and Early Intervention (PEI) plan, is to provide screening, brief intervention, education, linkages, and referrals to individuals with co-occurring disorders who access the SDCPH CRU, EPU, and Crisis Clinic. Active outreach in the form of education and screenings is made to patients and family members in the waiting rooms of the EPU and the Crisis Clinic. The program also offers follow-up short-term assertive peer case management support to link participants to needed treatment or other problem-solving resources to instill hope, reduce stigma about seeking treatment through the use of peer mentors, and reduce suicidal risk factors. Using a short-term assertive peer case management model, brief intervention is delivered to educate and engage at-risk individuals with substance abuse and/or trauma issues, who appear to have low mental health needs but would benefit from peer mentoring and/or case management. The Bridge to Recovery program also provides referral to specialty care services for those identified as needing more extensive treatment.

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

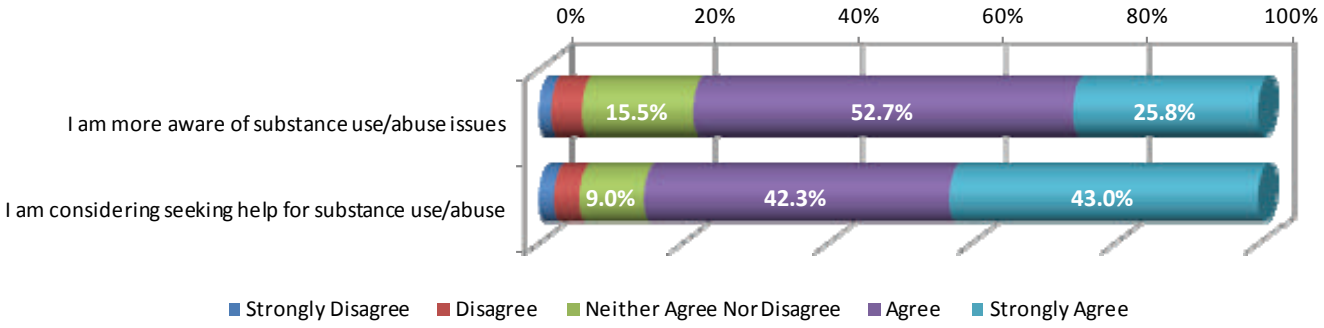
PEI Outcomes and Satisfaction



Participants were asked to assess both their improvement in several areas and their satisfaction with the Bridge to Recovery Program. These items were given to participants after completion of the first session of the intervention, and the number of respondents varied for each item. A majority of the participants either "Agreed" or "Strongly Agreed" that, because of the intervention, "I know where to get help when I need it" (83.4%) and "I am more comfortable seeking help" (81.6%). A little over half of the respondents "Agreed" or "Strongly Agreed" that, "I am better able to handle things" (53.4%). It is likely that fewer participants agreed with this question due to the timing of the survey—only a moderate response on overall improvement in coping can be expected after one contact with a participant. A large majority of participants either "Agreed" or "Strongly Agreed" that, "Overall, I am satisfied with the services I received here" (93.2%).

Program Specific Outcomes

Bridge to Recovery participants also assessed the benefit they received from the program. These items were again only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of the participants either "Agreed" or "Strongly Agreed" that, because of the program, "I am more aware of substance use/ abuse issues" (78.5%) and, "I am considering seeking help for my substance use/abuse" (85.3%).

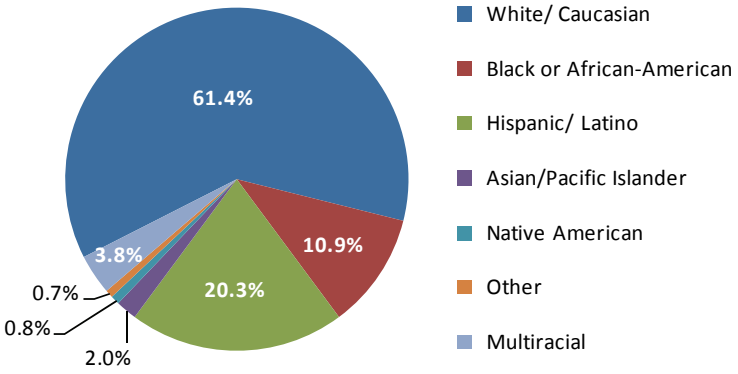


Participant Demographics

During fiscal year 2010-11, Bridge to Recovery provided services to 1,064 participants. The majority of the participants were male (66.5%), White/Caucasian (61.4%), and 25-59 years old (77.4%). Mean age was 36.8 years.

