Mental Health Services Act Annual Update

Fiscal Year 2025-2026

BEHAVIORAL HEALTH SERVICES

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COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

San Diego County Board of Supervisors

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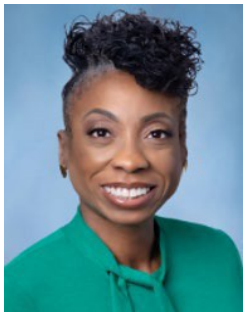

Monica Montgomery Steppe
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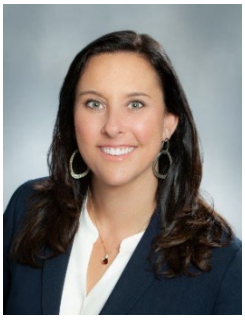

Kimberly Giardina, DSW
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Nadia Privara Brahms, MPA
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Health and Human Services Agency

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LETTER FROM THE BEHAVIORAL HEALTH SERVICES ACTING DIRECTOR

I am honored to step into the role as the Acting Director of Behavioral Health Services (BHS) for San Diego County. And while the scope of this role is significant, and the changes continue to become increasingly complex, the BHS team remains committed to supporting the continuity of essential services to ensure people have access to the care they need when they need it.

As we move through this period of significant transition due to the many State initiatives and impending federal policy changes to Medicaid, BHS remains committed to advancing the important work already underway, including the Behavioral Health Services Act (BHSA), the Mental Health, Substance Use, and Children's Optimal Care Pathways (OCP) Models, Behavioral Health Payment Reform, the Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Initiative, and many others.

The Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2025-26 is an opportunity for the County of San Diego (County) Health and Human Services Agency (HHSA), BHS to inform stakeholders, partners, consumers, community members, and others of the array of MHSA-funded programs, funding priorities, and key accomplishments from FY 2023-24. This will be the final Annual Update before counties across the state transition to the BHSA on July 1, 2026. BHSA will include new program reporting, community engagement, and data requirements, new funding components, and other significant changes. Extensive planning work is underway to implement BHSA and will include expanded engagement with stakeholders and the provider network to ensure community voices are being heard.

This Annual Update outlines enhancements to MHSA-funded services to ensure access to care for our region's most vulnerable populations. Several enhancements to highlight include, increased funds for housing within Strengths-Based Case Management, Safe Haven, and Assertive Community Treatment programs, along with funding for two new Crisis Stabilization Units (CSUs), and increased support for tailored community engagement. Other broader areas to highlight, include the launch of Senate Bill 43 on January 1, 2025, operationalizing a new electronic health care record, SmartCare, and continued implementation of behavioral health payment reform across Medi-Cal programs, and ongoing efforts to optimize our role as a health plan.

Though many challenges continue to arise, we look forward to partnering with stakeholders, providers, consumers, and other community members to navigate them together. We will continue building a system that is accessible, provides quality care, and is financially sustainable now and into the future. We remain steadfast in our commitment to services that are equitable and culturally aware to support the long-term health and wellness of children, adults, and families in the San Diego region.

Sincerely,

Nadia Privara Brahms, MPA, Acting Director
Behavioral Health Services, County of San Diego Health and Human Services Agency

MHSA OVERVIEW

BACKGROUND

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

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

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

As required by the Welfare and Institutions Code, counties must complete a three-year plan and subsequent annual updates for MHSA-funded programs. The most recent MHSA Three-Year Plan for Fiscal Years (FY) 2023-24 through 2025-26 provided program and expenditure information for the five MHSA components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). This MHSA FY 2025-26 Annual Update provides an overview of the recent Community Planning Process (CPP), summarizes outcomes for FY 2023-24, and outlines adjustments to the Three-Year Plan.

INVESTMENTS

The proposed MHSA spending plan for FY 2025-26 is $303,129,678 as outlined in the following table. The budget reflects an increase of $16,503,288 from the amended MHSA Three-Year Plan budget for FY 2025-26. By the end of FY 2025-26, it is estimated that the County will have invested approximately $3 billion in MHSA programs since implementation in 2005.

MHSA Component	Three Year Plan FY 2025-26 Budget	Annual Update FY 2025-26 Budget	Variance	Percent of MHSA Budget*
Community Services and Supports (CSS)	**$ 239,628,451**	**$ 227,119,611**	**$ (12,508,841)**	**74.9%**
Prevention and Early Intervention (PEI)	**$ 39,461,818**	**$ 51,021,969**	**$ 11,560,152**	**16.8%**
Innovation (INN)	**$ -**	**$ 17,369,025**	**$ 17,369,025**	**5.7%**
Workforce Education and Training (WET)	**$ 7,536,121**	**$ 7,619,073**	**$ 82,952**	**2.5%**
Capital Facilities and Technological Needs (CFTN)	**$ -**	**$ -**	**$ -**	**0.0%**
Total	**$ 286,626,390**	**$ 303,129,678**	**$ 16,503,288**	**100%**

**Figures are rounded, and total may not add up to 100%*

The MHSA budget is based on priorities identified during CPP in conjunction with staff recommendations. Summary of proposed expenditures by each MHSA component is available in Appendix A. Summaries of all programs funded with MHSA dollars are available in Appendix C.

LIVE WELL SAN DIEGO

Implementation of the MHSA demonstrates our ongoing commitment to the regional *Live Well San Diego* vision of achieving a healthy, safe, and thriving region. BHS is committed to providing accessible, community-based, and client-oriented services to all six Health and Human Services Agency (HHSA) service regions: North Coastal, North Inland, North Central, Central, East, and South.

The MHSA enhances access to services, and encourages self-sufficiency, health, and well-being in children, adults, and families as demonstrated by the personal stories embedded throughout this report. By collaborating with individuals, community partners, local government, schools, and others, the County continues its goal of achieving healthy, safe, and thriving communities through collective impact.

HHSA Service Delivery Regions

In FY 2023-24, MHSA-funded programs provided services to more than 66,000 children, transition-age youth, adults, and older adults in the San Diego County, with an emphasis on individuals who were previously unserved or underserved.

MHSA CAPACITY ASSESSMENT

The County conducted the MHSA capacity assessment utilizing six HHSA regions examining them from a population health lens. The North Coastal, North Inland, North Central, Central, East, and South regions are HHSA defined geographic areas located in San Diego County. The following key statistics were identified noting that the data in the assessment is aggregated across all HHSA regions. The assessment examined the mental health needs of the community, specifically the needs of the unserved and underserved. This was conducted via the Behavioral Health Equity Index (BHEI) which is a data-driven tool that allows users to explore differences in the root causes, also known as social determinants of behavioral health, across neighborhoods in San Diego County. The indices are constructed from over 30 indicators, organized into eight domains that map to five social determinants of behavioral health. As the social determinants of behavioral health are multifaceted and complex, the BHEI is a composite index which combines information from multiple sources into a single score. The MHSA Capacity Assessment examined the data available from a population health perspective looking at the county level data to get a sense of the community need, utilization of the current services, and the individuals served. The analysis demonstrated that San Diego County is a diverse county, impacted by many social determinants of health that can impact mental health access and availability of services. Data showed a need for greater services for populations such as Asian/Pacific Islanders, Native American, and Hispanics. The mapping conducted also demonstrated a need for additional services in the Central region, in addition to it having the highest uninsured population in the region. In examining the special populations served, there was evidence of higher rates of trauma and co-occurring disorders for both the children and youth and the adult and older adult special populations (homeless, LGBTQIA+, probation/justice involved, child welfare involved, and military) when compared to the overall system, demonstrating the need for additional services to these unserved and underserved populations. Additionally, there is a need to improve access times for both routine and urgent psychiatric and mental health services, to ensure timely care for individuals, especially if in crisis. A detailed Capacity Assessment can be found in Appendix D.

ADVANCING DIVERSITY AND HEALTH EQUITY

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

To identify and address unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs, BHS partnered with the University of California, San Diego (UCSD) to develop the Community Experience Partnership (CEP). The CEP is a joint initiative to promote behavioral health equity and inform culturally responsive, data-informed behavioral health service planning.

The CEP continues to refine and maintain key resources, including the CEP website and Community Experience Dashboards (CED). The CED allows users to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Users can evaluate indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement and more. The dashboards are regularly updated with current data and enhanced features.

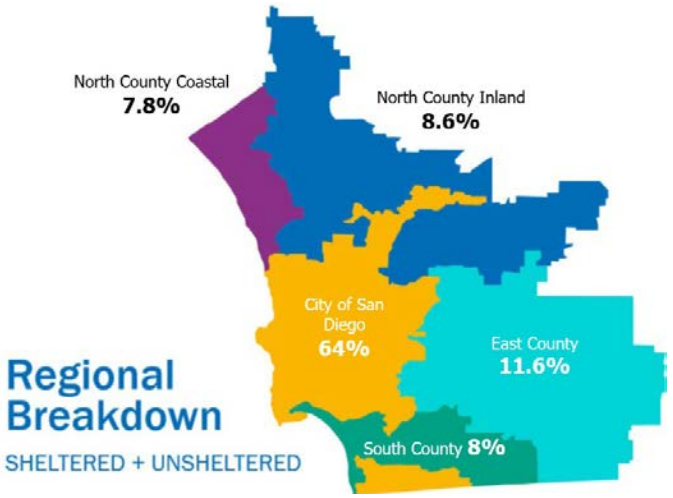
Recent work includes the development of the BHEI, which was the tool used to conduct the MHSA Capacity Assessment. Areas with higher BHEI scores, are relatively less likely to have access to the resources, opportunities, and conditions that promote behavioral health, compared to neighborhoods with lower BHEI scores. Areas with higher scores may benefit from behavioral health service enhancements

or quality improvement efforts. In addition to the BHEI, UCSD has developed a custom application designed to help ensure service provision is informed by data, based on cultural and regional considerations, and targeted to communities that may be at greatest risk for unmet behavioral health needs. Specifically, the tool uses data to help identify areas in San Diego County where target populations for BHS services are likely to be highly concentrated.

The CEP's efforts meet needs at the service, administrative, and community levels. This promotes a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans that will aid in informing the design of BHS programs, including services funded through MHSA.

HOMELESSNESS AND HOUSING

Obtaining stable housing is critical in achieving health and wellness for individuals who are experiencing homelessness, or who are at risk of experiencing homelessness, and struggling with serious mental illness. The Point-in-Time Count is an annual effort to identify the number of persons experiencing homelessness that is conducted by hundreds of volunteers and outreach workers across San Diego County. The Regional Taskforce on Homelessness conducted the annual Point-in-Time Count of unsheltered persons in January 2024. There was a 3% increase in overall homelessness (sheltered and unsheltered) in 2024 with a total of 10,605 individuals compared to 10,264 the prior year. The City of San Diego has the largest count of persons experiencing homelessness, with 6,783 individuals, compared to the other HHSA regions in San Diego County, as shown on the chart and map to the right.



Region	% of the Region	Total Homeless Persons
City of San Diego	64%	6,783
North County Inland	8.6%	876
North County Coastal	7.8%	865
South County	8%	849
East County	11.6%	1,232

Regional Task Force on Homelessness

The WeAllCount 2024 Regional Breakdown Report[1] shows that among persons experiencing homelessness, 3,177 individuals were in Emergency Shelter, 60 individuals had Safe Haven, 1,258 individuals were in Transitional Housing, and 6,110 individuals were unsheltered. Of those unsheltered, 44% were chronically homeless, 28% were females, 9% were veterans, 8% were unsheltered youth, and 2% were families. MHSA programs continue to provide extensive outreach, engagement, treatment services, and permanent supportive housing to individuals with SMI who are experiencing homelessness[1].

BHS developed a five-year (2022-2027) Strategic Housing Plan to set forth goals, strategies, and priorities for supportive housing that best supports BHS clients. It was developed through intensive outreach that included a wide variety of opportunities to gather input from people with lived experience/expertise and a broad range of stakeholders who care deeply about housing and behavioral health. Through this process, key goals were identified with focus areas that called for purposeful action. These new housing and services resources are designed to support critical interventions that address the substantial need for new supportive/affordable housing resources, particularly for people experiencing homelessness with behavioral health concerns.

[1] San Diego Regional Task Force on Homelessness, 2024 WeAllCount Report, retrieved on 3/4/2024 from https://www.rtfhsd.org/reports-data/

PROJECT ONE FOR ALL (POFA)

In 2016, the San Diego County Board of Supervisors (Board) implemented Project One for All (POFA) with a goal of connecting 1,250 individuals with SMI who are experiencing homelessness to housing and behavioral health services. POFA provides adults with SMI who are experiencing homelessness with fully integrated services, including outreach, case management, mental health treatment services, substance use disorder (SUD) services, referrals to primary health care, social services, and housing to ensure stability and live their best life. The goal of connecting 1,250 individuals with SMI who are experiencing homelessness to housing and behavioral health services has not only been met but exceeded. As of March 2024, a total of 2,682 individuals experiencing homelessness were housed and received BHS services through POFA. The program officially ended in March 2024.

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM WITH MHSA PROGRAMS

The County has dedicated more than $53 million of MHSA CSS funds to the California Housing Finance Agency (CalHFA) for the Local Government Special Needs Housing Program (SNHP) and its predecessor, the MHSA Housing Program. These programs will result in approximately 350 permanent supportive housing units – of which, 219 units are utilizing funding through MHSA and 131 units through SNHP. There are also 57 services-only units where the County does not fund the construction of the unit but does fund supportive services. Similar to what was reported in the prior MHSA Report for FY 2024-25, County funds are supporting a total of 407 units.

NO PLACE LIKE HOME

In 2018, Proposition 2 authorized the sale of up to $2 billion in revenue bonds and the use of a portion of Proposition 63 taxes for the MHSA No Place Like Home (NPLH) program. It provides funding for permanent supportive housing developments to house clients who are experiencing homelessness and have a mental health condition. The San Diego County allocation was approximately $127.8 million.

As of October 2024, there were seven operational developments totaling 221 NPLH units. There are 14 new housing developments planned to add another 223 units, which will bring the total NPLH units to 444.

Status of NPLH Units	# of Projects	# of Housing Units
Operationalized	7	221
Under Construction or Planned for Development	14	223
Total Housing Units	**21**	**444**

COLLABORATION WITH JUSTICE PARTNERS

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

BHS received $8 million in Proposition 47 Cohort 4 Grant Program funding from the California Board of State and Community Corrections to implement a new Forensic Assertive Community Treatment (FACT) program. FACT serves individuals with serious mental illness who are involved with the criminal justice system by providing customized supports based on criminogenic needs and risks, while bridging the behavioral health and criminal justice systems. It is designed to improve client outcomes that support the transition from justice involvement. Services are expected to increase client engagement in treatment and housing retention. These enhanced services will reduce time spent in detention, avoid unnecessary psychiatric visits to emergency departments, reduce unnecessary admissions to psychiatric hospitals, increase participation into treatment, and increase public safety.

In addition to FACT services, BHS continues to collaborate with justice partners on the Board directed Alternatives to Incarceration efforts to divert individuals from justice involvement or repeated justice involvement by developing strategies to instead engage and connect individuals with behavioral health conditions to care and housing. In FY 2025-26, the total estimated investment in justice-related MHSA programs will be nearly $46.9 million. See Appendix E for a list of MHSA programs that serve justice-involved clients.

BEHAVIORAL HEALTH TRANSFORMATION

Significant changes in the administration and reimbursement of behavioral health services are underway and forthcoming with the implementation of BHSA beginning in July 2026. A number of legislative bills has also impacted service delivery in a major way. Priorities driven by stakeholders, including the Board of Supervisors, the public, local cities, community stakeholders, the Behavioral Health Advisory Board, and various other obligations inform the development of the services across our continuum. BHS will continue leaning further into its role as a health plan by building out essential infrastructure, such as information technology, data science, clinical expertise, and population health capacity, along with establishing new functions necessary to ensure the network of care is meeting the needs of the region. BHS strives to be proactive in anticipating changes that may impact funding and services and is developing strategies to mitigate risks and impacts.

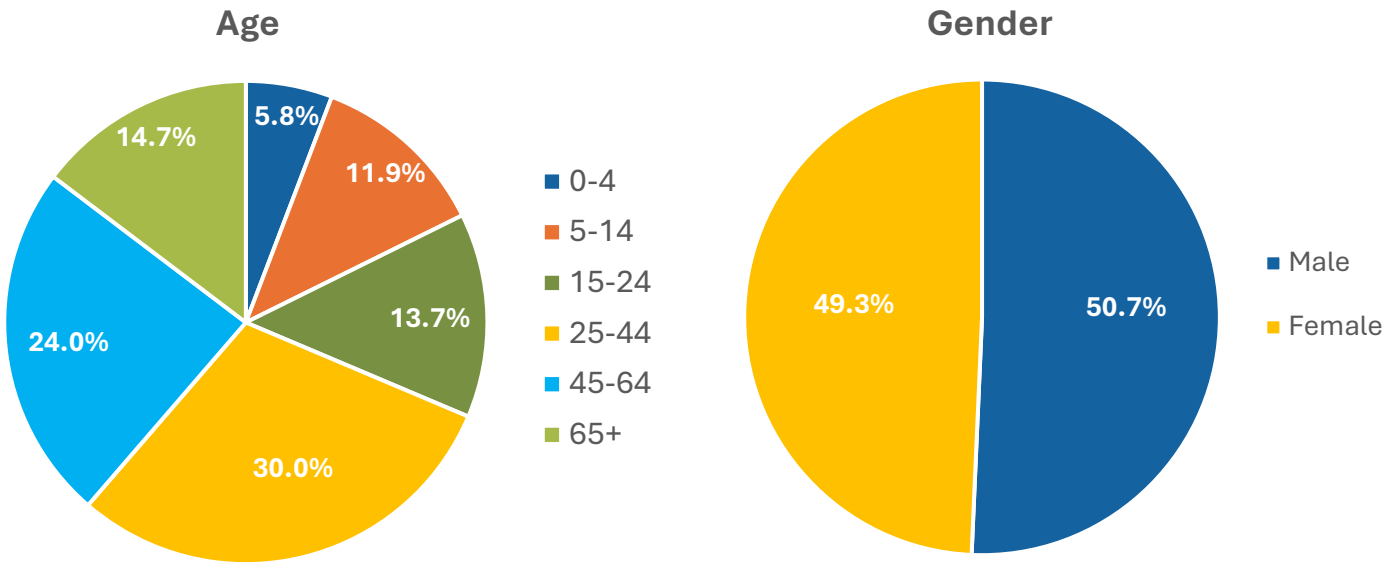
Changes that will have significant impacts locally to services and operations, include:

- Implementing **Proposition 1, BHSA,** which will make changes across our system, including shifting a large amount of funding away from billable clinical services to housing, shifting Prevention funds to the State, and include additional requirements around data and financial reporting to support increased transparency.
- Pursuing new **Proposition 1 Behavioral Health Continuum Infrastructure Program grant funds** to add new treatment capacity.
- Developing the **East Region Crisis Stabilization Unit (CSU),** which is anticipated to open by the end of 2025. It is a crucial part of the Continuum of Care and will provide short-term psychiatric stabilization services and connections to care.
- Expanding **licensed Board and Care facility capacity** available to people with serious mental illness through the Behavioral Health Bridge Housing grant funding from Round 1.

- Implementing the **California SB 43 Involuntary Behavioral Health Treatment** on January 1, 2025, which expands the eligibility criteria for who can be detained for involuntary care. In response, BHS expanded treatment services, infrastructure, and provided training to staff and providers.
- Partnering with the County Public Safety Group to address increased referrals for court-appointed forensic evaluations.

DEMOGRAPHICS

San Diego County, California is located near the Pacific Ocean in the far southwestern part of the United States, has nearly 70 miles of coastline, and shares an 80-mile international border with Mexico. According to the U.S. Census, San Diego County has an area that encompasses 4,210 square miles. It is among the nation's most geographically varied regions with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. San Diego County's population for 2022 was 3,289,701[2], making it the second-most populous county in California and the fifth-most populous county in the U.S. The culturally diverse region boasts robust technology and health industries, a business-friendly climate, green practices, and a high quality of life. It is home to world-class educational institutions and a large military presence. There are over 194,517[3] veterans who reside in the region along with more than 115,000[4] active-duty military personnel and their families. The pie charts below show the estimated demographics for San Diego County based on 2018-2022 U.S. Census data from the American Community Survey 5-year estimates.[5] [6]



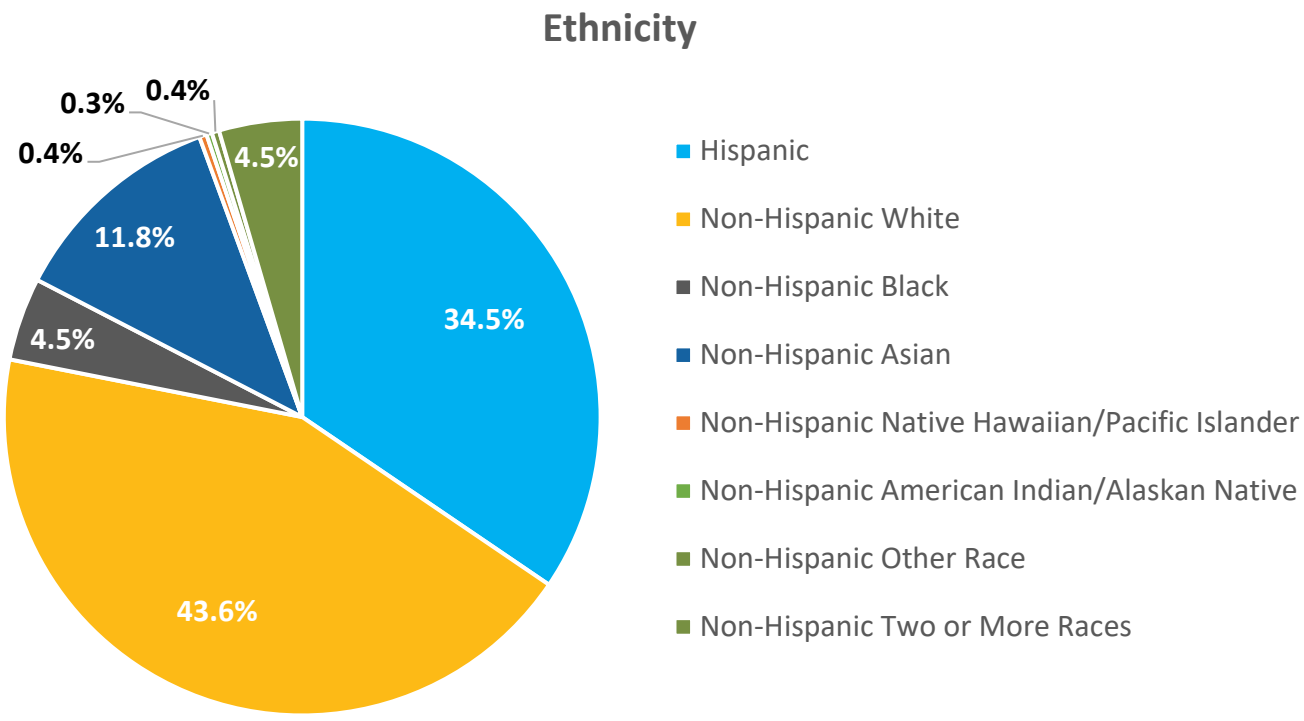
[2] U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, Table B01001 retrieved on 8/5/2024 from https://data.census.gov/table/ACSDT5Y2022.B01001?q=B01001&g=050XX00US06073

[3] U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, Table S2101 retrieved on 8/5/2024 from https://data.census.gov/table/ACSST5Y2022.S2101?q=veterans&g=050XX00US06073

[4] San Diego Military Advisory Council (n.d.) *Military in San Diego*. Retrieved on 8/5/2024 from https://sdmac.org/military-in-san-diego/

[5] U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, Table B01001 retrieved on 8/5/2024 from https://data.census.gov/table?q=B01001&g=050XX00US06073&y=2022

[6] U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, Table B03002 retrieved on 8/5/2024 from https://data.census.gov/table/ACSDT5Y2022.B03002?q=B03002&g=050XX00US06073&y=2022



According to the Census data, in 2022, San Diego County's population was 34.5% Hispanic. Among the non-Hispanic population, 43.6% were White, 11.8% were Asian, 4.5% were Black, and Non-Hispanic Two or More Races comprised 4.5%. Native Hawaiian/Pacific Islander, Other Race, and American Indian/Alaskan Native combined, represented 1% of the county population. The region has a steady increase in the Hispanic population and continuing growth in diverse ethnic backgrounds. The County threshold languages are Somali, Arabic, Chinese (Mandarin), Korean, Persian (including Farsi and Dari), Spanish, Tagalog, and Vietnamese. The two most widely spoken languages at home are English and Spanish. Additional demographic data for San Diego County is in Appendix F.

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

BHS is committed to engaging a wide range of community members and stakeholders in identifying priorities, provide feedback, and recommending strategies to address community behavioral health needs. Guided by the principle that everything we do should be created *for* and *with* the people we serve, BHS strives to reflect the needs and voices of the community across services within the behavioral health continuum of care to improve access, enhance the service quality, and ensure equitable resources. Collaboration activities occur throughout the year to ensure community stakeholders can receive information, provide input, identify priorities, address concerns, and are aware of ongoing policy shifts specific to MHSA and the broader behavioral health system.

Through the Community Program Planning (CPP) process, community engagement activities ensure local stakeholders have the opportunity to inform investments, priorities, and the array of behavioral health services funded through the MHSA. This includes large-scale outreach efforts to adults and seniors with SMI, families, service providers, justice and education partners, health care organizations, race/ethnic groups, and other communities of shared social identity (i.e., groups with shared characteristics, values, beliefs, or experiences) to recommend improvements, provide feedback, identify unmet needs, and make recommendations about MHSA investments.

To inform the MHSA Annual Update, a series of listening sessions, focus groups, and interviews were facilitated, in concert with the University of California, San Diego Health Partnership. To reach a wider audience, an online input form was developed to allow stakeholders to submit feedback and ideas throughout the year. In 2024, listening sessions were held across all San Diego County regions in accessible locations such as libraries and at community-based events and meetings. Focus groups brought together providers, community advocates, consumers, and other stakeholders to explore opportunities for service improvement. Interviews involved discussions with community leaders and professionals in behavioral health to gather insights on local needs and challenges. The feedback collected through these interactive activities guide program planning and improve MHSA-funded services. Full details of the CPP process can be found in the Stakeholder Engagement & CPP Process Report in Appendix G.

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD

A draft of the Annual Update for FY 2025-26 was posted on the BHS website from April 1 through May 1, 2025, for public review and comments. The draft Annual Update was sent to BHS stakeholders, including the San Diego Mental Health Coalition, Mental Health Contractors Association, and hospital partners for review and comment.

The County Behavioral Health Advisory Board (BHAB) is comprised of consumers, family members, prevention specialists, and professionals from the mental health and substance use disorder fields who represent each of the five County Supervisorial districts. BHAB held a public hearing on May 1, 2025, at the conclusion of the 30-day public review and comment period for the MHSA Annual Update. Stakeholder comments on the Annual Update is available in Appendix S.

The MHSA Issue Resolution Process for filing and resolving stakeholder concerns related to the CPP Process helps ensure consistency between program implementation and approved plans and is available in Appendix H.

MHSA FUNDED PROGRAMS

The sections below summarize accomplishments in FY 2023-24 and budgetary changes from the MHSA Three-Year Plan for programs for FYs 2024-25 and 2025-26. Changes are outlined for each of the five MHSA components, including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). A detailed budget by component can be found in Appendix A.

COMMUNITY SERVICES AND SUPPORTS (CSS)

CSS provides comprehensive services for children, youth, families, adults, and older adults experiencing SMI or SED. CSS programs enhance the mental health system of care resulting in the highest benefit to the client, family, and community, with a focus on unserved and underserved populations. In FY 2025-26, the estimated total budget for CSS programs is $227,119,611.

Approximately $7 million of CSS funds annually will be transferred to the Workforce Education and Training (WET) component in 2025-26 to continue funding programs identified in the WET section of this report.

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

As required by the California Code of Regulations (CCR), Title 9, Division 1, Chapter 14, Article 6, Section 3620 (c), each county “shall direct the majority of its Community Services and Supports funds to the Full-Service Partnership Service Category.” FSP programs account for a majority of the MHSA CSS budget in FY 2025-26.

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

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

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

CSS PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES

CSS programs for children, youth, and families (CYF) serve children and adolescents with SED and their families, including transition age youth ages 16-21. CSS programs for CYF offers a wide variety of services, from early intervention to residential services, aiming to meet the unique linguistic and cultural needs of San Diego County residents. Full-Service Partnerships (FSP) programs for children include school-based outpatient services, walk-in assessments, mobile assessment teams, medication support, intensive mental health services, case management, referrals and linkages, and assessments and interventions for people with co-occurring disorders. The FY 2023-24 FYP Outcomes Report for Children and Adolescents is available in Appendix J.

Student Yoga Affirmations

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

In FY 2025-26, the estimated total MHSA budget for CY-FSP programs is $63,923,367 and the estimated annual cost per client served in CY-FSP programs is $7,707, inclusive of all funding. The estimated number of clients to be served is 8,294.

HIGHLIGHTS FROM FY 2023-24:

INCREDIBLE YEARS (CY-FSP)

Incredible Years provides a full range of family focused, strength based, comprehensive, and integrated mental health services to children up to age five and their families, using the Incredible Years evidence-based program. This evidence-based program is designed to teach positive interaction skills, social problem-solving strategies, anger management, and appropriate school behaviors to young children. The program also strengthens parent-child relationships and helps parents develop positive behavior guidance strategies. The program includes parent/teacher training and treatment services for children within a preschool setting. In FY 2023-24, the program provided services to 48 schools and over 12,000 students in classroom services.

THERAPEUTIC BEHAVIORAL SERVICES (TBS) (CY-FSP)

The TBS program provides intensive, individualized, one-on-one coaching to children and youth up to age 21, who are experiencing an emotional or behavioral challenge. TBS supports children/youth and families with learning new methods to increase successful behaviors and improve skills to manage challenging behaviors. In addition to the one-to-one coaching, the program provides family education and supports with events that promote family connections and resiliency building. In FY 2023-24, TBS served 292 clients.

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

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth up to age 21, and their families who are involved with the County HHSA, Child and Family Well-Being (CFWB) and/or Probation Department. The program provides team-based care planning and coordination of needs and services to facilitate the youth transitioning home from a residential or home-based care setting or staying in their home. During FY 2023-24, the program served over 250 clients.

FUNDING ENHANCEMENTS AND CHANGES FOR FY 2024-25 AND 2025-26:

CHILDREN'S SCHOOL-BASED FULL-SERVICE PARTNERSHIP (FSP) (CY- FSP)
School-based FSP programs provide culturally competent outpatient services in easily accessible locations throughout the county, including clinics, schools, homes, and the community. Services include individual therapy, family therapy, case management, rehabilitation support, and medication management to children, youth, and their families. The services are client- and family-driven, and are provided by specialized teams of staff, including family partners who are employees with lived experience. Services offered are trauma informed and recognize that a whole person approach is critical to promote overall well-being. Partnership with the family, primary care, and education is a primary focus of successful treatment. In FY 2025-26, the budget increased by $311,638 allowing for increased capacity due to shifting of funds from Family Therapy Participation Engagement component as a result of program redesign.

FAMILY THERAPY (CY- FSP)
The Family Therapy Participation engagement program is a component of selected outpatient mental health clinics which uses peer support specialists with lived experience to provide education and support to caregivers of children and youth with SED. The program educates caregivers on the benefits of being actively engaged in the treatment process and works collaboratively with the family to address and resolve barriers to participation. In FY 2025-26,the budget decreased by $538,707 due to a shifting of funds to Children's School-Based Full-Service Partnership as a result of program redesign with a focus on increased treatment slots.

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

As of FY 2025-26, no programs remain in CY-OE funding as programs have been transferred to other funding components.

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

In FY 2025-26, the estimated total MHSA budget for CY-SD programs is $24,144,327; the estimated cost per client served in CY-SD programs is $7,682 inclusive of all funding; and the estimated number of clients is 3,143.

HIGHLIGHTS FROM FY 2023-24:

COMMERCIALLY SEXUALLY EXPLOITED CHILDREN (CSEC) (CY- SD)
The CSEC program serves youth that are at risk for, or currently a victim of, commercial sexual exploitation and have mental health or co-occurring substance use recovery needs. Individuals have access to individual, group and/or family therapy with psychiatric medication management seven days a week. The program offers a safe space for youth through Drop-In Centers, to receive behavioral health and supportive services such as caregiver support groups, internship programs, and peer support. In FY 2023-24, the program provided a full array of mental health services to 66 youth at Drop-in Centers offering supportive services.

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

The Our Safe Place program provides individual, group, family therapy and medication management to lesbian, gay, bisexual, transgender, and questioning youth, and their families. The program also operates Drop-in Centers, which provides supportive services such as youth groups, social activities, and educational trainings in an environment that emphasizes acceptance for LGBTQ youth and their families. The program serves one of San Diego County's most vulnerable populations to appropriately manage and overcome non-supportive environments in their homes, schools, and communities. In FY 2023-24, the program provided 57 clinic clients with supportive services with 142 youth utilizing the Drop-in Centers.

PERSONAL STORY
MENTAL HEALTH SERVICES FOR LGBTQ

The program assisted a non-binary youth, who was experiencing high levels of distress, had a history of suicide attempts, (one of which resulted in hospitalization), and periodic, ongoing self-harm. The team connected with the client and learned about the youth's severe dissociation, post-traumatic stress symptomology, gender and body dysphoria, excessive sleeping to cope with the self-harming behaviors and suicidal thoughts, and feelings of extreme isolation. After seven months working with this client, the youth reported an improved sleeping pattern and more frequent hygiene practices. The youth also reported a decrease in feeling isolated and an increase in motivation to work on hobbies. Most recently, when handling a new high-stress situation, the youth noted no desire to self-harm and continues to work on treatment goals by accessing the program's services on a regular basis.

FUNDING ENHANCEMENTS AND CHANGES FOR FYs 2024-25 AND 2025-26:

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

Optum San Diego serves as the ASO for BHS, facilitating the County's role in administering certain inpatient and outpatient Medi-Cal and realignment-funded specialty mental health services. Optum conducts ongoing quality review of therapy treatment plans and evaluation reports prepared for CFWB cases and evaluation reports prepared for Juvenile Probation cases. The ASO also operates a 24-hour Access and Crisis Line for callers to access and navigate the behavioral health system of care. It provides referrals and information for mental health and substance use, access to emergency mental health services, and other services. In FY 2025-26, the budget increased by $305,966 to support staffing increases and to align with annual contract budget increases.

BRIDGEWAYS (CY-SD)

Bridgeways provides individual, group, and family therapy with medication management to youth that are at risk or currently involved in the juvenile justice system and have mental health or co-occurring substance use needs. Services are provided in the community or home to offer better access to services. Bridgeways also provides psychoeducational groups and coordinates with the youth's probation officer to assist with linkage to services. In FY 25-26, the budget decreased by $560,000 to repurpose funding for Behavioral Health (BH) Links to advance the Next Move program as the primary outpatient provider for youth with justice involvement.

MEDICATION CLINIC (CY-SD)

The Medication Clinic program provides ongoing medication management to children and youth who have successfully completed mental health treatment, and have medication needs that are too complex for their primary care physician to manage. In FY 2025-26, the budget increased by $1,461,000 to continue supporting the medication needs of youth in Short-Term Residential Therapeutic Programs (STRTPs) and youth transitioning out from juvenile detention facilities and enhancing services beyond the initial term.

CSS PROGRAMS FOR TRANSITION AGE YOUTH, ADULTS, AND OLDER ADULTS

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

Full-Service Partnership (FSP) Assertive Community Treatment (ACT) programs use a "whatever it takes" model to comprehensively address individual and family needs and focus on resilience and recovery to help individuals achieve their mental health treatment goals. Adult FSP programs provide: ACT services, supported housing (temporary, transitional, and permanent), intensive case management, wraparound services, community-based outpatient services, rehabilitation, and recovery services, supported employment and education services, dual-diagnosis services, peer support, justice system transition support, and other services. The FSP/ACT outcome report for TAY, adults and older adults is available in Appendix K. The Five Year (2022-27) Strategic Housing Plan is available in Appendix L. View details of the housing projects funded through MHSA CSS funds here: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa_housing.html

Client Artwork

TAY, ADULTS AND OLDER ADULTS – FULL-SERVICE PARTNERSHIPS (TAOA-FSP)

In FY 2025-26, the estimated total MHSA budget for TAOA-FSP programs is $116,339,943, with estimated cost per client served in TAOA-FSP programs at $17,792 inclusive of all funding and the estimated number of clients to be served is 6,539.

HIGHLIGHTS FROM FY 2023-24:

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

Strengths-Based Case Management (SBCM) is designed to provide continuity of care through County-operated behavioral health services to adults living with serious and persistent mental health and co-occurring disorders. County case managers provide psychosocial rehabilitation intervention services along with resource management to assist individuals in obtaining optimum independence. Service plans might include assistance with accessing psychiatric treatment at the appropriate level, help with housing, educational and vocational planning, crisis management, life skills training, advocacy, and linkage and referral with other services such as physical health care, government assistance, legal services, and community based spiritual supports. Additionally, the program uses art as an integrative treatment for behavioral health conditions to help people manage their symptoms. It is also used as a medium for clients to share their stories. SBCM had its 6th Annual Art

Strengths-Based Case Management Art Show

Show on September 20, 2024, which featured an array of client artwork. In FY 2023-24, the program served 423 clients.

SHORT- TERM MENTAL HEALTH INTENSIVE CASE MANAGEMENT - HIGH UTILIZERS (TAOA- FSP)
The program provides short-term, intensive case management services utilizing the ACT treatment model. Teams work toward preventing unnecessary hospitalization, improving quality of life, and improving client function. The program uses evidence-based models of intervention, such as ACT and SBCM. Participation in the program results in reduced hospitalizations, reduced recidivism, and improved quality of life. In FY 2023-24 the program served a total of 146 clients with 100% of participants connected to treatment with 91% of clients still connected to treatment 60 days post discharge.

CARE ACT Program Staff

PERSONAL STORY
CARE ACT SERVICES

The CARE Team received an order from the court to complete an investigation for a 35-year-old male who was experiencing homelessness, was not engaged in treatment, and had been struggling with symptoms of psychosis and co-occurring substance use for the past several years. The CARE Team was able to build rapport with him and explain the services that could be provided to him through the CARE Act Program. He agreed to participate and was able to complete an intake and get into a sober living facility the same day. While in the sober living facility, he expressed willingness to receive medication management and explore education and employment services.

CARE ACT PROGRAM (TAOA-FSP)
The Community Assistance, Recovery & Empowerment (CARE) Act provides mental health and substance use disorder services to the most severely impaired individuals who are facing homelessness or incarceration without treatment. CARE is aimed at these individuals who are suffering from untreated mental health and substance use disorders leading to homelessness and/or justice involvement with access to critical behavioral health services, housing, and support through providing a comprehensive CARE plan. Since services began October 1, 2023, BHS has received 131 petitions with 66 dismissed and 65 active cases through June 30, 2024.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

ASSISTED OUTPATIENT TREATMENT (AOT) (TAOA-FSP)
AOT is an intensive, community-based service for persons who establish an AOT court settlement agreement, persons who are court-ordered to receive AOT, and persons who otherwise meet the AOT eligibility criteria. This program integrates behavioral health and rehabilitation treatment and recovery services for adults with SMI who have been identified as potential AOT candidates by the County. In FY 2025-26 this program received a budget increase of $1,083,623 for the creation of fifty additional CARE ACT program slots.

ASSISTED OUTPATIENT TREATMENT (AOT) HOUSING (TAOA-FSP)
AOT-Housing provides intensive community-based services for individuals who are homeless or at risk of homelessness and have SMI and qualify for Laura's Law and have been referred by the In-Home Outreach Team (IHOT). The program also provides AOT services to individuals who have a CARE agreement and have been referred by the County CARE team. In FY 2025-26 this new program received a budget of $346,451 to provide short-term rental assistance for CARE ACT clients.

CARE COURT SERVICES (TAOA-FSP)
The CARE Court services include, but are not limited to, outreach and engagement, clinical evaluation, service coordination, and behavioral health treatment services for individuals with serious mental illness who meet eligibility criteria and have a civil court ordered CARE plan, which may include treatment, housing, medication, and other social supports. In FY 2025-26 the budget decreased by $2,000,000 due to shifting of funds to FSP/ACT without impact to services.

COUNTY OF SAN DIEGO – STRENGTHS-BASED CASE MANAGEMENT (SBCM) HOUSING (TAOA-FSP)
SBCM is designed to provide continuity of care through County-operated behavioral health service to adults, living with serious and persistent mental health and co-occurring disorders. County case managers provide psychosocial rehabilitation intervention services along with resource management to assist individuals in obtaining optimum independence. Service plans might include assistance with accessing psychiatric treatment at the appropriate level, help with housing, educational and vocational planning, crisis management, life skills training, advocacy, and linkage and referral with other services such as physical health care, government assistance, legal services, and community based spiritual supports. In FY 2025-26 the budget increased by $742,000 to support short-term rental assistance services.

FULL-SERVICE PARTNERSHIP (FSP)/ASSERTIVE COMMUNITY TREATMENT (ACT) (TAOA-FSP)
FSP/ACT programs provide intensive community-based services for persons who are at risk of or experiencing homelessness, have an SMI, and who may have a co-occurring substance use disorder. These programs employ a “whatever it takes” model to help clients avoid the need for emergency services such as crisis stabilization, crisis outpatient, crisis residential, and services provided at the psychiatric hospital. ACT teams provide medication management, mental health services, vocational services, substance abuse services, and other services to help clients achieve success and independence and sustain the highest level of functioning while remaining in the community. In FY 2025-26 the budget increased by $2,607,500 to support short-term rental assistance services and due to shifting of funds from CARE court services.

FULL-SERVICE PARTNERSHIP (FSP)/ASSERTIVE COMMUNITY TREATMENT (ACT) – HOUSING (TAOA-FSP)
FSP/ACT housing programs provide housing and supports to persons experiencing SMI who are at-risk of or experiencing homelessness. Programs offer an array of short-term, transitional, and permanent supportive housing resources, including housing subsidies provided through partnerships with local housing authorities. Homeless-dedicated ACT programs have MHSA housing funds for rental and non-rental housing assistance, as well as dedicated housing staff such as housing coordinators and housing specialists to provide housing navigation and ongoing tenancy support services. In FY 2025-26, the budget increased by $6,247,466 to support short-term rental assistance and other housing resources.

FULL-SERVICE PARTNERSHIP (FSP) / ASSERTIVE COMMUNITY TREATMENT (ACT) – STEP DOWN FROM ACUTE (TAOA-FSP)
The FSP/ACT Step Down From Acute program provides ACT services to clients with SMI who are not connected to outpatient services, are at risk of or experiencing homelessness, and who are being discharged from an acute-care facility back into the community. The step down program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The ACT program also provides SBCM services to clients who are not able to transition to a stand-alone SBCM program. In FY 2025-26, the budget increased by $392,000 to support short-term rental assistance and other housing resources.

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

The FSP/ACT step down from IMD program provides ACT services to clients with SMI who are homeless or at risk of homelessness and stepping down from a long-term care facility such as a skilled nursing facility, state hospital or IMD. These clients are not connected to outpatient services and are being discharged from a long-term care facility back into the community. The step-down program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The program also provides strength-based case management (SBCM) services to clients who are not able to transition to a stand-alone SBCM program. In FY 2025-26, the budget increased by $392,000 for short-term rental assistance and other housing resources.

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

The FSP/ACT transitional residential program provides ACT services to adult clients with SMI who are homeless or at risk of homelessness within a transitional residential program to increase independent living and reduce hospitalizations through educational and employment opportunities. Clients are not connected to outpatient services. The program increases clinical and functional stability through a variety of mental health services, housing opportunities, and educational and employment support. The program also provides SBCM services to clients who are not able to transition to a stand-alone SBCM program. In FY 2025-26, the budget increased by $3,250,254 for an expansion of services under Adult Mental Health Transitional Residential Program.

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

The short-term mental health intensive case management program utilizes the ACT treatment model to work toward preventing unnecessary hospitalization, improving quality of life, and improving client function. The program uses evidence-based models of intervention, such as ACT and SBCM. Participation in the program results in reduced hospitalizations, reduced recidivism, and improved quality of life. In FY 2025-26, the budget increased by $1,320,000 to expand housing services.

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

SBCM programs provide case management services along with physical health referrals, peer counseling, linkage to services, and access to resources for persons who have SMI or SED through contracted providers. In FY 2025-26, the budget increased by $729,000 to support short-term rental assistance services for clients in the program.

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

In FY 2025-26, the estimated total MHSA budget for TAOA-OE programs is $2,487,849; the estimated cost per client served in TAOA-OE programs is $2,737 inclusive of all funding; and the estimated number of clients to be served is 909.

HIGHLIGHTS FROM FY 2023-24:

NORTH INLAND COUNTYWIDE HOMELESS OUTREACH PROGRAM (TAOA-OE)

The County Homeless Outreach Program conducts outreach and engages persons 18 and older with serious mental illness and/or substance use conditions who are unsheltered to provide a behavioral health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources. In FY 2023-24 the program served 3,309 clients during outreach services, with 820 receiving short-term case management services.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

There are no budgetary changes to report.

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

In FY 2025-26, the estimated total MHSA budget for TAOA-SD programs is $167,291,890; the estimated cost per client served in TAOA-SD programs is $4,541 inclusive of all funding; and the estimated number of clients to be served is 36,844.

HIGHLIGHTS FROM FY 2023-24:

NORTH INLAND MENTAL HEALTH CENTER (TAOA-SD)

The North Inland Mental Health Centers provide outpatient mental health rehabilitation and recovery services, urgent walk-in appointments, peer support services, homeless outreach, case management, and long-term vocational support services to adults with SMI, including individuals with co-occurring SUD. The program is designed to increase access to mental health services and overcome barriers such as language, wait times, and lack of knowledge or awareness of available services. In FY 2023-24, the center provided broad regional coverage through the Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery Centers and served 1,377 clients across two main locations and two satellite.

SAN DIEGO EMPLOYMENT SOLUTIONS (TAOA-SD)

The San Diego Employment Solutions program provides job opportunities to help adults with SMI obtain employment. The program uses a comprehensive approach that is community-based, client- and family driven, and culturally competent. In FY 2023-24, the program provided 169 intakes with 2,253 job preparation services, 1,663 job development services, and 1,099 post placement services.

TENANT PEER SUPPORT SERVICES (TPSS) (TAOA-SD)

The TPSS program provides housing support for clients experiencing homelessness to link them to appropriate resources and assist them with the tools to sustain housing. The program is dedicated to serving the homeless population. TPSS was named a 2022 National Association of Counties Achievement Award winner, which recognizes programs for innovative approaches to providing new or needed services, improving administration of existing programs, or promoting intergovernmental cooperation and coordination. In FY 2023-24, The program served 839 clients providing individuals with an opportunity to spend the holidays under their own roof. TPSS was able to provide housing support services to residents in 60 units at St. Teresa of Calcutta Villa.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

BIO-PSYCHOSOCIAL REHABILITATION (TAOA-SD)

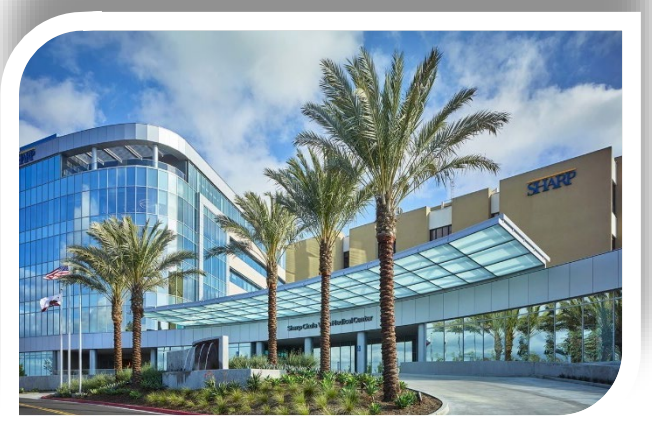
BPSR Wellness Recovery Centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support at multiple locations throughout the county. The program offers specific programs dedicated to TAY and older adult geriatric specialists who provide culturally and age-appropriate services. These programs help improve the individual's level of functioning, quality of life, and housing status, as well as linkage to services, obtaining employment, and linkage to primary care services. In FY 2025-26 the budget decreased by $1,345,722 due to low utilization of services without impact to clients.

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

The CSU serves individuals who may either come voluntary or be brought in on a California Welfare & Institutions Code (WIC) 5150 hold. The CSU also provides crisis stabilization services lasting less than 24 hours to persons in a psychiatric crisis due to a mental health condition that requires a timelier response than a regularly scheduled visit to prevent decompensation. In FY 2025-26 the budget for this new program is $5,338,177 for crisis stabilization services.

CRISIS STABILIZATION UNIT (CSU) – CHULA VISTA (TAOA-SD)

The CSU serves individuals who may either come voluntary or be brought in on a California WIC 5150 hold. The CSU also provides crisis stabilization services lasting less than 24 hours to persons in a psychiatric crisis due to a mental health condition that requires a timelier response than a regularly scheduled visit to prevent decompensation. The Sharp Chula Vista Medical Center CSU differs from other CSUs as it is co-located in an emergency department, thus enabling people with behavioral health needs to transition smoothly to a CSU without being discharged. In FY 2025-26 the budget for this new program is $9,101,721 to provide crisis stabilization services.



Sharp Chula Vista Medical Center

INPATIENT AND RESIDENTIAL ADVOCACY SERVICES (TAOA-SD)

Inpatient and Residential Advocacy Services offers ongoing support, advocacy services, and training to staff and residents who are currently in County-identified skilled nursing facilities and County-identified board and care facilities. The program provides patient representation at legal proceedings related to a denial of rights and handles patient complaints or grievances in these facilities. In FY 2025-26 the budget increased by $806,149 due to expansion of services, including providing education on patient rights and advocacy services, case management, and CARE Court activities.

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

The ICM program serves older adults, 60 years of age or older, with SMI who are in a long-term care setting, with case management services to help support their reintegration into the community. In FY 2025-26, the budget increased by $834,780 to provide short-term rental assistance and other housing resources.

MENTAL HEALTH ADVOCACY SERVICES (TAOA-SD)

The Mental Health Advocacy program provides outreach and engagement to clients receiving outpatient and non-residential services. In FY 2025-26 the budget increased by $872,426 for staff increases and expansion of services, including education and advocacy services, trainings on client rights, and case management.

PEER ASSISTED SUPPORT SERVICES (TAOA-SD)

The Peer-Assisted Support Services program provides coaching and social support services. The program focuses on improving mental health, reducing substance use, and increasing social support to individuals with SMI who are not connected to services. The program engages with individuals in inpatient or crisis residential programs and continues engagement until after discharge to ensure they are connected to the appropriate services. In FY 2025-26, the budget decreased by $892,995 due to redesign of program without impacting services.

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

The SSI Advocacy Services program assists eligible individuals with submitting their SSI applications to the Social Security Administration. The program helps expedite SSI awards to individuals and provides services, including trainings for SSI advocates to assist applicants, consultations, outreach, and education. In FY 2025-26 the budget increased by $247,537 for expansion of services and to align with the annual contract budget increases.

CSS PROGRAMS FOR ALL AGES

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

Group Parenting Classes

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

In FY 2025-26, the estimated total MHSA budget for ALL-OE programs is $4,375,712; the estimated cost per client served in ALL-OE programs is $790, inclusive of all funding; and the estimated number of clients to be served is 5,538.

HIGHLIGHTS FROM FY 2023-24:

BEHAVIORAL HEALTH SERVICES - VICTIMS OF TRAUMA AND TORTURE (ALL- OE) This program improves access to mental health services for survivors of trauma and torture, and/or asylum seekers who are experiencing or at risk of SMI, including co-occurring substance use conditions or SED and are at risk of developing new or worsening behavioral symptoms. Through culturally specific outreach and education, the program goal is to increase access to, and use of, mental health services, outreach, and education to the specific population. The program is Medi-Cal Certified and provides services in 47 languages. In FY 2023-24, the program served 159 clients.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

PSYCHIATRIC AND ADDICTION CONSULTATION AND FAMILY SUPPORT SERVICES (ALL- OE) The Psychiatric and Addiction Consultation and Family Support Services program provides behavioral health consultation services for primary care and behavioral health providers as well as client and caregiver support services for children, adolescents, and TAY under the age of 21. The program improves the confidence, competence, and capacity of primary care and behavioral health providers in treating behavioral health conditions and increases the identification and treatment of behavioral health issues in youth through consultations, education, referrals, and linkages. In FY 2025-26, the budget increased by $51,806 to align with the annual contract budget increases.

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2025-26, the estimated total MHSA budget for ALL-SD programs is $20,210,762; the estimated cost per client served in ALL-SD programs is $2,045, inclusive of all funding; and the estimated number of clients to be served is 9,883.

HIGHLIGHTS FROM FY 2023-24:

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

The MCRT is a 24/7 field-based program utilizing teams that consist of a clinician, case manager, and staff, that respond countywide to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis and connect them to the most appropriate level of care. During FY 2023-24, the program has diverted more than 80% of calls from higher levels of care with 97% of calls receiving a response by the program in less than an hour, with an average response time being 26 minutes.

Mobile Crisis Response Team

PERIPARTUM PROGRAM (ALL-SD)

The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) provides outpatient mental health treatment services for pregnant women and adolescents and new mothers experiencing peripartum depression or anxiety. Program services include individual, group, and family therapy, crisis intervention, case management/care coordination, medication services, peer support, and services (directly or by referral) for individuals with co-occurring mental health and substance use needs. ADAPT works closely with Public Health Nursing programs, such as the Maternal Child Health and Nurse Family Partnership, to provide comprehensive and supportive care for peripartum individuals at high risk, including offering consultations and case conferences for program participants with complex needs. ADAPT services are accessible for diverse populations, in person and by telehealth, and provided in the language of the participant and family, by bilingual staff or with professional interpreters. In FY 2023-24, the program served 156 clients.

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

The PERT program partners clinicians with specially trained police officers and deputies to ensure a more effective response to interactions involving law enforcement officers and individuals with mental illness. Teams are on-call and provide countywide services to individuals with a behavioral health crisis who have encounters with local law enforcement agencies and/or who need immediate behavioral health crisis intervention. In FY 2023-24, PERT provided 10,262 crisis intervention services to individuals experiencing a behavioral health crisis.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

CHALDEAN AND MIDDLE EASTERN SOCIAL SERVICES (ALL-SD)

The Chaldean and Middle Eastern Social Services program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle-Eastern descent who are experiencing SMI or SED. Children and youth with SED have access to outpatient clinical services and may be connected to acculturation groups. In FY 2025-26, the budget decreased by $303,599 due to the contract ending in March 2024.

CSS PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2025-26, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA CSS Work Plan	FY 2025-26 Proposed Budget (All Funding)	FY 2025-26 Estimated Number of Clients Served					FY 2025-26 Estimated Cost Per Client
		Children	TAY	Adult	Older Adults	Total	
CY-FSP	$ 63,923,366	6,954	1,340	-	-	8,294	$ 7,707
CY-SD	$ 24,144,327	2,188	955	-	-	3,143	$ 7,682
TAOA-FSP	$ 116,339,943	-	580	4,385	1,575	6,539	$ 17,792
TAOA-OE	$ 2,487,849	-	-	909	-	909	$ 2,737
TAOA-SD	$ 167,291,890	-	4,235	29,498	3,112	36,844	$ 4,541
ALL-OE	$ 4,375,712	3,311	149	2,041	37	5,538	$ 790
ALL-SD	$ 20,210,762	1,144	1,750	5,316	1,673	9,883	$ 2,045
Total CSS	**$ 398,773,849**	**13,597**	**9,008**	**42,148**	**6,396**	**71,150**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, FFP, and other funding. Administrative costs are not included.
- The FY 2025-26 estimated cost per client figures are based on the total proposed FY 2025-26 budget divided by the actual number of clients broken down by population served in FY 2023-24, plus the estimated new clients to be served in FY 2025-26. FY 2023-24 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figure will vary by service and contract based on the contracted rate, level of care, and number of clients.
- The annual projected unique clients for FY 2025-26 will vary from the number of unique clients served in Appendix I, J, and K because some programs no longer exist, and new programs will be added in FY 2025-26. Additionally, clients may receive one or more different services, so there may be duplication of clients across work plans.

PREVENTION AND EARLY INTERVENTION (PEI)

Prevention and Early Intervention (PEI) programs bring mental health awareness to members of the community through public education initiatives and dialogue. To ensure access to appropriate support at the earliest point of emerging mental health symptoms, PEI builds capacity for providing mental health early intervention services at sites where people go for other routine activities. Through PEI, mental health becomes part of wellness for individuals and the community, reducing the potential for stigma and discrimination against individuals with mental illness. In FY 2025-26, the estimated total budget for PEI programs is $51,021,969. As required by MHSA, a majority of funding for PEI programs must be directed to programs that serve persons less than 25 years of age. In FY 2025-26, this requirement will be met with more than 60% percent of the budget for PEI programs budgeted for programs serving persons less than 25 years of age.

A detailed budget for PEI may be found in Appendix A. The PEI FY 23-24 Annual Report can be found in Appendix M and the Three-Year PEI Evaluation Report can be found in Appendix N. A summary of the estimated cost per client is available at the end of the PEI section.

Client Artwork

HIGHLIGHTS FROM FY 2023-24:

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

Check Your Mood is an annual event held the first Thursday in October in conjunction with National Depression Screening Day which engages and encourages San Diegans to monitor and assess their emotional well-being. Organizations across the San Diego region come together to provide free mental health resources, information, and Check Your Mood screenings to the community which helps to raise awareness and reduces the stigma related to mental health. In 2024, BHS and other County staff partnered with local businesses, healthcare agencies, community partners, and volunteers to provide these services at 40 sites throughout the county.

Check Your Mood Outreach Team

CLUBHOUSE SERVICES PROGRAM (PS-01)

The Clubhouse program provides prevention and early intervention services through the provision of personal care assistance including showering and laundry services to persons experiencing homelessness to promote and assist participants with increased resiliency and self-care. The program also conducts outreach to underserved populations, including black, indigenous, people of color (BIPOC), and unhoused individuals in the Downtown area of East Village, to increase recognition of early signs of mental illness and access and linkage to treatment program. In FY 2023-24, the program enrolled 297 individuals through street outreach services exceeding the goal of 167 and provided clubhouse services to 366 members. The program provided shower services to 924 individuals and laundry services to 260 individuals.

County of San Diego Clubhouses

PERSONAL STORY
CLUBHOUSE SERVICES PROGRAM

During a mental health crisis, a client overheard the police discussing the need to place her under conservatorship. However, she took control of her situation, advocating for herself to ensure her hospital stay remained voluntary. Drawing on the skills and resources she learned as a member of the Clubhouse, she secured case management support to help her transition out of the hospital with a stable plan. She was approved to stay at a crisis house in North County while waiting for suitable housing. Now, she attends an outpatient program three times a week and is deeply grateful for the peer support partners who are integral to her recovery plan.

FAMILY PEER SUPPORT PROGRAM (PS-01)

The Family and Adult Peer Support programs, Friends in the Lobby and In Our Own Voice, provide outreach and awareness through training and the dissemination of education materials in primary care, senior centers, faith-based forums, and other venues. Individuals with lived experience promote social and emotional wellness for adults, older adults, and their families who are visiting individuals that have been hospitalized in psychiatric units. The programs reduce stigma and discrimination, increase acceptance of mental illness and awareness of treatment choices, and increase access and use of available services, especially in unserved and underserved communities. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the county. During FY 2023-24, the program provided 168 mental health presentations to 2,332 individuals. The Hotline provided 1,857 individuals with information services.

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

Positive Solutions provides home-based outreach, prevention, and intervention services to older adults who are homebound and socially isolated. The program reaches out to these adults and engages them with the Program to Encourage Active and Rewarding Lives (PEARLs) which is an evidence-based program that provides mental health screening, assessment, counseling, and referral and linkage to care. In FY 2023-24, staff attended 68 community outreach events countywide, served 1,404 seniors with PEI services and 249 older adults with the evidence-based PEARLs intervention.

VETERANS & FAMILY OUTREACH EDUCATION (VF-01)

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

members. In FY 2023-24 the program served 1,508 individuals and 2,051 families. There were 6,218 linkages to resources made, of which 98% of those successfully enrolled in and/or utilized services.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

ALLIANCE FOR COMMUNITY EMPOWERMENT (DV-03)
Alliance for Community Empowerment (ACE) is a community response-team program that engages siblings of identified gang members to teach and encourage resiliency. The ACE team members engage children and youth in schools, recreational centers, and their homes. Parents are also engaged and supported with various activities which increase resilience, coping skills, and improve overall quality of life. In FY 2025-26 the budget increased by $147,554 due to program demands and Medi-Cal eligibility redesign to maximize reimbursement.

BREAKING DOWN BARRIERS (PS-01)
Breaking Down Barriers is an outreach campaign that engages underserved communities including Latino, African American, Native American, African immigrants/refugees, and LGBTQ individuals to increase access to mental health services. The program reduces stigma and discrimination through increased awareness and acceptance of mental illness and treatment choices, thereby increasing access and use of available services. In FY 2025-26 the budget increased by $1,000,000 to expand program capacity for community engagement with underserved communities.

CONSUMER ADVOCACY (PS-01)
Consumer connection and empowerment activities cultivate meaningful relationships and feedback to improve behavioral health programming across San Diego County. Key efforts include organizing opportunities (e.g., town halls, listening sessions, educational workshops, annual events) for community dialogues to gather input from children, families, and unserved and underserved groups regarding a variety of behavioral health topics, programs, and services. Activities conducted throughout the year integrate resource-sharing, tool promotion (e.g., awareness for behavioral health mobile applications), and include different events and trainings designed to enhance awareness and access to the local continuum of care. In FY 2025-26, the budget for this new program is $750,000.

COUNTY OF SAN DIEGO YOUTH SUICIDE REPORTING AND CRISIS RESPONSE (PS-01)
The Youth Suicide Reporting and Crisis Response Pilot program aims to develop and test models for rapidly reporting and responding to suicides and suicide attempts among youth under 25 years old. San Diego County was selected due to having the second highest youth suicide count and rate in the state from 2018-2020. This program allows the County to enhance existing suicide prevention and crisis response efforts, such as improving data surveillance, implementing emergency department peer support programs, increasing outreach and behavioral health trainings, and enhancing coordination between community partners. In FY 2025-26, the budget decreased by $2,379,200 due to the pilot program ending in June 2025.

EARLY INTERVENTION FOR PREVENTION OF PSYCHOSIS (FB-01)
The Kickstart program identifies and trains community leaders to identify the indicators of early psychosis. These leaders refer teens and young adults with potential behavioral health issues to clinicians who provide crisis intervention, treatment, individual and group therapy, and in-home services. Additionally, these youth can be transitioned to outpatient programs if needed. Early treatment of behavioral health issues results in increased well-being, school success, family involvement, improved functioning, and the reduction of hospitalizations. In FY 2025-26 the budget increased by $186,800 to align with the annual contract budget increases.

FAMILY PEER SUPPORT PROGRAM (PS-01)
The Family Peer Support programs, Friends in the Lobby, and In Our Own Voice, provide outreach and awareness through training and the dissemination of education materials in primary care, senior centers, faith-based forums, and other venues. Individuals with lived experience promote social and emotional wellness for adults, older adults, and their families who are visiting individuals that have been hospitalized

in psychiatric units. The programs reduce stigma and discrimination, increase acceptance of mental illness and awareness of treatment choices, and increase access and use of available services, especially in unserved and underserved communities. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the county. In FY 2025-26 the budget increased by $339,660 for program enhancements to include guided navigation support for adults and families dealing with serious mental health conditions.

MENTAL HEALTH FIRST AID (MHFA) (PS-01)
The MHFA program provides individuals the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The program provides countywide, community-based education and training services. In FY 2023-24, MHFA provided over 517 trainings countywide – with 3,873 adults and 474 youth participating. Within the County, 1,149 HHSA employees received the training to better meet the needs of the communities they serve. In FY 2025-26 the budget increased by $218,870 to support staffing increases and operational needs.

PUBLIC MESSAGING FOR SUBSTANCE USE, MISUSE, AND OVERDOSE PREVENTION (PS-01)
Public messaging for Substance Use, Misuse, and Overdose Prevention delivers strategic and evidence-based public messaging initiatives to mitigate substance use-related harms and foster safer, healthier communities. The program employs environmental and community-based prevention strategies, emphasizing harm reduction approaches, health equity, and social determinants of health. Activities include the promotion of existing behavioral health campaigns (e.g., It's Up to Us, San Diego Opioid Project, Own Your Mindset), the development and implementation of focused public messaging campaigns that address underage drinking, cannabis misuse, opioid use, substance misuse challenges, and other similar topics. It also includes training, technical assistance, and planning tools for stakeholders to support the creation and dissemination of consistent, data-informed messages. The budget for this new program in FY 2025-26 is $400,000.

SUICIDE PREVENTION & STIGMA REDUCTION MEDIA CAMPAIGN – IT'S UP TO US (PS-01)
County-wide media and marketing efforts, collectively known as BHS' "It's Up to Us" campaign, focuses on educating the public about behavioral health topics, stigma reduction, and increasing public awareness around resources to support individuals' mental and emotional well-being. The campaign provides awareness of the stigma of mental illness, promotes individual acceptance of mental illness, and provides materials and information on options for intervention, treatment, and recovery. In FY 2025-26 the budget decreased by $2,392,770 due to shifting of funds to MHSA-Administration to support Ad Hoc public messaging, outreach, and education campaigns.

YOUTH ENGAGEMENT AMBASSADOR PROGRAM (PS-01)
Youth Engagement Ambassador activities aim to engage, equip, and enable youth and to promote mental health awareness, reduce stigma, and improve access to early intervention services through creative expression, leadership development, and community advocacy. By engaging youth in educational campaigns and outreach efforts, youth-led approaches are prioritized and the lived experiences of youth across the region are leveraged to foster meaningful connections and resilience among their peers. Additionally, such efforts support the improvement of California's broader public and private behavioral health system of care and help to address local concerns with youth-specific challenges regarding vaping, anxiety, depression, bullying, suicide risk, and social media influence and/or peer pressure. In FY 2025-26 this program is budgeted for $400,000 to support schools participating in Directing Change program activities, including contest submissions, promotional materials, and participant awards.

The table below represents the estimated cost per client for FY 2025-26, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services. The County PEI work plan structure reflected below was developed through a comprehensive stakeholder process and meets all state requirements. For additional details on the PEI work plan, please visit: *https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/documents/NOC/MHSA/FINAL-DRAFT-PEI-PLAN-11-19-08-complete.pdf*.

PEI PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

MHSA PEI Work Plan	Population Served	FY 2025-26 Proposed Budget (All Funding)	FY 2025-26 Estimated Number of Clients Served	FY 2025-26 Estimated Cost Per Client
CO-03 Integrated Peer & Family Engagement	ALL	$ 3,152,097	1,145	$ 2,753
DV-03 Alliance for Community Empowerment	Children, Youth	$ 1,145,403	1,032	$ 1,110
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$ 503,458	218	$ 2,309
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$ 1,392,470	3,086	$ 451
FB-01 Early Intervention for Prevention of Psychosis	Children, TAY	$ 2,580,153	190	$ 13,580
NA-01 Native American Prevention and Early Intervention	ALL	$ 2,581,150	8,045	$ 321
OA-01 Community-Based Services for Older Adults	OA	$ 573,080	2,089	$ 274
OA-02 Home-Based Services - For Older Adults	OA	$ 582,553	1,653	$ 352
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$ 1,088,217	96,300	$ 11
PS-01 Education and Support Lines	ALL	$ 14,849,319	22,641	$ 656
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$ 2,133,409	668	$ 3,194
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$ 302,070	-	-
SA-01 School-Based Program	Children, Youth	$ 13,148,384	17,866	$ 736
SA-02 School-Based Suicide Prevention & Early Intervention	Children, Youth, TAY	$ 2,473,469	18,963	$ 130
SA-03 Youth & Family Support Services	Children, Youth	$ 657,743	150	$ 4,385
VF-01 Veterans & Family Outreach Education	ALL	$ 1,593,589	1,084	$ 1,470
Total PEI		**$ 48,756,566**	**175,130**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, FFP, and other funding. Administrative costs and PEI assigned funds are not included.
- The RE-01: Independent Living Association program does not have client count data.
- The FY 2025-26 estimated cost per client figures are based on the total proposed FY 2025-26 budget divided by the actual number of clients served in FY 2023-24, plus the estimated new clients to be served in FY 2025-26. FY 2023-24 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figures will vary by service and contract based on the contracted rate, level of care, and number of clients.
- The annual projected unique clients for FY 2025-26 will vary from the number of unique clients served in Appendix M.

INNOVATION

Innovation (INN) projects are short-term, novel, creative mental health practices or approaches that contribute to learning. INN programs require data analysis and evaluation services to assess client and system outcome measures. Budget funds are allocated for program evaluation and services are provided by UCSD Child and Adolescent Services Research Center and/or UCSD Health Services Research Center. In FY 2025-26, the estimated INN expenditures will be $17,369,025.

A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix P. A summary of the estimated cost per client is available at the end of this section.

Behavioral Health Services Team

HIGHLIGHTS FROM FY 2023-24:

PUBLIC BEHAVIORAL HEALTH WORKFORCE DEVELOPMENT AND RETENTION PROGRAM (INN-25)

The Public Behavioral Health Workforce Development and Retention Program will implement strategies and incentives to address unmet needs within the region by recruiting, training, and retaining a diverse public behavioral health workforce. This program will distribute and monitor the use of funding to support individuals seeking a variety of training, tuition support, upskilling and incentive opportunities designed to attract and retain workers in the public behavioral health field. During FY2023-24, the program was in the implementation phase and began operating in FY 2024-25.

FUNDING ENHANCEMENTS AND CHANGES FOR FY 2024-25 AND FY 2025-26:

There are no budgetary changes to report.

INN ESTIMATED COST PER CLIENT

The table below represents the estimated cost per individual for FY 2025-26, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA INN Work Plan	Population Served	FY 2025-26 Proposed Budget (All Funding)	FY 2025-26 Estimated Number of Clients Served	FY 2025-26 Estimated Cost Per Client
INN-25 Public Behavioral Health Workforce Development and Retention Program	ALL	$ 15,103,500	590	$25,599
Total INN		**$ 15,103,500**	**590**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, FFP, and other funding. Administrative costs are not included.
- Estimated number of clients served is based on project proposal.

WORKFORCE EDUCATION AND TECHNOLOGY

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

In FY 2025-26, the estimated WET expenditures will be $7,619,073. Annually, up to $7 million in CSS funds will be transferred to the WET component to continue funding programs. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually. A detailed budget for WET may be found in Appendix A.

Behavioral Health Services Team

HIGHLIGHTS FROM FY 2023-24:

PUBLIC MENTAL HEALTH ACADEMY (WET-03)

The Public Mental Health Academy (PMHA) prepares students for local employment opportunities in entry level public behavioral health systems. The PMHA provides academic counseling and support for students interested in pursuing a career in public behavioral health. It was created to address the shortage and lack of diversity in public mental health service providers. The program provides a career pathway in public behavioral health by offering coursework leading to a Mental Health Work Certificate of Achievement. During the 2023-24 academic year, 51 new students were enrolled in the program with over half of them completing the certificate, contributing to 412 total graduates since program inception in 2010. As of March 2025, there were over 50 students enrolled in the program with over 450 academic counseling appointments provided to individuals for ongoing support and guidance.

FUNDING ENHANCEMENTS AND CHANGES FOR FYS 2024-25 AND 2025-26:

There are no budgetary changes to report.

PERSONAL STORY
PUBLIC MENTAL HEALTH ACADEMY

A client participated in car stunts as a teenager that resulted in the death of her friend. She was convicted of manslaughter and after being released, she fell into homelessness and struggled with substances. She was in a rehabilitation program but ended up back in jail. She claims serving jail time saved her life, which allowed her to "get sober, connect to God, and begin to heal." She was determined to create a positive future and connected to Mesa College's Rising Scholars Program for the incarcerated and formerly incarcerated students. She shared, "The program changed my life, the staff involved were my first and only support system since 2017 when I first became homeless...the staff truly believed in me and provided endless encouragement." The client finished associate degrees in psychology, social work, and social and behavioral sciences. She plans to pursue a bachelor's degree in psychology or social work.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

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

Tri-City Psychiatric Health Facility

FUNDING ENHANCEMENTS AND CHANGES FOR FY 2024-25 AND 2025-26:

CRISIS STABILIZATION UNIT (CSU) – EAST REGION (CFTN)

CSU provides voluntary and "5150" coded crisis stabilization services lasting less than 24 hours to persons in a psychiatric crisis due to a mental health condition that requires a timelier response than a regularly scheduled visit to prevent decompensation. The new 14,000 square foot building is on County-owned property in the City of El Cajon. In May 2024, an amendment to the MHSA Three-Year plan was approved by the Board to allocate CFTN funding for the construction and development of the CSU. In FY 2025-26 the budget decreased by $9,000,000 due to the completion of the East Region CSU.

MHSA DATA COLLECTION AND ANALYSIS

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

OPTUM SAN DIEGO

Optum San Diego serves as the Administrative Services Organization for BHS, facilitating the County's role in administering certain inpatient and outpatient Medi-Cal and realignment-funded specialty mental health services. Optum conducts ongoing quality review of therapy treatment plans and evaluation reports prepared for CFWB cases, and evaluation reports prepared for Juvenile Probation cases. Additionally, it operates a 24/7 Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care. The ACL provides referrals and information for mental health, substance use disorders and other services, and access to emergency mental health services.

UCSD CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

UCSD HEALTH SERVICES RESEARCH CENTER

The Health Services Research Center is a non-profit research organization located within the Department of Family and Preventive Medicine at UCSD. The research team specializes in the measurement, collection, and analysis of health outcomes data to help improve healthcare delivery systems and, ultimately, improve client quality of life. Both UCSD Research Centers collaborate with BHS to evaluate and improve behavioral health outcomes for county residents.

Aspects of the outcomes and service demographics are referenced throughout this MHSA Report with full reports in Appendices J, K, M, N, and P.

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MHSA APPENDICES

APPENDIX A

MHSA EXPENDITURE PLAN

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Funding Summary

County: San Diego

	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Totals
A. Estimated FY 2025/26 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	$ 81,769,599	$ 78,933,934	$ 52,648,626	$ 2,869,811	$ -	$ 33,478,186	$ 249,700,157
2. Estimated New FY2025/26 Funding [1]	$ 174,661,334	$ 43,665,333	$ 11,490,877	$ -	$ -	$ -	$ 229,817,544
3. Transfers in FY2025/26 [2]	$ (7,000,000)	$ -	$ -	$ 7,000,000	$ -	$ -	$ -
4. Access Local Prudent Reserve in FY2025/26	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Estimated Available Funding for FY2025/26	$ 249,430,933	$ 122,599,268	$ 64,139,503	$ 9,869,811	$ -	$ 33,478,186	$ 479,517,701
B. Estimated FY2025/26 MHSA Expenditures	**$ 227,119,611**	**$ 51,021,969**	**$ 17,369,025**	**$ 7,619,073**	**$ -**	**$ -**	**$ 303,129,679**
C. Estimated FY2025/26 Unspent Fund Balance *	**$ 22,311,321**	**$ 71,577,299**	**$ 46,770,478**	**$ 2,250,737**	**$ -**	**$ 33,478,186**	**$ 176,388,022**

* Above figures reflect projected receipts and the proposed budget. Figures are not reflective of actual expenditures, which have historically resulted in savings due to maximized FFP drawdown. Additional FFP revenue is anticipated to become available through the ongoing impact of the Medi-Cal Transformation, which began on 7/1/23. Though not fully reflected within FFP estimates above, it is anticipated that payment reform will generate additional revenue.

		Prudent Reserve Detail	
D. Estimated Local Prudent Reserve Balance	**Total**	*CSS*	*PEI*
1. Estimated Local Prudent Reserve Balance on June 30, 2025	$ 33,478,186	$ 26,712,351	$ 6,765,835
2. Contributions to the Local Prudent Reserve in FY 2025/26	$ -	$ -	$ -
3. Distributions from the Local Prudent Reserve in FY 2025/26	$ -	$ -	$ -
4. Estimated Local Prudent Reserve Balance on June 30, 2026	$ 33,478,186	$ 26,712,351	$ 6,765,835

(1) Balances projected utilize State consultant revenue estimates as of February 2025.
(2) Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Note: Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP)	$ 3,226,542	$ 1,383,086	$ 1,558,736	$ -	$ 284,720	$ -
Children's School Based Full Service Partnership (FSP)	$ 47,626,608	$ 14,464,966	$ 28,825,110	$ -	$ 4,336,532	$ -
Family Therapy	$ 542,424	$ 417,551	$ 124,873	$ -	$ -	$ -
Incredible Years	$ 930,376	$ 444,871	$ 485,505	$ -	$ -	$ -
Therapeutic Behavioral Services (TBS)	$ 4,898,569	$ 3,427,961	$ 1,470,608	$ -	$ -	$ -
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 6,698,848	$ 3,697,908	$ 1,108,494	$ -	$ 1,892,446	$ -
TAOA-FSP Full Service Partnerships for Ages 18-60+						
Adult Residential Treatment	$ 1,063,076	$ 1,063,076	$ -	$ -	$ -	$ -
Assisted Outpatient Treatment (AOT)	$ 2,530,081	$ 484,289	$ 2,045,793	$ -	$ -	$ -
Assisted Outpatient Treatment (AOT) - Housing	$ 348,842	$ 348,842	$ -	$ -	$ -	$ -
Behavioral Health Court	$ 2,979,761	$ 1,411,554	$ 1,068,207	$ -	$ 500,000	$ -
County of San Diego - Institutional Case Management (ICM)	$ 691,483	$ 495,483	$ -	$ -	$ 196,000	$ -
County of San Diego - Peer Support Services	$ 255,031	$ 255,031	$ -	$ -	$ -	$ -
County of San Diego - Probation	$ 604,140	$ 243,464	$ -	$ -	$ 360,676	$ -
County of San Diego - Strengths Based Case Management (SBCM)	$ 787,463	$ 787,463	$ -	$ -	$ -	$ -
County of San Diego - Strengths Based Case Management (SBCM) - Housing	$ 1,250,570	$ 1,250,570	$ -	$ -	$ -	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 65,869,278	$ 31,488,852	$ 29,276,745	$ -	$ 5,103,681	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 23,590,198	$ 23,147,480	$ -	$ -	$ 442,717	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,421,586	$ 1,565,164	$ 856,422	$ -	$ -	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,518,320	$ 862,294	$ 1,656,026	$ -	$ -	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 7,126,436	$ 4,101,480	$ 1,707,423	$ -	$ 1,317,533	$ -
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 2,078,699	$ 1,649,286	$ 429,413	$ -	$ -	$ -
Strengths Based Case Management (SBCM)	$ 2,224,980	$ 1,119,579	$ 1,105,401	$ -	$ -	$ -
Total Full Service Partnership (FSP) Programs	**$ 180,263,309**	**$ 94,110,248**	**$ 71,718,756**	**$ -**	**$ 14,434,305**	**$ -**
Non-FSP Programs						
All-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 992,151	$ 788,833	$ 203,318	$ -	$ -	$ -
Behavioral Health Services and Primary Care Integration Services	$ 1,559,147	$ 1,559,147	$ -	$ -	$ -	$ -
Clubhouse - Deaf or Hard of Hearing	$ 470,712	$ 470,712	$ -	$ -	$ -	$ -
Psychiatric and Addiction Consultation and Family Support Services	$ 1,353,702	$ 1,353,702	$ -	$ -	$ -	$ -
All-SD System Development for All Ages						
Mobile Crisis Response Team (MCRT)	$ 8,760,191	$ 7,085,151	$ -	$ -	$ 1,675,040	$ -
Peripartum Program	$ 716,464	$ 308,992	$ 407,472	$ -	$ -	$ -
Psychiatric Emergency Response Team (PERT)	$ 10,734,107	$ 6,986,372	$ -	$ -	$ 3,747,735	$ -
CY-OE Outreach & Engagement for Children & Youth						
CY-SD System Development for Children & Youth						
Acculturation Services	$ 52,359	$ 52,359	$ -	$ -	$ -	$ -

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Administrative Services Organization (ASO) - TERM	$ 3,155,903	$ 2,966,204	$ 119,633	$ -	$ 70,066	$ -
Commercially Sexually Exploited Children (CSEC)	$ 1,248,556	$ 432,293	$ 316,263	$ -	$ 500,000	$ -
County of San Diego - Juvenile Forensic Services	$ 1,107,590	$ 1,107,590	$ -	$ -	$ -	$ -
Crisis Action and Connection	$ 2,547,840	$ 1,186,874	$ 847,102	$ -	$ 513,864	$ -
Emergency Screening Unit (ESU)	$ 5,886,073	$ 357,112	$ 3,612,513	$ -	$ 1,916,448	$ -
Incredible Families	$ 1,873,767	$ 933,725	$ 148,356	$ -	$ 791,686	$ -
Medication Clinic	$ 3,020,700	$ 871,523	$ 2,149,177	$ -	$ -	$ -
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,953,386	$ 1,135,656	$ 217,730	$ -	$ 600,000	$ -
Placement Stabilization Services	$ 2,833,240	$ 1,496,556	$ 1,336,684	$ -	$ -	$ -
Rural Integrated Behavioral Health and Primary Care Services	$ 141,543	$ 91,543	$ -	$ -	$ 50,000	$ -
Supplemental Security Income (SSI) Advocacy Services	$ 302,070	$ 182,070	$ -	$ -	$ 120,000	$ -
Telemedicine	$ 21,300	$ 21,300	$ -	$ -	$ -	$ -
TAOA-OE Outreach & Engagement for Ages 18-60+						
Countywide Homeless Outreach Program	$ 2,487,849	$ 1,993,689	$ -	$ -	$ 494,160	$ -
TAOA-SD System Development for Ages 18-60+						
Acculturation Services	$ 266,105	$ 266,105	$ -	$ -	$ -	$ -
Adult Crisis Residential Treatment Program	$ 16,050,856	$ 1,822,705	$ 10,833,604	$ -	$ 3,394,547	$ -
Augmented Services Program (ASP)	$ 12,778,209	$ 11,128,209	$ -	$ -	$ 1,650,000	$ -
Behavioral Health Assessors	$ 689,727	$ 385,727	$ -	$ -	$ 304,000	$ -
Bio-Psychosocial Rehabilitation (BPSR)	$ 46,827,591	$ 17,943,871	$ 21,520,453	$ -	$ 7,363,267	$ -
Clubhouse	$ 5,323,421	$ 5,256,547	$ 66,873	$ -	$ -	$ -
Consumer Advocacy	$ 1,264,319	$ 815,335	$ -	$ -	$ 448,984	$ -
Crisis Stabilization - Chula Vista	$ 9,164,522	$ 622,106	$ 8,074,339	$ -	$ 468,078	$ -
Crisis Stabilization - East Region	$ 5,375,010	$ 1,424,759	$ 3,950,251	$ -	$ -	$ -
Crisis Stabilization - North Coastal Oceanside	$ 7,652,440	$ 2,293,161	$ 5,359,279	$ -	$ -	$ -
Crisis Stabilization - North Coastal Vista	$ 7,616,990	$ 2,878,990	$ 4,738,000	$ -	$ -	$ -
Crisis Stabilization - North Inland	$ 10,225,962	$ 1,100,811	$ 7,891,009	$ -	$ 1,234,142	$ -
Crisis Stabilization - South	$ 7,614,034	$ 751,294	$ 5,425,068	$ -	$ 1,437,672	$ -
Faith Based Services	$ 1,461,280	$ 1,461,280	$ -	$ -	$ -	$ -
Family Education	$ 1,043,800	$ 1,043,800	$ -	$ -	$ -	$ -
In-Home Outreach Teams (IHOT)	$ 4,280,199	$ 4,280,199	$ -	$ -	$ -	$ -
Inpatient and Residential Advocacy Services	$ 1,533,889	$ 1,091,574	$ 192,973	$ -	$ 249,342	$ -
Institutional Case Management (ICM) - Older Adults	$ 1,956,959	$ 1,544,767	$ 210,984	$ -	$ 201,208	$ -
Justice System Discharge Planning	$ 1,147,238	$ 777,238	$ -	$ -	$ 370,000	$ -
Mental Health Advocacy Services	$ 1,324,249	$ 536,246	$ -	$ -	$ 788,003	$ -
No Place Like Home BHS	$ 524,530	$ 316,156	$ -	$ -	$ 208,374	$ -
No Place Like Home Dept Pub Works Envir Svcs Unit	$ 27,690	$ 3,690	$ -	$ -	$ 24,000	$ -
No Place Like Home Housing & Community Dev Svcs	$ 1,207,429	$ 338,586	$ -	$ -	$ 868,844	$ -
North Coastal Mental Health Center and Vista Clinic	$ 6,680,354	$ 3,009,348	$ 3,671,006	$ -	$ -	$ -
North Inland Mental Health Center	$ 6,869,631	$ 3,265,474	$ 3,604,157	$ -	$ -	$ -
Public Defender - Behavioral Health Assessor	$ 241,656	$ 145,656	$ -	$ -	$ 96,000	$ -
San Diego Employment Solutions	$ 1,986,539	$ 1,531,370	$ -	$ -	$ 455,169	$ -
San Diego Housing Commission	$ 120,828	$ 108,828	$ -	$ -	$ 12,000	$ -

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Short-Term Bridge Housing	$ 1,516,572	$ 1,516,572	$ -	$ -	$ -	$ -
Supplemental Security Income (SSI) Advocacy Services	$ 752,695	$ 752,695	$ -	$ -	$ -	$ -
Telemedicine	$ 463,966	$ 438,966	$ -	$ -	$ 25,000	$ -
Tenant Peer Support Services	$ 3,303,200	$ 3,151,598	$ -	$ -	$ 151,602	$ -
Total Non-Full Service Partnership (FSP) Programs	**$ 218,510,540**	**$ 103,385,066**	**$ 84,896,243**	**$ -**	**$ 30,229,230**	**$ -**
CSS Administration	$ 29,624,297	$ 29,624,297	$ -	$ -	$ -	$ -
CSS MHSA Housing Program Assigned Funds	$ -	$ -	$ -	$ -	$ -	$ -
Total CSS Program Estimated Expenditures	**$ 428,398,146**	**$ 227,119,611**	**$ 156,615,000**	**$ -**	**$ 44,663,535**	**$ -**
FSP Programs as Percent of Total	79.4%	$ -	$ -	$ -	$ -	$ -

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2025/26						
	A	B	C	D	E	F	
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	PEI Category
PEI Programs							
1. CO-03 Integrated Peer & Family Engagement	$ 3,152,097	$ 2,902,097	$ -	$ -	$ 250,000	$ -	EI
2. DV-03 Alliance for Community Empowerment	$ 1,145,403	$ 512,699	$ 632,705	$ -	$ -	$ -	P
3. DV-04 Community Services for Families - Child Welfare Services	$ 503,458	$ 503,458	$ -	$ -	$ -	$ -	P
4. EC-01 Positive Parenting Program (Triple P)	$ 1,392,470	$ 952,470	$ -	$ -	$ 440,000	$ -	P
5. FB-01 Early Intervention for Prevention of Psychosis	$ 2,580,153	$ 1,000,395	$ 1,219,151	$ -	$ 360,607	$ -	EI
6. NA-01 Native American Prevention and Early Intervention	$ 2,581,150	$ 1,842,228	$ -	$ -	$ 738,922	$ -	P
7. OA-01 Community-Based Services for Older Adults	$ 573,080	$ 345,419	$ -	$ -	$ 227,661	$ -	P
8. OA-02 Home Based Services - For Older Adults	$ 582,553	$ 582,553	$ -	$ -	$ -	$ -	P
9. OA-06 Caregiver Support for Alzheimer & Dementia Patients	$ 1,088,217	$ 1,088,217	$ -	$ -	$ -	$ -	EI
10. PS-01 Education and Support Lines							P / EI / S&D / O
ACEs Prevention Parenting Program for Fathers	$ 2,109,949	$ 2,109,949	$ -	$ -	$ -	$ -	
Breaking Down Barriers	$ 1,447,721	$ 1,447,721	$ -	$ -	$ -	$ -	
Clubhouse Services Program	$ 503,450	$ 503,450	$ -	$ -	$ -	$ -	
Come Play Outside	$ 503,450	$ 503,450	$ -	$ -	$ -	$ -	
Consumer Advocacy	$ 755,175	$ 755,175	$ -	$ -	$ -	$ -	
County of San Diego - Community Health & Engagement	$ 909,239	$ 909,239	$ -	$ -	$ -	$ -	
Family Peer Support Program	$ 553,524	$ 254,019	$ 299,505	$ -	$ -	$ -	
Mental Health First Aid	$ 1,022,104	$ 908,848	$ -	$ -	$ 113,256	$ -	
Public Messaging for Substance Use, Misuse, and Overdose Prevention	$ 402,760	$ 402,760	$ -	$ -	$ -	$ -	
Recuperative Services and Support Program for Transitional Age Youth	$ 2,253,669	$ 1,798,014	$ -	$ -	$ 455,655	$ -	
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 2,901,144	$ 2,901,144	$ -	$ -	$ -	$ -	
Suicide Prevention Action Plan	$ 716,312	$ 716,312	$ -	$ -	$ -	$ -	
Supported Employment Technical Consultant Services	$ 368,063	$ 368,063	$ -	$ -	$ -	$ -	
Youth Engagement Ambassador Program	$ 402,760	$ 402,760	$ -	$ -	$ -	$ -	
11. RC-01 Rural Integrated Behavioral Health and Primary Care Services	$ 2,133,409	$ 2,133,409	$ -	$ -	$ -	$ -	EI
12. RE-01 Independent Living Association (ILA)	$ 302,070	$ 302,070	$ -	$ -	$ -	$ -	O
13. SA-01 School Based Program							EI
School Based Prevention and Early Intervention	$ 6,704,224	$ 6,704,224	$ -	$ -	$ -	$ -	
Screening to Care	$ 6,444,160	$ 6,444,160	$ -	$ -	$ -	$ -	
14. SA-02 School Based Suicide Prevention & Early Intervention	$ 2,473,469	$ 2,473,469	$ -	$ -	$ -	$ -	SP
15. SA-03 Youth & Family Support Services	$ 657,743	$ 657,743	$ -	$ -	$ -	$ -	EI
16. VF-01 Veterans & Family Outreach Education	$ 1,593,589	$ 1,593,589	$ -	$ -	$ -	$ -	P / EI / S&D / O
PEI Categories **A** - Access to Treatment **EI** - Early Intervention **O** - Outreach **P** - Prevention **S&D** - Stigma & Discrimination **SP** - Suicide Prevention *Individual programs may serve more than one area*							
PEI Administration	$ 6,602,866	$ 6,602,866	$ -	$ -	$ -	$ -	$ -
PEI Assigned Funds	$ 400,000	$ 400,000	$ -	$ -	$ -	$ -	$ -
Total PEI Program Estimated Expenditures	**$ 55,759,431**	**$ 51,021,969**	**$ 2,151,360**	**$ -**	**$ 2,586,102**	**$ -**	**$ -**

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding *	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
7. INN-25 Public Behavioral Health Workforce Development and Retention Program	$ 15,103,500	$ 15,103,500				
* Up to 5% for evaluation is embedded in estimated INN funding						
INN Administration	$ 2,265,525	$ 2,265,525				
Total INN Program Estimated Expenditures	**$ 17,369,025**	**$ 17,369,025**	**$ -**			

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-02 Training & Technical Assistance	$ 3,063,455	$ 3,063,455	$ -	$ -	$ -	$ -
2. WET-03 Mental Health Career Pathway Programs	$ 100,690	$ 100,690	$ -	$ -	$ -	$ -
3. WET-04 Residency and Internship Program	$ 4,454,928	$ 4,454,928	$ -	$ -	$ -	$ -
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	**$ 7,619,073**	**$ 7,619,073**	**$ -**	**$ -**	**$ -**	**$ -**

Appendix A
FY 2025-26 Annual Update Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2025/26					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects	$ -	$ -	$ -	$ -	$ -	$ -
1. CF-2 North County Mental Health Facility	$ -	$ -	$ -	$ -	$ -	$ -
2. CF-4 North Inland Crisis Residential Facility	$ -	$ -	$ -	$ -	$ -	$ -
3. CF-5 Emergency Screening Unit (ESU) Facility	$ -	$ -	$ -	$ -	$ -	$ -
4. CF-6 East Region Crisis Stabilization Unit (CSU)	$ -	$ -	$ -	$ -	$ -	$ -
CFTN Programs - Technological Needs Projects	$ -	$ -	$ -	$ -	$ -	$ -
1. SD-3 Personal Health Record	$ -	$ -	$ -	$ -	$ -	$ -
2. SD-5 Telemedicine Expansion	$ -	$ -	$ -	$ -	$ -	$ -
CFTN Administration	$ -	$ -				
Total CFTN Program Estimated Expenditures	**$ -**	**$ -**				

APPENDIX B

CERTIFICATIONS AND MINUTE ORDER

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: County of San Diego

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Luke Bermann, Ph. D.	Name: Julie BJerke, CPA
Telephone Number: 619-563-2766	Telephone Number: 858-694-2216
E-mail: Luke.Bergmann@sdcounty.ca.gov	E-mail: JulieL.Bjerke@sdcounty.ca.gov

Local Mental Health Mailing Address:
3255 Camino Del Rio South, San Diego, CA 92108

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

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

Signature 2/13/25
Date

I hereby certify that for the fiscal year ended June 30, 2024, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/22/2024 for the fiscal year ended June 30, 2024. I further certify that for the fiscal year ended June 30, 2024, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Julie Bjerke, CPA, Assistant Auditor and Controller
County Auditor Controller / City Financial Officer (PRINT)

Julie Bjerke 2/19/2025
Signature Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County: County of San Diego

Local Mental Health Director	Program Lead
Name: Nadia Privara Brahms, MPA, Acting Director	Name: Erendy Fong
Telephone Number: 619-846-1032	Telephone Number: 619-578-4530
E-mail: Nadia.Privara@sdcounty.ca.gov	E-mail: Erendy.Fong@sdcounty.ca.gov
County Mental Health Mailing Address: 3255 Camino Del Rio South, San Diego, CA 92108	

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 3, 2025.

