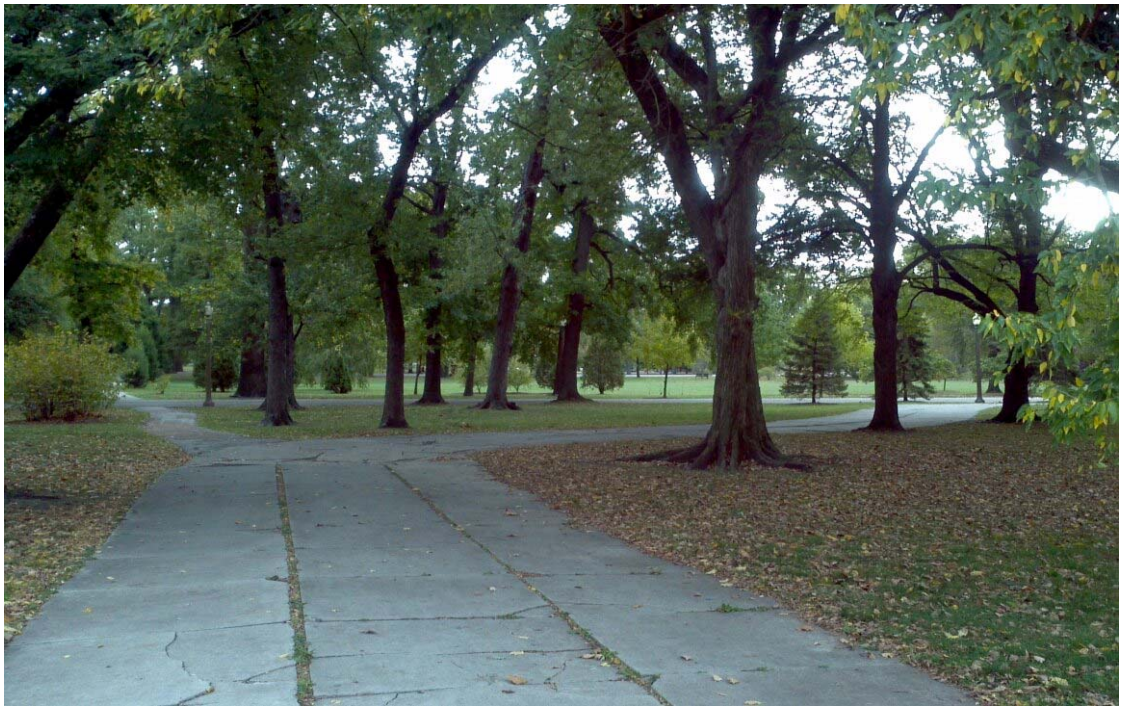
COUNTY OF SAN DIEGO MHSA ANNUAL PROGRAM & EXPENDITURE PLAN: FISCAL YEAR 2013-14



1/7/2014

MHSA: Transforming Behavioral Health

This report provides an update on the County of San Diego Health and Human Services Agency's programs funded by the Mental Health Services Act (MHSA) and an expenditure plan for Fiscal Year 2013-14 and program updates for Fiscal Year 2011-12.

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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MHSA Annual Program & Expenditure Plan: FY 2013-14

MHSA: TRANSFORMING BEHAVIORAL HEALTH

A LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR

Live Well San Diego is an innovative 10-year initiative that embodies the Health and Human Services Agency's effort to achieve the County vision for healthy, safe and thriving communities. The initiative aims to advance the overall wellbeing of the entire community.

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, young adults, adults and older adults. Since the launch of *Live Well San Diego,* Mental Health Services Act (MHSA) funds have been leveraged within the behavioral health system to advance the integration of coordinated and seamless care for patients with substance abuse, mental health and physical needs through a paired provider model - which is the first of its kind in the nation. Programs have addressed community needs by providing enhanced wraparound services, referrals to behavioral health consultants and nurse care coordinators, and psychiatric consultation services at Federally Qualified Health Clinics. The Behavioral Health Division has joined the National Council's Trauma Informed Care Learning Community, and has rolled out trauma informed services in Southeast Mental Health Clinic with the goal to expand to other sites.

Behavioral Health Division staff is evaluating the impact of the Affordable Care Act on the public system and continues to serve clients utilizing a holistic approach. The behavioral health system is transforming through integrating mental health services and alcohol and drug treatment services with a vision toward integrating physical and behavioral health. MHSA funds are building capacity through the Physical Health Integration Institute – a meeting of the behavioral and physical health minds.

In an effort to further the quality of services and meet the needs of clients, families and communities, staff evaluated each program to determine the adequacy of funding and the achievement of results. This review provided the Behavioral Health Division with the necessary information to make program refinements and funding adjustments where indicated.

The Behavioral Health Division will continue to advance the goals of *Live Well San Diego* through advancement of a comprehensive trauma informed system, providing all clients and family members with information necessary to make healthy lifestyle choices; reducing stigma so that those with mental illness or challenges with substance abuse have the same opportunities as others in employment, housing, and education; and creating a more informed public about the importance of resiliency in children, how to increase that resiliency, and about recovery principles.

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

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INTRODUCTION

In July 2010, the County of San Diego Board of Supervisors voted to adopt a comprehensive 10-year wellness initiative, called *Live Well San Diego*. Supporting the County's mission and 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. The initiative has become the blueprint for improving the quality of life for county residents through community involvement and the implementation of three core strategies: 1) Building Better Health; 2) Living Safely; and 3) Thriving. These three core strategies have distinct yet interwoven and 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; and
- Improving the Culture From Within County Government.

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

San Diego County has implemented the MHSA through the four major pillars of *Live Well San Diego* which are consistent with the tenets of MHSA.

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;
- Incorporation of statewide efforts of suicide prevention and stigma reduction into the *It's Up to Us* campaign;
- Improved coordination of services for high-risk populations; and
- Leveraging resources and collaborating with partners for the development of permanent supportive housing.

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.

- 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;
- *It's Up to Us* Stigma and Discrimination Reduction and Suicide Prevention Media Campaign continues to provide wellness tips through community bulletins and social media posts;

- Implementation of In-Home Outreach Team (IHOT) program provides intensive outreach and engagement services to individuals with serious mental illness who are reluctant to receive treatment and to their families or caretakers;
- Wraparound services for foster children helps transition youth from a residential group home placement to a family setting and provides youth mentoring; and
- The Father to Child program educates and supports fathers with being a positive influence and engaged in the lives of their children.

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

- Collaboration with community partners during a Regional Stigma Reduction Roundtable for San Diego and Imperial Counties to explore ways to engage community members and professionals to end the stigma around getting help for mental health challenges;
- Active participation in statewide efforts to reduce the stigma around mental health; and
- Assist in developing a best practice for suicide prevention through the use of media.

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 participate in:

- Community events such as walks for mental health, suicide prevention and recovery;
- Health Risk Assessments and Mix It Up, which challenges employees to eat more vegetables and fruits; and
- Various exercise opportunities, such as Zumba, yoga, and walking clubs.

LIVE WELL SAN DIEGO

Building Better Health

Living Safely

Thriving

COMMUNITY STAKEHOLDER PROCESS

The County of San Diego compiled information through a Community Program Planning process, which included input from stakeholder-led councils (Children, Youth and Families, Adult, and Older Adult Systems of Care Councils, and the Housing Council) the Mental Health Board and the Alcohol and Drug Advisory Board, in the development of the Fiscal Year (FY) 2013-14 Annual Program and Expenditure Plan. Membership within the stakeholder-led councils include 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.

Behavioral Health Services Quality Improvement staff, with input from stakeholders, developed an evaluation framework for all programs including those funded with MHSA dollars. Through this process, funding modifications were identified. The analysis to determine the programmatic funding included a review of stated program outcomes, priority needs and gaps in the community, a review of program services and activities. As a result, several MHSA programs were adjusted either monetarily or with modification to the program service or activity. These discussions took place during the County's annual operational planning process with the stakeholder councils.

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. Community input from these councils was collected during the FY 2013-14 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.

The Mental Health Board provided input for the FY 2013-14 funding enhancements for Community Services and Supports as well as Prevention and Early Intervention. The Board held a public hearing after the conclusion of the 30-day public review and comment period. 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 moving toward a completely integrated division with alcohol and drug services woven throughout mental health services and mental health services interwoven throughout the alcohol and drug services. These changes are taking place to better serve clients, families and communities. 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.

Annual update information and input requests were mailed to other stakeholder distribution lists, including the Mental Health Coalition, Mental Health Contractors Association and the Hospital Partners Association.

The draft annual report was posted on the County's Behavioral Health Services website and with the Clerk of the Board of Supervisors from October 4 through November 1, 2013. 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.

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WHAT IS MHSA?

The Mental Health Services Act (MHSA) addresses a broad continuum of prevention, early intervention and service needs, and the funding for necessary infrastructure, technology and training elements that will effectively support the public mental health 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)**

   The majority of MHSA programs and strategies are implemented through the CSS component; and approximately 78% of the total MHSA funding is allocated to these services. These programs insure that individualized services are provided to children and adults who have a severe emotional/mental illness. Programs provide adults and seniors with medically necessary mental health services, medications, and supportive services set forth in their treatment plan.

   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 CSS expenditure plan for FY 2013-14 is $93.824 million. For additional information about the CSS component, see the Fiscal Year 2013-14 Expenditure Plan section of this report.

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

   Prevention and early intervention programs are designed to prevent mental illness from becoming severe and disabling. Seventeen percent of the total MHSA funding is allocated to the PEI component. Programs utilize strategies to reduce negative outcomes that may result from untreated mental illness, such as: suicides, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue.

   The FY 2013-14 expenditure plan for PEI and PEI Training, Technical Assistance and Capacity Building is $29.504 million. For additional information about the PEI component, see the Fiscal Year 2013-14 Expenditure Plan section of this report.

3. **Innovation**

   Innovative programs are short-term programs that are novel, creative and/or ingenious mental health approaches that are expected to contribute to learning. Five percent of the total MHSA funding is allocated to the Innovation component.

   The expenditure plan for Innovation programming for FY 2013-14 is $9.230 million. For additional information about the Innovation component, see the Fiscal Year 2013-14 Expenditure Plan section.

4. **Workforce Education and Training (WET)**

   The intent of the Workforce Education and Training component is to remedy the shortage of qualified individuals within the public mental health workforce which provide services to address severe mental

illnesses. WET strategies include recruitment of high school students for mental health occupations, development of curriculum to train and retain staff, promotion of the meaningful employment of consumers and their families in the mental health system, stipend programs and promote the inclusion of cultural competency in training and educational programs.

The FY 2013-14 expenditure plan for WET is $3.247 million. For additional information about the WET component, see the Fiscal Year 2013-14 Expenditure Plan section.

5. Capital Facilities and Technological Needs

MHSA Capital Facilities projects support the 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.

The goals of MHSA funded Technological Needs 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 2013-14 is $10.662 million. For additional information about the Capital Facilities and Technological Needs component, see the Fiscal Year 2013-14 Expenditure Plan section.

FISCAL YEAR 2013-14 EXPENDITURE PLAN & FY 2011-12 PROGRAM UPDATE

The MHSA expenditure for Fiscal Year 2013-14 is $146.467 million. This includes expenditure plans for each of the MHSA components listed below. See Appendix A for detail of MHSA Expenditure Plan for FY 2013-14.

- Community Services and Supports (CSS) = $93.824 million
- Prevention and Early Intervention (PEI) = $29.504 million
- Innovation (INN) = $9.230 million
- Workforce Education and Training (WET) = $3.247 million
- Capital Facilities and Technological Needs (CFTN) = $10.662 million

Budgets adjustments were recommended for some programs as a result of staff's evaluation of each program within set parameters to determine whether programs have been adequately funded and if the program is achieving the results that were originally anticipated. The resultant modifications have been made in Fiscal Year 2013-14 and are detailed in Appendix A.