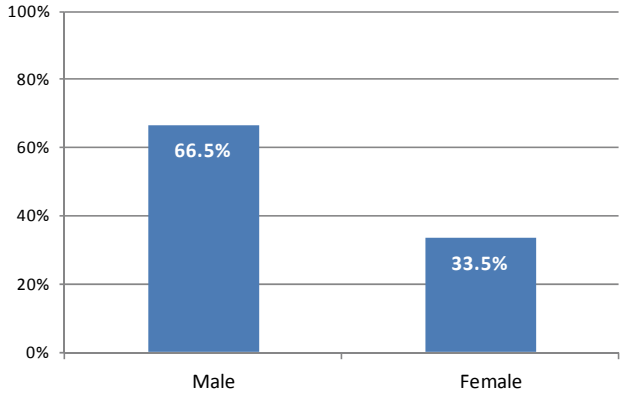
A small percentage of participants had served in the military (8.4%), with most serving in the Navy (31.0%), the Army (27.6%), or the Marine Corps (16.1%).

Race/Ethnicity



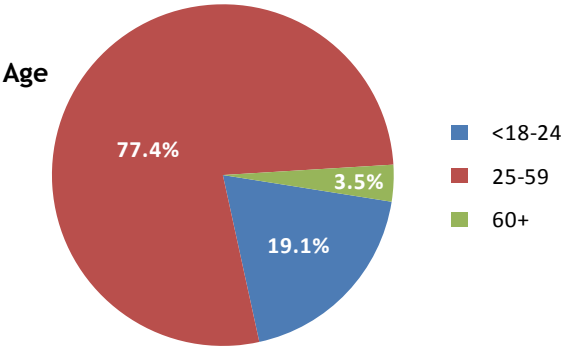
113 (10.6%) did not provide Race/Ethnicity

Gender



Gender "Other" = 1 (0.1%)

Age



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PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2010-11 REPORT

Community Based Alcohol and Drug Services Program

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

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

This Prevention and Early Intervention (PEI) project has added mental health counselors to 13 Alcohol and Drug Services (ADS) treatment programs to identify and screen for clients who exhibit mental health concerns. Interventions applied are best practices that are age appropriate, integrated, accessible, culturally competent, and strength based.

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

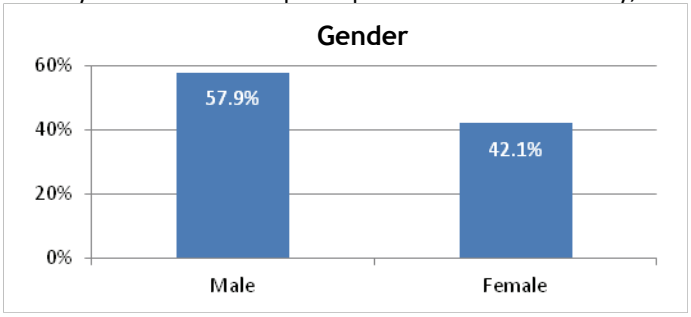
Counselors perform assessments, provide mental health education and brief counseling to reduce risk factors or stressors, facilitate linkages to additional mental health services, and assist clients in developing life skills to help them maintain longer periods of sobriety. They also provide support to ADS staff through consultation in team meetings.

Counselors also provide services that support the treatment and recovery of clients' family members, offering: prevention groups for children of parents in recovery that build protective factors and communication skills; family assessment and linkage to behavioral health and other services to decrease stress; and information and education for parents about early signs of problems with their children and ways to manage them.