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

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

Nadia Privara Brahms, MPA, Acting Director
Local Mental Health Director/Designee (PRINT)

6/12/25
Signature Date

County: San Diego

Date:

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, JUNE 03, 2025

MINUTE ORDER NO. 15

SUBJECT: RECEIVE AND APPROVE THE MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2025-26 (DISTRICTS: ALL)

OVERVIEW

The Mental Health Services Act (MHSA) provides ongoing dedicated funding to counties to address a broad continuum of mental health service needs, including prevention, early intervention, system development, technology, and training to effectively support the public mental health system. MHSA programs provide services for children and their families, transition age youth, adults, and older adults, with an emphasis on individuals who are unserved or underserved. MHSA is comprised of five components, including: 1) Community Services and Supports; 2) Prevention and Early Intervention; 3) Innovation; 4) Workforce Education and Training; and 5) Capital Facilities and Technological Needs.

On June 13, 2023 (22), the San Diego County Board of Supervisors (Board) approved the MHSA Three-Year Program and Expenditure Plan for Fiscal Years (FY) 2023-24 through 2025-26 (Three-Year Plan). As mandated by MHSA, the County of San Diego Behavioral Health Services (BHS) is required to submit the Three-Year Plan and an MHSA Annual Update (Annual Update) to the Department of Health Care Services (DHCS) and the California Behavioral Health Services Oversight and Accountability Commission (BHSOAC).

On June 4, 2024 (15 and 16) the Board approved an amendment to the Three-Year Plan and received an Annual Update for FY 2024-25. BHS is in the final year implementing the Three-Year Plan and will be submitting the Annual Update for FY 2025-26. This Annual Update includes budget and programmatic changes to the Three-Year Plan. A majority of services outlined in the Annual Update are a continuation of programs which were identified in the Three-Year Plan and include MHSA funding of $303.1 million in FY 2025-26.

Today's action requests the Board receive and approve the Annual Update for FY 2025-26 and to submit the report to the BHSOAC and DHCS. Today's item supports the County vision of a just, sustainable, and resilient future for all, specifically for communities and populations in San Diego County that have been historically left behind, as well as our ongoing commitment to the regional *Live Well San Diego* vision of healthy, safe, and thriving communities.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER

Receive and approve the Mental Health Services Act Annual Update (Annual Update) for Fiscal Year 2025-26 and authorize the Deputy Chief Administrative Officer, Health and Human Services Agency, to submit the Annual Update to the California Behavioral Health Services Oversight and Accountability Commission and the Department of Health Care Services.

EQUITY IMPACT STATEMENT

The vision of the Mental Health Services Act (MHSA) is to build a system in which mental health services are equitable and accessible to all individuals and families across the region who are in need. Data from the California Department of Healthcare Access and Information in 2022 showed that Black

or African American residents experienced disproportionately higher rates of emergency department visits for self-inflicted injury/suicide attempt, serious mental illness, and substance related disorders compared to other groups. Additionally, the California Health Interview Survey, conducted by the University of California Los Angeles in 2023, indicated that 6.4% of San Diego residents reported experiencing serious psychological distress in the past month. Notably, the prevalence of serious psychological distress was higher among residents who live below 200% of the federal poverty level, and individuals who identified as White, Hispanic/Latino, or multiracial.

MHSA funding supports timely access to culturally responsive behavioral health care for individuals who are experiencing serious mental illness, serious emotional disturbance, or have co-occurring substance use conditions including those with opioid use disorder. The County of San Diego (County) Behavioral Health Services (BHS) serves a diverse range of vulnerable, unserved, and underserved low-income populations who include, but are not limited to, all age groups, individuals experiencing homelessness, LGBTQ+, Black or African American, Indigenous, and People of Color. County-operated and contracted behavioral health programs are designed to address the social determinants of health by ensuring services are accessible, capable of meeting the needs of communities, and are equitably distributed to those most in need.

SUSTAINABILITY IMPACT STATEMENT
The Mental Health Services Act (MHSA) programs support the County of San Diego (County) Sustainability Goal #1 to engage the community in meaningful ways and seek stakeholder input to foster inclusive and sustainable communities. County Behavioral Health Services engages the community through the Community Planning Process, advisory boards, and stakeholder engagements to collaborate and encourage the community and stakeholders to partner and participate in decisions that impact their lives and communities.

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

FISCAL IMPACT
Funds for this request are included in the Fiscal Year (FY) 2025-26 CAO Recommended Operational Plan for the Health and Human Services Agency. If approved, this request will result in estimated Mental Health Services Act (MHSA) costs and revenues of approximately $303.1 million in FY 2025-26. The funding source is MHSA. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ACTION:
ON MOTION of Supervisor Montgomery Steppe, seconded by Supervisor Lawson-Remer, the Board of Supervisors took action as recommended.

AYES: Anderson, Lawson-Remer, Montgomery Steppe, Desmond
ABSENT: (District 1 Seat Vacant)

State of California)
County of San Diego) §

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

ANDREW POTTER
Clerk of the Board of Supervisors

Signed by Andrew Potter

JUNE 03, 2025

APPENDIX C

MHSA PROGRAM SUMMARIES

Fiscal Year 2025-2026 MHSA Annual Program Summaries

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	ALL-OE	Behavioral Health Services - Victims of Trauma and Torture	Survivors of Torture International (SOTI) Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC)	An outpatient BPSR WRC that is a Short-Doyle Medi-Cal (SD/MC) certified Mental Health Clinic. Provides services countywide to adults who experienced trauma and torture in their home countries and/or their journey to the United States, including refugees and/or asylum seekers, and have a serious mental illness (SMI), including those who may have a co-occurring substance use disorder.	Improve access to mental health services and provide culturally appropriate outreach and education to persons with a serious mental illness (SMI) or emotional disturbance who have been victims of torture. Provide referrals for victims of trauma and torture who are indigent and do not meet medical necessity.	Transition Age Youth (TAY) aged 18-25, adults aged 26-59, and older adults aged 60+ of uninsured, unserved individuals with a serious emotional disturbance (SED) and serious mental illness (SMI) who are victims of trauma and torture.	• Bio-psychosocial rehabilitation (mental health outpatient) services recovery • Urgent Walk-In • Culturally appropriate outreach, engagement, assessment, case management/brokerage, rehabilitation, crisis intervention, medication management, therapy, and mobile outreach+N68	Survivors of Torture International PO Box 371104 San Diego, CA 92137 (619) 278-2400
CSS	ALL-OE	Behavioral Health Services and Primary Care Integration Services	Behavioral Health and Primary Care Integration Services	Provides enhanced screening, brief intervention and referral to treatment through a collaborative care model for adult patients identified with behavioral health needs based on screenings at primary care sites.	Provide brief, effective, evidence-based treatment and increase access to behavioral health care in a primary care setting.	Adults 18 years and older.	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network Health Quality Partners 3710 Ruffin Rd San Diego, CA 92123 (619) 542-4300
CSS	ALL-OE	Clubhouse - Deaf or Hard of Hearing	The DCS Clubhouse	The DCS Clubhouse is an ongoing countywide program by Deaf Community Services that offers a member-operated clubhouse to adults 18 and over with serious mental illness with a specialization in deaf and hard of hearing adults and older adults. The DCS Clubhouse provides services to their members to help them achieve social, financial, health/ wellness, education, and vocational goals.	The goals of the Clubhouse program include member access to socialization and rehabilitation supports to facilitate reductions in social isolation while identifying personal areas of interest, improving functioning, increasing employment and education and improving health and quality of life.	The DCS Clubhouse provides countywide services to adults 18 years and older with a serious mental illness (SMI) that have Medi-Cal or are Medi-Cal eligigible including those with co-occurring substance use with a specialization in the Deaf and Hard of Hearing (HoH) community.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI advocacy services are provided to individuals who may be interested.	Deaf Community Services of San Diego Inc. 2240 Cleveland Ave National City CA 91950 (619) 618-0501
CSS	ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Psychiatric and Addiction Consultation and Family Support Program	Provides psychiatric, addiction consultation, and family support services for primary care and pediatric providers who serve patients with Medi-Cal or who are uninsured, Children and Transition Age Youth (TAY), and caregivers in San Diego County.	Enhance primary care and behavioral health providers' levels of competence, confidence, and capacity to assess and appropriately treat clients with behavioral health needs; improve identification and treatment of behavioral health issues in youth, including suicide and overdose risk; provide education, referrals, and linkages to support youth and families.	Children, Transition Age Youth.	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8825 Aero Dr, #315 San Diego, CA 92123 (858) 956-5906

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	ALL-SD	Mobile Crisis Response Team (MCRT)	Regional and North Coastal Mobile Crisis Response Team (MCRT)	The Mobile Crisis Response Team (MCRT) program offers 24/7 mobile support Countywide to people experiencing a mental health or substance use related crisis where they are, when they need it. MCRT is an alternative to law enforcement response with teams comprised of behavioral health experts who are trained to respond in the community and deescalate crises related to alcohol, drugs, or mental health conditions.	MCRT aims to help people experiencing behavioral health crisis by providing in-person support and crisis intervention and reduces unnecessary law enforcement involvement, ER visit, and hospitalizations.	All populations, all ages, and all communities.	• Stabilize the crisis through intervention and deescalation • Provide transportation to other behavioral health services as needed • Initiate and transport a 5150 hold • Connect to community resources and treatment • Coordinate initial treatment services for up to 30 days	Telecare Corporation 409 Camino del Rio South Suite 201 San Diego CA 92108 (619) 346-4020 (Main Office) Exodus Recovery, Inc. 536 W. Vista Way, Ste A Vista, CA 92083 (760) 758-1650
CSS	ALL-SD	Peripartum Program	Accessible Depression and Anxiety Peripartum Treatment (ADAPT)	Identifies at-risk peripartum women for engagement and provides services for peripartum women and families.	Reduce incidence and impact of postpartum depression and anxiety.	Peripartum women and partners, especially in underserved communities.	• Outreach and engagement through public health nurses • Trauma-informed interventions to treat and reduce negative consequences of postpartum depression and anxiety.	Vista Hill Foundation 6070 Missiob Gorge Rd. San Diego CA 92120 (619) 281-5031
CSS	ALL-SD	Psychiatric Emergency Response Team (PERT)	Psychiatric Emergency Response Team (PERT)	The Psychiatric Emergency Response Team (PERT) is made up of a licensed mental health clinician and a PERT trained law enforcement officer. Together, they seek to deescalate a mental health emergency and, when possible, redirect the individual to mental health services instead of hospitalization or incarceration.	Improve collaboration between mental health providers and law enforcement officers with the goal of deescalating incidents between law enforcement officers and those who are mentally ill and developmentally disabled.	Children, Transition Age Youth, Adults/Older Adults, with a focus on veterans, and homeless populations who are eligible for Medi-Cal funded services or are indigent.	• Care coordination • Deescalation and crisis intervention services • Training for law enforcement personnel and the community *Peer Supportive Services as referred by PERT Clinicians for additional support.	Community Research Foundation (CRF) 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0892
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Connections Community Counseling	Engage homeless and runaway youth to increase access to mental health services and family reunification. Individual/group/family services provided at schools, community, or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth, and their families.	Homeless children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	North County Lifeline (Lifeline Community Services) 3890 Murphy Canyon Rd Ste 250, San Diego CA 92123 (760) 842-6202 200 Michigan Ave. Vista, CA 92084 707 Oceanside Blvd. Oceanside, CA 92054 334 Via Vera Cruz Ste 152, San Marcos, CA 92078 8324 Allison Ave La Mesa 91942
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	Intensive transition planning and care coordination for children and youth who reside in County of San Diego Foster Family Agency (FFA) Intensive Service, and Foster Care (ISFC) homes to provide stabilization and treatment to foster youth with high acuity needs within the least restrictive setting possible. Services include the oversight of Therapeutic Foster Care (TFC) services, including the provision of specific Specialty Mental Health Services.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21, involved in Child & Family Well-Being (formerly Child Welfare Services) and reside in Foster Family Agency homes, who meet medical necessity and serious emotional disturbance criteria.	• Individual/group/family treatment • Care coordination • Intensive Home-Based Services • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement • Therapeutic Foster Care	San Diego Center for Children - FFAST 2655 Camino Del Rio N Suite 450 San Diego, CA 92108 (858) 277-9550 North County 145 Vallecitos de Oro, Suite 210 San Marcos, CA 92069 (858) 633-4115

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central East South Region (CES) School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-8471
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central Region Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Chaparral_IDEA-MERIT Wellness Center	Day School Services provides individual, group and family services at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co- occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Vista Hill Foundation 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Children's Mental Health (CMH) School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community and School Based Counseling Services (CSBCS)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle Central	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers - Logan Heights 2130 National Ave. San Diego, CA 92113 (619) 255-7859 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-5444

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CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Cornerstone	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd., Suite 14 San Diego, CA 92115 (619) 640-3269
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Crossroads	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Crossroads Family Center 700 N. Johnson Ave, Suite P El Cajon, CA 92020 (619) 441-1907
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Douglas Young	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Douglas Young Youth and Family Services 7917 Ostrow St., Suite A San Diego, CA 92111 (858) 300-8282
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Behavioral Health Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services 1870 Cordell Ct., Suite 101 El Cajon, CA (619) 448-9700
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Family Wellness Center - East County Outpatient Program	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment. Parent-Child Interaction Therapy (PCIT) utilized when indicated.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children East Region Outpatient 6386 Alvarado Ct Suite 310 San Diego CA 92120 (619) 668-6200 2655 Camino del Rio South San Diego, CA 92108

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CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Housing Case Management/Monarch Supportive Housing	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach and, when indicated, offers case management, peer support, and/or co-occurring substance use treatment. Housing case management component for children and families in the Monarch program.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who may attend a Juvenile Court and Community School and meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Mobile Adolescent Services Team 1260 Morena Blvd., Suite 200 San Diego, CA 92110 (619) 398-3261
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mobile Adolescent Services Team (MAST)					
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Learning Assistance Center Escondido & North Inland	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill Foundation - Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation - North Inland Ramona 1012 Main St., Suite 101 Ramona, CA 92065 (760) 788-9724
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mi Escuelita South Region School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	SBCS 430 F St. Chula Vista, CA 91910 (619) 420-3620
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Multi-Cultural Community Counseling	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Union of Pan Asian Communities Multicultural Community Counseling 8745 Aero Drive, Suite 330, San Diego, Ca. 92123 (619) 578-2211
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Coastal Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Coastal 3605 Vista Way, Suite 258 Oceanside, CA 92056 (760) 758-1480

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CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North County Outpatient School-Based Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	New Alternatives Inc 1529 Grand Ave. Suite A San Marcos CA 92078 (760) 798-0299
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Inland 2125 W. Citacado Pkwy., Suite 200 Escondido, CA 92025 (760) 294-9270
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland/North Coastal & Fallbrook School Based Full Service Partnership	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235 945 Vale Terrace Dr Vista CA 92084
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Nueva Vista	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family - focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familias	Individual/group/family services provided at pre-schools, home, or office/clinic location. Utilizing a team approach and, when indicated, offers case management, and peer support.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children up to age 5 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach and engagement	Episcopal Community Services Para Las Families 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	YMCA-TIDES 4451 30th St. San Diego, CA 92116 619-837-5764

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CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	VIVA Counseling	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline (Lifeline Community Services) 200 Michigan Ave. Vista, CA 92084 (760) 726-4900 North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118
CSS	CY-FSP	Family Therapy	Family Therapy Participation	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family - focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Nueva Vista	Individual,/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth, and their families.	Children and Youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Nueva Vista Youth & Family Services 1161 Bay Blvd., Ste B Chula Vista, CA 91911
CSS	CY-FSP	Family Therapy	Family Therapy Participation	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers 2130 National Ave. San Diego, CA 92113 (619) 255-7859 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-5444
CSS	CY-FSP	Family Therapy	Family Therapy Participation	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline (Lifeline Community Services) 200 Michigan Ave, Vista, CA 92084 (760) 726-4900

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	CY-FSP	Incredible Years	ChildNET Incredible Years North Coastal & North Inland	Individual/group/family services provided at pre-schools, home, or office/clinic location utilizing Incredible Years curriculum. Utilizing a team approach that, when indicated, offers case management and peer support.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children up to five years old and families, using the Incredible Years evidence-based curriculum.	Children up to age 5 who meet medical necessity and their families.	• Individual/group/family • Teacher training • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling Services 1002 E Grand Ave, Escondido, CA 92025 (760) 741-2660
CSS	CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services (TBS)	Ancillary short term one-to-one behavioral coaching for children & youth who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	Support permanency as well as promote successful return of children/youth to their family or family-like setting.	Children up to age 21 who are Medi-Cal eligible and who are receiving specialty mental health reimbursable services and experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	• One on one behavioral coaching	New Alternatives - TBS 8755 Aero Drive, Suite 230 San Diego, CA 92123 (858) 256-2180
CSS	CY-FSP	Wraparound Services (WRAP) - Child Welfare Services (CWS)	Wrapworks	Wraparound offers team based intensive and individualized case management to children/youth in CWS/Probation systems working within the context of their support system, leveraging both formal and informal supports.	Assist children/youth in reducing symptoms/behaviors so they can remain in their family setting or return to a family or family-like setting, as well as to support permanency and reduce recidivism.	Children and youth up to age 21 who are involved with the Child and Family Well-Being department or Probation.	• Case management and rehabilitative services • Intensive Care Coordination • Intensive Home-Based Services • Individual & family treatment • Crisis intervention • Medication management • Outreach at schools and the community	Central: 3002 Armstrong St. San Diego, CA. 92111 North: 235 W. 5th Ave, Suite 130, Escondido, CA 92025 South/East: 3322 Sweetwater Spring Blvd, Suite 104 Spring Valley, CA 91977
CSS	CY-SD	Acculturation Services	Acculturation Services	Culturally competent Acculturation Services are provided to Middle – Eastern students to promote adjustment at school and in a new cultural environment. Outreach and welcoming groups are facilitated on school campuses with connection to behavioral health treatment when indicated.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Acculturation/welcoming groups in schools for Middle Eastern and Chaldean population	Union of Pan Asian Communities Acculturation Services 8745 Aero Drive, Suite 330, San Diego, Ca. 92123 (619) 578-2211
CSS	CY-SD	BridgeWays Program	BridgeWays Program	Individual/group/family services provided at office/clinic, home, or other community locations. Utilizing a team approach that, when indicated, offers case management, peer support, and/or co-occurring substance use interventions.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth, and their families who are at risk of involvement or currently involved in the juvenile justice system.	Children and youth up to age 21, who are at risk of involvement or currently involved in the juvenile justice system, who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Home Based Services • Crisis intervention • Medication services • Outreach and engagement • Substance use services	North County Lifeline (Lifeline Community Services) 4180 Ruffin Rd. Ste. 295 San Diego, CA 92123 (760) 726 -4900

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	CY-SD	Commercially Sexually Exploited Children (CSEC)	I CARE	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use interventions. Supportive services at drop-in center.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth and their families that are at risk for or are victims of commercial sexual exploitation.	Youth, adolescents, young adults, and their caregivers identifying as at risk for or are victims of commercial sexual exploitation (CSEC) who are Medi-Cal beneficiaries, low-income, or uninsured.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement • Assistance with housing • Job skill assessment • GED preparation • Support groups • Peer support • Mentors	San Diego Youth Services I CARE Central San Diego (619) 521-2550 x 3816
CSS	CY-SD	County of San Diego - Juvenile Forensic Services	County of San Diego - Juvenile Forensics	Provides behavioral health services to youth transitioning out of juvenile detention and rehabilitative institutions.	Prepare youth for transition back to the community and work with youth on probation who have been released and are living in the community.	Youth transitioning out of juvenile institutions.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services	Youth Transition Campus 2801 Meadow Lark Drive 1st Flr. San Diego, Ca 92123-2711 (858) 298-6070 East Mesa Detention Facility 446 Alta Road San Diego, CA 92158 (619) 671-6558
CSS	CY-SD	Crisis ACTION and Connection	Crisis ACTION and Connection	Provides intensive support and linkage to services and community resources for children/youth who had a recent psychiatric episode.	Improve the ability of children and youth and their families to access and benefit from mental health services in order to divert or prevent readmission to acute services.	Children and youth up to age 21 who meet medical necessity and meet set criteria.	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services • Case management	New Alternatives/CAC 730 Medical Center Chula Vista, CA 91911 (619) 421-6979
CSS	CY-SD	Emergency Screening Unit (ESU)	Emergency Screening Unit	Provides crisis stabilization to children and youth experiencing a psychiatric emergency.	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness.	Children and youth under age 18 who are experiencing a psychiatric emergency.	• Crisis stabilization services for high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Emergency Screening Unit 4309 Third Ave. San Diego, CA 92103 (619) 876-4502
CSS	CY-SD	Incredible Families	Incredible Families	Behavioral health outpatient services to children and their families that are dependents of the Juvenile Courts, hence involved with Child & Family Well-Being (CFWB).	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement.	Families and their children 2-14 years old who are dependents of Juvenile Dependency Court due to abuse and/or neglect.	• Weekly multi-family parent and child visitation event and meal for all family members • Utilization of the Incredible Years evidence-based curriculum • A primary therapist is assigned to each family • Clinical support during family visitation events, as well as, during individual and family therapy	New Alternatives Inc. 8765 Aero Drive Ste 31A San Diego, CA 92123 730 Medical Center Ct. Chula Vista, CA 91911 1020 S. Santa Fe Ave. Ste D-1 Vista, CA 92064

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	CY-SD	Medication Clinic	Center for Child & Youth Psychiatry Medication Clinic	Outpatient psychiatric evaluation and medication support services utilizing face-to-face and telepsychiatry/telehealth practices for children and youth with complex psychiatric pharmacological needs, including children and youth who may be involved in the juvenile justice system, child welfare system, or have co-occurring needs.	Promote stabilization by providing psychotropic medication support to children and youth, who require complex medication management.	Children and youth, up to age 21, requiring on-going medication support, and who have successfully completed a comprehensive mental health treatment plan with a system of care provider.	• Medication management • Psychiatric consultation • Psycho-educational seminars and groups for families	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100
CSS	CY-SD	Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	Our Safe Place	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach and, when indicated, offers case management, peer support, and/or co-occurring substance use interventions. Supportive services at 5 drop-in centers.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children and youth who identify as LGBTQ+ and their families.	LGBTQ+ children and youth up to age 21 who meet medical necessity. Any LGBTQ+ youth who would benefit from supportive services at the drop-in centers.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • General Education Diploma (GED) preparation • Support groups • Peer support • Mentors	San Diego Youth Services Our Safe Place 3427 4th Ave. Second Floor San Diego, CA 92103 (619) 525-9903
CSS	CY-SD	Placement Stabilization Services	Comprehensive Assessment & Stabilization Services (CASS)	Outpatient mental health services, including a comprehensive behavioral health assessment, individual and family therapy, case management, individual rehab and psychiatric services/medical management for children and youth placed by Child & Family Well-Being in a resource family home and at risk of change of placement disruption.	Stabilize current placement, deter children and youth from placement in a higher level of care and support transition of children and youth back to their biological families.	Foster children and youth, up to age 21, who recently experience placement disruption and meet medical necessity.	• Assessment • Case management and rehabilitative services • Intensive Care Coordination • Intensive Home-Based Services • Crisis intervention • Medication management	New Alternatives, Inc. 3517 Camino del Rio South Suite 407 San Diego, CA 92108 (619) 955-8905
CSS	CY-SD	Placement Stabilization Services	Placement Stabilization Services Polinsky Children's Center	Short-term mental health supportive services for children and youth placed at the County of San Diego's Temporary Shelter Care Facility, Polinsky Children's Center (PCC).	Support emotional needs of children and youth while at PCC to promote stabilization.	Children and youth, up to age 18, who meet medical necessity brought to Polinsky Children's Center by Child and Family Well-Being for a short assessment period.	• Assessment • Case management and rehabilitative services • Intensive Care Coordination • Intensive Home-Based Services • Crisis intervention • Medication management	New Alternatives, Inc. 9400 Ruffin Ct. San Diego, CA 92123 (858) 357-6879

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	Provides Collaborative Care Model in rural community primary clinics, including routine screening, behavioral health consultation/education, prevention, early intervention, brief treatment, and assisting in accessing care.	Prevention, early identification, education and intervention, and treatment to prevent development of more serious mental health or substance use conditions, and increase access to care for children, transitional age youth and adults/older adults.	Children, Transition Age Youth, Adults/Older Adults.	• Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725
CSS	CY-SD	Supplemental Security Income (SSI) Advocacy Services	Children SSI Advocacy	Supplemental Security Income Advocacy Services is extended to children under age 18 who may be eligible for SSI benefits.	To provide outreach and education to child focused programs so that they assist guardians of potentially eligible mental health applicants under age 18 to complete the application process timely and accurately in order to obtain SSI benefits; and to provide assistance at the reconsideration and hearing/appeal level for those applicants who need it so that they may successfully obtain SSI benefits.	Provide SSI advocacy services for children under age 18 with an emphasis on those who are seriously emotionally disturbed (SED) and/or served in the BHS Children's Systems of Care who meet SSI eligibility criteria.	• Promote awareness through community partners of SSI advocacy services for children under the age of 18 • Submission of SSI applications to Social Administration • Provide follow up services as needed	Legal Aid Society of San Diego, Inc. 3853 Rosecrans Street San Diego, CA 92110
CSS	TAOA-FSP	Adult Residential Facility	Adult Residential Facility	Provides services to clients in a recovery-oriented learning, open residential environment with on-site services that include, but not limited to, psycho-educational and symptom/wellness groups, employment and education screening/readiness, skill development, peer support, and mentoring. The purpose is to return to independent living for adults with serious mental illness (SMI) and residents of San Diego County.	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach to assist the client's recovery and return to independent living.	Adults, 18 years and older, with a Title 9 diagnosis of a serious mental illness (SMI) or needing 24-hour care due to the inability to live independently.	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299
CSS	TAOA-FSP	Assisted Outpatient Treatment (AOT) and Community Assistance, Recovery and Empowerment (CARE) Treatment Services	Assisted Outpatient Treatment (AOT) and Community Assistance, Recovery and Empowerment (CARE) Assertive Community Treatment	A time-limited Assertive Community Treatment (ACT) Team services for persons who are assigned to court-ordered Assisted Outpatient Treatment (AOT), and for persons who otherwise meet AOT criteria and agree to participate in these services as an alternative to court-ordered AOT. In addition, program services clients who have entered into a CARE agreement.	Integrated behavioral health, rehabilitation treatment, recovery services for adults with a serious mental illness (SMI), who meet criteria for Assisted Outpatient Treatment (AOT), and for individuals who have entered into a CARE Agreement.	Adults 18 years and older who meet Title 9 criteria, as established under Laura's Law, and individuals with CARE agreements.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for transitional age youth with serious mental health conditions and may have co-occurring substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare Corporation 1660 Hotel Circle N., Suite 101 San Diego, CA 92108 (619) 481-3840
CSS	TAOA-FSP	Assisted Outpatient Treatment (AOT) and Community Assistance, Recovery and Empowerment (CARE) Treatment Services - Housing	Assisted Outpatient Treatment (AOT) and Community Assistance, Recovery and Empowerment (CARE) Assertive Community Treatment - Housing					

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Behavioral Health Court Assertive Community Treatment	Collaborative Behavioral Health Court Assertive Community Treatment	Uses the Assertive Community Treatment model to enhance the lives of individuals who are experiencing a serious mental illness (SMI) and co-occurring conditions through case management and mental health services.	Integrate mental health, substance- induced psychiatric disorder rehabilitation treatment, and recovery services for adults with serious mental illness (SMI) to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system.	Underserved adults,18 years and older, with serious mental and/or substance- induced psychiatric disorder illnesses, who have been incarcerated and have misdemeanor or felony offenses.	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corporation 4930 Naples St. San Diego, CA 92110 (619) 276-1176
CSS	TAOA-FSP	County of San Diego - Institutional Case Management (ICM)	County of San Diego - Institutional Case Management (ICM)	ICM provides care coordination and case management services to Transition Age Youth (TAY) and adults who have court ordered permanent conservatorships and reside in long-term placements including behavioral health units (BHU), jails, Skilled Nursing Facilities (SNF), Institutes of Mental Disease (IMD), and State hospitals.	ICM provides oversight of conservatees in long-term care settings, ensuring that their basic and treatment needs are met.	Adults, aged 18 -59, who reside in a State hospital or in out-of-county, in-county Institutions for Mental Disease (IMD), or Skilled Nursing Facilities. Can include jails and Behavioral Health Units.	• Case management program offering Institutional Case Management (ICM) services to LPS conservatees who reside in long-term locked placements. Services consist primarily of linking, coordinating, and monitoring functions while in long-term locked settings, and assistance with transitioning to a lower level of care upon discharge.	County of San Diego - Institutional Case Management (ICM) 1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715
CSS	TAOA-FSP	County of San Diego - Peer Support Services	County of San Diego - Strengths Based Case Management (SBCM) Peer Support Services	The Peer Support Services within the County Operated Direct Service Program: Strengths Based Case Management (SBCM) assists participants with increased resiliency and self-care, reduced substance use, improved medication adherence, decreased mental health symptoms through coping skills, reduced problems commonly associated with substance use, and improved mental and physical wellness. The program also links participants to health care treatment and other community resources as needed.	Improve the mental health and quality of life of adults managing severe mental illness through the integration of Peer Support Services. Peer Support Services improve engagement with treatment and recovery plans, reduce feelings of isolation, and empower individuals to be an active participant in their recovery. Increase access to needed mental health, medical, educational, social, prevocational, vocational, housing supports, rehabilitative and/or other community services.	Adults aged 18 - 59 years who have a serious mental illness (SMI), including those who may have a co-occurring substance use disorder, residing in the Central, North Central or East County community. Services are for Medi-Cal, Medicare and/or indigent populations.	• Strengths Based Case Management (SBCM) • Rehabilitation and recovery services • Care Coordination to needed services • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services	County of San Diego East County 1000 Broadway Suite 100 El Cajon, CA 92021 (619) 401-5424 County of San Diego, North Central Program 1250 Morena Blvd, 2nd Floor, San Diego, CA 92110 (619) 692-8715

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	County of San Diego - Probation	Probation Officers in BHS Justice-Involved ACT Programs	Probation Officers are embedded in 3 different Justice-Involved ACT Programs to support with case management and providing information on the clients' legal status and court conditions. The POs assigned to Behavioral Health Court play a more active role by case carrying for the enrolled participants.	Stabilize and link to services and reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness.	• Transition Age Youth, adults/older adults • Transition Age Youth and adults who have a serious mental illness (SMI)	• Interventions • Case management • Outreach and engagement	County of San Diego Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148
CSS	TAOA-FSP	County of San Diego - Strengths Based Case Management (SBCM)	County of San Diego - Strengths Based Case Management (SBCM) (Central/North Central & East)	SBCM provides clinical case management and mental health services with a rehabilitation and recovery focus to Transition Age Youth (TAY) and adults, managing severe mental illness and who may be diagnosed with a substance use condition. SBCM encourages recovery efforts in participants by identifying and coordinating a range of resources, both environmental and personal, to help people achieve their goals.	Improve the mental health and quality of life of adults who are managing severe mental illness. Increase access to needed mental health, medical, educational, social, prevocational, vocational, housing supports, rehabilitative and/or other community services.	Adults, aged 18 - 59, who have a serious mental illness (SMI), including those who may have a co-occurring substance use disorder, residing in the Central, North Central or East County community. Services are for SSI/Medi-Cal, SSA/Medicare and/or indigent populations.	• SBCM • Rehabilitation and recovery services • Care Coordination to needed services • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services	County of San Diego North Central 1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715
CSS	TAOA-FSP	Crisis Residential Services - North Inland	CRTP Esperanza Crisis Center	Crisis Residential Treatment Programs are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth (TAY) and adults, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit, or step-down from acute inpatient care.	Adults, age 18 and older, who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non- hospital intervention but are able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Esperanza Crisis Center 490 North Grape Street Escondido, CA 92025 (760) 975-993
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Catalyst	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SCBM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for Transitional Age Youth (TAY) with serious mental illness (SMI) who are homeless or at risk for homelessness.	Transition Age Youth, aged 16-25, who are homeless, at risk of homelessness, have a serious mental illness (SMI), or a co-occurring substance use condition and need the highest level of care to maintain in the community.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Catalyst Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT Justice Involved Services (Vida ACT)	FSP/ACT - Justice Involved.	Provides ACT services to persons with serious mental illness (SMI) who are justice involved.	Adults, aged 18 and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and have misdemeanor or felony offenses.	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Telecare Corporation 3491 Kurtz Street, Suite 150 San Diego, CA 92110 (619) 332-5830
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Justice Involved Housing					

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	ACT La Luz	Provides Assertive Community Treatment, Full Service Partnership to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Adults 18 years and older who are homeless, at risk of homelessness, have serious mental illness (SMI), or co-occurring diagnosis of substance use condition and are stepping down from a long-term care facility setting and need the highest level of care to maintain in the community.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare La Luz 3491 Kurtz St. Suite 150 San Diego, CA 92110 619-320-2404
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT La Luz Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	Step Down from Acute Care (Tesoro Act)	Provides Assertive Community Treatment, Full Service Partnership to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Adults 18 years and older who are homeless, at risk of homelessness, have a serious mental illness (SMI), or diagnosis of co-occurring substance use condition, and are stepping down from a behavioral health unit and need the highest level of care to maintain in the community.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare Tesoro 3491 Kurtz St, Suite 150 San Diego, CA 92110 619-320-2404
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Step Down from Acute Care Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Inreach to Long Term Care-Pathway to Recovery	Provides Assertive Community Treatment, Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM) to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Provides Assertive Community Treatment, Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM) to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Adults, aged 18-59, with serious mental illness (SMI) and are, or recently have been, in a long-term care institutional setting.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Inreach to Long Term Care-Pathways to Recovery Member Housing II					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice	24-hour community -based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness.	Provides Assertive Community Treatment Services to persons with very serious mental illness (SMI).	Adults 25 to 59 years old who have a serious mental illness (SMI) and adults 18 years and older who may have been homeless.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice HOUSING)					

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Strength Based Case Management (SBCM) - North	Program uses Strengths-Based Case Management (SBCM) team approach to deliver comprehensive, community based services and support for adults with serious mental health needs and may have a co-occurring substance use conditions.	Improve the mental health and quality of life of adults managing severe mental illness. Increase access to needed mental health, medical, educational, social, prevocational, vocational, housing supports, rehabilitative and/or other community services.	Transitional Age Youth ages 18-25 and Adults 26 to 59 years old who have a serious mental illness, are homeless or at risk of homeless.	• Strengths-Based Case Management (SBCM) • Rehabilitation and recovery services • Care Coordination to needed services • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services • Housing Support	Mental Health Systems Inc. (MHS) 1955 Citracado Parkway #300, Escondido CA 92029 (769) 294-1955
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT ACTION Central	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach. Additionally, program provides outpatient substance use (SU) treatment, recovery and ancillary services.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults, aged 18 and older who are homelessness, at risk of homelessness, with a serious mental illness (SMI) or a co-occurring diagnosis of substance use and need the highest level of care to maintain in the community. (This program provides SUD services under the same contract).	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) ACTION Central 1011 Camino Del Rio S STE 300 San Diego, Ca. 92108 (858) 380-4676
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT ACTION Central-Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT ACTION East	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach. Additionally, program provides outpatient substance use (SU) treatment, recovery and ancillary services.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults 18 years and older who are homeless, at risk of homelessness, have a serious mental illness (SMI), or a co-occurring diagnosis of substance use disorder and need the highest level of care to maintain in the community. (This program provides SUD services under the same contract).	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) ACTION East 10201 Mission Gorge Rd., Suite O Santee, CA 92071 (619) 383-6868
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT ACTION East - Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Persons with High Service Use	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach. Additionally, program provides outpatient substance use (SU) treatment, recovery and ancillary services.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults 18 years and older with very serious mental illness (SMI) who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and substance use conditions; • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3101
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Persons with High Service Use (HOUSING)					

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT- City Star	Provides ACT, FSP to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adult 18 years and older who are homeless, or at risk of homelessness, with a serious mental illness (SMI), or co- occurring diagnosis of substance use and need the highest level of care to maintain in the community.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and substance use conditions; • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) 8775 Aero Dr., Suite 132 San Diego, CA 92123 (858) 609-8742
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-City Star - Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT North Coastal	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach. Additionally, program provides ACT treatment services to individuals referred by the County Community Assistance, Recovery, and Empowerment (CARE) team for persons with untreated schizophrenia or other psychotic conditions.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adult 18 years and older who are homeless, or at risk of homelessness, with a serious mental illness (SMI), or co-occurring diagnosis of substance use and need the highest level of care to maintain in the community.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) 2122 El Camino Real #102 Oceanside, CA 92054 (760) 290-8170
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT North Coastal - Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT North Star	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach. Additionally, program provides ACT treatment services to individuals referred by the County Community Assistance, Recovery, and Empowerment (CARE) team for persons with untreated schizophrenia or other psychotic conditions.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults 25 to 59 years old who are homeless, at risk of homelessness with a serious mental illness (SMI), or co-occurring diagnosis of substance use and need the highest level of care to maintain in the community.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions; • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT North Star - Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT South Bay IMPACT	Provides ACT, FSP to persons with a serious mental illness (SMI) who may also have a co-occurring substance use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	• Rehabilitation and recovery services	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	South Bay IMPACT (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 934-5770
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT South Bay IMPACT - Housing					

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT Senior IMPACT (High Utilizer Integrated Services)	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons over age 60 with a serious mental illness (SMI) who may also have a co-occurring substance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults, aged 60 and older who are homeless or at risk of homelessness and have serious mental illness (SMI).	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions; • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Community Research Foundation (CRF) 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Senior IMPACT Supported - Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Central IMPACT	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring substance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults, aged 18-59, who are homeless or at risk of homelessness, have serious mental illness (SMI) , and who may also have a co-occurring condition of substance use in the North Central Region of San Diego.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions; • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Community Research Foundation (CRF) 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Central IMPACT - Housing					
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Downtown IMPACT	Provide Assertive Community Treatment (ACT), Full Service Partnership (FSP), with a Strengths-Based Case Management component (SBCM), to persons with a serious mental illness (SMI) who may also have a co-occurring subtance use condition. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach. Additionally, program provides ACT treatment services to individuals referred by the County Community Assistance, Recovery, and Empowerment (CARE) team for persons with untreated schizophrenia or other psychotic conditions.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness (SMI) who are homeless or at risk of homelessness.	Adults, aged 18 and over, who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central, East and South Regions of San Diego.	• Clinical Case Management • Multidisciplinary, wraparound treatment and rehabilitation services for adults with serious mental health conditions and may have co-occurring substance use conditions; • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Community Research Foundation (CRF) 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Downtown IMPACT - Housing					
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Agewise	Strengths-Based Case Management, and Institutional Case Management (ICM) for Older Adults.	Improve the mental health and quality of life of adults who are managing severe mental illness. Increase access to needed mental health, medical, educational, social, prevocational, vocational, housing supports, rehabilitative and/or other community services.	Older adults, who are aged 60 and older, and ICM population, who are 60 and older who have a public conservatorship.	• Strengths-Based Case Management (SBCM) and Institutional Case Management • Rehabilitation and recovery services • Care Coordination to needed services • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services	Telecare Corporation 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Transitional Residential Treatment Program	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility. Program provides transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness (SMI) and co-occurring disorders who will benefit from unlocked transitional residential rehabilitation services.	Provide an alternative to Long Term Care settings and support community reintegration after discharge. Provide rehabilitative residential resource for residents to remain independent in a community setting.	Adults eighteen (18) years of age or older, with primary serious mental illness (SMI) diagnosis that must have Medi-Cal Coverage and meet criteria for psychosocial rehabilitative services, benefits such as Supplemental Security Income and be residents of San Diego County.	• Functional adaptation skills training; • Integrated co-occurring disorder services; • Wellness Recovery Action Plan; • Cognitive Behavioral Therapy and Dialectical Behavioral Therapy; • Problem solving • Independent living skills	Crestwood Behavioral Health, Inc. 5550 University Ave, Suite B San Diego, Ca 92105 (619) 481-5447
CSS	TAOA-FSP	Full Service Partnership (FSP) / Transitional Residential Program	Full Service Partnership (FSP) / - Transitional Project-Based Subsidy Program for Homeless - Safe Haven AB2304 - C-HRT Safe Haven	Transitional residential housing program provides supportive services for those who are experiencing homelessness and have a serious mental illness (SMI). C-HRT services are for individuals experiencing homelessness and have substance use conditions, which may include co occurring conditions.	The program aims to create a supportive environment that helps residents enhance their ability to live independently. This includes developing social relationships, improving personal hygiene, and acquiring essential daily living skills. Additionally, the program will connect residents with ongoing care coordination, case management, and support services to assist them in transitioning to permanent housing.	Adults/Older Adults with a serious mental illness (SMI) or substance use conditions who are experiencing homelessness.	• Transitional housing for eligible individuals • Provide food • Case management	Uptown Safe Haven 2822 5th Ave. San Diego, CA 92103 (619) 294-7013 C-HRT Safe Haven 3690 Couts Street, San Diego, CA 92110 (619) 228-2800
CSS	TAOA-FSP	Full Service Partnership (FSP) / Transitional Residential Program	Casa Pacifica	Transitional residential treatment services provide a full-range of bio-psychosocial rehabilitative services to seriously mentally ill adults who have Medi-Cal coverage and benefits in a residential setting within the County of San Diego. These services are an integral component of the long-term care system in that the program serves as both a step-down and diversion function from higher level and more costly services.	Provide an alternative to Long Term Care settings and support community reintegration after discharge from Long Term Care facility. Provide rehabilitative residential resource for residents requiring Full Service Partnership Level of Care to remain successfully in a community setting to reduce need of additional locked placement.	Adults (age 18 and older) with a primary diagnosis of serious mental illness (SMI) that meets Medi-Cal criteria for psychosocial rehabilitative services and who will benefit from unlocked transitional residential rehabilitative services. Clients must have Medi-Cal coverage; benefits such as Supplemental Security Income; and be residents of San Diego County.	• Twenty-four hour, seven days a week services in accordance with Title 9 and Behavioral Health Services policy, including medication support, case management/brokerage. crisis intervention, rehabilitation and other rehabilitative and recovery interventions including peer supports.	Community Research Foundation 321 Cassidy Street Oceanside, CA 92054 (760) 721-2171
CSS	TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Safe Connection Program	NHA Safe Connections delivers Short-Doyle/Medi-Cal certified Care Coordination/Short-term intensive clinical case management services for clients 18 and older with serious mental illness (SMI).	Provides Short-Doyle/Medi-Cal-certified care coordination and short-term intensive clinical case management services for clients with serious mental illness (SMI) who have had high service use.	Adults, aged 18 and older, who are eligible for Medi-Cal funded services or are indigent, have a serious mental illness (SMI) (including those with co-occurring substance use), and reside in San Diego County.	• Provide care coordination/short-term intensive clinical case management. • Connect clients with appropriate behavioral health services and short-term housing if the client is homeless.	Safe Connections Neighborhood House Association 286 Euclid Ave. Ste. 104 San Diego, CA 92114 (858) 285-0979
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Maria Sardinas Wellness Recovery Center BPSR - South Region	SBCM provides clinical case management and mental health services with a rehabilitation and recovery focus to Transition Age Youth (TAY) and Adults, managing severe mental illness and who may be diagnosed with a substance use condition. SBCM encourages recovery efforts in participants by identifying and coordinating a range of resources, both envrionment and personal, to help people achieve their goals.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• SBCM • Rehabilitation and recovery services • Care Coordination to needed services medication management • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services.	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	South Bay Guidance Wellness Recovery Center BPSR- South Region	SBCM provides clinical case management and mental health services with a rehabilitation and recovery focus to Transition Age Youth (TAY) and Adults, managing severe mental illness and who may be diagnosed with a substance use condition. SBCM encourages recovery efforts in participants by identifying and coordinating a range of resources, both envrionment and personal, to help people achieve their goals.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• SBCM • Rehabilitation and recovery services • Care Coordination to needed services medication management • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services.	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661
CSS	TAOA-OE	Countywide Homeless Outreach Program	Countywide Homeless Outreach Program	The program conducts outreach and engages persons, aged 18 and older, with serious mental illness (SMI) and/or substance use conditions who are unsheltered to provide a behavioral health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	Assist persons experiencing homelessness by connecting them with housing, improving health and quality of life, and connection to community resources.	Persons served will be adults/older adults, aged 18 or older, with serious mental illness (SMI) and/or substance use conditions and are homeless.	• Provides behavioral health screening and short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	PATH San Diego's Connections Housing 1250 Sixth Ave., San Diego, CA 92101 (619) 810-8600
CSS	TAOA-SD	Adult Crisis Residential Treatment Program	CRTP Del Sur Crisis Center	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth, adults and older adults (TAOA), in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non-hospital intervention but are able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation CRF Del Sur Center 892 27th Street San Diego, CA 92154 (619) 575-4687
CSS	TAOA-SD	Adult Crisis Residential Treatment Program	CRTP Halcyon	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth, adults and older adults (TAOA), in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness (SMI) and who may have a co-occurring substance use condition. Services are on a voluntary basis for clients experiencing a mental health crisis and unable to function without this type of intensive non-hospital intervention, but able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation CRF Halcyon Crisis Center 1664 Broadway El Cajon, CA 92021 (619) 579-8685

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Adult Crisis Residential Treatment Program	CRTP Jary Barreto	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth, adults and older adults (TAOA), in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness (SMI) and who may have a co-occurring substance use condition. Services are on a voluntary basis for clients experiencing a mental health crisis and unable to function without this type of intensive non-hospital intervention, but able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation CRF Jary Barreto Crisis Center 2865 Logan Avenue San Diego, CA 92113 (619) 232-4357
CSS	TAOA-SD	Adult Crisis Residential Treatment Program	CRTP New Vistas	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth, adults and older adults (TAOA), in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness (SMI) and who may have a co-occurring substance use condition. Services are on a voluntary basis for clients experiencing a mental health crisis and unable to function without this type of intensive non- hospital intervention, but able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation CRF New Vistas Crisis Center 734 10th Avenue San Diego, CA 92101 (619) 239-4663
CSS	TAOA-SD	Adult Crisis Residential Treatment Program	CRTP Turning Point	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth, adults and older adults (TAOA), in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness (SMI) and who may have a co-occurring substance use condition. Services are on a voluntary basis for clients experiencing a mental health crisis and unable to function without this type of intensive non-hospital intervention, but able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation CRF Turning Point Crisis Center 1738 South Tremont Street Oceanside, CA 92054 (760) 439-2800
CSS	TAOA-SD	Adult Crisis Residential Treatment Program	CRTP Vista Balboa	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to Transition Age Youth, adults and older adults (TAOA), in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness (SMI) and who may have a co-occurring substance use condition. Services are on a voluntary basis for clients experiencing a mental health crisis and unable to function without this type of intensive non-hospital intervention, but able to be managed in a voluntary setting.	• Twenty-four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital.	Community Research Foundation CRF Vista Balboa Crisis Center 545 Laurel Street San Diego, CA 92101 (619) 233-4399
CSS	TAOA-SD	Augmented Services Program (ASP)	Augmented Services Program (ASP)	Augmented Services Program (ASP) provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults 18 years and older who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Casa El Cajon 306 Shady Lane El Cajon, CA, 92021 (619) 440-1335

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Augmented Services Program (ASP)	Carroll's Community Care Augmented Services Program (ASP)	Augmented Services Program (ASP) provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, 18 and older, who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Carroll's Community Care 523 Emerald Ave. El Cajon, CA, 92020 (619) 442-8893
CSS	TAOA-SD	Augmented Services Program (ASP)	Carroll's Residential Care Augmented Services Program (ASP)	Augmented Services Program (ASP) provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, 18 and older, who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Carroll's Residential Care 655 S. Mollison Street El Cajon, CA, 92020 (619) 444-3181
CSS	TAOA-SD	Augmented Services Program (ASP)	Casa De Oro Residential Care Augmented Services Program (ASP)	Augmented Services Program (ASP) provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, aged 18 and older, who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Anthem Compassionate Care LLC 3602 S. Cordoba Ave Spring Valley, CA, 91977 (619) 303-3717
CSS	TAOA-SD	Augmented Services Program (ASP)	Fancor Guest Home Augmented Services Program (ASP)	Augmented Services Program (ASP) provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, aged 18 and older, who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Fancor Guest Home 631-651 Taft Ave El Cajon, CA, 92020 (619) 588-1761
CSS	TAOA-SD	Augmented Services Program (ASP)	Orlando Residential Care Augmented Services Program (ASP)	Augmented Services Program (ASP) provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults. aged 18 and older, who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Orlando Guest Home 297-299 Orlando Street El Cajon, CA, 92021 (619) 444-9411
CSS	TAOA-SD	Augmented Services Program (ASP)	Rancho Digius - Enhanced Augmented Services Program (EASP)	Enhanced Augmented Services Program (ASP) to provide additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, aged 18 and older who have a serious mental illness (SMI) living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Rancho Digius 2445 Broadway Ave San Diego, CA, 92102 (619) 468-5700

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Alianza Wellness Recovery Center BPSR - Central/North Central for Latino & TAY	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent. This includes enhancements for Transitional age youth (TAY), geriatric, and Latino populations.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transition Age Youth (TAY) services • Older adult services	Mental Health Systems, Inc. Alianza Wellness Center 5555 Reservoir Dr. Ste. #204-A San Diego, CA 92120 (619) 822-1800
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Central Region BPSR WRC-Areta Crowell Center (ACC)	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive Housing • Supportive employment services • Transition Age Youth (TAY) services • Older adult services	Areta Crowell Wellness Recovery Center 1963 4th Ave. San Diego, CA 92101 (619) 233-3432
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Counseling & Treatment Center (CTC - AOA & TA BPSR & Geriatric)	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent. This includes enhancements for Transitional age youth (TAY) and geriatric populations.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transition Age Youth (TAY) services • Geriatric services	Union of Pan Asian Communities (UPAC) 7830 Clairemont Mesa Blvd. #100 San Diego, CA 92111
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Healing Oaks Clinic BPSR Wellness Recovery Center	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transition Age Youth (TAY) services • Older adult services	Healing Oaks Clinic 286 Euclid Ave. Suites 101,102, and 304 San Diego, CA 92114 (619) 859-6270

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Heartland Wellness Recovery Center BPSR - East Region	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Supportive Employment services • Transition Age Youth (TAY) services • Geriatric services • AB 109 enhanced services • Services are provided in English, Arabic, and Chaldean for individuals who identify as members of the Middle Eastern community	Community Research Foundation (CRF) East Region Heartland Center 460 North Magnolia Ave., Suite 110 El Cajon, CA 92020 (619) 440-5133
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Jane Westin Urgent Walk-In Program Central Region	Urgent Walk-In Services for mental health outpatient services that are consistent with psychosocial rehabilitation and recovery principles with persistent and serious mental illness (SMI) and, or co-occurring mental health and substance disorders. Program also provides crisis intervention as needed.	Provide eligible clients with same-day walk- in assessment, psychiatric consultation, and linkage to appropriate level of care for ongoing care once urgent services have been concluded on site.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in services • Behavioral health assessments • Psychiatric evaluation • Medication support • Case management/linkage • Crisis intervention	Jane Westin Center 1045 9th Ave San Diego, CA 92101 (619) 235-2600
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Maria Sardinas WRC BPSR	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Strengths-based case management • Care coordination • Peer support services • Mobile outreach • Supportive employment services • Transition Age Youth (TAY) services • Older adult services	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	North Central Region BPSR WRC (Douglas Young clinic)	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transition Age Youth (TAY) services • Older adult services	Community Research Foundation (CRF) - Douglas Young Clinic 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Promise Wellness Center	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and older adults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive Employment services • Transition Age Youth (TAY) services • Older Adult (OA) services	Union of Pan Asian Communities (UPAC) Main site 995 Gateway Center San Diego, CA 92102 Second Site: 3280 Main Street Suite 7C San Diego, CA 92113 (619) 232-6454 Third Site: 6919 Paradise Valley Rd, Suite A9 San Diego, CA 92139
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	South Bay Guidance Center BPSR-South Region	BPSR Wellness Recovery Center (WRC) that provides outpatient mental health treatment, rehabilitation, and recovery services to transition age youth, adults and olderadults (TAOA), who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery-oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Strengths-based case management • Care coordination • Peer support services • Mobile outreach •Supportive employment services • Transition Age Youth (TAY) services • Older adult services	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Adult Peer Support Line	Adult Peer Support Line (Warm Line)	Peer Support Line provides a non-crisis telephone and live chat service operated by and for Transition Age Youth, Adults and Older Adults (TAOA) who are in recovery from a mental illness.	Promote stability and provide support for situations that may lead to a crisis. The support line provides peer support service for people in mental health recovery, providing support, information, and referrals. The support operates as a non-crisis telephone and live chat service program.	Adults 18 and older who are in recovery from a mental illness and who are low income, indigent, Medi-Cal beneficiaries, or Medi-Cal eligible.	• A telephone and live chat service to provide peer support, information, resources, referrals, and non-crisis intervention.	National Alliance on Mental Illness (NAMI) San Diego 9665 Chesapeake Drive, Suite 450 San Diego, CA 92123 Mailing : PO Box 23700 San Diego, CA 92193 619-295-1055 858-727-9657
CSS	TAOA-SD	Clubhouse	The Meeting Place Clubhouse	The Meeting Place Clubhouse is an ongoing program by The Meeting Place, Inc. The program is a Clubhouse International accredited member-operated clubhouse in the Central Region. The clubhouse assists Transition Age Youth, Adults and Older Adults (TAOA) with a serious mental illness (SMI), including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals. The program also provides Supplemental Security Income (SSI) application assistance and advocacy services to individuals in the Central Region.	This program shall provide member-driven Clubhouse International accredited clubhouse services to the priority population of adults aged 18 years and above, with serious mental illness (SMI), including co-occurring substance use.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use, with a specialization in the Asian/Pacific Islander community.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI advocacy services are provided to individuals who may be interested.	The Meeting Place 2553 State St. Ste 101 San Diego, CA 92101 (619) 294-9582
CSS	TAOA-SD	Clubhouse	Connection 2 Community Clubhouse	This Clubhouse will serve Adults/Older Adults who have a serious mental illness (SMI) including those who may have a co-occurring substance use condition. The clubhouse will assist individuals with serious mental illness (SMI) to achieve social, financial, health/wellness, educational, and vocational goals and shall follow Clubhouse International Standards.	Overall goals of this program include: member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, and improving health and quality of life.	Homeless Adults/Older Adults who have a serious mental illness (SMI); Services are in Central Region with an emphasis in downtown San Diego.	• Clubhouse services including recovery education and support, supported employment, assistance with SSI application. Additional contract components include shower and laundry support, and street outreach services.	National Alliance on Mental Illness (NAMI) San Diego C2C Clubhouse 101 16th Street San Diego, CA 92101 (619) 776-8605

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Clubhouse	East Corner Clubhouse	East Corner Clubhouse is an ongoing program by NAMI San Diego. The program is a member-operated clubhouse in the East Region. The clubhouse assists Transition Age Youth, Adults and Older Adults (TAOA) with a serious mental illness (SMI), including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals. The program also provides Supplemental Security Income (SSI) application assistance and advocacy services to individuals in the East Region.	Overall goals of this program include but are not limited to: member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual, and recreational), improve functioning, increasing employment and education, and improving health and quality of life.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI advocacy services are provided to individuals who may be interested.	East Corner Clubhouse 1060 Estes St., #104 El Cajon, CA 92020 (619) 631-0441
CSS	TAOA-SD	Clubhouse	East Wind Clubhouse	The East Wind Clubhouse is an ongoing countywide program by Union of Pan Asian Communities (UPAC) that offers a member-operated clubhouse to adults 18 and over with serious mental illness with a specialization in the Asian Pacific Islander Community. The East Wind Clubhouse provides services to their members to help them achieve social, financial, health/ wellness, education, and vocational goals.	The goals of the Clubhouse program include member access to socialization and rehabilitation supports to facilitate reductions in social isolation while identifying personal areas of interest, improving functioning, increasing employment and education, and improving health and quality of life.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use., with a specialization in the Asian/Pacific Islander community.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens.	UPAC East Wind Clubhouse 5348 University Avenue Suite 108 San Diego CA92105 (858) 268-4933
CSS	TAOA-SD	Clubhouse	Escondido Clubhouse (North Inland)	Escondido Clubhouse is an ongoing program by Mental Health Systems, Inc. The program is a Clubhouse International accredited member-operated clubhouse in the North Inland Region. The clubhouse assists Transition Age Youth, Adults and Older Adults (TAOA) with a serious mental illness (SMI), including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals. The program also provides Supplemental Security Income (SSI) application assistance and advocacy services to individuals in the North Inland Region.	Overall goals of this program include: member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, and improving health and quality of life.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI advocacy services are provided to individuals who may be interested.	Mental Health Systems, Inc. (MHS) 474 W. Vermont Ave., Suite 105 Escondido, CA 92025 (760) 737-7125

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Clubhouse	Mariposa Clubhouse	Mariposa Clubhouse is an ongoing program by Mental Health Systems, Inc. The program is a member-operated clubhouse in the North Coastal Region. The clubhouse assists Transition Age Youth, Adults and Older Adults (TAOA) with a serious mental illness (SMI), including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals. The program also provides Supplemental Security Income (SSI) application assistance and advocacy services to individuals in the North Coastal Region.	Overall goals of this program include: member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, and improving health and quality of life.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI advocacy services are provided to individuals who may be interested.	Mental Health Systems (MHS), Inc. 1701 Mission Ave, Suite 120 Oceanside, CA 92058 (760) 439-2769
CSS	TAOA-SD	Clubhouse	NAMI SD - Casa Del Centro	Casa del Centro Clubhouse is an ongoing program by NAMI San Diego. The program is a member-operated clubhouse in the Central Region. The clubhouse assists adults/older adults with serious mental illness (SMI) ages 18 and older, including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals. The program also provides Supplemental Security Income (SSI) application assistance and advocacy services to individuals in the Central Region.	The goals of the Clubhouse program include member access to socialization and rehabilitation supports to facilitate reductions in social isolation while identifying personal areas of interest, improving functioning, increasing employment and education, and improving health and quality of life.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI application assistance and advocacy services are provided to individuals who may be interested.	National Alliance on Mental Illness (NAMI) San Diego Casa del Centro Clubhouse 2754 Imperial Ave San Diego, CA 92102 (619) 951-9007
CSS	TAOA-SD	Clubhouse	Oasis Clubhouse	Oasis Clubhouse is an ongoing program by Pathways Community Services. The program is a member-operated clubhouse in the Central Region. The clubhouse assists Transition Age Youth (TAY) with serious mental illness (SMI), including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals.	Overall goals of this program include but are not limited to; member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual, and recreational), improve functioning, increasing employment and education, and improving health and quality of life.	Transition Age Youth 16 to 25 years old with a serious mental illness (SMI) and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those with co-occurring substance use. who may have a co-occurring substance use.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens.	Pathways Community Services 3330 Market St. #A San Diego, CA 92102 (858) 300-0470

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Clubhouse	The Plaza Clubhouse	The Plaza Clubhouse is an ongoing program by NAMI San Diego. The program is a member-operated clubhouse in the South Region. The clubhouse assists adults/older adults with serious mental illness (SMI) ages 18 and older, including those who may have a co-occurring substance use condition, to achieve social, financial, health/wellness, educational, and vocational goals. The program also provides Supplemental Security Income (SSI) application assistance and advocacy services to individuals in the South Region.	The goals of the Clubhouse program include member access to socialization and rehabilitation supports to facilitate reductions in social isolation while identifying personal areas of interest, improving functioning, increasing employment and education, and improving health and quality of life.	Adults/Older Adults 18 years and older with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi-Cal beneficiaries, including those who may have co-occurring substance use.	• The program provides a clubhouse program within Clubhouse International standards. Members are provided an opportunity to engage in the Work Ordered Day working side by side staff to operate the clubhouse. Members can participate in all the work of the clubhouse with the aim to identify areas of personal interest and strengthen abilities to function independently. Services are provided within psychosocial principles within a trauma informed and culturally appropriate lens. SSI advocacy services are provided to individuals who may be interested.	National Alliance on Mental Illness (NAMI) San Diego 465 C Street Chula Vista, CA 91910
CSS	TAOA-SD	Consumer Advocacy	Consumer Advocacy	Consumer Advocacy provides recovery-oriented services to all BHS service recipients and their families, who have experience with their own behavioral health conditions and recovery process, and/or who are seeking to or are already working or volunteering within the County's Behavioral Health System of Care. In addition, collective consumer voice obtains consumer feedback and elevates to the BHS continuum of care.	Create a trauma informed system of care and minimize re-traumatization of consumers who continue to receive services in San Diego's Behavioral Health System.	All BHS service recipients and their families, including Transition Age Youth (TAY), Adult, and Older Adults.	• Recovery-oriented services that include advocacy training and peer support for persons and family members.	National Alliance on Mental Illness (NAMI) San Diego 9665 Chesapeake Drive, Suite 450 San Diego, CA 92123 Mailing: PO Box 23700 San Diego, CA 92193 (858) 634-6586
CSS	TAOA-SD	Crisis Stabilization - East Region	Crisis Stabilization and Expanded Recovery Bridge Center – East Region	The East Region Crisis Stabilization Unit (CSU) and Expanded Recovery Bridge Center (ERBC) offers services 24-hours, seven days a week for adult and older adults, including individuals who are Medi-Cal beneficiaries, indigent and/or underserved, and who are residents of San Diego County, who have serious mental illness (SMI) and who are experiencing a psychiatric emergency. This may also include co-morbid alcohol and other drug-induced conditions. The Expanded Recovery Bridge Center is a safe space for public inebriates or intoxicated individuals. Individuals may be dropped off by health, safety, and law enforcement agencies and are kept a minimum of four hours for sobering purposes in lieu of incarceration.	Crisis stabilization services assist with reducing the severity of a person's distress while experiencing a behavioral health crisis and may prevent the need for a higher level of care , while promoting care in a recovery-oriented treatment setting. Recovery Bridge Services provide safe, alcohol and other drug-free sobering services to adults identified as intoxicated by law enforcement and/or adults with symptoms of intoxication referred by health, safety and law enforcement agencies.	Services provided to Transition Aged Youth (TAY) 18-25 years, 25-59 years and older adults 60 years and up who have SMI including those with co- occurring substance use, eligible for Medi-Cal funded services or who are indigent. Voluntary clients and those on Welfare and Institutions Code 5150 hold who are experiencing a psychiatric crisis referred by health, safety, and law enforcement agencies in the East County region.	• Rapid access to mental health evaluation and assessment, crisis intervention, medication, collateral, care coordination and disposition planning.	Exodus Recovery, Inc. East Region CSU and RBC 200 N. Magnolia Ave. El Cajon, CA 92020 (702) 595-3403

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Crisis Stabilization - North Coastal Oceanside	Crisis Stabilization Unit North Region	The North Region Crisis Stabilization Unit operates 24-hours/7 days a week for adult and older adults, are Medi-Cal beneficiaries, indigent and/or underserved, and those who are residents of San Diego County, who have serious mental illness (SMI) and are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug-induced problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness (SMI) or co-occurring condition, while promoting care in a recovery-oriented treatment setting. CSU services shall last less than 24 hours (23.59 hours).	Services provided to Transition Aged Youth (TAY) 18-25 years, 25-59 years and older adults aged 60 years and up, who have a serious mental illness (SMI) including those with co-occurring substance use and who are eligible for Medi-Cal funded services or who are indigent. This includes voluntary clients and those on Welfare and Institutions Code 5150 hold who are experiencing a psychiatric crisis of such magnitude that it would place the health or safety of the individual or others.	• Psychiatric assessment • Transfer to inpatient services • Physical health assessment • Crisis intervention • Medication management • Linkage and care coordination • Transportation to short-term housing • Flex funds	Exodus Recovery, Inc. 1701 Mission Ave, Ste 130 Oceanside, CA 92058 Main: (760) 305-4848 Fax: (760) 305-4845
CSS	TAOA-SD	Crisis Stabilization - North Coastal Vista	North Coastal CSU	The North Coastal Vista Crisis Stabilization Unit operates 24-hours/7 days a week for adult and older adults, are Medi-Cal beneficiaries, indigent and/or underserved, and those who are residents of San Diego County, who have serious mental illness (SMI) and are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug-induced problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness (SMI) or co-occurring condition, while promoting care in a recovery-oriented treatment setting. CSU services shall last less than 24 hours (23.59 hours).	Services provided to Transition Aged Youth (TAY) 18-25 years, 25-59 years and older adults aged 60 years and up, who have a serious mental illness (SMI) including those with co-occurring substance use and who are eligible for Medi-Cal funded services or who are indigent. This includes voluntary clients and those on Welfare and Institutions Code 5150 hold who are experiencing a psychiatric crisis of such magnitude that it would place the health or safety of the individual or others.	• Psychiatric assessment • Transfer to inpatient services • Physical health assessment • Crisis intervention • Medication management • Linkage and care coordination • Transportation to short-term housing • Flex funds	Exodus Recovery, Inc. 524 W. Vista Way Vista, CA 92083 (760) 758-1150
CSS	TAOA-SD	Crisis Stabilization - North Inland	Crisis Stabilization Unit North Region	The Crisis Stabilization Unit in the North Inland Region operates 24-hours/7 days a week for adult and older adults, are Medi-Cal beneficiaries, indigent and/or underserved, and those who are residents of San Diego County, who have serious mental illness (SMI) and are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug-induced problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness (SMI) or co-occurring condition, while promoting care in a recovery-oriented treatment setting.	Services provided to Transition Aged Youth (TAY) 18-25 years, 25-59 years and older adults aged 60 years and up, who have a serious mental illness (SMI) including those with co-occurring substance use and who are eligible for Medi-Cal funded services or who are indigent. This includes voluntary clients and those on Welfare and Institutions Code 5150 hold who are experiencing a psychiatric crisis of such magnitude that it would place the health or safety of the individual or others.	• Psychiatric assessment • Transfer to inpatient services • Physical health assessment • Crisis intervention • Medication management • Linkage and care coordination • Transportation to short-term housing • Flex funds	Palomar Health 2185 Citracado Parkway Escondido, CA 92029 (760) 480-7901
CSS	TAOA-SD	Crisis Stabilization - South	Crisis Stabilization South Paradise Valley	The South Region Crisis Stabilization Unit provides 24-hour hospital-based crisis unit for Adults who are experiencing a psychiatric emergency.	Impact unnecessary and lengthy involuntary inpatient treatment, as well as promote care in voluntary recovery-oriented treatment settings.	Voluntary and involuntary adults and older adults with a serious mental illness (SMI).	• 24-hour, seven days a week, hospital-based crisis stabilization as an alternative to emergency room services. • Behavioral Health Assessments • Medication management • Case management • Linkage to community services	Prime Health Paradise Valley Bayview Crisis Stabilization Unit 330 Moss Street Chula Vista, Ca. 91911 (619) 426-6310

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Faith Based Services	Faith-Based Behavioral Health Training and Education Academy & Community Education (FBBHEA)	Provides trainings and presentations to faith-based leaders and behavioral health providers in the North Coastal and North Inland Regions to increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health, with an emphasis on reaching African-American and Latino communities.	Increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health. The FBBHEA and its community education trainings will facilitate behavioral health awareness and connection to resources within their community. Contractor shall conduct outreach to the target population on an ongoing basis to increase and maintain awareness, attendance, and support for FBBHEA and Community Education Presentations (CEP). Contractor shall follow best practices and principles of community outreach and engagement. Contractor shall conduct outreach to all faith groups. Contractor shall maintain a written outreach and engagement plan. Contractor shall update and revise the outreach and engagement plan at least annually, or more frequently as directed by COR.	Faith-based leaders and behavioral health providers, African American and Latino communities in North Coastal and North Inland Regions. Faith-based organizations, churches, synagogue, temples, mosques and other places of worship.	• Provide Community Education Presentations (CEPs) to the faith-based community. • Provide FBBHEA to faith leaders and behavioral health professionals. • Identify champions from FBBHEA sessions to create cadre of Facilitator Trainers (FT) within the designated region	Interfaith Community Services, Inc. 613 W. Valley Parkway Escondido, CA 92025 (760) 204-2025
CSS	TAOA-SD	Faith Based Services	Faith-Based Behavioral Health Training and Education Academy (FBBHTEA) & Community Education	Provides training and education to FBBHTEA participants using the developed curriculum for both faith leaders and behavioral health providers. The program outreaches, engages, and provides educational opportunities for faith-based leaders and behavioral health providers to participate in FBBHTEA combined trainings. This includes creating educational materials to address faith/spirituality principles and values, wellness, behavioral health conditions, and resource information to the African-American and Latino communities in designated regions.	Increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health. The FBBHTEA and its community education trainings will facilitate behavioral health awareness and connection to resources within their community. Contractor shall conduct outreach to the target population on an ongoing basis to increase and maintain awareness, attendance, and support for FBBHTEA and Community Education Presentations (CEP). Contractor shall follow best practices and principles of community outreach and engagement. Contractor shall conduct outreach to all faith groups. Contractor shall maintain a written outreach and engagement plan. Contractor shall update and revise the outreach and engagement plan at least annually, or more frequently as directed by COR.	Faith-based leaders and behavioral health providers, African American and Latino communities in North Coastal and North Inland Regions, faith-based organizations, churches, synagogue, temples, mosques and other places of worship,	• Provide Community Education Presentations (CEPs) to the faith-based community. • Provide FBBHTEA to faith leaders and behavioral health professionals. • Identify champions from FBBHTEA sessions to create cadre of Facilitator Trainers (FT) within the designated region	Stepping Higher, Inc. 7373 University Ave. Ste 201 La Mesa, CA 91942 (619) 577-6187
CSS	TAOA-SD	Faith Based Services	Project In-Reach Ministry	Provides in-reach, engagement; education; peer support; follow-up after release from detention facilities and linkages to services that improve participant's quality of life. The Faith-Based Wellness and Mental Health In- Reach Ministry will provide support services consistent with pastoral counseling and the individual's faith in addition to information, linkage and education about community- based resources.	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults.	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness (SMI).	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness (SMI) to assist in connecting clients with community-based treatment once released.	Neighborhood House Association Project In-Reach 5473 Kearny Villa Rd Suite 300 San Diego, CA 92123 (619) 737-2639

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Family Education	Family Education Services	Culturally appropriate outreach and engagement for the purpose of increasing access to mental health services.	Provide education and support that is built around goals and tools to help family members and friends understand, cope with, and respond to issues that arise due to mental illness, and shall promote the natural supports of family and friends' encouragement on recovery and resiliency.	Family members and friends of persons with behavioral health conditions.	• A series of educational classes presented by staff and/or family members using an established family education curriculum to provide education and support for persons who have relatives or close friends with behavioral health issues.	NAMI Family Education 9665 Chesapeake Drive, Suite 450 San Diego, CA 92123 Mailing : PO Box 23700 San Diego, CA 92193 858-634-6580
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team (IHOT)	IHOT provides mobile in-home outreach teams and engagement services to individuals with serious mental illness (SMI) who are reluctant to seek outpatient mental health services and to their family members or caretakers.	The goal of IHOT is to reduce the effects of untreated mental illness in individuals with serious mental illness (SMI), increase family member satisfaction with the mental health system of care while protecting public safety.	Adults/Older Adults 18 years of age and older reluctant to seek outpatient mental health services and to their family members.	• IHOT shall provide in-home assessment, crisis intervention, short term case management and peer and family/care-taker support services, psycho-education, linkage to outpatient mental health care, rehabilitation, recovery and other services to individuals with SMI, and their family or caretakers, as necessary. • IHOT outreach and engagement program shall facilitate follow up services that may include outpatient specialty mental health services, crisis intervention, acute care, alternatives to psychiatric hospitalization, conservatorship and case management services.	Telecare Corporation - IHOT 1080 Marina Village Pkwy,. Suite 100 Alameda, CA 94501 (619) 961-2120
CSS	TAOA-SD	Institutional Case Management (ICM) - Older Adults	Agewise Supported Housing	Agewise Supported Housing is a Strengths-Based Case Management, and Institutional Case Management for Older Adults.	Provide SBCM and ICM services to adults over age 60 who suffer from serious mental illness (SMI) and who may have a co-occurring substance use disorder. ICM population is on Public Conservatorship.	Older Adults (60+ y/o). ICM population is 60+ y/o and on Public Conservatorship.	• Strengths-Based Case Management and Institutional Case Management	Telecare Corporation 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Justice System Discharge Planning	Project In-Reach	Jail discharge planning provides in-reach, engagement; education; peer support; follow-up after release from detention facilities and linkages to services that improve participant's quality of life.	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults.	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness (SMI).	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness (SMI) to assist in connecting clients with community-based treatment once released.	Neighborhood House Association Project In-Reach 5473 Kearny Villa Rd, Suite 300 San Diego, CA 92123 (619) 766-5994
CSS	TAOA-SD	Mental Health Advocacy Services	Adult SSI Advocacy	This program is responsible for the submission of applications to the Social Security Administration and further follow-up as needed.	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs.	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS.	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid Society of San Diego Inc. 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC) (Vista)	BPSR WRC provides outpatient mental health treatment, rehabilitation, and recovery services to Transition Age Youth, Adults and Older Adults (TAOA) who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Supportive Employment services • Transition Age Youth (TAY) services • Older Adult (OA) services • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues • Weekend capability	Mental Health Systems, Inc. (MHS)/TURN BHS 550 West Vista Way Ste. 407 Vista, CA 92083 760-758-1092 Mental Health Systems, Inc. (MHS)/TURN BHS 1701 Mission Avenue Ste. 230 Oceanside, CA 92058 760-227-1490
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	North Coastal Mental Health Center (N. Coastal MHC)					

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Clinic BPSR - N. Inland Region	BPSR WRC provides outpatient mental health treatment, rehabilitation, and recovery services to Transition Age Youth, Adults and Older Adults (TAOA) who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness (SMI) including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Supportive Employment services • Transition Age Youth (TAY) services • Older Adult (OA) services • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues • Weekend capability	Mental Health Systems, Inc. (MHS) North Inland Mental Health Clinic 125 W. Mission, Suite 103 Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Escondido, CA 92025 (760) 480-2255 Kinesis North WRC--Ramona 1521 Main St. Ramona, CA 92065 (760) 736-2429 Kinesis North WRC - Fallbrook 591 East Elder St, Suite C Fallbrook, CA 92028 (760) 480-2255
CSS	TAOA-SD	North Inland Mental Health Center	Kinesis BPSR North Wellness Recovery Center					
CSS	TAOA-SD	Public Defender - Behavioral Health Assessor	Licensed Mental Health Clinicians Embedded in Public Defender's Holistic Services Unit	Licensed mental health clinicians assist in identifying the level of behavioral health need and link clients to behavioral health services in the community.	Public Defender Treatment Unit will reduce untreated mental illness by ensuring persons are connected to system of care.	Adults 18 years and older with a serious mental illness (SMI) who are incarcerated or Transition Age Youth at designated detention facilities who will be released in San Diego County.	• Identify level of behavioral health need •Link clients to behavioral health services in the community.	Public Defender 450 B St., Ste 1100 San Diego, CA 92101 (619) 338-4700
CSS	TAOA-SD	San Diego Employment Solutions	Continuum of Supported Employment	The Continuum of Supported Employment offers services and opportunities for Transition Age Youth, Adults and Older Adults with serious mental illness (SMI).	Increase competitive employment of adults 18 and older who have a serious mental illness (SMI) and who want to become competitively employed.	Adults 18 years and older who have a serious mental illness (SMI) and need assistance with employment.	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness (SMI) obtain competitive employment • Use a comprehensive approach that is community-based, client and family-driven, and culturally competent	Mental Health Systems, Inc. Employment Solutions 10981 San Diego Mission Rd. # 110 San Diego, CA 92108 (619) 521-9569
CSS	TAOA-SD	San Diego Housing Commission	SDHC Admin Home Finder Program	The SDHC Admin Home Finder Program provides support for 180 San Diego Housing Commission subsidies.	Provide support for housing.	Adults 18 years and older who have a serious mental illness (SMI) and are experiencing homelessness in the city of San Diego.	• Housing vouchers/subsidies	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-Term & Bridge Housing is a program for adults with serious mental illness (SMI) who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness (SMI) or serious emotional disturbance, by providing accessible Short-Term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness (SMI) by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness (SMI), and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Interfaith Community Services 550 W. Washington St., Suite B Escondido, CA 92025 (760) 489-6380