Community Services and Supports

FY 2013-14 Expenditure Plan = $93.824 million

Community Services and Supports (CSS) enhance the systems of care for delivery of mental health services to seriously emotionally and behaviorally challenged children and their families and the system of care for adults and older adults with severe mental illness results in the highest benefit to the client, family, and community. Full Service Partnerships (FSP) programs provide a full array of services to clients and families by using 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. Other programs funded through CSS provide outreach and engagement activities. In Fiscal Year 2011-12 a total of 32,201 clients were served countywide.

Programs for Children, Youth and Families

Programs for children and youth provide wraparound services consisting of an array of FSP 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.

FY 2011-12 HIGHLIGHTS

- The Family Youth Liaison program initiated "I Will Not Be a Bystander" campaign where people are asked to advocate and speak against bullying of all forms. Participants were encouraged to report incidents of bullying, or to pledge to put an end to all forms of bullying, thus promoting safe and healthy relationship awareness.

- Therapeutic Behavioral Services (TBS) collaborated with the Families Forward program to put on a Back-to-School Clothing & School Supply Drive. Donations of new and gently used articles of clothing, shoes, backpacks and school supplies were provided for in-need families. Parents "shopped" for complimentary items to insure back to school needs were met. Families receiving TBS services expressed appreciation for the support during the otherwise stressful time of the year.
- Approximately 562 children and their families were served through Full Service Partnerships in FY 2011-12. During the same reporting year, the annualized cost per client of $14,600 was calculated for those participating in the original three FSPs.

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 employment and education; dual diagnosis services; peer support services; and diversion and reentry services.

FY 2011-12 HIGHLIGHTS

- Center Star Assertive Community Treatment (ACT), a FSP program, is designed to serve a caseload of 111 individuals ages 25 to 59 who are diagnosed with a severe and persistent mental illness and involvement with the criminal justice system. The program follows the Housing First strategy that places clients in apartments maintained by the program, as well as in housing in the community. In Fiscal Year 2011-12 Center Star ACT provided services to 151 unduplicated clients. In addition, Center Star served 25 adults who have been chronically homeless and have a severe mental illness, as a part the Vulnerability Index Project.
- Catalyst provided FSP ACT services to over 223 unduplicated transition age youth (ages 18 through 24) clients. Catalyst FSP ACT services are recovery-oriented and strengths-based and include: mental health services, psychiatric services, nursing services, case management, benefits advocacy and management, supportive housing services and rental subsidy assistance, employment and education assistance, peer mentorship and counseling, and co-occurring disorders treatment.
- Oasis Clubhouse provided services to over 390 unduplicated members for Fiscal Year 2011-12. Staff conducted outreach and presented information to generate collaborations and partnerships to several community agencies such as San Diego Disability Help Center, Martin Luther King Recreational Center, Goodwill, Job Corps, and Qualcomm.
- Approximately 849 individuals ages 18 through 60+ were served in FY 2011-12 through Full Service Partnerships utilizing the Assertive Community Treatment model at an average of $13,700 per client.

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 with individualized/family-driven services and

supports. Clients are provided with necessary linkages to appropriate agencies for medication management and services for co-occurring substance abuse disorders. Some of the services are provided for specific populations and communities, including victims of trauma and torture, Chaldean and Middle Eastern communities, and individuals who are deaf or hard of hearing.

FY 2011-12 HIGHLIGHTS

- In January 2012, the Family Youth Partner (FYP) program responded to a community crisis following the shooting of a man. The shooting was witnessed by members of the victim's family, including a child and an adult. The program went to the family's home, provided a critical incident briefing following the Trauma Informed Care model, and provided follow-up and referral. The FYP supported the family with telephone follow-up and linking with psychological services.
- Chaldean Middle Eastern Social Services focus on members of the Middle Eastern community who have not traditionally accessed mental health services due to cultural or language barriers. The goal of the program is to decrease stigma around mental health issues through the provision of culturally competent services that increase wellbeing and symptom management. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals for Middle Eastern population and the manifestations of mental disorders in this population. The program collaborates with 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. In Fiscal Year 2011-12, Chaldean Middle Eastern Social Services provided assertive outreach and engagement, mental health counseling, intake and screening, and case management to 196 unduplicated clients. There were also 32 acculturation/welcome groups.

Housing

The County's goal is to have at least 85% of MHSA Full Service Partnership clients living in housing. As of June 1, 2012, over 90% of FSP clients were housed with 71% of clients living in permanent housing, an increase over the previous year in which 67% of clients were living in permanent housing. A detailed report of the Housing Projects funded through CSS may be found at http://goo.gl/3F2tiD.

FY 2011-12 HIGHLIGHTS

- Twelve (12) housing developments with 194 MHSA units were in the development pipeline, representing 80% of the Housing Plan's development goal.
- A total of 53 MHSA units have completed construction and occupancy as of June 2012. The 34th Street Apartments have been fully leased since April 2011; units located at 15th & Commercial celebrated its grand opening in December 2011; and Cedar Gateway opened its doors in March 2012.
- Three new MHSA projects (Citronica One, Citronica Two, and Parkview) were added to the pipeline.
- Four projects totaling 48 MHSA units began construction: Tavarua Senior Apartments, The Mason, Citronica One, and Connections Housing.

- Three new projects totaling 48 units received CalHFA and State approval: Comm 22, Citronica Two, and 9th & Broadway.

Prevention and Early Intervention

FY 2013-14 Expenditure Plan = $29.504 million

Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To ensure access to appropriate support at the earliest point of emerging 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. Through PEI, mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness. In Fiscal Year 2011-12, a total of 52,632 unduplicated clients were served countywide.

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 reduces risk factors or stressors, builds protective factors and skills and increases support throughout the community. Some highlights from FY 2011-12 are listed below.

FY 2011-12 HIGHLIGHTS

- In March 2012, an 18-month study of the *It's Up to Us* stigma reduction and suicide prevention media campaign was conducted. Results of the study were compared with the results of the 6-month study. Findings from the 18-month study indicate that 88% (up from 83%) of San Diego residents were aware of at least one message or ad pertaining to the campaign. Hispanic residents were the most aware of the campaign and had the greatest increase in awareness from one year ago (93%, up from 85%). There was an increase in awareness among those aged 45 and older (88%, up from 81%) as well as males (85%, up from 78%).
- Deaf Community Services opened a new program that offers activities for deaf adults. Their clubhouse is open to those deaf and hard of hearing adults who may be at risk of a mental health issue and want to improve their social and vocational skills.
- The "Step Into My Shoes" interactive booth launched in March 2012 as an experiential marketing tool for the Housing Matters anti-stigma campaign. The interactive booth reinforces accurate information about supportive housing, homelessness and mental illness. The booth is another successful component of the Housing Matters campaign, which has increased awareness of supportive hosing by 11% Countywide in just more than a year. The booth is designed and structured to depict a home, reinforcing the supportive housing concepts that recovery begins with the security and stability that comes from having a home, and that supportive housing give people hope.

Early Intervention

Early intervention programs target individuals or a subgroup whose risk of developing mental illness is significantly higher than average, or who are experiencing early symptoms. These programs typically offer relatively short term, 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.

FY 2011-12 HIGHLIGHTS

- Bridge to Recovery (Bridge) has become an important program at the San Diego County Psychiatric Hospital as well as in the community. Screening, Brief Intervention, and Referral to Treatment (SBIRT) services were provided to 2,133 clients. Bridge held 176 groups focused on psychoeducation and skill development with total attendance of 697 individuals.
- SmartCare has expanded its psychiatric consultation for adults in the Federally Qualified Health Center system to now include consultation from providers serving children who are covered by Medi-Cal. Expanded services for children also include educational groups for families referred by pediatricians.
- The Courage to Call program partially funds the Veteran's Treatment Review Calendar (VTRC) to divert veterans from incarceration. While on VTRC probation, the 41 participants had a 7.3% recidivism rate with three participants suffering new cases, all misdemeanors. The ten graduates of VTRC have had a 0.0% recidivism rate.
- 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-Americans and Filipinos by Promotoras, a Latin American approach that uses community peer workers, and community health workers. In Fiscal Year 2011-12, 837 older adults were screened, found eligible and agreed to receive services, which is 105% of their goal. 100% of participants were satisfied with their services.
- SALUD provides integrated care for mental health and medical conditions to Hispanic older adults. Early intervention includes integrated diabetes/depression care management by a registered nurse, and intervention is delivered in primary care settings. In Fiscal Year 2011-12, the SALUD program reach 490 unduplicated clients through outreach and prevention services and educated 79 adults with diabetes self-management skills, with a 100% participant satisfaction rate.
- Kickstart provides outreach, education and intervention services for individuals at risk for developing or experiencing a psychotic break. The goal of this program is to provide services in the early stages of illness to individuals experiencing mental illness and to reduce the potential negative outcomes associated with these mental health challenges. The target population is youth and transitional age youth in the Central Region. In Fiscal Year 2011-12, PIER gatekeeper trainings were provided to over 350 participants in the community. These trainings provide education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis.

Prevention & Early Intervention (PEI) Training, Technical Assistance & Capacity Building

The primary goal of the PEI Training Technical Assistance and Capacity Building funding is to improve the capacity of local PEI partners outside of the mental health system. All knowledge gained from these projects has been shared statewide.

FY 2011-12 HIGHLIGHTS

- **Supporting Students with Behavioral Health Challenges:** Attended by Community College staff from the Southern California region, this conference deepened the dialogue between community colleges, county agencies and behavioral health providers to support the growing number of students with behavioral health needs. Participants experienced engaging speakers, plenary discussion panels and innovative opportunities to build a team approach and create seamless referral mechanisms for community college students experiencing behavioral health challenges. The conference was organized around networking opportunities to infuse diverse perspectives.
- **Impact of Trauma and Violence:** The County of San Diego, in partnership with Riverside, San Bernardino and other Southern California counties identified the need to increase awareness of the impact of violence and trauma in our communities. The County of San Diego Behavioral Health Services hosted a one and half day conference offering participants the opportunity to engage in peer sharing of successes and challenges within the southern region and throughout California. Together participants examined the benefit of responding to issues of gangs, bullying in schools and domestic violence with a trauma-informed approach. The *Impact of Trauma and Violence: Building Solutions Toolkit* was developed as a result of this conference and can be found at http://goo.gl/abo2Xh.
- **Behavioral Health 101 for First Responders: A Trauma Informed Approach** was developed to give San Diego County First Responders new resources and means to respond with a trauma informed approach. The curriculum was developed to raise awareness and understanding of the signs and symptoms of those experiencing behavioral health challenges. The curriculum was modified specifically for military personnel. The curricula, facilitator's notes, manual and participant handouts are accessible at http://goo.gl/BXdP0v. Trainings were provided on base for military first responders. The training was presented 20 times to approximately 310 first responders from as far south as Southwestern Community College and as far north as Palomar Community College between March and June 2012. Written evaluations were completed by over 250 participants, and were overwhelmingly positive. A majority of participants requested further training.
- **Physical Health Integration** prepares and supports San Diego County's behavioral health and primary care providers to become effective and passionate change agents in an evolving integrated health care system. Information, toolkits, learning communities and topics of interest can be found at http://www.sandiegointegration.org/.

Innovation

FY 2013-14 Expenditure Plan = $9.230 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. See Appendix A for budgets by program.

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

- **Wellness and Self-Regulation for Children and Youth** will be ending in October 2013. Since the program's outcome appear to be very positive, portions of the program will be implemented throughout the Children's Behavioral Health System of Care. A comprehensive report is being developed and will be available to stakeholders once finalized.

- **Hope Connections** provides peer and family engagement to those accessing the County's emergency psychiatric unit (EPU), the psychiatric hospital (SDCPH) and the County operated outpatient specialty mental health clinics. Hope Connections has been doing many more warm "hand offs" wherein a Community Specialist assigned to an individual post-discharge meets with outpatient mental health clinic staff while the client is still in the Inpatient Unit, thereby increasing success in follow-up care and successful connection to outpatient clinics. In FY 2011-12, Hope Connections assisted 758 clients at the EPU, 666 clients SDCPH, and 268 at the outpatient mental health clinics. These services resulted in 84% success rate of number of clients linked from EPU to mental health services and 94% success rate in number of clients linked from SDCPH to mental health services. Additionally, 100% of all clients served were screened for primary care referrals.