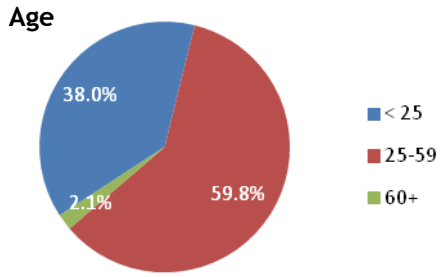
These report results are remarkable given the relatively short time PEI has been implemented, and the small number of clients with follow-up assessments. Although more work is needed to further examine the effect of programs in all domains of the testing instrument being used (CHOIS), preliminary results show that PEI ADS programs are making an important impact on client treatment and recovery.

Participants

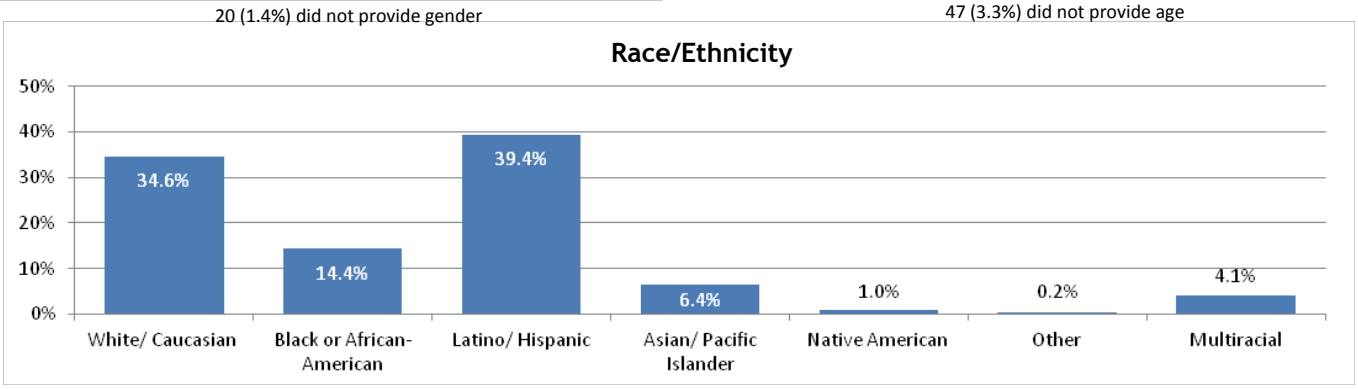
Demographics were collected for 1,404 participants. The number of responses to the demographics items is greater than the unduplicated number of participants in ADS programs because some participants may have participated in more than one program and completed the demographics more than once. Participants reflect the diverse population found in San Diego County. About 4% of the participants were in the military, with each branch of the military represented.