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-term & Bridge Housing for adults with serious mental illness (SMI) who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness (SMI) or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness (SMI) by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness (SMI), and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	United Homes 515 North Horne St. Oceanside, CA 92054 (760) 612-5980
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-term & Bridge Housing for Transition Age Youth (TAY) with serious mental illness (SMI) or serious emotional disturbance who are experiencing homelessness.	Provide housing and support services to TAY with serious mental illness (SMI) or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients and case management.	TAY, 18 to 24 years of age, who have a serious emotional disturbance or a serious mental illness (SMI), and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and transitional beds that has staff available during all operating hours. • Case management • Provide 3 meals a day for residents. • Safe and sanitary quarters on a nightly basis.	Urban Street Angels, Inc. 1404 Fifth Ave San Diego, CA 92101 (619) 415-6616
CSS	TAOA-SD	Short-Term Bridge Housing	Short Term Bridge Housing	Short-term & Bridge Housing is a program for adults with serious mental illness (SMI) who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness (SMI) or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness (SMI) by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness (SMI) and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Rick's Independent Living 1021 South 37th Street San Diego, CA 92113 (619) 944-5795
CSS	TAOA-SD	Short-Term Bridge Housing	Short Term Bridge Housing	Short-term & Bridge Housing for adults with serious mental illness (SMI) who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness (SMI) or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness (SMI) by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness (SMI), and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Stars & Stripes 8064 Allison Ave #125 La Mesa, CA 91942 (619) 786-3486
CSS	TAOA-SD	Supplemental Security Income (SSI) Advocacy Services	SSI Advocacy	Supplemental Security Income Advocacy Services is responsible for the submission of applications to the Social Security Administration and further follow-up as needed.	Expedite awards, provide training and consultation to designated adult clubhouse advocates, and provide outreach and education to child focused programs.	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of Behavioral Health Services.	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid Society of San Diego, Inc. 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
CSS	TAOA-SD	Supplemental Security Income (SSI) Advocacy Services	SSI Advocacy	Supplemental Security Income Advocacy Services is responsible for the submission of application to the Social Security Administration and further follow-up as needed.	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs.	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, Housing and Disability Advocacy Program and mental health consumers (children and adults) of Behavioral Services.	• Provide initial training of designated Clubhouse SSI Advocates. • Provide training and consultation to the Clubhouse SSI Advocates to assist qualified applicants. • Submission of SSI applications to Social Administration. •Provide follow up services as needed.	Legal Aid Society of San Diego, Inc. San Diego: 1130 Tenth Avenue San Diego, CA 92101 Chula Vista: 690 Oxford Street Chula Vista, CA 91911 El Cajon: 220 South First Street El Cajon, CA 92019 Escondido: 649 West Mission Avenue Escondido, CA 92025 Oceanside: 3708 Ocean Ranch Blvd Oceanside, CA 92056 San Diego Psychiatric Hospital: 3853 Rosecrans Street San Diego, CA 92110
CSS	TAOA-SD	Tenant Peer Support Services	Tenant Peer Support Services (TPSS)	TPSS is a program that provides housing navigation and support for persons with serious mental illness (SMI) who are experiencing homelessness.	On-going support for clients experiencing homelessness who are connected to permanent supportive housing resources. Services include housing navigation and tenant support services. Includes nonclinical services for MHSA developed units, such as No Place Like Home (NPLH) units.	Adults 18 years and older with serious mental illness (SMI) who are experiencing homelessness. Small number of families who are accessing family MHSA units will also be served.	• Support identifying and securing safe and affordable housing • Provides flex funds to support resident retention • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness (SMI)	Alpha Project 667 Camino Del Rio S., San Diego CA 92108. (619) 542-1877
PEI	CO-03	Integrated Peer & Family Engagement	Integrated Peer & Family Engagement Program - Next Steps	The program assists participants with increased resiliency and self-care, reduced substance use, improved medication adherence, decreased mental health symptoms through coping skills, reduced problems commonly associated with substance use, and improved mental and physical wellness. The program also links participants to health care treatment and other community resources as needed.	Services aim to engage clients by linking them to appropriate treatment and support services spanning the entire continuum of care, including mental health, substance use disorder, and primary care clinics to reduce the need for hospitalizations.	Adults 18 years and older.	• Services are provided at SDCPH and in the community • Screening, brief treatment, and referrals and linkages to resources and services in the community	National Alliance on Mental Illness (NAMI), San Diego P.O. Box #23700 San Diego, CA 92193 (858) 643-6580
PEI	DV-03	Alliance for Community Empowerment	Community Violence Services (ACE)-Central	This program provides trauma informed, community centered, family driven and evidenced-based community violence response services, support, referrals, and linkages to care countywide.	Increase in resilience; increased knowledge of services; increased problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma.	Community members of all ages affected by community violence.	• Immediate support and assistance, referrals and linkages to care after an incidence of community violence • Grief counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities (UPAC) 5348 University Ave., Suites 202 San Diego, CA 92105 (619) 500-1128

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	This program provides family preservation, family support, and family reunification services to children and families in the Child and Family Well Being (CFWB) system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Home Start 5005 Texas St., Suite 203 San Diego, CA 92108 (619) 629-0727
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	This program provides family preservation, family support, and family reunification services to children and families in the Child and Family Well Being (CFWB) system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	North County Lifeline (Lifeline Community Services) 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	This program provides family preservation, family support, and family reunification services to children and families in the Child and Family Well Being (CFWB) system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children 0 to 17 years old and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Social Advocates for Youth 8755 Aero Dr., Suite 100 San Diego, CA 92123 (858) 565-4148
PEI	DV-04	Community Services for Families - Child Welfare Services	Point of Engagement (CWS Contract)	The Point of Engagement program provides family preservation, family support, and family reunification services to children and families in the Child and Family Well Being (CFWB) system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children 0 to 17 years old and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	SBCS 430 F St. Chula Vista, CA 91910 (619) 420-3620
PEI	EC-01	Positive Parenting Program (Triple P)	Positive Parenting Program	The Positive Parenting Program provides mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum.	Specialized culturally and developmentally appropriate mental health Prevention and Early Intervention (PEI) services to promote social and emotional wellness for children and their families.	Countywide parents and caregivers of children and adolescents, and child care staff who care for children in Head Start, Early Start and Education Enrichment Services centers.	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Service 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3210
PEI	FB-01	Early Intervention for Prevention of Psychosis	KickStart	Provides Prevention and Early Intervention (PEI) services for persons who have emerging 'prodromal' symptoms of psychosis.	Reduce incidence and severity of mental illness and increase awareness and usage of services.	Countywide youth 10 to 25 years old in San Diego County and their families and substantial public component on psychosis.	• Transportation to short-term housing	Pathways Community Services, LLC 6160 Mission Gorge Rd. Ste 100 San Diego, CA 92120
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	The Native American Prevention and Early Intervention (PEI) provides substance use disorder prevention and treatment services for Native Americans.	Increase community involvement and education through services designed and delivered by Native American communities.	American Indians; Alaska Natives; tribal members of North Region tribes; and qualified family members residing on reservations; All age groups; North Regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410

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MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides Prevention and Early Intervention (PEI) services for Native American Indian/Alaska Native urban youth.	Increase community involvement and education through services designed and delivered by Native American communities.	At risk and high risk urban American Indian and Alaska Native children and Transitional Age Youth.	• Specialized culturally appropriate prevention and early intervention services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center.	San Diego American Indian Health Center 2602 1st Ave., Ste. 105 San Diego, CA 92103 (619) 234-1525
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides Prevention and Early Intervention (PEI) and substance use disorder prevention and treatment services for Native Americans.	Increase community involvement and education through services designed and delivered by Native American communities.	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188
PEI	OA-01	Community-Based Services for Older Adults	Older Adult Prevention and Early Intervention (PEI) Community-Based Program	Community-Based Services for Older Adults provides outreach, education, advocacy, peer mentoring support and transportation coordination services to unserved and underserved Latino, African American, Asian, Pacific Islander, Filipino, East African and Middle Eastern seniors.	Enable timely identification of mental health issues and the prevention of mental health issues, reduce inappropriate utilization of hospital emergency rooms (ER) and inpatient hospital admissions, enhance timely access and engagement to need mental and physical health services, enhanced resource utilization, service capacity and improve quality of care.	Multicultural Seniors, refugees, 60 years and older. who are experiencing, or at risk of experiencing mental health symptoms	• Outreach and education • Referral and linkage • Benefits advocacy • Peer mentoring • Transportation services • Home and community-based services	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 619-481-2645
PEI	OA-02	Home Based Services - For Older Adults	Older Adult Prevention and Early Intervention (PEI) - Caregiver Support Services	The Older Adult Prevention and Early Intervention (PEI) – Caregiver Support Services provides outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model.	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduces stigma associated with mental health concerns and disparities in access to services.	Homebound older adults 60 years and older who are at risk for depression or suicide.	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 619-481-2652
PEI	OA-06	Caregiver Support for Alzheimer & Dementia Patients	Older Adult Prevention and Early Intervention (PEI) Services Homebound Program	The Caregiver Support Services Program provides prevention and early intervention services to support the wellness and mental health of adult or older adult caregivers who are caring for an adult or older adult parent, spouse, partner, family member who is experiencing a mental health condition.	Early intervention (PEI) mental health services to adult or older adult caregivers serving an adult or older adult with a mental health condition.	Adult Caregivers 18 years and older.	• Outreach • Information dissemination • Early intervention • Prevention education	Southern Caregiver Resource Center 891 Kuhn Drive, Suite 200 Chula Vista, CA 91914 (800) 827-1008
PEI	PS-01	ACEs Prevention Parenting Program for Fathers	ACEs Prevention Parenting Program for Fathers	Adverse Childhood Experiences (ACEs) Prevention Parenting Program for Fathers provides an evidence-based parenting education and mental health wellness curriculum, community-based ACES prevention presentations and provides social recreational bonding experiences for children and their fathers.	Improve attitudes toward fathering, increase fathering knowledge, and enhance fathering skills among participants to reduce ACE factors and promote positive childhood experiences.	Fathers, guardians and male caregivers.	•Outreach and Engagement •Prevention and Education •Community presentations •Social and Recreational Activities •24/7 Dad Curriculum education	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412

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PEI	PS-01	ACEs Prevention Parenting Program for Fathers	ACEs Prevention Parenting Program for Fathers East Region	Adverse Childhood Experiences (ACEs) Prevention Program for Fathers provides an evidence-based parenting education and mental health wellness curriculum, community-based ACES prevention presentations and provides social recreational bonding experiences for children and their fathers.	Improve attitudes toward fathering, increase fathering knowledge, and enhance fathering skills among participants to reduce ACE factors and promote positive childhood experiences.	Fathers, guardians and male caregivers.	•Outreach and Engagement •Prevention and Education •Community presentations •Social and Recreational Activities •24/7 Dad Curriculum education	Mental Health America of San Diego 8580 La Mesa Blvd, Ste 102A La Mesa, CA 91942 (619) 543-0412
PEI	PS-01	ACEs Prevention Parenting Program for Fathers	ACEs Prevention Parenting Program for Fathers North Central	Adverse Childhood Experiences (ACEs) Prevention Program for Fathers provides an evidence-based parenting education and mental health wellness curriculum, community-based ACES prevention presentations and provides social recreational bonding experiences for children and their fathers.	Improve attitudes toward fathering, increase fathering knowledge, and enhance fathering skills among participants to reduce ACE factors and promote positive childhood experiences.	Fathers, guardians and male caregivers.	•Outreach and Engagement •Prevention and Education •Community presentations •Social and Recreational Activities •24/7 Dad Curriculum education	New Alternatives 241 E 3rd Ave Escondido, CA 92025 (619) 254-4332
PEI	PS-01	ACEs Prevention Parenting Program for Fathers	ACEs Prevention Parenting Program for Fathers North Coastal	Adverse Childhood Experiences (ACEs) Prevention Program for Fathers provides an evidence-based parenting education and mental health wellness curriculum, community-based ACES prevention presentations and provides social recreational bonding experiences for children and their fathers.	Improve attitudes toward fathering, increase fathering knowledge, and enhance fathering skills among participants to reduce ACE factors and promote positive childhood experiences.	Fathers, guardians and male caregivers.	•Outreach and Engagement •Prevention and Education •Community presentations •Social and Recreational Activities •24/7 Dad Curriculum education	Vista Community Clinic 1000 Vale Terrace Dr Vista CA, 92084 (760) 631-5000
PEI	PS-01	ACEs Prevention Parenting Program for Fathers	ACEs Prevention Parenting Program for Fathers North Inland	Adverse Childhood Experiences (ACEs) Prevention Program for Fathers provides an evidence-based parenting education and mental health wellness curriculum, community-based ACES prevention presentations and provides social recreational bonding experiences for children and their fathers.	Improve attitudes toward fathering, increase fathering knowledge, and enhance fathering skills among participants to reduce ACE factors and promote positive childhood experiences.	Fathers, guardians and male caregivers.	•Outreach and Engagement •Prevention and Education •Community presentations •Social and Recreational Activities •24/7 Dad Curriculum education	New Alternatives 241 E 3rd Ave Escondido, CA 92025 (619) 254-4332
PEI	PS-01	ACEs Prevention Parenting Program for Fathers	ACEs Prevention Parenting Program for Fathers South Region	Adverse Childhood Experiences (ACEs) Prevention Program for Fathers provides an evidence-based parenting education and mental health wellness curriculum, community-based ACES prevention presentations and provides social recreational bonding experiences for children and their fathers.	Improve attitudes toward fathering, increase fathering knowledge, and enhance fathering skills among participants to reduce ACE factors and promote positive childhood experiences.	Fathers, guardians and male caregivers	•Outreach and Engagement •Prevention and Education •Community presentations •Social and Recreational Activities •24/7 Dad Curriculum education	SBCS 430 F St Chula Vista, CA 91910 (619) 420-3620

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PEI	PS-01	Breaking Down Barriers	Breaking Down Barriers	The Breaking Down Barriers program provides outreach, engagement and community organizing to reduce the stigma associated with mental illness and improve mental health well-being.	Reduce mental health stigma to culturally diverse, unserved and underserved populations.	Unserved and underserved populations; Latino; Native American; African; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); African-American.	• Outreach and education to reduce mental health stigma to culturally diverse, unserved and underserved populations • Collaboration with community-based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Jewish Family Services of San Diego 8804 Balboa Ave San Diego., CA 92123 (858) 637-3000
PEI	PS-01	Clubhouse Services Program	Connection 2 Community Clubhouse	This Clubhouse will serve adults/older adults with a serious mental illness (SMI) ages 18 and older including those who may have a co-occurring substance use condition. The clubhouse will assist individuals with serious mental illness (SMI) to achieve social, financial, health/wellness, educational, and vocational goals and shall follow Clubhouse International Standards located at: https://clubhouse-intl.org/resources/quality-standards/.	Provide services to adults aged 18 years and older, with serious mental illness (SMI), including co-occurring substance use. Overall goals of this program include member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual, and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Homeless Adults/Older Adults who have a serious mental illness (SMI); Services are in Central Region with an emphasis in downtown San Diego.	• Clubhouse services including recovery education and support, employment assistance with SSI application • Additional Clubhouse components include shower and laundry support, and street outreach services	National Alliance on Mental Illness (NAMI) San Diego C2C Clubhouse 101 16th Street San Diego, CA 92101 (619) 776-8605
PEI	PS-01	Come Play Outside	Come Play Outside	The Come Play Outside program offers community-based programming inclusive of Parks After Dark curriculum to support the health and wellness of children, youth, and families.	Connect participants with outdoor activities within their community to increase pro-social interactions, promoting wellness, positive self-image while emphasizing confidence, respect, and a sense of responsibility.	Children, youth and their families.	• Outreach and engagement • Socialization, pro-social and wellness activities	City of San Diego Parks & Recreation Department 202 C W St. San Diego, Ca 92101 (619) 525.8211
PEI	PS-01	County of San Diego - Community Health & Engagement	County of San Diego - Community Health & Engagement	This contract provides community engagement activities in efforts to work towards behavioral health equity in the San Diego County region.	The goal of this program is to assist BHS in a year-round community engagement and input processes.	Underserved and unserved populations.	• Outreach activities • Listening sessions • Focus groups • Interviews • Data Workshops • Annual report	University of California San Diego 9500 Gilman Drive, MC 0602, La Jolla, CA 92093 858-822-3843
PEI	PS-01	Family Peer Support Program	Family Adult Peer Support	The Family Peer Support Program provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue.	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	Family members and friends of psychiatric inpatients.	• Resources and support to family and friends visiting loved ones in psychiatric inpatient units in San Diego area • Public education	National Alliance on Mental Illness (NAMI), San Diego P.O. Box #23700 San Diego, CA 92193 (858) 643-6580

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PEI	PS-01	Mental Health First Aid	Mental Health First Aid (MHFA)	MHFA is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis.	Provide county-wide community- based mental health literacy education and training services.	Countywide Adults/Youth/HHSA Employees/Permanent Supportive Housing Residents and Staff.	• Mental Health First Aid Training	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412
PEI	PS-01	Recuperative Services and Support Program for Transitional Age Youth	Just Be You	Short Term Recuperative Services and Supports (up to 120 days) for Transition Age Youth (TAY) who have been diagnosed or are at risk of developing with severe mental illness (SMI), including those who may be experiencing first episode psychosis, and may also have a co-occurring substance use disorder. Program will prioritize services for Transition Age Youth (TAY)with the greatest vulnerabilities, including those who are homeless or at risk of homelessness, are unconnected to services, and are repeat utilizers of acute/emergency mental health services. Program provides short-term assistance with Instrumental Activities of Daily Living (ADLs), coordination of transportation for appointments, connection to services for mental health and substance use services, and others.	Improve outcomes of TAY at risk of developing or diagnosed with SMI through engagement and stabilization through recuperative services and connection to ongoing treatment, housing and supportive services. Other goals include employment, education, reduction in stigma associated with their symptoms or mental health condition and increase in knowledge of how to access behavioral health services and housing supports.	Transitional Age Youth (TAY), ages 18-25.	• Linkage to Mental health, substance Use, physical health, medication assisted treatment, psychiatric, and holistic. • Case Management • Assessment for housing needs and linkages to housing subsidies	Urban Street Angels, Inc. 1404 Fifth Avenue San Diego, CA. 92101
PEI	PS-01	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	Stigma Reduction, Sucide Prevention, and Substance Use Prevention Multimedia Campaign (It's Up to Us)	This is a stigma reduction, suicide prevention, and substance use prevention multi-media campaign, aimed to promote mental health awareness, and reduce stigma associated with mental illness and substance use treatment.	The It's Up to Us campaign was designed to empower San Diego County residents to talk openly about mental illness, recognize symptoms, utilize local resources, and seek help. The campaign seeks to increase the public's awareness on suicide prevention and stigma reduction by using a variety of media tools including, but not limited to, television, radio and billboards, enduring written materials, websites, social media sites, and other social marketing tools.	Countywide individuals with mental illness; families of individuals with mental illness; general public.	• Public media campaign to education and promote mental health awareness • Print, radio, and TV ads • Printed materials Public multimedia messaging to provide education, outreach using a variety of media tools including, but not limited to, television, radio and billboards, enduring , printed materials, website updates and maintenance, social media sites, and other social marketing tools	Rescue Agency Public Benefit, LLC 2437 Morena Blvd San Diego, CA 92110 (619) 231-7555
PEI	PS-01	Suicide Prevention ACTION Plan	Suicide Prevention ACTION Plan	The Suicide Prevention ACTION Plan provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies.	Reduce the number of suicides in San Diego County. Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	General population, mental health service consumers, local planners, and mental health organizations.	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives • Facilitate Suicide Prevention Council and workgroups.	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974

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PEI	PS-01	Supported Employment Technical Consultant Services	Supported Employment Technical Consultant Services	The Supported Employment Technical Consultant Services provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness (SMI). Behavioral Health Services coordinates and integrates services to develop new employment resources.	Develop 5-Year Strategic Plan and implement strategies within BHS programs that include Supported Employment. Additionally, will operate as sub-committee of the BHS Adult Council.	Service providers, employers, agencies, government organizations, and other stakeholders.	• Case management • Provide follow up services as needed.	San Diego Workforce Partnership, Inc. 9246 Lightwave Ave. #210 San Diego, CA 92123 (619) 228-2900
PEI	RC-01	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	This program provides prevention and early intervention services. The program works in partnerships with various primary care clinics in rural areas and utilizes a Screening, Brief Intervention and Referral to Treatment model to identify persons at risk for behavioral health issues. Treatment services are strengths-based, time limited and embrace the concepts of resilience and recovery for adults and children with severe emotional disturbance (SED), and their families.	Program staff provide health education and community engagement events, brief behavioral health interventions, psychiatric consultations, case management services, wellness screenings and referrals to treatment.	Children, Transition Age Youth, Adults/Older Adults.	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725
PEI	RE-01	Independent Living Association (ILA)	Independent Living Association (ILA) & Recovery Residence Association (RRA) services	This program oversees and manages the Independent Living Association and Recovery Residence Association,. These programs are serving as vital resources for identifying, promoting, and developing independent living opportunities. These programs increase housing capacity and connect individuals in need with essential community housing resources.	Promote the highest quality home environments for adults with severe mental illness and other disabling health conditions. Serve residents that do not need medication oversight, are able to function without supervision, and live independently. Identify housing options for CARE Court services.	Member operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources countywide.	• Education and training to member operators and residents. • Website listings • Resources to support clients • Resources to develop their business • Marketing tools • Advocacy support • CARE Court housing options	Community Health Improvement Partners 5059 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-Central & North Central	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330

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PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-Central Southeastern	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-East	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Youth Services 3845 Spring Dr. Spring Valley, CA 91977 (619) 258-6877
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-North Coastal	The School Based Prevention and Early Intervention provides services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-North Inland	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation 1029 N. Broadway Escondido, CA 92026 (760) 489-4126

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PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-South	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	SBCS 430 F St. Chula Vista, CA 91910 (619) 420-3620
PEI	SA-01	Screening to Care	Screening to Care Central	Screening to Care is a School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Social emotional programming is provided through group sessions at school campuses to strengthen student's coping skills. Care coordination is offered to students who need higher level of behavioral health treatment. Promoters work to engage the caregivers to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from behavioral health services and provide social emotional support and skill building.	Students with an emphasis on middle schools.	• Coordination of Student SEL Screening through the school • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check-ins • Student referrals to higher level of care • Caregiver Groups • Caregiver Outreach	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330
PEI	SA-01	Screening to Care	Screening To Care East County	Screening to Care is a School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Social emotional programming is provided through group sessions at school campuses to strengthen student's coping skills. Care coordination is offered to students who need higher level of behavioral health treatment. Promoters work to engage the caregivers to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from behavioral health services and provide social emotional support and skill building.	Students with an emphasis on middle schools.	• Coordination of Student SEL Screening through the school • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check-ins • Student referrals to higher level of care • Caregiver Groups • Caregiver Outreach	Fred Finch Youth Center 3845 Spring Drive Spring Valley, CA 91977 (619) 797-1090 ext 1045
PEI	SA-01	Screening to Care	Screening to Care North Coastal	Screening to Care is a School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Social emotional programming is provided through group sessions at school campuses to strengthen student's coping skills. Care coordination is offered to students who need higher level of behavioral health treatment. Promoters work to engage the caregivers to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from behavioral health services and provide social emotional support and skill building.	Students with an emphasis on middle schools.	• Coordination of Student SEL Screening through the school • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check-ins • Student referrals to higher level of care • Caregiver Groups • Caregiver Outreach	Palomar Family Counseling Service 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
PEI	SA-01	Screening to Care	Screening to Care North Inland & Poway	School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Social emotional programming is provided through group sessions on school campuses to strengthen student's coping skills with care coordination offered to students who need higher level of behavioral health treatment. Promoters work to engage the caregivers to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from behavioral health services and provide social emotional support and skill building.	Students with an emphasis on middle schools.	• Coordination of Student SEL Screening through the school • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check ins • Student referrals to higher level of care • Caregiver Groups • Caregiver Outreach	Vista Hill Foundation 1029 N Broadway Escondido, CA 92026 1012 Main St. Ste 101 Ramona, CA 92065 (760) 214-5207
PEI	SA-01	Screening to Care	Screening to Care South	Screening to Care is a School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Social emotional programming is provided through group sessions at school campuses to strengthen student's coping skills. Care coordination is offered to students who need higher level of behavioral health treatment. Promoters work to engage the caregivers to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from behavioral health services and provide social emotional support and skill building.	Students with an emphasis on middle schools.	• Coordination of Student SEL Screening through the school • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check ins • Student referrals to higher level of care • Caregiver Groups • Caregiver Outreach	SBCS Corporation 430 F Street Chula Vista, CA 91910 (619) 952-6308
PEI	SA-02	School Based Suicide Prevention & Early Intervention	School Based Suicide Prevention & Early Intervention	This program provides school-based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth (TAY).	Reduces suicide ideation, suicides, bullying and the negative impact of suicide in schools. Increases education of community and families.	Middle school, high school, and Transition Age Youth.	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600
PEI	SA-03	Youth & Family Support Services	Youth & Family Support Services	Provide supportive behavioral health services to residents in the Southeastern region who would benefit from case management, care coordination, support and education groups and connection to behavioral health services when needed.	Outreach, engagement and supportive prevention and early intervention services including case management, support and education groups and linkage to behavioral heath services for children and youth up to age 21, and their families.	Latino, Asian and African American children and youth up to age 21.	• Outreach and Engagement • Peer Support • Case management • Care Coordination • Focus groups • Support and Education Groups • Community Presentations	Harmonium, Inc. 5275 Market St, Ste E San Diego, CA 92114 (858) 226-1982
PEI	VF-01	Veterans & Family Outreach Education	Veterans & Family Outreach Education (Courage to Call)	The Veterans & Family Outreach Education program provides confidential, peer- staffed outreach, education, referral and support services to the Veteran community & families and its service providers.	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors and/or stressors. Improves access to mental health and PEI services, information, and support.	• Education and outreach • Peer counseling/support groups • Linkages to mental health services and other resource • Support hotline	• Education • Peer counseling • Linkage to mental health services • Mental health information • 7/24/365 support hotline	Mental Health Systems, Inc. (MHS) 9465 Farnham St. San Diego, CA 92123 (858) 585-9234

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
WET	WET-02	Cultural Competency Academy	Specialized Training Modules (Cultural Competency)	The Cultural Competency Academy (CCA) provides training to Behavioral Health Services (BHS) and BHS contracted staff with trainings focused on clinical and recovery interventions for multicultural populations. The goal of CCA is to provide awareness, knowledge and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications.				San Diego State University Research Foundation 5250 Campanile Dr. San Diego, CA 92182 (619) 594-1900
WET	WET-02	Interfaith Behavioral Health Workforce Centers Of Excellence (COE)	Interfaith Grant Agreement	The Behavioral Health Workforce Centers of Excellence is a regional training center of excellence that provides training, education, and licensure to the workforce to advance career opportunities and fill behavioral health positions. The regional training center will provide opportunities for diverse populations to enter the behavioral health workforce and provide connected care to historically underserved communities.				Interfaith Community Services, Inc. 550 W. Washington Ave. Escondido, CA 92025 (760) 489-6380
WET	WET-02	Training and Technical Assistance	Big Why Conference	The Training and Technical Assistance program provides administrative and fiscal training support services to County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop, and execute training contracts between RTC and trainers/consultants, coordinate with BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs.				Regional Training Center 6155 Cornerstone Ct., Suite 130 San Diego, CA 92121 (858) 550-0040
WET	WET-02	Training and Technical Assistance	Training and Technical Assistance (TTA)					
WET	WET-02	Training and Technical Assistance	We Can't Wait Annual Conference (Early Childhood)					
WET	WET-03	Public Mental Health Academy	Public MH Academy - Academic Counselor	The Public Mental Health Academy provides an academic counselor to support student success in the community-based public mental health certificate program. This certificate program assists individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be matriculated into an Associates and/or Bachelor Degree program to assist in the career pathway continuum.				San Diego Community College District 3375 Camino Del Rio South San Diego, CA 92108 (619) 388-6555

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION
WET	WET-04	Community Psychiatry Fellowship	Residency Internship Programs Community Psychiatry Fellowship	The Community Psychiatry Fellowship programs are for physicians and public mental health nurse practitioners. One program i s for adult psychiatry residents and fellows and another program is for child and adolescent psychiatry residents and fellows. There are up to seven public mental health nurse practitioners who are studying at local universities. These programs foster the development of leaders in community psychiatry and provide exposure to the unique challenges and opportunities, and targeted approaches to ethnically and linguistically diverse populations.				Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396

Note: These programs are available Countywide. They have an open door policy and accept clients from all districts.

APPENDIX D

MHSA CAPACITY ASSESSMENT AND NEEDS ANALYSIS

Mental Health Services Act Capacity Assessment and Needs Analysis

OVERVIEW

The County of San Diego conducted the Mental Health Services Act (MHSA) Capacity Assessment and Needs Analysis on the six Health and Human Services Agency (HHSA) regions, examining them from a population health lens. The Central, East, North Central, North Coastal, North Inland, and South regions are HHSA-defined geographic areas located in San Diego County. Key statistics were identified below, noting that the data in the assessment is aggregated across all HHSA regions. The assessment examined the mental health needs of the community, specifically the needs of individuals unserved, underserved, and inappropriately served. This was conducted via the Behavioral Health Equity Index (BHEI) which is a data-driven tool that allows users to explore differences in the root causes (i.e., social determinants) of behavioral health across neighborhoods in San Diego County. Because the social determinants of behavioral health are multifaceted and complex, the BHEI is a composite index which combines information from multiple sources into a single score.

The MHSA Capacity Assessment examined county level data from a population health perspective to get a sense of the community need, utilization of current services, and individuals served. The analysis demonstrated that San Diego County is a diverse county, impacted by many social determinants of health that can affect mental health access and availability of services. Data showed a need for additional services for populations such as Asian/Pacific Islanders, Native American, and Hispanics. The mapping conducted also demonstrated a need for additional services in the Central region, in addition to it having the highest uninsured population in the region. In examining the special populations served, there was evidence of higher rates of trauma and co-occurring disorders for both the children and youth, and the adult and older adult special populations (those experiencing homelessness, LGBTQ+, probation/justice-involved, child and family well-being involved and military) when compared to the overall system, demonstrating the need for additional services to these unserved/underserved populations.

ADVANCING DIVERSITY AND HEALTH EQUITY

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

transition age youth (TAY), and older adults.

To identify and address unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs, BHS partnered with the University of California, San Diego (UCSD) to develop the Community Experience Partnership (CEP). The CEP is a joint initiative to promote behavioral health equity and inform culturally responsive, data-informed behavioral health service planning.

The CEP continues to refine and maintain key resources, including the CEP website and Community Experience Dashboards (CED). The CED allows users to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Users can evaluate indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement and more. The dashboards are regularly updated with current data and enhanced features. The integration of inpatient and emergency department discharge data is currently in progress.

Recent work includes the development of the Behavioral Health Equity Indices (BHEI). The BHEI is a descriptive, data-driven tool that allows users to explore differences in the underlying, or root causes, of behavioral health across neighborhoods and regions in San Diego County. The indices are constructed from over 30 indicators, organized into eight domains that map to five social determinants of behavioral health. Areas with higher BHEI scores are relatively less likely to have access to the resources, opportunities, and conditions that promote behavioral health than neighborhoods with lower BHEI scores. Areas with higher scores may benefit from behavioral health service enhancements or quality improvement efforts. In addition, UCSD has developed a tool that is a custom application designed to help ensure service provision is informed by data, based in cultural and regional considerations, and targeted to communities that may be at greatest risk for unmet behavioral health needs. Specifically, the tool uses data to help identify areas in San Diego County where target populations for BHS services are likely to be highly concentrated.

As the next step in the continued enhancement of CEP, BHS in collaboration with UCSD, is also developing an advanced network analysis initiative that will further identify and address barriers. It will use a network adequacy approach to define, identify, and address behavioral health service expansion opportunities for unserved and under-resourced populations in San Diego County. This includes creating interactive maps, evaluating network capacity, identifying disparities, analyzing service enhancements, and developing recommendations to optimize BHS services. This will align with CEP's vision of the integration of data and community engagement to achieve behavioral health equity and the mission of establishing a continuous feedback process by which issues can be identified. Specific objectives include:

1. **Mapping and describing the client/provider network:** This includes interactive maps to visualize the locations of BHS clients and providers. These maps can be filtered by client and provider characteristics (i.e. language, race/ethnicity, housing status, service type) to better understand the network's reach and inclusivity.
2. **Evaluating network capacity and identifying disparities:** This assesses the network's ability to meet current and future needs by examining factors like travel times, wait times, provider-to-enrollee ratios, and penetration estimates (percentage of an eligible population (e.g. Medi-Cal beneficiaries) that received mental health services). It will identify disparities across regions and for vulnerable subgroups, including racial/ethnic minorities, TAY, and non-English speakers. By combining network data with community data from sources like the BHEI, Service Planning Tool, and forthcoming California Department of Health Care Services Medi-Cal population points, we can further identify unserved populations.
3. **Analyzing service expansion opportunities and their impact:** This defines and operationalizes service expansion opportunities and examines their associations with client outcomes. Example analyses might include estimating data-informed time/distance thresholds or exploring the effects of service proximity on client outcomes.
4. **Optimizing current and future BHS networks:** For example, this can identify the best locations for new providers/services or improve referral processes by considering factors like distance and language.

The CEP's efforts meet needs at the service, administrative, and community levels. This promotes a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans that will aid in informing the design of BHS programs, including services funded through MHSA.

ASSESSMENT

In conducting an MHSA capacity assessment, San Diego County was assessed utilizing the Health and Human Services Agency (HHSA) regions by examining the regions from a population health lens. The Central, East, North Central, North Coastal, North Inland, and South regions are HHSA geographies within San Diego County. The estimated population size of the county is nearly 3.3 million people, according to the U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates. The following key aggregate statistics were identified across all HHSA regions:

- Racial/Ethnic Identities: 34% of San Diego County residents identified as Hispanic, 44% as non-Hispanic (NH) White, 5% as NH Black, 12% as Asian/Pacific Islander (API), <1% as NH American Indian/Alaska Native (AI/AN), and 5% as NH Multiracial.
- Poverty: 11% of residents were living below the federal poverty line (FPL) and 25% were living below 200%, or twice, the FPL.
- Educational Attainment: 11% of residents did not have a high school diploma and 59% did not have a bachelor's degree.

- Unemployment: 6% of residents reported being unemployed compared to 6% of San Diego County residents.
- Limited English-Speaking Ability: 13% of residents over age five reported speaking a language other than English at home and speaking English less than very well.
- Receipt of Food Stamps/SNAP: 8% of residents received Food Stamps/SNAP.
- Health Insurance: 20% of residents were Medi-Cal insured, 69% had private insurance, and 7% were uninsured.
- Housing: 55% of renters reported excessive cost burden for housing, defined as spending more than 30% of their income on housing costs.

Next, the assessment examined the mental health needs of the community, specifically the needs of unserved, underserved/inappropriately served, through the use of the newly BHEI. Because the social determinants of behavioral health are multifaceted and complex, the BHEI is a composite index which combines information from multiple sources into a single score. This is a valuable tool to summarize data in a way that is interpretable and can help build community consensus for action. Understanding where inequities exist in our community is a first step towards identifying and addressing the policies, laws, and services that may contribute to behavioral health disparities.

The BHEI is constructed from over 30 individual variables (also known as indicators), which are organized into eight domains that map to the social determinants of health. Indicators are drawn from over 10 different data sources including the U.S. Census Bureau's American Community Survey, Center for Disease Control and Prevention's PLACES, and the Opportunity Atlas. After normalizing, weighting, and aggregating the variables, an equity score is calculated for each of the census tracts, zip codes (ZCTAs), Subregional Areas (SRAs), and HHSA Regions in San Diego County. Each neighborhood is then assigned a rank based on its equity score. The indicators, domains, and weights were developed in partnership with local subject matter experts, including community representatives. Areas with higher BHEI scores may not have access to the resources and services that promote behavioral health and therefore may serve as priority zones for equity work and service enhancements.

The BHEI is not intended to be applied or interpreted without context. The ranks do not reflect the strengths, values, or priorities of neighborhoods or regions and the individuals who live there. While the BHEI can help users identify neighborhoods that may benefit from service enhancements and quality improvement efforts, final decisions about needs, policy, and resourcing would require community outreach and local understanding of communities. While the data below highlights the need by HHSA region, it is further analyzed at the zip code level within each region to guide program development and resource allocation.

Figure 1: Rates of Uninsured by HHSA Region

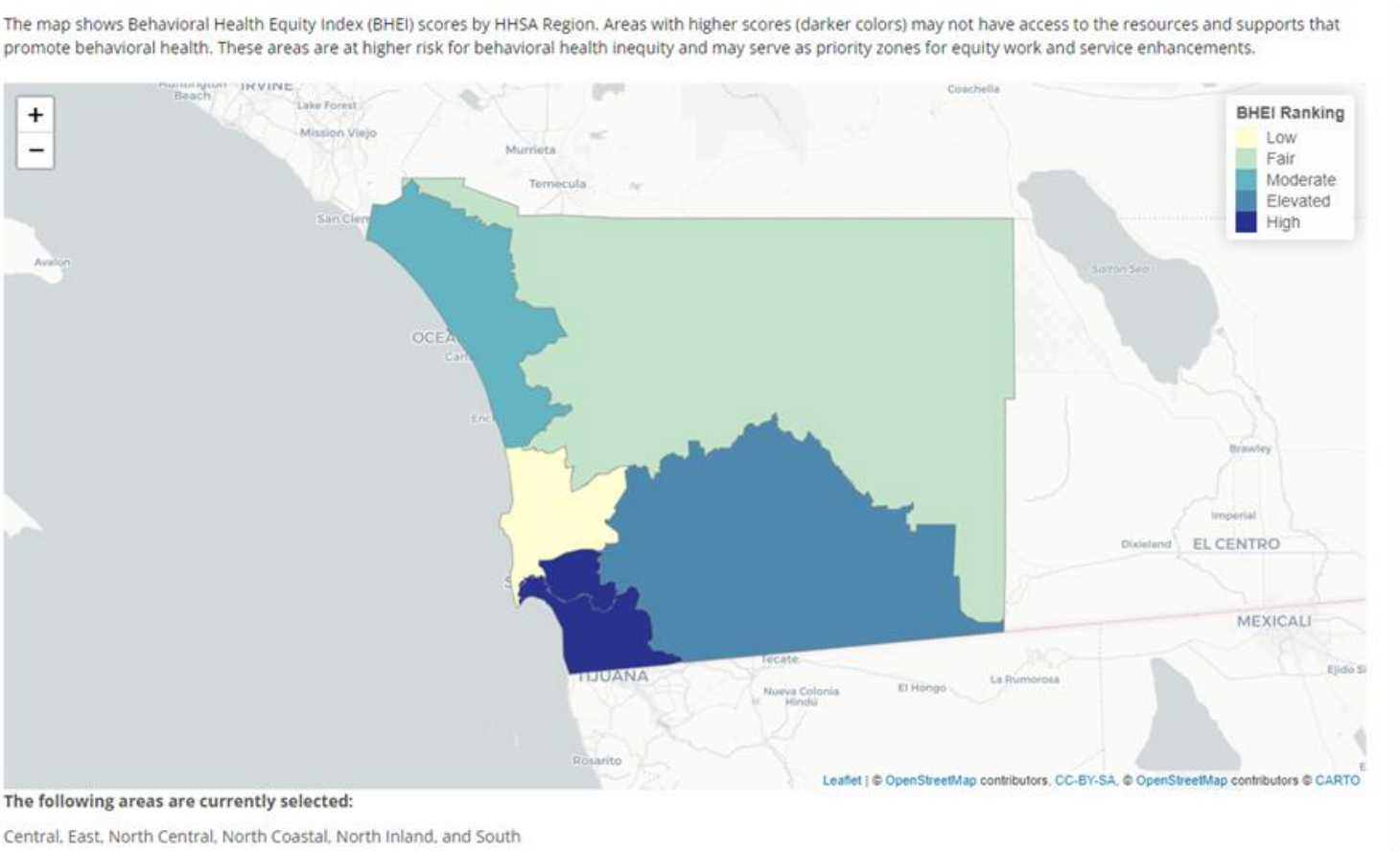


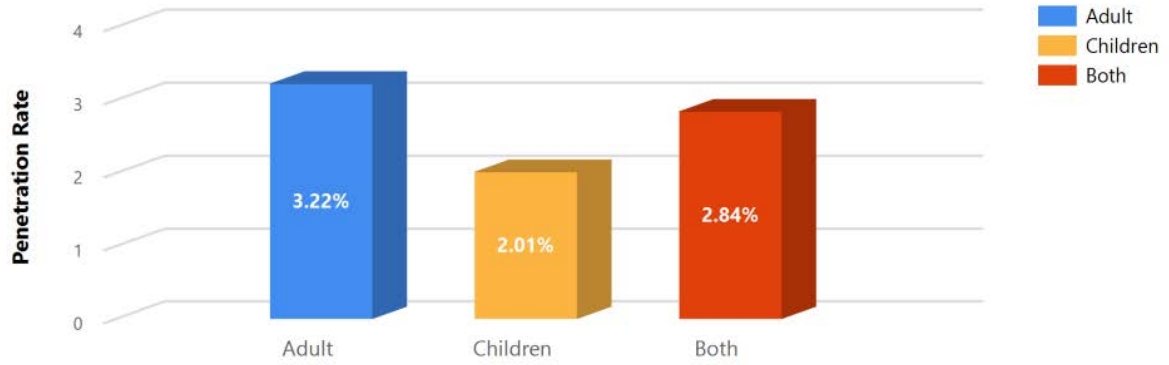
Figure 1 shows the rates of uninsured by HHSA region, noting that the Central Region had the highest rate of uninsured individuals.

After identifying the HHSA regions with the highest risk, further analysis is conducted on the individuals that may quality for MHSA programs and services, with data presented below.

Table 1: Rates of Uninsured by HHSA Regions

Ranking Based on %	Area	Uninsured (%)	Uninsured (n)	Description
All	All	All	All	All
6	Central	10	48390	48,390 of 485,407= 10%
5	South	8.7	41768	41,768 of 478,589= 9%
4	North Coastal	7.5	37758	37,758 of 500,914= 8%
3	North Inland	7	42334	42,334 of 600,750= 7%
2	East	6.3	30829	30,829 of 491,206= 6%
1	North Central	4.8	29988	29,988 of 623,319= 5%

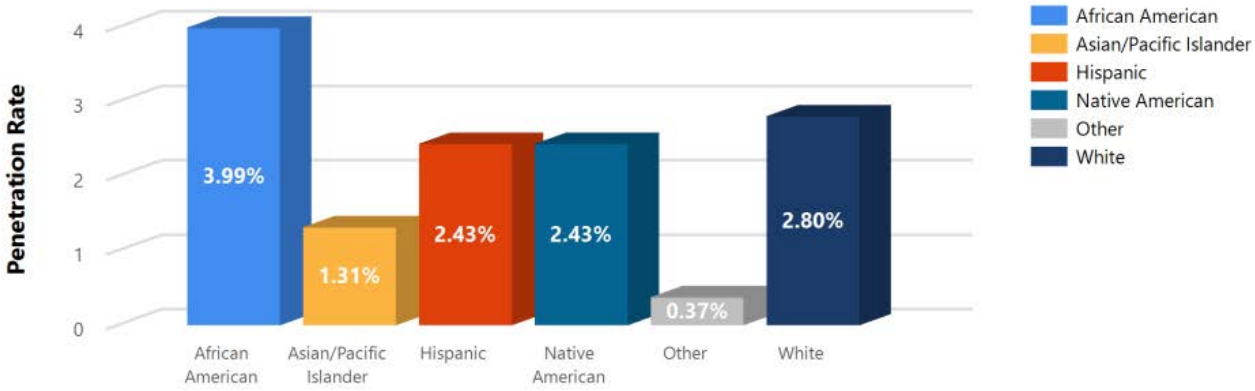
Figure 2: Overall Medi-Cal Penetration Rate (Quarter 4: FY 2023-2024)



Population	Medi-Cal Eligible Clients in the County of San Diego	Medi-Cal Eligible Clients Served (Distinct)	Percentage
Adult & Older Adult	689,790	22,178	3.22
Children & Youth	309,395	6,229	2.01
Total	999,185	28,407	2.84

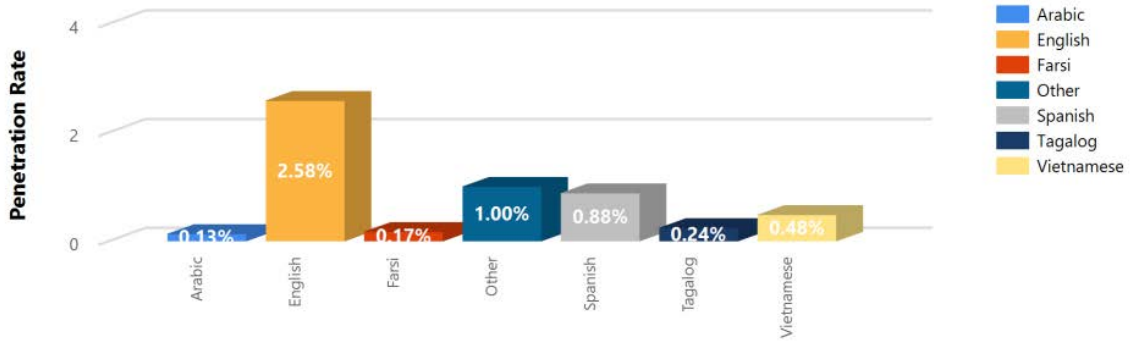
Figure 2 shows the penetration rate by race/ethnicity and language for children and youth and adults and older adults through Quarter 4 of fiscal year (FY) 2023-24. The overall penetration rate for San Diego County is 2.84, with a higher rate for the adult and older adult population (3.22) versus the children and youth (2.01%).

Figure 3: Children and Youth by Race



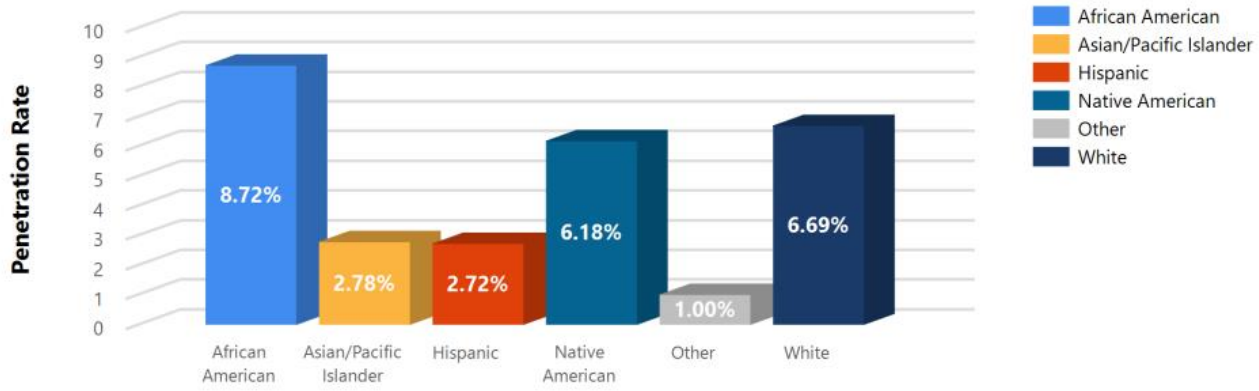
Race	Eligible Clients	Clients Served	Rate (%)
African American	15,103	603	3.99
Asian/Pacific Islander	14,845	194	1.31
Hispanic	166,467	4,037	2.43
Native American	1,112	27	2.43
Other	72,614	269	0.37
White	39,254	1,099	2.80

Figure 4: Children and Youth by Language



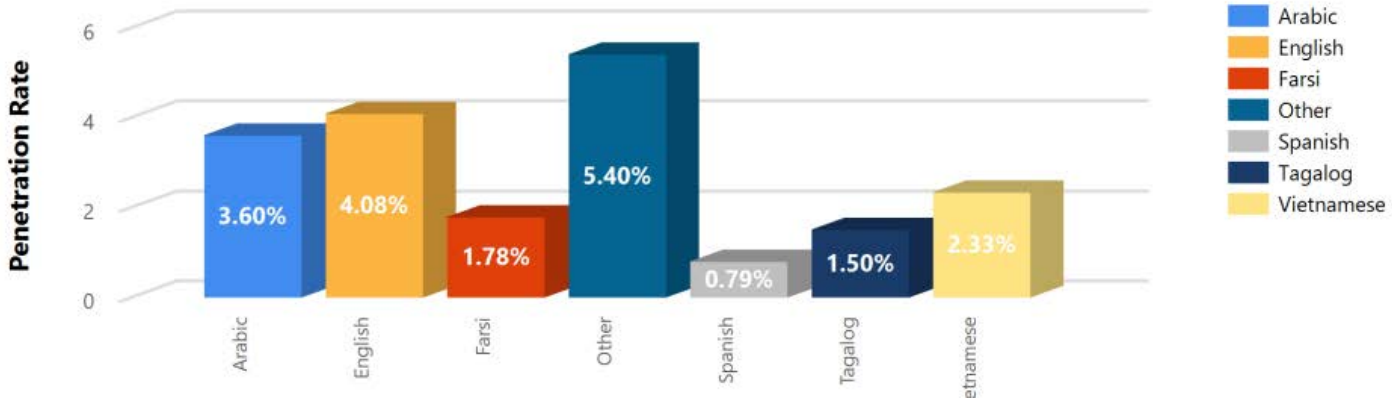
Language	Eligible Clients	Clients Served	Rate (%)
Arabic	4,453	6	0.13
English	209,588	5,397	2.58
Farsi	1,807	3	0.17
Other	7,884	79	1.00
Spanish	83,784	736	0.88
Tagalog	418	1	0.24
Vietnamese	1,461	7	0.48

Figure 5: Adult and Older Adult by Race



Race	Eligible Clients	Clients Served	Rate (%)
African American	32,677	2,850	8.72
Asian/Pacific Islander	51,713	1,439	2.78
Hispanic	274,376	7,464	2.72
Native American	2,606	161	6.18
Other	205,660	2,050	1.00
White	122,758	8,214	6.69

Figure 6: Adult and Older Adult by Language



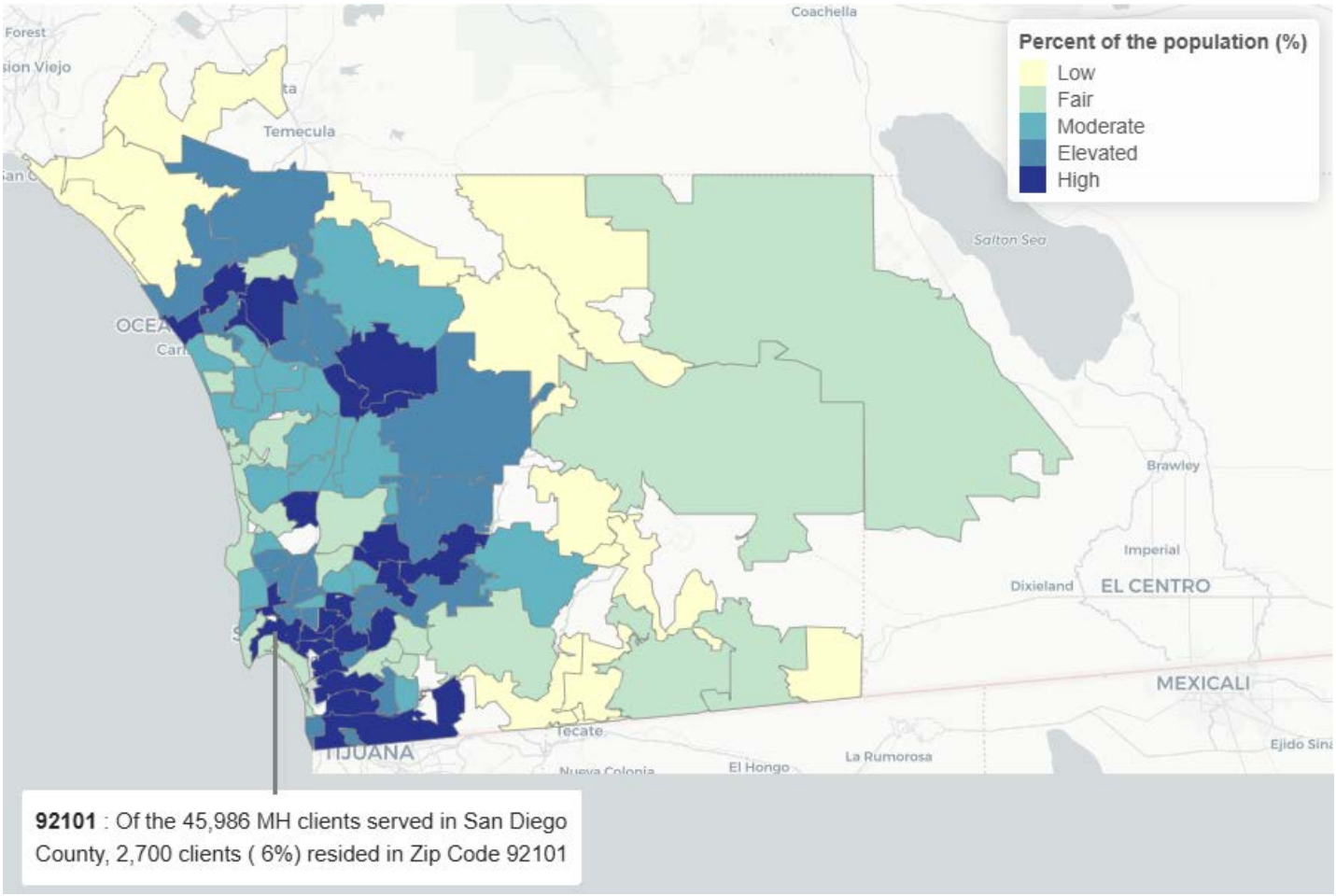
Language	Eligible Clients	Clients Served	Rate (%)
Arabic	11,250	405	3.60
English	464,148	18,957	4.08
Farsi	3,762	67	1.78
Other	19,439	1,049	5.40
Spanish	176,506	1,394	0.79
Tagalog	4,333	65	1.50
Vietnamese	10,352	241	2.33

Data shown in ***Figures 2 through 6***, identifies lower penetration rates among Asian/Pacific Islanders, Native Americans, and Hispanics in the Children and Youth System of Care, while in the Adult/Older Adult System of Care, lower penetration rates were seen among Asian/Pacific Islanders and Hispanics. Examining the penetration rate data by language was not as telling as the number of individuals served outside of English and Spanish speakers were fairly small.

Lastly, data was assessed for the capacity to implement MHSA programs and the current utilization of mental health services. While BHS conducts the required Network Adequacy Certification Tool, additional analysis of the services, individuals served, and access times were examined.

Figure 7 shows the percentage of mental health clients residing in each zip code. A darker color means the percentage is relatively higher. The higher cluster of mental health clients are the Central region. Zip codes such as 92101 demonstrate a higher percentage of mental health clients. Nearly 46,000 mental health clients served in San Diego County, 2,700 (6%) reside in this zip code.

Figure 7: Percentage of Mental Health Clients Residing in Each Zip Code



Figures 8 through 12 shows the examination of 11,191 youth unserved/underserved in the Children, Youth & Families (CYF) Program. This report, prepared by the Child and Adolescent Services Research Center, was published on June 6, 2024. Data were sourced from Community Care Behavioral Health, Child and Family Well-Being, and Probation, with extraction completed in October 2023.

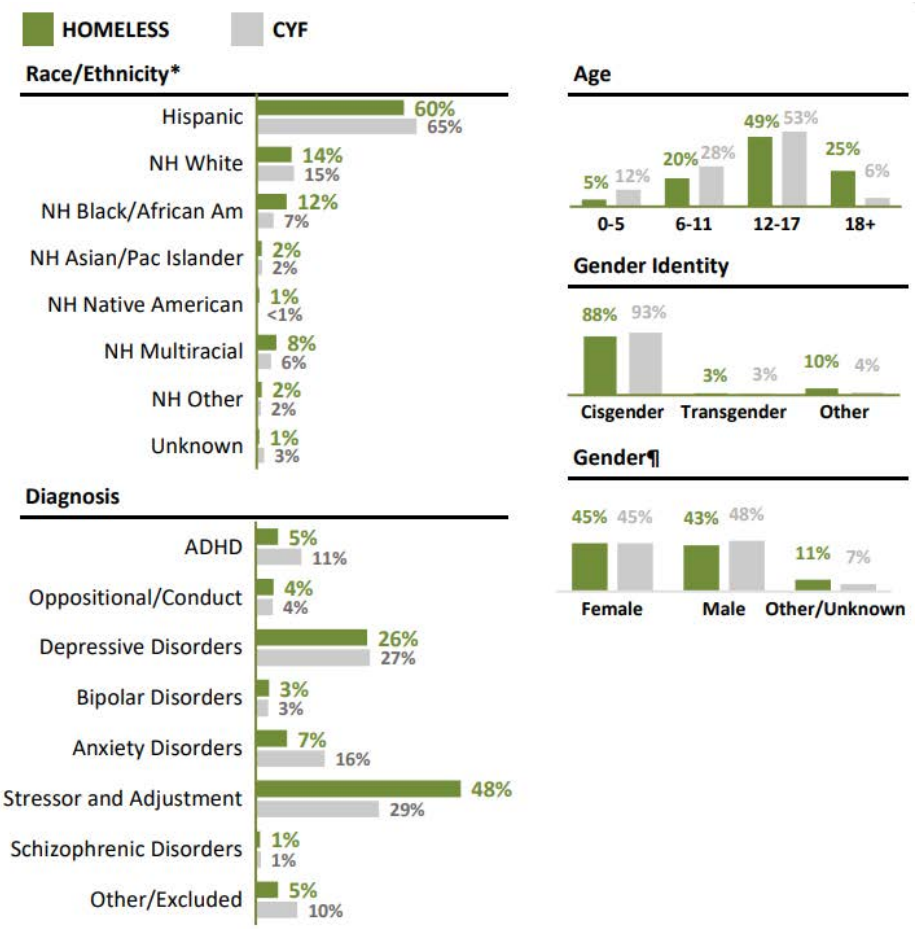
Figure 8: FY 2022-2023: Special Populations Report – Children, Youth & Families – Homeless

Homeless (1% n=99)

LOC†	%	CYF%
Outpatient Services	90%	90%
JFS	0%	7%
Wraparound	6%	3%
TBS	0%	3%
Residential	6%	4%
Emergency/Crisis	16%	10%
Inpatient	10%	5%

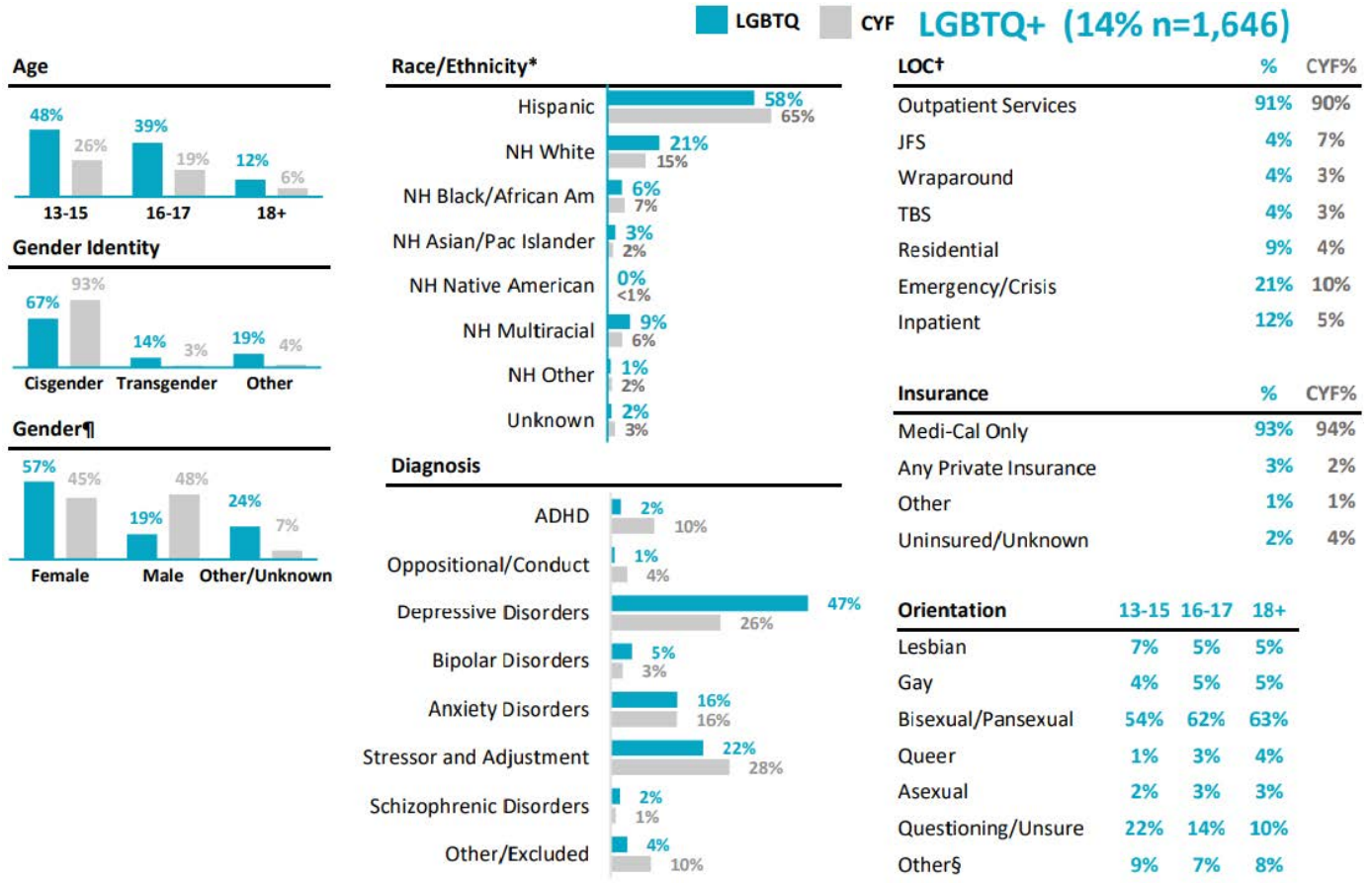
Insurance	%	CYF%
Medi-Cal Only	88%	94%
Any Private Insurance	3%	2%
Other	0%	1%
Uninsured/Unknown	9%	4%

Living Arrangement	%
Unhoused	26%
Temporary Shelter	22%
Couch Surfing	52%



* NH refers to Non-Hispanic/Latino.
† Level of Care (LOC) designations were updated in FY 2020-21 and may not be directly comparable to previous years.
JFS refers to Juvenile Forensic Services.
TBS refers to Therapeutic Behavioral Services.
§ Other sexuality includes heterosexual.
¶ Gender is how clients currently identify, not sex assigned at birth.
Please note: Data may be impacted starting March 2020 due to COVID-19. This report is limited to Mental Health Services clients.

Figure 9: FY 2022-2023: Special Populations Report – CYF – LGBTQ+



LOC†	%	CYF%
Outpatient Services	91%	90%
JFS	4%	7%
Wraparound	4%	3%
TBS	4%	3%
Residential	9%	4%
Emergency/Crisis	21%	10%
Inpatient	12%	5%

Insurance	%	CYF%
Medi-Cal Only	93%	94%
Any Private Insurance	3%	2%
Other	1%	1%
Uninsured/Unknown	2%	4%

Orientation	13-15	16-17	18+
Lesbian	7%	5%	5%
Gay	4%	5%	5%
Bisexual/Pansexual	54%	62%	63%
Queer	1%	3%	4%
Asexual	2%	3%	3%
Questioning/Unsure	22%	14%	10%
Other§	9%	7%	8%

* NH refers to Non-Hispanic/Latino.
† Level of Care (LOC) designations were updated in FY 2020-21 and may not be directly comparable to previous years.
JFS refers to Juvenile Forensic Services.
TBS refers to Therapeutic Behavioral Services.
§ Other sexuality includes heterosexual.
¶ Gender is how clients currently identify, not sex assigned at birth.
Please note: Data may be impacted starting March 2020 due to COVID-19. This report is limited to Mental Health Services clients.

Figure 10: FY 2022-2023: Special Populations Report – CYF – Probation & Children, Youth and Families Behavioral Health Services (CYFBHS)

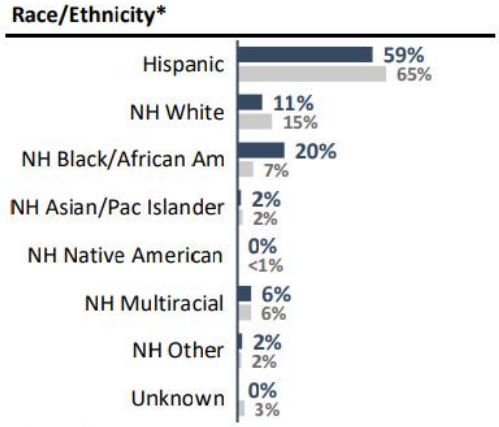
Probation & CYFBHS (5% n=642)

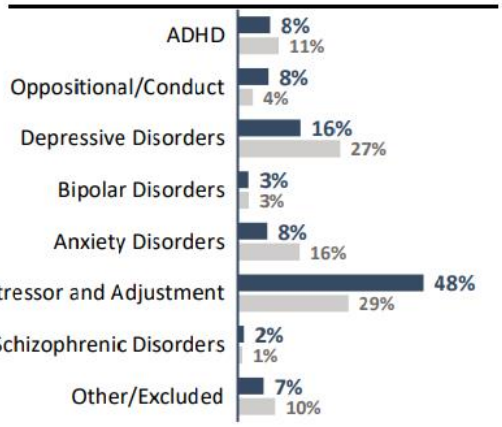
PROBATION/CYF CYF

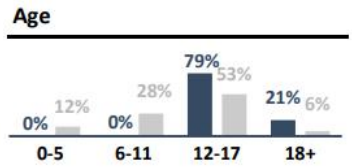
LOC†	%	CYF%
Outpatient Services	25%	90%
JFS	90%	7%
Wraparound	10%	3%
TBS	1%	3%
Residential	10%	4%
Emergency/Crisis	4%	10%
Inpatient	3%	5%

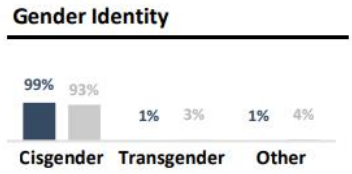
Insurance	%	CYF%
Medi-Cal Only	80%	94%
Any Private Insurance	3%	2%
Other	1%	1%
Uninsured/Unknown	17%	4%

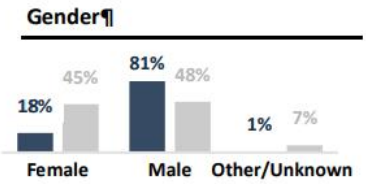
Living Arrangement	%	CYF%
House or Apartment	22%	85%
Correctional Facility	70%	5%
Foster Home	<1%	4%
Group Home	6%	2%
Children's Shelter	<1%	1%
Homeless	1%	1%
Other	<1%	1%





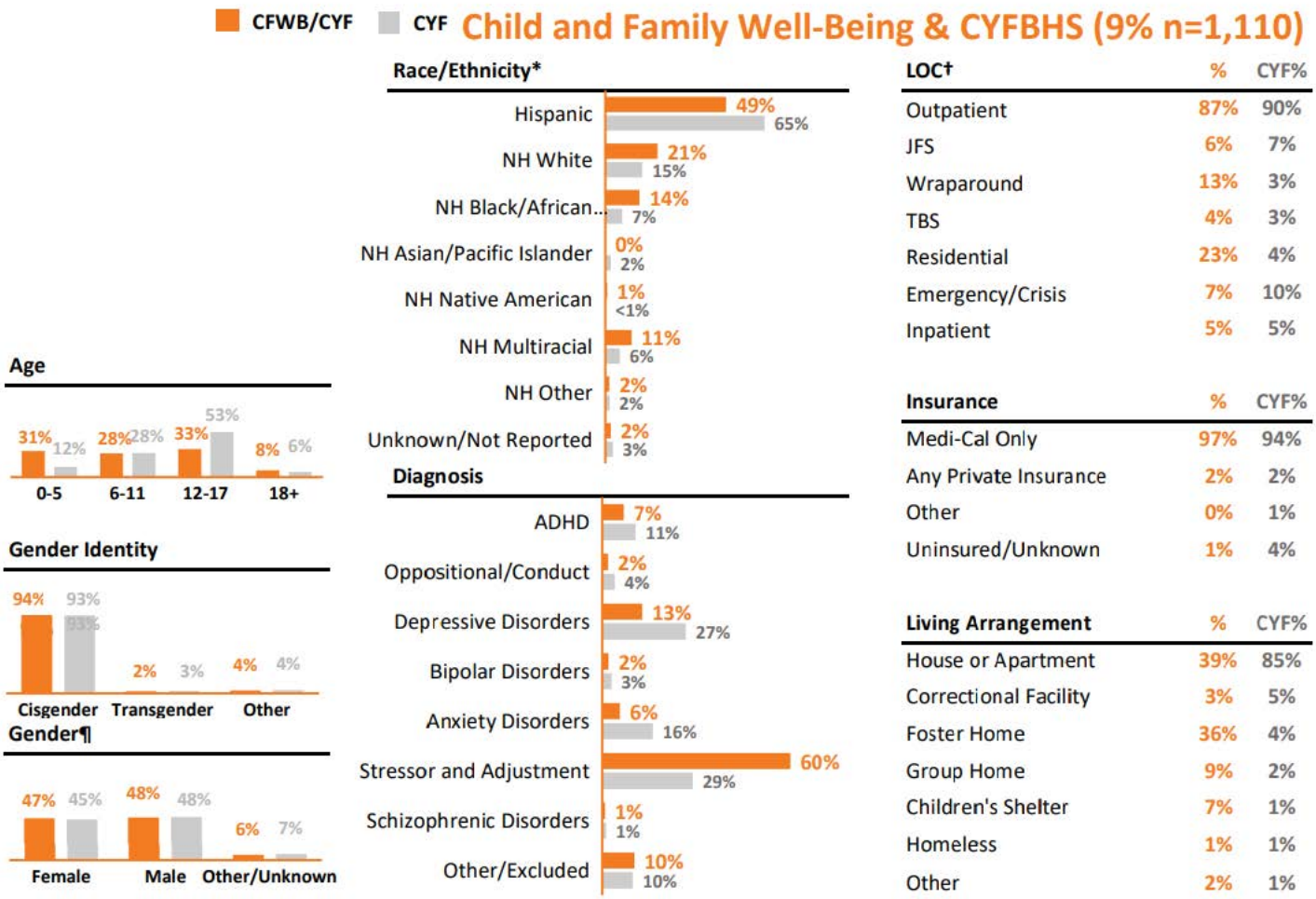






* NH refers to Non-Hispanic/Latino.
† Level of Care (LOC) designations were updated in FY 2020-21 and may not be directly comparable to previous years.
JFS refers to Juvenile Forensic Services.
TBS refers to Therapeutic Behavioral Services.
§ Other sexuality includes heterosexual.
¶ Gender is how clients currently identify, not sex assigned at birth.
Please note: Data may be impacted starting March 2020 due to COVID-19. This report is limited to Mental Health Services clients.

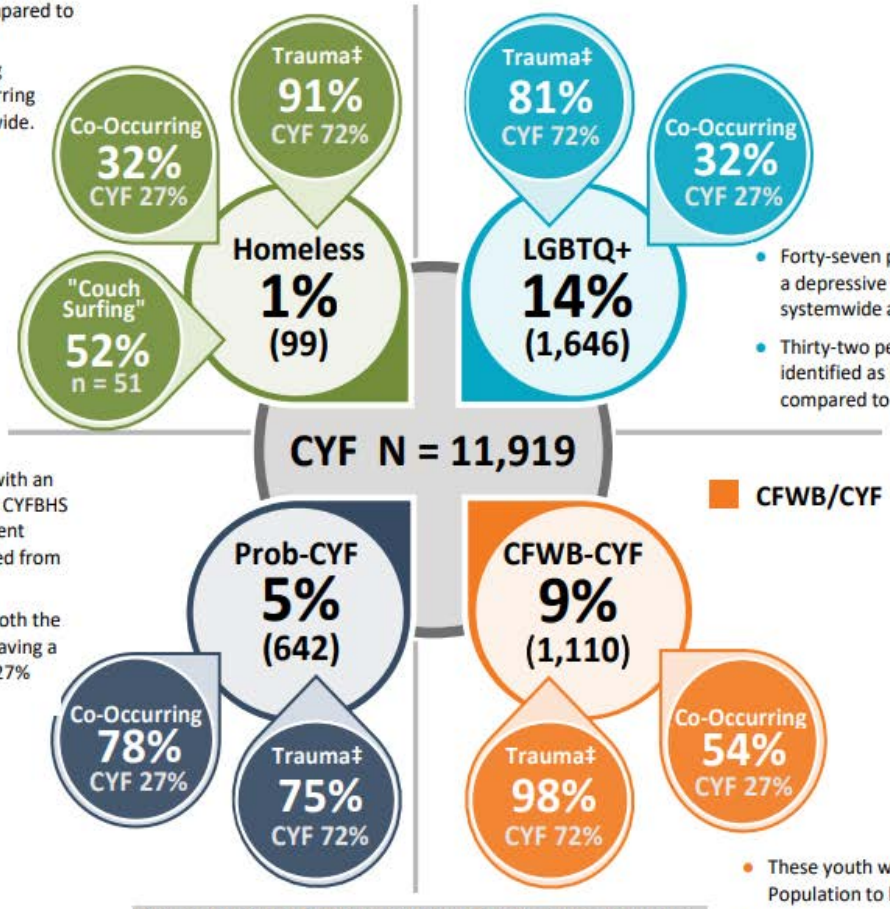
Figure 11: FY 2022-2023: Special Populations Report – CYF – Child and Family Well-Being & CYFBHS



* NH refers to Non-Hispanic/Latino.
† Level of Care (LOC) designations were updated in FY 2020-21 and may not be directly comparable to previous years.
JFS refers to Juvenile Forensic Services.
TBS refers to Therapeutic Behavioral Services.
§ Other sexuality includes heterosexual.
¶ Gender is how clients currently identify, not sex assigned at birth.
Please note: Data may be impacted starting March 2020 due to COVID-19. This report is limited to Mental Health Services clients.

Figure 12: Trauma and Co-Occurring Substance Use Issue Among Homeless, LGBTQ+, Probation & CYFBHS, and Child and Family Well-Being & CYFBHS

- Ninety-one percent of youth experiencing homelessness were reported to have a history of trauma, as compared to 72% systemwide.
- Thirty-two percent of youth ages 12+ experiencing homelessness were identified as having a co-occurring substance use issue, as compared to 27% systemwide.



- Forty-seven percent of LGBTQ+ youth were diagnosed with a depressive disorder, as compared to 26% in the CYFBHS systemwide average.
- Thirty-two percent of LGBTQ+ youth ages 13+ were identified as having a co-occurring substance use issue, as compared to 27% systemwide.

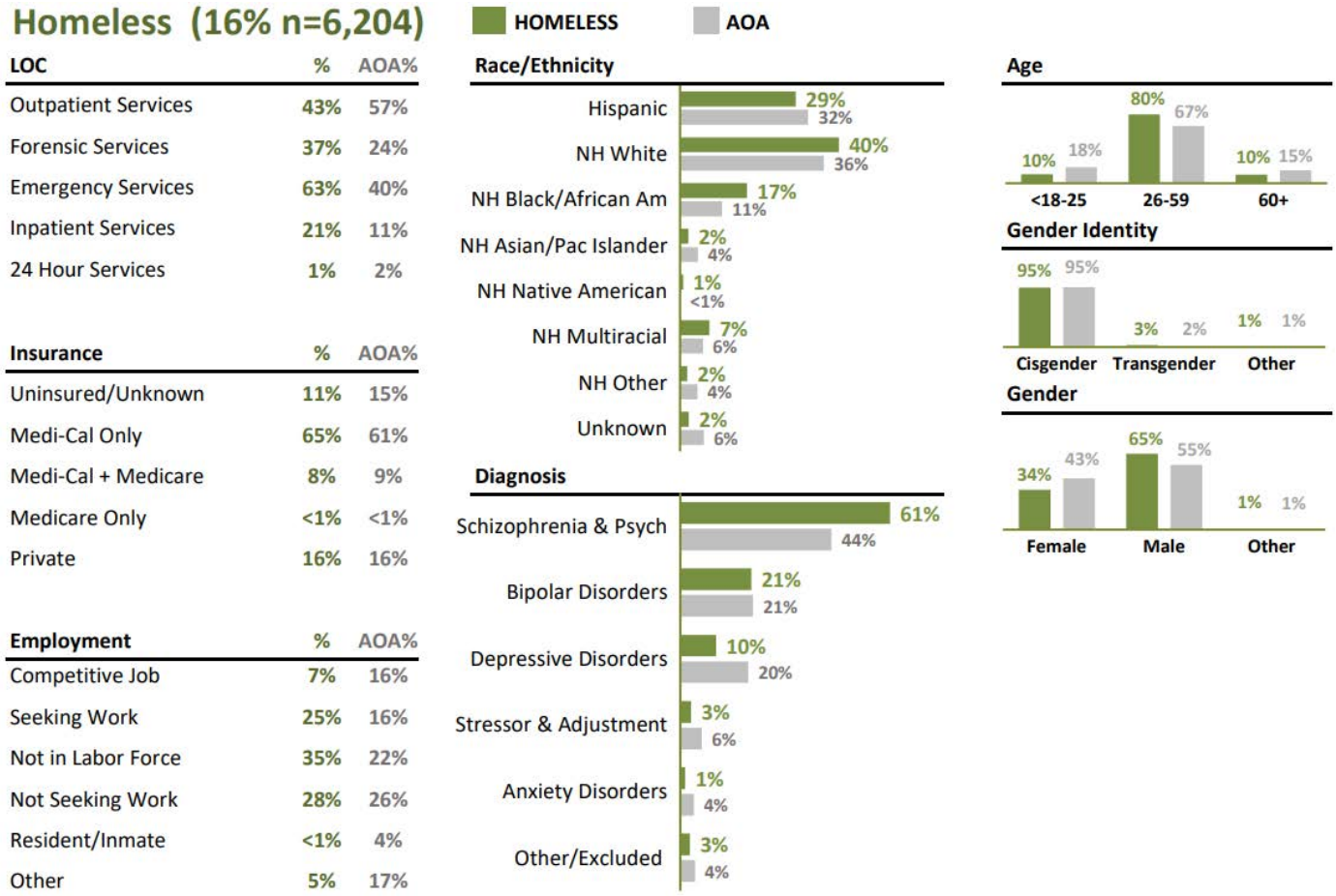
- These youth were twice as likely to be diagnosed with an oppositional/conduct disorder as compared to the CYFBHS systemwide average. The rate of stressor/adjustment disorder diagnosis among these youth has increased from 38% in FY 2020-21 to 49% in FY 2022-23.
- Seventy-eight percent of youth ages 12+ open to both the Probation and CYFBHS sectors were identified as having a co-occurring substance use issue, as compared to 27% systemwide.

- These youth were more likely than any other CYF Special Population to have experienced trauma.
- Fifty-four percent of youth ages 12+ open to both the Child Welfare and CYFBHS sectors were identified as having a co-occurring substance use issue, as compared to 27% systemwide.

‡Excludes clients for whom history of trauma was unknown.

Figures 13 through 17 shows the examination of 43,155 individuals unserved/underserved, in the Adult and Older Adult (AOA) Program. This is referred to as the Adult and Older Adult, Behavioral Health Services (AOABHS) system. This report, prepared by the Health Services Research Center and Child and Adolescent Services Research Center, was published on February 8, 2024. Data was sourced from Community Care Behavioral Health, with extraction completed in September 2023.

Figure 13: FY 2022-2023: Special Populations Report – AOA – Homeless



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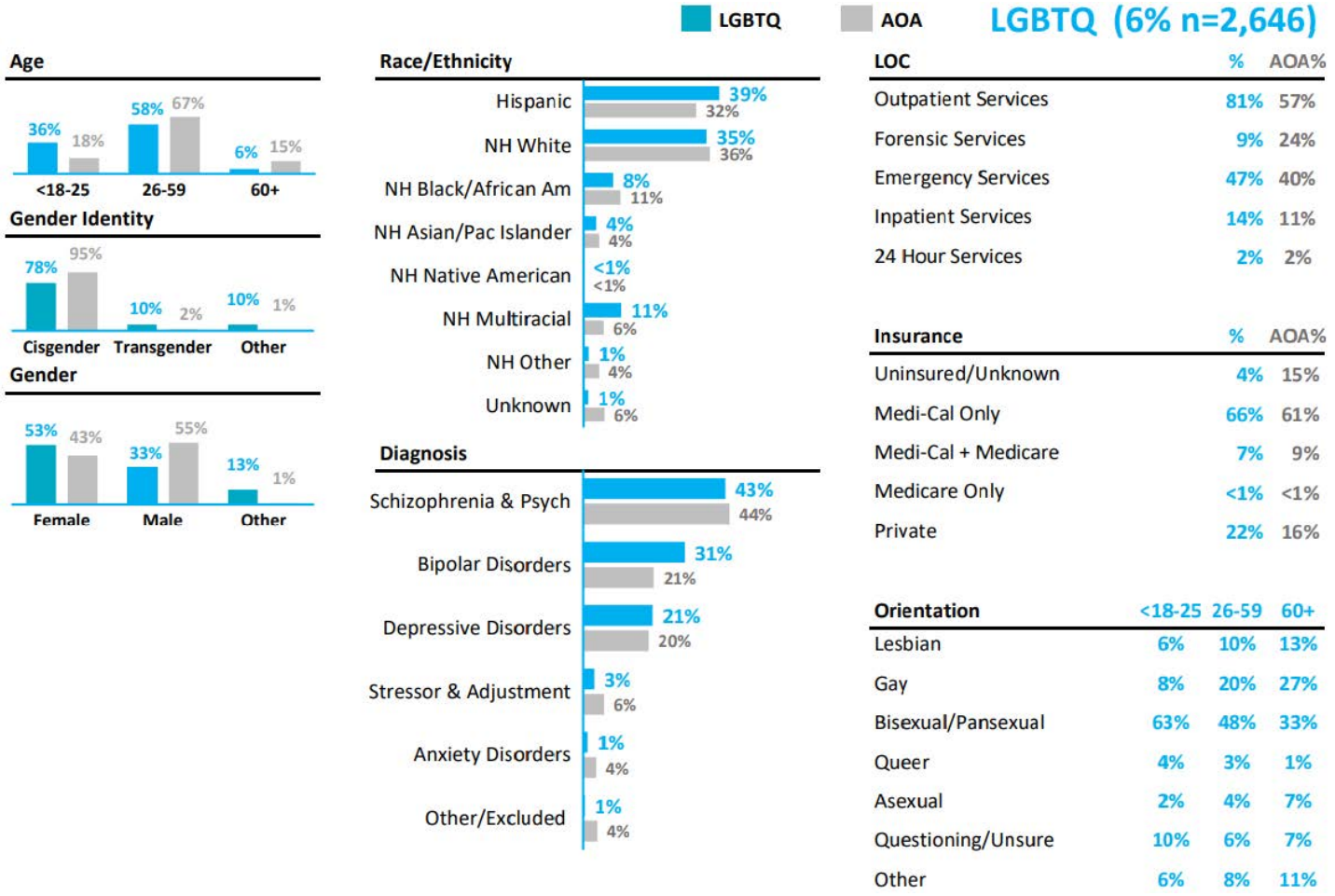
Please note: Data may be impacted starting March 2020 due to COVID-19.
This report is limited to Mental Health Services clients.

Figure 14: FY 2022-2023: Special Populations Report – AOA – LGBTQ+



LOC	%	AOA%
Outpatient Services	81%	57%
Forensic Services	9%	24%
Emergency Services	47%	40%
Inpatient Services	14%	11%
24 Hour Services	2%	2%

Insurance	%	AOA%
Uninsured/Unknown	4%	15%
Medi-Cal Only	66%	61%
Medi-Cal + Medicare	7%	9%
Medicare Only	<1%	<1%
Private	22%	16%

Orientation	<18-25	26-59	60+
Lesbian	6%	10%	13%
Gay	8%	20%	27%
Bisexual/Pansexual	63%	48%	33%
Queer	4%	3%	1%
Asexual	2%	4%	7%
Questioning/Unsure	10%	6%	7%
Other	6%	8%	11%

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Other sexuality includes heterosexual.
Gender is how clients currently identify, not sex assigned at birth.
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This report is limited to Mental Health Services clients.