- **Integrated Care Resources (ICare)** creates person-centered medical homes for individuals with serious mental illness in a primary care setting. ICare has undergone its first data evaluation with preliminary findings showing that participants who have been in the program for six months have reduced emergency department visits and increased medication adherence. Slated to end this fiscal year, staff believes there is much more to learn from this project and may continue the project to insure that the learning goals have been met.

- **Mobility Management in North San Diego County** provides several innovative strategies to increase access to transportation for adult and older adult mental health clients. It has undergone changes due to the difficulty in finding peers that are willing to drive others to their appointments. The program has been modified to remove the Ride Share component.

- **Positive Parenting for Men in Recovery** ended on June 30, 2013. It was a program that offered an integrated approach to education that incorporates parenting skills, mental health wellness, substance abuse education, and violence/trauma prevention for 300 fathers who are in alcohol and substance abuse treatment. A comprehensive report is being developed and will be available to stakeholders once finalized.

- **In-Home Outreach Teams (IHOT)** is a voluntary program that provides outreach, engagement, screening, crisis management, case management, educational and supportive services to family members and individuals who are resistant to receiving mental health treatment. IHOT will expand from the original three regions to provide these services county wide, which will provide staff with more data about the community need, utilization patterns and trends in access to mental health and substance abuse services, length of treatment in these services, and associated costs and

savings. Data regarding individuals who are served by IHOT but would potentially be eligible for Laura's Law will also be analyzed.

- Information about After School Inclusion, Transition Age and Foster Youth, and Independent Living Facilities will be available after the program outcomes have been analyzed and evaluated.

Workforce Education and Training

FY 2013-14 Expenditure Plan = $3.247 million

Funding provided through the MHSA Workforce Education and Training (WET) component is one-time, rather than ongoing, funding. The majority of WET programs were planned using a five-year funding period. These funds provide training and financial incentives to increase the public behavioral workforce, as well as to improve the competency and diversity of the workforce to better meet the needs of the populations receiving services.

FY 2011-12 HIGHLIGHTS

- The Community Academy is a WET program out of Alliant International University. Alliant recognizes that while preparing a consumer-led workforce is vital, preparing the workforce to accept these individuals into their organizations is equally as important. Through the Academy, Alliant organized a training to build up the behavioral health workforce. The training targeted directors, managers and contract administrators interested in developing and expanding consumer-led behavioral health services in San Diego County. The day included: a nationally recognized speaker in workforce, John Morris of the Annapolis Coalition; a panel presentation by Recovery Innovations of California, National Alliance on Mental Illness, and the Family and Youth Roundtable; and peer presentations.

- The Public Mental Health Academy (PMHA) at San Diego City College hosted its 1st Annual Professional Development Conference entitled "Current Considerations in Entry-Level Mental Health Work: What's Hot? What's Not?" The conference was targeted to PMHA students and individuals from the community who currently work in or are interested in entry level mental health work. The keynote address was delivered by Alfredo Aguirre who gave a description of his own professional journey and presented the public mental health opportunities available in San Diego County. There was a panel discussing "Trends in the Field", and a workshop describing how to find initial work, prepare for interviews, and develop resumes. A final workshop discussed the important topic of prevention of compassion fatigue in this field of work.

Capital Facilities and Technological Needs

FY 2013-14 Budget = $10.662 million

Capital Facilities and Technological Needs (CFTN) funding is one-time funding. A total of $4.814 million was allocated to Capital Facilities projects and $5.848 million was allocated to Technological Needs projects. Total one-time funding for this component is to be expended by June 30, 2018.

Capital Facilities

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 County's staff will focus on the following three capital facilities projects.

1. Juvenile Hall Mental Health Services Office Building
2. North Coastal Health Facility
3. Potential future Central Region Health Facility

Implementing a capital project involves a significant amount of due diligence, research, studies, and potentially special licensing. As a result, the first two projects – Juvenile Hall Office Building and the North Coastal Facility – will be the primary focus for this year. The Juvenile Hall facility was completed this calendar year.

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 as has been done with the implementation of Anasazi. The Technological Needs projects include:

CONSUMER/FAMILY EMPOWERMENT

San Diego County is one of three cities in the nation selected to test an innovated Virtual Senior Center web-based application. The Virtual Senior Center would serve an older adult population that is at risk of social isolation and resultant mental health issues and could potentially pave the way for a regularly funded program through private organizations. The cohort of participants will be those that are served through the home delivered meals program. Technological Needs funding ($40,000) will be utilized for installation of the touch-screen devices in the homes of 45-50 homebound older adults selected for participation. The funding will to cover the costs of high-speed internet charges for the Virtual Senior Center participants, project management and support.

A Request for Proposal (RFP) has been issued for services related to the implementation of the consumer/family empowerment projects. The RFP is currently in the evaluation phase of the procurement process. It is anticipated that services will begin on January 1, 2014.

As of April 2013, the following technology accomplishments have been made:

1. Seventeen sites serving adults of all ages now are capable of providing telepsychiatry services, with a plan for another six sites to offer telepsychiatry;
2. Nineteen site serving children, youth and families are in the pipeline for having telepsychiatry services;
3. Doctor's Homepage, the ability of doctors to electronically order prescriptions, has been launched;

4. Signature pads have been purchased and installed which simplifies the processes for the client as well as the clinician;
5. Automated appointment reminders are now being utilized;
6. Common Ground, software that prepares a client for their appointment with their healthcare provider, will soon be available to clients; and
7. Thirteen clubhouses are now better able to track service usage through operational support software.

The following projects totaling $2.731 million remain on hold.

- Personal Health Record;
- SpeED Link; and
- Data Exchange Pilot.

The planning for the utilization of this CFTN funding will take place next fiscal year.

APPENDIX A – MHSA BUDGET SUMMARY

Included in this section are the following summaries:

1. MHSA Expenditure Plan: Fiscal Year 2013-14
2. FY 2013-14 MHSA Funding Summary

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MHSA Expenditure Plan: Fiscal Year 2013-14

PROGRAM	Annual Program Expenditure	FY 2013-14 Budget Adjustment	Total Expenditure Plan	Description of Budget Adjustment
Community Services and Supports (CSS)				
Full Service Partnerships for Children and Youth	7,934,220	(100,000)	7,834,220	Funds redirected to reduce clinic wait times in the North Inland Region; anticipate 40 additional clients.
Outreach and Engagement for Children and Youth	3,447,749	(97,134)	3,350,615	Reduced and funds redirected to other work plans.
System Development for Children and Youth	8,851,813	(30,866)	8,820,947	Funds redirected for additional medication management to approximately 80 clients who no longer require a high level of therapy; for additional short-term crisis stabilization services
Full Service Partnership for Ages 18-65+	29,275,406	316,800	29,592,206	Funds redirected to include 7 additional housing slots and administration and management of housing units; and to decrease caseload size for Strength Based Case Management programs.
System Development for Ages 18-65+	24,753,706	2,661,765	27,415,471	Enhancement to increase support for homeless population through flex funds, more access to employment consultant services, to increase availability of transitional housing days to facilitate more movement through services in support of recovery principles, and enhacement to North Inland Crisis Residential.
Outreach and Engagement for All Ages	2,487,704	0	2,487,704	
System Development for All Ages	2,160,556	(75,000)	2,085,556	Reduced and funds redirected to other work plans.
CSS Admin Cost	11,836,673	401,335	12,238,008	15% of program budgets
CSS Total	**90,747,827**	**3,076,900**	**93,824,727**	
Prevention and Early Intervention (PEI)				
Education and Support Lines (PS-01)	5,837,293	250,000	6,087,293	Annually train 2,500 youth, children and families in Mental Health 1st Aid.
Families as Partners (DV-01)	500,008	0	500,008	
South Region Trauma Exposed Services (DV-02)	801,907	(100,000)	701,907	Reduced and funds redirected to other work plans.
Alliance for Community Empowerment (DV-03)	618,085	0	618,085	
Positive Parenting Program (EC-01)	1,300,000	150,000	1,450,000	To sustain the Positive Parenting Program.
Kick Start (FB-01)	1,775,000	0	1,775,000	
Dream Weaver Native American Consortium (NA-01)	1,795,000	0	1,795,000	
Elder Multicultural Access & Support Services (OA-01)	542,153	27,000	569,153	To expand the area available to clients.
Positive Solutions (OA-02)	583,805	0	583,805	
Reaching Out (OA-04)	540,380	0	540,380	
Salud (OA-05)	702,595	0	702,595	
SmartCare (RC-01)	1,550,000	(150,000)	1,400,000	Reduced and funds redirected to other work plans.
School-Based Program (SA-01)	3,100,000	0	3,100,000	
Suicide Prevention Education Awareness and Knowledge (SA-02)	750,000	0	750,000	
Courage to Call (VF-01)	1,011,499	0	1,011,499	
Bridge to Recovery (CO-01)	1,685,000	0	1,685,000	
Co-Occurring Disorders (CO-02)	2,153,166	0	2,153,166	
Statewide Training Technical Assistance and Capacity Building (TTACB)	267,682	0	267,682	
PEI Admin Cost	3,786,884	26,550	3,813,434	15% of program budgets. TTACB does not have admin cost.
PEI Total	**29,300,457**	**203,550**	**29,504,007**	
Innovation (INN)				
Wellness and Self Regulation for Children and Youth (INN-01)	437,500	0	437,500	
Peer and Family Engagement (INN-02)	1,602,714	0	1,602,714	
Physical Health Integration (INN-03)	908,000	0	908,000	
Mobility Management in North County San Diego (INN-04)	350,000	(70,000)	280,000	Reduced.
After School Inclusion (INN-06)	1,150,000	0	1,150,000	
Transition Age and Foster Youth Program (INN-07)	1,812,706	0	1,812,706	
Independent Living Facilities (INN-08)	428,593	0	428,593	
Health Literacy (INN-09)	0	0	0	on hold
In-Home Outreach Teams (INN-10)	1,143,341	263,512	1,406,853	Enhancement for extensive analysis and evaluation.
INN Admin Cost	1,174,928	29,027	1,203,955	15% of program budgets
INN Total	**9,007,782**	**222,539**	**9,230,321**	

PROGRAM	Annual Program Expenditure	FY 2013-14 Budget Adjustment	Total Expenditure Plan	Description of Budget Adjustment
Workforce Education and Training (WET) - One Time Funds				
Workforce Staffing Support (WET-01)	295,958	18,750	314,708	To sustain WET Consultant
Training and Technical Assistance (WET-02)	866,332	140,325	1,006,657	To expand training
Mental Health Career Pathway Programs (WET-03)	674,787	45,000	719,787	For conference
Residency and Internship Program (WET-04)	866,959		866,959	
Financial Incentive Program (WET-05)	338,416		338,416	
WET Total	**3,042,452**	**204,075**	**3,246,527**	
Capital Facilities and Technological Needs (CFTN) - One Time Funds				
Technological Needs (TN):				
Management Information System	24,781		24,781	
Consumer/Family Empowerment	1,447,966		1,447,966	
Personal Health Record	775,000		775,000	
Telemedicine Expansion	1,240,360		1,240,360	
MIS Enhancement/Expansion (Document Management, Doctors' Homepage and Signature Pads)	759,682		759,682	
SpeED Link	600,000		600,000	
Data Exchange Pilot	1,000,000		1,000,000	
TN Subtotal	5,847,789	0	5,847,789	
Capital Facilities (CF):				
Juvenile Hall, North Coastal	3,423,236		3,423,236	
CFTN Admin Cost	1,390,654	0	1,390,654	15% of project budgets
CFTN Total	**10,661,678**	**0**	**10,661,678**	
TOTAL MHSA EXPENDITURE PLAN: FY 2013-14			**146,467,260**	
Annual Program Expenditure - Ongoing Funds	112,257,581			
Annual Program Expenditure - One Time Funds	12,313,477			
Administration	18,189,139			
Subtotal	**142,760,196**			
FY 2013-14 Program Enhancement	3,250,152			
Administration	456,912			
Total Expenditure Plan	**146,467,260**			**Final 11/07/2013**