20 (1.4%) did not provide gender



47 (3.3%) did not provide age

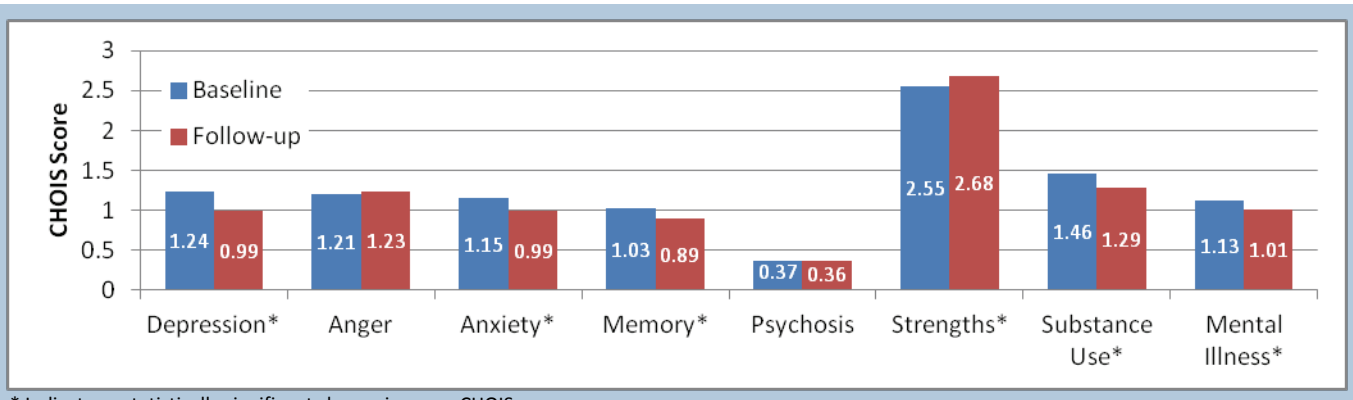


68 (7.7%) did not provide Race/Ethnicity

PROGRAM OUTCOMES

The potential range for the Depression, Anger, Anxiety, Memory, Psychosis, and Strengths subscales is 0 to 4 (Likert items ranging from "Never" to "Always"), and the potential range for the Substance Use subscale is 0 to 3 (Likert items ranging from "Never" to "Past Month"). The Overall Mental Illness subscale represents the mean of every item within the Depression, Anger, Anxiety, Memory, Psychosis, and Substance Use subscales. In each of the subscales, with the exception of Strengths, lower ratings indicate reduced mental illness. For the Strengths subscale, higher scores indicate greater resilience and protective factors.

Overall results indicated a statistically significant change from baseline to follow-up in the domains of depression, substance use, anxiety, memory problems, strengths, and overall mental illness. Specifically, clients were more resilient, and had fewer psychological problems and reduced substance use after participation in the ADS programs.

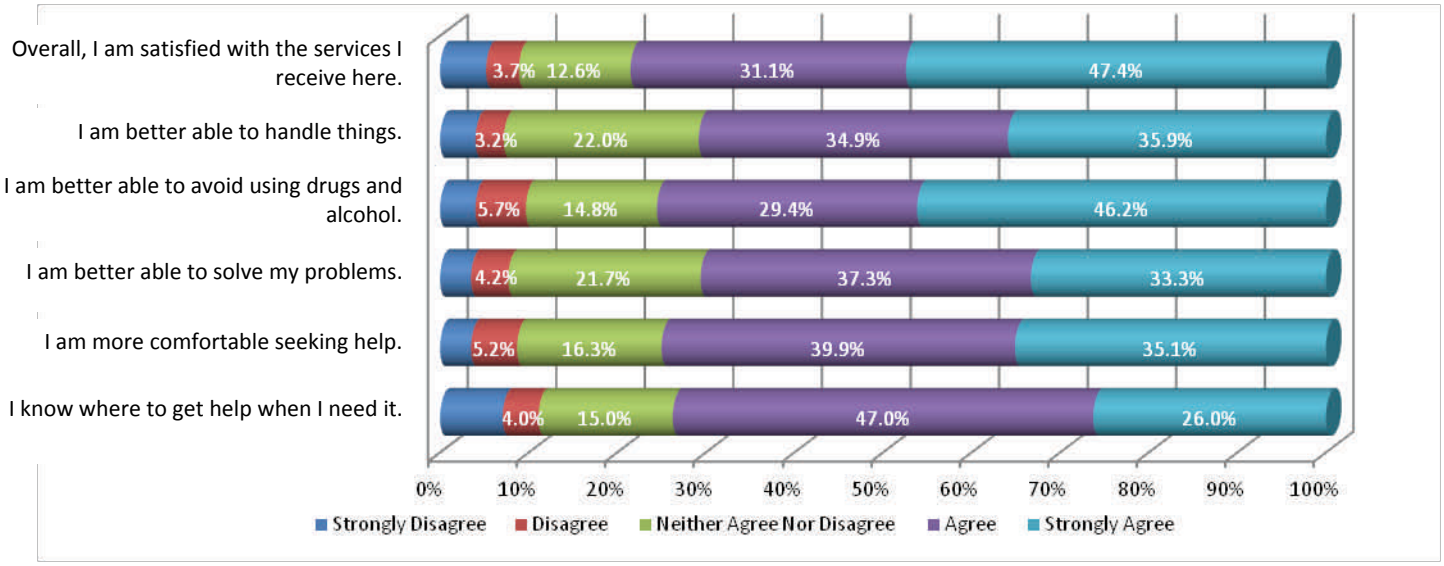


* Indicates a statistically significant change in mean CHOIS score

n at Baseline = 1,345; n with Outcome Data = 281

Upon completion of the program, clients are asked six questions regarding their satisfaction with the program. We examined how clients feel about the program overall, and how the program has helped them. These items were only given to participants who completed the intervention, and the number of respondents varied for each item.