Figure 15: FY 2022-2023: Special Populations Report – AOA – Justice System

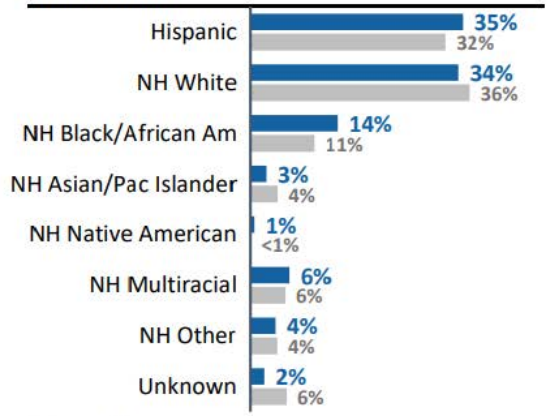
Justice System (42% n=18,078)

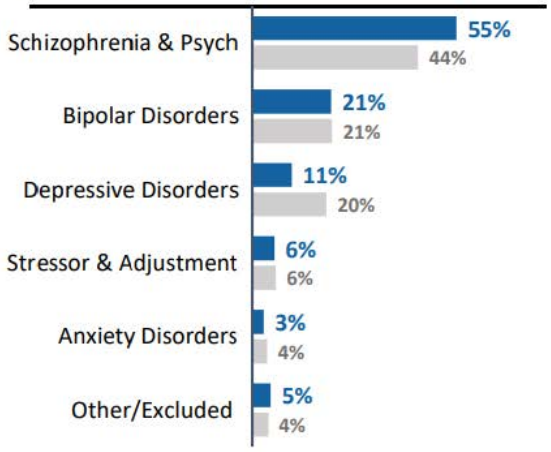
JUSTICE AOA

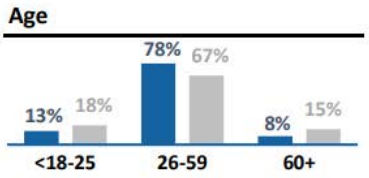
LOC	%	AOA%
Outpatient Services	41%	57%
Forensic Services	58%	24%
Emergency Services	37%	40%
Inpatient Services	14%	11%
24 Hour Services	3%	2%

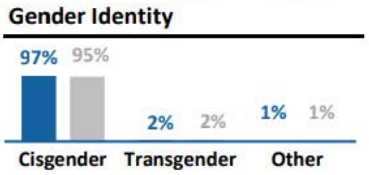
Insurance	%	AOA%
Uninsured/Unknown	15%	15%
Medi-Cal Only	63%	61%
Medi-Cal + Medicare	7%	9%
Medicare Only	<1%	<1%
Private	15%	16%

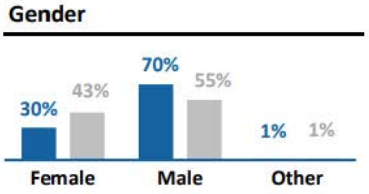
Employment	%	AOA%
Competitive Job	11%	16%
Seeking Work	22%	16%
Not in Labor Force	23%	22%
Not Seeking Work	25%	26%
Resident/Inmate	9%	4%
Other	10%	17%





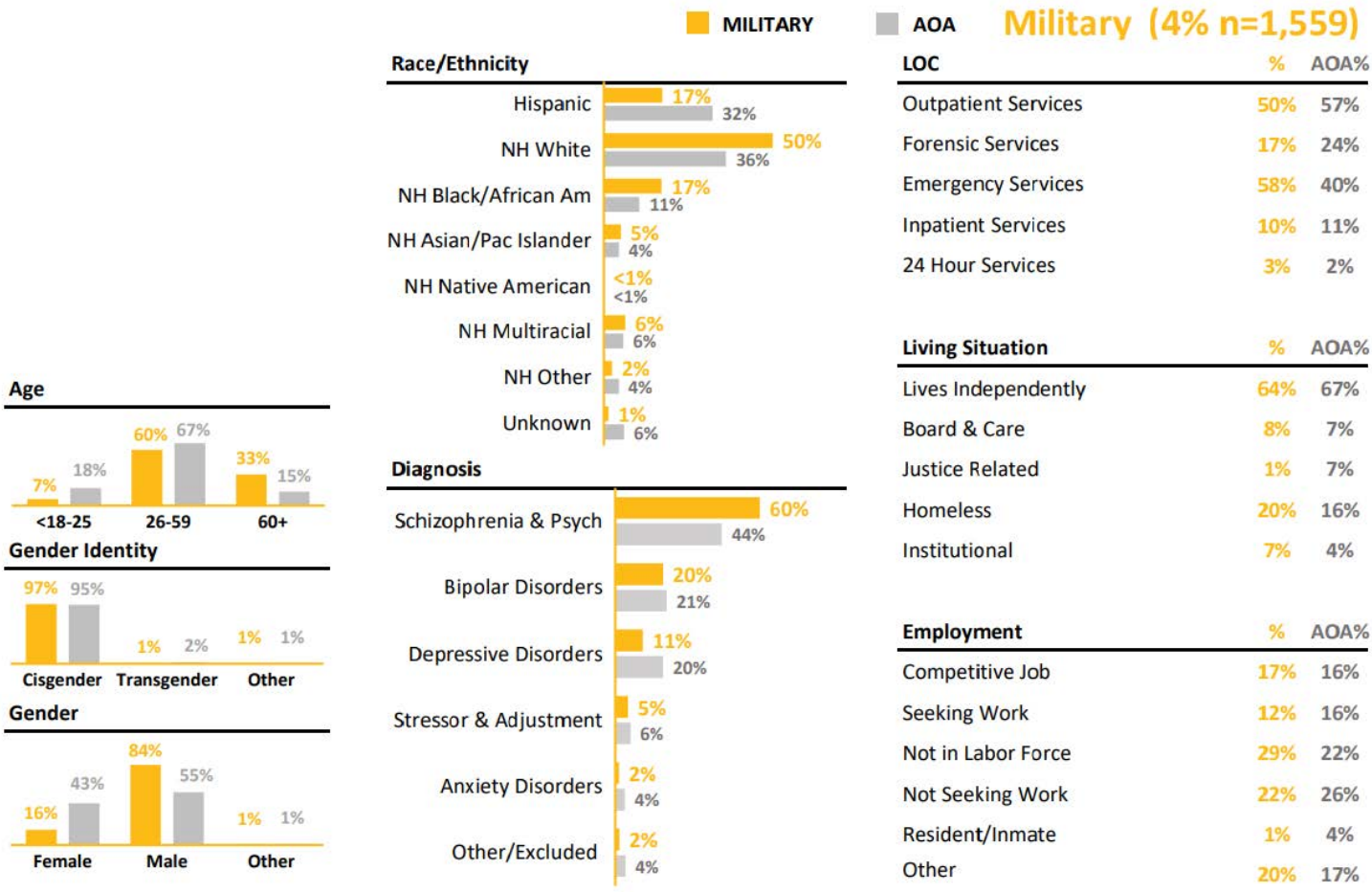






* NH refers to Non-Hispanic/Latino.
Other sexuality includes heterosexual.
Gender is how clients currently identify, not sex assigned at birth.
Please note: Data may be impacted starting March 2020 due to COVID-19.
This report is limited to Mental Health Services clients.

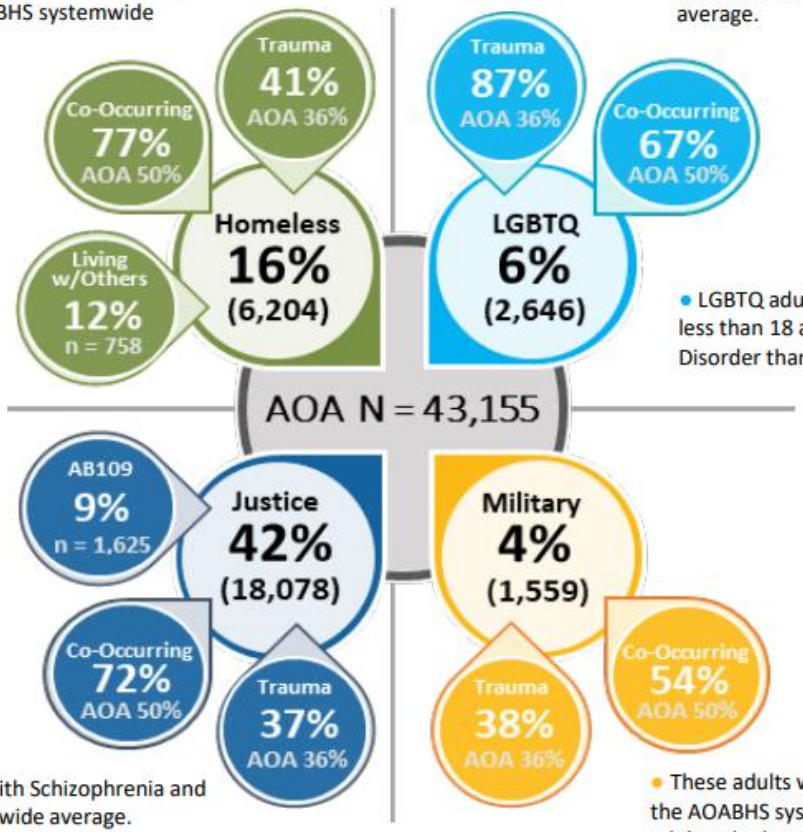
Figure 16: FY 2022-2023: Special Populations Report – AOA – Military



* NH refers to Non-Hispanic/Latino.
Other sexuality includes heterosexual.
Gender is how clients currently identify, not sex assigned at birth.
Please note: Data may be impacted starting March 2020 due to COVID-19.
This report is limited to Mental Health Services clients.

Figure 17: Trauma and Co-Occurring Substance Use Issue Among Homeless, LGBTQ+, Justice System, Military

- Homeless adults were more likely than the AOABHS systemwide averages to be male, non-Hispanic White, and to be diagnosed with Schizophrenia and Other Psychotic Disorder.
- Seventy-seven percent of homeless adults were reported to have a co-occurring disorder, as compared to 50% in the AOABHS systemwide average.



- Eighty-seven percent of LGBTQ adults were reported to have a history of trauma, as compared to 36% in the AOABHS systemwide average.
- LGBTQ adults were more likely to be female, between the ages of less than 18 and 25 years old, and be diagnosed with Bipolar Disorder than the AOABHS systemwide average.
- These adults were more likely to be diagnosed with Schizophrenia and Other Psychotic Disorder than the AOABHS systemwide average.
- Seventy-two percent of adults who have been involved with the justice system were reported to have a co-occurring disorder, as compared to 50% in the AOABHS systemwide average.
- These adults were more likely to report a history of trauma than the AOABHS systemwide average. Additionally, the percentage of adults who have reported that they had served in the military and have a history of trauma has increased over the past three years.
- Over the past three years, the percentage of these adults reported to have a co-occuring disorder has decreased slightly.

Data shown in ***Tables 2a – 2c*** for FY 23-24, provides information on the access times for individuals requesting mental health services within the Children, Youth, and Family (CYF) Programs. Data is shown by response type (routine or urgent); the count of requests received for services (duplicated as patients may be included in multiple programs); the type of services requested (Mental Health (MH) or Psychiatry (PSYCH); average number of days until the first offered/available appointment; and by preferred language. MH services include psychotherapy, group therapy, case management, and others, and the individual will be provided a Mental Health Assessment. PSYCH refers to services that require a prescriber and will include a Medication Assessment. Based on the California Department of Healthcare Services (CDHS), programs are required to adhere to specific access time requirements for when an appointment is first offered to the client – 10 business days for routine MH appointments, and 15 business days for routine PSYCH appointments. For urgent response types, appointments need to be offered within two calendar days (48 hours).

Overall, the data shows that BHS is exceeding the access time requirements for routine MH appointments (17.3 days on average) but are meeting the requirement for routine PSYCH appointments (10.9 days on average). For those requiring urgent MH and PSYCH services, BHS is not meeting the access time requirements (17.9 calendar days, and 81.5 business days, on average, respectively). Factors contributing to this could be due to the variability with reporting across multiple providers and some information being incorrectly entered. Quality improvement efforts are underway to improve data entry and reporting. In addition, access times could have been extended as clients may have a preferred program and are willing to wait until there is availability, which ends up extending the average days before the first offered/available appointment.

Table 2a: Access Times for the CYF Programs for FY 23-24, By Response Type

Response Type				
MH or PSYCH	MH		PSYCH	
Response Type	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
Routine (business days)	5,491	17.3	2,787	10.9
Urgent (calendar days)	71	17.9	15	81.5

Table 2b: Urgent Access Times for the CYF Programs for FY 23-24, By Preferred Language

Preferred Language – Urgent (48 hours/2 calendar days)				
MH or PSYCH	MH		PSYCH	
Preferred Language	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
Arabic	2	0.5	1	5.0
English	59	20.2	14	87.0
Spanish	10	7.6	n/a	n/a

Note: Some threshold languages are not listed as there were no urgent requests received during the reporting period.

Table 2c: Routine Access Times for CYF Programs for FY 23-24, By Preferred Language

Preferred Language – Routine (Business Days)				
MH or PSYCH	MH		PSYCH	
Preferred Language	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
American Sign Language	n/a	n/a	1	4.0
Arabic	8	17.3	5	11.2
Dari	1	0.0	1	6.0
English	4,672	17.1	2,368	10.8
Farsi	2	12.0	1	28.0
French	n/a	n/a	1	4.0
Japanese	1	1.0	2	9.0
Korean	n/a	n/a	6	4.5
Mandarin	3	6.7	4	3.3
Mien	7	160.6	n/a	n/a
Other non-English	12	1.9	2	4.0
Portuguese	1	18.0	2	2.5
Russian	2	0.5	1	0.0
Somali	n/a	n/a	1	4.0
Spanish	727	16.7	370	12.4
Tagalog	n/a	n/a	3	1.0
Turkish	1	1.0	n/a	n/a
Unknown / Not Reported	42	31.3	13	4.6
Vietnamese	12	3.3	6	3.3
Total	**5,491**	**17.3**	**2,787**	**10.9**

Data shown in ***Tables 3a – 3c*** provides information on access times for individuals requesting mental health services within outpatient Adult and Older Adult (AOA) programs. Data is shown by response type (routine or urgent); the count of requests received for services (duplicated as patients may be included in multiple programs); the type of services requested (Mental Health (MH) or Psychiatry (PSYCH); average number of days until the first offered/available appointment; and by preferred language. MH services include psychotherapy, group therapy, case management, and others, and the individual will be provided a Mental Health Assessment. PSYCH refers to services that require a prescriber and will include a Medication Assessment. Based on CDHS, programs are required to adhere to specific access time requirements for when an appointment is first offered to the client – 10 business days for routine MH appointments, and 15 business days for routine PSYCH appointments. For urgent response types, appointments need to be offered within two calendar days (48 hours).

Overall, the data shows that BHS is meeting the access time requirements of 10 business days for routine MH appointments (3.8 days on average) and 15 days for routine PSYCH appointments (3.9 days on average). For Urgent responses, the access time requirements are two calendar days (within 48 hours). For those requiring urgent MH and PSYCH services, BHS is meeting the access time requirement (1.5 calendar days) for MH services but exceed the requirements for PSYCH appointments (3.1 calendar days). This data may be impacted by the limited number of prescribers available at outpatient programs. Additionally, data may be affected by the variability with reporting across multiple providers and some information being incorrectly entered. Quality improvement efforts continue to be underway to improve data entry and reporting. As discussed above, access times could also have been extended as clients may have a preferred program and are willing to wait until there is availability, which ends up extending the access time.

Table 3a: Access Times for the AOA Programs for FY 23-24, By Response Type

Response Type				
MH or PSYCH	MH		PSYCH	
Response Type	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
Routine (business days)	7,145	3.8	5,317	3.9
Urgent (calendar days)	348	1.5	317	3.1

Table 3b: Urgent Access Times for the AOA Programs for FY 23-24, By Preferred

Preferred Language – Urgent (48 hours/2 calendar days)				
MH or PSYCH	MH		PSYCH	
Preferred Language	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
Arabic	1	3.0	n/a	n/a
Dari	1	1.0	n/a	n/a
English	317	1.6	285	3.2
Other (non-English)	5	2.0	4	4.3
Russian	1	1.1	1	1.0
Spanish	22	0.7	25	2.6
Unknown / Not Reported	1	1.0	2	2.5

Note: *Some threshold languages are not listed as there were no urgent requests received during the reporting period.*

Table 3c: Routine Access Times for the AOA Programs for FY 23-24, By Preferred Language

Preferred Language – Routine (Business Days)				
MH or PSYCH	MH		PSYCH	
Preferred Language	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
American Sign Language	3	0.7	1	2.0
Arabic	56	2.4	36	4.1
Cambodian	7	4.7	5	12.4
Cantonese	3	0.0	1	0.0
Dari	7	1.7	6	9.5
English	6,404	3.9	4,747	3.9
Farsi	18	2.0	10	9.1
French	2	0.0	2	0.0
German	2	0.5	n/a	n/a
Korean	2	0.0	n/a	n/a
Laotian	5	11.6	1	13.0
Mandarin	4	1.3	3	7.3
Mien	4	2.3	3	1.0
Other Chinese Langs & Dialects	1	1.0	1	1.0
Other Filipino Dialect	1	5.0	1	17.0
Other non-English	29	2.8	17	7.9
Polish	3	3.3	1	6.0
Portuguese	2	0.5	2	0.5
Russian	13	1.9	11	9.0

Preferred Language – Routine (Business Days)				
MH or PSYCH	MH		PSYCH	
Preferred Language	Requests for Service Count	Average days to first offered/available appointment	Requests for Service Count	Average days to first offered/available appointment
Samoan	2	1.5	1	2.0
Somali	10	2.1	8	11.9
Spanish	459	2.7	398	3.3
Tagalog	12	12.1	7	7.1
Thai	3	3.0	4	4.8
Unknown / Not Reported	69	3.0	32	3.8
Vietnamese	23	2.4	18	2.7
Total	**7,145**	**3.8**	**5,317**	**3.9**

SUMMARY OF FINDINGS

The MHSA Capacity Assessment examined county level data from a population health perspective to get a sense of the community need, identifying the mental health needs of the community, as well as the utilization of current services and the individuals served. The analysis demonstrated that San Diego County is a diverse region, impacted by many social determinants of health that can impact mental health access and availability of services. Penetration rates showed a need for additional services for populations such as Asian/Pacific Islanders, Native American and Hispanics. Additionally, there is a need for additional services in the Central region, which has the highest population of uninsured individuals in San Diego County. In examining the special populations served, there was evidence that there are higher rates of trauma and co-occurring disorders for both the children and youth and the adult and older adult special populations (persons experiencing homelessness, LGBTQ+, probation/justice involved, child and family well-being involved, and military) when compared to the overall system, demonstrating the need for additional services to these unserved/underserved populations.

ADDRESSING BARRIERS TO PROGRAMS AND SERVICES

BHS is addressing barriers identified in the capacity assessment and needs analysis in several ways. The Community Experience Partnership not only allows for data analysis of service capacity, community needs, and access barriers, but also promotes community engagement. For example, community engagement forum activities were implemented in five of the six HHSA regions of San Diego County. UC San Diego Health Partnership also utilized standing regional meetings to engage the community through community engagement forums. The goal of each regional community engagement forum was to convene stakeholders and the community to gather input regarding resources, services, and barriers specific to each HHSA region, to inform the County BHS Continuum of Care and improve the behavioral health equity at a regional level. In further collaboration with the County BHS Continuum of Care, the UC Health Partnership held a listening session with the Behavioral Health Advisory Board and System of Care Council members. Additionally, BHS is

collaborating with the Local Health Jurisdiction, County Public Health Services (PHS), to become more integrated and involved in their community planning process for the development of the Community Health Improvement Plan for the county. For example, BHS staff attend monthly Community Leadership Team (CLT) meetings, which are situated in each of the HHSA regions and include regional leaders and community organizations. BHS staff serve as support and subject matter experts on these CLTs for any behavioral health related concerns or topics of interest that arise. BHS epidemiologists also present community data at the CLTs to help inform the development of each region's community enrichment plans, which includes community priorities and the plan of action to address those priorities. Collaboration between PHS and BHS, as well as enhancement of the CEP, is ongoing, with a strong emphasis on community engagement in helping to identify and address barriers to programs and services.

APPENDIX E

MHSA JUSTICE INVOLVED PROGRAMS

Population Served	*Program Name and Description*	*FY 2025-26 MHSA Annual Update Plan Funding**	*MHSA Component*
All Ages	The **Mobile Crisis Response Team (MCRT)** is a field based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non 911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care.	$ 8,700,159	CSS
All Ages	The **Psychiatric Emergency Response Team (PERT)** is made up of a licensed mental health clinician and a PERT trained law enforcement officer. Together, they seek to deescalate a mental health emergency and, when possible, redirect the individual to mental health services instead of hospitalization or incarceration.	$ 10,660,549	CSS
Children & Youth	The **Commercially Sexually Exploited Children (CSEC)** program provides outpatient treatment to youth who have been commercially sexually exploited (CSEC) and includes a drop-in center that offers supportive services.	$ 1,240,000	CSS
Children & Youth	**Medication Clinic** includes a component that supports Medi-Cal and unfunded youth discharged from Juvenile Detention Facilities and who require transitional/time-limited medication support services while they are linked to behavioral health services and/or prescriber.	$ 3,000,000	CSS
Children & Youth	The **Wraparound Services (WRAP) - Child Welfare Services (CWS)** program provides team based intensive and individualized case management to children and youth up to age 21 who are involved with child and family well-being (CFWB) or probation .	$ 6,652,943	CSS
Youth	**Children's School Based Full Service Partnership (FSP)** is an outpatient treatment program that serves children and youth in the community who are involved with the justice system. The program enhancement allows for increased psychiatry coverage.	$ 2,035,000	CSS
Youth	The **County of San Diego Juvenile Forensics** team provides behavioral health services to youth transitioning out of the juvenile detention and rehabilitative institutions.	$ 1,100,000	CSS
Adults	The **Behavior Health Assessor** is a program for courts in south and central regions that provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 435,000	CSS
Adults	The **Behavioral Health Court Assertive Community Treatment** are services for adults involved in the justice system. Participation in the program serves as diversion to jail time.	$ 2,959,342	CSS
Adults	The **Faith Based Services** wellness and mental health in-reach ministry which focuses on adults diagnosed with serious mental illness (SMI) while incarcerated at sheriff's detention facilities.	$ 926,485	CSS
Adults	The **Full Service Partnership (FSP)/Assertive Community Treatment (ACT)** program is designed to improve the behavioral health and quality of life of adults in the community who are involved in the justice system, are homeless, and have a serious mental illness and a substance use disorder. The improvements will be achieved by increasing clinical and functional stability through an array of rehabilitative mental health services, intensive case management, housing, educational and employment supports. Evidence-based practices to address criminogenic needs are integrated into treatment to reduce recidivism.	$ 7,196,722	CSS
Adults	**County of San Diego-Probation is** dedicated to specific assertive community treatment (ACT) teams to provide support and case management of individuals with serious mental illness (SMI) who are on probation.	$ 600,000	CSS
Adults	**Justice System Discharge Planning** services to at risk African-American and Latino citizens who are incarcerated adults or transition age youth (TAY) at designated detention facilities and will be released in San Diego County.	$ 1,139,376	CSS
Adults	The **Public Defender-Behavioral Health Assessor** adds two licensed mental health clinicians to provide discharge planning, care coordination, referral and linkage to services, and short term case management for persons with serious mental illness (SMI) who have been referred by the Court for services.	$ 240,000	CSS
Grand Total		**$ 46,885,576**	

-

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

APPENDIX F

COUNTY OF SAN DIEGO DEMOGRAPHICS

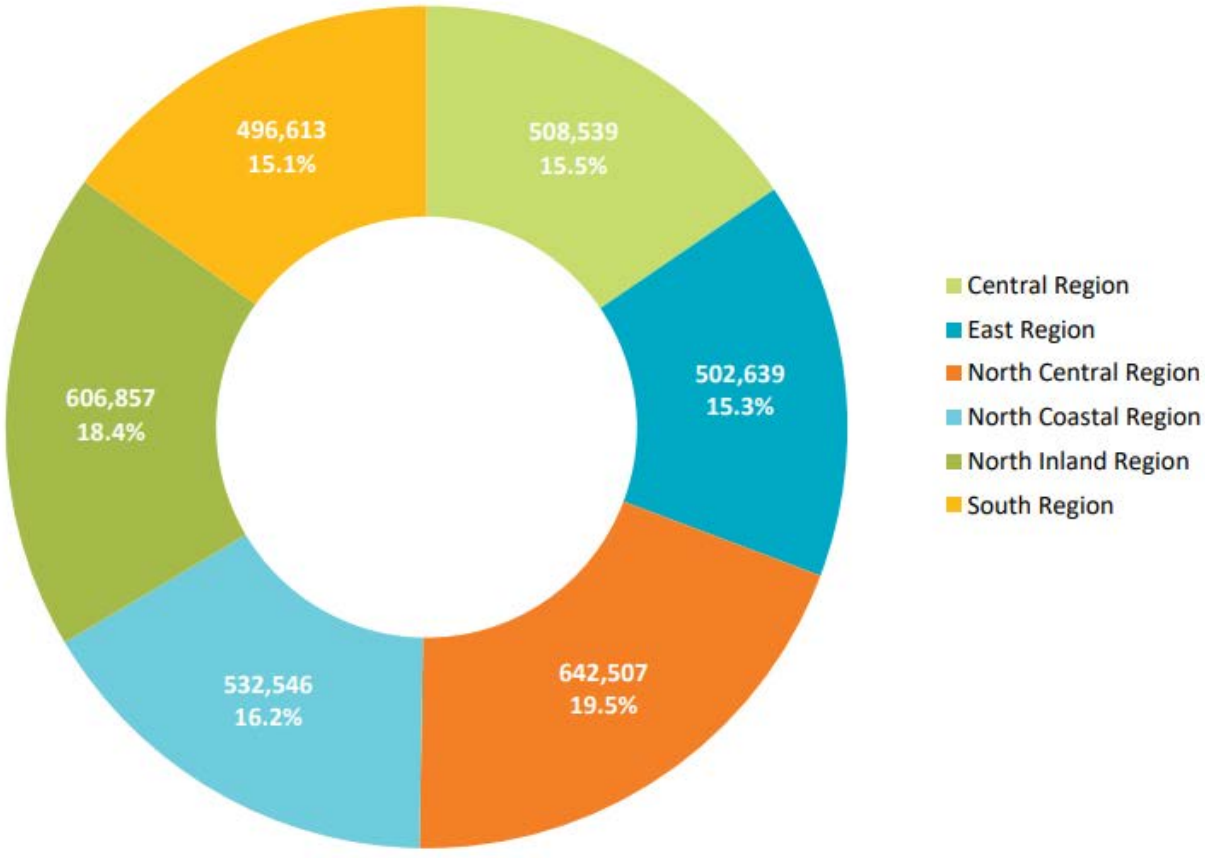
Demographics

SAN DIEGO COUNTY POPULATION DISTRIBUTION BY HHSA REGIONS, 2022

HHSA Region	Population	%
Central Region	508,539	15.5%
East Region	502,639	15.3%
North Central Region	642,507	19.5%
North Coastal Region	532,546	16.2%
North Inland Region	606,857	18.4%
South Region	496,613	15.1%
San Diego County Total	**3,289,701**	**100.0%**

Figures above show the number of persons living at each Health and Human Services Agency (HHSA) Region. In 2022, San Diego had a population of nearly 3.3 million**.**
Source: U.S. Census Bureau; 2018-2022 American Community Survey 5-Year Estimates, Table B01001.

San Diego County Population Distribution by HHSA Regions, 2022

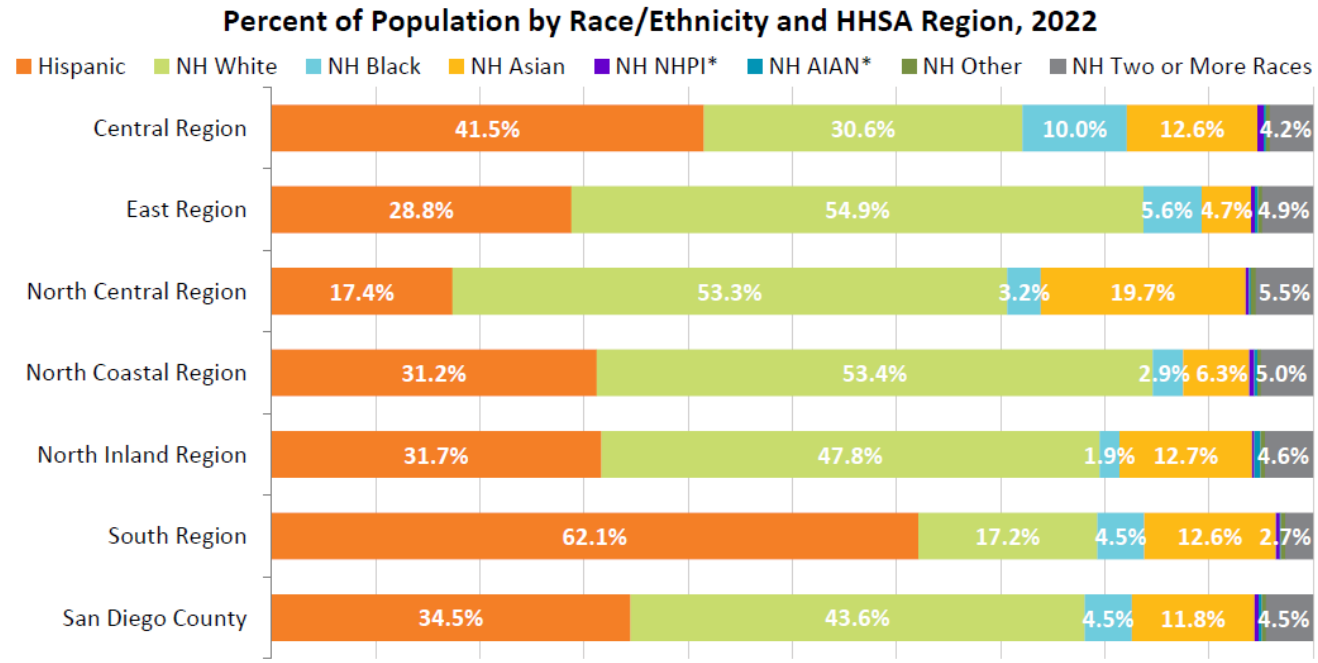


Source: U.S. Census Bureau; 2018-2022 American Community Survey 5-Year Estimates, Table B01001.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2024.

RACE/ETHNICITY BY HHSA REGIONS, 2022

HHSA Region	Hispanic	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic Native Hawaiian / Pacific Islander	Non-Hispanic American Indian/ Alaskan Native	Non-Hispanic	Non-Hispanic Two or More Races
Central Region	211,169	155,534	50,905	63,842	2,948	1,144	1,837	21,160
East Region	144,807	275,950	28,164	23,790	1,848	1,482	1,999	24,599
North Central Region	111,741	342,205	20,531	126,486	1,968	1,038	3,303	35,235
North Coastal Region	166,323	284,256	15,629	33,761	2,432	1,597	1,865	26,683
North Inland Region	192,243	290,180	11,658	77,298	1,306	3,549	2,595	28,028
South Region	308,364	85,473	22,218	62,792	1,883	528	2,068	13,287
San Diego County Total	**1,134,647**	**1,433,598**	**149,105**	**387,969**	**12,385**	**9,338**	**13,667**	**148,992**

Source: U.S. Census Bureau; 2018-2022 American Community Survey 5-Year Estimates, Table B03002.

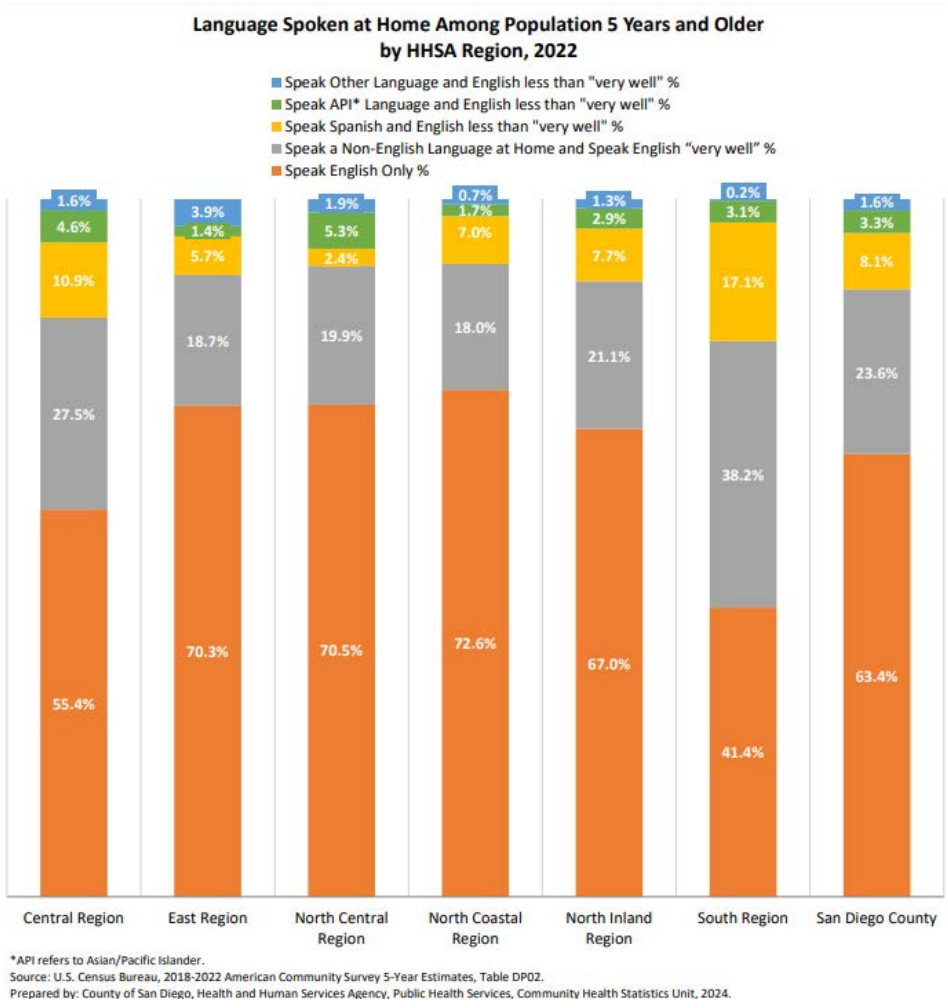


NH refers to Non-Hispanic or Latino.
*NHPI refers to Native Hawaiian or Pacific Islander; AIAN refers to American Indian/ Alaska Native.
Source: U.S. Census Bureau; 2018-2022 American Community Survey 5-Year Estimates, Table B03002.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2024.

LANGUAGE SPOKEN AT HOME AMONG POPULATION 5 YEARS AND OLDER BY HHSA REGION, 2022

HHSA Region	Population Age 5+	Speak English only%	Speak a non-English language at home and English "Very Well" %	Speak Spanish and Speak English less than "Very Well" %	Speak (API) Asian and Pacific Islander language and English less than "Very Well" %	Speak Other Language and English less than "Very Well" %
Central Region	483,140	55.4%	27.5%	10.9%	4.6%	1.6%
East Region	470,959	70.3%	18.7%	5.7%	1.4%	3.9%
North Central Region	607,183	70.5%	19.9%	2.4%	5.3%	1.9%
North Coastal Region	501,181	72.6%	18.0%	7.0%	1.7%	0.7%
North Inland Region	567,692	67.0%	21.1%	7.7%	2.9%	1.3%
South Region	468,628	41.4%	38.2%	17.1%	3.1%	0.2%
San Diego County	**3,098,783**	**63.4%**	**23.6%**	**8.1%**	**3.3%**	**1.6%**

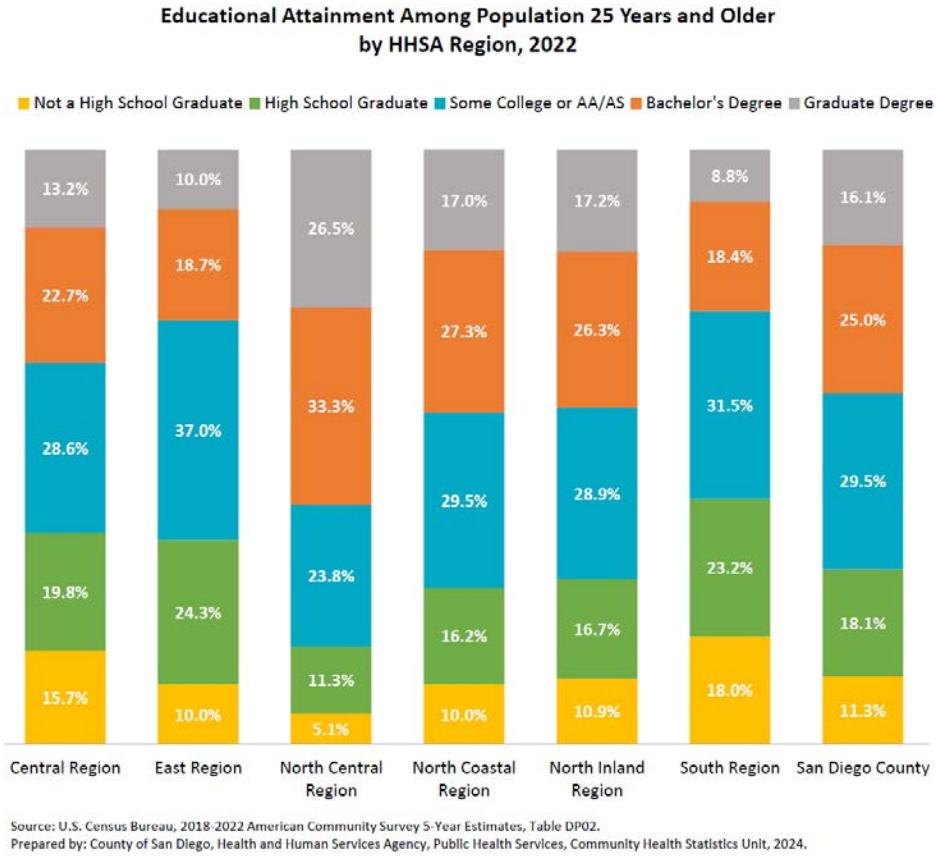
Source: U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, Table DP02.



EDUCATIONAL ATTAINMENT AMONG POPULATION 25 YEARS AND OLDER BY HHSA REGION, 2022

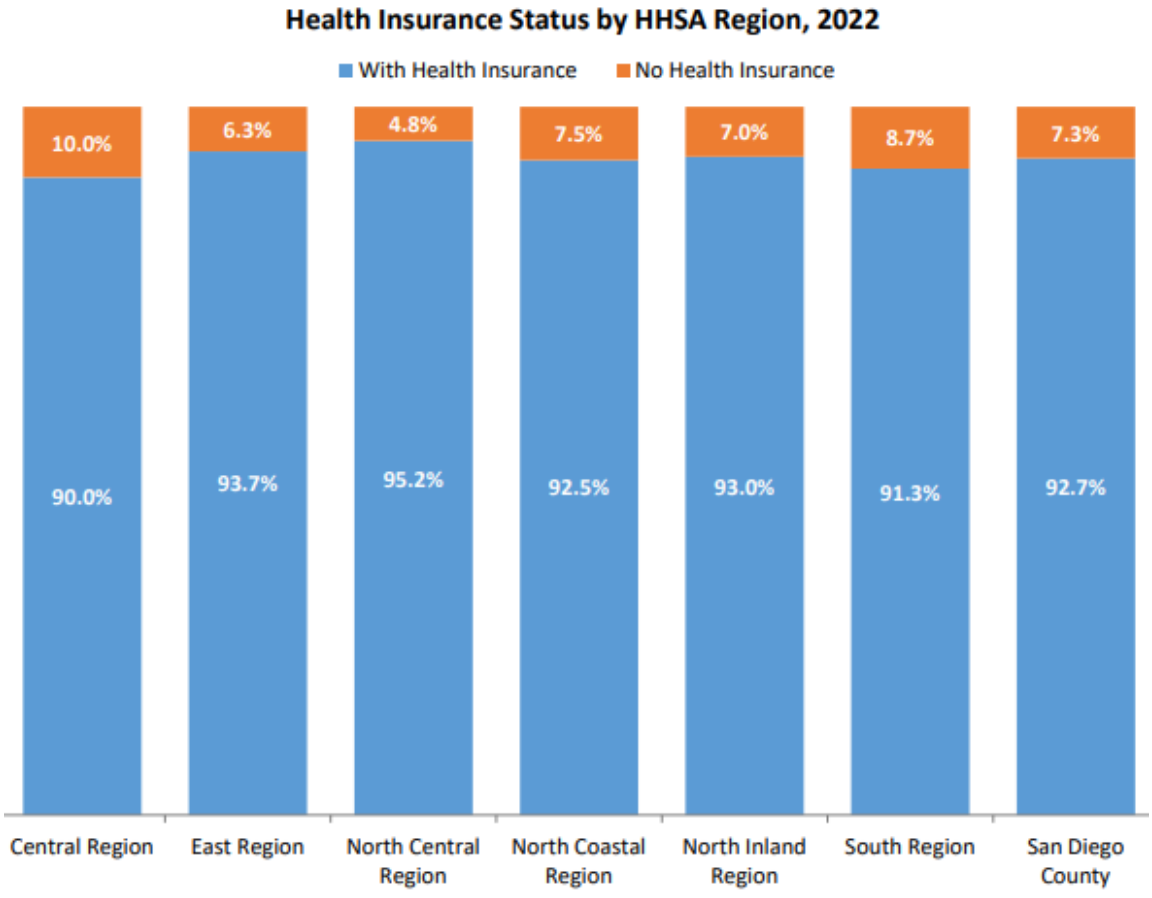
HHSA Region	Population Age 25+	Not a High School Graduate	High School Graduate	Some College or AA/AS	Bachelor's Degree	Graduate Degree
Central Region	358,441	15.7%	19.8%	28.6%	22.7%	13.2%
East Region	343,712	10.0%	24.3%	37.0%	18.7%	10.0%
North Central Region	454,274	5.1%	11.3%	23.8%	33.3%	26.5%
North Coastal Region	353,726	10.0%	16.2%	29.5%	27.3%	17.0%
North Inland Region	417,676	10.9%	16.7%	28.9%	26.3%	17.2%
South Region	329,791	18.0%	23.2%	31.5%	18.4%	8.8%
San Diego County	**2,257,620**	**11.3%**	**18.1%**	**29.5%**	**25.0%**	**16.1%**

Source: U.S. Census Bureau; 2018-2022 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.



HHSA Region	With Health Insurance	No Health Insurance	0-18 with Health Insurance	19-25 with Health Insurance	26-44 with Health Insurance	45-64 with Health Insurance	65+ with Health Insurance
Central Region	90.0%	10.0%	94.8%	86.5%	86.4%	88.2%	98.6%
East Region	93.7%	6.3%	95.9%	91.0%	90.4%	92.9%	98.8%
North Central Region	95.2%	4.8%	97.6%	93.3%	92.5%	94.8%	99.2%
North Coastal Region	92.5%	7.5%	96.0%	87.8%	87.3%	91.5%	99.1%
North Inland Region	93.0%	7.0%	96.1%	86.6%	88.7%	92.1%	99.0%
South Region	91.3%	8.7%	95.0%	85.8%	87.2%	89.9%	98.3%
San Diego County	**92.7%**	**7.3%**	**96.0%**	**88.7%**	**88.9%**	**91.8%**	**98.9%**

Source: U.S. Census Bureau; 2018-2022 American Community Survey 5-Year Estimates, Table B27001.



Source: U.S. Census Bureau, 2018-2022 American Community Survey 5-Year Estimates, Table B27001.
Prepared by: County of San Diego, Health and Human Services Agency, Public Health Services, Community Health Statistics Unit, 2024.

APPENDIX G

STAKEHOLDER ENGAGEMENT & COMMUNITY PROGRAM PLANNING PROCESS REPORT

Table of Contents

Overview

The Mental Health Services Act (MHSA) **Community Program Planning (CPP)** process is statutorily required to ensure local stakeholders have the opportunity to provide input regarding investments, priorities, and the array of behavioral health services funded through the MHSA. This report summarizes MHSA stakeholder engagement activities conducted by the department to inform its **Fiscal Year (FY) 2025-26 MHSA Annual Update** (MHSA Annual Update) and outlines input and feedback from stakeholders collected through CPP activities. It also includes strategies around ongoing efforts to refine and broaden engagement.

Pursuant to *California Welfare and Institutions Code (WIC) Section 5848(a)*, the CPP process requires counties to administer an inclusive community engagement and feedback process to gather input about the experiences of community members and stakeholders within MHSA-funded programs. The CPP process includes an array of local stakeholders, including adults and seniors with serious mental illness (SMI), families, service providers, justice partners, education partners, health care organizations, community members with interest in the local behavioral health services, and other communities with shared characteristics based on ethnicity, religion, disability, age, or other social identity factors. The CPP process facilitates opportunities for community members to provide feedback, identify unmet needs, recommend improvements, and make recommendations about MHSA investments.

The MHSA CPP process aligns with the County of San Diego enterprise-wide goal of ensuring communities have opportunities to participate in meaningful discussions and decision-making about local behavioral health services to ensure programs are reflective of the needs and voices of the community. Over the last year, the County of San Diego Behavioral Health Services (BHS) department has continued to enhance community engagement efforts. Additionally, significant new State policies and County initiatives have further emphasized the importance of stakeholder participation. The passage of Proposition 1 by California voters in March 2024 and the Behavioral Health Services Act (BHSA) will require further enhancements to the CPP process.

San Diego County At-A-Glance

San Diego County, located in Southern California along the Pacific Coast, shares a border with Mexico and features a diverse landscape that includes beaches, mountains, and deserts. San Diego County consists of 18 cities, 37 unincorporated communities, and 18 federally recognized Indian reservations. According to the United States (U.S.) Census Bureau, as of 2022 San Diego County has an estimated population of about 3.3 million people, making it the second most populous county in California. The population is diverse across various demographics:

- Approximately 54% are adults aged 25 to 64, 17.7% of residents are children under 14 years old, 14.7% are older adults aged 65 and over, and 13.7% are transition age youth (TAY) aged 15-24.

- In terms of ethnicity, 43.6% identify as White, 34.5% as Hispanic, 12.2% as Asian American or Pacific Islander (AAPI), and 4.5% as Black or African American, with smaller numbers identifying as Native American or other groups.
- The gender distribution is nearly equal, with 50.7% male and 49.3% female residents.

Engaging Local Stakeholders

To inform the FY 2025-26 MHSA Annual Update, a series of listening sessions, focus groups, and interviews were facilitated, in concert with the University of California, San Diego Health Partnership (UCSD Health Partnership), to gather stakeholder input from residents with unique perspectives across San Diego County. An online input form was also developed allowing stakeholders to submit feedback and ideas throughout the year.

Descriptions of featured and host organizations are outlined in Appendix D.

Stakeholder Participation Activities

The following information outlines stakeholder participation activities specifically conducted as part of the MHSA CPP process. The information collected was reviewed by BHS and UCSD Health Partnership to identify community and regional behavioral health needs and priorities to help inform the investment of MHSA funds.

Each activity was completed to discuss the following key questions with stakeholders:

1. What are the most pressing issues related to mental health and substance use in your community?
2. What are some of the biggest challenges to accessing resources for mental health and substance use?
3. What are some ideas that might help address priority mental health and substance use needs?

Cumulative demographic information for participants across all completed activities may be found in the **Participant Demographics** section of this report.

Community Listening Sessions

Nine listening sessions were held in collaboration with local partners, including behavioral health providers and/or other social services support for people in San Diego County. Partners informed the structure and guided sessions that were held across multiple regions. Sessions were held in-person, lasted one to two hours, and featured opportunities for partners to share information about their organization, upcoming initiatives, and how their program supports the health and wellness of the local community. Accommodations were also made to support people with interpretation or translation needs.

Partners Featured in Listening Sessions Include:

- Better Cuts Mental Health Alliance
- Diverse Research Now, Inc.
- Fallbrook Regional Health District
- Grama Blue's House
- Healthy San Diego Justice-Involved Workgroup
- Mental Health Ministry Network
- National Alliance on Mental Illness (NAMI)
- San Diego City College
- SBCS *(formerly South Bay Community Services)*

A sample of the presentation provided during listening sessions may be found in **Appendix A** of this report. Additionally, a list of sessions conducted, including corresponding dates and locations can be found in **Appendix C**. For additional information on each listed partner, please see **Appendix D/Figure D1** of this report.

Focus Groups

Eight focus groups were held to identify specific strengths and resources currently available to each participating population, as well as the needs and challenges communities are experiencing in accessing behavioral health resources. The focus groups were offered virtually and in-person at locations individuals and community members gather.

Host Partners Include:

- Jewish Family Service of San Diego-*Breaking Down Barriers* Outreach Team
- Jewish Family Service of San Diego-Patient Advocacy Team
- Peer Professionals of California
- Rady Children's Hospital Clinic
- San Diego Rescue Mission
- Somali Family Services
- Telecare-AgeWise
- Telecare-Mobile Crisis Response Team

Refer to **Appendix C** of this report for a list of the focus groups conducted, including corresponding dates and locations. For additional information on each listed partner, please see **Appendix D/Figure D2** of this report.

Interviews

A total of 10 individual interviews were completed with people who have lived experience and/or expertise. Discussions provided an opportunity to gain insight from residents affiliated with local organizations who self-identified as part of an unserved, underserved, or hard-to-reach population.

Affiliated Organizations of Interviewees Include:

- Disabled in Higher Education
- Disabled LGBTQIA+ Coalition
- Gooden Center
- Grow Lead Motivate (GLM) House
- HEAL Network
- Homelessness Hub
- Interfaith Community Services
- Inspired Mind
- Recovery International
- Unhoused Collective

Refer to **Appendix C** of this report for a list of the interviews conducted, including corresponding dates and locations.

Online Input Form

An input form tool was utilized through Qualtrics to gather data from people interested in providing input on mental health and substance use. Individuals were encouraged to indicate which engagement forums were of interest, inclusive of listening sessions, focus groups, and interviews. Respondents were also prompted to provide feedback on behavioral health in San Diego County. The form was promoted in different ways across the region including:

- During listening sessions, focus groups, and interviews, participants were informed about the form and encouraged to share it with their networks.
- With partner organizations and their clients.
- Through outreach and engagement events via a QR code on the UCSD Health Partnership banner, flyers, and other resource booth materials, including a summary document that included past learnings from previous years.

Existing Networks

In addition to these CPP process activities, the department continued to learn from the insights of its local behavioral health Board/Commission and other established BHS councils and collaboratives. These longstanding groups are designed to generate feedback and inform the delivery of behavioral health services for specific populations. Descriptions of these departmental groups are noted below.

BHS Councils and Collaboratives

The Behavioral Health Advisory Board (BHAB) and BHS' System of Care (SoC) Councils work directly with BHS and other system partners to examine disparities in care and collaboratively identify recommendations. Membership includes participation from over 200 individuals representing a variety of disciplines and community sectors. Participants contribute their time and

expertise to collaboratively discuss opportunities and solutions to behavioral health challenges via monthly and ad-hoc general meetings, as well as separate subcommittee convenings.

- **BHAB:** Serves as San Diego County's local Board/Commission for behavioral health and reviews and evaluates the community's behavioral health needs, services, programs, facilities, and procedures used to ensure citizen and professional involvement in the planning process. Monthly Brown Act meetings facilitated by BHAB Executive Officers ensure community involvement in identifying, assessing, and addressing challenges within the County behavioral health system. Additionally, BHAB holds subcommittee meetings where community stakeholders can discuss specific and pressing behavioral health issues and provide recommendations to BHAB. General BHAB meetings can be attended in-person or virtually on the first Thursday of every month.
- **Adult SoC Council:** Examines and informs planning/programming for the public adult system of care for San Diego County and provides recommendations to the department.
- **Older Adult SoC Council:** Examines and informs planning/programming for the public older adult system of care for San Diego County and provides recommendations to the department.
- **Children, Youth, and Families SoC Council:** Examines and informs planning/programming for services for children, youth, and families and provides recommendations to the department; advances systems and services to ensure these populations are healthy, safe, lawful, successful in school, and in their transition to adulthood.
- **Transition Aged Youth (TAY) SoC Council:** Examines and informs planning/programming for services for TAY (ages 16 to 25 years) and provides recommendations to the department.
- **Cultural Competence Resource Team (CCRT):** Collaborates with SoC Councils and other BHS collaboratives to examine and address health care disparities and social determinants of health in unserved and underserved communities, particularly around access to care and workforce goals.
- **Housing Collaborative:** Facilitates design, implementation, and evaluation of housing interventions to address the behavioral health needs of individuals at risk of or experiencing homelessness or housing insecurity.

Community-Based Convenings

BHS and the UCSD Health Partnership also attended existing community-based convenings to learn about behavioral health needs and enlist new and diverse stakeholders. Descriptions of these existing community convenings are noted below.

- ***Live Well San Diego* Community Regional Leadership Team (CLT) Meetings:** Five separate regional CLTs convene across San Diego County, hosting both general and

supplementary Work Group/Subcommittee meetings. Meetings are held on a hybrid, monthly basis, and participants include community partners, agencies, and advocates that work together to identify the priorities of their respective region, including behavioral health needs.

- **NAMI Peer Council Meetings:** NAMI peer leaders with lived experience host meetings monthly. Meetings bring together peers, community members, service providers, organizations, and County representatives to discuss effective ways to improve the BHS system of care.
- **Partners in Equity Coalition Meetings:** Monthly, hybrid, community-based meetings, facilitated by the YMCA of San Diego County, focused on addressing and combating structural racism and inequities within the child welfare system. These meetings leverage the expertise of community members and families with lived experience to formulate ideas for change in the child welfare system.
- **Spring Valley Collaborative Meetings:** Monthly meetings hosted and facilitated by the Spring Valley Collaborative, a coalition of over 50 local organizations. These gatherings convene non-profit organizations, local government, healthcare providers, educational institutions, and community leaders, offering a platform for open dialogue, resource sharing, and collaborative efforts to improve conditions for Spring Valley residents.
- **Re-Entry Roundtable Meetings:** Monthly workgroup meetings hosted by the San Diego Re-Entry Roundtable focus on supporting individuals transitioning from incarceration back into the community. This collaborative forum includes diverse stakeholders such as representatives from correctional institutions, law enforcement agencies, faith-based organizations, community-based organizations, and individuals with lived experience in the criminal justice system to participate in meaningful dialogue to enhance re-entry efforts.

Community Outreach

Community outreach was conducted to inform stakeholders about opportunities to provide feedback and participate in the CPP process. Outreach was facilitated by UCSD Health Partnership through their network of community partners and included people with an understanding of MHSA populations who supported recruitment of other community members to increase CPP process participation. Outreach materials were translated into Spanish and included information about requesting interpreter services. Sample flyers promoting stakeholder participation activities can be found in **Appendix B/Figure B2** of this report.

To foster trust and encourage CPP process participation, efforts were conducted alongside community organizations and leaders with trusted relationships within their communities. Population-specific outreach and recruitment was also supported by community leaders and organizations to ensure diversity and relevance and to support engagement of people who may not otherwise participate in the CPP process. Outreach focused on connecting with communities often

identified as being underserved, unserved, or having limited participation in engagement activities, including:

- People with serious mental illness (SMI)
- People with disabilities
- People with lived experience
- People experiencing homelessness
- People with justice-involvement
- Faith-based communities
- Older adults
- Refugee communities
- Transition aged youth (TAY)
- Black and African Americans
- Asian American and Pacific Islanders (AAPI)
- Hispanic and Latinos
- LGBTQIA+ populations

Social Media Promotion

In March 2024, the UCSD Health Partnership launched an Instagram account (**@ucsd.hp**) to enhance promotional efforts and promote upcoming CPP input opportunities and community meetings/events, connect with community partners, build relationships, and share resources. Sample social media posts promoting stakeholder participation activities may be found in **Appendix B/Figure B1 of this report**.

Resource Booths and Community Events

The UCSD Health Partnership hosted resource booths at multiple local community events to share information on CPP process engagement opportunities, including listening sessions and upcoming community events. These networking activities supported connection with a diverse range of community members, advocates, and behavioral health workers. Information on health and wellness resources, mental health support, and available community services was also provided.

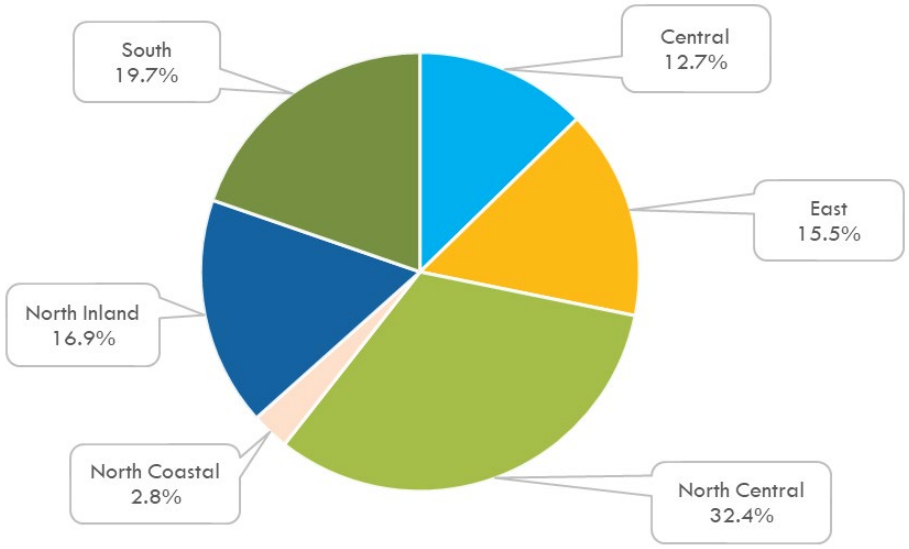
For more information on resource booth events, including corresponding dates and locations, refer to **Appendix C: Activities for Stakeholder Input - Resource Booths**.

Participant Demographics

Participants at CPP process activities varied in age, gender, ethnicity, and geographic location, providing a diverse representation of people residing in San Diego County. Participants were encouraged to complete a questionnaire via Qualtrics, or a written form, to allow for demographic information to be collected for this report.

Approximately 44% of participants completed the questionnaire following a CPP activity.

- *Age*
    - 58.6% were between 26-59 years of age
    - 32.4% were aged 60 years and over
- *Race/Ethnicity*
    - 51.9% identified as Hispanic/Latino/a
    - 18.5% identified as White
    - 13% identified as Black or African American
- *Primary Language*
    - 58.2% reported English
    - 38.2% reported Spanish
- *Veteran Status*
    - 6% of participants indicated their Veteran status
- *Living with a Disability*
    - Over 36% of respondents indicated they were living with at least one type of disability, including physical impairments, mental health conditions, difficulty seeing or hearing, learning disabilities, developmental disabilities, and others. Participants also had the option to indicate other specific conditions.
- *Geographic Location*
    - Respondents' region (by County of San Diego HHSA Service Region):

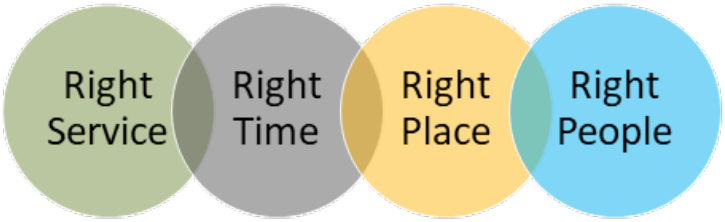


The characteristics representing the people who participated in one of the CPP input activities and completed the questionnaire may be found in **Appendix E** of this report.

Community Recommendations and Recent Efforts

Overwhelming feedback received from the community through recent CPP process activities reinforced a continued need for individuals and families to have access to behavioral health care that meets their unique circumstances -- ***"the right service, at the right time, in the right place, and by the right people."***

Community Vision for Behavioral Health Services



- ***"Right Services"*** to ensure people receive effective, high quality, tailored services within the level of care they need.
- ***"Right Time"*** to ensure people have timely access to the care they need when they need it, including flexible hours of service and no waitlists.
- ***"Right Place"*** to ensure barriers around access to care are reduced or eliminated, including services that are close to transportation and language accessibility.
- ***"Right People"*** to ensure services are provided by culturally competent practitioners who reflect the diversity of the communities being served.

Stakeholders expressed the need for enhanced community outreach efforts to reduce behavioral health stigma, raise awareness of services, and improve health literacy of community members related to behavioral health resources. They also highlighted challenges in navigating the complexities around behavioral health care and the need for more seamless care coordination.

Opportunities to Improve Care

In FY 2024–25, BHS continued to accelerate transformation of the behavioral health continuum of care by enhancing, expanding, and innovating the array of services available. This includes enhancements to services and infrastructure with a focus on integrated and preventative care that improves outcomes over time and is tailored to reduce health disparities. BHS continued to enhance care by making significant investments across the continuum of care through MHSA and other funding sources; however, opportunities remain to continue to improve care across the continuum.

Eight priority areas were elevated by participants through CPP process activities as areas for enhancement within the continuum of care. These include:

1. Accessibility
2. Care Coordination and Navigation
3. Community Outreach and Education

4. Crisis Response Services
5. Culturally Appropriate and Affirming Care
6. Support for People Experiencing Homelessness
7. Services for Youth and Transition Age Youth (TAY)
8. Workforce Capacity and Diversity

These areas remain consistent with learnings from the last two years of the current three-year MHSA cycle and highlight complex and longstanding systemic challenges. The following section provides a general overview of each area and the community's recommendations, as well as related departmental updates from FY 2024-25, and anticipated opportunities to improve care within the local public behavioral health system. The department looks forward to ongoing collaboration with BHAB, SoC Councils, and other existing stakeholder groups to continue efforts to identify and improve behavioral health care in San Diego County.

Area 1: Accessibility

Participants identified significant barriers to care, including extensive wait times, insurance limitations, funding disparities, and geographic disparities. Participants with behavioral health needs who are eligible for Medi-Cal reported experiencing delays in accessing care and noted that providers often wouldn't accept their insurance because of the low reimbursement rates. Participants shared that the lack of access, waitlists, and/or the need for out-of-pocket expenses often resulted in a crisis escalation or a higher demand for emergency care. These likely would have been prevented through more upstream preventative or outpatient care.

Additionally, community providers identified the lack of dedicated, ongoing funding for behavioral health care as a primary barrier to providing accessible, continuous, and effective mental health and substance use services. Insufficient funding was identified as a factor leading to shorter program lifespans, inconsistencies with providing effective healthcare, and subsequently resulting in waitlists and instability for clients. Smaller organizations that are trusted by stakeholders to provide community-based supports, identified challenges in being equipped to compete with larger entities when new funding opportunities were available.

Many stakeholders also identified geographic disparities as significantly impacting access to care, which are most pronounced in suburban or rural areas, where the nearest facilities to receive care may require driving or taking transportation for long periods of time.

Community Recommendations

To ensure behavioral health care is provided in locations and ways that are easier and more convenient for the community to access, stakeholders provided the following recommendations:

- Provide more services at local community spaces (e.g., libraries or places of worships) and implement activities such as mobile behavioral health clinics and community-based naloxone distribution events, where the applicable resource is brought to the community.

- Expand telehealth and remote care options, particularly for low-income and rural communities.
- Explore investments to help make transportation options available for people in need of care.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve access to care:

- The **Tri-City Psychiatric Health Facility (PHF)** in Oceanside is a 16-bed, 13,600-square-foot facility that provides access to care for adults experiencing a behavioral health crisis.
- The **Sharp Chula Vista CSU**, located adjacent to the emergency department, provides behavioral health care to adults who are Medi-Cal eligible and experiencing a behavioral health crisis.
- Construction of the new 14,300-square-foot **East Region Crisis Stabilization Unit (CSU)** is underway in the City of El Cajon to provide care to adults who are Medi-Cal eligible and experiencing a behavioral health crisis.

Area 2: Care Coordination and Navigation

Participants identified care coordination and navigation as a critical area of need. Individuals described the challenges related to accessing integrated and comprehensive healthcare services, with specific barriers for people who have a dual diagnosis and/or co-occurring mental health and substance use conditions. This often requires people to choose one type of care over another, resulting in fragmented care that did not fully address their needs. The complexity of cases was described by representatives from some programs as overwhelming and without an easy long-term solution. Stakeholders also expressed a desire for investments in more dynamic resources that help people access information about available services "in one place," significantly improving the experience of those navigating County-specific resources.

Community Recommendations

To improve care coordination across the behavioral health system, stakeholders provided the following recommendations:

- Increase the availability of integrative treatment models and programs that target both mental health and substance use challenges. These models are essential for providing comprehensive care to individuals with co-occurring disorders.
- Enhance communication across behavioral health silos to foster smooth transitions for clients, enabling warm hand-offs that ensure continuity of care.
- Establish clear protocols for seamless collaboration among crisis teams, law enforcement, and providers as a mechanism to improve responses to mental health crises and ensure that individuals receive the support they need in a timely and coordinated manner.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to support care coordination and navigation:

- Starting in 2025, a new program, **San Diego Relay (SD Relay),** is leveraging Peer Support Specialists to provide care coordination and engagement within several Hospital Emergency Departments (EDs). Peer Support Specialists connect with people while they are in EDs following a nonfatal opioid overdose or a behavioral health-related involuntary hold and help to provide "warm hand-offs" to other local providers and services. Services may include medication-assisted treatment, medical care, harm reduction tools, and community-based services.
- **System flow mapping** for suicide reporting and crisis response, particularly for youth and young adults, is underway through a pilot program with the California Department of Public Health through June 2025. This exercise will assist with identifying gaps related to local reporting and crisis response systems and bolsters connections across various community sectors.
- In Summer 2025, a **new public messaging campaign** will be released to enhance promotion of the San Diego Access & Crisis Line (ACL). Now accessible through the national three-digit dialing code 9-8-8, the ACL serves as the local crisis call center for the region and is a recommended "first stop" for those seeking guidance and support with behavioral health services. The ACL offers support in various crises and helps to facilitate connections to local resources, including adult and children outpatient services, deployment of mobile response teams (e.g., MCRT or PERT) if appropriate, and referrals to community and hospital-based CSUs.

Area 3: Community Outreach and Education

Participants identified the need to enhance and increase community outreach and education efforts around behavioral health resources to help keep people informed and feel empowered to seek care. The complexity and lack of understanding was noted as a significant gap, often delaying a person's ability to receive care. Stakeholders emphasized the need to develop comprehensive public health messaging and utilize various communication channels to connect with broader audiences. This would help reduce stigma, promote mental wellness, increase community education, support suicide prevention, and empower people to prevent substance misuse.

Community Recommendations

To improve community outreach and education, stakeholders provided the following recommendations:

- Develop more comprehensive education and outreach strategies.
- Increase ongoing public messaging via social media platforms.
- Increase additional print and digital advertising.
- Increase in-person engagement opportunities.

In addition to existing stigma reduction and suicide prevention efforts, participants indicated a desire for broader health education and health promotion programming to increase awareness and learning of strategies and skills to support mental wellness and combat substance misuse. This includes more overdose prevention workshops to continue to inform the public about the latest wave of the opioid epidemic, the dangers of illicit fentanyl, and to train stakeholders on the availability and administration of life-saving naloxone.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve community outreach and engagement. These include

- The **Breaking Down Barriers (BDB)** program was enhanced to provide increased outreach, education, and community engagement, including new community engagement activities required under the Behavioral Health Services Act.
- The ***It's Up to Us*** public messaging program was enhanced to provide increased support for outreach and public messaging efforts.
- The **BHS Communication & Engagement** team enhanced health promotion activities to increase stakeholder feedback and support program planning, including:
    - Data and public messaging workshops conducted with the BHS Population Health Unit and other County teams, where regional population health data on self-harm, suicide, fatal and non-fatal overdoses were presented to community convenings.
    - A *"30-Day Mental Wellness Practice"* initiative provided community members with a fun, free, accessible way to identify and engage in self-care activities to support their mental health.
    - Community dialogues with stakeholders through *It's Up to Us "Let's Talk About…"* events resulting in the identification of key areas of focus to help guide health promotion programming in the coming year. These topics include:
        - Bolstering socio-emotional competence and wellness
        - Promoting behavioral health literacy
        - Preventing social isolation and deaths by suicide
        - Substance use and overdose prevention
- BHS also continues to emphasize the importance and benefits of tailoring engagement opportunities to the unique experiences of groups of shared social identity.

Area 4: Crisis Response Services

Participants consistently emphasized the importance of shifting away from models with law enforcement as the primary responder for behavioral health crises. They advocated for peers and behavioral health professionals to respond, when appropriate, with an emphasis on delivering recovery-focused care, to de-escalate situations where individuals are experiencing emotional distress. While community perception of the County Mobile Crisis Response Team (MCRT) program appears to be positive as people experience its impact firsthand, some stakeholders noted challenges in communication, coordination, and accessibility. Systemic shortages, such as the low availability of behavioral health professionals to staff MCRTs, were noted. Participants also

identified the need for enhanced law enforcement training around behavioral health conditions and highlighted the importance of addressing racial disparities, particularly for the Black, Indigenous, and people of color (BIPOC) population who experience heighted control measures or are perceived to be dangerous by law enforcement.

Community Recommendations

To improve behavioral health crisis response, stakeholders provided the following recommendations:

- Expand the Psychiatric Emergency Response Teams (PERTs) and Mobile Crisis Response Teams (MCRTs). PERT and MCRT programs include personnel with specific training in behavioral health. They improve collaboration between the behavioral health and law enforcement systems to de-escalate situations and connect individuals to the care that they need.
- Ensure more immediate service access to 24/7 Drop-in Centers and CSUs to support individuals in crisis.
- Expand harm reduction services.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve crisis response services:

- More than **40 MCRTs are available countywide** with response times generally less than an hour and teams operational 24 hours a day, 7 days a week.
- As of November 2024, **MCRTs are responding to schools**, including charter, adult, and public-school districts in San Diego County (grades K-12) and school personnel may contact MCRT directly.
- Community-based **crisis response panel presentations** are being coordinated on an ad-hoc basis to promote availability of services and to explain to community members how different crisis response services interact and complement each other.

Area 5: Culturally Appropriate and Affirming Care

Participants identified the need for culturally appropriate and affirming community-based services and supports. Cultural competency was raised as a critical factor in ensuring behavioral health services can effectively meet the diverse needs of people within the community. Community members emphasized a desire for programs to be tailored to respect cultural practices, chosen families, and community connections to build rapport, enhance relevancy, and increase accessibility to care. Stakeholders highlighted the importance of family-oriented behavioral health care and community support systems.

Faith-based communities were also identified as critical in helping address gaps across behavioral health care, particularly for populations where stigma remains a significant barrier to individuals seeking care. They highlighted the need to explore strategies to integrate community-led initiatives into formal systems to create more inclusive, person-centered care.

Lastly, informal peer relationships and community engagement events were deemed important contributors to behavioral health support. Behavioral health fairs and similar events offer opportunities for community members to connect, collaborate, and learn about available resources.

Community Recommendations

To improve culturally appropriate and affirming care, stakeholders provided the following recommendations:

- Enhance culturally appropriate services to better serve diverse populations.
- Offer cultural humility training for behavioral health practitioners to foster understanding and respect for the diverse communities they serve.
- Hire more bilingual staff, including translators and ASL interpreters, to better meet the needs of people receiving care.
- Utilize cultural liaisons to build rapport and understanding with communities.
- Increase support for immigrant and refugee communities.
- Increase support to parents and other adults in parenting and caregiving roles.
- Collaborate with community-based and faith-based organizations to create programming.
- Expand resources and services available in multiple languages to enhance accessibility.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 related to culturally appropriate and affirming care. These include:

- An **Emotional Wellness & Self-Care educational program** was piloted to deliver culturally sensitive and responsive interventions to refugee children and families transitioning to the region. The program provided emotional support and helped to prevent acute and chronic negative mental health outcomes following an individuals' transition to the region. The program was delivered by community Afghan leaders, health educators/navigators and/or cultural brokers in Pashto, Farsi and Dari.
- Afghan cultural brokers and community leaders involved with BDB outreach and education efforts also led **peer support groups and workshops** with refugee communities. These efforts started gathering feedback from community listening sessions and engagement with local groups, including El Cajon Collaborative, International Rescue Committee, and Afghan Family Services. Embedding community leadership into service delivery in this way has helped to expand behavioral health access**.**
- **BHS community health workers (CHWs)** were hired for the first time to conduct outreach and education activities and share information on behavioral health topics and services. These include suicide prevention and mental wellness, crisis services such as San Diego Access & Crisis Line, MCRTs, PERTs, and CSUs, and education for youth, their parents and caregivers, and other education sectors. CHWs also disseminated **information about behavioral health programs**, including the Community Assistance, Recovery, and Empowerment (CARE) Act Program, County-operated outpatient behavioral health centers, and naloxone administration.

Area 6: Support for People Experiencing Homelessness

Participants identified the need for additional housing and support for people experiencing homelessness who have behavioral health conditions. Unhoused populations face unique challenges in engaging in treatment, and for many who face a daily struggle to secure food and shelter, attending healthcare appointments or following through with care plans is not the priority. This can result in people deprioritizing their care needs, experiencing difficulty in taking consistent medications, and conditions rapidly worsening. Overall, recommendations aimed to improve quality of live and housing stability for people experiencing homelessness.

Community Recommendations

To improve access to behavioral health care and housing for people experiencing homelessness, stakeholders provided the following recommendations:

- Increase availability of services to support basic needs, including food, shelter, and clothing.
- Expand job and workforce opportunities to help people gain employment and financial stability.
- Increase supportive housing options and utilizing single-point housing navigators to secure housing.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve access to care and housing for people experiencing homelessness:

- To improve service delivery, BHS established the **Housing & Homelessness Services unit**, which provides oversight of County-funded programs that provide behavioral health care and housing to people experiencing homelessness.
- Planning is underway within BHS to integrate the new **BHSA Housing component** that will be established under the BHSA. This will allocate 30% of County BHSA funding for housing interventions to support people with behavioral health needs who are homeless or at risk of homelessness.

Area 7: Services for Youth and Transition Age Youth (TAY)

Participants identified services for youth and transition age youth (TAY) as an urgent priority. A need for more comprehensive support and education on mental health and substance use, including enhanced behavioral health education in schools, is needed. As mental health challenges continue to rise among young people, expanded mental health and substance use educational efforts are important to raise awareness at an early age. This includes prevention education on topics such as vaping and marijuana use to reduce these behaviors among youth.

Participants highlighted that the disconnect between education and employment often places youth in vulnerable situations that can lead to poor outcomes later in adulthood. They also noted challenges for TAY in navigating and accessing care within the local system where services may be

categorized within children and adult cohorts, creating a gray area for TAY who may not fall into either.

Community Recommendations

To improve access to behavioral health care for youth and TAY, stakeholders provided the following recommendations:

- Ensure children, youth, and family constituents who are accessing services have opportunities to engage in spaces that are accessible and comfortable for them and consider their needs and preferences.
- Increase awareness and promotion of available services for youth and TAY populations to encourage help-seeking, self-sufficiency, and well-being.
- Bolster workforce development efforts, including those focused on service provision for children ages 0-5 to address infant and early child mental health.
- Enhance mental health services within schools by adding more counselors and therapists, bolstering mental health curriculum, and promoting opportunities for parents and caregivers of students to become involved.
- Review community-based programs at the regional and state level and explore strategies to implement and scale-up evidence-based programs with positive outcomes.
- Develop a resource directory tailored for TAY to support them in accessing the care that they need.
- Increase workshops and other educational opportunities for youth and their families to learn about behavioral health concerns, healthy coping strategies, and available resources to address them.
- Expand efforts to reduce vaping and marijuana use among youth.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve the access to care for youth and TAY. These include:

- ***Own Your Mindset*** (www.OwnYourMindset.org) is a new youth public messaging brand, informed and developed in collaboration with local youth, youth-led, and youth-serving organizations, to help reduce stigma and promote open discussions among youth around their mental health. Released in the last year, brand content focuses on elevating simple, tangible tips and tools for teens to help them explore their feelings and encourage agency and ownership of their emotional well-being. Activities promote the importance of mental health "check-ins" and resources to help youth identify common signs that may indicate they could benefit from mental health support, whether from a trusted individual in their social circle or a trained behavioral health expert.
- Additional **local youth-oriented public messaging for suicide prevention** is forthcoming to complement *Never A Bother* resources released by the California Department of Public Health earlier this year.
- **Enhancements to health education and health promotion**, including workshops for youth, TAY, and their parents and caregivers is also anticipated in 2025. Programming will

include new *It's Up to Us "Let's Talk About…"* community events to continue to encourage people to talk openly about behavioral health topics, challenges, and needs, promote local organizations and available resources to support wellness, and reduce stigma through community dialogues.

- ***"What I Wish My Parents Knew"* forums** will be held in collaboration with various community-based partners that emphasize youth training, conflict communication and resolution, and encourage youth to openly discuss issues that may be causing them anxiety or distress.
- Enhancements to existing **youth-directed mental health resources,** such as the Organized Support Companion in an Emergency Room Junior (oscER, Jr.) mobile app, are also planned. Designed for youth, oscER, Jr. provides emergency guidance and help resources to children who are relatives or friends of an individual suffering from a mental illness.
- **Screening to Care (S2C)** efforts continue, in collaboration with the San Diego County Office of Education, with regional contractors providing support in all service regions of the county. S2C provides universal screenings for middle school students to determine socioemotional needs and provides therapeutic interventions.
- In the coming year, BHS will also develop a **Children, Youth, and Transition Age Youth Behavioral Health Continuum Framework** for those across the 0 to 25 age continuum, consistent with previous work performed on the BHS adult-focused Optimal Care Pathways (OCP) Model. The framework leverages available data to help quantify optimal service levels and inform a comprehensive long-term plan to address identified gaps in services. Efforts will be in collaboration with other HHSA departments and integrate community input and feedback.

Area 8: Workforce Capacity and Diversity

Participants identified workforce capacity and diversity as a major ongoing priority within the local public behavioral health system. Stakeholders highlighted opportunities for better cultural representation across mental health and substance use service providers, ensuring staff are reflective of the communities they serve. Some participants expressed that providers may lack experience to serve diverse communities effectively and in a culturally responsive manner. Increased representation is pivotal to building trust and fostering inclusivity in service delivery.

Participants also noted the importance of a workforce that includes individuals with lived experience who are uniquely positioned to provide support to clients who are navigating the behavioral health system of care. Peer support models hold immense value in that they foster connection, reduce stigma, and enrich care models.

The public behavioral health system of care has continued to experience high turnover rates, staff burnout, lack of competitive pay, inadequate staffing ratios, and limited resources to support workforce training, many of which were highlighted in the *Addressing San Diego's Behavioral Health*

Worker Shortage report published in August 2022. This workforce shortage continues to remain a challenge in supporting continuity of care and coordination between services for stakeholders.

Community Recommendations

To improve workforce capacity and diversity efforts within the local public behavioral health system, stakeholders provided the following recommendations:

- Utilize peers and other community experts with lived experience, such as CHWs and Promotores in Spanish-speaking communities.
- Hire a more diverse array of behavioral health practitioners.
- Maximize partnerships with community-based organizations who provide mild-to-moderate mental health and/or other social service supports.
- Maintain more community-based dissemination points and co-locating resources in locations where community members congregate.
- Train and compensate community experts who are culturally representative and self-identify with particular communities to educate those communities, provide tailored outreach and education, and address language barriers.
- Integrate more effectively into community services to improve outcomes for clients navigating behavioral health and justice systems.

Departmental Updates & Anticipated Opportunities

Below are highlights on efforts in FY 2024-25 to improve the public behavioral health workforce. These include:

- Onboarding the administrator for the **MHSA Public Behavioral Health Workforce Development and Retention Program Innovation Program** in October 2024, which will establish an outcomes-based renewable training and tuition fund and an upskilling program to support people in the public behavioral health in advancing their career path.
- A new **Medi-Cal Training and Technical Assistance Program** to engage and equip small and minority-owned community-based organizations to deliver Medi-Cal funded mild-to-moderate mental health and substance use care to improve health outcomes for the BIPOC population. Focus groups and other community engagement events will occur in 2025.

Looking Ahead

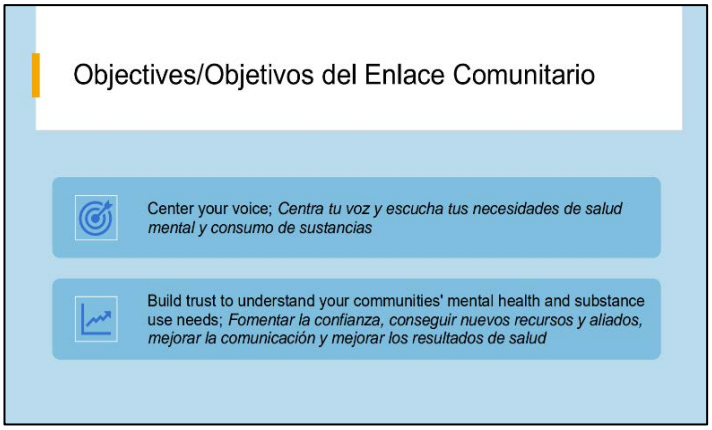
Although great strides have been made in enhancing community engagement and participation to ensure services meet the needs of the diverse local community, there are still opportunities to expand within existing places that facilitate participation and representation of underserved, unserved, and hard-to-reach communities. BHS continues to prioritize innovative community engagement approaches to facilitate stakeholder collaboration, education, involvement, and feedback in order to meet the unique needs of the community. This includes tailored outreach to communities of shared identity to uplift their voices.

In response to significant State and federal policy changes, changes across HHSA and the broader County enterprise, and feedback from the community, BHS continues to streamline and optimize community engagement activities. While the new BHSA will require changes to funding allocations, service requirements, and the CPP process, it also presents an opportunity to re-evaluate stakeholder engagement activities to support more cohesive and inclusive community collaboration. Over the next several months, BHS will be working closely with department councils and collaboratives, community-based organizations, contractors, and other stakeholders to design and refine opportunities focused on continuing to address the recommendations in this report and improving community engagement strategies.

APPENDICES

Appendix Guide

Appendix A: Listening Session Presentation



Appendix A: Listening Session Presentation *(continued)*

Conversation #1

What are the **most pressing or high priority issues** related to mental health or substance use in your community?

Conversación #1

¿Cuáles son los problemas más apremiantes o de mayor prioridad relacionados con la salud mental o el consumo de sustancias en su comunidad?

Conversation #2

What are the **biggest challenges/barriers to accessing resources** for mental health or substance use in your community?

Conversación #2

¿Cuáles son los mayores desafíos/barreras para acceder a recursos para la salud mental o el uso de sustancias en su comunidad?

Conversation #3

What **mental health and substance use activities and programs** would you like to see in your community?

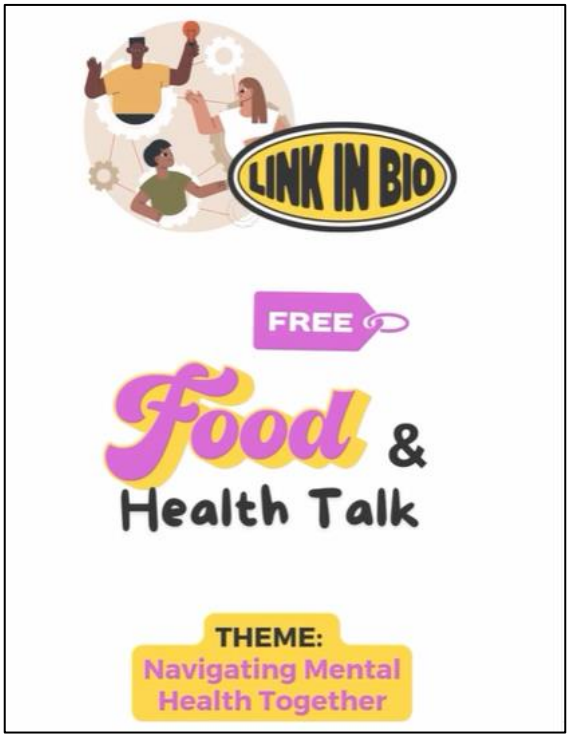
Conversación #3

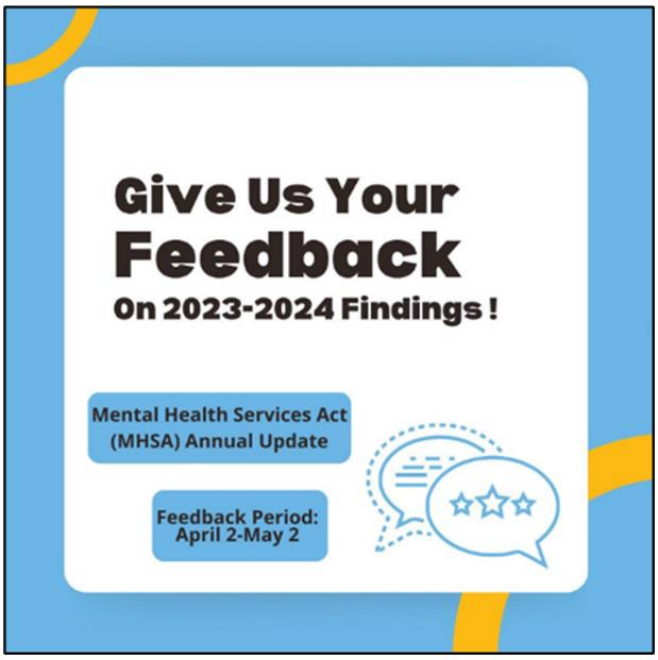
¿Qué actividades y programas de salud mental y abuso de sustancias le gustaría ver en su comunidad?