FY 2013/14
MHSA FUNDING SUMMARY

County: San Diego **Date:** 11/7/2013

	MHSA Funding						
	CSS	**WET**	**CFTN**	**PEI**	**TTACB**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2013/14 Funding							
1. Estimated Unspent Funds from Prior Fiscal Yea	$31,897,820	$8,348,820	$28,911,264	$18,933,155	$333,526	$16,986,250	
2. Estimated New FY 2013/14 Funding	$65,773,299			$17,107,937		$4,362,170	
3. Transfer in FY 2013/14[a/]							
4. Access Local Prudent Reserve in FY 2013/14							
5. Estimated Available Funding for FY 2013/14	$97,671,119	$8,348,820	$28,911,264	$36,041,092	$333,526	$21,348,420	
B. Estimated FY 2013/14 Expenditures	$93,824,727	$3,246,527	$10,661,678	$29,236,325	$267,682	$9,230,321	
C. Estimated FY 2013/14 Contingency Funding	$3,846,392	$5,102,293	$18,249,586	$6,804,767	$65,844	$12,118,099	

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

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	$42,193,120
2. Contributions to the Local Prudent Reserve in FY 2013/14	$0
3. Distributions from Local Prudent Reserve in FY 2013/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$42,193,120

Additional funding sources for FSP requirement:
County must provide the majority of MHSA funding toward Full Service Partnerships (FSPs). If not, the county must list what additional funding sources and amount to be used for FSPs. In addition, the funding amounts must match the Annual Cost Report. Refer to DMH FAQs at http://www.dmh.ca.gov/Prop_63/ MHSA/Community_Services_and_Supports/docs/FSP_FAQs_04-17-09.pdf

Note: The Fiscal Year 2011-12 MHSA Revenue and Expenditure Report is the basis for the Revenue Sources other than CSS in the calculation to determine the majority of funds for the FSP

CSS Majority of Funding to FSPs

		Other Funding Sources									
	CSS	**State General Fund**	**Other State Funds**	**Medi-Cal FFP**	**Medicare**	**Other Federal Funds**	**Re-alignment**	**County Funds**	**Other Funds**	**Total**	**Total %**
Total Mental	$34,935,212	$0	$0	$5,589,634	$0	$0	$0	$0	$1,746,761	$42,271,607	52%

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APPENDIX B – SYSTEM OUTCOME REPORTS

Included in this section are the following reports:

1. Full Service Partnerships – Children
2. Full Service Partnerships – Adult
3. Prevention and Early Intervention – Children
4. Prevention and Early Intervention – Adult
5. Prevention and Early Intervention – County

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Full Service Partnerships
OUTCOMES REPORT

Children, Youth & Families FSP Summary

FY 2011-12

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

What is This?

Full Service Partnership (FSP) programs are comprehensive behavioral health programs which provide all necessary services and supports, including intensive services, to clients with a high level of need to enable them to live in their community. Services may include in-home and community-based intensive case management to provide support and assistance in obtaining such things 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?

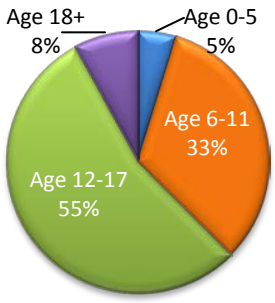
FSP programs support individuals and families, using a "whatever it takes" approach to establish stability and maintain engagement. The programs build on client strengths and assist in the development of abilities and skills so clients can become and remain successful. They help clients reach identified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

Who Are We Serving?

In FY 2011-12, 1768 unduplicated clients received services through 11 FSP programs, an 11% increase from the number of FSP clients in FY 2010-11 (N=1591).

FSP Client Demographics & Diagnoses (N=1768)

AGE



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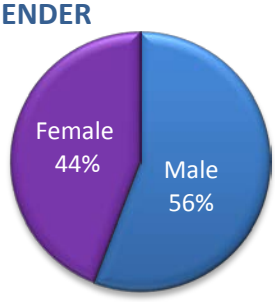
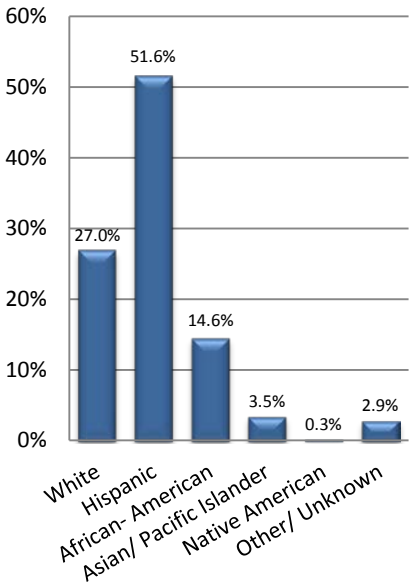
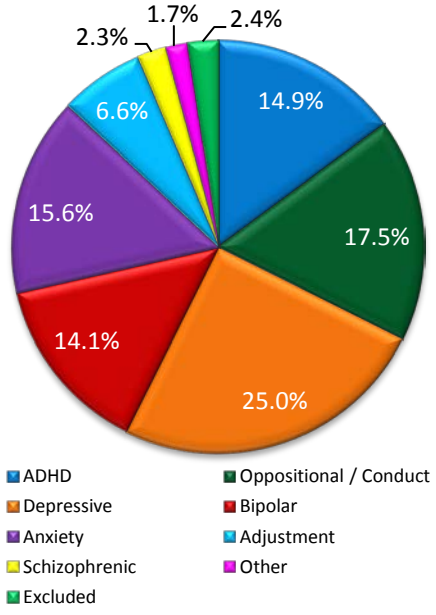


RACE/ETHNICITY



PRIMARY DIAGNOSIS



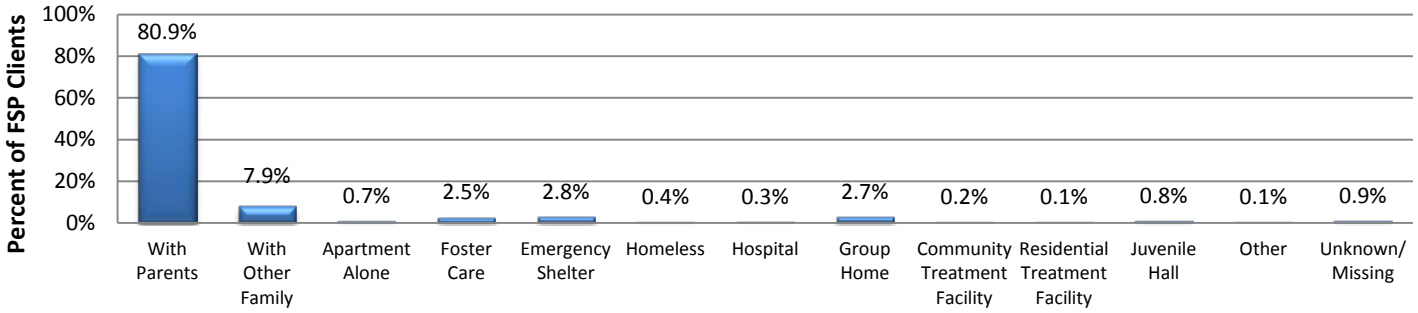
CASRC child and adolescent services research center

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 FSP programs in FY 2011-12. Referral sources were also entered; FSP referrals in order of frequency were as follows: a family member (28%), mental health facility (24%), the school system (15%), social service agency (8%), Juvenile Hall (7%), self-referral (5%), primary care physician (4%), acute psychiatric facility (4%), homeless shelter (2%), a friend (1%), or another County agency (1%).

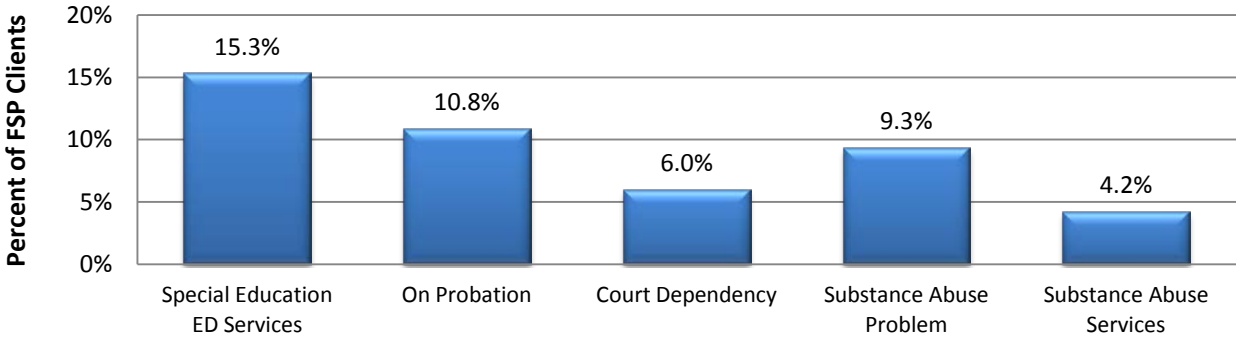
Residential Status at Intake (N=1053)

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



Risk Factors at Intake (N=1053)

The most prevalent risk factor for more intensive service use among youth entering FSP programs was Special Education services status. Clients may have had more than one risk factor.



Forensic Services

In FY 2011-12, 6 continuing FSP clients had an arrest recorded in the DCR. Two FSP continuing clients were noted to have been on probation. By comparison, 9 continuing FSP clients had an arrest recorded in the DCR and one was noted to have been on probation in FY 2010-11.

Inpatient and Emergency Services

Of the 1768 unduplicated clients who received services from an FSP program in FY 2011-12, 41 (2.3%) had at least one inpatient (IP) episode and 42 (2.4%) had at least one emergency service unit (ESU) visit during the treatment episode, as compared to 13 (2.5%) and 19 (3.6%), respectively, of 1591 unduplicated clients in FY 2010-11.

Are Children Getting Better?

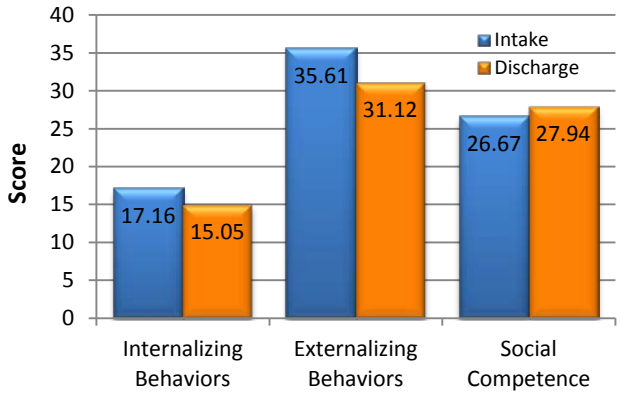
FSP Providers collected outcomes data with the Child and Adolescent Measurement System (CAMS) and the Children's Functional Assessment Rating Scale (CFARS). Scores for youth discharged from FSP services in FY 2011-12 who had both Intake and Discharge scores for all measure domains were analyzed.

CAMS Scores

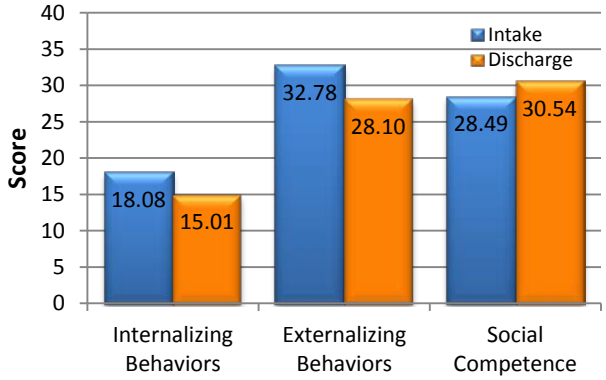
The CAMS measures a child's competency, behavior and emotional problems; it is administered to all caregivers, and to youth ages 11 and older. A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered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

These CAMS results (N=279 Parent CAMS and N=144 Youth CAMS) **revealed improvement in youth behavior and emotional problems following receipt of FSP services**, with youth reporting greater improvement than caregivers.