Most participants "Strongly Agreed" or "Agreed" that as a result of the program, "I know where to get help when I need it" (73.0%), "I am more comfortable seeking help" (75.0%), "I am better able to solve my problems" (70.6%), "I am better able to avoid using drugs and alcohol" (75.6%), and "I am better able to handle things" (70.8%). Overall, 78.5% of the participants were satisfied with the additional mental health services. See the graph below for a detailed breakdown of responses.



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UNIVERSITY OF CALIFORNIA, SAN DIEGO

APPENDIX D – STAKEHOLDER INPUT

This section includes the following:

1. MHSA Annual Program & Expenditure Plan: Fiscal Year 2012-13 Stakeholder Input

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MHSA Annual Program & Expenditure Plan: Fiscal Year 2012-13
Stakeholder Input

DATE	COMMENT	RESPONSE
5/20/12	It sounds like much input and thought has been put in this report. I would like to mention a few things that I would like to see differently. A/D Counselors in Children's Mental Health- It is great that integration is being thought of. I do think that the amount that is presented might be unnecessary. I do think that this will help but I do not think the numbers will support this yet. I would recommend a test pilot to see if it works first before implementing this type of resources. MH Counselors in A/D programs- this has been proven to work. I do feel that more is needed that what is presented. Many of the programs do not have adequate Mental Health coverage to support the needs of our clients. We have very high risk clients and need much more support than what is presented in this report. Another need in the community- specifically for ADS clients is psychiatric services. The outpatient clinics that have been decentralized are inadequate for the needs of our clients. They only see the SMI clients and our clients do not always qualify. Psychiatic services are really needed at the ADS sites. The small amount that is needed would outweigh the need for hospitalization and other costly services later.	The number of AOD counselors planned is based on an estimated number of clients with co-occurring disorders; as with all programs, these services will be monitored to determine if the capacity to serve matches the need.
5/21/12	There is a vital need to expand the number of residential beds in Integrated Substance Abuse/Mental Health programs for adolescents who are co-occurring and experiencing both mental health and substance abuse disorders. There is only one long-term integrated treatment facility in San Diego County for adolescents and the County-funded beds have gone from 20 down to 16 over the past 10 years (funding never increased however expenses did). Currently, there is a waitlist of 25 adolescents waiting (6-9 months) for intensive integrated residential services and there are youth/families turned away daily. Unfortunately, the need to serve these youth and families has increased dramatically over the past 2 years and the County must consider enhancing the integrated services available so that agencies can serve more youth.	Noted; will be considered in future planning efforts
5/30/12	This is to support increased funding for services for people with co-occurring substance abuse and other mental disorders (COD). The need is great. We currently run the UCSD COD Treatment and Recovery Program, the only countywide specialty treatment program for clients with COD. We usually have 20-30 people show up for our orientation group weekly seeking services and only have a a capacity for approximately 130 unduplicated patients. We witness the suffering in our clients' lives and how challenging it has been for them to obtain integrated services. Many have told us that for the first time they feel understood in our program. We run the Bridge to Recovery Program, an innovative program which identifies individuals with substance abuse in addition to other mental disorders and helps to educate, motivate and provide case management as we link them to residential treatment and other services. We are helping to stop the revolving door in and out of the hospital. We have screened approximately 2638 patients evaluated at the San Diego County Psychiatric Hospital (SDCPH)since March, 2010 who were identified as having COD. SDCPH Hospital staff estimate that we are reaching only 24% of those who present for services and suffer from COD because of limitations in staffing. We believe that provision of additional services for those with COD would be a wise use of MHSA dollars and will help to improve the safety, health and welfare of individual clients, their families and community.	All Mental Health Services outpatient clinics have integrated treatment for co-occurring disorders, however, the outcomes as to the impact of this integration need to be evaluated. The UCSD/COD program is a dually enhanced program which we have only one (with excellent outcomes) and the Bridge program is also the only one provided at SDCPH. We will continue the review of substantive data which will be a driver for consideration of future funding opportunities.
5/29/12	Adult Council supports the Fiscal Year 2012/13 expenditure plan in general and notes that the plan addresses uyearly goals set by the Adult Countil including addressing stigma and discrimination, continue with integration of primary care, mental health and substance abuse, providing education and training development, inreach to jails and reducing disparities.	Noted
5/30/12	I want to express my desire for clarity of the process and to ensure that we are having an informed planning process. I had heard that Dawn Griffin, Ph.D. was doing a needs assessment the County's Mental Health Department and that process would be inclusive on community stakeholders perspectives. I was hoping that our funding allocations would be driven by identified needs and infused community input. I strongly believe that all allocations need to be tied to a need and should be reflective of an improved/desired outcome. I would like the plan to identify needs and indicate whether it is a system improvement and/or community improvement and what is the desired impact to be achieved. If the plan could layout this level of detail it would allow all stakeholders to fully understand how the plan is linked to needs and we would be more informed and better able to provide input to the County. Also, it would be helpful that the needs assessment provided by Dr. Griffin would be available and presented to all stakeholder groups, keeping everyone informed. Again, I am in support of the overall County plan but I believe a more informed process would be beneficial.	Funding allocations are driven by needs identified in past and current stakeholder processes, component requirements, and program indicators. Although the information requested is contained in historical public documents, consideration will be given to including that information in future MHSA Annual Reports.
6/1/12	As a Mental Health Clinician for UPAC Positive Solutions working exclusively with homebound seniors I've found an increased need for a Clubhouse-inspired program in Downtown San Diego. Many of our seniors are homebound because of lack of access to age-appropriate activities, safety and transportation issues.	Noted; will be considered in future planning efforts