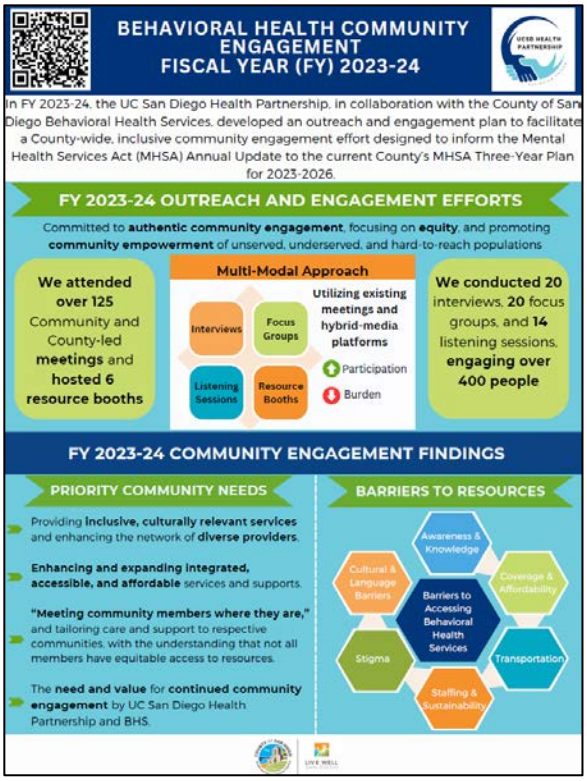
Appendix A: Listening Session Presentation *(continued)*

Appendix B: Social Media Posts/Promotional Outreach

Figure B1. Promotional Instagram Posts (Instagram: @ucsd.hp)

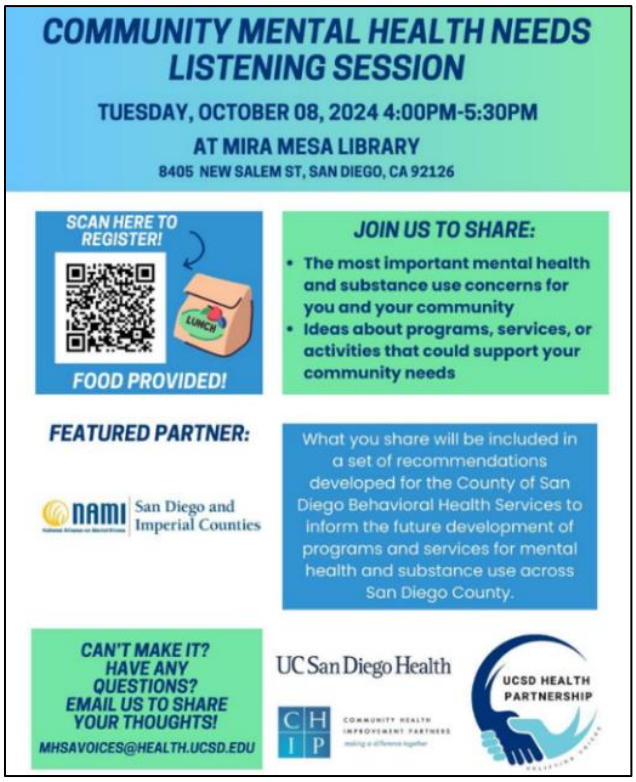


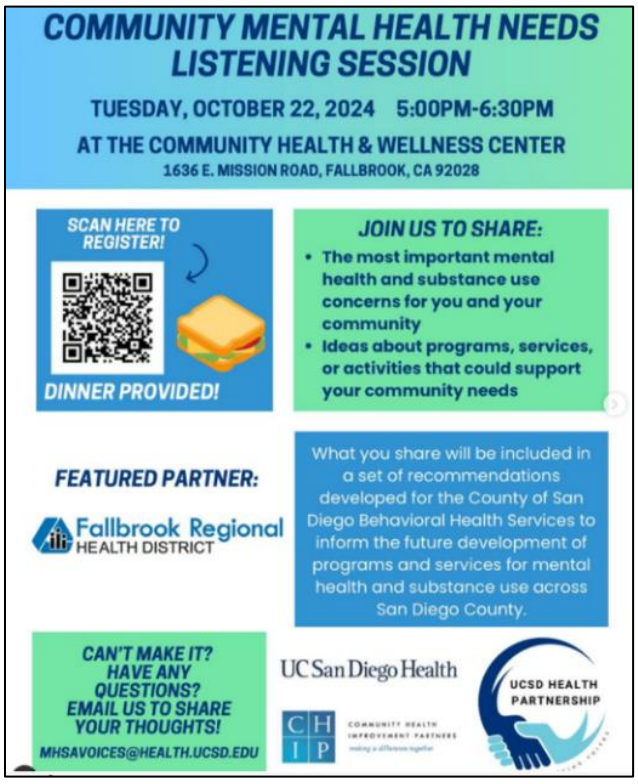




Appendix B: Social Media Posts/ Promotional Outreach *(continued)*

Figure B2. Promotional Flyers/Instagram Posts (Instagram: @ucsd.hp)






COMMUNITY MENTAL HEALTH NEEDS LISTENING SESSION
TUESDAY, NOVEMBER 5, 2024 11:00 AM-1:00 PM
AT LAUDERBACH CENTER
333 OXFORD ST CHULA VISTA, CA 91911
SCAN HERE TO REGISTER!
FOOD PROVIDED!
JOIN US TO SHARE:
• The most important mental health and substance use concerns for you and your community
• Ideas about programs, services, or activities that could support your community needs
• Session will be held in Spanish*
FEATURED PARTNER:
STRENGTHENING SBCS COMMUNITIES
What you share will be included in a set of recommendations developed for the County of San Diego Behavioral Health Services to inform the future development of programs and services for mental health and substance use across San Diego County.
CAN'T MAKE IT? HAVE ANY QUESTIONS? EMAIL US TO SHARE YOUR THOUGHTS!
MHSAVOICES@HEALTH.UCSD.EDU
UC San Diego
SCHOOL OF MEDICINE
CHIP
COMMUNITY HEALTH IMPROVEMENT PARTNERS
UCSD HEALTH PARTNERSHIP


NECESIDADES DE SALUD MENTAL DE LA COMUNIDAD: UNA SESIÓN DE ESCUCHA
MARTES, 5 DE NOVIEMBRE DE 2024 11:00 AM -1:00 PM
EN EL CENTRO LAUDERBACH
333 OXFORD ST CHULA VISTA, CA 91911
¡ESCANEA AQUÍ PARA REGISTRARSE!
¡COMIDA PROPORCIONADA!
ÚNETE CON NOSOTROS PARA COMPARTIR:
• Las preocupaciones más importantes sobre la salud mental y el consumo de sustancias para usted y su comunidad
• Ideas sobre programas, servicios o actividades que podrían apoyar las necesidades de su comunidad
SOCIO DESTACADO:
STRENGTHENING SBCS COMMUNITIES
Lo que usted comparte se incluirá en un conjunto de recomendaciones desarrolladas para los Servicios de Salud Conductual del Condado de San Diego para informar el desarrollo futuro de programas y servicios para la salud mental y el uso de sustancias en todo el Condado de San Diego.
¿NO PUEDES VENIR? ¿TIENES ALGUNA PREGUNTA? ¡ENVÍANOS UN CORREO ELECTRÓNICO PARA COMPARTIR TUS PENSAMIENTOS!
MHSAVOICES@HEALTH.UCSD.EDU
UC San Diego
SCHOOL OF MEDICINE
CHIP
COMMUNITY HEALTH IMPROVEMENT PARTNERS
UCSD HEALTH PARTNERSHIP

Appendix C: Activities for Stakeholder Input

Interviews		
Description	**Date**	**Engagement Site/ City**
Staff Member from Grow Lead Motivate (GLM) House	08/06/2024	Lemon Grove Café *HHSA East Region*
Staff Member from The Gooden Center	08/07/2024	Virtual *HHSA North, East, & Central Regions*
Staff Member from Disabled in Higher Education	08/08/2024	Virtual *HHSA South Region*
Staff Member from Interfaith Community Services	08/09/2024	Kensington Café *HHSA All Regions*
Staff Member from Continuum of Care/Homelessness Hub	08/15/2024	Virtual *HHSA North & Central Regions*
Staff Member from Inspired Mind	08/19/2024	Virtual *HHSA North & Central Regions*
Staff Member from Homeless-experienced Advocacy and Leadership (HEAL) Network	08/29/2024	Virtual *HHSA Central Region*
Staff Member from San Diego Unhoused Collective	08/30/2024	House of Black Coffee Company *HHSA North Inland Region*
Staff Member from the Disabled LGBTQ+ Coalition	09/11/2024	Virtual *HHSA North Central Region*
Interview with Staff Member from Recovery International	10/24/2024	San Diego *HHSA Central Region*
Focus Groups		
Description	**Date**	**Engagement Site/ City**
Peer Specialists of California	08/13/2024	San Diego *HHSA All Regions*
Rady Children's Hospital Staff	08/27/2024	Virtual *HHSA North Coastal Region*
Telecare Service Providers to Older Adults with Serious Mental Illness	09/18/2024	Virtual *HHSA All Regions*
Telecare – Mobile Crisis Resource Team (MCRT) Staff	09/25/2024	San Diego *HHSA Central Region*
Somali Family Services (SFS)	10/03/2024	SFS of San Diego *HHSA East Region*
San Diego Rescue Mission	10/09/2024	Virtual *HHSA Central Region*
Focus Group with Jewish Family Service – Patients	10/28/2024	Jewish Family Service of San Diego *HHSA North Central Region*
Focus Group with Jewish Family Service – Administration & Outreach Staff	10/28/2024	Jewish Family Service of San Diego *HHSA North Central Region*

Appendix C: Activities for Stakeholder Input *(continued)*

Listening Sessions		
Description	**Date**	**Engagement Site/ City**
Central Region Listening Session with Grama Blue's House Inc.	09/28/2024	City Heights/Weingart Library *HHSA Central Region*
San Diego Community College Listening Session	10/03/2024	Classroom at San Diego City College *HHSA Central Region*
North Central Listening Session with National Alliance on Mental Illness (NAMI) Next Steps	10/08/2024	San Diego *HHSA North Central Region*
Justice Involved Listening Session with Health SD Justice Involved Meeting	10/16/2024	Virtual *HHSA All Regions*
North Region Listening Session with Spotlight Partner: Fallbrook Regional Health District	10/22/2024	Community Health and Wellness Center *HHSA North Inland Region*
Listening Session with Diverse Research Now	10/24/2024	Church of Nazarene *HHSA Central Region*
South Region Listening Session with SBCS Promise Neighborhoods	11/05/2024	Lauderbach Center *HHSA South Region*
Mental Health Ministries Listening Session	11/19/2024	Good Shepard Catholic Church *HHSA North Central Region*
Better Cuts Therapy Listening Session	11/21/2024	Southeastern Live Well Center *HHSA Central Region*
Resource Booths		
Description	**Date**	**Engagement Site/ City**
Community Health and Resource Fair	09/04/2024	Jackie Robinson Family YMCA *HHSA Central Region*
Annual Walk in Remembrance with Hope	09/08/2024	Balboa Park *HHSA Central Region*
Mental Health America Meeting of the Minds Behavioral Health Conference	10/10/2024	Marina Village Conference Center *HHSA North Central Region*
Out of the Darkness San Diego Walk	10/19/2024	Naval Training Center Park *HHSA Coastal Region*
Live Well Advance Conference & School Conference	11/21/2024	San Diego Convention Center *HHSA Central Region*

Appendix D: Partner Organizations for Input Activities

Figure D1. Partners Featured During Listening Sessions

Better Cuts Mental Health Alliance - By integrating mental health advocacy into the barbershop experience, this organization aims to break down barriers and provide essential resources through safe spaces created by trauma-informed barbers within Black and Brown communities. In November, a listening session was held in collaboration with Better Cuts Mental Health Alliance.

Diverse Research Now Inc. - Nonprofit organization aims to empower historically underrepresented communities by bridging the gap in clinical research diversity and ensuring that these communities have a voice in advancing medical discoveries. In November, a listening session was held in partnership with Diverse Research Now Inc.

Fallbrook Regional Health District - A single-function, non-enterprise, independent government agency serving the evolving health and wellness needs of the community with a Community Health & Wellness Center serving as a hub for District Health & Wellbeing Programs. In October, a bilingual listening session was held in collaboration with Fallbrook Regional Health District.

Grama Blue's House - Nonprofit organization created to provide support, counseling, resources, and a place of healing to women with co-occurring disorders and substance misuse. UC San Diego Health Partnership collaborated with Grama Blue's House to host a listening session in the Central region of San Diego in September.

Healthy San Diego Justice-Involved Workgroup - A workgroup dedicated to addressing issues raised by the criminal justice sector and justice-involved population. In October, a listening session was held during a monthly meeting to engage the justice-involved stakeholders in attendance.

Mental Health Ministry Network - A network of active ministries with mental health leaders who supply prayer, accompaniment, and human connections to supplement the treatment of mental illness. In November, a bilingual listening session was held in one of the active parishes.

NAMI Next Steps - Working in partnership with San Diego County Psychiatric Hospital and BHS, NAMI Next Steps is a recovery-oriented peer and family support program that provides outreach and engagement to help access behavioral health services as needed. In October, UC San Diego Health Partnership collaborated with NAMI Next Steps to host a listening session in the North Central region of San Diego.

San Diego City College - A community college located in Downtown San Diego. In October, the UC San Diego Health Partnership held a listening session in a classroom at San Diego City College with college students training to work in the behavioral health sector.

SBCS (formerly South Bay Community Services) - A community-based nonprofit organization that transforms communities to support the well-being and prosperity of children, youth, and families throughout San Diego County. UC San Diego Health Partnership collaborated with SBCS to host a Spanish-led listening session in the South region of San Diego.

Figure D2. Partners Featured During Focus Groups

- **Jewish Family Service (JFS)** - is currently considered one of San Diego's most impactful nonprofit human services agencies, providing compassionate care and supportive services to more than 70,000 people every year. The services provided by JFS range from patient advocacy to running safe parking lots.
- **Peer Professionals of California** - is a 501(c)(3) nonprofit community-based organization that provides services to communities in need. Their services address the justice-involved, peer support, and community health needs throughout San Diego County.
- **Mobile Crisis Response Team (MCRT)** - is a 24/7 county-wide alternative to law enforcement response with teams comprised of behavioral health experts who are trained to respond in the community and de-escalate crises related to alcohol, drugs, or mental health conditions.
- **Rady Children's Hospital Clinic** – is located in Escondido and provides services to the communities in the North County, from Poway, San Marcos, and Julian to Borrego Springs, and also Pauma Valley. The clinic provides urgent care services along with psychiatric care.
- **San Diego Rescue Mission** – provides meals, shelter, clothing, education, and job-skills training for men, women, and single parents with children experiencing homelessness. The services provided by San Diego Rescue Mission vary from emergency shelters, to services for children, to mobile shower trailers.
- **Somali Family Services (SFS)** – is a community-based social service organization that provides culturally and linguistically appropriate programs and services to refugee and immigrant communities of San Diego. SFS provides services in English, Somali, Swahili, Arabic, and Farsi.
- **Telecare AgeWise** – is an older adult case management services program that collaborates with primary care physicians and coordinates with home health agencies, senior centers, and other community resources for older adults to ensure they get the most comprehensive care possible.

Appendix E: Stakeholder Data & Demographics

Table E1. Characteristics of Persons Participating in Input Activities

Age Group	**N=111**	**%**
16-25 years old	3	2.7%
26-59 years old	65	58.6%
60 years old and over	36	32.4%
Prefer not to answer	7	6.3%
Race/Ethnicity[1]	**N=108**	**%**
Another Hispanic, Latino/a, or Spanish origin	2	1.9%
Black or African American	14	13.0%
Filipino	8	7.4%
Filipino, Native Hawaiian	1	0.9%
Hispanic, Latino/a, or Spanish origin: Mexican, Mexican American, or Chicano	56	51.9%
Native or Indigenous American	1	0.9%
Samoan	1	0.9%
Vietnamese	1	0.9%
White	20	18.5%
Race or ethnic identity not captured above	1	0.9%
Prefer not to answer	3	2.8%
Primary Language	**N=110**	**%**
English	64	58.2%
Farsi	1	0.9%
Spanish	42	38.2%
Tagalog	2	1.8%
Vietnamese	1	0.9%
Veteran Status	**N=106**	**%**
Yes	6	5.7%
No	96	90.6%
Other	2	1.9%
Prefer not to answer	2	1.9%
Sex Assigned at Birth	**N=107**	**%**
Female	85	79.4%
Male	22	20.6%

Table E1. Characteristics of Persons Participating in Input Activities *(continued)*

Gender	**N=110**	**%**
Female	87	79.1%
Male	21	19.1%
Genderqueer/gender non-conforming	2	1.8%
Sexual Orientation	**N=95**	**%**
Bisexual/pansexual/sexually fluid	2	2.1%
Gay or Lesbian	2	2.1%
Queer	2	2.1%
Heterosexual or straight	81	85.3%
Prefer not to answer	8	8.4%
Disability[1]	**N=108**	**%**
Has some form of disability	39	36.1%
Does not have a disability	64	59.3%
Prefer not to answer	5	4.6%
Additional Groups with Whom Participants Identify	**N=92**	**%**
African	3	3.3%
Homeless	1	1.1%
Immigrant	33	35.9%
LGBTQIA+	4	4.3%
Refugee/Newcomer	1	1.1%
Veterans/Military	5	5.4%
Other groups not mentioned above	4	4.3%
Do not identify as any of these additional groups	33	35.9%
Prefer not to answer	8	8.7%

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

APPENDIX H

MHSA ISSUE RESOLUTION PROCESS

Mental Health Services Act Issue Resolution Process

Updated August 2024

Purpose:

This procedure supplements the Department of Health Care Services (DHCS) Beneficiary Problem Resolution Process and local policies which provide detailed guidelines for the County of San Diego (County) Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) contracted Patient Advocacy program in addressing grievances and appeals regarding services, treatment, and care provided by the Mental Health Plan and Drug Medi-Cal Organized Delivery System in alignment with DHCS contracts. In addition, this procedure provides a process for addressing issues, complaints, and grievances about Mental Health Services Act (MHSA) program planning process and implementation, as required per DHCS Performance Contract Exhibit A.

DHCS requires the counties' local MHSA issue resolution process be exhausted before accessing State venues, which include the Behavioral Health Services Oversight and Accountability Commission (BHSOAC) or the California Mental Health Planning Council (CMHPC) in addition to DHCS.

BHS has adopted an issue resolution process for clients, family members, providers, and/or community members in San Diego County to file and resolve issues that are related to the MHSA Community Program Planning process and ensure consistency between program implementation and approved plans.

BHS is committed to:

- Addressing issues regarding MHSA in an expedient and appropriate manner;
- Providing several avenues to file an issue, complaint, or grievance;
- Ensuring assistance is available, if needed, for the client, family member, provider, and/or community member to file their issue; and
- Honoring the issue filer's desire for anonymity.

Types of MHSA issues to be resolved in this process include:

- Appropriate use of MHSA funds.
- Allegations of fraud, waste, and abuse of funds are excluded from this process. Allegations of this type will be referred directly to the County Business Assurance and Compliance Office for investigation.
- Inconsistency between the approved MHSA Plan and its implementation.
- The San Diego County Community Program Planning Process pursuant to Welfare and Institutions Code Section 5848 (a).

Process:

- An individual may file an issue related to the MHSA planning process or MHSA Plan and/or its implementation, as well as a complaint or grievance related to any aspect of the Mental Health Plan and Drug Medi-Cal Organized Delivery System at any point and through any avenue within these systems of care. These avenues include, but are not limited to, the BHS Director, BHS Assistant Directors, BHS Deputy Directors, BHS Councils, County Business Assurance and Compliance Office, MHSA Issue Resolution Contact, Patient Advocacy Program, and BHS providers. Issues may be filed via letter, email, or phone.
- The MHSA issue shall be forwarded to the MHSA Issue Resolution Contact (IRC) listed below for review within three (3) business days of receipt.
- The IRC shall provide the Issue Filer a written acknowledgement confirming receipt of the issue, complaint, or grievance within two (2) business days.
- The IRC shall notify the BHS MHSA Coordinator of an issue received while maintaining anonymity of the Issue Filer within two (2) business days if BHS is not already in receipt of the issue, complaint, or grievance.
- If the issue does not fall within the scope of the MHSA Issue Resolution Process, the issue will be referred to other resources such as Patient Advocacy, Medi-Cal, and other State/Local resources that are appropriate to the issue and relevant timelines will then be followed.
- If the issue is within the scope of the MHSA Issue Resolution Process, the IRC will investigate the issue.
    - IRC may convene an MHSA Issue Resolution Committee (MIRC) whose membership includes unbiased, impartial individuals who are not employed by the County.
    - IRC will communicate with the Issue Filer every seven (7) business days while the issue is being investigated and resolved.
- Upon completion of the investigation, IRC shall issue a committee report to the BHS Director within 15 business days for awareness.
    - Report shall include a description of the issue, brief explanation of the investigation, IRC/MIRC recommendation, and the County resolution to the issue.
    - IRC shall notify the Issue Filer of the resolution in writing within sixty (60) calendar days of original receipt of the issue and provide information regarding the appeal process and State-level opportunities for additional resolution.
- If the filer does not agree with the local resolution, the filer may file an appeal with the following agencies at any time:

Behavioral Health Services Oversight and Accountability
Commission (BHSOAC)
1812 9th Street, Suite 1700
Sacramento, CA 95811

Phone: (916) 500-0577 Fax: (916) 623-4687
Email: bhsoac@bhsoac.ca.gov

California Behavioral Health Planning Council (CBHPC)
MS 2706
PO Box 997413
Sacramento, CA 95899-7413
Phone: (916) 701-8211 Fax: (916) 319-8030

California Department of Health Care Services (DHCS)
Department of Health Care Services Mental Health Services Division
Attention: MHSA Issue Resolution Process
1500 Capitol Avenue, MS 2702
P.O. Box 997413
Sacramento, CA 95899-7413
Email: mhsa@dhcs.ca.gov

The BHS Director will provide a quarterly MHSA Issue Resolution Report to the Behavioral Health Advisory Board.

Issue Resolution Contact (IRC):
Consumer Center for Health Education & Advocacy – CCHEA

Samantha Manganaro
110 S Euclid Avenue San Diego, CA 92114 (877) 534-2524
samantham@lassd.org

APPENDIX I

COMMUNITY SERVICES AND SUPPORTS (CSS) ANNUAL REPORT FY 2024-25

FY 2023-24 Community Services and Supports (CSS)

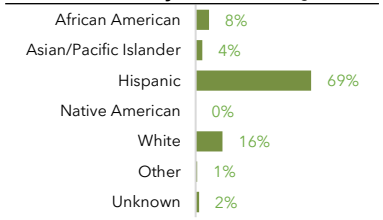
County of San Diego Behavioral Health Services

MHSA CSS Programs

Children & Youth – Full-Service Partnership (CY-FSP; n=7,373)

Living Situation	%
Children's Shelter	0%
Correctional Facility	1%
Foster Home	2%
Homeless	1%
House/Apartment	94%
Institutional	0%
Other/Unknown	2%

Race/Ethnicity (excludes missing/invalid)



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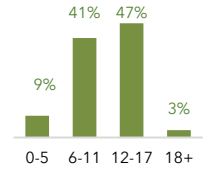
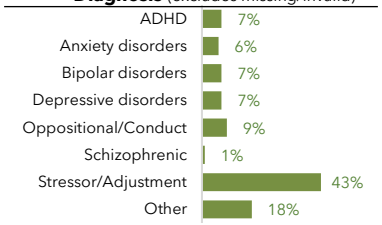
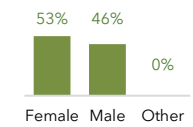


Language	%
Arabic	0%
English	84%
Farsi	0%
Spanish	15%
Tagalog	0%
Vietnamese	0%
Other/Unknown	1%

Diagnosis (excludes missing/invalid)



Gender



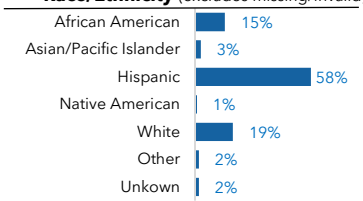
Children & Youth – Outreach and Engagement (CY-OE; n=0)

Total CSS Clients (unduplicated) N = 34,740

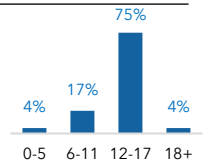
Children & Youth – System Development (CY-SD; n=2,844)

Living Situation	%
Children's Shelter	3%
Correctional Facility	25%
Foster Home	7%
Group Home	1%
Homeless	1%
House/Apartment	58%
Other/Unknown	5%

Race/Ethnicity (excludes missing/invalid)

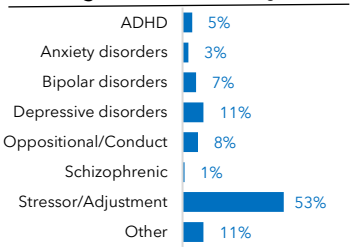


Age

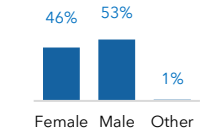


Language	%
Arabic	0%
English	91%
Farsi	0%
Spanish	6%
Tagalog	0%
Vietnamese	0%
Other/Unknown	2%

Diagnosis (excludes missing/invalid)

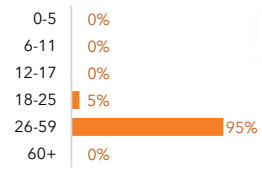


Gender

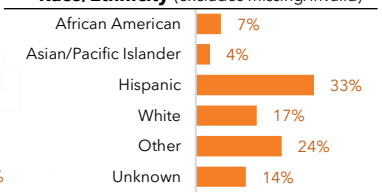


All CSS – Outreach and Engagement † (ALL-OE; n=139)

Age

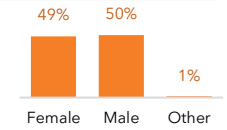


Race/Ethnicity (excludes missing/invalid)

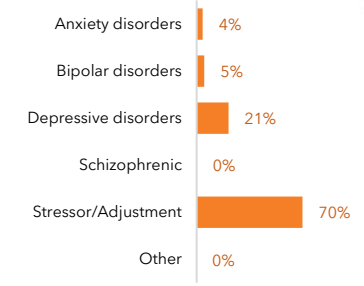


Living Situation	%
Board & Care	0%
Correctional Facility	0%
Homeless	7%
House or Apartment	92%
Institutional	0%
Other/Unknown	1%

Gender



Diagnosis (excludes missing/invalid)



Language	%
Arabic	10%
English	8%
Farsi	8%
Spanish	30%
Tagalog	0%
Vietnamese	0%
Other/Unknown	43%

† Clients may be duplicate

CSS Report Source: Optum | Data Source: Optum Monthly Data Extracts | Report Date: 10/07/2024.

Note: Clients may have received services from more than one CSS category within the fiscal year. Only CSS programs that enter data into Cerner Community Behavioral Health (CCBH) are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. Percentages may not add up to 100% due to rounding.

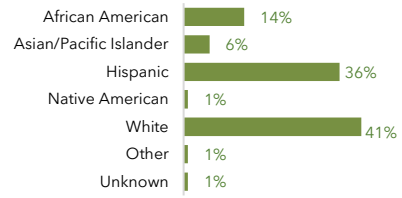
FY 2023-24 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

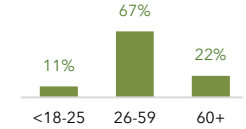
Transition Age Youth, Adult, Older Adult – Full-Service Partnership (TAOA-FSP; n=6,644)

Living Situation	%
Board & Care	13%
Correctional Facility	1%
Homeless	12%
House or Apartment	56%
Institutional	15%
Other/Unknown	3%

Race/Ethnicity (excludes missing/invalid)

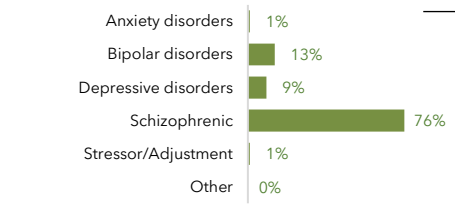


Age

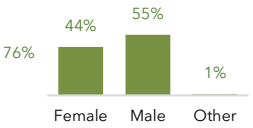


Language	%
Arabic	0%
English	90%
Farsi	0%
Spanish	8%
Tagalog	0%
Vietnamese	0%
Other/Unknown	1%

Diagnosis (excludes missing/invalid)



Gender



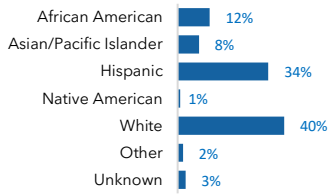
Transition Age Youth, Adult, Older Adult – Outreach and Engagement (TAOA-OE; n=0)

Total CSS Clients (unduplicated) N = 34,740

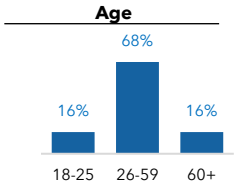
Transition Age Youth, Adult, Older Adult – System Development (TAOA-SD; n=15,790)

Living Situation	%
Board & Care	8%
Correctional Facility	1%
Homeless	19%
House or Apartment	65%
Institutional	3%
Other/Unknown	4%

Race/Ethnicity (excludes missing/invalid)

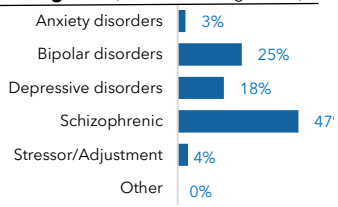


Age

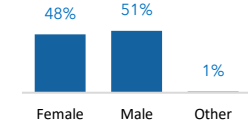


Language	%
Arabic	1%
English	88%
Farsi	0%
Spanish	6%
Tagalog	0%
Vietnamese	1%
Other/Unknown	3%

Diagnosis (excludes missing/invalid)

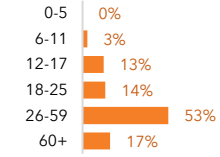


Gender

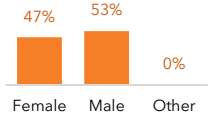


All CSS – System Development † (ALL-SD; n=9,367)

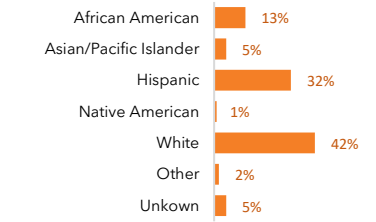
Age



Gender

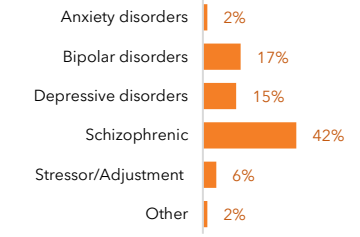


Race/Ethnicity (excludes missing/invalid)



Living Situation	%
Board & Care	3%
Correctional Facility	1%
Homeless	22%
House or Apartment	69%
Institutional	1%
Other/Unknown	4%

Diagnosis (excludes missing/invalid)



Language	%
Arabic	1%
English	92%
Farsi	0%
Spanish	5%
Tagalog	0%
Vietnamese	0%
Other/Unknown	2%

† Clients may be duplicate

CSS Report Source: Optum | Data Source: Optum Monthly Data Extracts | Report Date: 10/07/2024.

Note: Clients may have received services from more than one CSS category within the fiscal year. Only CSS programs that enter data into Cerner Community Behavioral Health (CCBH) are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. Percentages may not add up to 100% due to rounding.

APPENDIX J

FULL SERVICE PARTNERSHIP (FSP) OUTCOMES REPORT FY 2023-24 CHILDREN, YOUTH, AND FAMILIES

Full Service Partnerships OUTCOMES REPORT

Behavioral Health Services for Children and Youth ***FY 2023-24***

What Is This?

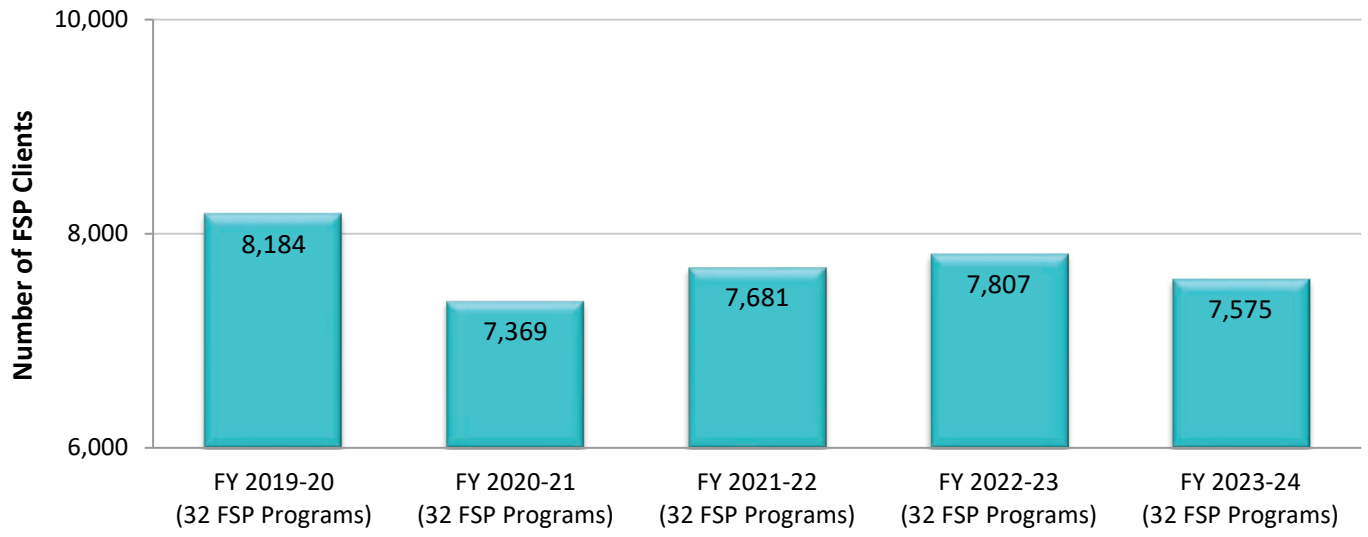
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals. Clients can access designated staff 24 hours a day, 7 days a week. FSP services address client and family needs through intensive services, supports, and strong connections to community resources with a focus on resilience and recovery. An FSP offers ancillary support(s), when indicated, provided by case managers, substance use disorder (SUD) counselors or certified peer specialists. Services are trauma-informed, with a recognition that a whole person approach is critical to promoting overall wellbeing. Emphasis on partnership with the family, natural supports, primary care, education, and other systems working with the family is a recognized core value.

Why Is This Important?

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

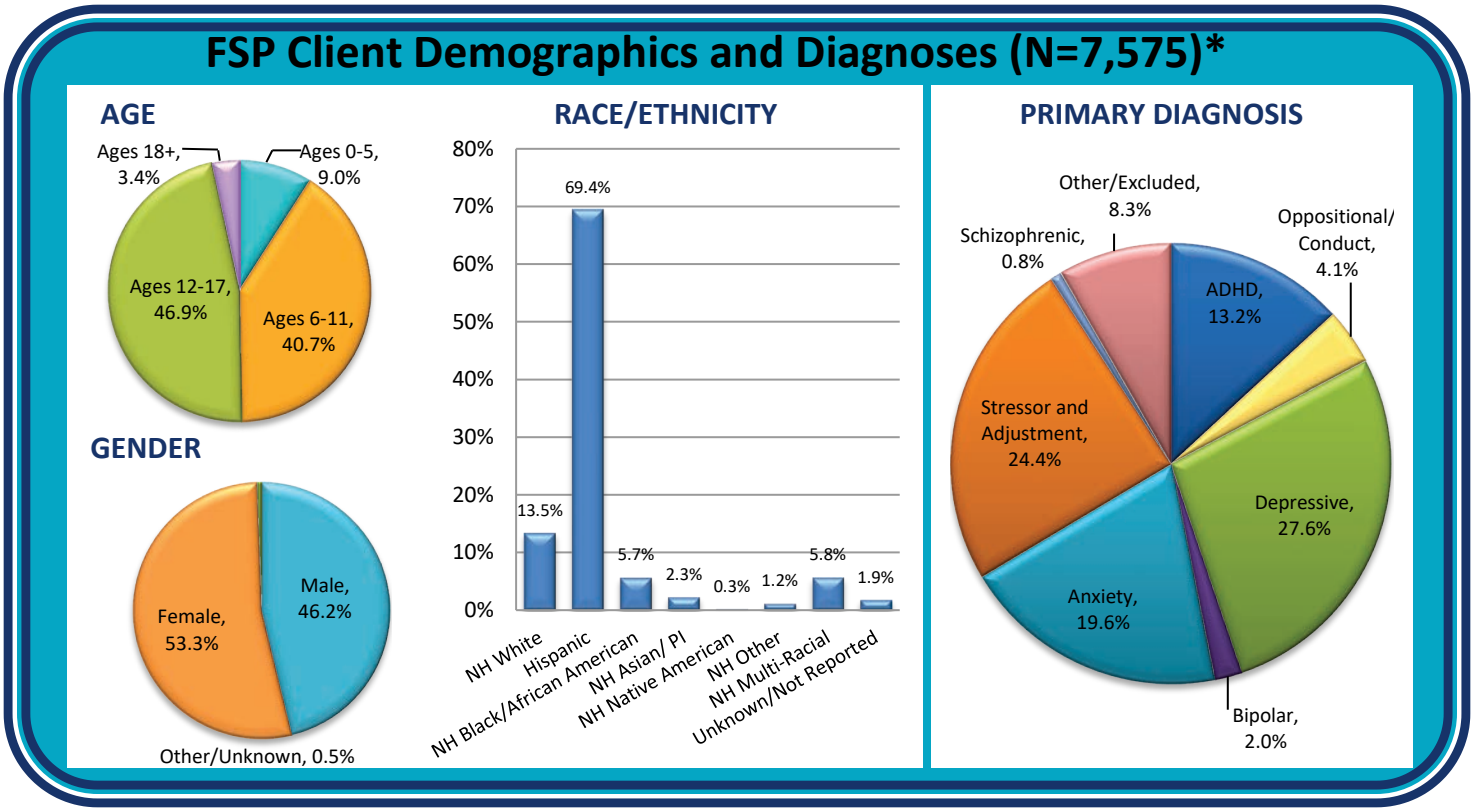
Who Are We Serving?

In Fiscal Year (FY) 2023-24, a total of 7,575 unduplicated clients received services at 32 Behavioral Health Services for Children and Youth (BHS-CY) FSP programs, a 3% decrease from 7,807 FSP clients served in 32 BHS-CY FSP programs in FY 2022-23.



Who Are We Serving?

In FY 2023-24, FSP clients were more likely to be female (53%), Hispanic (69%), and between the ages of 12 and 17 (47%). Depressive disorders were the most common diagnosis, affecting 28% of FSP clients.



**Data may differ from those reported elsewhere due to differences in download dates, recoding rules, and exclusion criteria.*
NOTE: Percentages may not add up to 100% due to rounding.

Data Collection and Reporting System (DCR)

FSP providers collected client and outcomes data using the California Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR). Referral sources were entered for new clients to FSP programs in FY 2023-24.

Referral Sources (N=3,875)

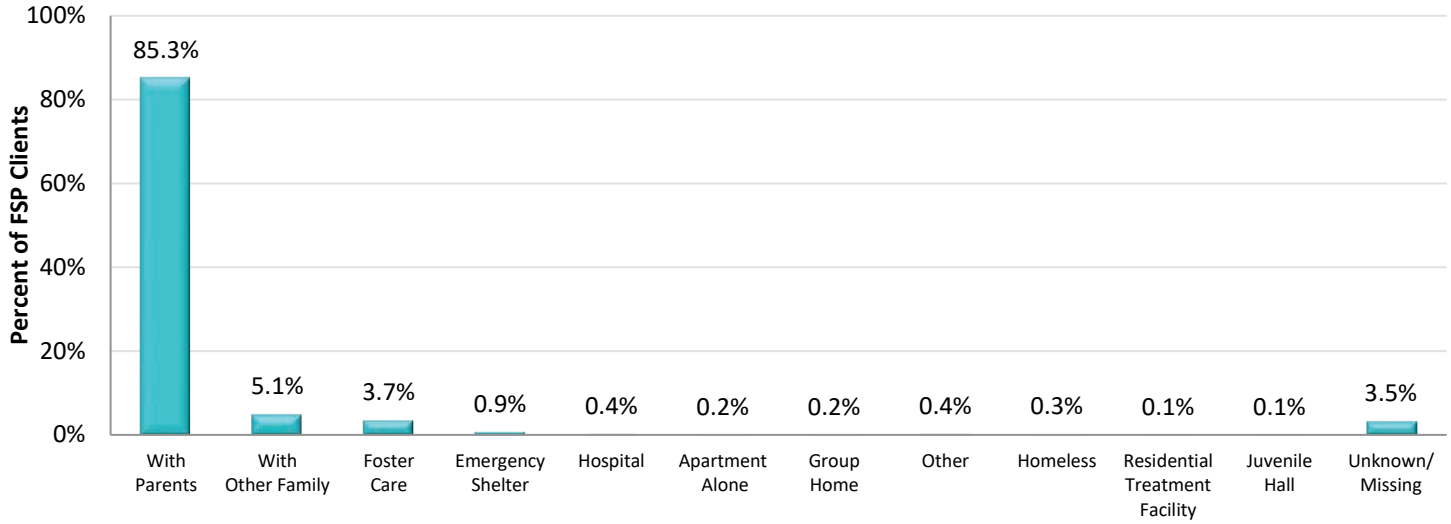
FSP referrals for clients with an intake assessment in FY 2023-24 were as follows (in order of frequency): school system (47%), family member (20%), primary care physician (10%), self-referral (7%), mental health facility (6%), social service agency (5%), other county agency (1%), Juvenile Hall (1%), acute psychiatric facility (1%), emergency room (1%), friend (<1%), homeless shelter (<1%), substance abuse treatment facility (<1%), and faith-based organization (<1%). The remaining 2% were referred by an unknown or unspecified source.

Who Are We Serving? (continued)

Living arrangement and risk factors were entered in the DCR for new clients to FSP programs in FY 2023-24.

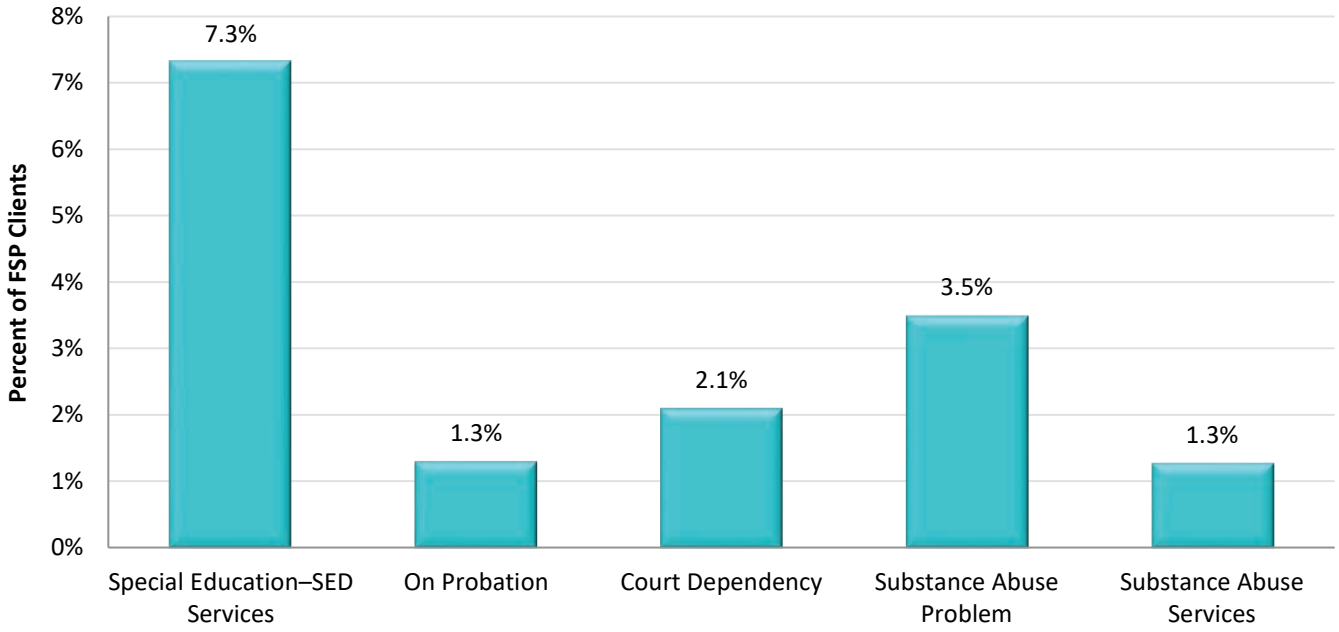
Living Arrangement at Intake (N=3,875)*

The majority (85%) of youth entering FSP programs were living with their parents.



Risk Factors at Intake (N=3,875)*

The most prevalent risk factor for more intensive service utilization among youth entering FSP programs was related to Special Education—Serious Emotional Disturbance (SED) Services. A total of 3,172 (82%) of new clients did not have a risk factor identified on the intake form. Clients with identified risk factors may have had more than one risk factor endorsed.



**Clients with intake assessment in the DCR within FY 2023-24.*
NOTE: Percentages may not add up to 100% due to rounding.

Who Are We Serving? (continued)

Client involvement in the juvenile justice sector and emergency service provision was tracked by FSP providers.

Forensic Services

In FY 2023-24, a total of 13 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of 7,575 unduplicated clients who received services from an FSP program in FY 2023-24, 291 (3.8%) had at least one inpatient (IP) episode and 425 (5.6%) had at least one Emergency Screening Unit (ESU) visit during the treatment episode.

Are Children Getting Better?

FSP providers collected outcomes data with the Pediatric Symptom Checklist (PSC), the Pediatric Symptom Checklist-Youth (PSC-Y), the Child and Adolescent Needs and Strengths (CANS), and the Child and Adolescent Needs and Strengths-Early Childhood (CANS-EC). Scores were analyzed for youth discharged from FSP services in FY 2023-24 who were in services at least 60 days, and who had both initial assessment and discharge scores completed. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP programs augmented with a SUD component in FY 2023-24, who were in services for at least one month.

FSP PSC Scores

The PSC measures a child's behavioral and emotional problems; it is administered to caregivers of youth ages 3 to 18, and to youth ages 11 to 18 (PSC-Y). Improvement on the PSC/PSC-Y is evaluated three ways:

Amount of Improvement

Percentage of all clients who reported an increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and a large improvement (9+ point reduction). This reflects the amount of change youth and their caregivers report from intake to discharge on the symptoms evaluated by the PSC/PSC-Y. Amount of improvement was calculated using Cohen's d effect size.

Reliable Improvement

Percentage of all clients who had at least a 6-point reduction on the PSC/PSC-Y total scale score. Reliable improvement was defined by the developers and means that the clients improved by a statistically reliable amount.

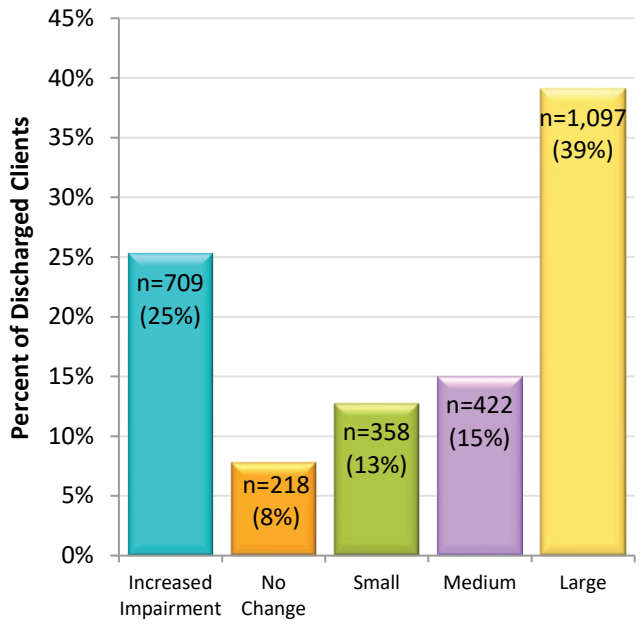
Clinically Significant Improvement

Percentage of clients who started above the clinical cutoff on at least one of the three subscales or total scale score at intake and ended below the cutoff at discharge. Additionally, these clients must have had at least a 6-point reduction on the PSC/PSC-Y total scale score. Clinically significant improvement was defined by the measures' developers and means that treatment had a noticeable genuine effect on clients' daily life and that clients are now functioning like non-impaired youth.

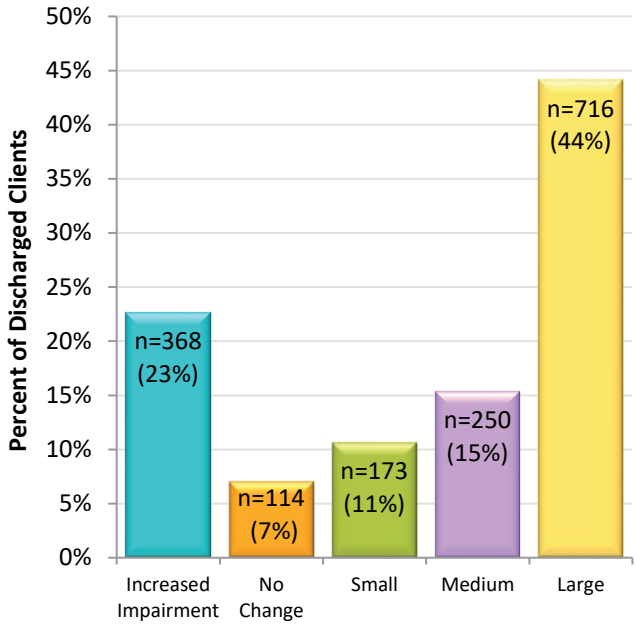
Are Children Getting Better? (continued)

PSC Amount of Improvement from Intake to Discharge

FSP Parent/Caregiver (N=2,804)

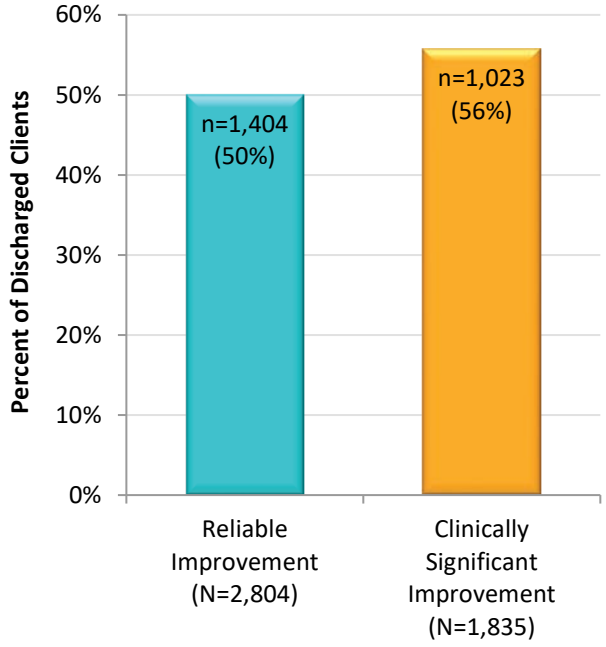


FSP Youth (N=1,621)

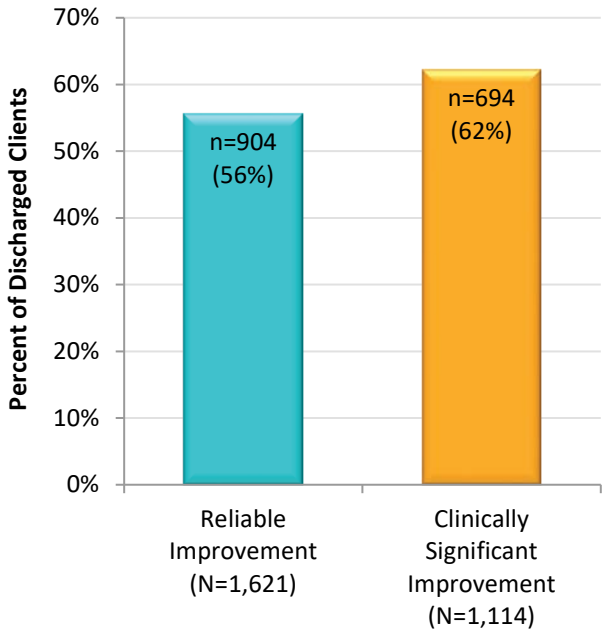


PSC Reliable and Clinically Significant Improvement from Intake to Discharge

FSP Parent/Caregiver



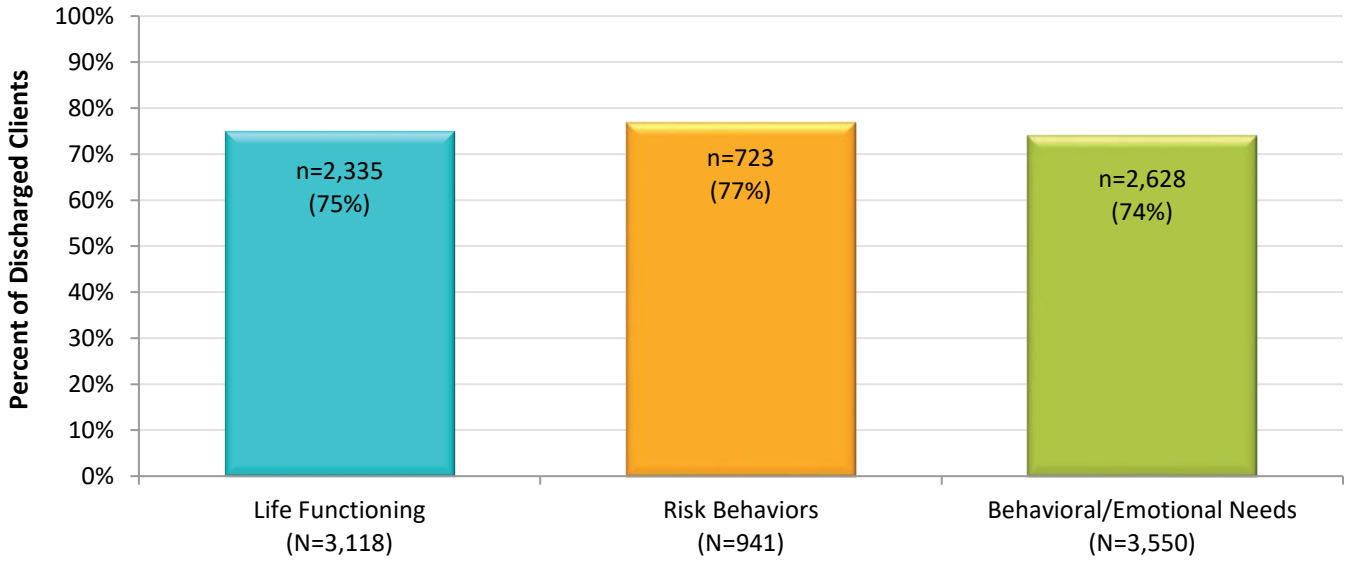
FSP Youth



Are Children Getting Better? (continued)

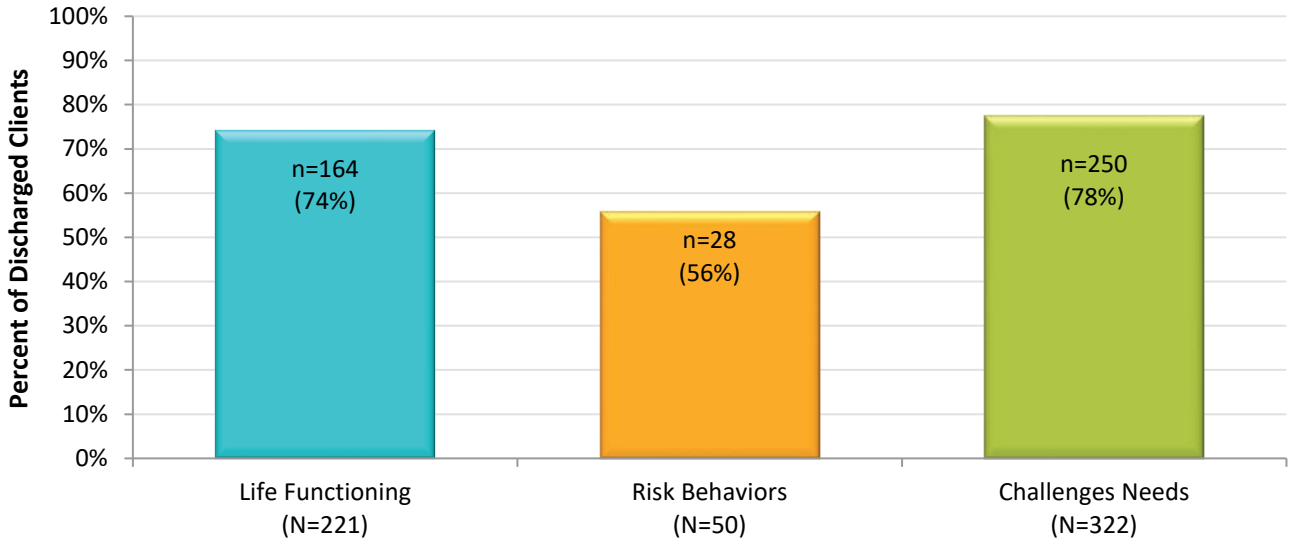
FSP CANS Scores

The CANS is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 6 through 21. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors, and/or Child Behavioral and Emotional needs (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment).



FSP CANS-EC Scores

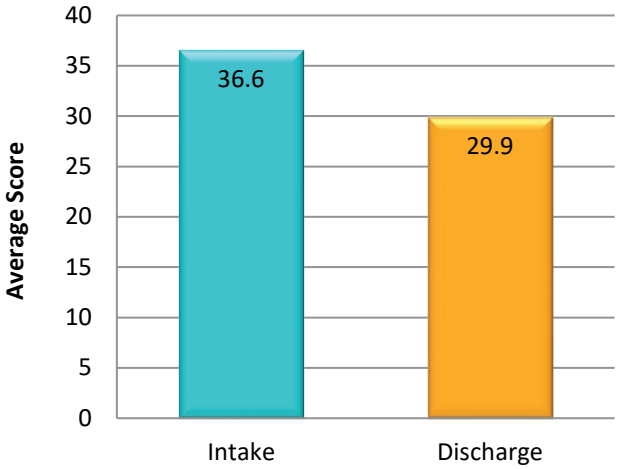
The CANS-EC is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 0 through 5. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors, and/or Challenges needs (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment).



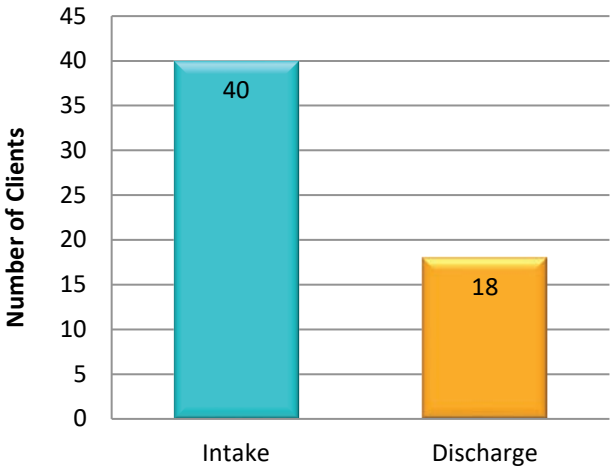
FSP PESQ Scores

The PESQ screens adolescents for substance abuse and is administered to youth ages 12 to 18 by their SUD counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 62 discharged clients in FY 2023-24.

PESQ Severity Scale (N = 62)



PESQ Clinical Cutpoint

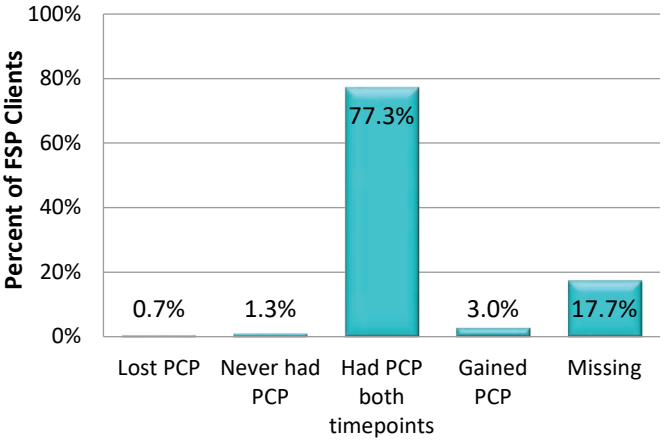


Are Children Getting Better? (continued)

FSP providers collected client and outcomes data on primary care physician (PCP) status, school attendance, and academic performance. These were recorded in the DCR for continuing clients with multiple assessments. Outcomes are calculated for clients who meet the following eligibility criteria: (a) Discharged within the current fiscal year; (b) In services for at least 120 days; (c) Between the ages of 5 and 18; (d) Served by a primary program (i.e., ancillary programs were excluded); (e) Eligible to receive a Partnership Assessment Form (PAF) assessment at intake. The most recent assessment was compared to intake.

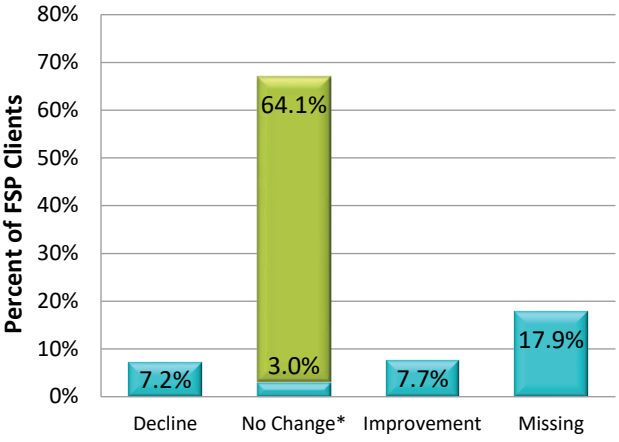
Primary Care Physician (PCP) Status (N=2,953)

80% of FSP clients gained or maintained a PCP.



School Attendance (N=2,953)

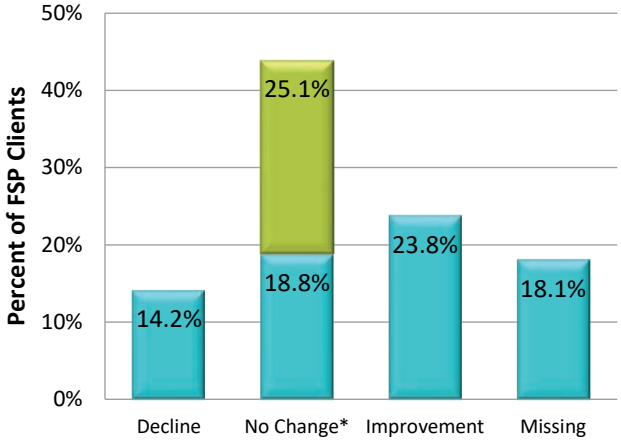
72% of FSP clients either improved (8%) or sustained high (64%) school attendance at follow-up assessment as compared to intake.



**Of the 67% of clients for whom no change was noted, 64% (green portion of bar) had "High" School Attendance Sustained (Clients who had ratings of "Always attends school (never truant)" or "Attends school most of the time" at both the initial assessment and the last quarterly (3M) assessment).*

Academic Performance (N=2,953)

49% of FSP clients either improved (24%) or sustained high (25%) grades at follow-up assessment as compared to intake.



**Of the 44% of clients for whom no change was noted, 25% (green portion of bar) had "High" Academic Performance Sustained (Clients who had academic ratings of "Very Good" or "Good" at both the initial assessment and the last quarterly (3M) assessment.).*
NOTE: Percentages may not add up to 100% due to rounding.

What Does This Mean?

- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms and reductions in needs, according to client, parent, and clinician reports. The CANS-EC data showed that a majority of clients 5 and under showed reductions in the Life Functioning and Challenges domains between intake and discharge.
- On average, children and youth who received treatment by SUD counselors showed improvement in their risk for substance abuse.
- The majority of FSP youth clients maintained a PCP during their participation in FSP programs.
- Nearly half of FSP youth clients improved or maintained high grades during their participation in FSP programs and over 70% either improved or sustained high school attendance.

Next Steps

- There should be continued collaboration between FSP programs and schools to improve or maintain FSP clients' academic performance and school attendance.

For more information on *Live Well San Diego*, please visit www.LiveWellSD.org

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

APPENDIX K

ANNUAL ASSERTIVE COMMUNITY TREATMENT (ACT) REPORT FY 2023-24

Annual Systemwide ACT Report

Fiscal Year 2023-24

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

The County of San Diego's Full Service Partnership (FSP) programs use a "whatever it takes" model to comprehensively address individual and family needs, foster strong connections to community resources, and focus on resilience and recovery to help individuals achieve their mental health treatment goals. Targeted to help clients with the most serious mental health needs, FSP services are intensive, highly individualized, and aim to help clients achieve long-lasting success and independence.

Assertive Community Treatment (ACT) programs, which include services from a team of psychiatrists, nurses, mental health professionals, employment and housing specialists, peer specialists, and substance use specialists, provide medication management, vocational services, substance use disorder services, and other services to help FSP clients sustain the highest level of functioning while remaining in the community. Services are provided to clients in their homes, at their workplace, or in other community settings identified as most beneficial to the individual client. Crisis intervention services are also available to clients 24 hours a day, 7 days a week.

Drawing from multiple data sources, this report presents a system-level overview of service use and recovery-oriented treatment outcomes for those who received FSP services from the 18 ACT programs* in San Diego County during fiscal year (FY) 2023-24.

- Demographic data and information about utilization of inpatient and emergency psychiatric services were obtained from the County of San Diego Cerner Community Behavioral Health (CCBH) data system.
- Information related to:
    1. basic needs, such as housing, employment, education, and access to a primary care physician and
    2. emergency service use and placements in restrictive and acute medical settings

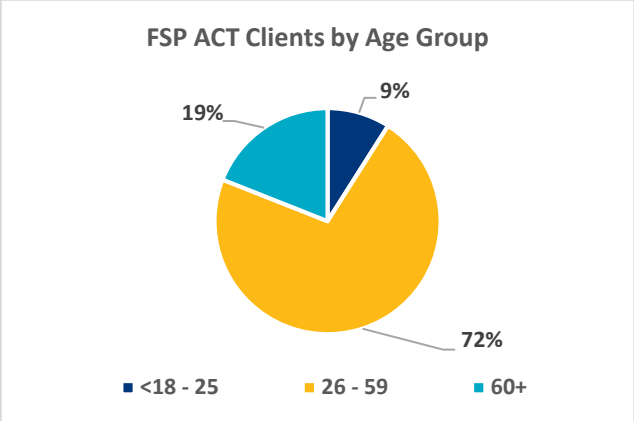
  were retrieved from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) system used by FSP programs across the State of California.
- Recovery outcomes and progress toward recovery were obtained from the County of San Diego's Mental Health Outcomes Management System (mHOMS).

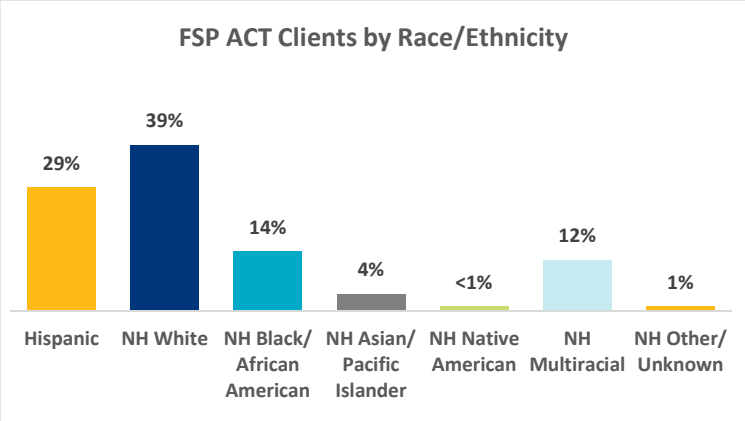
*Data from the following programs are included in this report (program name and sub-unit): CRF Downtown IMPACT (3241, 3246), Telecare Gateway to Recovery (3312, 3318), Telecare LTC (3331, 3332), MHS North Star (3361), CRF IMPACT (3401, 3405), MHS Center Star (3411, 3417), CRF Senior IMPACT (3481, 3483, 3484), Telecare MH Collaborative Court (4201, 4205), Telecare Assisted Outpatient Treatment (4211), MHS City Star (4221), MHS Action Central (4242), MHS Action East (4251), Pathways Catalyst (4261, 4265), CRF Adelante (4341,4344), MHS North Coastal (4351), Telecare Vida (4401), Telecare Tesoro (4411), and Telecare La Luz (4421).

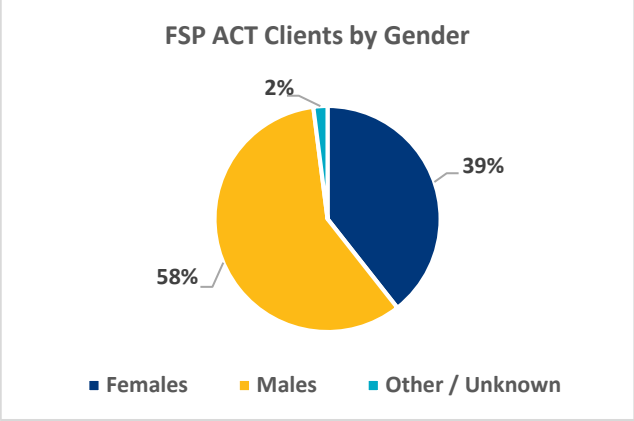
Note: Due to rounding, percentages in this report may not sum to 100%.

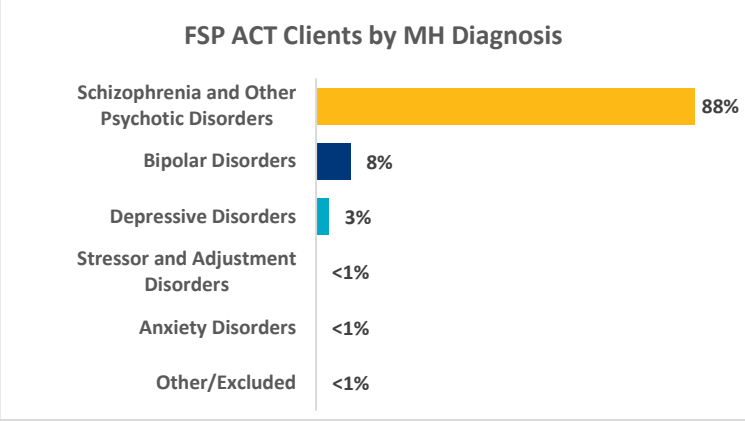
Demographics and Diagnoses

During FY 2023-24, 3,278 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (72%), a majority were male (58%), and the vast majority had a primary mental health diagnosis of schizophrenia or another psychotic disorder (88%). The next most common primary mental health diagnosis among FSP ACT clients served during the fiscal year was bipolar disorder (8%). In addition to their primary mental health diagnosis, 83% of FSP ACT clients served during FY 2023-24 had a history of substance use disorder. Two-fifths of FSP clients who received services from ACT programs during this period were Non-Hispanic (NH) White (39%), over one-fourth were Hispanic (29%) and nearly one-fifth were NH African American (14%).

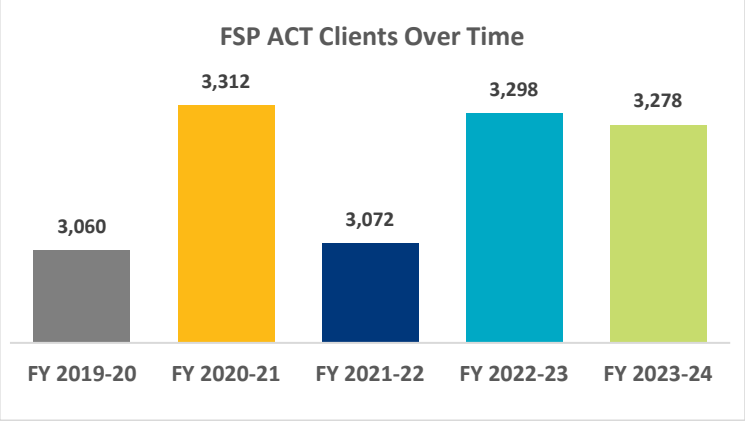








In FY 2020-21, there was an 8% increase in FSP clients served by ACT teams each year compared to the number of FSP clients served by ACT programs in FY 2019-20. In FY 2022-23, there was an increase (7%) in the number of FSP clients served by ACT teams compared to FY 2021-22, then a slight decrease from FY 2022-23 to FY 2023-24. Overall, the distribution of the key demographics highlighted above among FSP ACT clients served during FY 2023-24 is similar to the demographics of the clients served by these programs during the previous two fiscal years.



Meeting FSP ACT Clients' Basic Needs*

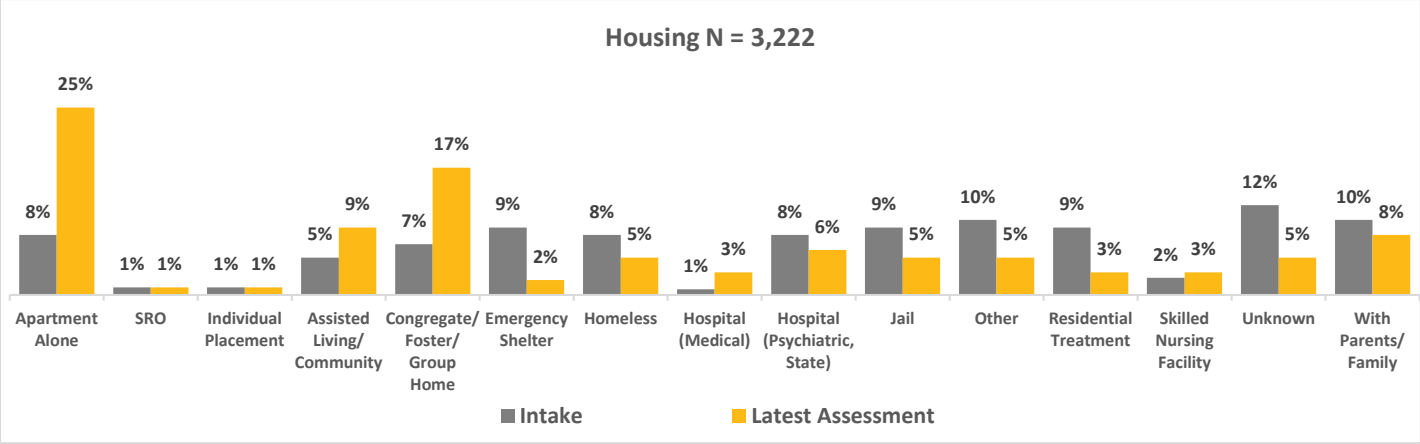
Housing

During FY 2023-24, FSP clients served by ACT programs showed progress in several areas of basic needs. Compared to intake, over three times as many clients were living in an apartment alone setting at the time of their latest assessment (8% at intake versus 25% at the latest assessment). Similarly, the proportion of clients living in a congregate, foster, or group home setting more than doubled from intake (7%) to the latest assessment (17%), and the proportion of clients living in an assisted living or community setting nearly doubled from intake (5%) to the latest assessment (9%).

Notable decreases in the proportion of clients living in specific housing settings were also observed from intake to latest assessment. The proportion of clients housed in an emergency shelter decreased from 9% to 2%, the proportion of clients reporting a psychiatric hospital as their current living situation decreased from 8% to 6%, and the proportion of homeless clients decreased by nearly half from intake (8%) to latest assessment (5%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment alone** setting more than **tripled** from intake (8%) to latest assessment (25%).
- The proportion of **clients** housed in an **emergency shelter decreased** from 9% at intake to 2% at the latest assessment.
- The proportion of **homeless clients decreased** by nearly **one-half** from intake (8%) to latest assessment (5%).



Employment

Many FSP clients served by ACT programs are connected to meaningful vocational opportunities as part of their recovery. Depending on individual need, vocational activities can include volunteer work experience, supported employment in sheltered workshops, and/or competitive paid work.

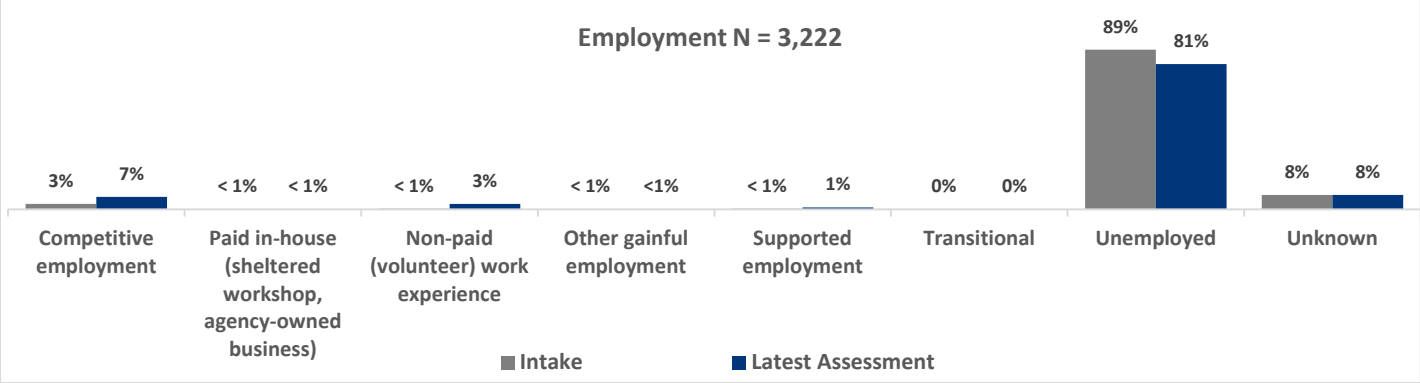
While most clients remained unemployed at the time of the latest assessment (81%), there was an 9% reduction in the number of clients that were unemployed at the latest assessment (2,607 clients) compared to intake (2,857 clients). A notable increase in employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (3 clients at intake compared to 85 clients at the latest assessment). Additionally, there were nearly three times as many FSP ACT clients employed in competitive settings at the time of the latest assessment (235 clients) compared to the number employed at intake (86 clients). Similarly, there were over four times as many FSP ACT clients working in supported employment settings at the time of the latest assessment (27 clients) compared to intake (6 clients).

*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2023-24, as of the 10/2023 DHCS DCR download.

Lastly, while only two clients were employed in another gainful employment setting at intake, 13 clients were employed in this setting at the time of the latest assessment.

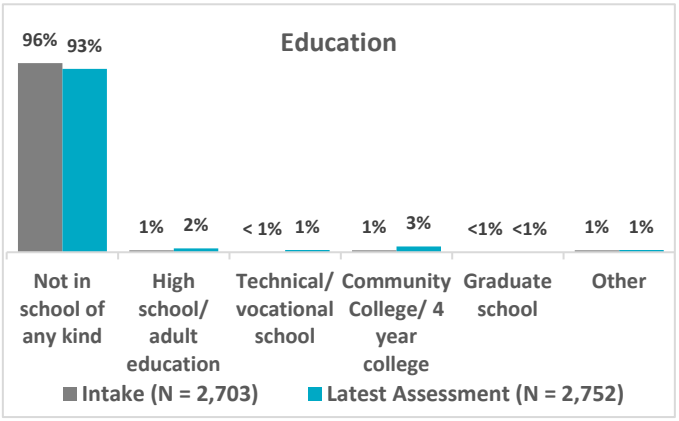
Key Findings: Employment

- There was an 9% **reduction** in the number of clients that were **unemployed** at the latest assessment compared to intake.
- Compared to intake, there were notable **increases** in the number of clients employed in **non-paid** (volunteer), **competitive**, **supported,** and **other gainful** employment settings.



Education

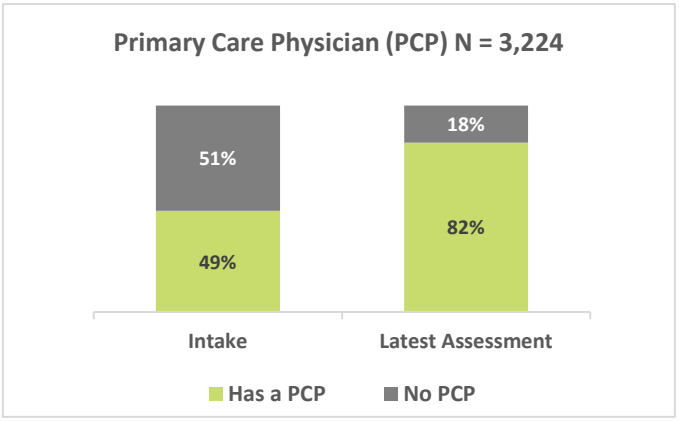
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 2,703 FSP ACT clients with education information available at intake[†], 95 (3%) were enrolled in an educational setting. At the time of the latest assessment, 189 of the 2,752 FSP ACT clients with educational information available (6%) were enrolled in an educational setting[†]. The largest increase from intake to latest assessment was observed in the proportion of clients enrolled in a community or four-year college (1% at intake versus 3% at the latest assessment) compared to other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2023-24, there was a large increase in the number and proportion of clients who had a primary care physician at the time of the latest assessment compared to intake. Slightly less than half (49%; 1,580 clients) had a primary care physician at intake, while a majority (82%; 2,462 clients) had a primary care physician at the time of their latest assessment.

Overall, changes in basic needs from intake to latest assessment during FY 2023-24 were similar to those observed during previous fiscal years.



[†]Education information was missing for 521 clients at intake, and 472 clients at the time of the latest assessment.

Changes in Service Use and Setting

Use of Inpatient and Emergency Services (Pre/Post)‡

These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as Crisis Stabilization (CS), Urgent Outpatient (UO), Psychiatric Emergency Response Team (PERT) services, Mobile Crisis Response Team (MCRT), Crisis Residential (CR), and services provided at the psychiatric hospital. Overall, utilization of these types of services decreased by more than half (56%) from pre to post assessment during FY 2023-24. While utilization of all types of emergency services decreased from pre to post assessment, there was a greater reduction in the number of CR and psychiatric hospital services compared to the other types of emergency services.

Similar to the reduction in overall emergency service utilization, there was a 54% reduction in the number of unique FSP ACT clients who used emergency services from pre to post assessment with the largest reductions observed among clients receiving CR services (75%) and services at the psychiatric hospital (59%) or UO (59%). The number of clients who received a PERT service decreased by 49%, and the number of clients who received a CS service decreased by 42%, respectively, from pre to post assessment.

A reduction in the overall mean number of emergency services per client was also observed from pre to post assessment (6%). The most notable reduction observed among those receiving services from the psychiatric hospital (21%).

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2023-24 were similar to reductions in utilization observed among this population during FY 2021-22 and FY 2022-23. MCRT served 78 clients being at pre-assessment and 141 clients at post assessment and 159 services being provided at pre-assessment and 343 services at post assessment. MCRT began services right before the beginning of FY 2021-22 and has been growing since, which could lead to the increase of services and clients served during FY 2023-24.

Key Findings: Use of Inpatient and Emergency Services

- Utilization of **all emergency services, except MCRT decreased** among FSP ACT clients from pre to post assessment.
- The **greatest reductions** in emergency service utilization were observed in the **CR** and **psychiatric hospital** LOCs.
- A **reduction** in the overall **mean number of emergency services per client** was observed from pre to post assessment.

	# OF SERVICES			# OF CLIENTS*			MEAN # OF SERVICES PER CLIENT		
Type of Emergency Service	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
CS	1,465	895	-39%	499	289	-42%	2.94	3.10	5%
UO†	1,252	455	-64%	559	231	-59%	2.24	1.97	-12%
PERT	970	412	-58%	533	274	-49%	1.82	1.50	-17%
MCRT	159	343	116%	78	141	81%	2.04	2.43	19%
CR	948	239	-75%	533	133	-75%	1.78	1.80	1%
Psychiatric Hospital	2,221	717	-68%	809	330	-59%	2.76	2.17	-21%
Overall	**7,015**	**3,061**	**-56%**	**3,011**	**1,398**	**-54%**	**2.33**	**2.19**	**-6%**

**The overall number of clients at Pre (n=1,161) and Post (n=609) represent unique clients, many of whom used multiple, various services, while some clients did not use any emergency services.*

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

Note: Clients in this analysis (n=1,688) had an enrollment date ≤ 7/1/2023 and discontinued date (if inactive) > 7/1/2023. Data may include individuals discharged from FSP during the fiscal year but who continued to receive services from a different entity.

†Formerly Crisis Outpatient (CO)

‡Pre-period data encompasses the 12-months prior to each client's FSP enrollment and are sourced from the 10/2023 CCBH download. The 10/2023 DHCS DCR download was used to identify active clients, and for Post period data.

Placements in Restrictive and Acute Medical Settings (Pre/Post)[§]

Similar to previous fiscal years, there were overall decreases from pre to post assessment in the number of days spent (67% reduction), and number of FSP ACT clients (58% reduction) residing in the following restrictive settings: jail/prison, state psychiatric hospital, and long-term care. The largest reductions observed from pre to post assessment were in the number of days clients spent in a state psychiatric hospital (85% reduction) and the number of clients who resided in a state psychiatric hospital (79% reduction). Notable reductions were also observed in the number of days (68% reduction) and the number of clients (60% reduction) residing in long-term care settings from pre to post assessment.

The residential status of individuals receiving FSP services is changed to "Acute Medical Hospital" when admission to a medical hospital setting occurs for a physical health reason such as surgery, pregnancy/birth, cancer, or another illness requiring hospital-based medical care. Data pertaining to placements in acute medical care settings are reported separately in the table below. Compared to pre-assessment, there was an increase nearly five times (386%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 58% increase in the number of FSP ACT clients in an acute medical hospital setting at post assessment. It is possible that this increase may be partly facilitated by the ACT programs as FSP ACT clients may have delayed seeking necessary medical care during crises prior to enrollment in an ACT program.

In general, during FY 2023-24 the rates of change between pre and post assessment for each type of restrictive setting mirrored the rates observed for these settings during the previous fiscal year. One change from last fiscal year is that the mean number of days per FSP ACT client in a jail or prison setting decreased by 17% from pre to post during FY 2023-24 but increased by 1% during FY 2022-23 (not shown). Also, to note, is the observed 27% decrease in the mean number of days per client spent in a state psychiatric hospital setting, a trend consistent with the increase observed during FY 2022-23.

Key Findings: Placements in Restrictive and Acute Medical Settings

- Placements in restrictive settings such as **jail/prison,** the **state psychiatric hospital,** and **long-term care** settings **decreased** among FSP ACT clients from pre to post assessment.
- Placements in **acute medical hospital** settings **increased** among FSP ACT clients from pre to post assessment.
- The mean number of days per client in the **acute medical hospital** settings **increased** from pre to post assessment while the mean number of days per client in **jail/prison, long-term care,** and **state psychiatric hospital** settings **decreased**.

	# OF DAYS			# OF CLIENTS*			MEAN # OF DAYS PER CLIENT		
Type of setting	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change****
Jail/Prison	52,969	20,622	-61%	435	203	-53%	121.77	101.59	-17%
State Hospital	10,576	1,609	-85%	67	14	-79%	157.85	114.93	-27%
Long-Term Care	95,599	30,506	-68%	320	127	-60%	298.75	240.20	-20%
Overall	**159,144**	**52,737**	**-67%**	**822**	**344**	**-58%**	**193.61**	**153.31**	**-21%**
Acute Medical Hospital	4,974	24,197	386%	226	358	58%	22.01	67.59	207%

**The overall number of clients at Pre (n=776) and Post (n=332) represent unique clients who may have been placed in multiple and/or various types of settings.*

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

[§]Data source: DHCS DCR 10/2023 download; 12-month pre-enrollment DCR data rely on client self-report.