FSP Caregiver CAMS (N=279)

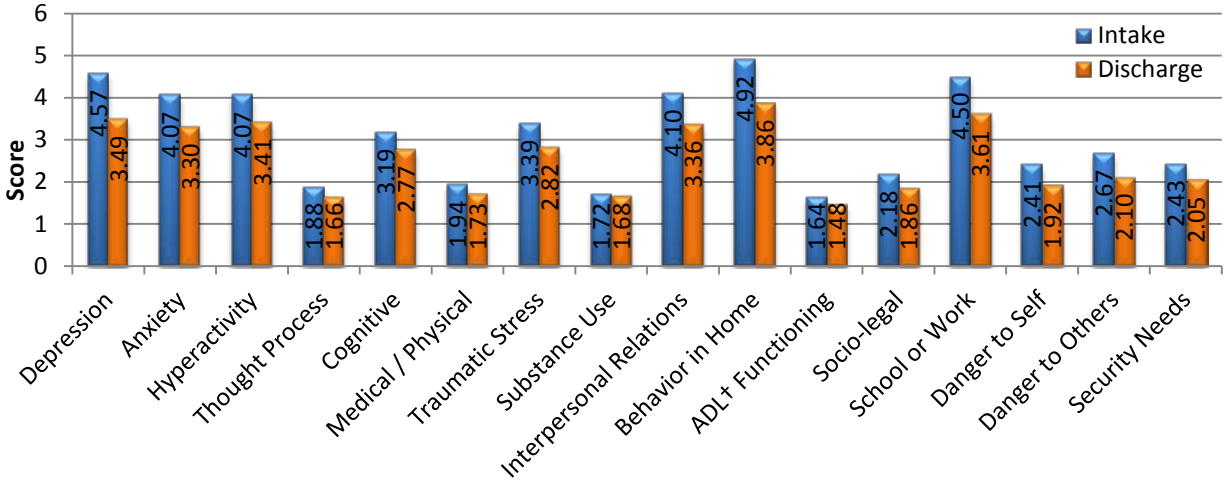


FSP Youth CAMS (N=144)



CFARS Scores (N=781)

The CFARS measures symptoms and behavior and is completed by the client's clinician. A *decrease* on any CFARS domain is considered an improvement. CFARS data were available on 781 FSP clients and **revealed improvement in youth symptoms and behavior** following receipt of mental health services.



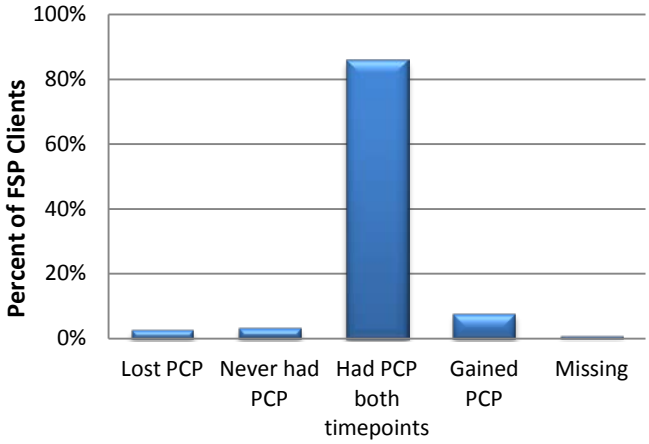
†Activities of Daily Living

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.

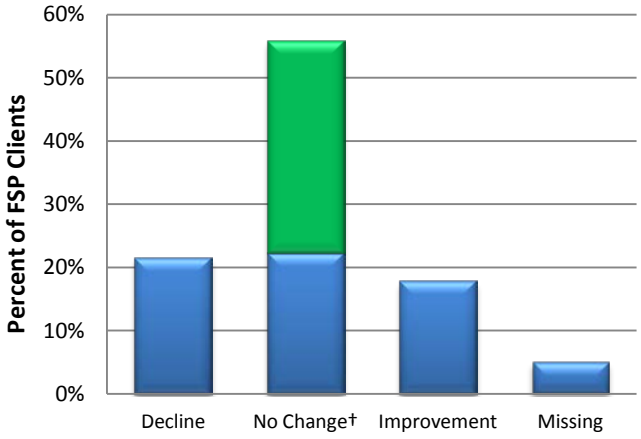
Primary Care Physician (PCP) Status (N=1144)

86% of FSP clients had and maintained a Primary Care Physician.



School Attendance (N=1144)

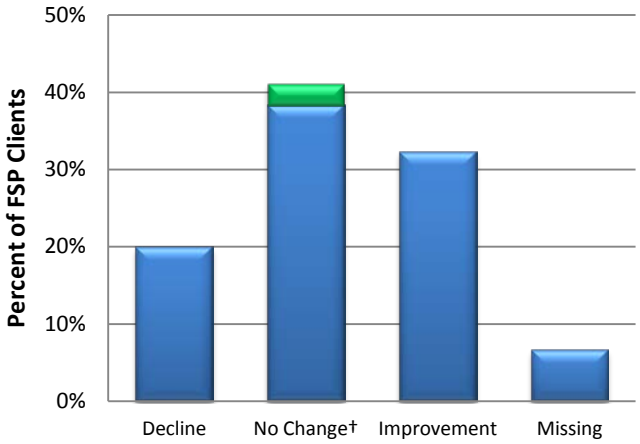
51% of FSP clients either improved or maintained excellent school attendance at follow-up assessment as compared to intake.



†Of the 56% of clients for whom no change was noted, 34% (green portion of bar) had consistently excellent attendance.

Academic Performance (N=1144)

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



†Of the 41% of clients for whom no change was noted, 3% (green portion of bar) had consistently excellent grades.

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.

CASRC child and adolescent services research center

Systemwide FSP ACT Model Report

Fiscal Year 2011-12

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

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

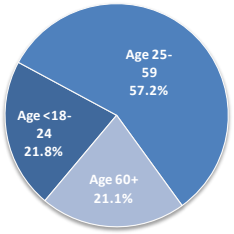
Full fidelity assertive community treatment (ACT) teams—which include psychiatrists, nurses, mental health professionals, employment specialists, peer specialists, and substance-abuse specialists—provide medication management, vocational services, substance abuse services, and other services to help 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.

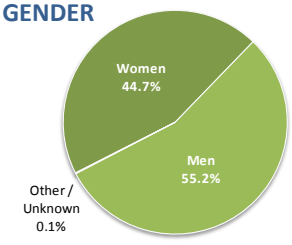
Drawing from a variety of sources, this report presents information on service use and recovery-oriented treatment outcomes for individuals who received Full Service Partnership services during Fiscal Year 2011-12. Demographic and inpatient/emergency services use data (EPU, PERT, Crisis Residential, Psychiatric Hospital) come from the San Diego County Anasazi data system. Data on basic needs (Housing, Employment, Education, Access to Primary Care Physician) and placements in restrictive and acute medical settings (Jail/Prison, State Hospital, Long-term Care, and Medical Hospital) are drawn from the California Department of Mental Health Data Collection and Reporting (DCR) System used by all FSPs. Recovery outcomes and progress toward recovery data presented are from San Diego County's Health Outcomes Management System (HOMS).

901 Clients Served in FY 2011-12 — Demographics & Diagnoses

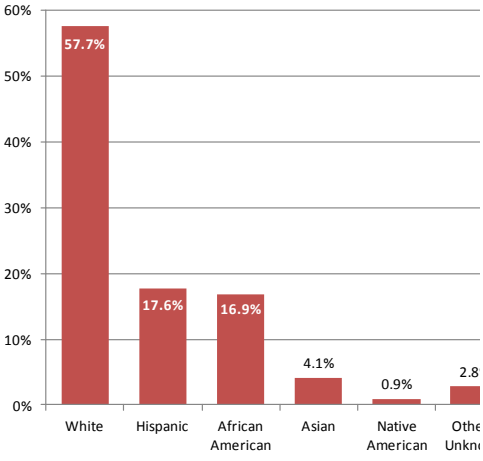
AGE



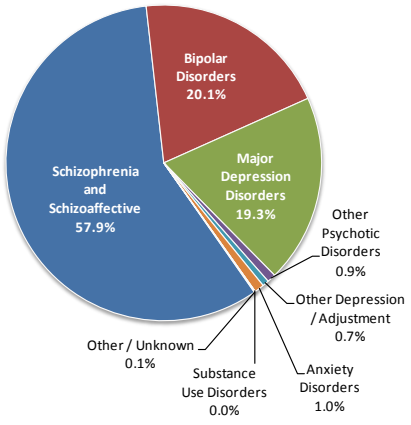
GENDER



RACE / ETHNICITY



PRIMARY MENTAL HEALTH DIAGNOSIS

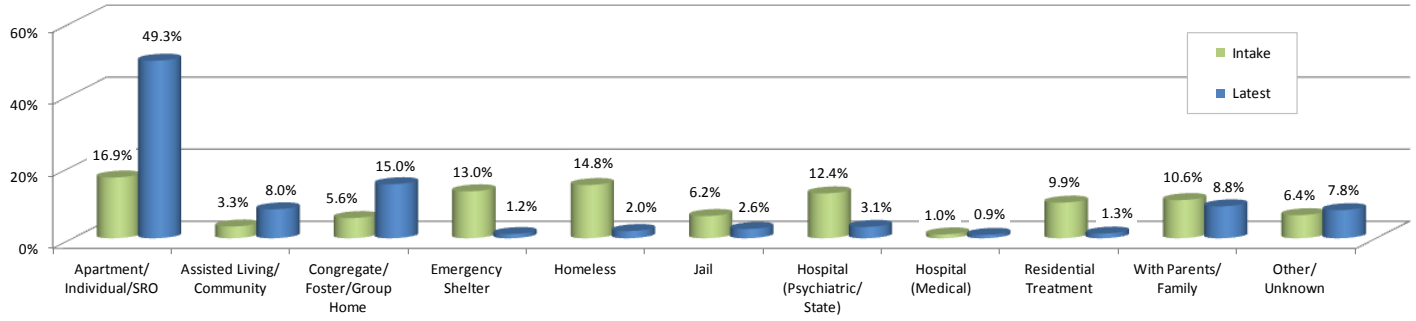


Data source: Anasazi 10/2012 download

MEETING FSP CLIENTS' BASIC NEEDS

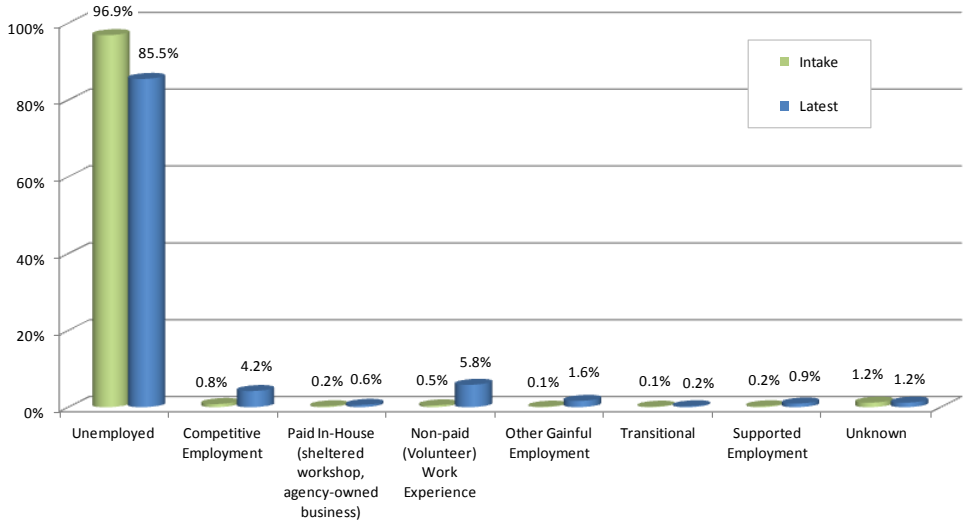
In FY 2011-12, FSP clients showed improvement in many areas of basic needs. Significant improvements were seen in movement of people from homelessness (14.8% at intake vs. 2.0% latest) and emergency shelter (13.0% at intake vs. 1.2% latest) into better living arrangements. Significantly larger percentages of clients were able to secure more adequate housing: 49.3% in an apartment or individual living situation and 15.0% in congregate/foster or group homes. About a quarter as many clients were in psychiatric hospital settings (12.4% at intake vs. 3.1% latest).