DATE	COMMENT	RESPONSE
6/4/12	Overall, we are supportive of the diverse programs and the number of clients who potentially will benefit from these enhancements. The Council asks you to consider the following recommendations as the Expenditure Plan is finalized (programs not commented on that pertain to older adults we support): • Expansion of FSP: To the extent possible, 20% of the additional clients should be older adults. • Client-Operated Peer-Support Services: We were unsure why this is included and to which specific program it is directed. We learned that there was difficulty "filling all seats" at the most recent countywide consumer educational event. Perhaps, these funds (plus more) could be used better to educate smaller groups of clients with a special emphasis on helping Medi-Cal beneficiaries understand how to access health services, especially in the light of the SPD population being mandatorily enrolled in managed care, and upcoming Dual Eligible Demonstration Project. • Clubhouse Enhancement: This item should be competitive and funds added as necessary to assure job development in each region. In addition, there's a high concentration of low-income older adults (including many Asian-Americans) in the Downtown San Diego and we believe that a clubhouse specifically for older adults would prove successful and in line with the purpose of MHSA. • Housing has been consistently identified by clients as the number one issue (reiterated most recently in the RICA survey) and, as such, we strongly support enhancing supportive housing wherever and whenever possible.	Noted. Noted. Noted. Noted. Noted. Noted.
6/4/12	• Family Engagement in Psychiatric Hospitals: While this is a fine program, expansion should include intervention on psychiatric units in acute care hospitals where low-income clients are overwhelmingly represented. • Co-Occurring Disorder- Screening by community-based AOD Providers: Behavioral Health Integration $492,000. We couldn't find this item in the budget, rather an item for $1.14 million. We note that alcoholism is a serious and growing problem among older adults. This population should be included in this initiative.	Noted. The correct amount is $1.14 M
6/19/12	• Most were positive about the enhancements/expansions of programs. Encouraged that there are no funding cuts. • Transportation (pass passes) are needed for consumers with the central and east regions. • Consumers need assistance obtaining California ID cards and birth certificates. • Clubhouse needs van with wheelchair access. • More affordable housing is needed, there is a lack of options. • Access to a gym is desirable. • More support with recovery from drug and alcohol issues is needed. • There are not enough openings in shelters. It is difficult to maintain sobriety without shelter. • More groups and therapy is needed to recover from trauma.	• Noted. • Expansion of the capacity for treatment of co-occurring and expansion of permanent supportive housing capacity will be considered for future enhancements. • Staff will review current program Statements of Work to determine if modifications are needed to provide assistance in obtaining identification documents; transportation, and addressing trauma.