Measuring Progress Towards Recovery**

Overall Assessment Means for Assessments 1 and 2

FSP ACT clients' progress toward recovery is measured by two different instruments:

- **Illness Management and Recovery Scale** (IMR) and
- **Recovery Markers Questionnaire** (RMQ).

Clinicians use the IMR scale to rate their clients' progress towards recovery, including the impact of substance use on functioning. The IMR is comprised of 15 individually scored items, and assessment scores can also be reported as an overall score or by three subscale scores:

- Progress towards recovery (**Recovery**),
- Management of symptoms (**Management**), and
- Impairment of functioning through substance use (**Substance**).

Clients can use the 24-item self-rated RMQ tool to rate their own progress towards recovery. Mean IMR and RMQ scores range from 1 to 5, with higher ratings on both assessments' indicative of greater recovery.

The IMR and RMQ scores displayed in the charts to the right compare scores of New FSP ACT clients to those of All FSP ACT clients.

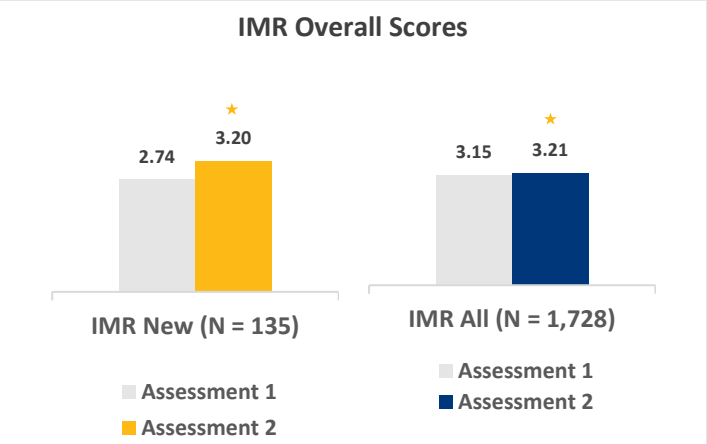
- **New** clients are defined as those who:
  1. began receiving ACT services in 2023 or later,
  2. had two IMR or RMQ assessments during FY 2023-24 (assessments 1 and 2), and
  3. had a first service date within 30 days of their first IMR assessment.
- **All** clients include every FSP ACT client with at least two IMR or RMQ assessments during FY 2023-24 (assessments 1 and 2), regardless of the length of FSP services from ACT programs.

Clients receiving FSP services from ACT programs are generally reassessed on these IMR and RMQ measures every six months to measure progress towards recovery. In general, assessment scores for New clients tend to more directly demonstrate the effect of FSP ACT services on client outcomes because All clients include individuals who may have received services for many years.

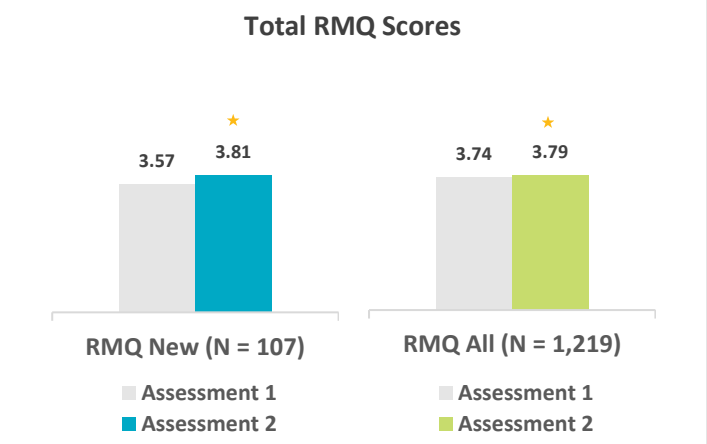
As expected, overall IMR and RMQ assessment 1 mean scores for New clients were lower than assessment 1 mean scores for All clients. For both groups overall IMR assessment 2 mean scores were significantly higher than overall IMR assessment 1 mean scores ($p < .05$).

The mean assessment 1 score from All clients was relatively high compared to mean scores among New clients, suggesting that clients enrolled in ACT services for a longer period of time may reach the maintenance phase in their recovery where improvement is no longer expected.

Overall RMQ mean scores were statistically significantly higher at assessment 2, compared to assessment 1 for both New and All clients. RMQ assessment scores for New and All clients were higher than their IMR scores indicating that both groups of clients rated their progress higher than clinicians.



★ *Statistically significant difference between pre and post scores ($p < .05$).*



★ *Statistically significant difference between pre and post scores ($p < .05$).*

**Outcomes data are sourced from mHOMS FY 2023-24; Data include all mHOMS entries as of 11/18/2024 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2023-24, and who had paired IMR or RMQ assessments 4 to 8 months apart.

IMR Subscale Means for Assessments 1 and 2

Changes in mean scores on each of the three IMR subscales from assessment 1 to assessment 2 were also analyzed for each group of clients (New and All). On average, both New and All FSP ACT clients had significantly higher mean Recovery and Management subscale scores ($p < .05$) at assessment 2 than they did at assessment 1. These data suggest that New and All clients made significant progress towards recovery from assessment 1 to assessment 2.

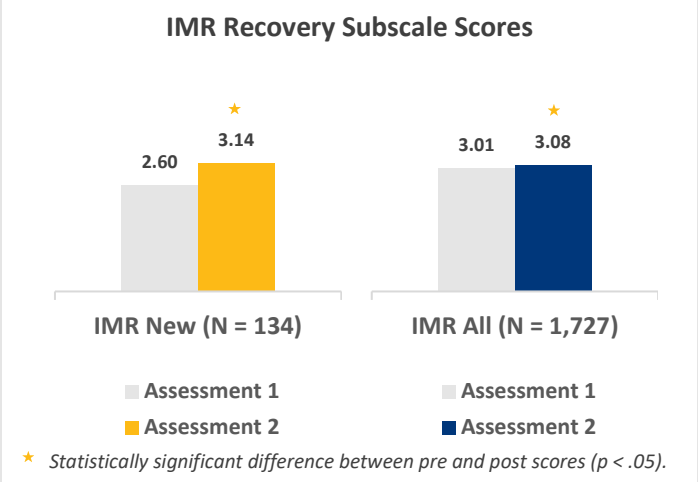
Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or minimal impairment in functioning due to drug or alcohol use as a higher rating is indicative of greater recovery.

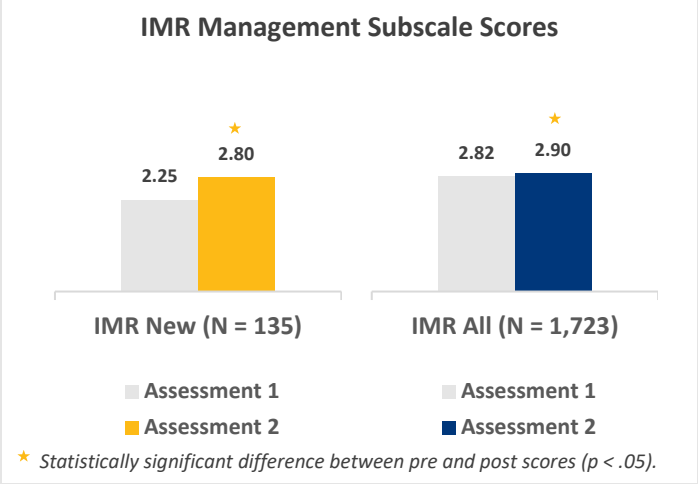
New and All FSP ACT clients had slightly higher mean Substance Use scores at assessment 2 compared to assessment 1; however, this difference in mean scores was not statistically significant for All FSP ACT Clients.

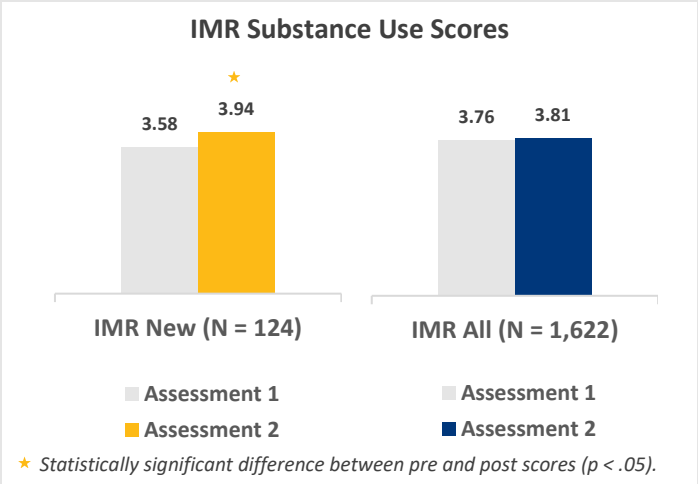
Key Findings: Assessment Outcomes

- Mean **Overall IMR** scores were **significantly higher** at the latest assessment compared to the first assessment for **New and All** clients.
- Mean **Recovery and Management** subscale scores were **significantly higher** at the latest assessment compared to the first assessment for both **New and All** clients.
- Mean **Substance Use** subscale scores were **significantly higher** at assessment 2 compared to the assessment 1 for **New** clients.
- Mean **Overall RMQ** scores were **significantly higher** at the latest assessment compared to the first assessment for **New** and **All** clients
- RMQ ratings suggest that both **New** and **All** clients rated their progress higher than clinicians did.

These findings suggest that drug and alcohol use may be a factor in impairment of functioning among new FSP clients but may not be a primary focus of early treatment and may be an area addressed when clients are in services for a while.

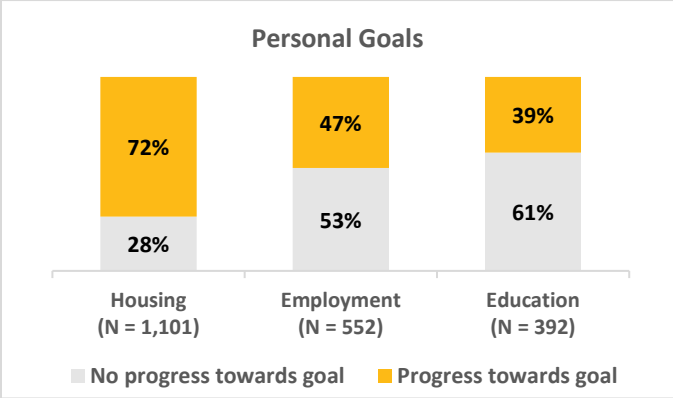






Progress Towards Key Treatment Goals

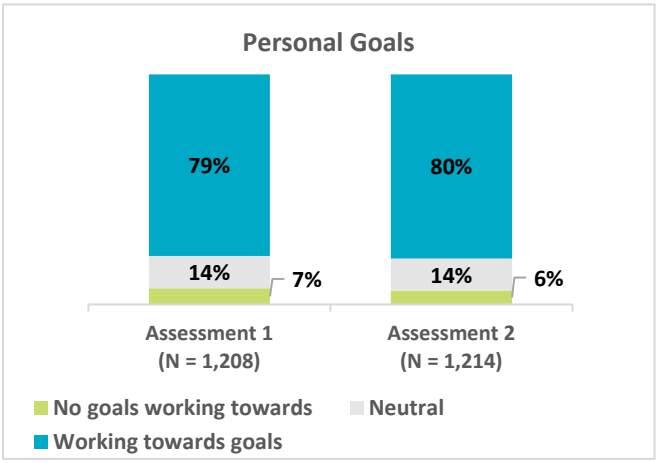
At the time of their follow-up IMR assessments, clinicians also noted client progress towards goals related to housing, education, and employment. Similar to trends observed during FY 2022-23, most FSP ACT clients served during FY 2023-24 with a completed Goal assessment had a goal related to housing (1,101 clients; 72%) on their treatment plan. Of these clients, clinicians reported that 77% made progress towards their individual housing goal at the time of the latest assessment. Fewer FSP ACT clients had goals related to employment (552 clients; 47%) or education (392 clients; 39%) on their treatment plan, compared to the number with housing related goals. Additionally, nearly two-fifths of clients with treatment goals related to employment (38%) and less than one-third of clients with goals related to education (27%) made progress towards their goals at the time of the most recent assessment. These results may reflect a



"housing first" approach in that obtainment of stable housing may be a primary focus for most FSP ACT clients, while goals related to employment and education may be secondary and an area of focus after stable housing is obtained.

Personal Goals

One of the items in the RMQ assessment asks clients if they have goals which they are working towards achieving. More than three-quarters of FSP ACT clients at assessment 1 (79%) and assessment 2 (80%) agreed or strongly agreed that they had a goal (or goals) they were working towards. At assessment 1 and assessment 2, 14% of clients reported they were "neutral" about working towards goals. There were 72 FSP ACT clients (6%) disagreed or strongly disagreed with the statement that they were working towards achieving goals at the time of the latest assessment. Responses to this RMQ item were unavailable for 11 clients at assessments 1 and five clients at assessment 2 and the chart to the right exclude these clients from percentage calculations.



Level of Care

Completed by clinicians, the Level of Care Utilization System (LOCUS) is a short assessment of a client's current level of care needs and provides a system for assessment of service need for adults. The LOCUS is based on the following six evaluation parameters:

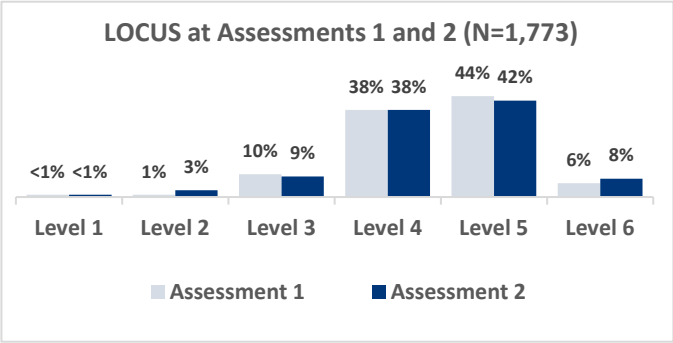
1. risk of harm,
2. functional status,
3. medical, addictive, and psychiatric co-morbidity,
4. recovery environment,
5. treatment and recovery history, and
6. engagement and recovery status.

In the LOCUS, levels of care are viewed as levels of resource intensity. Lower numbered levels correspond with lower intensity resources and services.

LOCUS Resource Levels

	Level of Care Description
Level 1	Recovery maintenance and health maintenance
Level 2	Low intensity community-based services
Level 3	High intensity community-based services
Level 4	Medically monitored non-residential services
Level 5	Medically monitored residential services
Level 6	Medically managed residential services

Similar to LOCUS results from previous fiscal years, the greatest proportion of FSP ACT clients were recommended for medically monitored non-residential services (Level 4) and medically monitored residential services (Level 5) by clinicians at both assessments. A reduction in the proportion of clients recommended for medically monitored residential services (Level 5) was observed from assessment 1 to assessment 2, and an increase in proportion of clients recommended for medically managed residential services (Level 6) was observed between assessments.



Note: Percentages are rounded.

Key Findings: Goals and LOCUS

- **Majority** of FSP ACT clients (72%) had a **housing related goal** on their treatment plan.
- Of the clients with a housing goal on their treatment plan, a **majority** (77%) **made progress** towards that goal by assessment 2.
- **Most** clients (80%) agreed or strongly agreed that they were **working towards a treatment goal** at assessment 2.
- Clients were most likely to be recommended for a **Level 4** or **Level 5** treatment setting at both times points.
- **A reduction** in the proportion of clients recommended for medically monitored residential services **(Level 5)** was observed from assessment 1 to assessment 2, and **an increase** in proportion of clients recommended for medically managed residential services **(Level 6)** was observed between assessments.

Conclusion

With the addition of several new FSP ACT programs within the San Diego County Behavioral Health System of Care during the past few years, there has been increased interest in learning more about the impact of these programs on clients' service use and outcomes. The FSP ACT model aims to serve homeless clients with severe mental illness, as evidenced by the vast majority of clients served during FY 2023-24 with 1) a housing-related goal (72%), 2) a diagnosis of schizophrenia or psychotic disorder (88%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 88% at intake).

Similar to trends reported from previous fiscal years, FSP ACT clients served during FY 2023-24 showed progress in the following areas of basic needs: housing, employment, and having a primary care physician. Notably, the proportion of clients living in an apartment only setting more than tripled from intake (8%) to latest assessment (25%), the proportion housed in an emergency shelter decreased from 9% at intake to 2% at the latest assessment, and the proportion of homeless clients decreased from 8% at intake to 5% at the latest assessment. There was also an 9% reduction in the number of clients unemployed at the latest assessment compared to intake and an 67% increase in the number of clients with a primary care physician at the time of the latest assessment, compared to intake.

Additional success of the FSP ACT model is evident from reductions observed in 1) utilization of inpatient and emergency services and 2) placements in restrictive settings among clients. For example, overall, utilization of inpatient and emergency services decreased by 56% compared to utilization rates prior to receipt of services from ACT programs. Similarly, placements in restrictive settings, such as jail/prison, state psychiatric hospital, and long-term care settings, were also reduced from intake to latest assessment, as measured by the number of days FSP ACT clients spent in these settings (67% reduction), and the number of clients housed in these types of settings (58% reduction). Progress towards recovery among FSP ACT clients was also exhibited by 1) significant improvements in clinician-rated IMR scores for New FSP ACT clients and 2) progress towards treatment plan goals for All ACT clients between two assessment time points.

Overall, improvements were observed in several key areas among FSP clients served by ACT programs during FY 2023-24, mirroring improvements observed among this population during previous fiscal years and demonstrating a positive effect of services on the lives of clients served by the ACT programs.

APPENDIX L

HOUSING UPDATE
EXECUTIVE SUMMARY

County of San Diego Behavioral Health Services
Five Year (2022-2027) Strategic Housing Plan
Implementation Plan FY 2024-25 (Year 3)

Strategic Housing Plan – Implementation Plan Overview

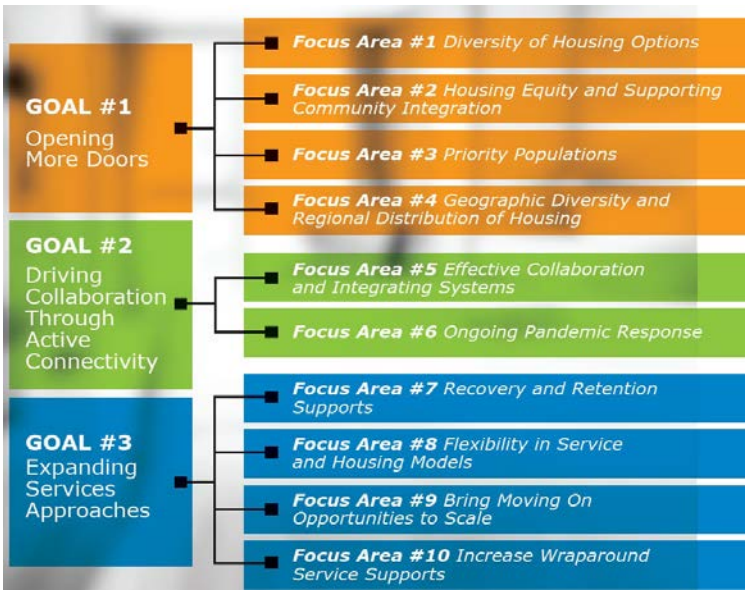
The Five-Year Strategic Housing Plan envisions *Creating Homes with Intention, Purpose and Collaboration*. It outlines guiding principles and targeted responses that maximize a range of housing options for people with behavioral health issues (people with serious mental illness/serious emotional disorders and/or substance use disorder) and limited resources through policy decisions, funding commitments, and programmatic initiatives. The Plan's approach is rooted in principles of equity and inclusion and the goals are driven by the voices of people with lived expertise. The Plan aims to maximize opportunities for community integration as well as choice in housing and services options that best meet individual needs and recovery goals. The plan includes three key goals: Opening More Doors; Driving Collaboration through Active Connectivity; and Expanding Service Approaches. Each goal area has focus areas with strategies or action steps for implementation. There will be a one-year implementation plan developed for each year of the five-year Plan based on the priorities identified by the Housing Council for the strategies to be acted upon in each fiscal year.

This one-year implementation plan will be **for fiscal year 2024-25** and represents year **three** implementation of the BHS Strategic Housing Plan. It describes the specific priorities identified by the housing council at their retreat in March, 2024, which featured in-depth discussions of anticipated change impacts of SB43 and Proposition 1. This plan is intended to be used as a management tool for monitoring progress in implementing the strategies set forth within the five-year plan and accomplishing its goals. **It shall be updated on a quarterly basis for review by the Housing Council and indicate progress made in meeting the priorities of the housing council. Housing Council leads are assigned to each priority area to monitor activity/action steps within the noted priority area and report out to Housing Council on opportunities for advocacy, input and/or progress.**

Implementation & Monitoring Plan

The FY 2024-25 implementation Plan (Year 3) is organized according to the BHS Housing Strategic Plan Goals and Focus Areas. Actions were prioritized for this fiscal year at the Housing Council planning retreat in **March, 2024.**

This Implementation & Monitoring Plan identifies Housing Council advocacy priorities within each goal area and recommended actions to address the housing-related needs of BHS clients.



Goal #1 OPENING MORE DOORS			
Housing Council Priorities	**Housing Council Advocacy**	**Recommended** BHS Consideration	**Quarterly Update**
Housing Access/Support for people who are/have been Justice-Involved.	• Support Federal, State and Local Legislative actions that support people who are/have been justice-involved to lower barriers to accessing housing and related assistance to retain housing • Advocate for fair housing compliance/legal support for formerly incarcerated justice-involved who are denied housing or have difficulty accessing housing	• Incentives program for housing providers to provide low barrier housing to justice-involved tenants • Training for staff/front line workers to assist people who are/have been justice-involved	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
Housing Support for families involved in child welfare services	• Federal, State and Local Legislative actions that provide housing support for households/people who are/have been involved in child welfare services	• Utilize funding for foster care for housing subsidies and other assistance for families involved in child welfare services	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
Increased funding for supportive housing; SUD and/or SMI residents and/or other special need populations	• Advocate for full utilization of housing vouchers with all Housing Authorities that have capacity to increase vouchers in the San Diego region, and other rental housing subsidies to support special need populations. • Advocate for maximum funding available for supportive housing programs from Prop 1 funds and other available BHSA funding, and any other state funding opportunities. • Explore regional funding opportunities and maximizing utilization of special purpose programs (e.g. HOPWA, FUP, VASH, etc.)	• Maximize Prop 1 funding for supportive housing opportunities in San Diego County • Continue other county funding for housing for BHS clients, including SUD and SMI households • Recovery Residence funding programs; new builds or existing renovation/rehab • Requirements/monitoring for full-service documentation by FSPs; lead focus group discussions to better understand needs for training, policy development and related matters.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:

Education and Data Support	• Advocate for development of an outreach/educational publication on why housing matters; better control of the narrative	• Track Recovery Residence funding by client; identify opportunities reduce any potential duplication of services • Training and education to create better understanding of housing needs/challenges for low income, SMI, SUD residents	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
High Housing Quality/Supportive Service Standards	• Assist in effort to create buy-in for maintaining high quality residences (all types of housing)	• Implement quality of housing and support services monitoring; quality control measures and requirements	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
More Housing Opportunities	• Advocate for creativity in producing additional housing opportunities such as shared housing, short-term permanent housing solutions, rental subsidies, master leasing of homes (similar to Brilliant Corners). • Explore opportunities for innovation and impactful models to increase housing (e.g. in partnership with Managed Care Plans; other models; etc.).	• Consider master leasing of rental homes by government agencies and/or contracted housing providers to reduce barriers to housing access by BHS clients and/or a funding for a service provider led “holding fee” program • Coordinate with other County departments to include a BHS/MHSA client housing-set aside when county property is noticed for private affordable housing development via RFPs.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:

GOAL #2 Driving Collaboration Through Active Connectivity			
Housing Council Priorities	**Housing Council Advocacy**	**Recommended BHS Consideration**	**Quarterly Update**
Training for on-site housing property management/ resident services staff in permanent supportive housing	• Advocate for more educational/training opportunities for property management and/or resident services staff on-site at supportive housing developments	• Required trainings for all on-site property management/resident services staff at permanent supportive housing; better understand needs of BHS clients (SUD, SMI & other Special Need populations)	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
Seamless System to build connections between counties; reduced barriers for client transfers to other county agencies within Southern California (and beyond as needed)	• Advocate for more collaboration between counties to assist BHS clients as they move from one county to another/into other areas within the state.	• Identify opportunities for Behavioral Health Services Departments across the state to share best practices and common challenges/resolutions for various service transfers in an effort to lower barriers when clients move to other counties	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
Comprehensive Assessment of current needs and gaps in services	• Advocate for surveys and/or other types of assessments of gaps in services for BHS clients (current service needs that are not being met)	• Host informal gatherings (quarterly) for service providers to come together and collaborate in both informal and formal ways to meet needs of clients • Host trainings to help service and housing providers better understand the resources available to BHS clients	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
System to gather input from Peer Support Specialists at all levels of policy/program developments and implementation	• Advocate for more peer support specialists to advise on all aspects of county policy/ program development and implementation	• Partner with other agencies training and hiring peer support specialists to advise on county program development & implementation; provide funding to ensure peer support specialists are appropriately compensated for their knowledge and experience	Q1 Update: Q2 Update: Q3 Update: Q4 Update:

GOAL #3 Expanding Service Approaches			
Housing Council Priorities	**Housing Council Advocacy**	**Recommended BHS Consideration**	**Quarterly Update**
More collaboration with Regional Task Force on Homelessness	• Expand service populations for Brilliant Corners program beyond veterans, including SUD populations	• Leverage existing infrastructure for Prop 1 that already places veterans in PSH beds to include SUD and/or SMI populations	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
Universal Housing Application	• Advocate for the same documentation used for all applications. • Advocate for single application with a single fee by property owner.	• Facilitate development of a Universal Housing Application (e.g. for PBS8; explore opportunities to streamline application processes and documents)	Q1 Update: Q2 Update: Q3 Update: Q4 Update:
Moving In and Housing Retention Services	• More peer support to advocate for clients to retain housing & avoid eviction; skills development • Pre-application background checks and assistance with clearing/addressing record	• Provide funding for Peer and Employment Specialists to deploy "move in" wrap around support services for new residents and long term housing retention programs/services • Develop a landlord education program for special needs populations, including information on benefits of government rental subsidies • Collaborate with other county departments to fund and develop an early background check program to assist low/no income housing applicants, including assistance	Q1 Update: Q2 Update: Q3 Update: Q4 Update:

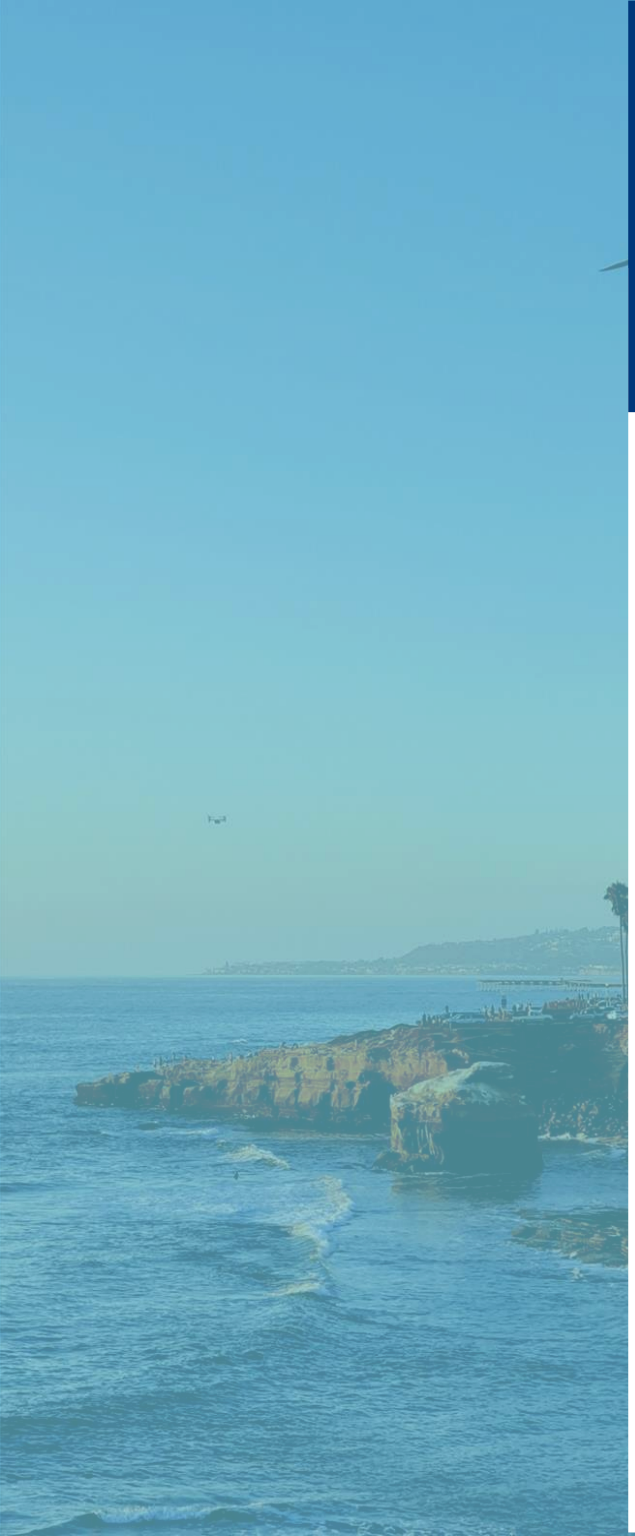
APPENDIX M

PREVENTION AND EARLY INTERVENTION (PEI) ANNUAL REPORT FY 2023-24

CHILD & FAMILY PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2023-24 ANNUAL REPORT

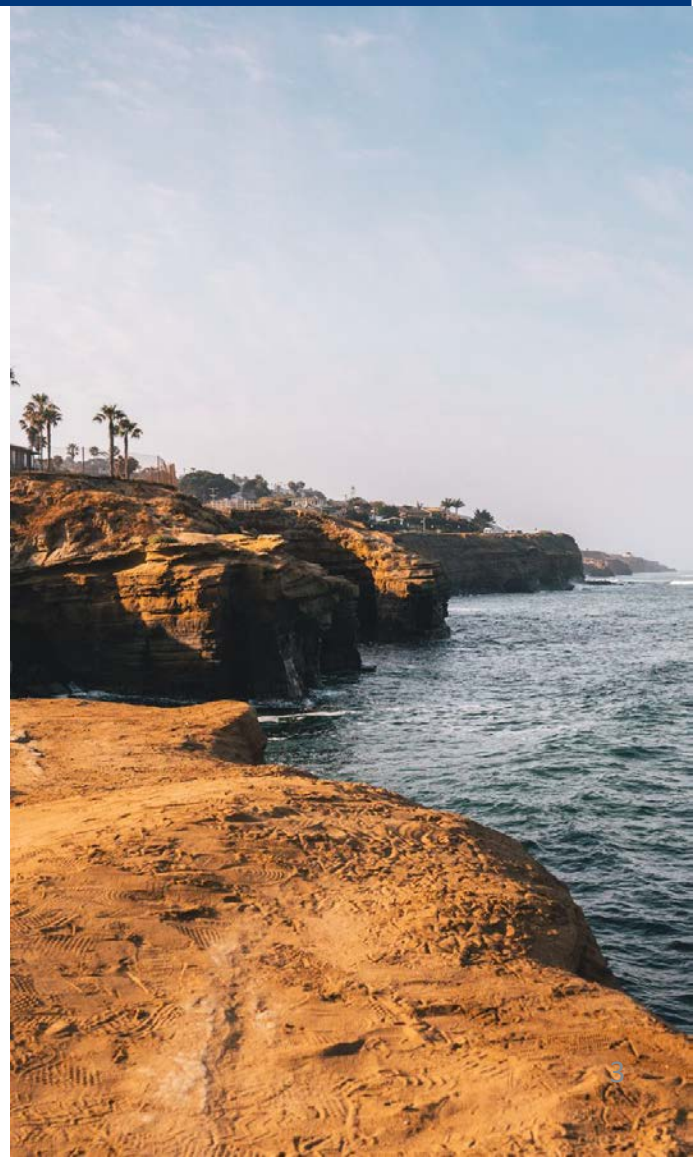


REPORT CONTENTS

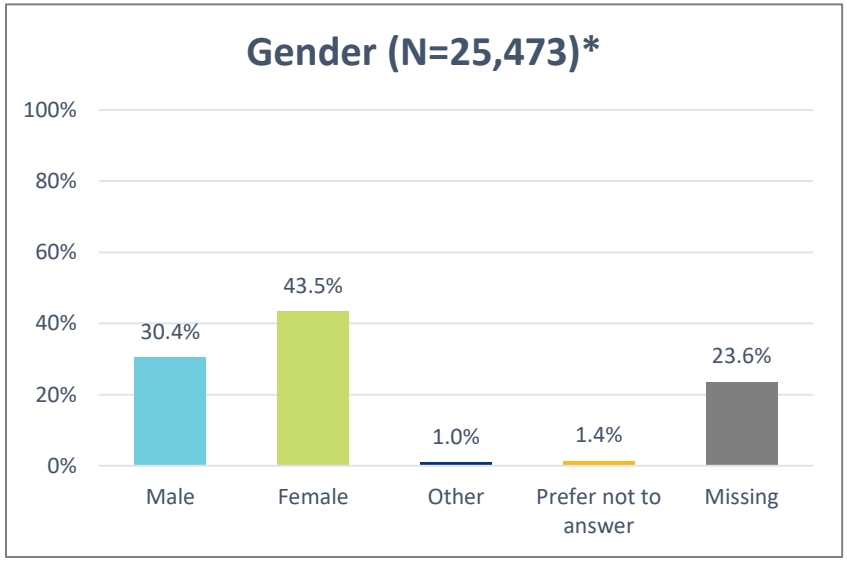
CHILD & FAMILY PEI PROGRAMS: BACKGROUND

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. The County of San Diego has funded contractors to provide PEI programs for youth and their families. The focus of these programs varies widely, from teaching caregivers how to cope with behavior problems in young children to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by a PEI program via outreach efforts, including but not limited to: presentations, community events, and fairs.

DATA: Child and Adolescent PEI Programs
REPORT PERIOD: 7/1/2023-6/30/2024
NUMBER OF PARTICIPANTS WITH DATA IN FY 2023-24: 25,473 Unduplicated*†
**Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators referenced in this report (N=25,473 vs. N=9,673).* *†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.*



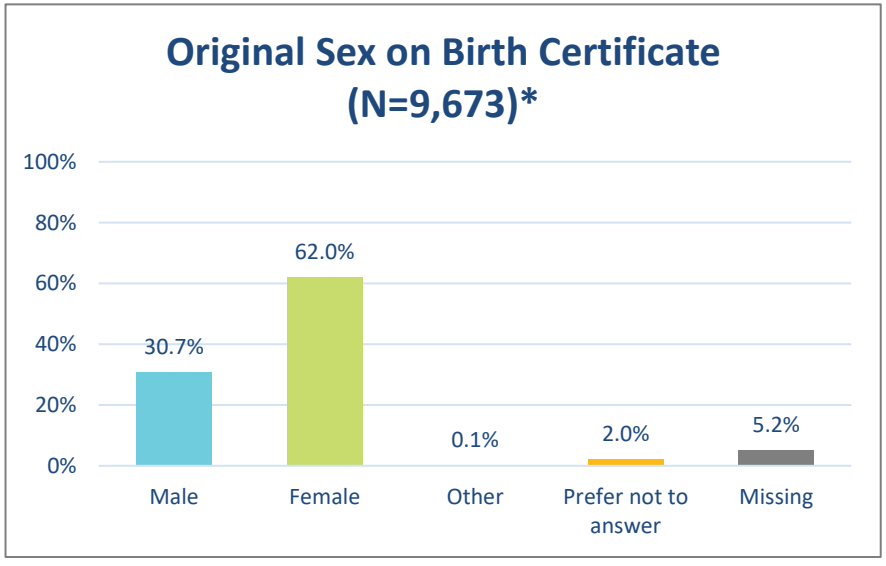
PARTICIPANT DEMOGRAPHICS



Forty-four percent of participants identified as female. One percent of participants endorsed another gender identity. One percent of participants preferred not to answer this question.

**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*

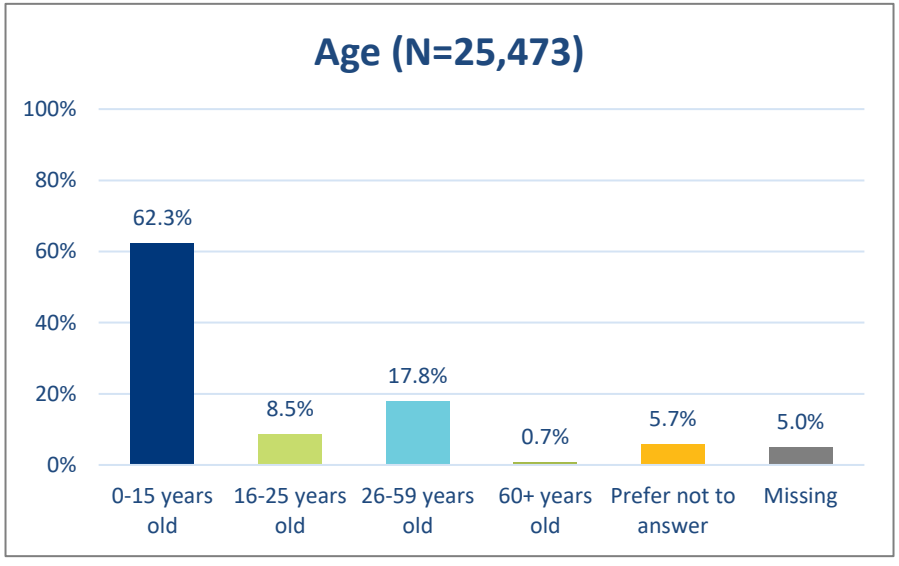
Note: Percentages may not add up to 100% due to rounding.



Sixty-two percent of respondents reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =9,673 vs. N= 25,473).*

PARTICIPANT DEMOGRAPHICS continued



Primary Language (N=9,673)*	Count	%
Arabic	73	0.8%
English	4,277	44.2%
Farsi	25	0.3%
Mandarin	20	0.2%
Spanish	4,185	43.3%
Tagalog	16	0.2%
Vietnamese	57	0.6%
Other	237	2.5%
Prefer not to answer	99	1.0%
Missing	684	7.1%

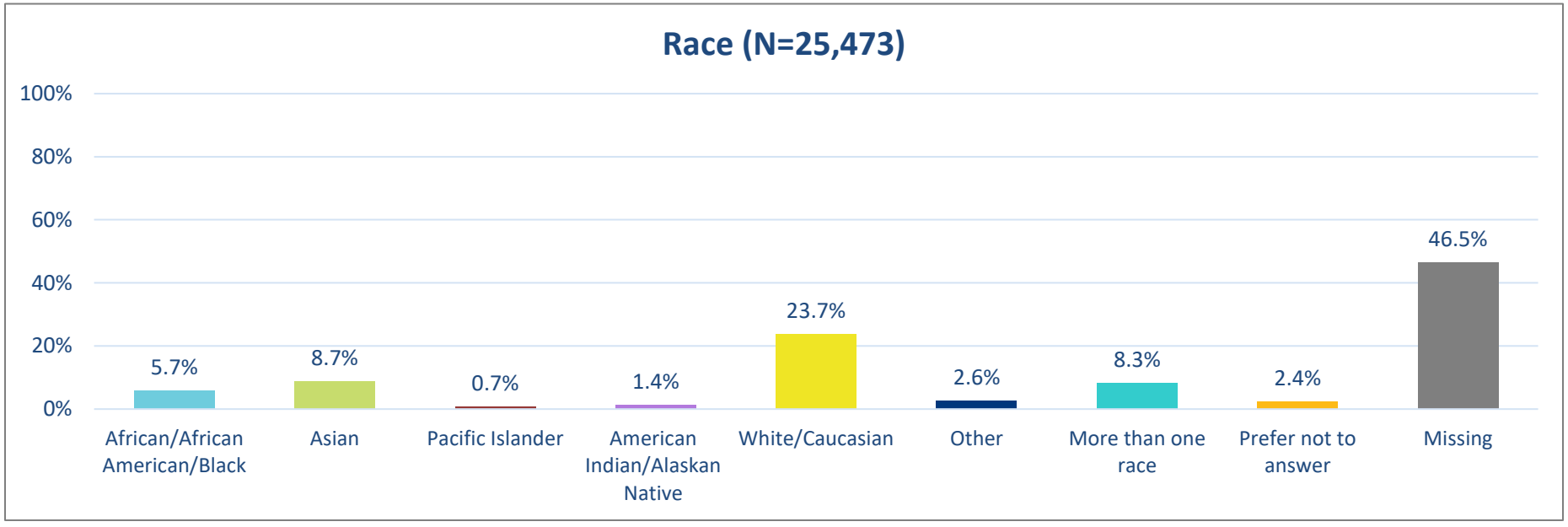
The majority (62%) of participants were 15 or younger. Many participants were older than 18 because several Child & Family PEI programs target caregivers, community members and Transitional Age Youth (TAY).

Note: Percentages may not add up to 100% due to rounding.

Forty-three percent of participants identified their primary language as Spanish. Forty-four percent of participants identified their primary language as English.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=9,673 vs N=25,473).*
Note: Percentages may not add up to 100% due to rounding.

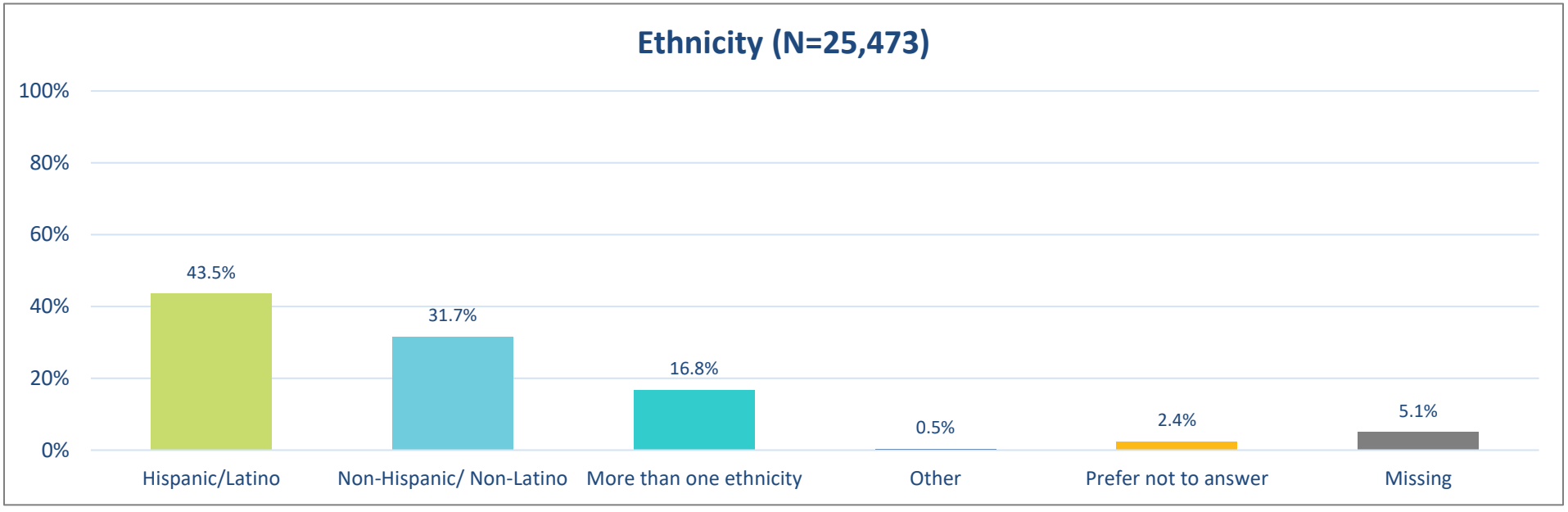
PARTICIPANT DEMOGRAPHICS continued



Twenty-four percent of participants identified their race as White/Caucasian. Six percent of participant identified as African, African American or Black and 9% identified as Asian. The missing category includes participants who endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

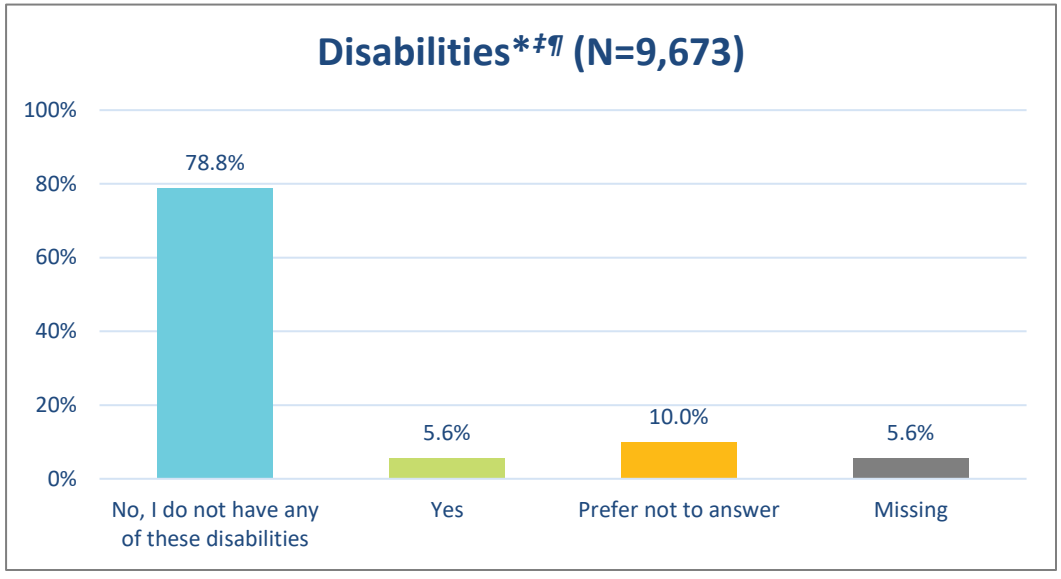
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Forty-four percent of participants identified their ethnicity as Hispanic/Latino. Seventeen percent of participants identified as more than one ethnicity.

PARTICIPANT DEMOGRAPHICS continued

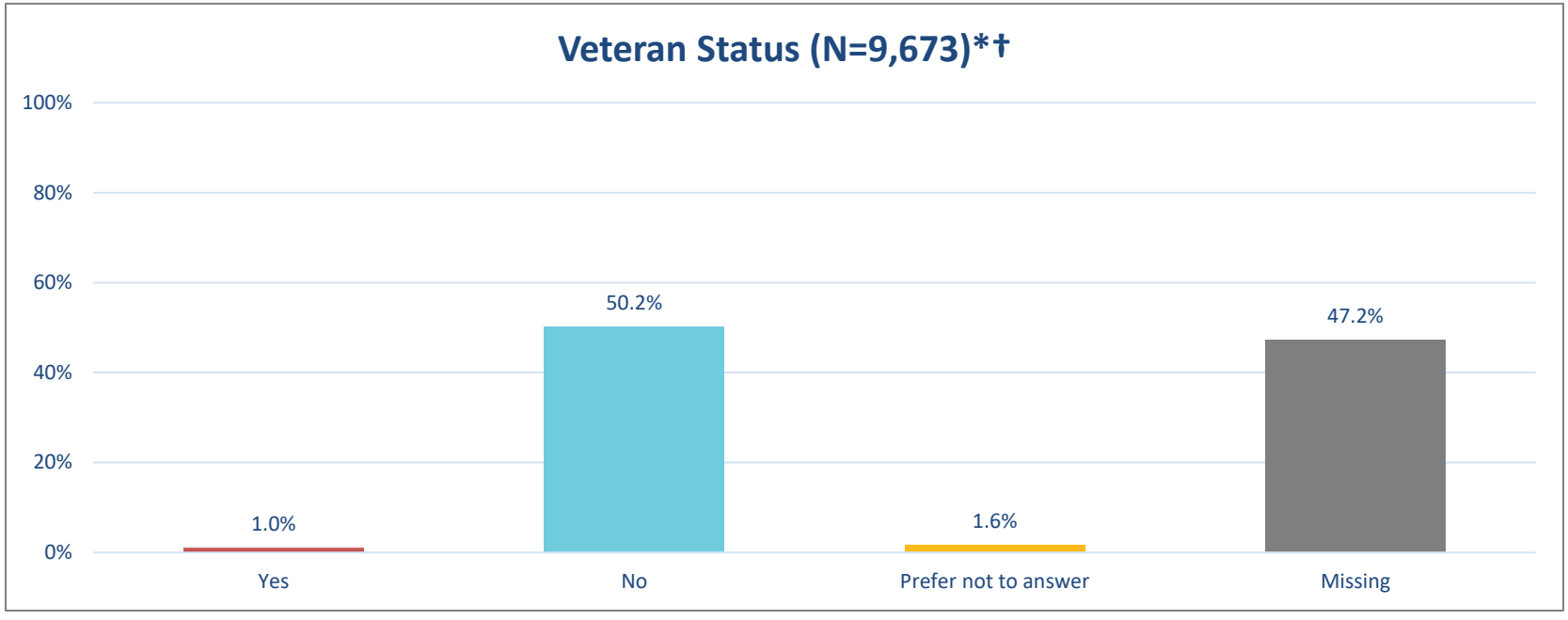


Six percent of participants reported having a disability. Two percent of participants reported having a mental disability (not including a mental illness). Ten percent of participants preferred not to answer this question.

Disabilities*†‡ (N=9,673)	Count	%
Difficulty seeing	125	1.3%
Difficulty hearing or having speech understood	76	0.8%
Other communication disability	24	0.2%
Mental disability not including a mental illness	192	2.0%
Learning disability	91	0.9%
Developmental disability	61	0.6%
Dementia	7	0.1%
Other mental disability not related to mental illness	33	0.3%
Physical/mobility disability	65	0.7%
Chronic health condition/chronic pain	38	0.4%
Other	125	1.3%
Prefer not to answer	967	10.0%
Missing	544	5.6%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability .
‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 9,673 vs N=25,473).
¶ Percentages may not add up to 100% due to rounding.

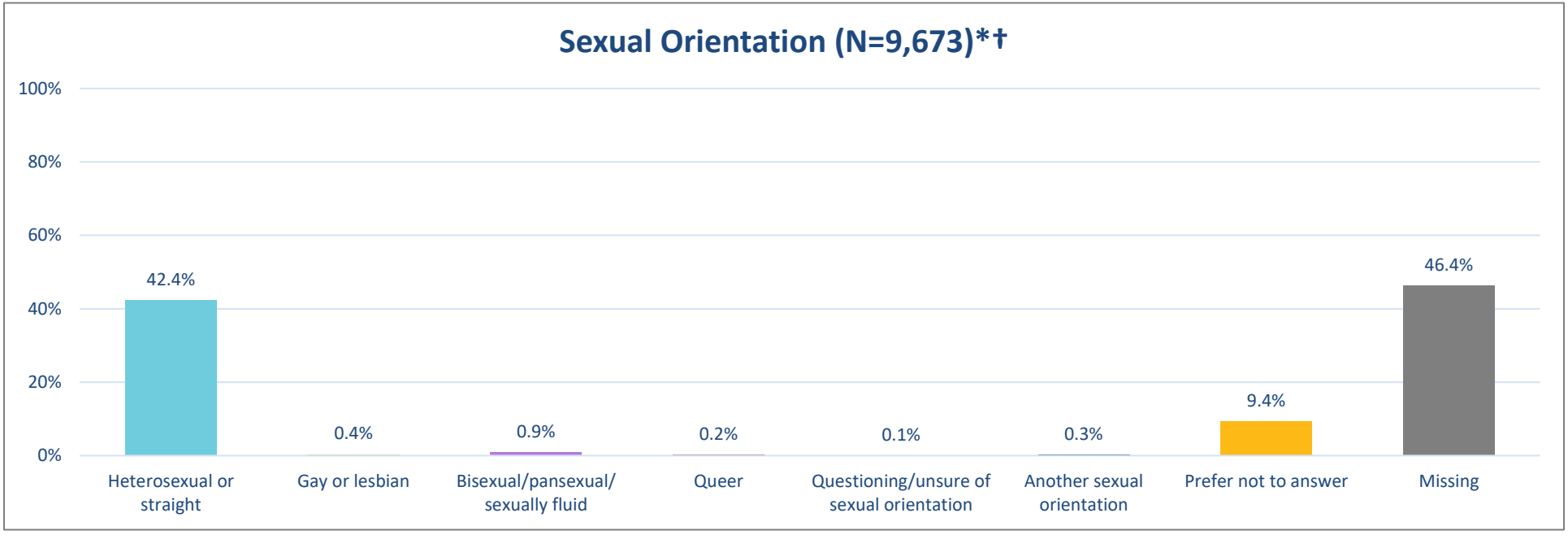
PARTICIPANT DEMOGRAPHICS continued



One percent of participants reported that they had served in the military. Less than 1% of participants reported currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 9,673 vs N=25,473).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."

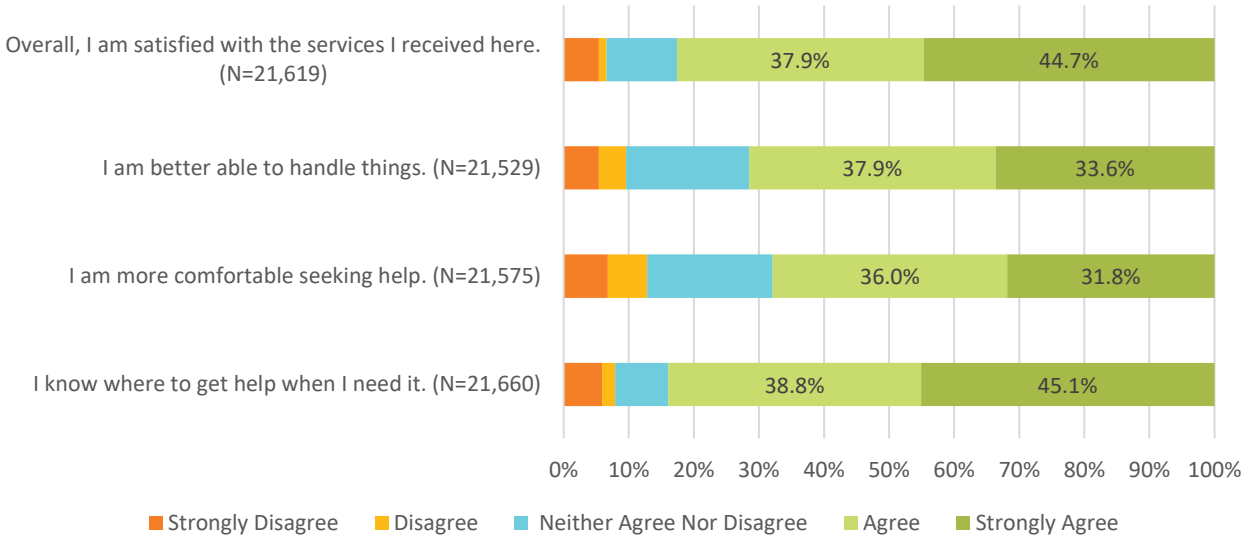
PARTICIPANT DEMOGRAPHICS continued



Forty-two percent of the participants identified their sexual orientation as heterosexual or straight. One percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Nine percent of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 9,673 vs N=25,473).*
†Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT SATISFACTION AND OUTCOMES*†



*Satisfaction and outcome data are not available for all participants.
† Satisfaction data may include duplicate participants.

Eighty-three percent of participants agreed or strongly agreed that they were satisfied with the services they received. Seventy-two percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Sixty-eight percent of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. Eighty-four percent of participants agreed or strongly agreed that they knew where to get needed help as a result of the program.

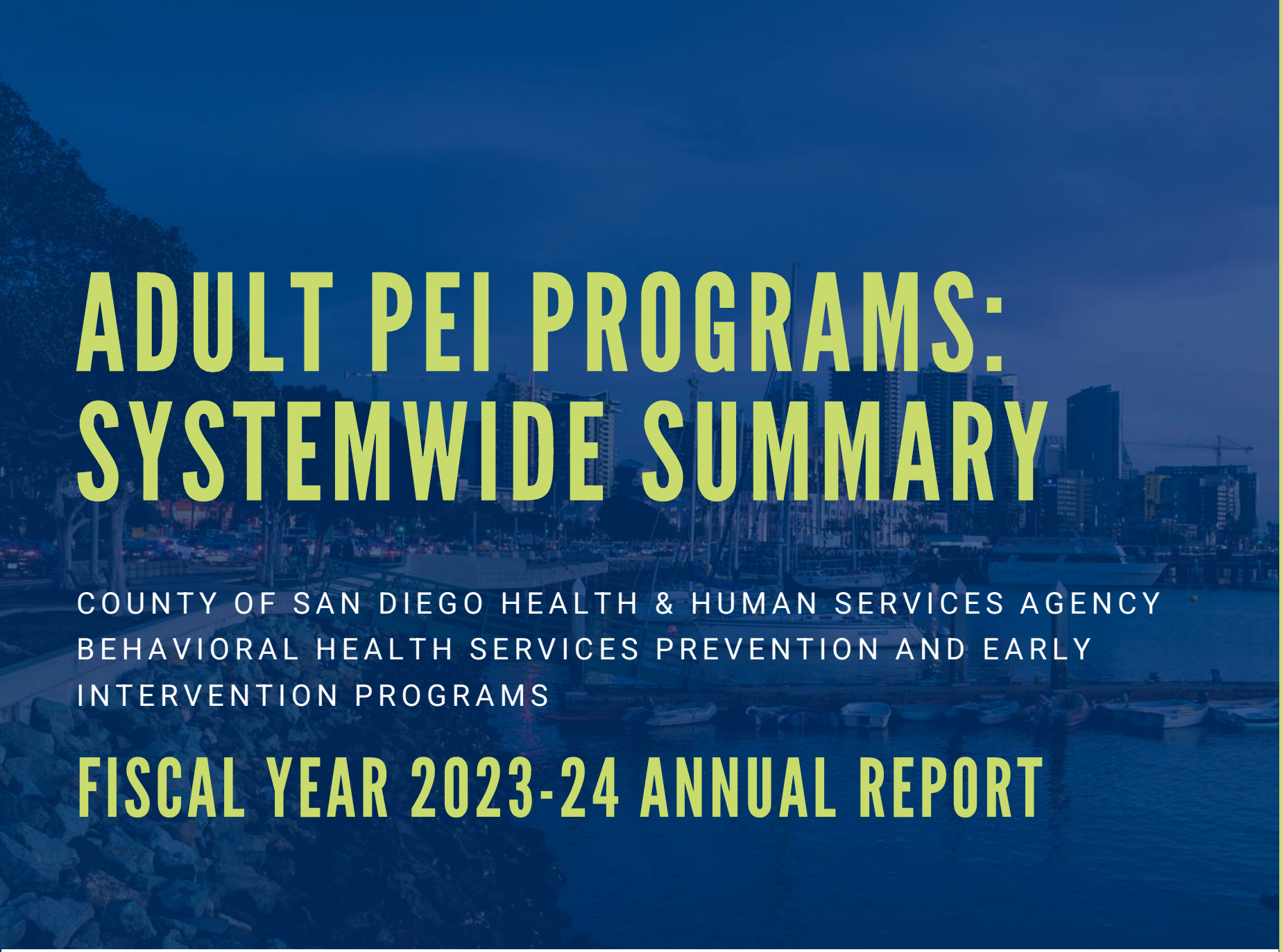
REFERRAL TRACKING SUMMARY*

- In FY 2017-18, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2023-24, a total of 248 participants received a mental health referral, and 192 of these participants received a mental health service as a result of the referral (Linkage Rate = 77.4%)
- A total of 17 participants received a substance use referral, and 14 of these participants received a substance use service as a result of the referral (Linkage Rate = 82.3%)
- The average time between referral and linkage to services was twenty-three days.

*Not all programs are required to collect referral data.

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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



ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

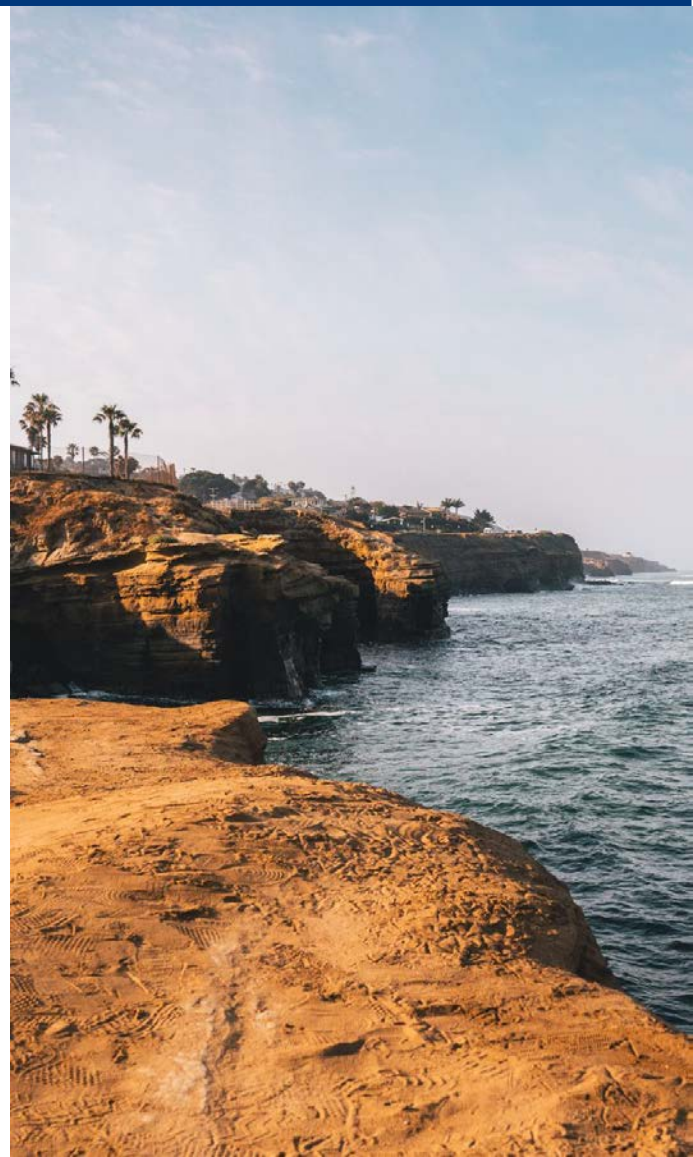
FISCAL YEAR 2023-24 ANNUAL REPORT

REPORT CONTENTS

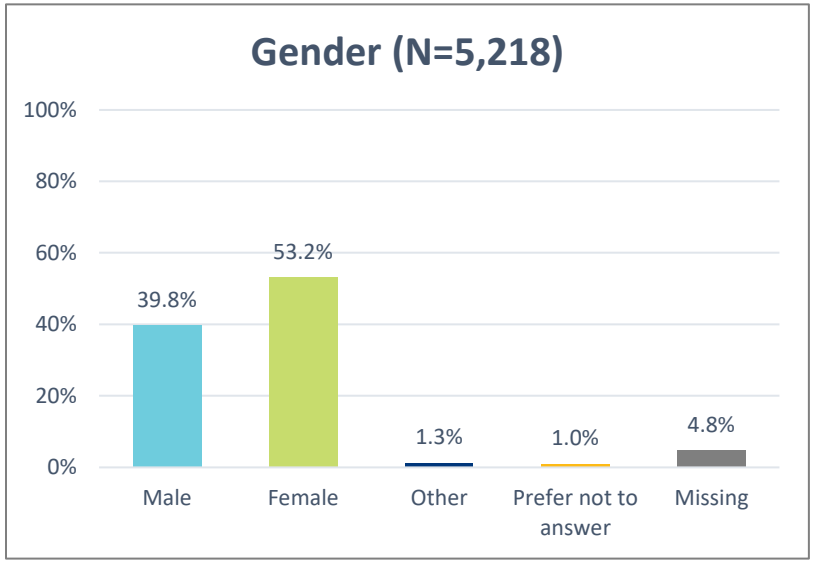
ADULT PEI PROGRAMS: BACKGROUND

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. The County of San Diego has funded contractors to provide PEI for adults. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing depression in Hispanic caregivers of individuals with Alzheimer's disease. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided.

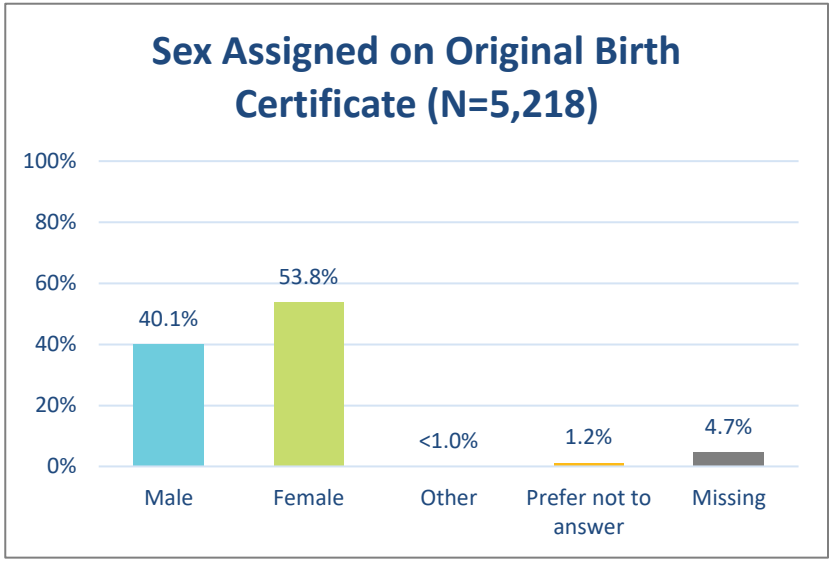
DATA: Adult PEI Programs
REPORT PERIOD: 7/1/2023 - 6/30/2024
NUMBER OF PARTICIPANTS WITH DATA IN FY 2023-24: 5,218 Unduplicated



PARTICIPANT DEMOGRAPHICS



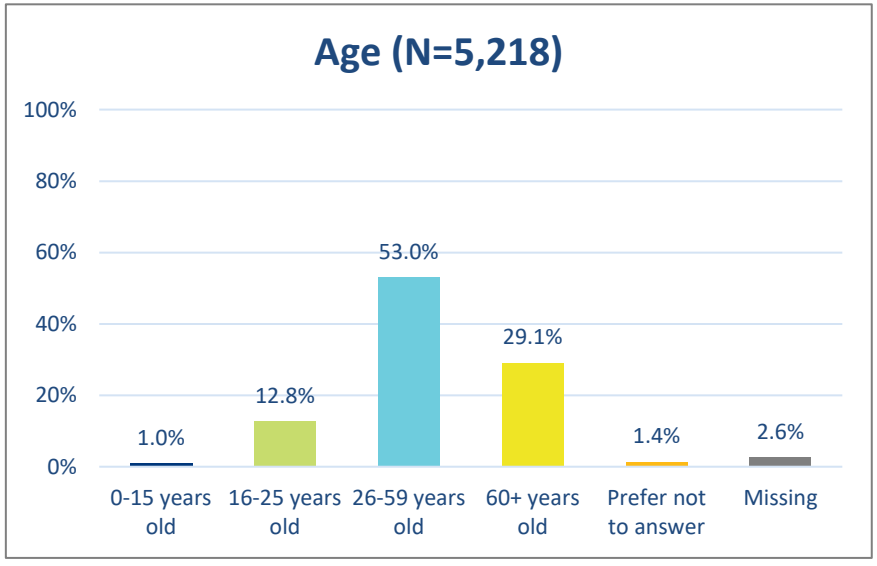
Fifty-three percent of participants identified as female. One percent of participants endorsed another gender identity. One percent of participants preferred not to answer this question.



Fifty-four percent of participants reported that the sex they were assigned on their original birth certificate was female.

Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



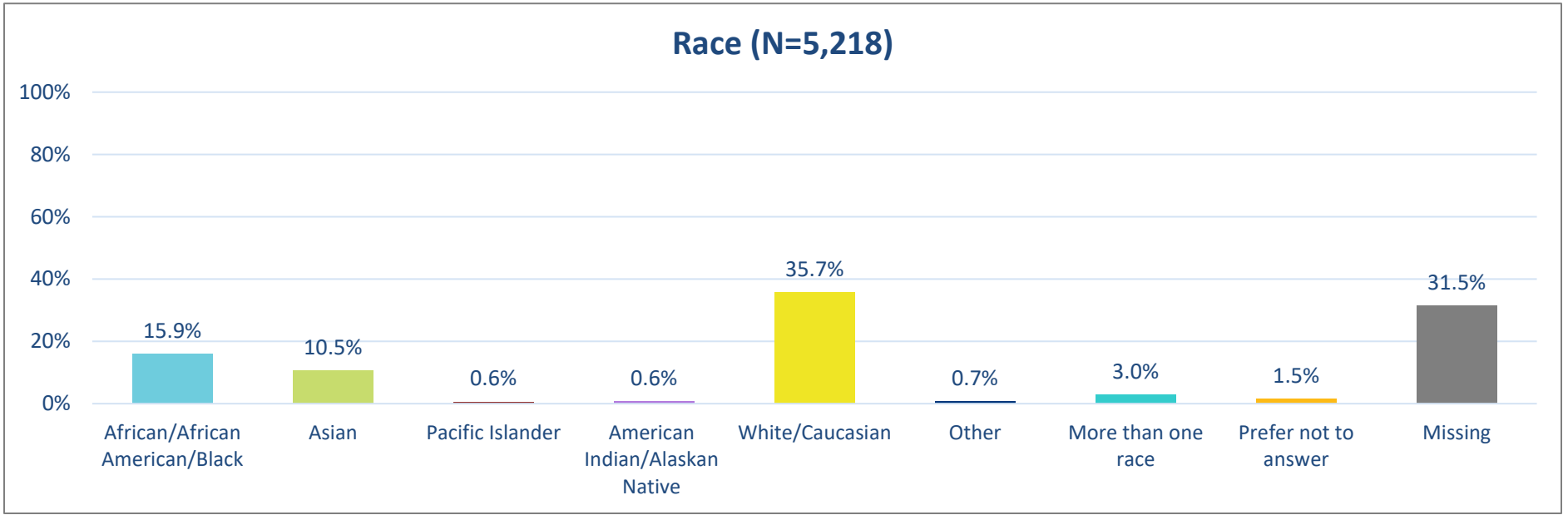
Primary Language (N=5,218)	Count	%
Arabic	134	2.6%
English	3,436	65.8%
Farsi	13	0.2%
Spanish	455	8.7%
Tagalog	183	3.5%
Vietnamese	15	0.3%
Other	716	13.7%
Prefer not to answer	41	0.8%
Missing	225	4.3%

The greatest proportion (53%) of participants were 26-59 years old.

Nine percent of participants identified their primary language as Spanish. Sixty-six percent of participants identified their primary language as English.

Note: Percentages may not add up to 100% due to rounding.

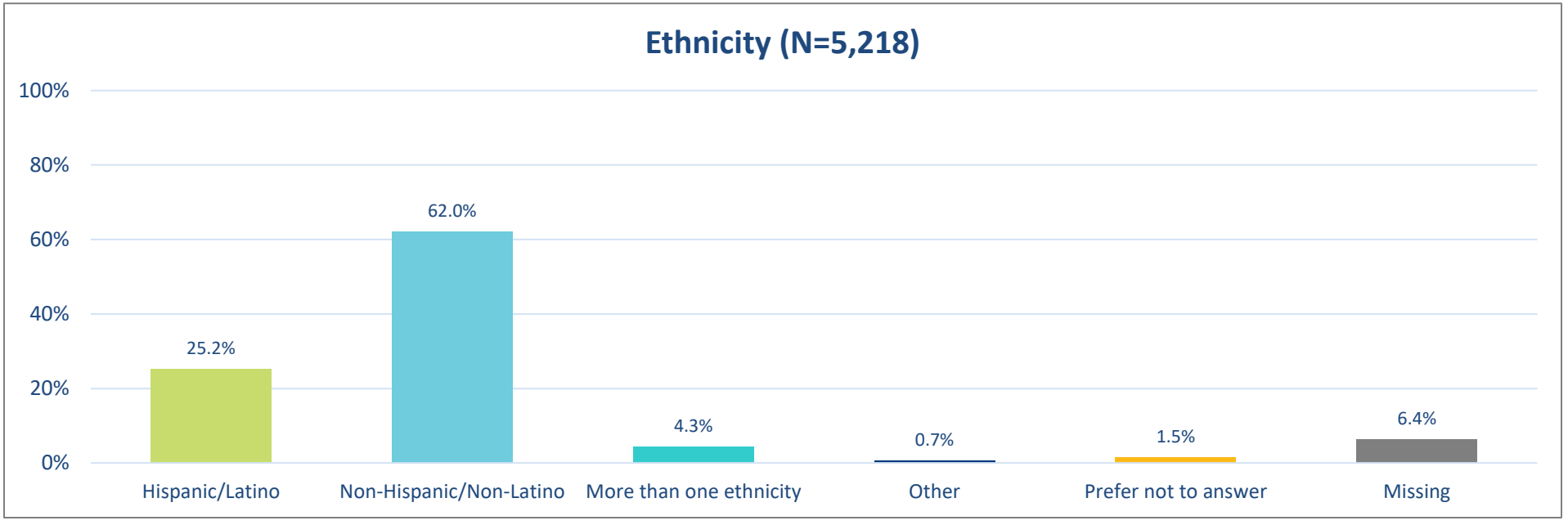
PARTICIPANT DEMOGRAPHICS continued



Thirty-six percent of participants identified their race as White/Caucasian. Sixteen percent of participants identified as African, African American or Black and 11% identified as Asian. The missing category includes participants who endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

Note: Percentages may not add up to 100% due to rounding.

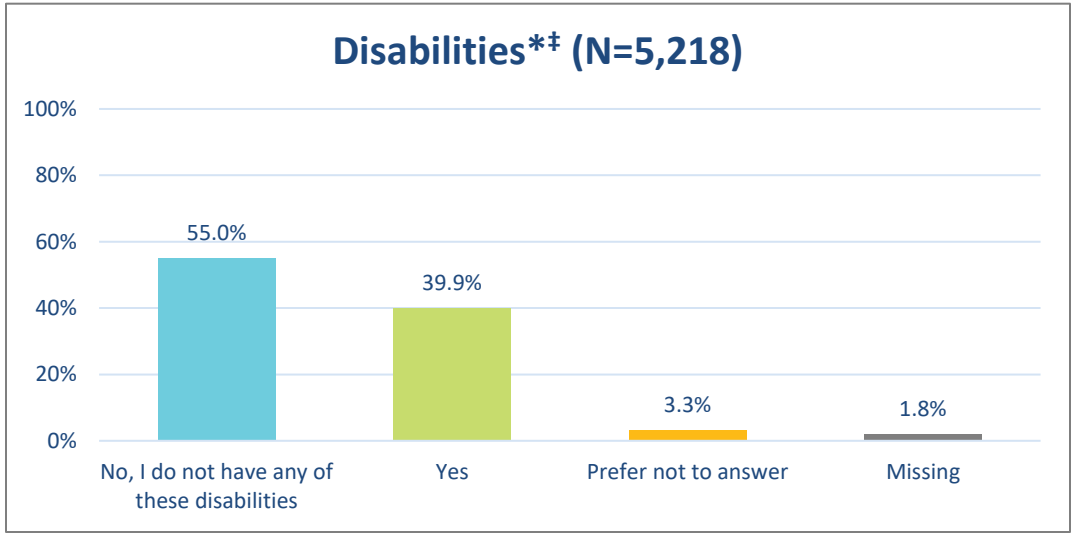
PARTICIPANT DEMOGRAPHICS continued



Twenty-five percent of participants identified their ethnicity as Hispanic/Latino. Four percent of participants identified as more than one ethnicity.

Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Forty percent of participants reported having a disability. Twenty-five percent of participants indicated that they had a chronic health condition or chronic pain. Three percent of participants preferred not to answer this question.

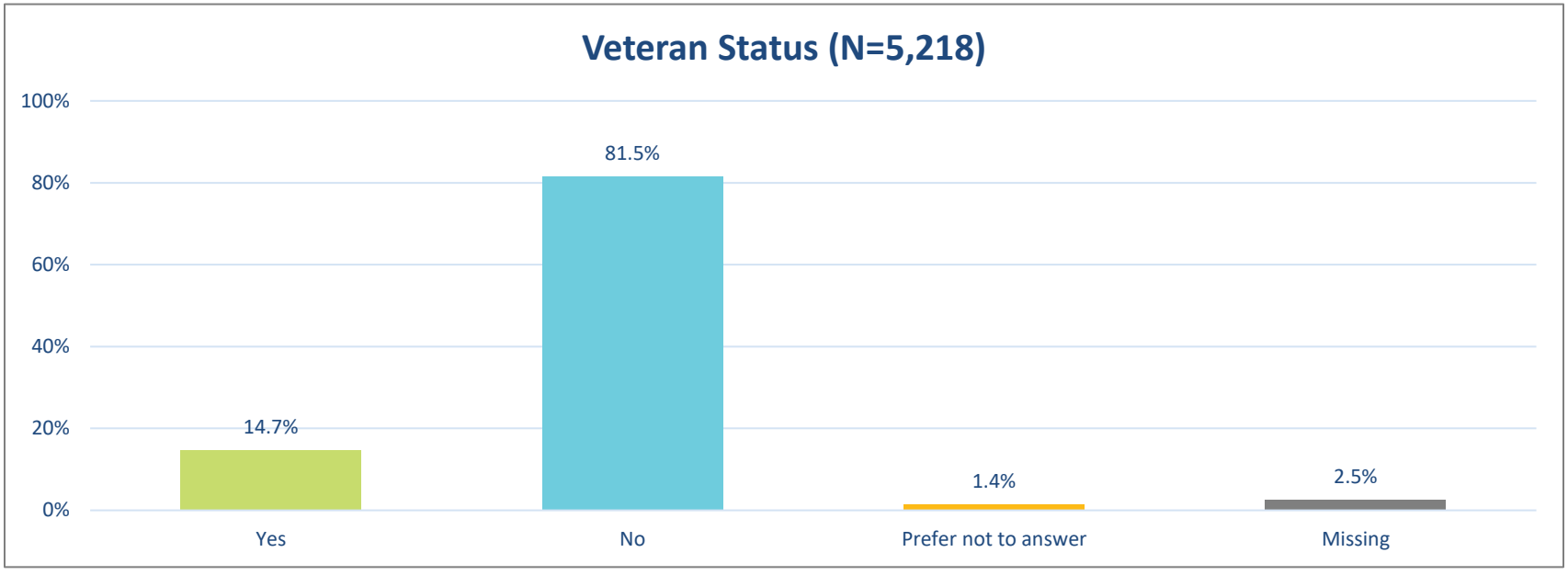
Disabilities*† (N=5,218)	Count	%
Difficulty seeing	188	3.6%
Difficulty hearing or having speech understood	81	1.6%
Other communication disability	<5	<1.0%
Mental disability not including a mental illness	286	5.5%
Learning disability	109	2.1%
Developmental disability	40	0.8%
Dementia	8	0.2%
Other mental disability not related to mental illness	129	2.5%
Physical/mobility disability	338	6.5%
Chronic health condition/chronic pain	1,282	24.6%
Other	309	5.9%
Prefer not to answer	170	3.3%
Missing	96	1.8%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*

† The sum of the percentages may exceed 100% because participants can select more than one type of disability .

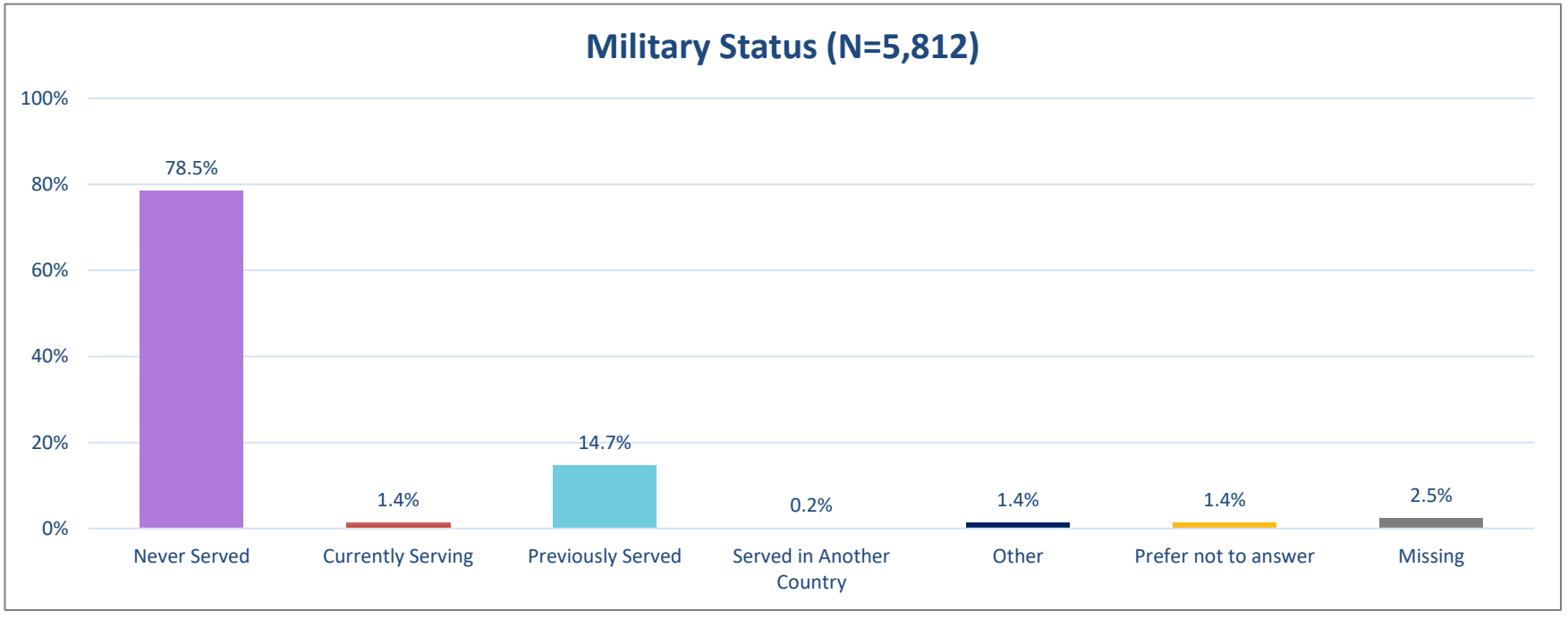
‡ Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



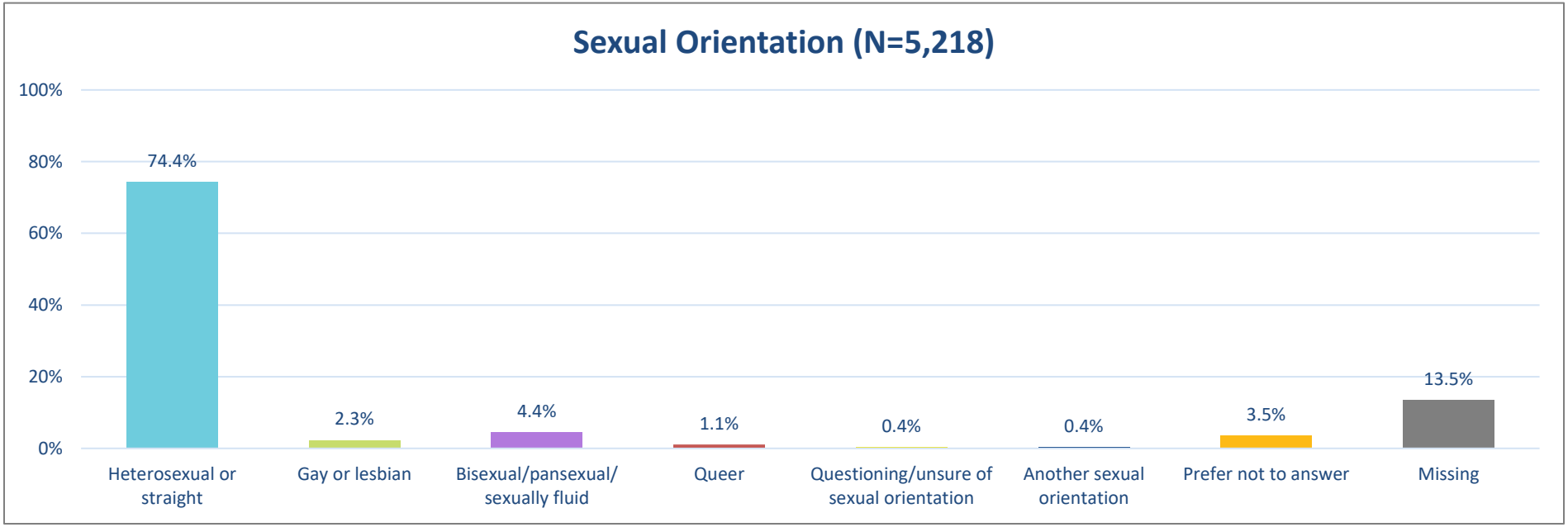
Fifteen percent of participants had served in the military. Additionally, 1.4% of participants reported currently serving in the military (data not shown).

PARTICIPANT DEMOGRAPHICS continued



Seventy-nine percent of participants had never served in the military. One percent of participants were currently serving in the military and 15% reported that they had previously served in the military.