HOUSING



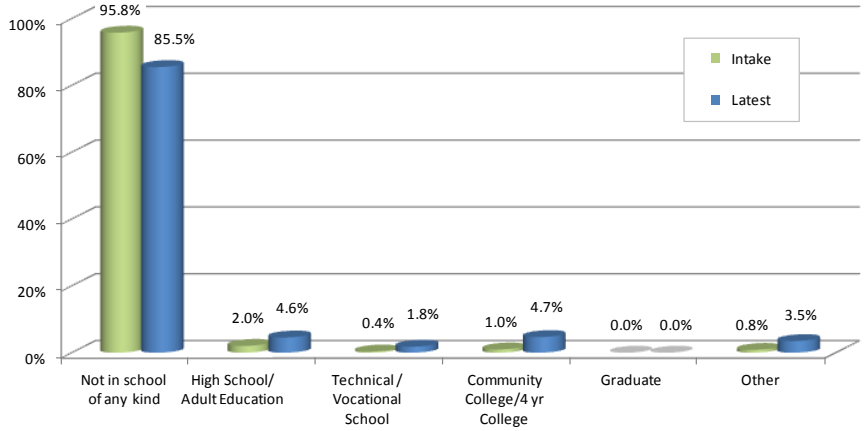
For some clients, involvement in meaningful occupational activities is an important part of recovery. FSPs can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (85.5%), there was an improvement from intake to latest assessment with some clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (from 0.5% to 5.8%) and competitive employment (from 0.8% to 4.2%).

EMPLOYMENT



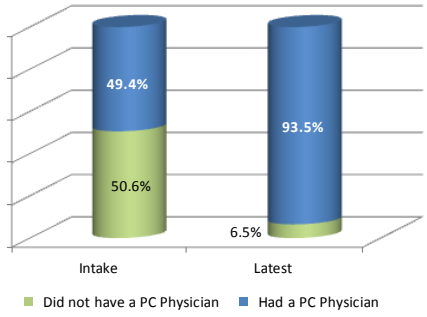
Education is a goal for some, but not all, [illegible] intake, 4.2% of clients were enrolled in educational settings vs. 14.5% at the latest assessment.

EDUCATION



people reported having access to a primary care physician, while 93.5% of clients reported having a primary care physician at [illegible] time of their latest assessment.

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) 12/17/2012 download; (N=860); Education data missing for 28 (intake) 26 (latest) clients.

CHANGES IN SERVICE USE & SETTING

The "whatever it takes" model of care provided by full fidelity FSP ACT programs aims to help people avoid the need for emergency care (Emergency Psychiatric Unit or EPU, Psychiatric Emergency Response Teams or PERT, Crisis Residential and Psychiatric Hospital). Overall, use of these services in FY 2011-12 decreased by 61.6% as measured by number of services, and 54.1% when considering the number of individuals using services. The mean number of emergency services used per person decreased across EPU, PERT, and Crisis Residential categories with the largest decrease occurring for Crisis Residential (22.2%). The mean number of Psychiatric Hospital inpatient services used per person increased slightly (3.16%). Overall number of services used person decreased 16.2%.

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	# OF SERVICES			# OF CLIENTS			MEAN # OF SERVICES PER CLIENT		
TYPE OF EMERGENCY SERVICE	PRE	POST	% CHANGE	PRE	POST	% CHANGE	PRE	POST	% CHANGE
EPU	648	174	-73.15%	286	84	-70.63%	2.27	2.07	-8.58%
PERT	169	127	-24.85%	115	89	-22.61%	1.47	1.43	-2.90%
Crisis Residential	356	101	-71.63%	192	70	-63.54%	1.85	1.44	-22.18%
Psychiatric Hospital	515	247	-52.04%	228	106	-53.51%	2.26	2.33	3.16%
Overall	**1,688**	**649**	**-61.55%**	**412***	**189***	**-54.13%**	**4.10**	**3.43**	**-16.19%**

*The overall numbers of clients PRE (n=412) and POST (n=189) indicate unique clients, many of whom used multiple, various services, whereas some clients used no emergency services.

PRE period data encompass the 12 months prior to each client's FSP enrollment and are from Anasazi 10/12 and InSyst 10/09 downloads; FY11-12 California Department of Mental Health Data Collection and Reporting System (DCR) data from 12/17/2012 download used to identify active clients and for POST period data.

Clients in this analysis (n=690) had an enrollment date <= 7/1/2011 and Discontinued date (if inactive) > 7/1/2011. Data may include people who were discharged from FSP during the Fiscal Year but who continued to receive services elsewhere in the System of Care.

In FY 2011-12, there was an overall decrease in the mean number of days per individual spent in restrictive settings: jail/prison, state hospital, and long-term care. The data on placement in acute medical settings are considered separately in the table below. The residential status of individuals receiving FSP services is changed to "Acute Medical Hospital" when admission to a medical hospital setting occurs for a physical health reason such as surgery, pregnancy/birth, cancer or other illnesses requiring hospice or hospital-based medical care.

- Overall, both the number of days spent in restrictive settings and the number of people in placement decreased (by 79.5% and 63.1%, respectively).
- The largest decrease in the number of people in placement was for State hospital, with an 87.5% decrease.
- Both the number of days and number of individuals in acute medical settings increased (by 63.9% and 60.4%, respectively), suggesting that clients' access to medical treatment increased after FSP enrollment.
- Overall, the average number of days per individual in restrictive settings decreased by 44.3% while the overall average number of days per person in medical settings increased 2.2%.

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

	# OF DAYS			# OF CLIENTS			MEAN # OF DAYS PER CLIENT		
TYPE OF SETTING	PRE	POST	% CHANGE	PRE	POST	% CHANGE	PRE	POST	% CHANGE
Jail/Prison	15,017	3,192	-78.74%	136	54	-60.29%	110.42	59.11	-46.47%
State Hospital	2,471	206	-91.66%	24	3	-87.50%	102.96	68.67	-33.31%
Long-Term Care	2,774	761	-72.57%	13	6	-53.85%	213.38	126.83	-40.56%
Overall	**20,262**	**4,159**	**-79.47%**	**160***	**59***	**-63.13%**	**126.64**	**70.49**	**-44.34%**
Medical Hospital	687	1,126	63.90%	53	85	60.38%	12.96	13.25	2.20%

Data source: California Department of Mental Health Data Collection and Reporting System (DCR) 12/17/2012 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (n=588): had an Enrollment date <= 7/1/2011 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 (n=160) and POST (n=59) indicate unique clients, many of whom used multiple, various services, whereas some clients used no services.

MEASURING PROGRESS TOWARDS RECOVERY

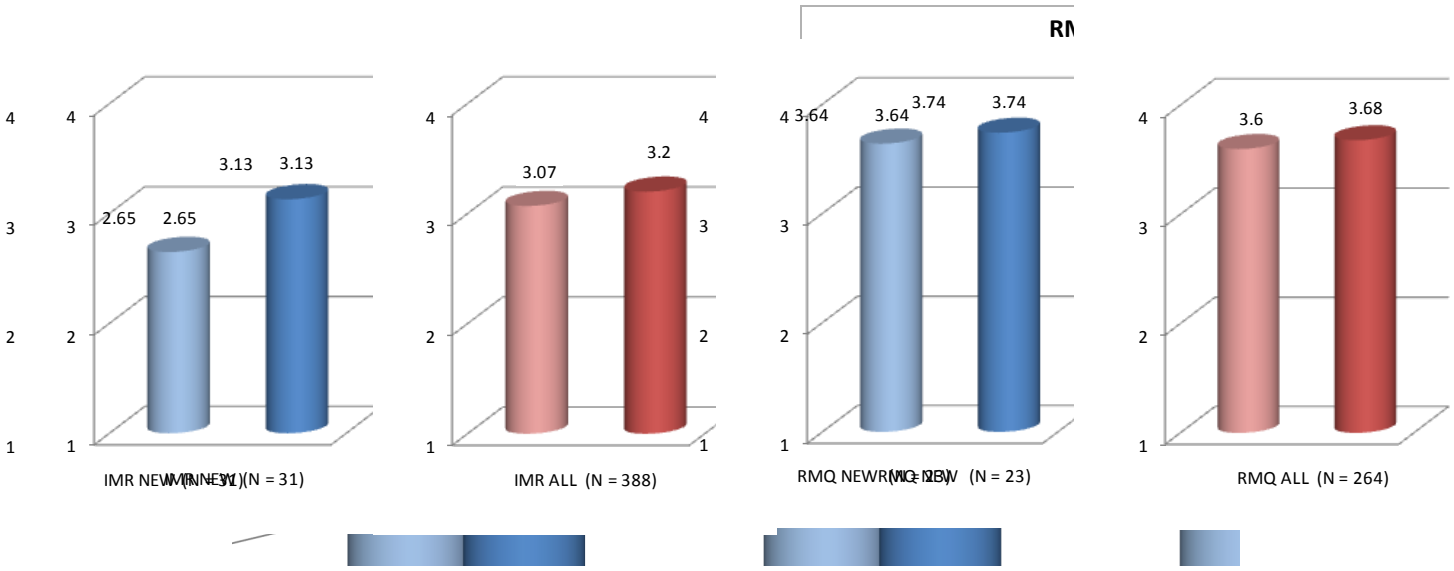
Comparing NEW and ALL FSP ACT Program Clients

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

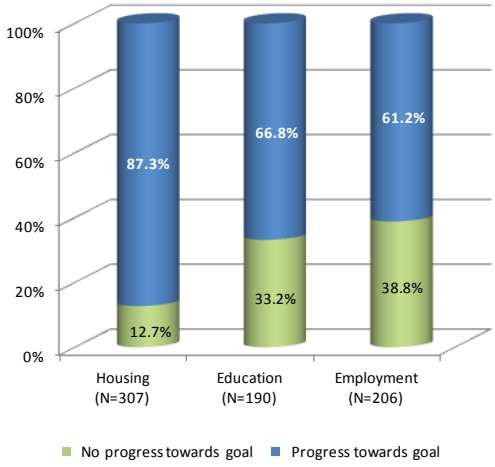
The IMR and RMQ scores displayed in the charts below compare scores of "New Clients" to those of "All Clients." New Clients are those who started receiving services in 2011 or later, who had two IMR/RMQ assessments during FY 2011-12 (assessments 1 and 2), and whose first service date was within 30 days of their first IMR assessment; All Clients includes every individual who had two IMR/RMQ assessments during FY 2011-12 (assessments 1 and 2), regardless of how long they have received FSP services. Scores for New Clients more directly demonstrate the effect of FSP services on client outcomes because All Clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP 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

ess than RMQ scores for All Clients.



MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



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

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

Of those people with a housing goal on their treatment plan, 87.3% demonstrated progress toward the goal, while 12.7% did not. Of those with an education goal on their treatment plan, 66.8% demonstrated progress, while 33.2% did not demonstrate progress. And of those people with an employment goal on their treatment plan, 61.2% demonstrated progress toward the goal, while 38.8% did not.

lude all HOMS entries as of 12/15/2012 for clients active in all FSP ACT Model Programs during FY 2010-11 and who had paired IMR/RMQ assessments within 6 months.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

CHILD & FAMILY PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2011—12 ANNUAL REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

CASRC child and adolescent services research center

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 13 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.

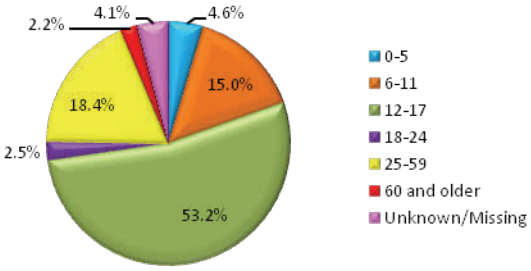
DATA:	**Child and Adolescent PEI Programs**
REPORT PERIOD:	**7/1/2011-6/30/2012**
NUMBER OF PARTICIPANTS WITH DATA:	**41,494 unduplicated *†**

**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.*

† Totals for the Jewish Family Service of San Diego's Triple P program were weighted to reflect the true number of participants served.

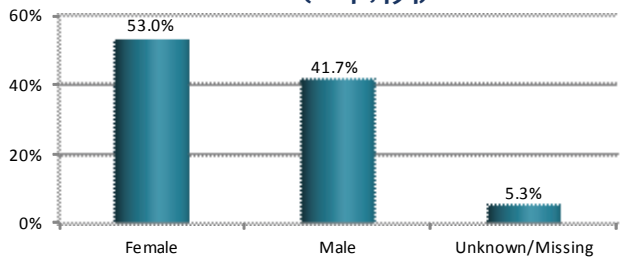
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

AGE (N=41,494)*



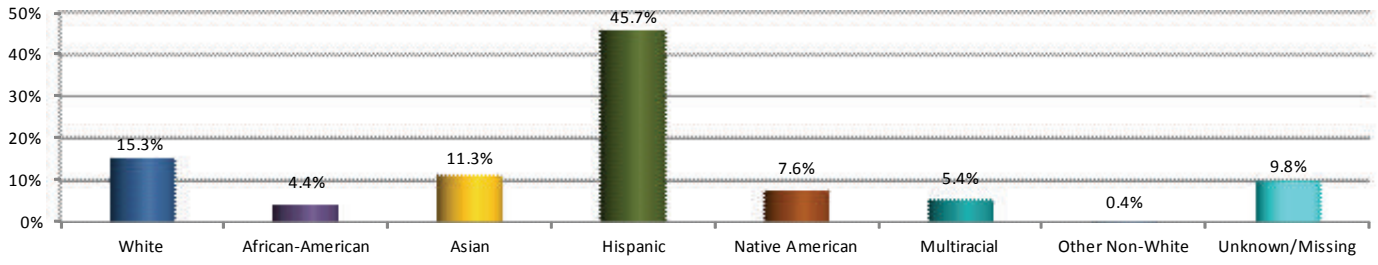
Fifty-three percent of participants were ages 12-17. Some participants were older than 18 because several children's PEI programs include caregivers and community members.

GENDER (N=41,494)

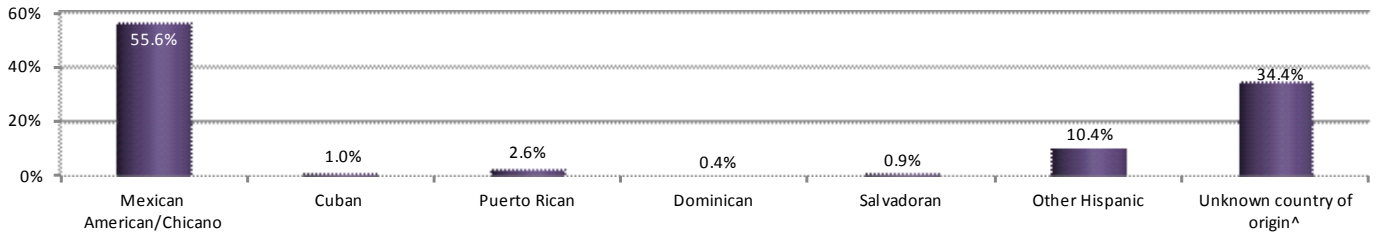


Fifty-three percent of the participants who received services identified their gender as female.

RACE/ETHNICITY (N=41,494)



Forty-six percent of participants who received services identified their ethnic background as Hispanic.

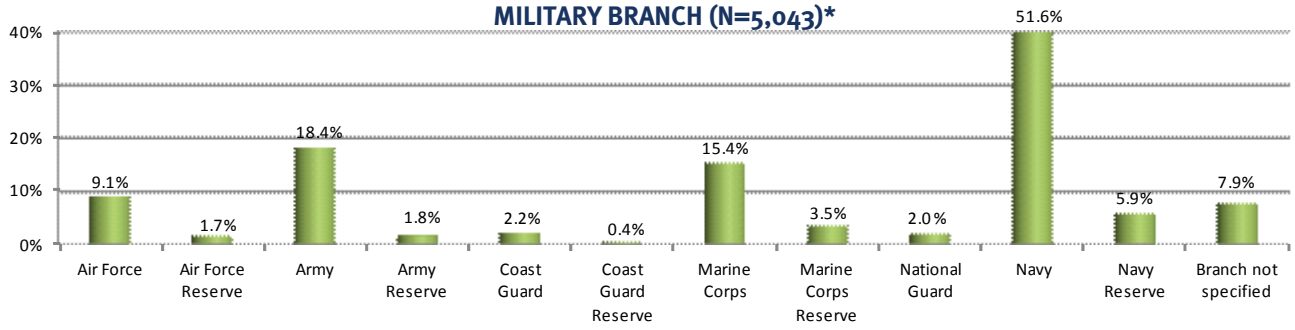


Of the Hispanic population served, 53% identified their ethnic background as Mexican American/Chicano.

**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.

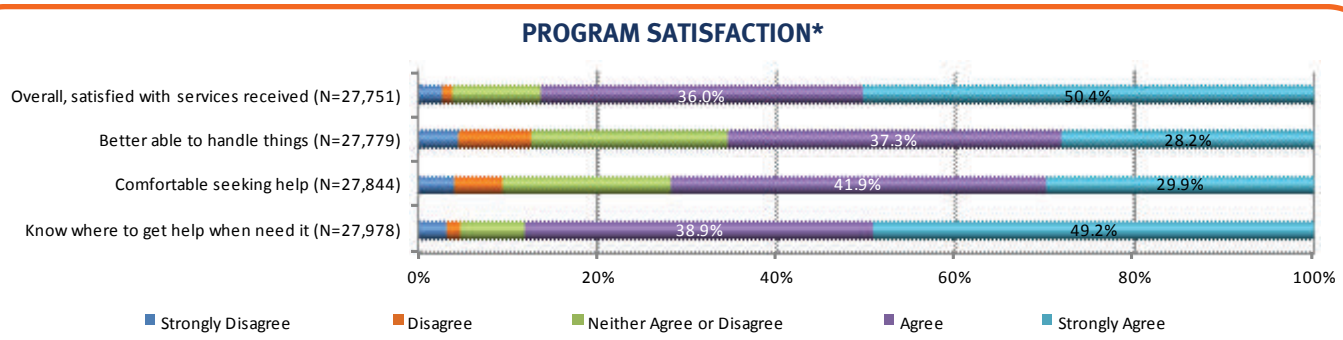
CAREGIVER INVOLVEMENT IN MILITARY SERVICE



Of the 22,709 participants for whom caregiver involvement in the military was reported, 5,043 (22%) reported that the youth's caregiver had served in the military. Of these caregivers, 2,602 (52%) served in the Navy, 926 (18%) served in the Army and 779 (15%) served in the Marine Corps. The remaining branches were not as highly represented.

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

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 67% 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, 86% 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.

ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2011—12 ANNUAL REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

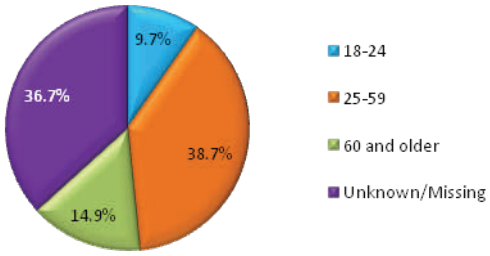
HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

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:	**7/1/2011-6/30/2012**
NUMBER OF PARTICIPANTS WITH DATA:	**11,138 unduplicated**

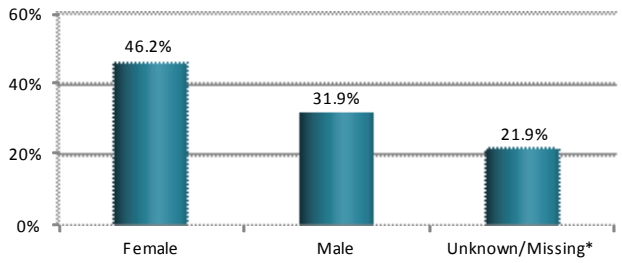
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

AGE (N=11,138)



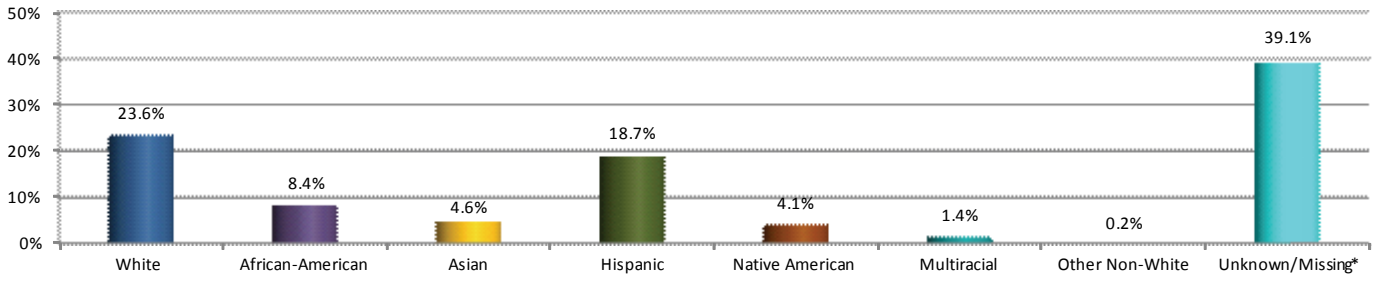
Forty-eight percent of participants who received services were reported to be ages 18-59.

GENDER (N=11,138)



Forty-six percent of participants who received services identified their gender as female.

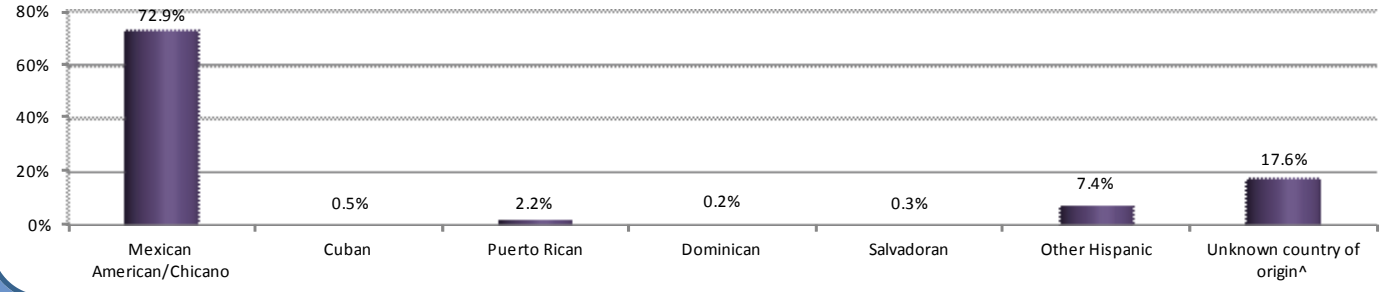
RACE/ETHNICITY (N=11,138)



Forty-two percent of participants who received services identified their racial/ethnic background 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.*

MEXICAN/HISPANIC/LATINO ORIGIN (N= 2,078)*



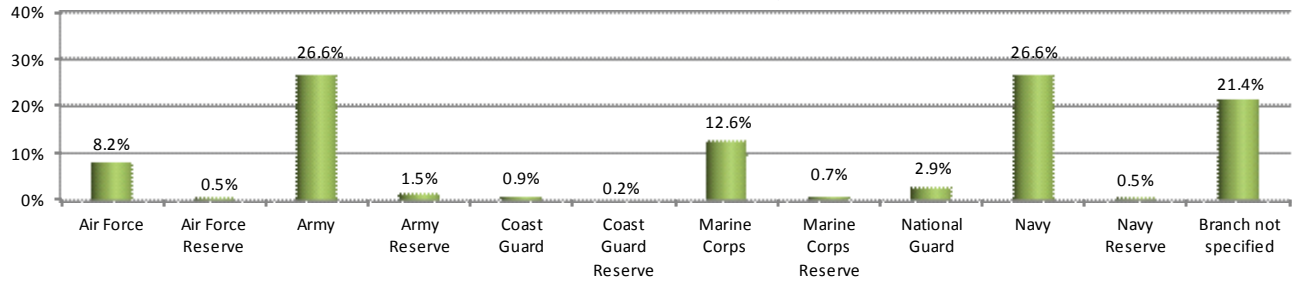
Of the Hispanic population served, 73% identified their ethnic background as Mexican American/Chicano.