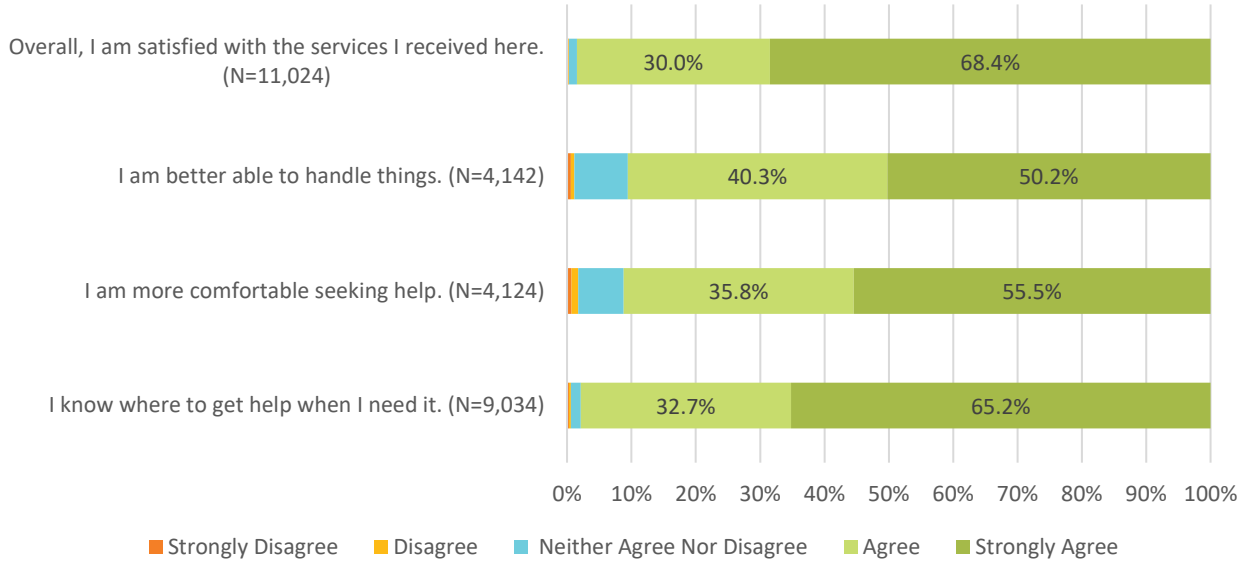
PARTICIPANT DEMOGRAPHICS continued



Seventy-four percent of participants identified their sexual orientation as heterosexual or straight. Four percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Four percent of participants preferred not to answer this question.

Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT SATISFACTION AND OUTCOMES*



**Satisfaction and outcome data are not available for all participants.*
Note: Satisfaction data may include duplicate participants.

Ninety-eight percent of participants agreed or strongly agreed that they were satisfied with the services they received. Ninety-one percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Ninety-one percent of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. Ninety-eight percent of the participants agreed or strongly agreed that they knew where to get needed help as a result of the program.

REFERRAL TRACKING SUMMARY*

- In FY 2017-18, the County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2023-24, a total of 326 participants received a mental health referral, and 51 of these participants received a mental health service as a result of the referral (Linkage Rate = 15.6%)
- A total of 397 participants received a substance use referral, and 113 of these participants received a substance use service as a result of the referral (Linkage Rate = 28.4%)
- The average time between referral and linkage to services was seven days.

** Not all PEI programs make referrals.*

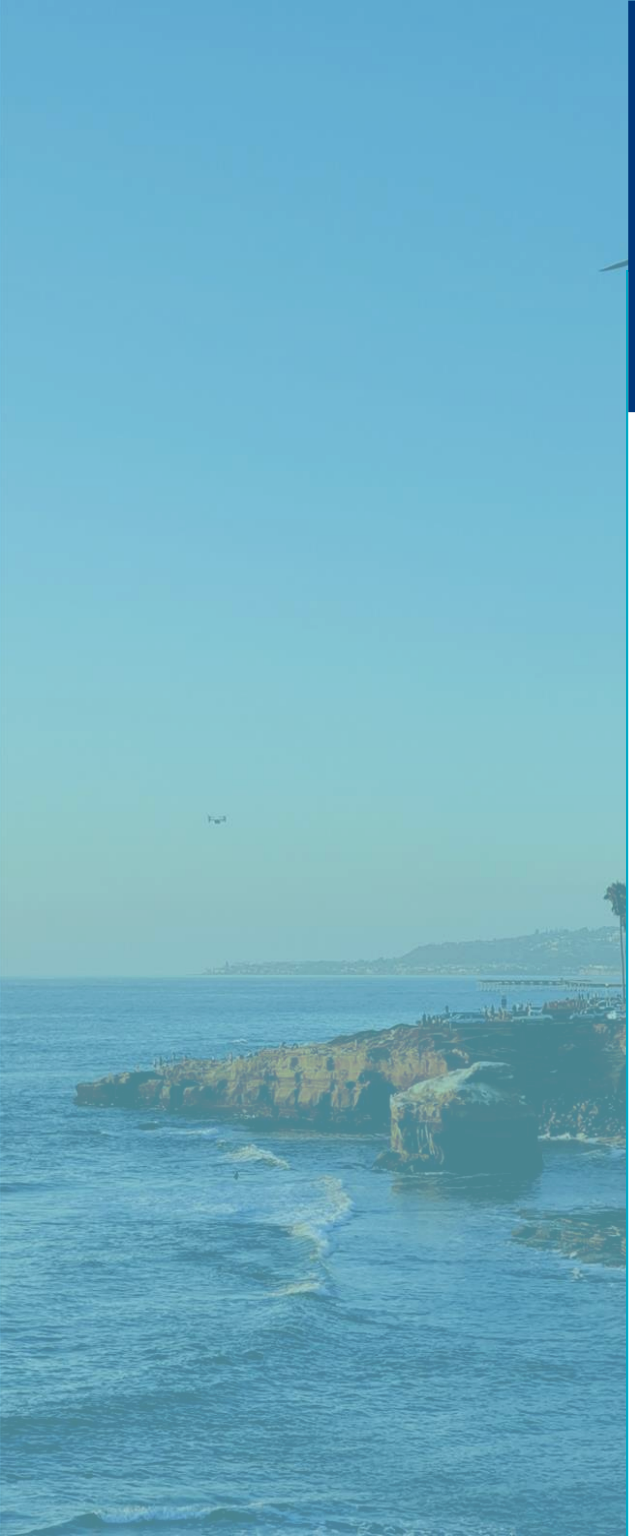
HEALTH SERVICES RESEARCH CENTER

The Health Services Research Center (HSRC) at the University of California, San Diego is a non-profit research organization within the Herbert Wertheim School of Public Health and Human Longevity Science. HSRC works in collaboration with the Quality Improvement Unit of the County of San Diego Behavioral Health Services to evaluate and improve behavioral health outcomes for County residents. Our research team specializes in the measurement, collection, and analysis of health outcomes data to help improve health care delivery systems and, ultimately, to improve client quality of life. For more information please contact Andrew Sarkin, PhD at 858-622-1771.

CHILD & ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

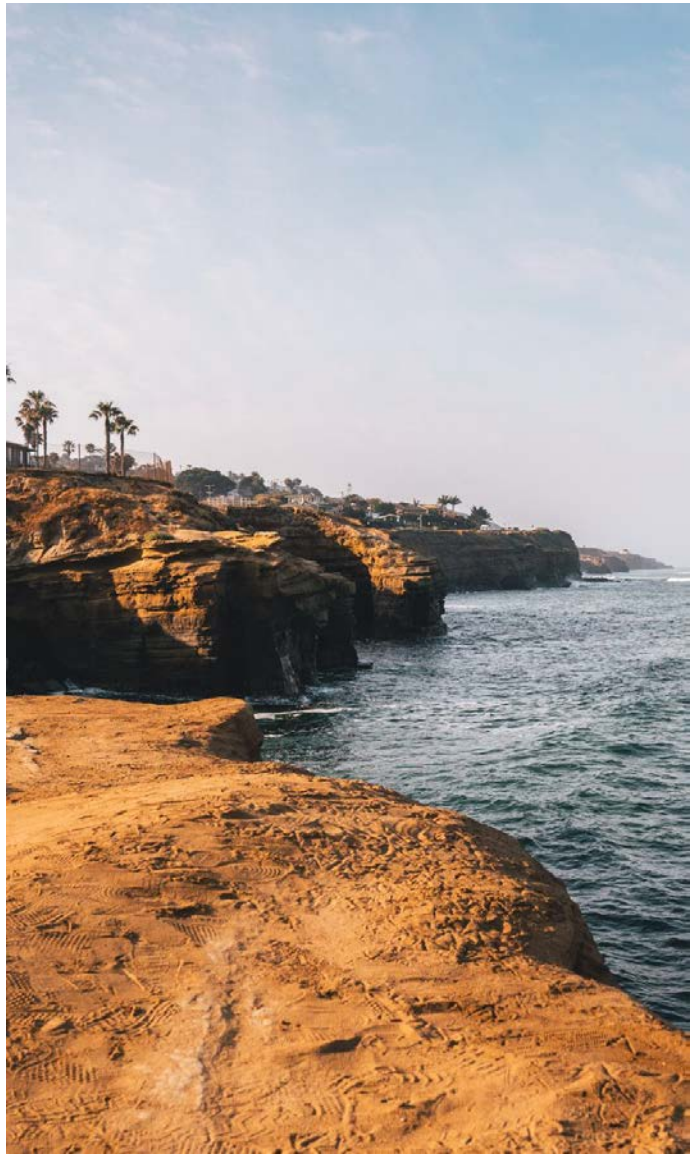
FISCAL YEAR 2023-24 ANNUAL REPORT



REPORT CONTENTS

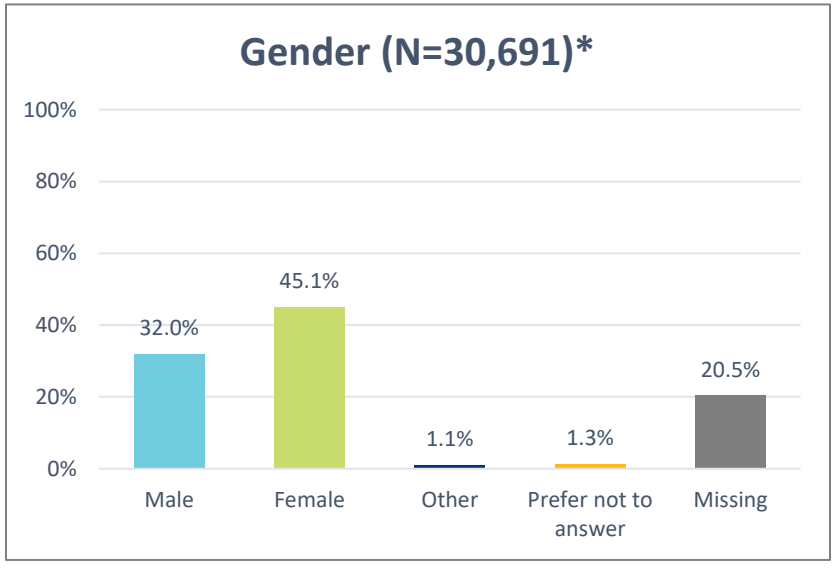
CHILD & ADULT PEI PROGRAMS: BACKGROUND

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. With this funding source, the County of San Diego contracted with providers for PEI programs for adults and older adults, youth and transition age youth (TAY), and their families. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by the program via outreach efforts, including but not limited to: presentations, community events, and fairs.



DATA: Child and Adult PEI Programs
REPORT PERIOD: 7/1/2023-6/30/2024
NUMBER OF PARTICIPANTS WITH DATA IN FY 2023-24: 30,691 Unduplicated*†
**Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators referenced in this report (N=30,691 vs. N=14,891).* *†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.*

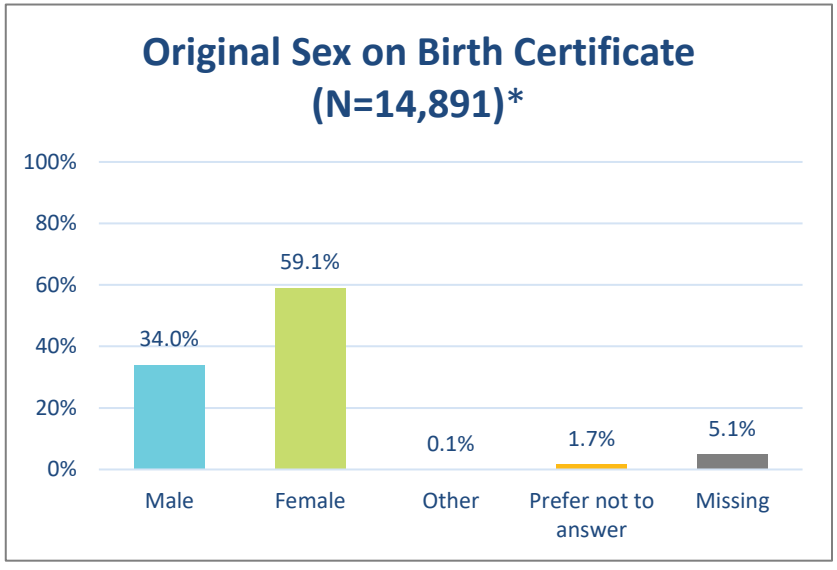
SYSTEMWIDE DEMOGRAPHICS



Forty-five percent of participants identified as female. One percent of participants endorsed another gender identity. One percent of participants preferred not to answer this question.

**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*

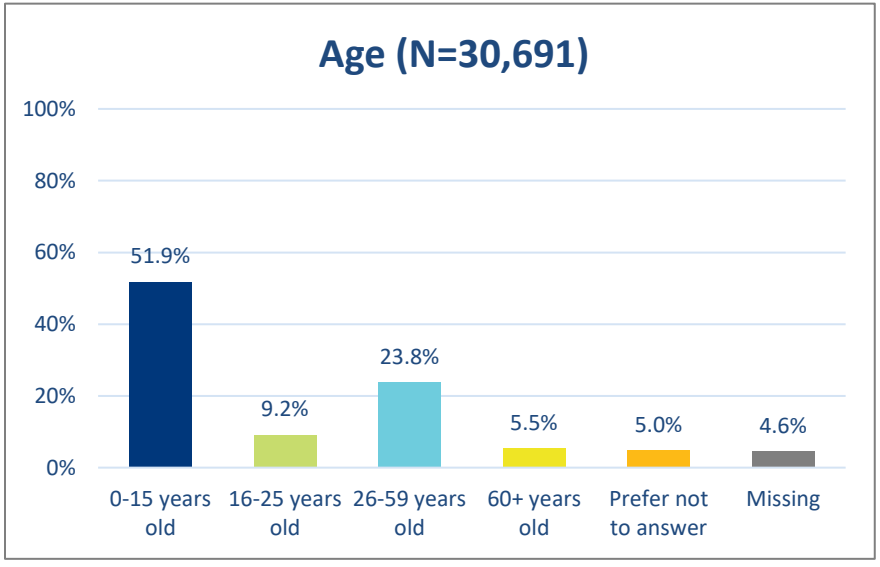
Note: Percentages may not add up to 100% due to rounding.



Fifty-nine percent of participants reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =14,891 vs. N=30,691).*

SYSTEMWIDE DEMOGRAPHICS continued



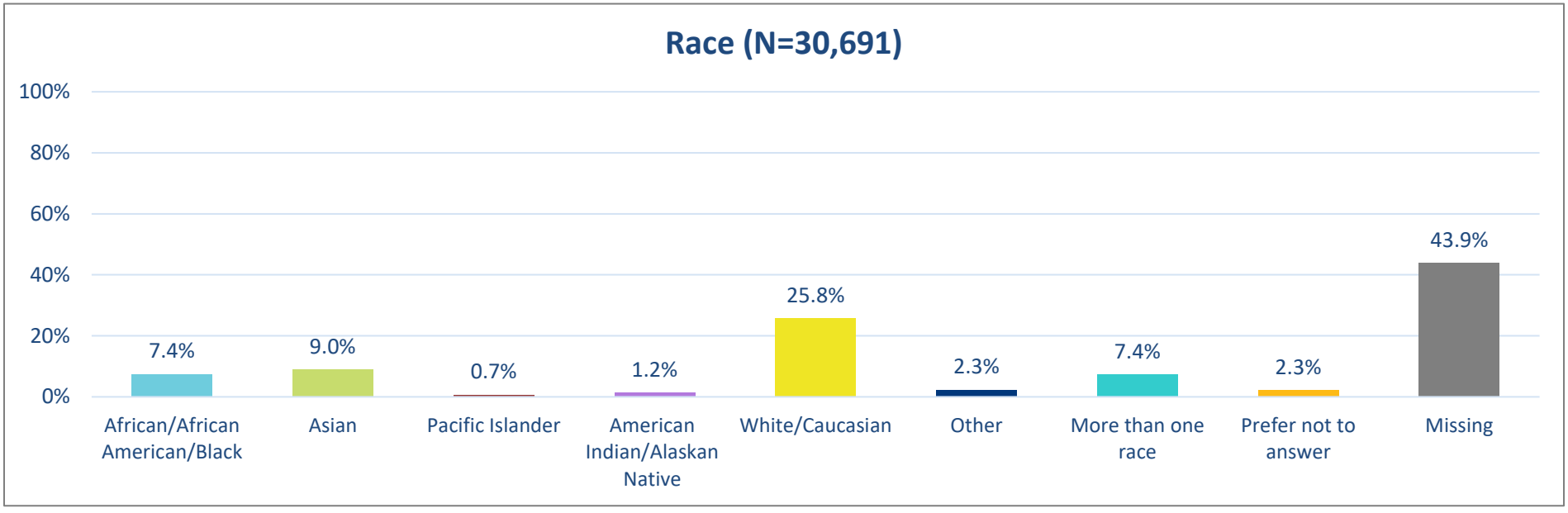
Fifty-two percent of participants were 15 or younger. Twenty-four percent of participants were between the ages of 26 and 59.

Primary Language (N=14,891)*	Count	%
Arabic	207	1.4%
English	7,713	51.8%
Farsi	38	0.3%
Spanish	4,640	31.2%
Tagalog	199	1.3%
Vietnamese	72	0.5%
Other	973	6.5%
Prefer not to answer	140	0.9%
Missing	909	6.1%

Thirty-one percent of participants identified their primary language as Spanish. Fifty-two percent of participants identified their primary language as English.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =14,891 vs. N=30,691).*
Note: Percentages may not add up to 100% due to rounding.

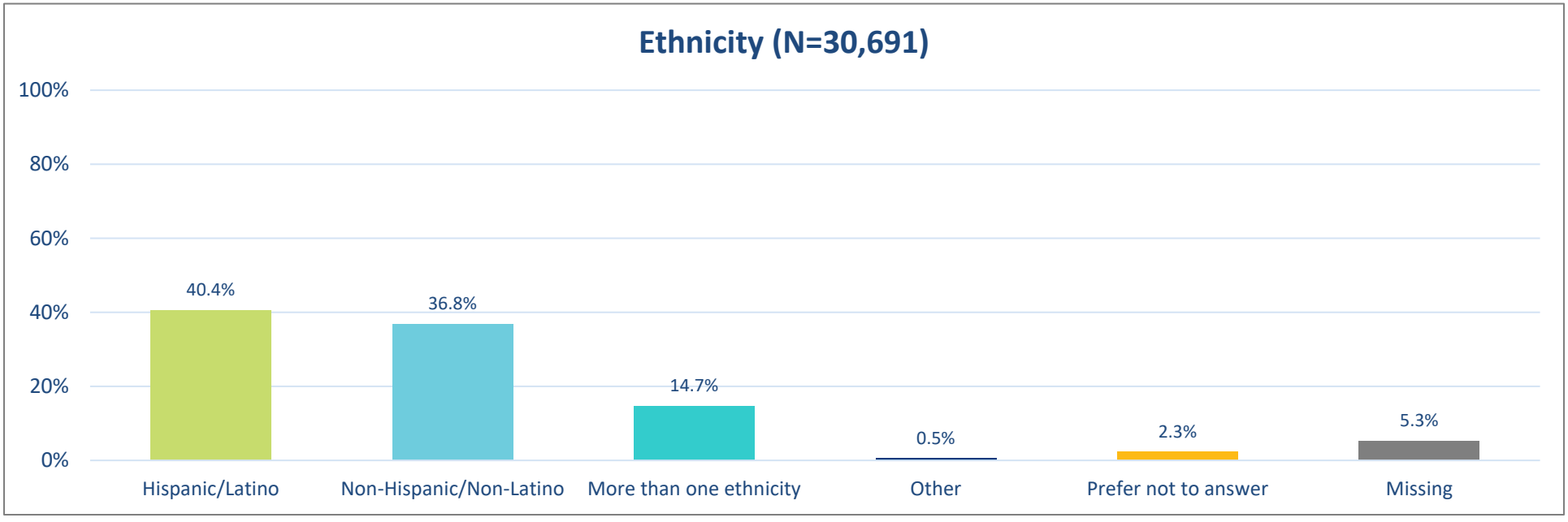
SYSTEMWIDE DEMOGRAPHICS continued



Twenty-six percent of participants identified their race as White/Caucasian. Seven percent of participants identified as African, African American or Black and 9% identified as Asian. The missing category includes participants who endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

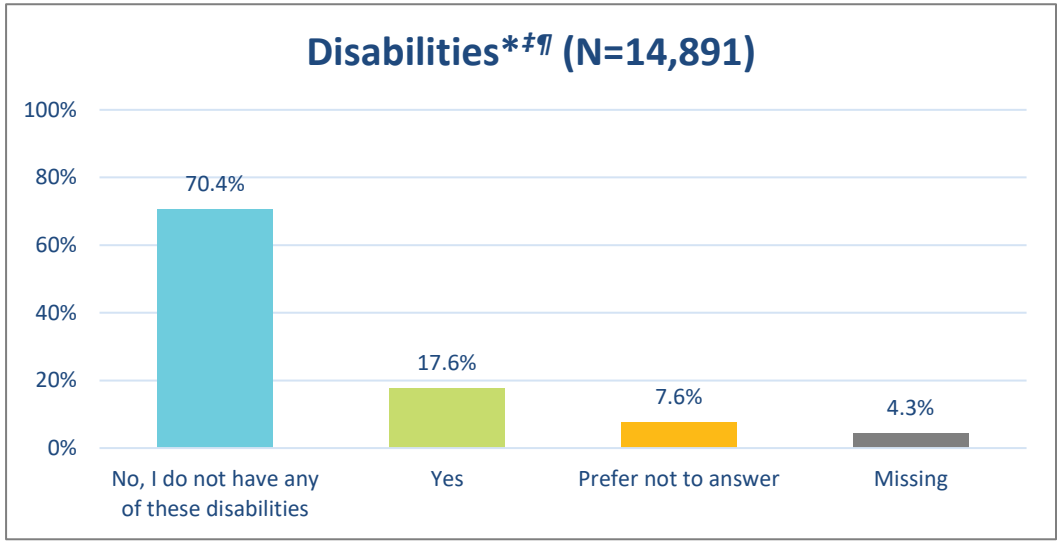
Note: Percentages may not add up to 100% due to rounding.

SYSTEMWIDE DEMOGRAPHICS continued



Forty percent of participants identified their ethnicity as Hispanic/Latino. Fifteen percent of participants identified as more than one ethnicity.

SYSTEMWIDE DEMOGRAPHICS continued

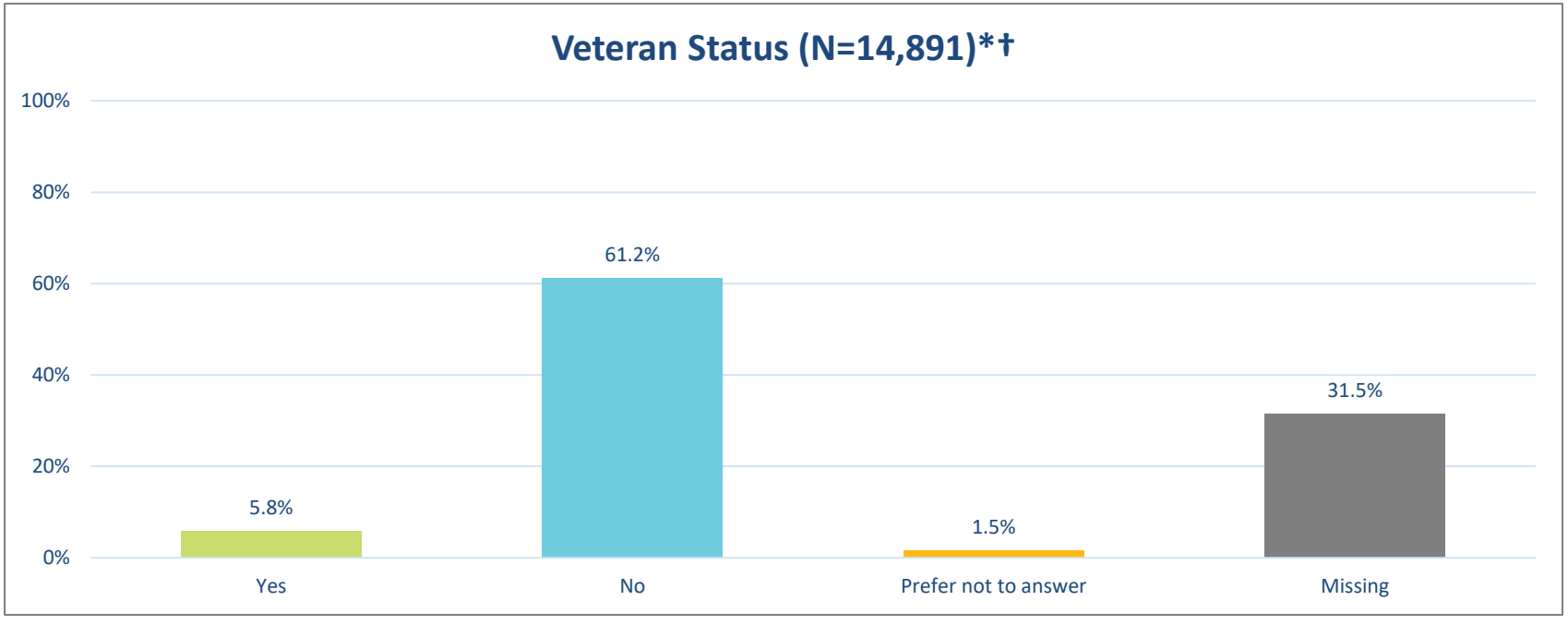


Eighteen percent of participants reported having a disability. Nine percent of participants indicated that they had a chronic health condition or chronic pain. Eight percent of participants preferred not to answer this question.

Disabilities*†‡ (N=14,891)	Count	%
Difficulty seeing	313	2.1%
Difficulty hearing or having speech understood	157	1.1%
Other communication disability	29	0.2%
Mental disability not including a mental illness	478	3.2%
Learning disability	200	1.3%
Developmental disability	101	0.7%
Dementia	15	0.1%
Other mental disability not related to mental illness	162	1.1%
Physical/mobility disability	403	2.7%
Chronic health condition/chronic pain	1,320	8.9%
Other	434	2.9%
Prefer not to answer	1,137	7.6%
Missing	640	4.3%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability.
‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =14,891 vs. N=30,691).
¶ Percentages may not add up to 100% due to rounding.

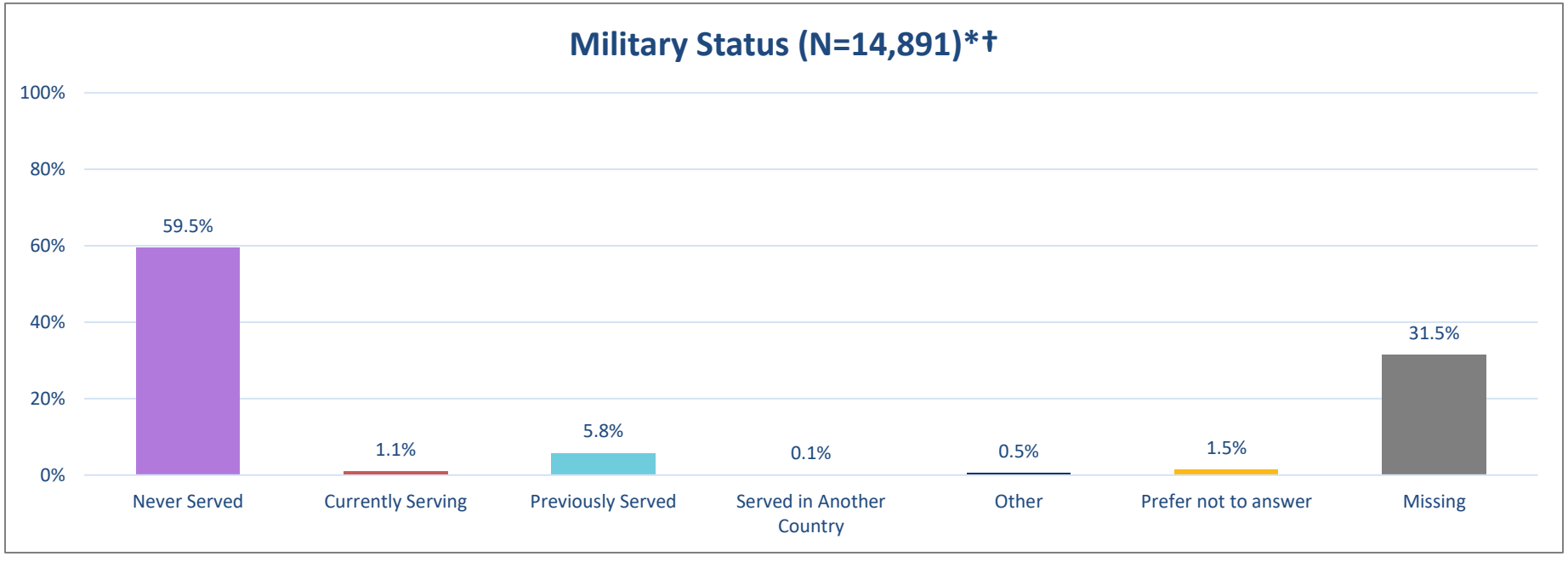
SYSTEMWIDE DEMOGRAPHICS continued



Information on veteran status indicated that 6% of participants had served in the military. One percent of participants reported that they are currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =14,891 vs. N=30,691).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."

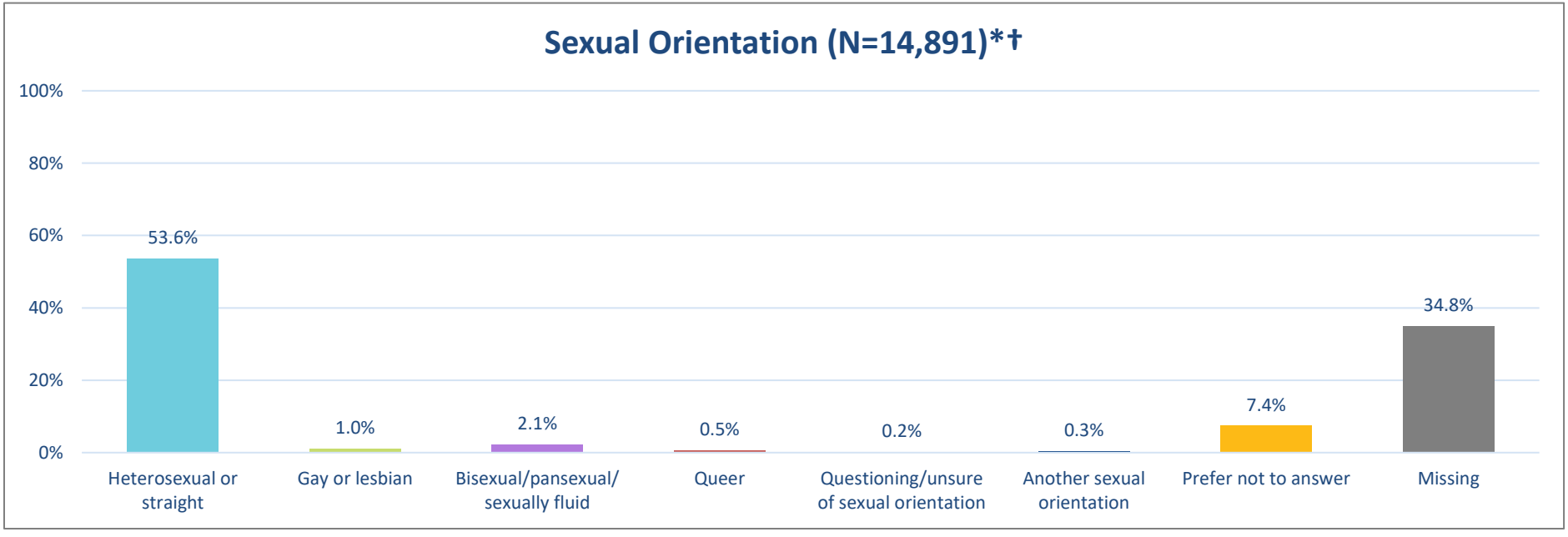
SYSTEMWIDE DEMOGRAPHICS continued



Sixty percent of participants had never served in the military. One percent of participants indicated that they are currently serving in the military and 6% indicated that they had previously served in the military.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =14,891 vs. N=30,691).*
† Military status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

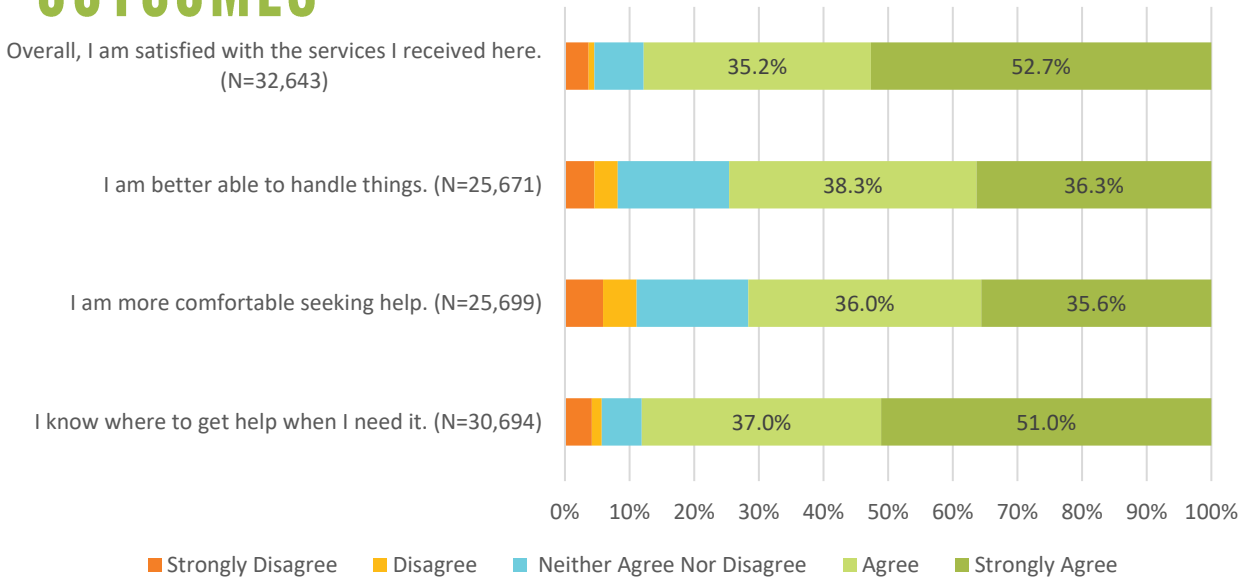
SYSTEMWIDE DEMOGRAPHICS continued



Fifty-four percent of participants identified their sexual orientation as heterosexual or straight. Two percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Seven percent of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =14,891 vs. N=30,691).*
† Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

SYSTEMWIDE SATISFACTION AND OUTCOMES* †



**Satisfaction and outcome data are not available for all participants.*
† Satisfaction data may include duplicate participants.

Eighty-eight percent of participants agreed or strongly agreed that they were satisfied with the services they received and 88% of participants agreed or strongly agreed that they knew where to get needed help as a result of the program. Seventy-five percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Seventy-two percent of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program.

SYSTEMWIDE REFERRAL TRACKING SUMMARY*

- In FY 2017-18, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2023-24, a total of 574 participants received a mental health referral, and 243 of these participants received a mental health service as a result of the referral (Linkage Rate = 42.3%)
- A total of 414 participants received a substance use referral, and 127 of these participants received a substance use service as a result of the referral (Linkage Rate = 30.7%)
- The average time between referral and linkage to services was sixteen days.

**Not all PEI programs make referrals.*

HEALTH SERVICES RESEARCH CENTER

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CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

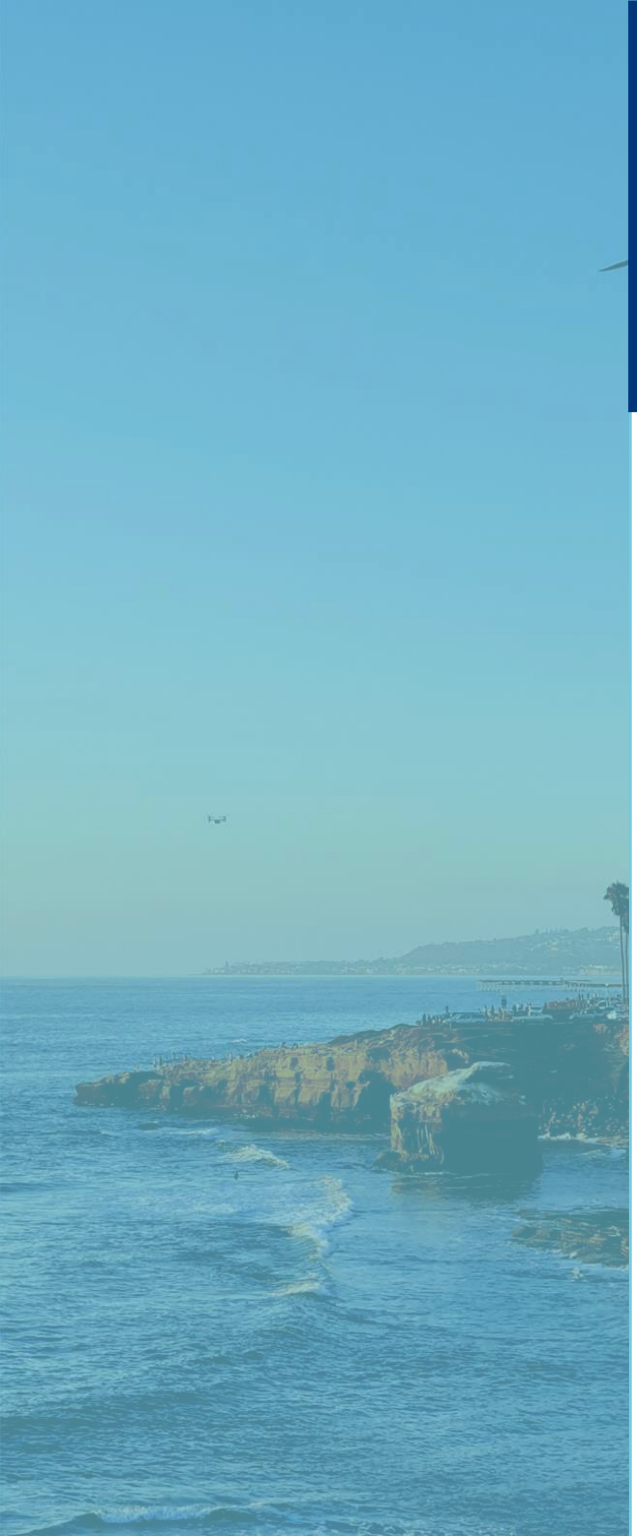
The Child and Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California San Diego, San Diego State University, University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

KICKSTART (FB01) PATHWAYS COMMUNITY SERVICES

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

FISCAL YEAR 2023-24 ANNUAL REPORT

REGION: Central & North Central – District 4



REPORT CONTENTS

BACKGROUND

The purpose of this program is to provide prevention and early intervention services to youth and young adults ages 10-25 who may have clinical high risk (CHR) symptoms of psychosis or have had their first episode of psychosis (FEP). The prevention component of the program focuses on providing psychoeducation and outreach to the community, including other behavioral health providers, school staff, hospital staff, faith-based leaders, and others who may have contact with youth in general community settings. These community leaders are provided education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis. The early intervention component of the program includes a comprehensive assessment (the Structured Interview for Psychosis-Risk Syndromes) to determine the risk for, or the presence of, severe mental illness. This instrument also assesses for emotional dysregulation, physical health needs, stress tolerance, cognitive functioning, substance use issues, and potential safety concerns. Based upon results of the assessment, youth and their families may be referred and linked to outside community resources to best meet their needs. Youth who screen positive for CHR or FEP symptoms receive an intake into this program and participate in a variety of services: psychoeducation workshops, multi-family groups, and support services including medication/nursing services, occupational therapy, peer support services, and education/employment support. Treatment interventions include individual, family, and group therapy. These services may be provided via telehealth. This report focuses on youth and community demographics and youth outcomes.

MAJOR DATA POINTS

CONTRACTOR: Pathways Community Services	
CONTRACT START DATE: 12/01/2009	DATA COLLECTION START DATE: 05/2010
PROGRAM SERVICES START DATE: 4/1/2010	**REPORT PERIOD: 7/1/2023-6/30/2024**

524

CLIENTS WITH DEMOGRAPHIC DATA IN FY 2023-24 (UNDUPLICATED)

188

COMMUNITY CLIENTS WITH DATA IN FY 2023-24 (UNDUPLICATED)

6,896

COMMUNITY MEMBERS WHO RECEIVED TRAININGS SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE PARTICIPANTS)

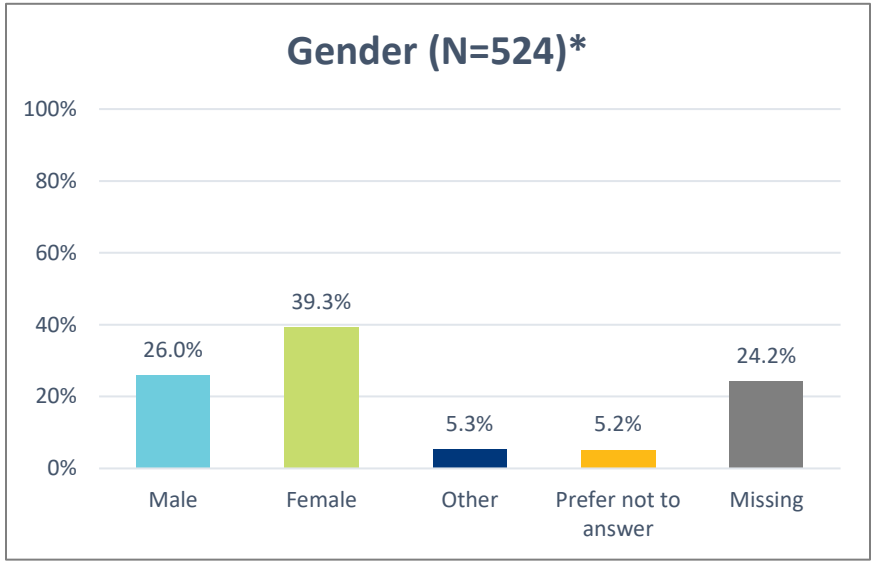
2,174

YOUTH SCREENED SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE YOUTH)

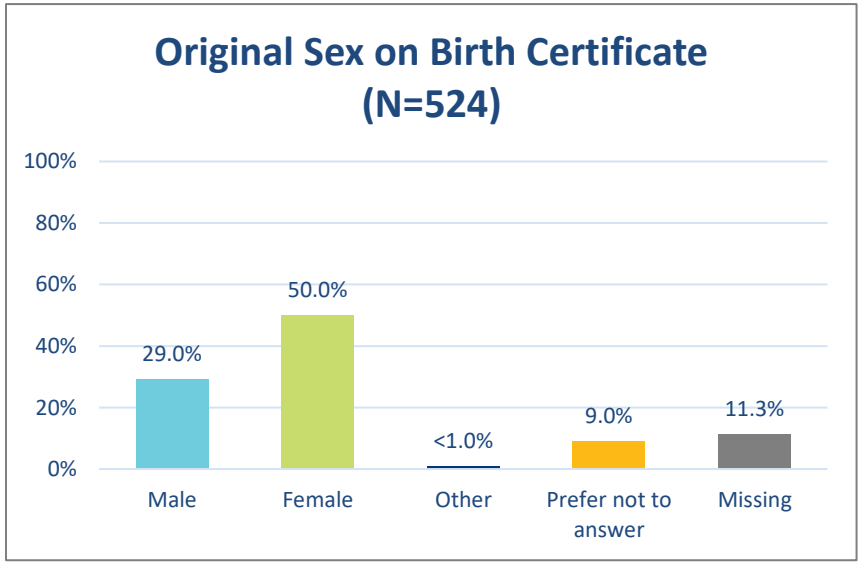
1,338

YOUTH ENROLLED SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE YOUTH)

PARTICIPANT DEMOGRAPHICS



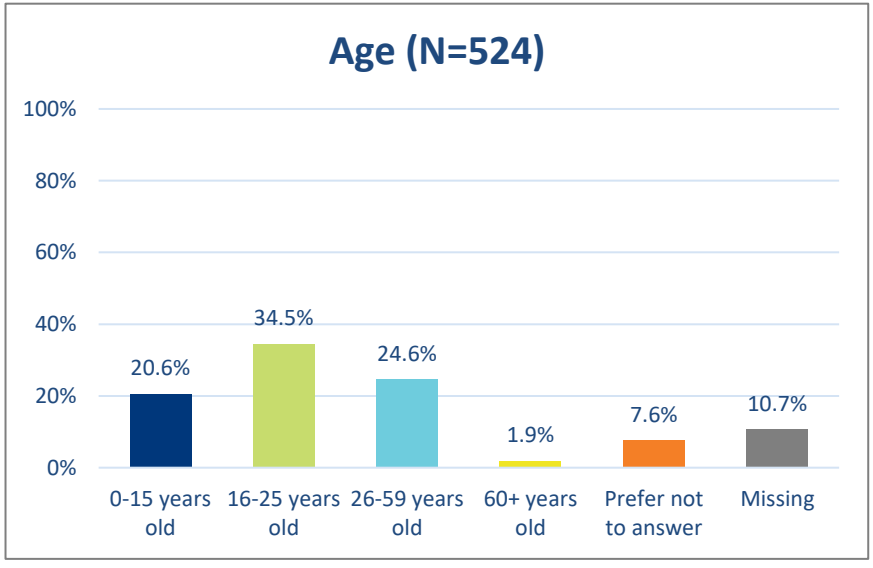
Thirty-nine percent of participants identified as female. Five percent of participants endorsed another gender identity. Five percent of participants preferred not to answer this question.



Fifty percent of participants reported that the sex they were assigned on their original birth certificate was female.

**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



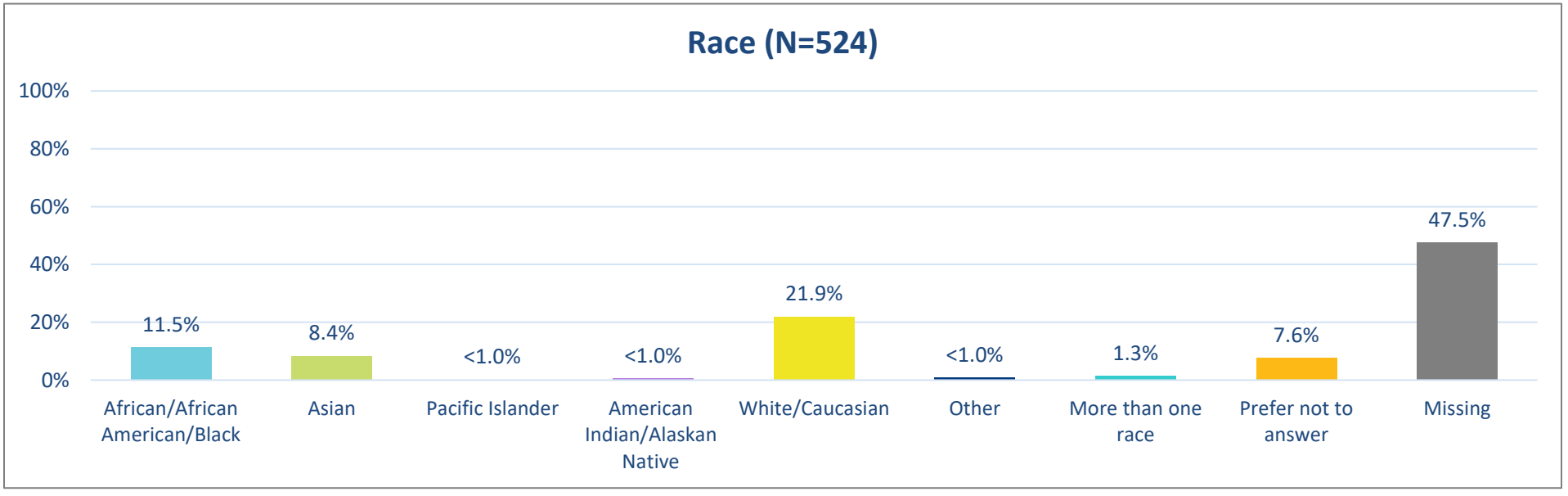
Primary Language (N=524)	Count	%
English	399	76.1%
Spanish	17	3.2%
Arabic	<5	<1.0%
Farsi	<5	<1.0%
Tagalog	<5	<1.0%
Other	6	1.1%
Prefer not to answer	31	5.9%
Missing	61	11.6%

Thirty-five percent of participants were 16 to 25 years old.

Three percent of participants identified their primary language as Spanish. Seventy-six percent of participants identified their primary language as English.

Note: Percentages may not add up to 100% due to rounding.

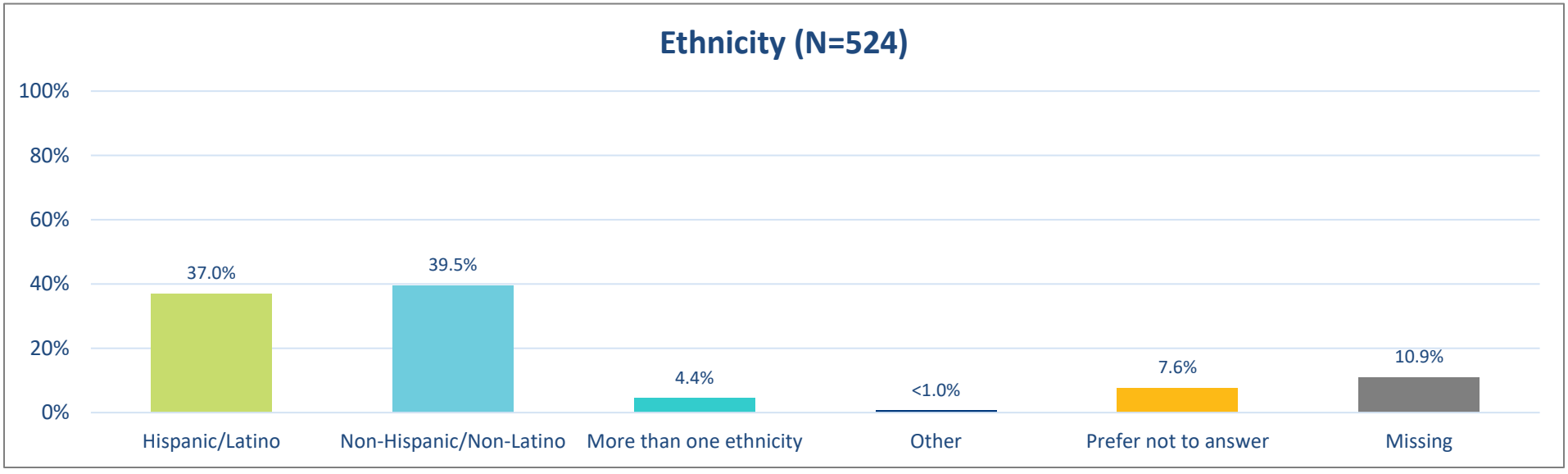
PARTICIPANT DEMOGRAPHICS continued



Twenty-two percent of participants identified their race as White/Caucasian. Twelve percent of participants identified as African, African American or Black and 8% identified as Asian. The missing category includes participants who endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

Note: Percentages may not add up to 100% due to rounding.

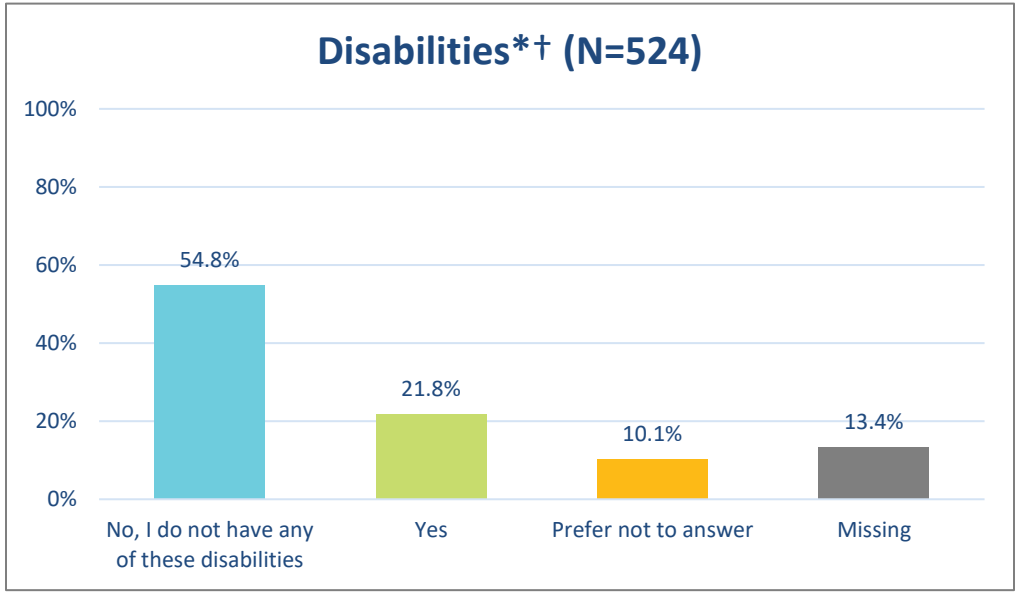
PARTICIPANT DEMOGRAPHICS continued



Thirty-seven percent of participants identified their ethnicity as Hispanic/Latino.

Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Twenty-two percent of participants reported having a disability. Eight percent of participants indicated having a mental disability (not including a mental illness). Ten percent preferred not to answer this question.

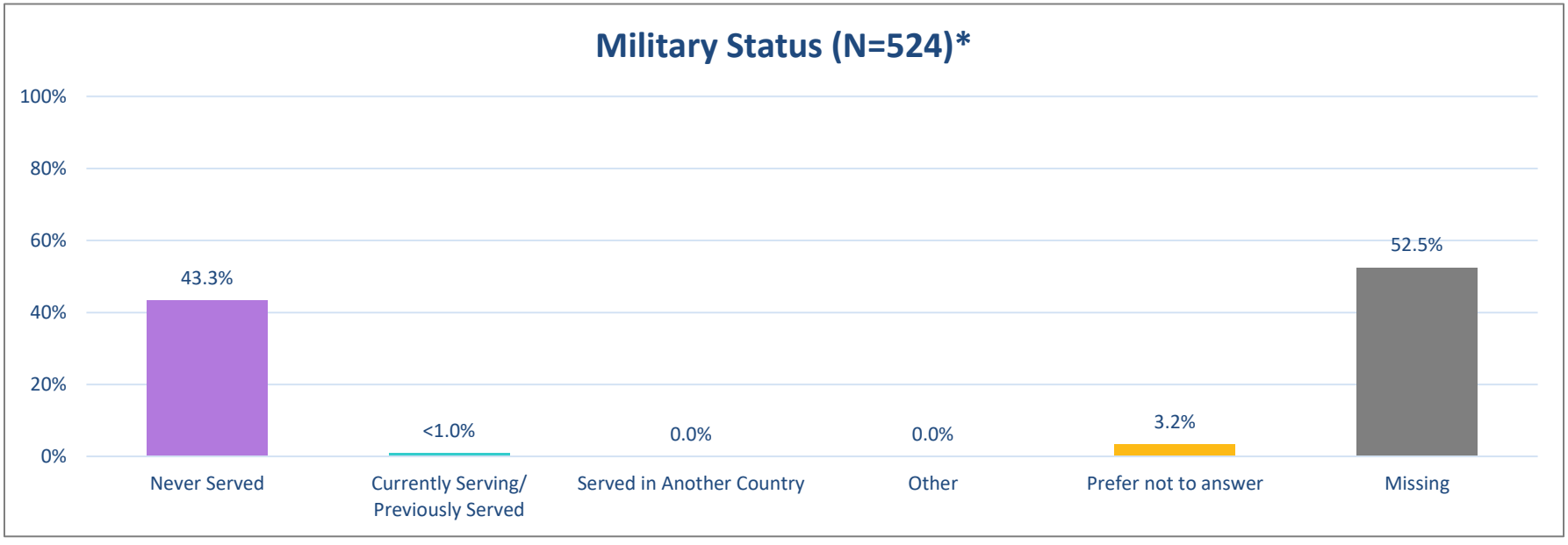
Disabilities*† (N=524)	Count	%
Difficulty seeing	35	6.7%
Difficulty hearing or having speech understood	7	1.3%
Other communication disability	<5	<1.0%
Mental disability not including a mental illness	41	7.8%
Learning disability	20	3.8%
Developmental disability	15	2.9%
Dementia	<5	<1.0%
Other mental disability not related to mental illness	<5	<1.0%
Physical/mobility disability	7	1.3%
Chronic health condition/chronic pain	6	1.1%
Other	35	6.7%
Prefer not to answer	53	10.1%
Missing	70	13.4%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*

† The sum of the percentages may exceed 100% because participants can select more than one type of disability.

Note: Percentages may not add up to 100% due to rounding.

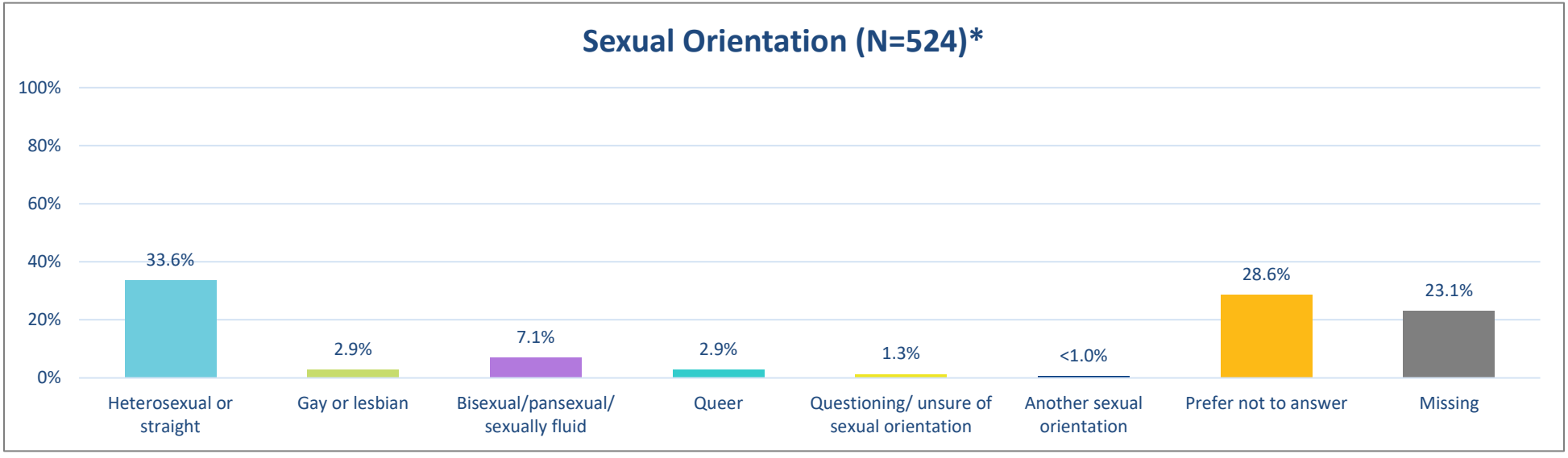
PARTICIPANT DEMOGRAPHICS continued



Less than 1% of participants are currently serving or had previously served in the military.

**Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Thirty-four percent of the participants identified their sexual orientation as heterosexual or straight. Seven percent identified their sexual orientation as bisexual/pansexual/sexually fluid and 3% identified as gay or lesbian. Twenty-nine percent of participants preferred not to answer this question.

**Sexual orientation not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

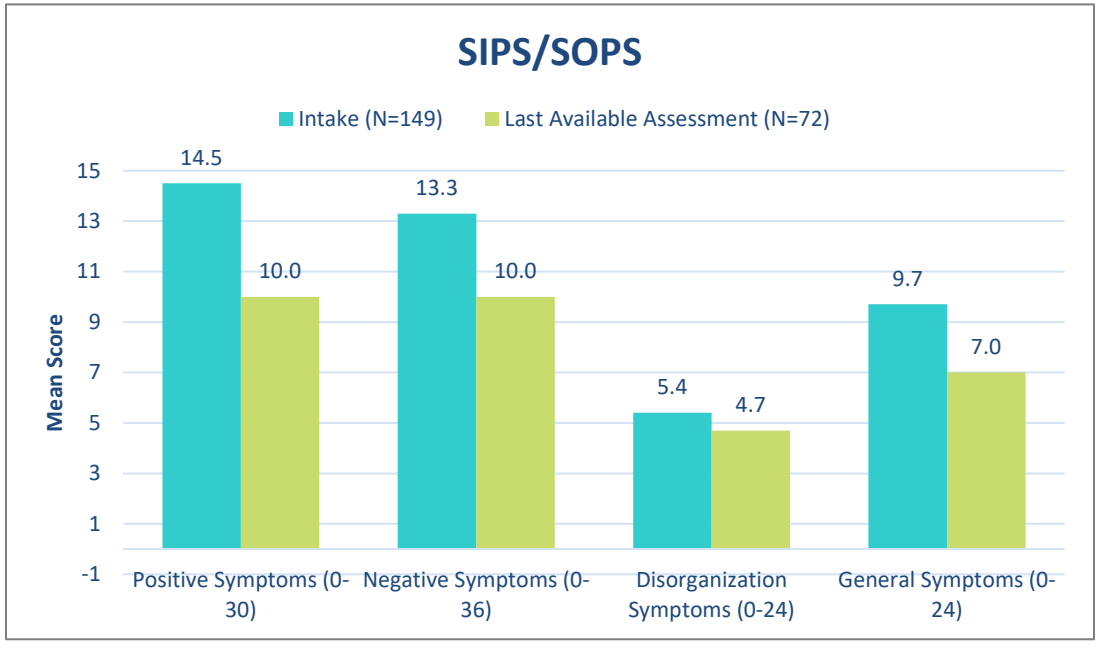
INTAKE: PHONE SCREENS

SYMPTOMS REPORTED AT INITIAL SCREENING*	N	%
Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty concentrating), N=208	178	85.6
Changes in perception (auditory, visual, tactile, olfactory abnormalities), N=212	168	79.2
Changes in speech (disorganized communication, tangential speech), N=207	133	64.3
Changes in view (of self, others, or the world in general), N=195	115	59.0
Changes in emotions (depression, mood swings, irritability, flat affect), N=208	178	85.6
Vegetative symptoms (sleep problems, changes in appetite, social isolation), N=212	182	85.8
Family history of mental illness (schizophrenia, bipolar disorder, schizoaffective disorder, psychosis), N=198	116	58.6
Dramatic reduction of overall functioning, N=195	140	71.8

In FY 2023-24, 221 youth were screened for admission into the Kickstart program. The majority of phone screen participants experienced changes in thinking, emotions, and vegetative symptoms. Additionally, 72% of phone screen participants reported experiencing a dramatic reduction in overall functioning.

**Not all youth had complete data for every item on the screener.*

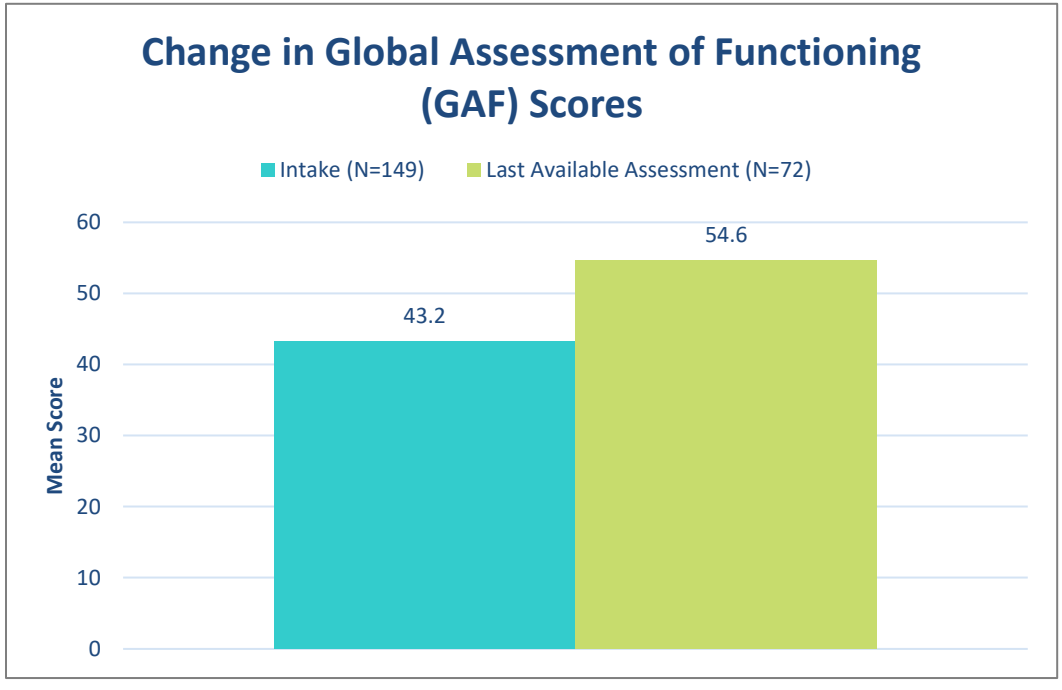
YOUTH OUTCOMES



A higher score on any Structured Interview for Psychosis-Risk Syndromes/Scale of Prodromal Symptoms (SIPS/SOPS) domain indicates higher symptom severity. On average, by the last available assessment, the severity of prodromal symptoms decreased compared to intake. Additional analyses were conducted with participants who had both an intake assessment and at least one other assessment. Participants included in these analyses showed statistically significant improvements ($p<.001$) on the Positive Symptoms, Negative Symptoms and General Symptoms Subscales.

*Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

YOUTH OUTCOMES continued

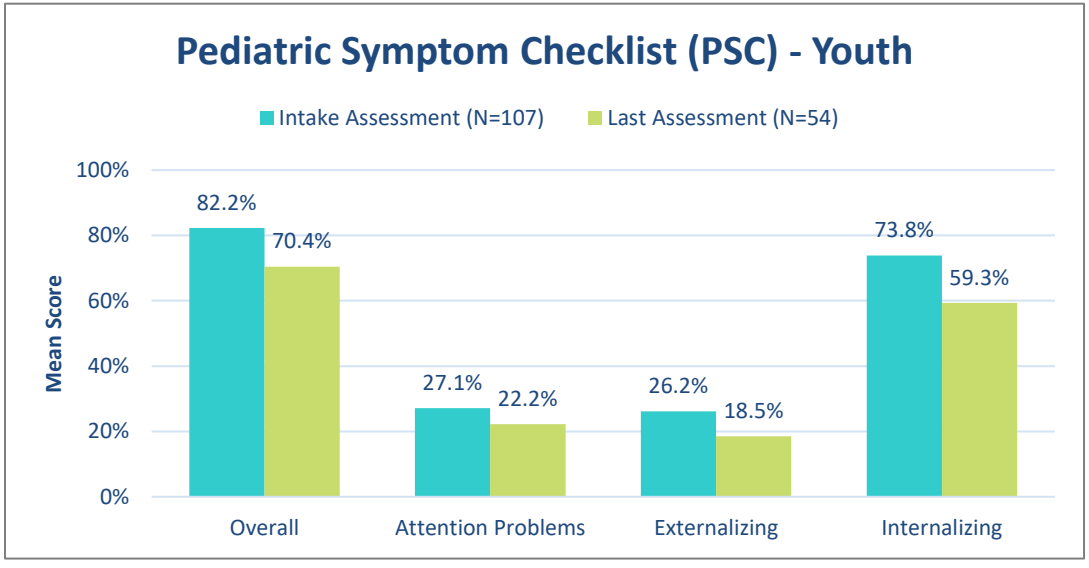


The GAF is scored on a scale of 0-100; a higher score indicates better social and psychological functioning. On average, participants' functioning improved between the intake and the last available assessment. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvements on their GAF Score ($p<.001$).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

YOUTH OUTCOMES continued

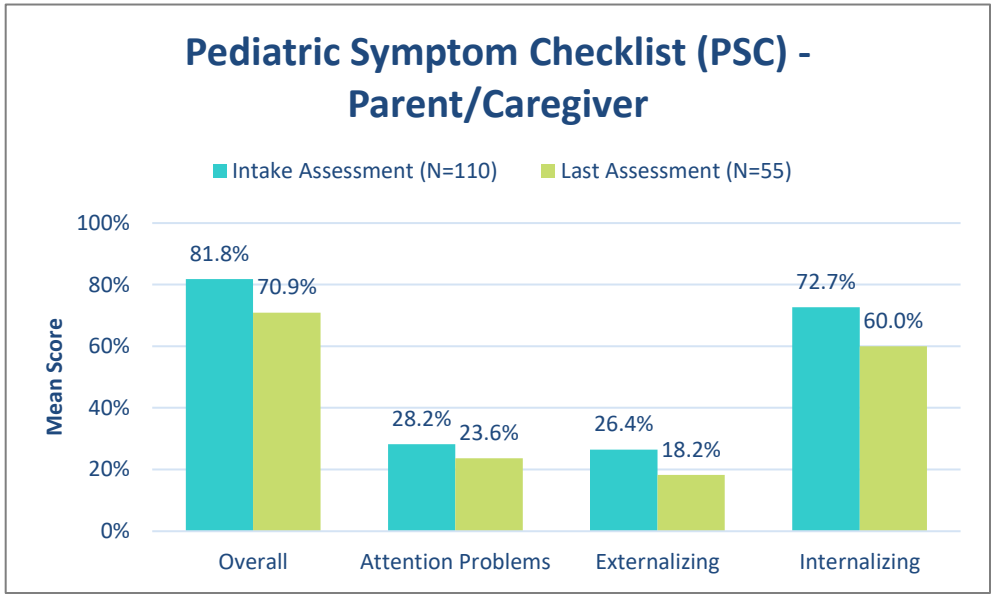
The Pediatric Symptoms Checklist (PSC) is completed by youth participants ages 11 to 18. At intake, 82% percent of youth met the criteria for psychosocial impairment. Seventy-four percent of youth met the criteria for internalizing problems. On average, between the intake and the last assessment, the percent of youth whose scores indicated that they experienced impairment decreased for the total impairment score and all three subscales.



Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

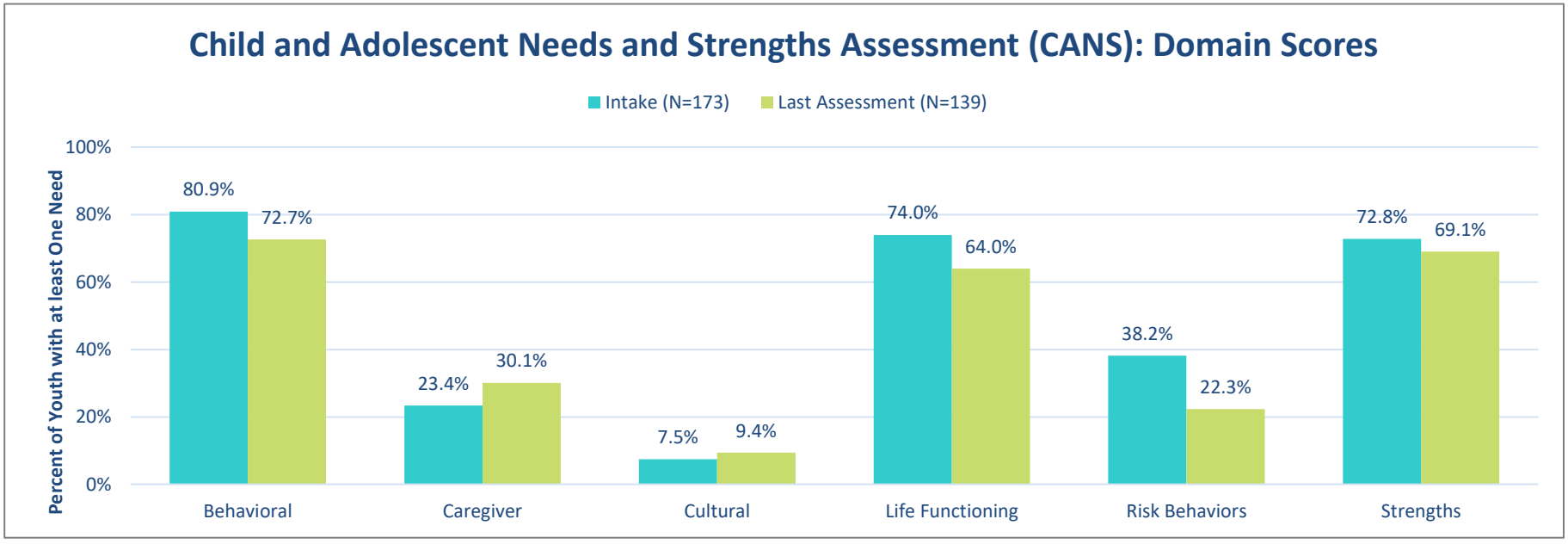
YOUTH OUTCOMES continued

The Pediatric Symptoms Checklist (PSC) is also completed by the parent/caregiver of youth participants ages 18 and younger. At intake, 82% of parents/caregivers indicated that their child met the criteria for experiencing overall psychosocial impairment. Seventy-three percent of parents/caregivers reported that their child met the criteria for experiencing internalizing symptoms. On average, between the intake and the last assessment, the percent of parents/ caregivers that reported that their child experienced impairment decreased for all subscales.



Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

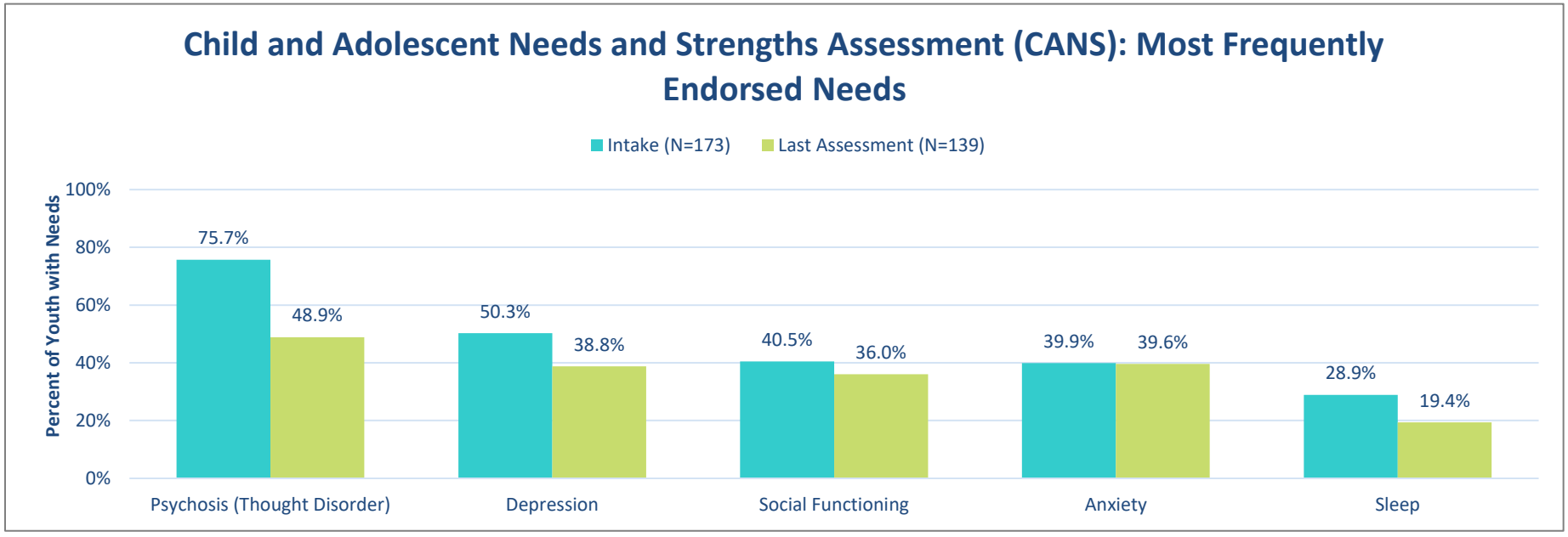
YOUTH OUTCOMES continued



The CANS is a 50-item measure completed by clinicians of youth ages 21 and younger. An analysis of the CANS subscales indicated that at intake 81% of youth participants had at least one behavioral or emotional need and 74% had at least one area of impaired life functioning. Seventy-three percent of youth were identified as having at least one strength. With the exception of the strengths subscale, a decrease in the percent of respondents with need indicates improvement. Between intake and the last assessment, there were decreases in the behavioral, life functioning, risk behaviors and strengths subscales. The difference in behavioral, life functioning and risk behaviors were statistically significant at the $p<.01$ level.

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

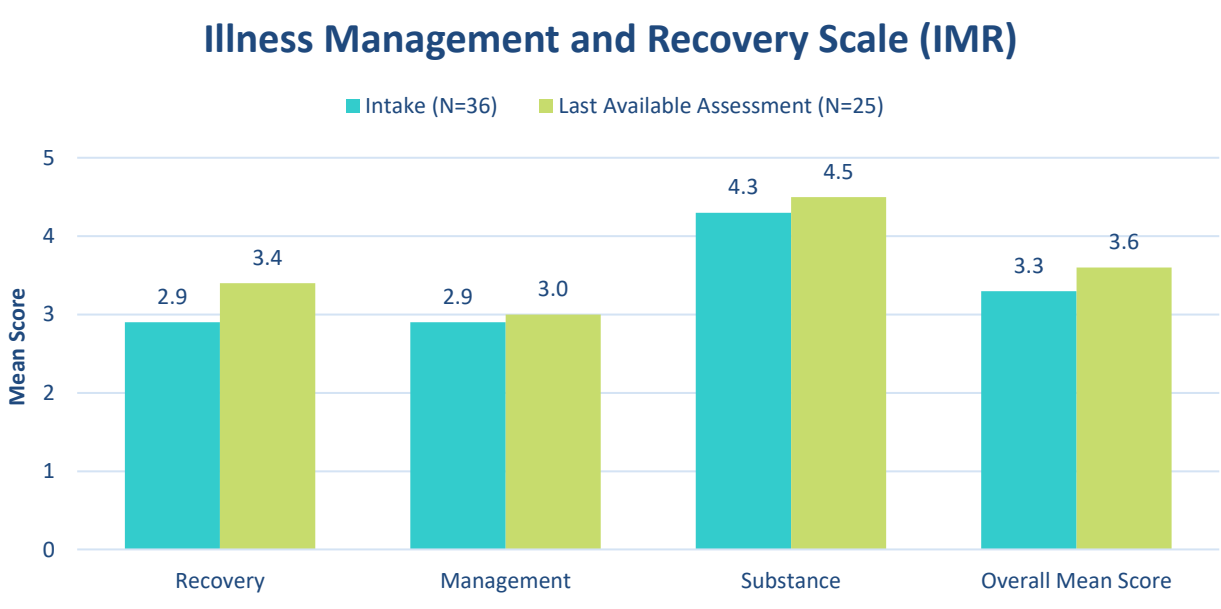
YOUTH OUTCOMES continued



In addition to analyzing the CANS subscales, the individual areas of need can also be evaluated. According to the clinicians' assessments, youth experienced the greatest needs at intake in the areas of psychosis (thought disorder), depression, social functioning, anxiety and sleep. On average, between the intake and the last assessment there were decreases in each of these areas of need. Separate analyses were conducted for youth with both an intake and at least one additional assessment. These analyses indicated statistically significant decreases in the areas of psychosis and depression ($p<.01$).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

OUTCOMES FOR YOUTH OVER 18



The IMR assessment is completed by the clinicians of participants 18 and older. Scores range between 1 and 5. An increase on any IMR subscale indicates improvement. On average, participants' overall mean scores improved between the intake and last available assessment. An additional analysis was conducted with participants who had both an intake and a second assessment. Participants included in this analysis showed statistically significant improvements on the Recovery and Overall Subscales ($p<.01$).

The **Recovery Markers Questionnaire (RMQ)** is administered to participants 18 and older. Scoring ranges between 1 and 5. An increase on the RMQ mean score indicates improvement. Participants' scores improved between the intake assessment (mean= 3.6; N=30) and the last available assessment (mean = 3.7; N=15).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

FAMILY MEMBER INCREASES IN KNOWLEDGE

Of the 58 caregivers* who attended the family psycho-education group and completed both a pre-test and a post-test, 34 (59%) demonstrated an increase in knowledge of how to support youth with prodromal symptoms. Additionally, 11 caregivers (19%) had a perfect score on both the pre-test and the post-test.

58

CAREGIVERS ATTENDED THE GROUP AND COMPLETED BOTH A PRE-TEST AND A POST-TEST

34

CAREGIVERS DEMONSTRATED AN INCREASE IN KNOWLEDGE OF HOW TO SUPPORT YOUTH WITH PRODROMAL SYMPTOMS

11

CAREGIVERS HAD A PERFECT SCORE ON BOTH THE PRE-TEST AND POST-TEST

*May include duplicate data

COMMUNITY OUTREACH PSYCHO–EDUCATION GROUP

The most endorsed community role among outreach psychoeducation group participants was mental health professional (30%).

Of the 188 community members who attended the outreach trainings and completed both a pre-test and a post-test, 146 (78%) demonstrated an increase in knowledge of risk factors for the development of psychosis and early intervention procedures. Additionally, 20 community members (11%) had a perfect score on both the pre-test and the post-test.

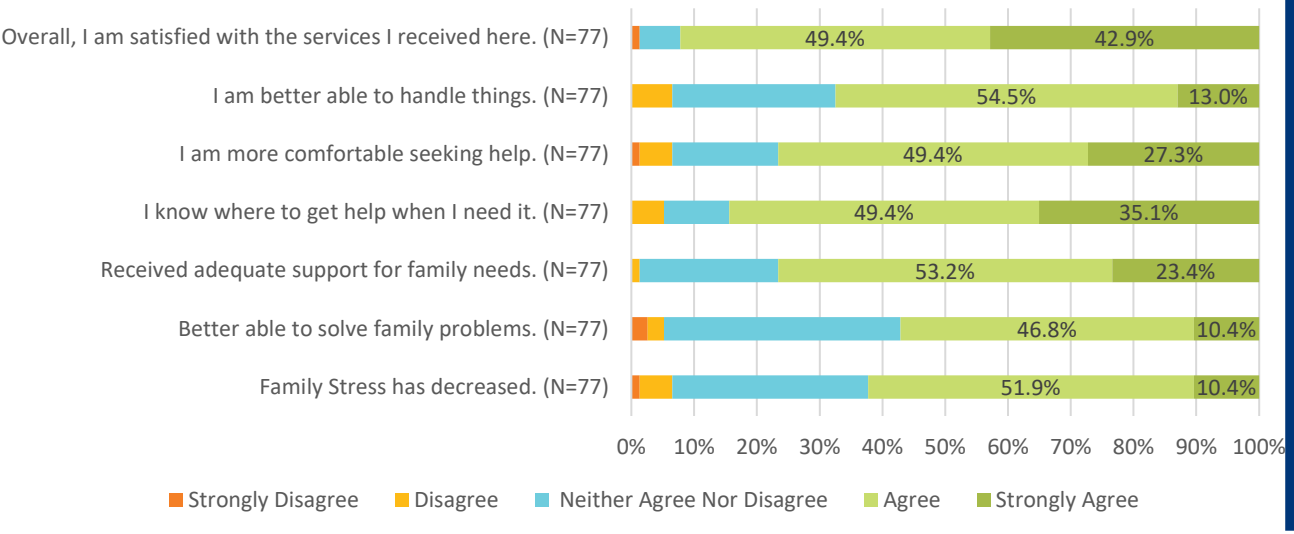
Community Role* (N=236)	N	%
School Professional	23	9.7%
Medical professional	6	2.5%
Mental health professional	71	30.1%
Substance Abuse Counselor	<5	<1.0%
Youth Worker	14	5.9%
Multicultural leader	<5	<1.0%
Member of the Media	<5	<1.0%
Employer	<5	<1.0%
Parent	<5	<1.0%
Member of a community group	11	4.7%
High School Student	<5	<1.0%
College Student	24	10.2%
Missing	94	39.8%

**The sum of the percentages may exceed 100% because participants can identify as more than one role.*

Note: Percentages may not add up to 100% due to rounding.