**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

MILITARY BRANCH (N=548)*

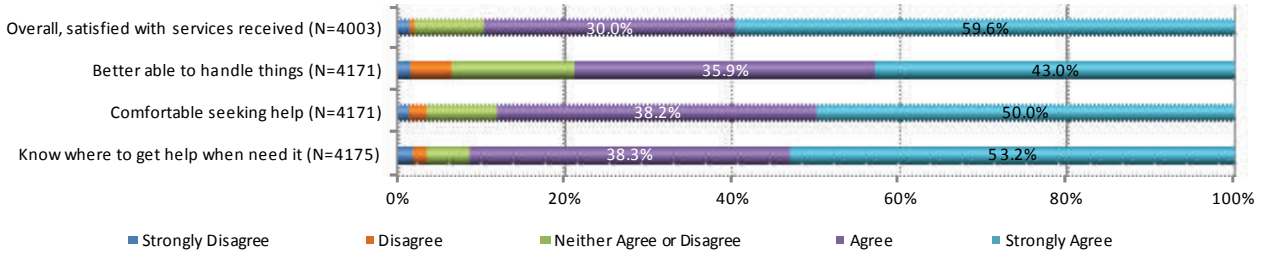


Of the 6,283 participants for whom military service status was known, 548 (9%) had served in the military. Of those participants, 146 (27%) served in the Navy, 146 (27%) served in the Army and 69 (13%) served in the Marine Corps. The remaining military branches were not as highly represented. 117 (21%) participants did not specify a military branch of service.

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

PROGRAM SATISFACTION

PROGRAM SATISFACTION*



For each satisfaction question, responses were obtained from approximately 37% 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, 90% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

The Health Services Reseach 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 Behavioral Mental Health Services to evaluate and improve behavioral health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve client quality of life. For more information please contact Andrew Sarkin, PhD at 858-622-1771.

CHILD & ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2011—12 ANNUAL REPORT

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 older adults, and 13 contractors for youth and transition age 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.

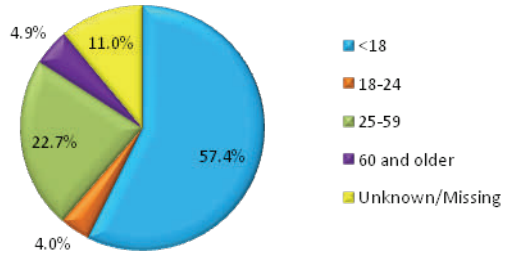
DATA:	**Child and Adult PEI Programs**
REPORT PERIOD:	**7/1/2011-6/30/2012**
NUMBER OF PARTICIPANTS WITH DATA:	**52,632 unduplicated*†**

**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.*

† Totals for the Jewish Family Service of San Diego's Triple P program were weighted to reflect the true number of participants served.

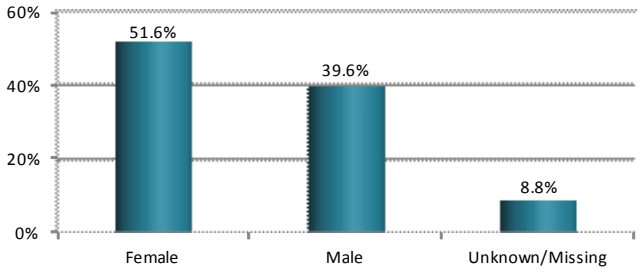
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

AGE (N=52,632)



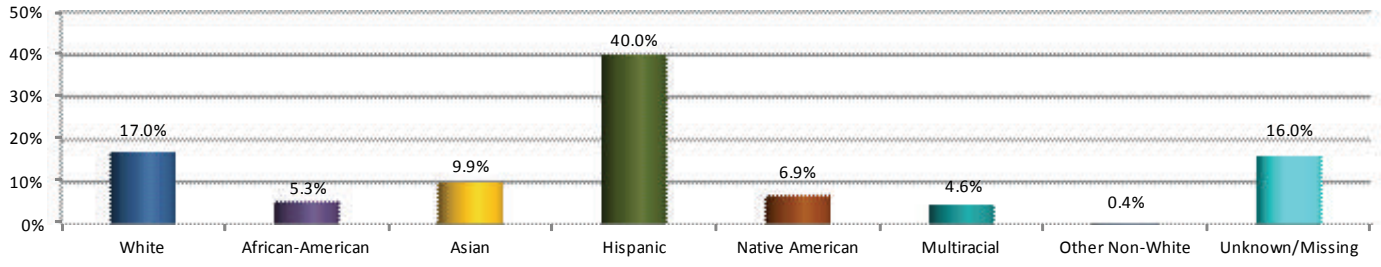
Fifty-seven percent of participants were under the age of 18; 23% were between the ages of 25-59.

GENDER (N=52,632)

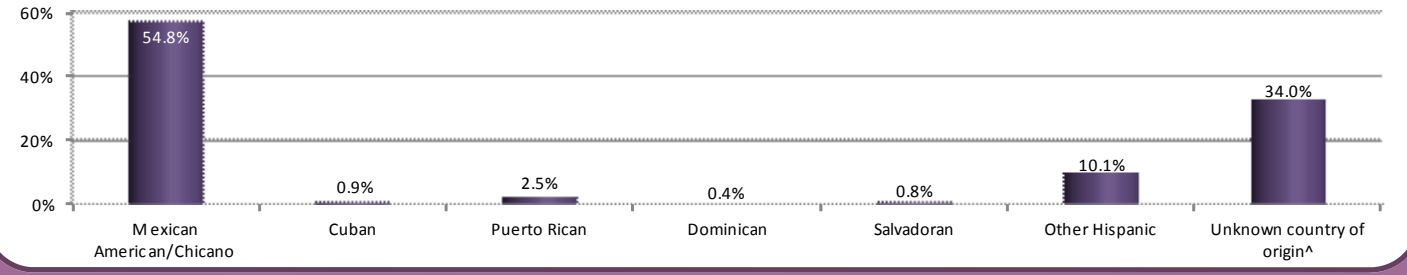


Fifty-two percent of participants who received services identified their gender as female.

RACE/ETHNICITY (N=52,632)



Forty percent of participants who received services identified their ethnic background as Hispanic.

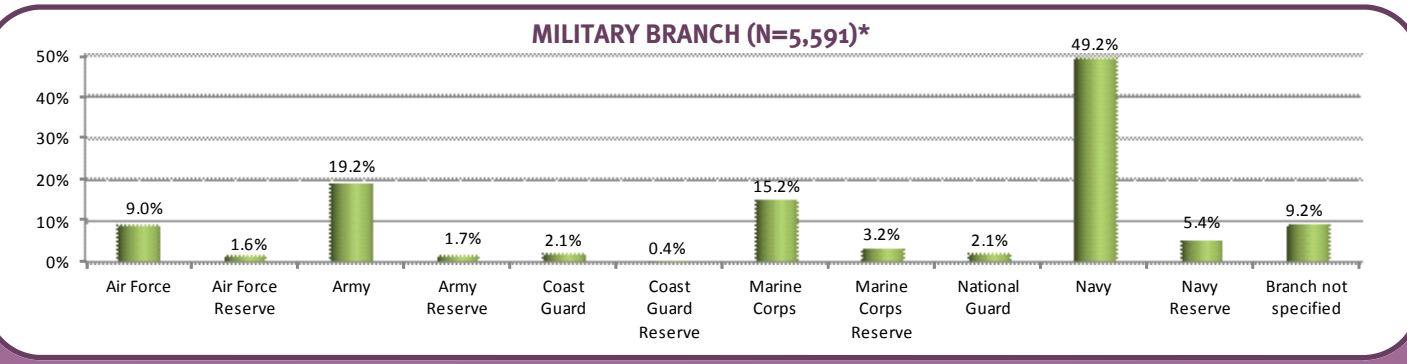


Of the Hispanic population served, 55% identified their ethnic background as Mexican American/Chicano.

**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.

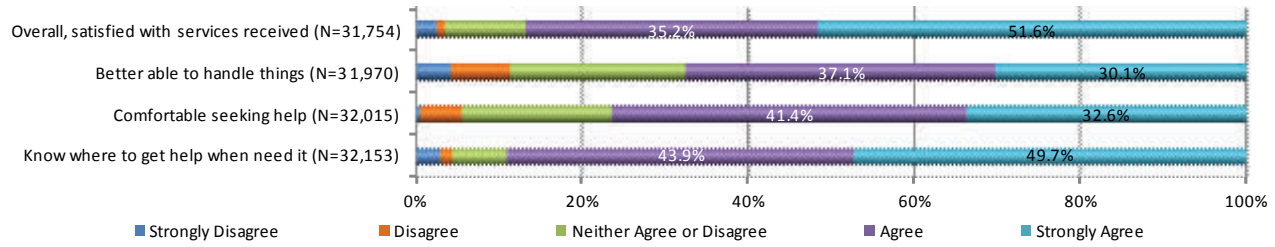
MILITARY SERVICE



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 28,993 participants in both systems for whom military service status was known, 5,591 (19%) stated that either they or their child's caregiver had served in the military. The majority of these individuals served in the Navy (49%), the Army (19%), or the Marine Corps (15%). The remaining military branches 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 61% 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.

The Health Services Reseach 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 Behavioral Health Services to evaluate and improve behavioral health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve client quality of life. For more information please contact Andrew Sarkin, PhD at 858-622-1771.

APPENDIX C – STAKEHOLDER INPUT

Included in this section are the following reports:

1. MHSA Annual Program & Expenditure Plan: Fiscal Year 2013-14 Stakeholder Input

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MHSA Annual Program and Expenditure Plan: FY 2013-14 Stakeholder Input		
DATE	**COMMENT**	**RESPONSE**
10/9/2013	I am the project manager for the Mobility Management Program, one of the innovations projects referenced in the report. I reviewed the portion of the draft report which references the Mobility Management Program and would like to point out a misprint on page 21.	Modifcation made.
10/18/2013	Budget: If I had not been at presentations at Adult Council where the process of making budget adjustments was explained, I would have questions about why funds were decreased in some areas. The phrase reduced and funds redirected to other work plans doesn't explain why the money wasn't needed in a certain area. (If this is in the report, I missed it). Maybe a footnote that states that the County thoughtfully did an analysis and how reductions were determined. Outcomes: A comment/question about the Recovery Outcomes, Illness Management and Recovery Scales for the different programs. I would be interested in some interpretation about possible reasons for the statistically significant changes (the darker arrows). For the first program, I found myself wondering why some of the changes happened (e.g., a decrease in knowledge in all clients for a program which seems negative and unexpected). (This is on page 4 of 40 appendix C). Perhaps some guide on how to interpret the significant changes, or a comment on them. Perhaps the interpretation comes on Page 6 of 40 in the Comparing Center Start ACT to FSPs Overall where it states the decrease for NEW client is based on two individuals—I had figured that out by the time I got to the interpretation but if there was a statement before the raw data noting that comments/interpretations will come in a following section it would have made it easier for me. I appreciated the comparison of each program to FSPs overall.	Taken under advisement.

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