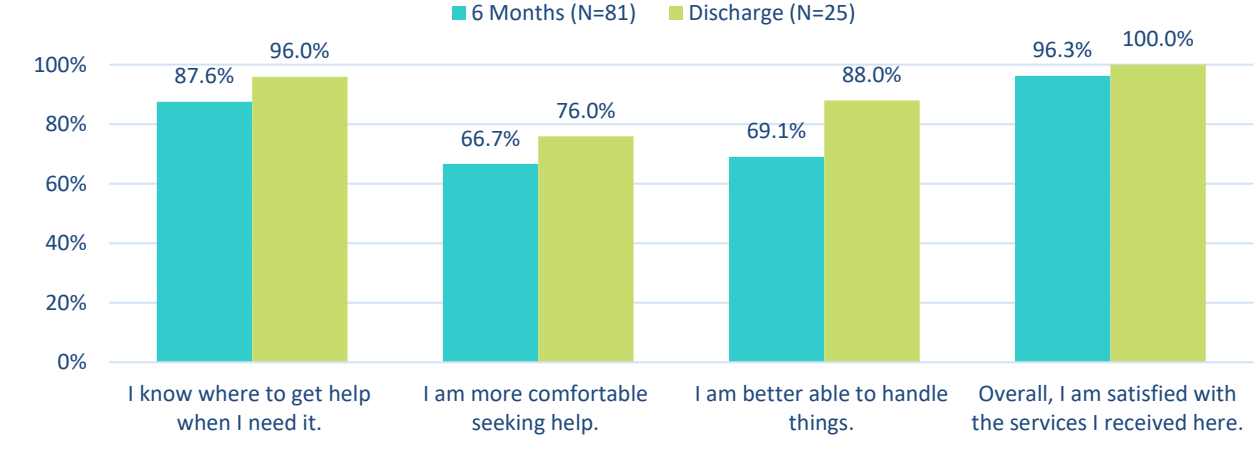
PARTICIPANT SATISFACTION* AND OUTCOMES

Family Satisfaction



Ninety-two percent of caregivers who completed a satisfaction survey agreed or strongly agreed that they were satisfied with the services they received. Eighty-five percent agreed or strongly agreed that they knew where to get help as a result of the Kickstart program. Seventy-seven percent agreed or strongly agreed that they received adequate support for their family needs as a result of the Kickstart program.

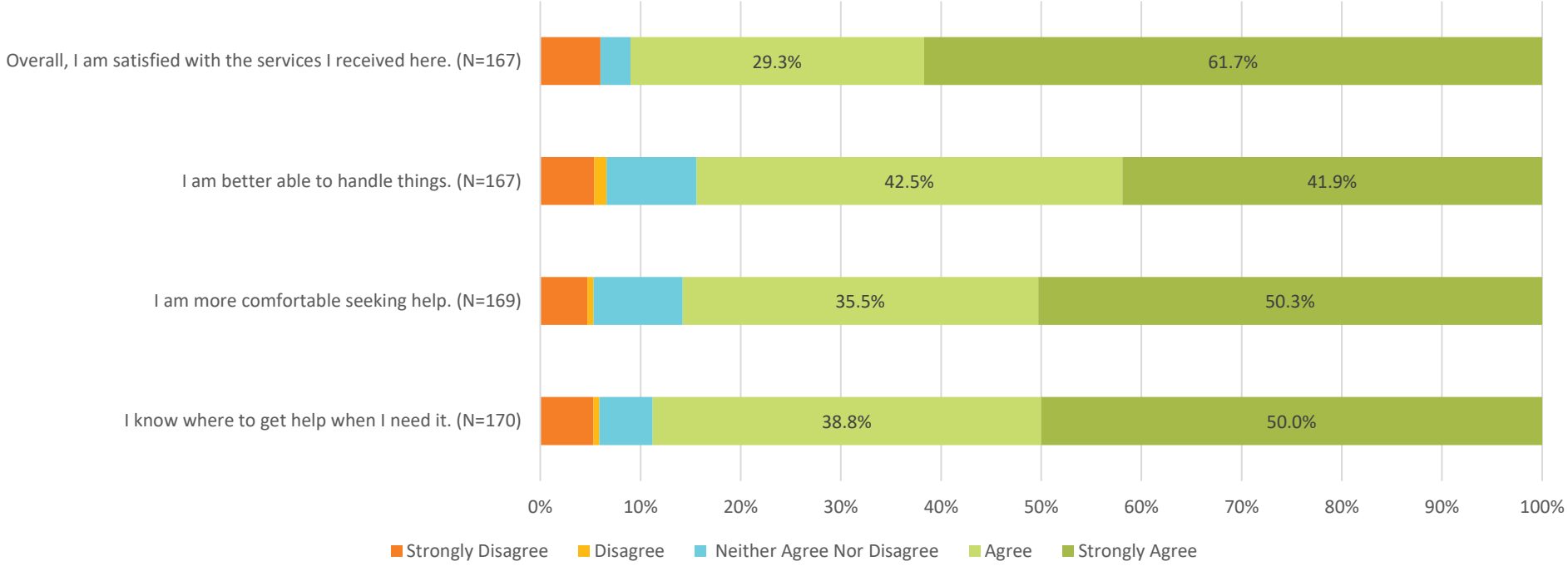
Youth Satisfaction



The majority of youth who responded to satisfaction questions at 6 months agreed or strongly agreed that they were satisfied with the services they received (96%) and that they knew where to get help as a result of the Kickstart program (88%). Youth at discharge agreed or strongly agreed that they were satisfied with services they received (100%) and that they knew where to get help as a result of the kickstart program (96%).

*Satisfaction data are not available for all participants.

COMMUNITY OUTREACH PARTICIPANT PROGRAM SATISFACTION*



Of the participants who completed an outreach satisfaction assessment, most agreed that they knew where to get help when they needed it as a result of the program (89%). Most also endorsed/said that they felt more comfortable seeking help after receiving services (86%). Overall, 91% of participants who responded were satisfied with the services they received.

*Satisfaction data are not available for all participants.

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

APPENDIX N

PRVENTION AND EARLY INTERVENTION (PEI) THREE-YEAR EVALUATION

COUNTY OF SAN DIEGO

PREVENTION AND EARLY INTERVENTION THREE-YEAR EVALUATION REPORT

January 2025

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

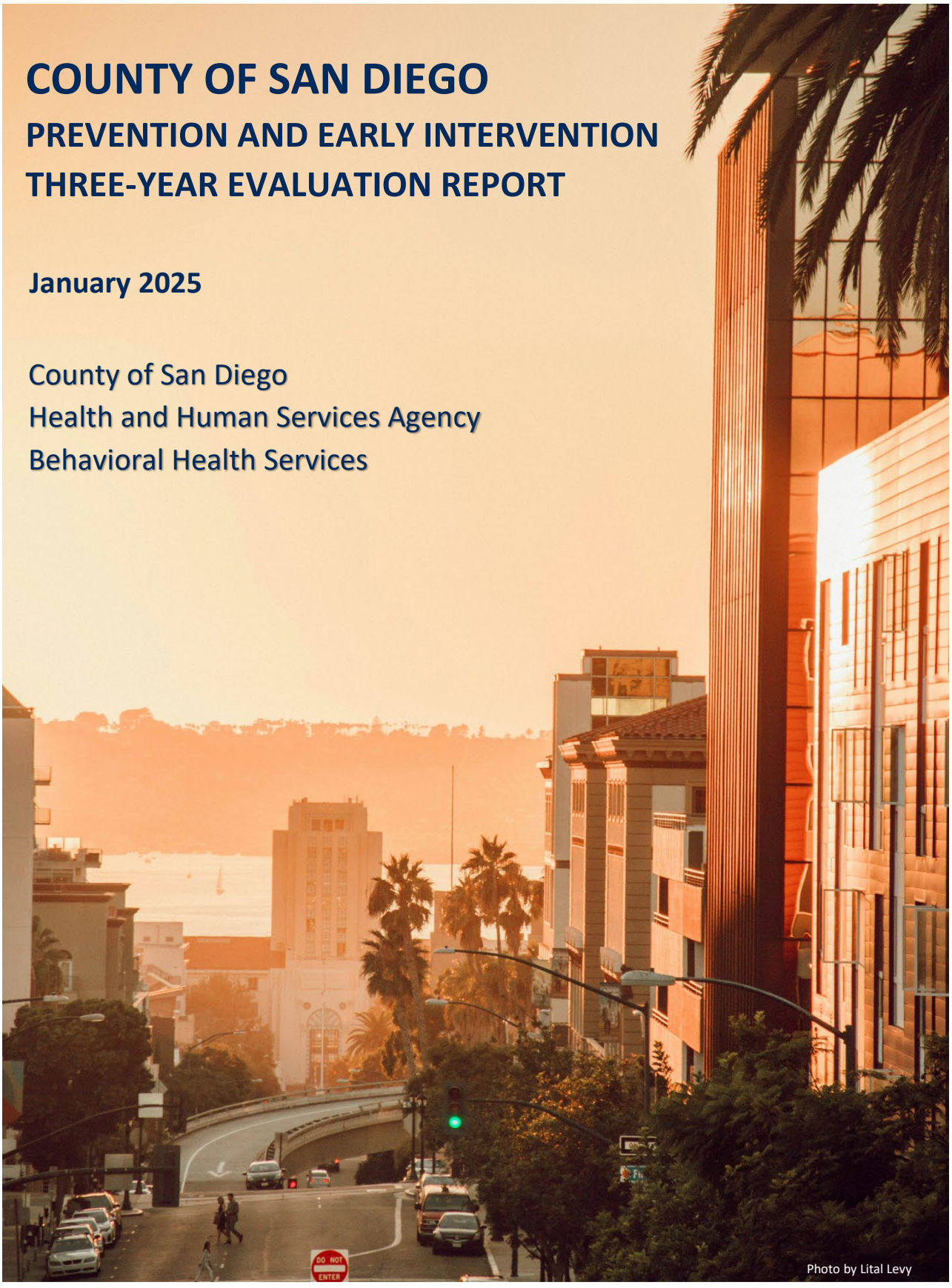


Photo by Lital Levy

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Background

The Mental Health Services Act (MHSA) system of care approach for San Diego County Behavioral Health Services (SDCBHS) is designed to develop and provide a system where service access is easier and timelier, utilization of out-of-home and institutional care is reduced, and stigma towards individuals with serious mental illness (SMI) and serious emotional disturbance (SED) is removed. The County of San Diego's MHSA Three-Year Plan was developed based on input from community partners and stakeholders. Specifically, the Prevention and Early Intervention (PEI) component of the MHSA system of care reflects the focused strategies to reduce negative outcomes that may result from untreated mental illness and help bring awareness of mental health into the lives of community members through public education initiatives and training. The purpose of the current report is to provide an overview of the MHSA PEI outcomes, methodology and 3-year outcome results, as required in the MHSA regulations.

Senate Bill 1004 (SB1004) Priorities

In 2018, California Senate Bill 1004 (SB1004) was passed, revising the structure of PEI programming to focus on six priority areas that address: (1) childhood trauma prevention and early Intervention, (2) early psychosis and mood disorder detection and intervention, (3) youth outreach and engagement strategies, (4) culturally competent and linguistically appropriate prevention and intervention, (5) older adults, and (6) early identification programming of mental health symptoms and disorders. The County of San Diego provides a variety of PEI programs that run the spectrum of services from outreach and prevention to early intervention and linkage to services. A brief description of the implementation strategy of each of the six PEI priority types as described in Senate Bill 1004 and the corresponding local County of San Diego program names are provided in the following section. Please refer to the Appendix for descriptions of all the SDCBHS PEI programs.

Childhood Trauma Prevention and Early Intervention

(The Community County-Wide Violence Response Team, Community Services for Families (CSF), Triple P-Positive Parenting Program, Father2Child, six regional PEI school-based programs)

The childhood trauma prevention and early intervention priority refers to a program that targets children exposed to, or who are at risk of exposure to, adverse and traumatic childhood events and prolonged toxic stress in efforts to manage the early origins of mental health needs and prevent long-term mental health concerns.

Early Psychosis and Mood Disorder Detection and Intervention

(Kickstart, Rural Integrated Behavioral Health and Primary Care Services)

The early psychosis and mood disorder detection and intervention priority programs focus on reducing mental health risk factors and improving access to mental health services, information, and support. These objectives are accomplished by providing psychoeducation, assessments, and referrals to appropriate mental health or substance use programs, as needed in serving children, transition age youth, and adults/older adults.

Youth Outreach and Engagement Strategies

(Kickstart, Dream Weaver Program, HERE Now, Come Play Outside)

The youth outreach and engagement priority supports youth in school and community settings from secondary school to college level. Locally, SDCBHS conducts outreach at schools, Parks and Recreation centers, and various community locations. These programs focus on providing education, information, and connections to mental health services.

Culturally Competent and Linguistically Appropriate Prevention and Intervention

(Dream Weaver Program, Elder Multicultural Access Support, Positive Solutions, REACH, Supported Employment Technical Assistance, Suicide Prevention and Stigma Reduction Media Campaign Up2Us, Suicide Prevention Action Plan, Father 2 Child, Family and Adult Peer Support, Breaking Down Barriers, Mental Health First Aid, Independent Living Associations, Courage to Call)

San Diego strives for cultural competency across all County programs and PEI promotes this goal. The culturally competent and linguistically appropriate prevention and intervention priority focuses on reaching underserved cultural populations and addresses specific barriers related to racial, ethnic, cultural, language, gender, age, economic, or other disparities in mental health services access, quality, and outcomes.

Older Adults

(Dream Weaver Program, Elder Multicultural Access Support Services, Positive Solutions, REACH)

The older adult priority includes outreach and engagement strategies for caregivers of older adults or family members with chronic illness, victims of elder abuse, and older individuals living alone or isolated. The programs include early identification of mental health symptoms through screening and assessment, with a focus on referrals to appropriate services.

Early Identification Programming of Mental Health Symptoms and Disorders

(Next Steps, Kickstart, REACH, Rural integrated Behavioral Health and Primary Care, School-Based Programs, HERE Now)

This final priority area includes programs focused on early identification of mental health symptoms and disorders, including, but not limited to, anxiety, depression, and psychosis. It is expected that programs in this priority address the following: (1) childhood trauma prevention and early intervention to deal with the early origins of mental health needs; (2) early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan; (3) youth outreach and engagement strategies for secondary school and transitional-aged youth, including partnering with college mental health programs.

How the PEI Measures Were Chosen

PEI evaluation measures were created based on the MHSA's goals for PEI programs. These goals aim to increase access to services, reduce stigma and discrimination towards mental illness, and increase positive coping skills. Additionally, there was a desire to measure participants' level of satisfaction with the PEI services provided. The PEI MHSA regulations require that each county collect demographic and supplemental outcome data to evaluate MHSA-funded PEI programs.

Research specialists at the Health Services Research Center (HSRC) and the Child and Adolescent Services Research Center (CASRC), in collaboration with staff at the County of San Diego Health and Human Services Agency's Behavioral Health Services, facilitated diverse stakeholder group discussions in 2015 to gather community input on mapping MHSA's goals for PEI to appropriate outcome survey questions. The stakeholder groups represented the focus areas and priority populations listed in Table 1.

Table 1: Focus Areas and Priority Populations Represented in Stakeholder Interviews

Focus Areas	Priority Populations
• Native American Communities • Veterans and their Families • Dual Diagnosis Adults, Older Adults, and Youth • Early Childhood/Education-Based Services • Individuals Exposed to Community/Domestic Violence • First Break of Mental Illness • Rural East, North Inland and Mountain Communities • Services for Older Adults	• Trauma-Exposed Individuals • Individuals Experiencing Onset of Serious Psychiatric Illness • Children/Youth in Stressed Families • Children/Youth at Risk for School Failure • Children/Youth at Risk for Juvenile Justice Involvement

By using a participatory approach with stakeholders, research specialists and BHS staff were able to assess, prioritize, and create four outcome measures that reflected the MHSA goals. The responses to the following outcome survey questions comprise a 5-point Likert scale from "s*trongly disagree"* to "*strongly agree".*

- Outcome 1 (Access to Services): "I know where to get help when I need it."
- Outcome 2 (Reduced Stigma): "I am more comfortable seeking help."
- Outcome 3 (Coping Skills): "I am better able to handle things."
- Outcome 4 (Satisfaction): "Overall, I am satisfied with the services I receive here."

Research Methods

The evaluation of the County of San Diego's PEI program is conducted in collaboration with two research centers at UC San Diego. CASRC coordinates the evaluation efforts for programs for children and youth. HSRC is responsible for the evaluation of the adult PEI programs.

Due to the diverse nature of the County of San Diego's PEI programs, there are two types of data collection methods for the demographics and outcome questions. Programs that focus on outreach, training, and one-point-in-time contact with participants provide the demographic and outcome questions to participants at the conclusion of multi-day and one-time events. For instance, programs that have mental health training provide the survey to attendees at the end of the training session, along with mental health resources.

PEI programs that meet with participants more than once administer the PEI surveys at different time points to assess change over time. The initial survey includes the demographic measures and is given to the participant upon entry to the program. The evaluation outcome items are administered to participants at the last session of a service event, at discharge, or at a standard follow-up interval (e.g., three or six months) depending on the duration of services.

Programs have the option to use one of several data collection systems based on their own program needs. Many of the programs utilize the Mental Health Outcomes Management System (mHOMS) developed by HSRC for data capture and reporting. One child and youth program uses Teleforms, which are scanned into a database using the Teleform System. Programs that rely on their own electronic health record (EHR) or data collection system for clinical purposes, have the option to export their data into Excel and share the data through a secure data sharing system. Lastly, due to the COVID-19 pandemic, many programs began providing services through telehealth or trainings online using web-based tools such as Zoom, Facebook, or Instagram. These programs have their participants complete the PEI survey via Qualtrics designed by CASRC or HSRC.

The programs that use mHOMS also have access to automated reports that aggregate demographic and outcome data based on date range. These reports provide for timely review of outcomes and demographics. They are used by programs to share feedback to program staff and improve services to underrepresented populations. Ultimately, this demonstrates that the data obtained not only assist in evaluation efforts, but also provide useful information for program planning and clinical utility for program managers and staff.

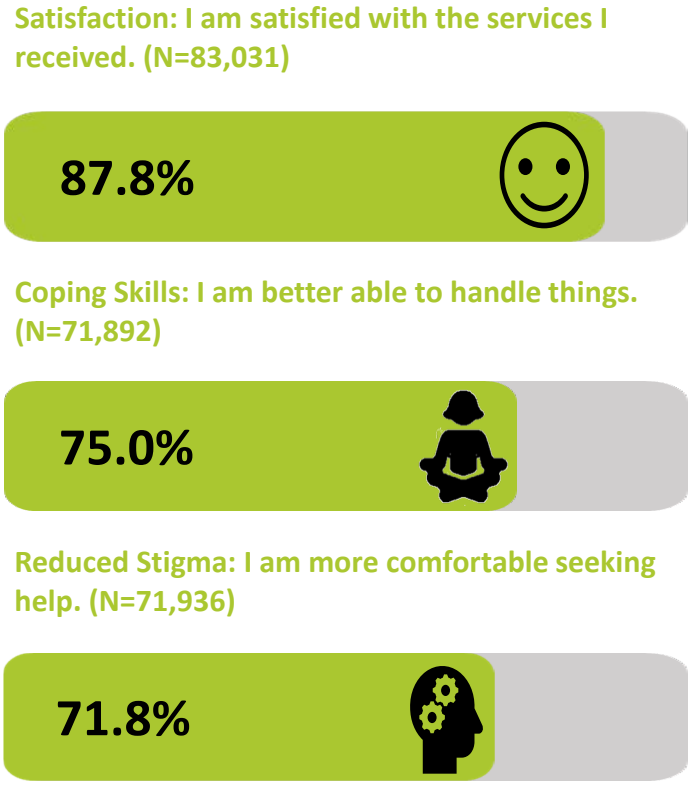
PEI Evaluation Measure Results

This section provides the results of the County of San Diego's four PEI outcomes combined for fiscal years 2021-22, 2022-23 and 2023-24. Sometimes participants did not answer all four survey items. In this section, the total number of non-missing responses is shown for each outcome item.

One of the most significant outcomes was regarding access to services, which was defined by participants reporting that as a result of the PEI program, they knew where to get help when they needed it. Among over 80,000 respondents, 87.8% stated they "agreed" or "strongly agreed".

Figure 1: Participant-Reported Access to Services Outcomes (N=80,581)

Figure 2: Participant-Reported Outcomes for Satisfaction, Reduced Stigma, and Coping Skills



There were also positive results in each of the other three outcomes regarding satisfaction, reduced stigma, and coping skills. Figure 2 shows the results of each of these outcome questions. Satisfaction with PEI programs was high with 87.8% of respondents stating they "agreed" or "strongly agreed" with the satisfaction outcome. Approximately 75% of clients reported they "agreed" or "strongly agreed" that they were better able to handle things and almost 72% were more comfortable seeking help as a result of the PEI program.

These positive evaluation outcomes help demonstrate the effectiveness of the PEI programs and strategies in supporting children, youth, adults, and older adults who are addressing their mental health concerns early on.

The results of the County of San Diego's four PEI outcome questions are included in Table 2. This table includes both the count of responses for each outcome and the percentage who reported "strongly disagree or disagree," "neutral," or "agree and strongly agree".

Table 2. PEI Outcome Questions

(As a result of the program…)*	N	Strongly Disagree & Disagree	Neutral	Agree & Strongly Agree
Access to Services: I know where to get help when I need it.	80,581	5.5%	6.7%	87.8%
Reduced Stigma: I am more comfortable seeking help.	71,936	10.6%	17.6%	71.8%
Coping Skills: I am better able to handle things.	71,892	7.7%	17.3%	75.0%
Satisfaction: Overall, I am satisfied with the serviced I received here.	83,031	4.3%	7.9%	87.8%

**Percentages may not sum to 100 percent due to rounding.*

At the three-year reporting period, MHSA regulations require submission of three years of PEI demographic data as delineated in the regulations. These data were submitted to Mental Health Services Oversight and Accountability Commission (MHSOAC) in a supplemental file.

Conclusion

The County of San Diego serves a variety of populations, ages, and participants with varying degrees of mental health concerns. The positive results of the implementation of PEI in the County are demonstrated by most participants reporting that, because of the program, they know where to get help when needed. These results show that the County of San Diego's PEI program is effective in providing access to treatment and linking participants to the mental health and substance use resources and services that may be needed.

APPENDIX

County of San Diego PEI Programs	
Program Name	**Program Description**
Community County-Wide Violence Response Team (DV03)	The countywide Community Violence Response Team (CVRT) PEI program provides culturally appropriate support and services to victims and witnesses of community violence. These services include, but are not limited to, therapeutic support, short-term system navigation assistance, case management, crisis intervention, grief counseling, and referrals to community partners and other needed services. CVRT offers interventions designed to build and increase community resiliency and decrease the negative effects of violence. The program also aims to enhance the skills of providers, schools, and community- and faith-based organizations to ensure coordinated neighborhood responses to community violence. CVRT is capable of responding within forty-eight (48) hours after an incident of community violence when it is determined safe to do so.
Community Services for Families (DV04)	Family Support Clinicians work within San Diego's Child and Family Well Being Department (CFWB) to enhance parents' ability to create stable and nurturing home environments for their children. The Family Support Clinician (FSC) engages with clients who have a reported incident or history of domestic violence to provide clinical assessments. FSC staff work with CFWB to prioritize cases based on the clients' need for immediate services. The clinicians conduct a thorough assessment of all relevant family members to determine their risk for involvement in domestic violence, mental health issues, and substance abuse. The assessment also focuses on clients' strengths and is client-driven. Clinicians seek input from families on recommendations for referrals, which may include both formal and informal supports. These recommendations are then shared with the families and their social workers so that the families can be linked with needed services, such as therapy or parenting classes. Family Support Clinicians are currently employed at four regionally located, community-based organizations. Clinician services are short-term, often limited to one visit, and may be provided in a telehealth format due to COVID-19, as needed or when appropriate.

County of San Diego PEI Programs	
Program Name	**Program Description**
The Triple P - Positive Parenting Program (EC01)	The Triple P – Positive Parenting Program serves Child Development Establishments, including but not limited to Head Starts (HS), Early Head Starts (EHS), preschools, elementary schools, middle and high schools, and community centers. Services strengthen the skills of parents, childcare staff, and educators in promoting the development, growth, health, and social competence of young children and adolescents. Services are designed to benefit the child and/or adolescent by teaching caregivers and staff at childcare or youth-serving sites specific parenting skills and techniques for managing misbehavior while promoting effective communication. This Triple P program provides three levels of service: Triple P Level 2 Selected (Seminar), Triple P Level 3 Primary Care (Individual), and Triple P Level 4 Group training for group and individual participants. Staff are also trained to provide ongoing support to the family/caregiver once the Triple P curriculum is completed. This program serves all of San Diego County. Triple P offers optional virtual services for all levels to reduce accessibility barriers for families throughout the county.

County of San Diego PEI Programs	
Program Name	**Program Description**
Kickstart Program (FB01)	The purpose of this program is to provide prevention and early intervention services to youth and young adults ages 10-25 who may have clinical high risk (CHR) symptoms of psychosis or have had their first episode of psychosis (FEP). The prevention component of the program focuses on providing psychoeducation and outreach to the community. These include other behavioral health providers, school staff, hospital staff, faith-based leaders, and others who may have contact with youth in general community settings. These community leaders are provided education and information on the early detection of behaviors and symptoms that are risk factors for developing psychosis. The early intervention component of the program includes a comprehensive assessment (the Structured Interview for Psychosis-Risk Syndromes) to determine the risk for, or the presence of, severe mental illness. This instrument also assesses for emotional dysregulation, physical health needs, stress tolerance, cognitive functioning, substance use issues, and potential safety concerns. Based upon the results of the assessment, youth and their families may be referred and linked to outside community resources to best meet their needs. Youth who screen positive for CHR or FEP symptoms receive an intake into this program. They then participate in a variety of services such as: psychoeducation workshops, multi-family groups, and support services, which include medication/nursing services, occupational therapy, peer support services, and education/employment support. Treatment interventions include individual, family, and group therapy. These services may be provided via telehealth. This report focuses on youth and community demographics and youth outcomes.

County of San Diego PEI Programs	
Program Name	**Program Description**
Dreamweaver Program (NA01)	The Dream Weaver Consortium offers PEI services provided by the San Diego American Indian Health Center, Indian Health Council, and Southern Indian Health Council. These providers offer prevention and early intervention activities which promote community wellness and cultural awareness. Emphasis is placed on increasing awareness and access to cultural events that are known to support resilience. These services include: cultural programs that maintain language and crafts, nutrition programs, self-esteem activities, elder navigator services, early intervention services, positive parenting, mental health awareness, exercise programs, and referral for and the promotion of overall increased health. All of these services are intended to prevent the onset of serious mental health problems and to increase access to services when needed.
Come Play Outside (PS01)	The Come Play Outside program is a community-based initiative designed to support the health and wellness of children, youth, and families participating in activities organized by the City of San Diego Parks & Recreation Department. The program primarily operates on Thursday, Friday, and Saturday evenings at selected Parks and Recreation sites during the summer months. The intergenerational programming is designed to strengthen family bonds and community connections while aiming to reduce instances of community violence. The program also aims to improve behavioral health in children and youth by encouraging positive social interactions, bolstering self-image, and nurturing hope, confidence, and a sense of responsibility.

County of San Diego PEI Programs	
Program Name	**Program Description**
School-Based Programs (SA01)	The School Based Prevention and Early Intervention Programs provide culturally appropriate, multi-tiered prevention and intervention services in public elementary schools across San Diego County's six regions. The program serves early elementary students (e.g., preschool/kindergarten through third grade) and their families in participating schools, regardless of insurance status. Services are designed to promote emotional and social competence and to prevent, reduce, and treat behaviors that negatively impact student functioning. The programs provide the following key components: • Social-Emotional Screening: All students in PreK-3rd grades with parental consent are screened to identify the appropriate level of intervention needed. • Interventions utilizing the Incredible Years Curriculum (IY) - Classroom Lessons: Weekly sessions that are designed to enhance students' social and emotional skills. - Small Groups: Targeted intervention groups for a subset of students, where students learn and practice age-appropriate social skills to promote positive interactions with peers and adults. - Parent Groups: Sessions for parents and caregivers at the participating schools designed to promote positive parenting practices that mirrors what the students are learning. • Community Outreach Specialists, also called Promotoras, work with parents, school, and the community to determine prevention needs and provide resources and or connection to services that focus on family wellness, strengthening resilience, reducing disparities in accessing mental health services, reducing stigma and discrimination, and helping families make connections with the schools and other services/supports in the community. These services shall increase the protective factors and resilience of the family, reduce family isolation, and increase parent involvement with the schools

County of San Diego PEI Programs	
Program Name	**Program Description**
HERE Now (SA02)	San Diego Youth Services (SDYS), Lifeline Community Services(LCS), and South Bay Community Services (SBCS) are collaborating through the Helping, Engaging, Reconnecting and Educating (HERE) Now program to prevent youth suicide and suicidal ideation and create a safer place to learn in San Diego County. The HERE Now Program focuses on preventing suicide by educating youth (7th through 12th grade) and their families on the risk factors of suicide and reducing the stigma around seeking help for themselves or others. The HERE Now program seeks to shift social norms about the stigma attached to individuals who seek mental health services by: being proactive in reaching out to the community and community leaders; promoting education about mental health; teaching in the schools; reaching out to parents; changing policies; implementing bullying prevention; and, having in place a seamless system of services that identifies youth who need help before they attempt suicide. HERE Now helps students acknowledge safety warning signs and encourages them to reach out for support through a trusted adult, both at school and at home. The program also highlights online and tele-resources such as the San Diego Access and Crisis phone and text lines as well as San Diego's LiveWell@Home 30-Day Challenge.
Next Steps (CO03)	Next Steps is a recovery-oriented peer and family support program providing outreach and engagement to participants and their family members. Next Steps is led by National Alliance on Mental Illness (NAMI) San Diego, in collaborative partnership with Mental Health Systems Inc (MHS), and Union of Pan Asian Communities (UPAC). Next Steps uses an integrated care model with peer support specialists that address the needs of participants in the areas of mental health, physical health, substance use and quality of life. Next Steps supports participants on the path to achieving their whole-health goals and recovery journey.

County of San Diego PEI Programs	
Program Name	**Program Description**
Elder Multicultural Access and Support Services (OA01)	Elder Multicultural Access and Support Services (EMASS) provides multicultural and linguistically appropriate PEI services to underserved Latino, African American, Asian, Pacific Islander, Filipino, East African, and Middle Eastern seniors over 60 years old utilizing the Promotora model. We aim to identify and prevent mental health issues, reduce ER visits and hospital admissions, improve access to health, mental health care and enhance the service capacity and quality of older adult care. We also link East African and Middle Eastern refugees over 60 years old with Special Immigrant Visas to translation services, acculturation education, citizenship and adjustment to the main culture classes, as well as medical and mental health navigation.
Positive Solutions (OA02)	The Positive Solutions program provides psychoeducation, linkage to services, prevention, and short-term early intervention mental health services to underserved older adults who are racially, ethnically, and culturally diverse, and who report signs and symptoms of depression. This program seeks to increase knowledge of mental health warning signs and reduce stigma and disparities in access to mental health services. Positive Solutions utilizes an evidence-based therapeutic modality called PEARLS, a combination of Problem-Solving Therapy (PST) and Motivational Interviewing (MI) to treat signs and symptoms of depression. Therapy is short-term and limited up to 15 therapeutic sessions.

County of San Diego PEI Programs	
Program Name	**Program Description**
Southern Caregiver Resource Center's REACH Program (OA06)	Cuidadores Acompanandose y Luchando para Mejorar y Seguir Adelante (CALMA), derived from REACH- Resources for Enhancing Alzheimer's Caregiver Health, for Spanish language families, and "Caregiver TLC: Thrive, Learn & Connect" (CG TLC), derived from "Coping with Caregiving" is operated by the Southern Caregiver Resource Center (SCRC) and makes it possible for people with dementia to live in their own homes longer by addressing problems related to caregiver health that often force people to move their loved ones to long-term care facilities. CALMA is a four-class series (delivered via telehealth technology or in person) that teaches family caregivers the skills to find solutions for caregiver stress, challenging behaviors, home safety, depression, self-care, and social support. The program improves the caregiver's overall quality of life, increases involvement in self-care, increases level of connectedness and social support, increases caregiving abilities, decreases feelings of anger, decreases levels of stress, and decreases caregiver depressive symptoms. CG TLC is a six-class series, specifically designed to be delivered via telehealth technology (Zoom). The virtual design for the CG TLC intervention was developed to help increase access to the proven supportive services of CWC, helping overcome barriers imposed by the confinement and restrictions of the COVID-19 pandemic. CG TLC was created to support caregiver stressors unique to those supporting loved ones with dementia/memory loss and physical chronic illness. In this evidenced-based class, caregivers learn about topics of stress and stress management, behavioral activation for mood stabilization, resilience and their support team, self-care, frustration and anger management, and how to reduce isolation and stay socially connected while staying primarily at home.

County of San Diego PEI Programs	
Program Name	**Program Description**
Family Adult Peer Support Program (PS01)	The Family Adult Peer Support Program is a prevention program that promotes social and emotional wellness for adults, older adults, and their families by two trained community speakers in meeting format. Trained speakers share their personal stories about living with mental illness and achieving recovery. Additionally, written information on mental health topics and resources are provided with compassionate support to families and friends who have loved ones who were hospitalized with a mental illness. The aim is to reduce stigma about mental illness and improve hope for recovery from a mental health condition. The program also provides resource navigation and compassionate support for family members and individuals with a behavioral health condition through a call center helpline and in person lobby services.
Father2Child Program (PS01 F2C)	Father2Child is an ACEs Prevention Program provided by Mental Health America of San Diego County (MHASD) in central and east county, Vista Community Clinic in north coastal county, New Alternatives in north central and north inland county, and South Bay Community Services in south county. The intent of the program is to provide a best practice parenting program to unserved and underserved fathers that enhances fathering knowledge, skills, and positive attitudes while connecting the relationship between reducing mental health stigma and having a successful fathering relationship with the child(ren). The program aims to reduce Adverse Childhood Experiences (ACEs) in children. It is a free court-approved 12-week program for fathers of all ethnicities.
Breaking Down Barriers (PS01C)	Breaking Down Barriers is provided by Jewish Family Service (JFS) and works with seven priority populations that include people who identify with and/or serve members of the following communities: Latino, African American, LGBTQ+, African/Refugee, Middle Eastern, Asian/Pacific Islander, and Native American. Breaking Down Barriers aims to reduce mental health stigma by (1) providing mental health outreach, engagement, and education to members of unserved and underserved communities and (2) creating effective collaborations with other agencies, community groups, client and family member organizations, and other stakeholders to support the program's mental health stigma and discrimination reduction campaign.

County of San Diego PEI Programs	
Program Name	**Program Description**
Mental Health First Aid San Diego (PS01H)	Mental Health First Aid (MHFA) is an evidence-based Adult and Youth free certification offered to all individuals across the County of San Diego, including faith, rural, businesses (non- and for-profit), and refugee communities and County Health and Human Service Agency employees. MHFA is designed to help participants recognize risk factors and warning signs of existing and emerging mental health challenges in every day and crisis situations. MHFA aims to empower participants to provide appropriate support, timely intervention and provide resources where to seek help. MHFA demystifies and reduces stigma and changing how the community as a whole view those experiencing mental health challenges.
Supported Employment Technical Consultant Services (PS01)	Provides consultant services for increased employment opportunities for adults with SMI.
Rural Integrated Behavioral Health and Primary Care Services (RC01)	The Rural Integrated Behavioral Health (RIBH) and Primary Care Services program has established fully integrated, behavioral health/primary care services for children, adolescents, transitional age youth, adults, and older adults in partnered federally qualified health clinics (FQHC) in five rural communities in San Diego County. The locations include Ramona, Julian, Valley Center, Alpine and Campo. This program implements services that prevent patients from developing an increased level of behavioral health issues, severe mental illness, or addiction by addressing behavioral health needs early. The patients of this program are referred by providers or can be self-referred so long as they are patients of the clinic. The program is comprised of behavioral health consultants that are licensed mental health clinicians and para-professional behavioral health educators that provide screening, brief interventions, case management, and triaging services. The team provides wellness events to the greater communities to destigmatize mental illness, educate on mental fitness and behavioral health, and provide resources and social collaboration within the communities.

County of San Diego PEI Programs	
Program Name	**Program Description**
Independent Living Association and Recovery Residence Association (RE01)	Independent livings are privately-owned or operated homes or complexes that provide shared housing for adults with disabilities, including mental illness and others who may benefit from a shared living environment. Tenants in independent livings can live independently, are often on a fixed income, and do not need supervision or care from their landlord. The Independent Living Association (ILA) is a collaborative community-wide effort focused on supporting independent living operators, tenants, and the community by promoting high-quality independent livings. This groundbreaking project, which began in July 2012 in San Diego County, is the first of its kind to organize and promote Independent Livings. Since 2012, the ILA has expanded to Alameda County (2017) and Fresno County (2018).
Courage to Call-Veterans and Family Outreach Education (VF01)	The Courage to Call program provides a confidential peer support hotline and navigation services to refer, link resources and services for veterans, active duty, military, reservists, National Guard, and their families. Specifically, the 7/24/365 hotline provides mental health information, linkages to mental health services (including psychiatry when indicated), navigation to link to essential services, and other resources.

APPENDIX O

PEI COMPONENTS AND PRIORITIES

PREVENTION AND EARLY INTERVENTION (PEI) PRIORITY AREAS FISCAL YEAR 2025-26							
WORKPLAN*	**CONTRACTORS/PROVIDERS**	**REVENUE AND EXPENDITURE PROGRAM NAME**	**1 Child Trauma PEI**	**2 Early Psychosis**	**3 Youth Outreach**	**4 Culturally Competent**	**5 Older Adults**
CO 03	National Alliance on Mental Illness, San Diego	Integrated Peer & Family Engagement		x			
DV 03	Union of Pan Asian Communities	Alliance for Community Empowerment	x				
DV 04	Home Start | North County Lifeline | Social Advocates for Youth, San Diego | SBCS	Community Services for Families	x				
EC 01	Jewish Family Service of San Diego	Positive Parenting Program (Triple P)	x				
FB 01	TBD (ongoing procurement)	Early Intervention for Prevention of Psychosis		x	x		
NA 01	Indian Health Council, Inc | San Diego American Indian Health Center | Southern Indian Health Council, Inc	Native American Prevention and Early Intervention			x	x	x
OA 01	Union of Pan Asian Communities	Community-Based Services for Older Adults				x	x
OA 02	Union of Pan Asian Communities	Home Based Services - For Older Adults				x	x
OA 06	Southern Caregiver Resource Center	Caregiver Support for Alzheimer & Dementia Patients				x	x
PS 01	Mental Health America of San Diego County | New Alternatives, Inc. | SBCS | Vista Community Clinic	ACEs Prevention Parenting Program for Fathers	x			x	
PS 01	Jewish Family Service of San Diego	Breaking Down Barriers				x	
PS 01	National Alliance on Mental Illness, San Diego	Clubhouse Services Program				x	
PS 01	City of San Diego	Come Play Outside			x		
PS 01	County of San Diego	County of San Diego - Community Health & Engagement			x	x	x
PS 01	National Alliance on Mental Illness, San Diego	Family Peer Support Program				x	
PS 01	Mental Health America of San Diego County	Mental Health First Aid				x	
PS 01	TBD (ongoing procurement)	Recuperative Services and Support Program for Transitional Age Youth		x	x		
PS 01	Rescue Agency Public Benefit, LLC	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us				x	
PS 01	Community Health Improvement Partners	Suicide Prevention Action Plan				x	
PS 01	San Diego Workforce Partnership	Supported Employment Technical Consultant Services				x	
PS 01	County of San Diego	Youth Engagement Ambassador Program			x	x	
PS 01	Center for Community Research	Public Messaging for Substance Use, Misuse, and Overdose Prevention				x	
PS 01	National Alliance on Mental Illness of San Diego & Imperial Counties	Consumer Advocacy			x	x	x
RC 01	Vista Hill	Rural Integrated Behavioral Health and Primary Care Services		x			
RE 01	Community Health Improvement Partners	Independent Living Association (ILA)				x	
SA 01	SBCS | Palomar Family Counseling Service | San Diego Unified School District | Vista Hill	School Based Prevention and Early Intervention	x				
SA 01	Fred Finch Youth Center | San Diego Unified School District | SBCS | Palomar Family Counseling Services | Vista Hill	Screening to Care	x				
SA 02	San Diego Youth Services	School Based Suicide Prevention & Early Intervention			x		
SA 03	Harmonium	Youth & Family Support Services			x		
VF 01	Mental Health Systems	Veterans & Family Outreach Education				x	

*Additional details on the respective workplans can be found in Appendix C - Program Summaries

PRIORITY AREAS

1	Childhood Trauma Prevention and Early Intervention
2	Early Psychosis and Mood Disorder Detection and Intervention
3	Youth Outreach and Engagement Strategies Targeting Secondary School and Transitional Age Youth, Priority on College Mental Health Program
4	Culturally Competent and Linguistically Appropriate Prevention and Intervention
5	Strategies Targeting the Mental Health Needs of Older Adults

APPENDIX P

INNOVATION REPORTS

ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT) INNOVATIONS-18

Final Report

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

v.6.07.2024

Table of Contents

Introduction

The County of San Diego Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The ADAPT program started providing services during fiscal year (FY) 2019-20 and was designed to address unmet treatment needs, improve access to treatment and reduce the negative health outcomes of perinatal mood and anxiety disorders with a focus on women and families from underserved communities. A key component of the ADAPT program was the collaboration with HHSA Nurse Family Partnership (NFP) and Maternal Child Health (MCH) Home Visiting programs, with the goal of providing mental health services to Public Health Nursing (PHN) participants. ADAPT provides therapeutic treatment, peer support and advocacy, resource linkage and navigation to community resources and support for the entire family. Due to the COVID-19 pandemic, in FY 2019-20, the ADAPT program transitioned from providing services primarily in-home and in-person to services via telephone and then ultimately to telehealth. The program has since re-introduced in-person services and continued to provide telehealth with reduced reliance on telephone-based services. ADAPT also substantially expanded their referral partners during FY 2021-22 to accept eligible referrals of persons experiencing peripartum depression and anxiety from anywhere in San Diego County.

Program Description

ADAPT program services are provided by behavioral health clinicians and peer support staff from Vista Hill Foundation, a community-based nonprofit organization. Based on the positive results achieved by the ADAPT program during the INN-funded pilot project phase, BHS determined that ADAPT services should be integrated into the overall BHS system of care with the specialized peripartum services to continue past the end of the INN-funded services on 12/31/2023.

ADAPT was originally designed to provide mental health services to participants of HHSA public health NFP and MCH home visiting programs who have, or are at risk of, perinatal mood or anxiety disorders. The NFP is a voluntary program that provides in-home nurse visitation services to qualifying first-time mothers from the 28th week of pregnancy through the child's second birthday. NFP is free of cost, which is important as many of the mothers are low income. Through NFP, PHNs provide support, education and

counseling on health, behavioral, and self-sufficiency issues. MCH is also a free, voluntary prevention program that provides in-home nurse visitation to at-risk, pregnant, and postpartum women, and their children from birth to 5 years old. Similar to NFP, PHNs in the MCH program provide support, health and parenting education, and address bonding issues, medical, and mental health risks.

The ADAPT program was developed to address the high prevalence of unmet treatment needs for perinatal anxiety and depression among the women served by the MCH and NFP programs to prevent the negative consequences related to perinatal mood disorders including challenges to the family unit, difficult infant temperament, emotional and cognitive delays in children, and suicidal ideation. Depressive disorders, the most common peripartum complication, affect approximately 20-30% of pregnant and postpartum women with debilitating effects on the mother, her child, family, and society (Curry et al., 2019). Recent Center for Disease Control Maternity Mortality data demonstrated that mental health conditions were the leading cause of pregnancy-related deaths (22.7% of all maternal deaths), nearly twice that of the next most common causes, postpartum hemorrhage and cardiac disease (Trost et al., 2022). United States rates of maternal morbidity and mortality are increasing, with depressive disorders playing a major contributing role, especially in underserved populations (Delker et al., 2023; Wisner et al., 2024).

ADAPT provides therapeutic treatment, peer support and advocacy, family support, linkages and navigation to community resources, and other therapeutic interventions such as skill-building education, group skill-building, and case management. Services are evidence-informed and include care coordination and case consultation. While ADAPT was designed to primarily provide services in-home, the COVID-19 pandemic demanded flexibility. This turned out to be a valuable component of ADAPT that remains today: services are now provided in-home, via telehealth or via telephone when necessary.

From the beginning, a key innovative component of the ADAPT program was the close partnership between ADAPT mental health clinicians, PHNs, and the certified peer support partners. During FY 2021-22, this network expanded and ADAPT began accepting eligible referrals (i.e., on Medi-Cal/able to qualify for Medi-Cal) from anywhere in San Diego County.

The ADAPT program was designed to provide two tiers of services:

- **Level 1** participants met criteria for Title IX specialty mental health services and peripartum criteria, evidenced by significant functional impairments including, but not limited to, clinically significant depression and/or anxiety. The participants in Level 1 received ongoing therapy as well as other supportive services.

- **Level 2** participants did not meet full criteria for specialty mental health services and presented with less acute symptoms. However, they demonstrated impairments in functioning as well as risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors.
    - Level 2 also included participants who met BHS eligibility for Level 1 services but were receiving services from another mental health provider or were not interested in receiving mental health services at the time of initial assessment.

- Since ADAPT attempted to enhance the role of fathers/partners in therapeutic interventions as a way to reduce symptoms of maternal and paternal mental health disorders, Level 2 could also include family members of Level 1 participants.

Impact of COVID-19 Pandemic on the ADAPT Program

The COVID-19 pandemic first affected the San Diego region in a substantial manner during March 2020. The County of San Diego issued a public health order effective 3/13/2020, limiting the size of public gatherings to less than 250 persons and restricting access to hospitals and long-term care facilities serving seniors. This was followed by a statewide public health order on 3/19/2020 that required all non-essential workers to stay at home. During this time period, County BHS programs, including ADAPT, had to quickly adjust to the new service delivery environment to protect both participants and staff safety while continuing to provide mental health services.

Referrals

The onset of the pandemic disrupted efforts at outreach and development of referral networks. Further, PHNs gained additional COVID-19-related responsibilities which limited their availability and consequently, the number of referrals to ADAPT. As a result, enrollment totals were lower than expected (see Table 1, page 9). In response, to reach more individuals and families in need of ADAPT services, the County approved an expansion of the program's referral base to include other community organizations serving peripartum populations (discussed in more detail below).

Service Delivery

During the public health emergency, the ADAPT program suspended the practice of providing in-home assessments and clinical sessions and transitioned to providing these services via telephone or telehealth where available. This created organizational challenges and strain for both the potential referral partners and for ADAPT staff as everyone adjusted to the new service delivery environment. However, ADAPT managed this transition while minimizing disruptions to services to maintain continuity of care. Additionally, to support their PHN partners, the ADAPT team conducted wellness check-ins with PHN participants who were experiencing extra stress during the challenging times even if they were not ADAPT participants.

ADAPT services initially transitioned to telephone, but then throughout FY 2020-21 most service contacts were shifted again to be completed via telehealth so that ADAPT participants and service providers could see each other. As conditions allowed, ADAPT reinstated efforts to meet in person when desired by the participant, with these visits typically occurring in outdoor settings conveniently accessible to the participant. Most COVID-19-related County official public health orders were ended as of June 15, 2021, however, some service provider agency protocols to promote safety continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided.

An unanticipated impact of the pandemic was the transformative change in attitudes regarding the provision of mental health care via telehealth. Throughout the pandemic, the collective learning experience led to a normative shift resulting in a more favorable perception of telehealth for behavioral health treatment by both clinicians and participants. For ADAPT, even when participants were again able

to choose to receive in-person visits, the majority of services continued to be provided via telehealth, with in-person visits provided based on participant preferences or clinical determinations.

Assessment of Primary Program Objectives

The main goals of the ADAPT project included the following:

1. ***To learn if collaboration with the PHN Home Visiting programs is effective in engaging mothers and fathers in treatment for postpartum depression and anxiety.***

   Despite some challenges, particularly those brought about by the COVID-19 pandemic, the results from the Innovations-funded phase of the ADAPT program indicated that collaboration with PHNs was an effective approach for 1) identifying mothers experiencing peripartum depression and anxiety throughout San Diego County and 2) connecting them to specialized treatment services provided by the ADAPT program. Partner PHN programs referred 772 individuals to ADAPT, resulting in 330 enrollees (78.6% of all ADAPT enrollees).

   Notably, the number of PHN referrals and resulting ADAPT enrollees likely would have been substantially higher without the occurrence of the COVID-19 pandemic. The onset of the pandemic greatly influenced collaboration and coordination of the ADAPT program with PHNs. Further, it critically impacted program operations in the first year when inter-organizational relationships, outreach, educational processes, and referral protocols were still being established and refined. In the first months of the pandemic, safety precautions eliminated the ability to provide services in-person (notably, the primary method for delivering ADAPT services) or hold in-person meetings and trainings with PHNs. Further, the PHN workload and the type of interactions they could have with their participants changed significantly, with much of their attention directed toward addressing COVID-19-related community service needs. The immediate impact for ADAPT was a precipitous reduction in new referrals from PHNs to ADAPT and a substantial disruption to the efforts to fully integrate and coordinate ADAPT within PHN operations. For more information, see the "Impact of COVID-19 Pandemic on the ADAPT Program" section of this report.

   With reduced referrals from PHNs due to COVID-19, the ADAPT program was approved by BHS to receive referrals from other relevant service providers throughout the San Diego County such as the Sharp Mary Birch Hospital for Women and Newborns and Best Start Birthing Center. These non-PHN sources resulted in 228 referrals and 90 ADAPT enrollees.

   Feedback from both PHN and non-PHN referral partners suggested that the availability of a specialized program like ADAPT was viewed very positively and as an overall improvement in the local system of care available for women experiencing peripartum depression and anxiety. In general, ADAPT was perceived as providing an opportunity to get persons who were identified as having peripartum depression and/or anxiety concerns quickly into care that was tailored to their unique circumstances and needs.

2. ***To identify how to best equip the PHNs in effectively connecting both parents/partners to services related to postpartum depression and anxiety.***

   ADAPT staff reported that periodic face-to-face interactions with PHNs best facilitated the referral stream and coordination of activities; however, the COVID-19 pandemic and related safety practices

substantially limited or prevented these types of interactions. There were ongoing efforts by PHNs, PHN supervisors, and the ADAPT staff focused on increasing e-mail communication, establishing regularly scheduled virtual meetings, hosting periodic virtual "round-tables" to answer PHN questions, and continued education about ADAPT eligibility criteria to minimize ineligible referrals. These efforts helped to support effective collaboration between PHNs and the ADAPT program. ADAPT was also available for case consultation as needed to allow PHNs the opportunity to discuss whether certain participants were appropriate to refer, and/or to strategize about engagement and care coordination activities for individuals receiving services simultaneously from both programs.

An unavoidable challenge was the differing eligibility criteria between the respective programs with the more limited eligibility for ADAPT (i.e., Medi-Cal enrolled, Medi-Cal eligible, or below 200% of the federal poverty level). Because of the eligibility criteria differences, many individuals identified by PHNs as in need of services for peripartum mental health did not receive ADAPT services. A total of 71 PHN referrals were deemed ineligible for ADAPT, and other individuals who would benefit from peripartum mental health services were not referred by PHN because of Medi-Cal ineligibility.

3. To learn if embedded behavioral health staff can provide effective, short-term treatment services that meet the needs of identified mothers and fathers/partners.

Overall, the results from the Innovations-funded phase of the ADAPT program provided evidence of the effectiveness of a specialized program tailored to the unique needs of women experiencing peripartum depression and anxiety. As discussed in more detail in Goal #5 below, there were very few fathers/partners enrolled in ADAPT (i.e., less than 10), so the following discussion of effectiveness will only focus on outcomes and feedback from the mothers.

The Edinburgh Postnatal Depression Scale (EPDS; validated for both pregnancy- and post-natal depression) was the primary outcome tool used to assess for the presence of peripartum depression and anxiety. This tool was administered upon enrollment as well as monthly for the duration of enrollment, to assess for reductions in depressive symptoms or identify persistent depression. A total of 312 ADAPT participants completed a baseline EPDS and at least one follow-up EPDS. The average baseline score was 13.4, which research suggests is at the borderline between "mild" and "moderate" depression. At the conclusion of ADAPT services, the average EPDS score reduced to 8.3 (a 5.1-point reduction), which is considered close to the boundary between "no depression" and "mild depression". These results suggest that women typically experienced a reduction in their depressive symptoms after enrolling in ADAPT with 42.6% demonstrating a treatment response of at least a 50% reduction from their baseline EPDS score. Additional analyses indicated that therapeutic benefits may occur relatively quickly for at least some women with the average EPDS scores decreasing from 13.4 to 10.9 (a 2.5-point reduction) within 30 days of enrolling in ADAPT.

Additional assessments by ADAPT clinicians identified meaningful improvements related to reductions in symptom distress, increased coping skills and knowledge about managing mental health, progress towards achieving personal goals, as well as an overall decrease in functional impairment due to peripartum depression and anxiety.

Both quantitative and qualitative feedback from ADAPT participants indicated high levels of perceived satisfaction with ADAPT services. In addition to reduced depression and anxiety, participants noted a wide range of benefits associated with their participation in ADAPT services including improvements

in sleep, satisfaction with social relationships, ability to manage daily roles and activities, and increased skills to help manage potential relationship stress. ADAPT participants also benefited from the direct support provided by ADAPT (e.g., diapers, clothing, and baby care items) as well as from the extensive referral network of community providers facilitated by the ADAPT team (e.g., housing, financial, educational and/or legal assistance).

4. To identify barriers in parent and partner willingness to access treatment.

With many potential barriers to treatment, engagement and retention efforts were necessary areas of emphasis throughout the Innovations-funded phase of the ADAPT program. Approximately 15% of referrals (13.2%) to ADAPT declined to enroll in services even after determined to be eligible. Additionally, 20% of those who enrolled in ADAPT were in services for less than 45 days, with many exiting the program prior to fully achieving program objectives. Feedback from ADAPT staff highlighted the fact that while ADAPT services were generally positively regarded, participants often experienced a range of substantial financial-, health-, legal-, relationship- and/or housing-related pressures and challenges that inhibited their engagement. With many responsibilities and time pressures, taking time to care for oneself by engaging in treatment may not be feasible or a priority. For some, stigma associated with participating in mental health treatment services was likely a contributing factor toward not engaging in treatment.

ADAPT team members worked to address these barriers by offering assistance with non-mental health-related needs either directly or through referrals to other community resources. ADAPT team members provided education in an attempt to "normalize" the experience of peripartum depression and anxiety, and emphasize how treatment can lead to improved well-being and ability to care for their child. From the start, ADAPT was designed to reduce logistical barriers to treatment such as transportation, time, and childcare. While the in-home approach was initially disrupted by the COVID-19 pandemic, the ADAPT program quickly shifted towards the provision of telephone and telehealth services to maintain convenient and accessible treatment services. By the conclusion of the Innovations-funded phase of the ADAPT program, ADAPT had shifted into a "hybrid" mode of in-person and telehealth-based service delivery, with the specific mix largely determined by the preference of the individual receiving services.

5. To learn if fathers and partners are willing to participate in engagement efforts and to better understand the characteristics of paternal symptomatology.

One goal of the ADAPT program was to enroll family members, particularly fathers and partners, into treatment services if mental health needs existed. The effort led to the development of Level 1 and Level 2 services to offer a range of engagement options to meet the needs of fathers/partners and other relevant family members. The ADAPT team made efforts to involve family members; however, this aspect of the ADAPT program did not develop as expected. The main reasons included:

- Fathers/partners or other family members can be a source of conflict
- Other family members may not be interested or willing to participate
- Participants may not be interested in including others because therapy is a rare opportunity to dedicate time to their own personal needs and concerns

There were very few male partners who enrolled in ADAPT services (i.e., less than 10) and while family therapy was offered, it represented only 1.1% of all therapy visits provided by the ADAPT team. One potential barrier to engaging more men in services could be the lack of male therapists; however, having very few men involved made it difficult to justify adding male therapists to the treatment team. Overall, the original objective of engaging fathers/partners directly into ADAPT services, for their own treatment and/or in support of the treatment for the mothers, was not achieved. Given these experiences, while offering family therapy remains an option to involve interested fathers/partners or other family members in the ongoing ADAPT program, the Level 2 component of the program was discontinued at the conclusion of the Innovations-funded phase of ADAPT.

6. To evaluate the effectiveness of culturally competent referrals and the outcomes of engagement and efficacy of culturally appropriate referrals.

The ADAPT program served a racially and ethnically diverse population. Two-thirds of enrollees identified as Hispanic (i.e., 66.2%), which is a substantially larger proportion than found among the population living in San Diego County (35%) or in the overall Adult and Older Adult (AOA) BHS service system (approximately 30%). This high proportion suggests the ADAPT program successfully utilized culturally competent strategies to engage with Hispanic populations such as having a diverse staff of therapists and peer partners that reflected the range of communities served. Similarly, 21% of ADAPT enrollees indicated Spanish as their preferred language, which substantially exceeds the 6% of Spanish-speaking participants among overall BHS AOA populations served.

The EPDS was the primary outcome measure for this evaluation. Average baseline EPDS scores for both White and Hispanic participants was 13.3, but by their last available follow-up, the score for Hispanic participants decreased 5.7 points to an average of 7.6 while scores for non-Hispanic White participants decreased 2.9 points to an average of 10.4. This suggests that peripartum depression and anxiety symptoms reduced more substantially for Hispanic participants. In a similar manner, a higher percentage of Hispanic participants (47.1%) demonstrated a treatment response of at least a 50% reduction in EPDS scores when compared to non-Hispanic White participants (26.7%). Of note, within the Hispanic population, there was no meaningful differences in EPDS score improvements or responsiveness to treatment between those who preferred to speak English compared to those who preferred to speak Spanish. Additionally, while there were relatively few participants who indicated their race as non-Hispanic, African American only (n=34), their EPDS scores and response rates were similar to that of Hispanics and in general (i.e., exhibited more improvement than non-Hispanic Whites). These results demonstrated that a behavioral health program can successfully create and implement strategies to effectively engage with and treat priority racial and ethnic populations that have been historically underserved.

7. To learn what percentage are linked to existing resources and identify system gaps, if any.

In addition to the therapy, education, and emotional support provided by ADAPT team members, the program attempted to address other needs of the mothers and their families either directly or through connections to other community resources. A total of 257 participants (61.2% of all ADAPT enrollees) had at least one referral for additional services recorded in the Linkage Tracker system. The most common referrals were for additional mental health-related services followed by referrals in the topical domains of social health (e.g., support groups, parenting classes, etc.), basic needs (e.g., food, clothing, etc.), and financial/legal assistance (e.g., legal counsel, food stamps, etc.). At least 85 ADAPT

enrollees (20.2%) successfully received one or more community benefits facilitated by ADAPT. Feedback from ADAPT staff highlighted the importance of linking families to needed resources to both: 1) improve family well-being, and 2) assist with participant retention and engagement by removing stressors and providing further opportunities to collaborate with the families to obtain these additional tangible benefits. Even for referrals who were ineligible for ADAPT services, ADAPT implemented a "no wrong door" policy and attempted to facilitate connections to an appropriate service provider.

However, staff reported challenges in keeping up-to-date on a rapidly evolving system of care in the community. Identifiable services and resources were limited, particularly related to housing and childcare. Additional barriers to moving participants from "referral" to "successfully connected" included eligibility requirements and waitlists at other organizations as well as hesitancy on the part of participants to initiate connections to another new organization, even with the support of the ADAPT team member.

Future Directions

The experiences and successes of the ADAPT program during the Innovations-funded phase led BHS to incorporate a modified version of ADAPT into the overall BHS System of Care as an ongoing service program. Following the conclusion of a competitive procurement process in which organizations throughout San Diego County could submit proposals offering to provide ongoing ADAPT program services, the contract was awarded to Vista Hill, the same organization and service provider team who operated the ADAPT program during the Innovations-funded phase.

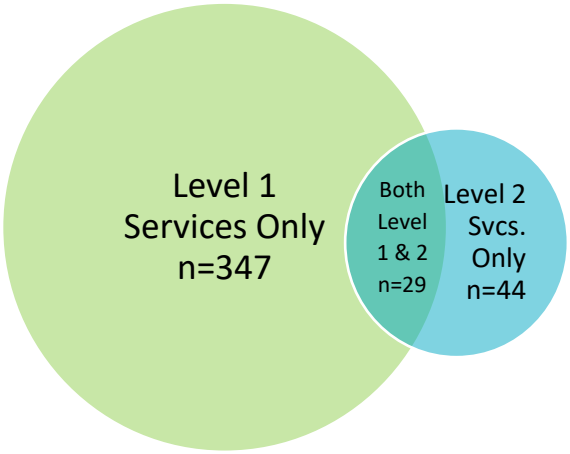
Level 1 services will continue but with modified enrollment targets. The enrollment goal of 200 per year in the Innovations-funded phase was not achieved, due in large part to the onset of the COVID-19 pandemic and the impacted ability of ADAPT to get fully established and connected with PHN program partners. Even after the pressures of the pandemic lessened, Level 1 enrollment increased but remained around 100 per year. As such, the enrollment goal of the next phase of ADAPT will be 100 participants per year.

Level 2 services, delivered primarily by peers and focused on education, skill building, emotional support, and connections to resources for those who were not interested in or demonstrated medical necessity for therapy but could still benefit from general support, was eliminated from future services. Enrollment into Level 2 was not as high as expected, with very few family members participating in such care. The limited demand for Level 2 services and the emphasis on long-term sustainability through billable services contributed to the decision to end this aspect of the original ADAPT program.

ADAPT Enrollment and Referrals

A total of 420 unduplicated participants enrolled in the ADAPT program during the Innovations-funded phase. As shown in Figure 1, 347 unduplicated individuals only participated in Level 1 services and 44 participants only utilized Level 2 services. There were 29 individuals who utilized both Level 1 and 2 services during their time with ADAPT with transitions occurring in both directions (i.e., participants who initially enrolled into Level 1 services but moved to Level 2 as symptoms improved, or participants who began with Level 2 services, but later exhibited a need for the more intensive Level 1 care) (see Figure 1).

Figure 1. Unduplicated Level 1 and Level 2 ADAPT Service Utilization



A total of 376 unduplicated individuals enrolled into ADAPT Level 1 services during the MHSA Innovations-funded phase of the program. Table 1 lists the number of unduplicated ADAPT enrollees in each fiscal year. Please note that those who enrolled in Level 1 services in multiple years are listed only in the first year that they received those services. The impact of the COVID-19 pandemic on ADAPT enrollment was particularly evident in FY 2020-21 when only 48 participants enrolled; however, the pandemic likely reduced enrollment across other years as well as it diverted public health nursing time, energy and resources.

Table 1. ADAPT Program "First Time" Enrollment by Year for Level 1 Services

Fiscal Year	n	% of Total
FY 2019-20	82	21.8
FY 2020-21	48	12.8
FY 2021-22	95	25.3
FY 2022-23	101	26.8
Partial FY 2023-2024 (i.e., 7/1/2023 to 12/31/2023, the end of Innovations funding)	50	13.3
Total unique ADAPT enrollees	**376**	**100**

As shown in Table 2, the ADAPT program received almost 1,000 referrals from a range of community partners, with the majority (77.0%; n=762) originating from the two PHN programs. In FY 2021-22, the ADAPT program received approval to accept referrals from outside the PHN programs. At that time, ADAPT engaged in community outreach and education activities to develop additional referral partners within San Diego County. Sharp Mary Birch Hospital for Women and Newborns was the primary non-PHN referral source, followed by Best Start Birthing Center. As awareness of the ADAPT program increased, ADAPT even received a few "self" referrals where individuals contacted the program directly. It is expected that the network of community referrals will continue to expand with the ongoing ADAPT

program. The primary reasons for not enrolling in ADAPT included inability to initiate contact (n=139; 14.0% of all referrals), declined services (n=131; 13.2% of all referrals), lost contact after initial connection (n=101; 10.2% of all referrals), and ineligibility due to insurance restrictions (n=71; 7.3% of all referrals).

Table 2. ADAPT Referrals and Enrollment by Referral Source

Fiscal Year	Referrals		Enrolled	
	n	%	n	%
Public Health Nursing – Maternal Child Health	506	51.1	204	48.6
Public Health Nursing – Nurse Family Partnership	256	25.9	126	30.0
Sharp Mary Birch Hospital for Women and Newborns	94	9.5	37	8.8
Best Start Birthing Center	53	5.4	16	3.8
Rady Children's Hospital	20	2.0	8	1.9
SIDS	12	1.2	6	1.4
Self	7	0.7	5	1.2
Other	42	4.2	18	4.3
Totals	990	100	420	100

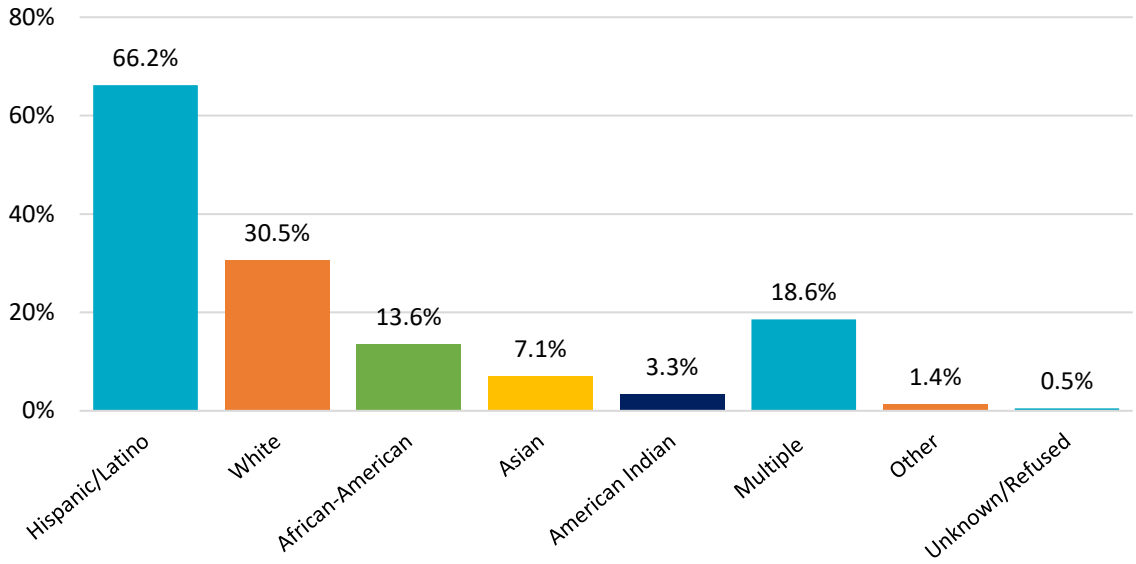
Participant Characteristics

A brief overview of the characteristics of the 420 unduplicated participants who enrolled in the ADAPT program (i.e., Level 1 + Level 2) during the Innovations-funded phase is presented here, with a more complete listing in the appendix.

Across both service levels, 97.6% of participants identified as female (n=410). Most participants (80.7%, n=339) were postpartum when they enrolled in the ADAPT program, while 19.3% (n=81) were still pregnant. The majority indicated English was their primary language (74.5%; n=313), while 20.7% (n=87) selected Spanish and were served by Spanish-speaking ADAPT staff. Most participants (89.3%; n=375) identified as heterosexual or straight. While the majority of ADAPT participants were aged 26 or older (62.9%; n=264), 37.1% were Transitional Age Youth (TAY) aged 18-25 (n=156). As shown in Figure 2, the ADAPT program served a racially and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (66.2%; n=278).

ADAPT participants completed the Adverse Childhood Experiences (ACE) questionnaire at program intake. The ACE seeks to quantify a participant's exposure to specific types of childhood trauma. Scores range from 0 to 10, with higher values signifying a higher number of traumatic experiences. A score of 4 or more is considered to be a risk factor for experiencing health and mental health problems as an adult. The average ACE score among ADAPT participants was 4.4, with close to half (47.2%) having an ACE score of 4.0 or greater, indicating that many of the participants served by ADAPT have experienced substantial levels of childhood trauma that may be affecting their current well-being.

Figure 2. Race/Ethnicity of ADAPT Participants (N=420)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

Utilization of Program Services

As shown in Table 3, the proportion of pregnant and postpartum participants was similar for Level 1 and Level 2 services.

Table 3. ADAPT Level Utilization by Pregnancy Status

Pregnancy Status	Level 1		Level 2	
	n	%	n	%
Pregnant	74	19.7	14	19.2
Postpartum	302	80.3	59	80.8
Total	**376**	**100**	**73**	**100**

Level 1 Services

Based on data from the BHS electronic health record system, Table 4 describes the number and type of services provided during an average 30-day period by licensed and license-eligible ADAPT clinicians during the life of the program.

For each 30-day period in ADAPT, participants received an average of 4.4 services with therapy representing half (2.2 services per month). While individual, group, and family therapy services were offered by ADAPT, almost all (98.7%; n=3,612 contacts) sessions were individual therapy. Generally, psychotherapy is recommended as the first-line approach for perinatal women with a depression episode (O'Connor et al, 2016). Mothers generally prefer psychotherapy due to concerns about the effects of medication on their infants (Dennis & Chung-Lee, 2006). A 2023 meta-analysis supported psychotherapy

as an effective treatment for peripartum depression, with effects that last at least 6–12 months (Cuijpers et al., 2023). Feedback from the ADAPT team indicated that female participants strongly preferred individual therapy, in large part because the women felt they had few opportunities to get focused attention on their needs and concerns.

Additional services were provided as needed including regular assessments, case management, and peer-provided rehabilitation support. Of note, ADAPT team members were available to respond to crisis events, but did so only on ten occasions during the life of the program. The rarity of such events suggests that the ADAPT team was generally able to provide support and services that prevented the need for crisis care for almost all participants, highlighting the importance of having a program like ADAPT connected with these persons to address potentially serious situations.

Table 4. ADAPT Level 1 Services during Life of Program

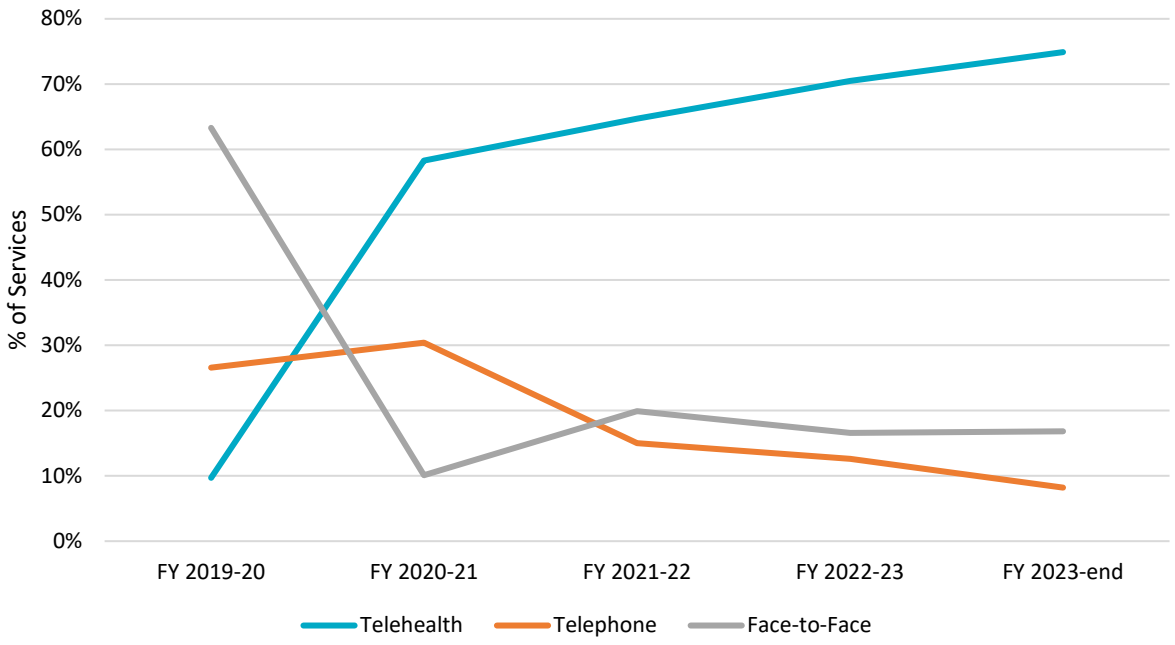
ADAPT Service Type	Participants with at least one service		Total ADAPT services provided	Average number of services per participant, per 30-day period
	n	%		
Any ADAPT service	371	98.7	7,193	4.4
Assessment/treatment plan development	364	96.8	1,225	0.7
Therapy (i.e., by licensed clinician)	300	79.8	3,661	2.2
Rehabilitation (i.e., by peer support or other professional)	131	34.8	595	0.4
Peer/self-help services	37	9.8	110	0.1
Crisis	10	2.7	12	<0.1
Case management	226	60.1	924	0.6
Other services (e.g., collateral)	216	57.4	666	0.4

Another method to analyze service utilization is by amount of time (i.e., hours) provided to each ADAPT participant. On average, ADAPT provided 14.9 hours of services to each participant while enrolled in the ADAPT program, with psychotherapy comprising 11.3 of those hours.

As shown in Figure 3, the majority of ADAPT services were provided face-to-face prior to the COVID-19 pandemic. During the initial months of the pandemic (i.e., the end of FY 2019-20), services shifted away from in-person interactions toward telephone and telehealth. Initially, telephone was utilized much more often than telehealth. However, utilization of telehealth has steadily increased over time (i.e., from 9.7% in FY 2019-20 to 74.9% in FY 2023-end) reflecting an increased capacity and comfort of both staff and participants engaging in this treatment modality. Over the past several years, in-person contacts have comprised approximately 15-20% of the interactions with ADAPT participants. It is anticipated that while having capacity to provide in-person visits remains an important characteristic of ADAPT services, telehealth will continue to be the primary mode of providing therapy and other supportive services for the majority of ADAPT participants for the foreseeable future.

For the 340 participants discharged from ADAPT Level 1 services by 12/31/2023, the average length of time enrolled in the ADAPT program was 136 days (with a median duration of 146.5 days). A closer examination of enrollment data indicated substantial variability such that 25% of participants were engaged with ADAPT for a relatively short period of time (i.e., 60 days or less), while another 25% stayed enrolled in ADAPT for more than 180 days (i.e., approximately 6 months).

Figure 3. Trends in ADAPT Service Types Over the Years



Level 2 Services

A total of 73 participants engaged in Level 2 services offered by ADAPT. These individuals received a total of 932 unique service contacts. Table 5 highlights the most common types of services provided in Level 2, which typically focused on educational/skill-building opportunities or assistance with basic needs. Both staff and participants noted the importance of being able to help address basic needs (e.g., food insecurity) as this can alleviate a major source of family distress. Additional types of supports provided to some Level 2 participants addressed a wide range of other issues including housing assistance, employment services, navigating public benefits or legal issues, or assistance with obtaining needed physical health care (see Table 5).

For the 73 participants who discharged from Level 2 ADAPT services, the average time in the ADAPT program was 110.9 days (median of 101.0 days). Level 2 participation was generally shorter than Level 1, however, 25% participated in services for least 174 days (i.e., approximately 5 months), which is a similar percentage to that of longer-term service utilizers found in Level 1.

Table 5. Most Common Types of FY 2022-23 ADAPT Level 2 Service Encounters

Category	ADAPT Level 2 Service Encounters			
	Total participants (n=73)		Total services (n=932)	
	Number of participants with service	% of participants with service	Number of services	% of total services*
Goal Setting Skills	49	67.1%	167	17.9
Basic Needs	44	60.3%	100	10.7
Self-Regulation Skills	42	57.5%	272	29.2
Mental Health Education	42	57.5%	119	12.8
Mindfulness Skills	35	47.9%	192	20.6
Parenting Skills	26	35.6%	70	7.5
Social Health	25	34.2%	56	6.0
Organization	22	30.1%	48	5.2

** Total may exceed 100% as multiple services could be provided during an encounter.*

Behavioral Health Service Utilization Patterns

Utilization of Other BHS Services

Based on an examination of the BHS electronic health record, very few ADAPT participants had any interaction with the BHS system. Across all 420 ADAPT participants, during the 180 days prior to enrolling in ADAPT there were only a combined 11 instances that involved any of the following: inpatient hospitalizations, crisis stabilization, urgent outpatient, or mobile crisis response team visits. During ADAPT and in the following 180 days after discharging from ADAPT the total number of those crisis and acute care interactions decreased further to less than 5 (note: exact number suppressed; de-identification of data requires masking of very low numbers to prevent identification of participants). Similarly, while involvement with BHS outpatient care was also rare prior to enrolling in ADAPT (e.g., less than 5), a total of 13 participants were connected to outpatient care after discharging from ADAPT. Overall, the BHS service utilization data indicated that very few ADAPT participants had any connection to BHS services outside of the ADAPT program. The limited number of interactions that did occur suggests a decreasing need for crisis and acute care services during and after ADAPT with greater connections to outpatient treatment services after ADAPT. These outcomes are consistent with the overall goals of ADAPT and programs of similar nature.

Key Treatment Outcome Findings

Edinburgh Postnatal Depression Scale

The EPDS is a 10-item self-report scale developed to identify individuals who may have postpartum depression in outpatient, home-visit settings, or at the 6-8 week postpartum physician examination. The EPDS was administered upon entry into ADAPT and then regularly thereafter as part of clinical/safety assessment and treatment planning. The EPDS was re-administered more frequently than other evaluation measures due to its direct use as part of treatment and risk assessment/mitigation. Scores were analyzed for ADAPT enrollees with an initial and at least one follow-up EPDS assessment.

The EPDS asks participants to indicate, on a scale from 0 to 3, which response is closest to how they have felt over the previous seven days. Higher scores reflect more distress. The maximum score is 30, with a score of 10 or higher indicating a high likelihood of depression. At intake, 77.9% (n=243) scored a 10 or higher, with 37.5% (n=117) reporting scores in that range on their last available EPDS assessment. However, 77.2% (n=241) demonstrated at least some reduction in depression symptoms and 42.6% (n=133) demonstrated a clinically meaningful treatment response of at least a 50% reduction from their initial EPDS score. Average scores reduced from 13.4 to 8.3, a statistically significant improvement (see Table 6). Approximately 50% had final EPDS score of 7 or less, which is consistent with depression remission thresholds.

Table 6. Change in EPDS Scores from Initial Assessment to Last Follow-up Assessment (N=312)

EPDS Item	Initial EPDS Mean	Last available EPDS Mean
	Scale of 0 to 3 where higher value = more serious concern	
I have been able to laugh and see the funny side of things	0.7	0.4**
I have looked forward with enjoyment to things	0.9	0.5**
I have blamed myself unnecessarily when things went wrong	1.9	1.3**
I have been anxious or worried for no good reason	2.1	1.4**
I have felt scared or panicky for no very good reason	1.5	0.9**
Things have been getting on top of me	1.8	1.2**
I have been so unhappy that I have had difficulty sleeping	1.3	0.9**
I have felt sad or miserable	1.5	0.9**
I have been so unhappy that I have been crying	1.3	0.7**
The thought of harming myself has occurred to me	0.2	0.1**
EPDS Total Score	13.4	8.3**
Likely Depression (i.e., score >=10)	**77.9%**	**37.5%**
Treatment Response Rate (i.e., 50% or greater reduction in EPDS score)	**42.6% (n=133)**	

***statistical significance at p < 0.01*

Analysis of EPDS patterns in the first 30 days of treatment (i.e., intake to 30-days post-intake) revealed a statistically significant reduction from an average of 13.4 to 10.9 (with median value decreasing similarly from 14 to 11). Almost two-thirds (62.5%; n=195) exhibited at least some reduction in depressive symptoms, and approximately 20% (19.6%; n=61) experienced a clinically meaningful 50% or more reduction from initial EPDS score. While the overall data showed that improvements occurred from intake to last EPDS assessment, these findings in particular indicate that many participants experienced a substantial reduction in depressive symptoms within the first 30 days of ADAPT enrollment.

The current standard of treatment for depression is typically psychotherapy combined with an antidepressant medication when necessary. A systematic review of the literature in 2020 (Shortis et al., 2020) identified five randomized controlled trials of cognitive behavioral therapy (CBT) interventions and their effect on peripartum (i.e., pregnancy through 1-year post-birth) depression. All of the trials reported large improvements in depression scores following the intervention compared to those observed in the control groups. Similarly, Pettman et al. (2023) conducted a systematic review of 31 randomized control trials and found that CBT-based interventions for peripartum depression were effective both during pregnancy and the postpartum period for symptoms of depression. Mothers who received CBT as part of their in-home nursing program (Ammerman et al., 2013), as a group-based intervention (Bittner et al., 2014; Alhusen et al., 2021), or even via an internet-based program (Pugh et al., 2016) also showed greater improvements in EPDS scores post-intervention than their counterparts assigned to a control or treatment as usual condition with no psychotherapy component. Burns et al. (2013) had similar results in a trial of CBT that was limited to pregnancy only: EPDS scores improved from 16.5 pre-treatment to 7.9 post-treatment. In comparison to these studies utilizing CBT as a primary treatment for peripartum depression, the ADAPT program achieved generally similar reductions in depressive symptoms.

While the EPDS total score is typically utilized as an overall indicator of the extent to which a person is experiencing depressive symptoms, an examination of the individual EPDS items presented in Table 6 can help identify the specific types of changes experienced. For people served by ADAPT, changes were evident across all dimensions. The items with the largest changes from intake were feelings of anxiety, scared/panic, sad/misery, crying, self-blame, and being overwhelmed (i.e., average EPDS differences of at least 0.6). While not a commonly endorsed item at intake, it is important to note that a critical risk item ("thoughts of self-harm") decreased approximately 50% by follow-up (See Table 6). Overall, ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

Table 7 shows the average EPDS score at initial assessment and last available follow-up, the average reduction in EPDS score, and the treatment response rate (i.e., percentage of participants demonstrating at least a 50% reduction from their initial EPDS score at last available follow-up) for select comparison groups (as indicated in Table 7 by color groupings). Overall, statistically significant and clinically meaningful reductions were evident within all comparison groups. The treatment response rates were within a narrow range of 41% to 48% for all comparison groups except for participants who identified as White/Caucasian with a response rate of 26.7%. Participants who identified as Hispanic, a primary population group of emphasis for the ADAPT program, had the largest average reduction in EPDS scores (5.7 points) as compared to African Americans (4.4 points) and Whites/Caucasians (2.9 points). Of note, there was almost no difference in average reduction in EPDS scores and in treatment response rates between those whose preferred language was Spanish as compared to those who spoke English. Also, the

results indicated there were no overall differences in average outcomes based upon whether someone enrolled earlier in the program (i.e., before 1/1/2022, the period impacted most by COVID-19 pandemic) or later in the Innovations-funded phase of ADAPT (i.e., 1/1/2022 to 12/31/2023), as the average reduction in EPDS scores and response rates were nearly identical. These results suggest that the benefits of participating in the ADAPT program were experienced by many different population groups and reflect the successful efforts to particularly support Hispanics and those who speak Spanish as they generally exhibited the highest levels of improvement.

Table 7. Comparisons of EPDS Score Changes from Initial Assessment to Last Follow-up Assessment

EPDS Comparison Groups	n	Initial EPDS Mean	Last available EPDS Mean	Average Reduction in EPDS Score	Treatment Response Rate %
		Scale of 0 to 3 where higher value = more serious concern			*50% or greater reduction in EPDS score*
Pregnant	62	12.0	6.7**	5.2	48.4
Postpartum	250	13.7	8.7**	5.1	41.2
Hispanic (Preferred language English)	139	13.7	8.0**	5.7	48.2
Hispanic (Preferred language Spanish)	71	12.6	6.8**	5.8	45.1
Hispanic	201	13.3	7.6**	5.7	47.1
African American	34	13.0	8.6**	4.4	44.1
White/Caucasian	60	13.3	10.4**	2.9	26.7
Transitional Age Youth (TAY; age 18-25)	107	13.5	8.5**	5.0	42.1
Non-TAY (age 26+)	204	13.3	8.2**	5.1	42.9
Enrolled before 1/1/2022	149	13.6	8.5**	5.1	42.3
Enrolled on or after 1/1/2022	163	13.2	8.1**	5.1	42.9

***statistical significance at p < 0.01*

Illness Management and Recovery Scale-Reduced

To measure clinician perceptions of participant recovery and improved illness management, a shortened version of the Illness Management and Recovery-Reduced (IMR-R) scale was completed by ADAPT providers. Representatives from ADAPT, BHS, and the University of California San Diego (UCSD) team evaluating the ADAPT program reviewed and chose 9 of the 15 items from the full IMR that were most relevant to the ADAPT program services and the focal service population (see Table 8). Each item on the scale has a 5-point behaviorally-defined response option tailored to that specific domain, with higher values indicating less impairment/better functioning. The IMR-R was administered upon entry into ADAPT and then at 90-day follow-up intervals, documenting the amount of potential initial impairment and the extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians.

As shown in Table 8, the initial IMR-R ratings varied substantially across the individual items. Average baseline ratings for many items were between 2 and 3, generally indicative of moderate impairment. Symptom distress was the item rated with the most severe score upon entry to ADAPT (i.e., 2.0), indicative of fairly high levels of mental health-related distress. Conversely, alcohol and drug use were rated as areas that were generally not a concern (i.e., intake ratings of 5.0).

Table 8. Change in IMR-R Scores from Initial Assessment to Last Follow-up Assessment (N=236)

IMR-R Item	n	Baseline Mean	Last Available Mean
		Scale of 1 to 5 where higher value = better functioning	
Progress towards personal goals	226	2.7	3.6**
Knowledge about symptoms, treatment, coping strategies, and medication	235	2.8	3.7**
Involvement of family and friends in mental health treatment	236	2.9	3.3**
Symptom distress	236	2.0	3.2**
Impairment of functioning	235	2.5	3.5**
Coping with mental or emotional illness from day to day	236	2.7	3.7**
Effective use of psychotropic medication[1]	22	4.1	4.5
Impairment of functioning through alcohol use	229	5.0	5.0
Impairment of functioning through drug use	229	5.0	5.0
Overall	**236**	**3.2**	**3.9****

***statistical significance at p < 0.01*

[1] This item was only completed for participants who were taking psychotropic medications at the time of the initial and last IMR-R assessment.

At the last available follow-up, the average overall IMR-R score increased from 3.2 to 3.9, indicating a statistically significant change and clinically meaningful improvements within the participant population. Among the individual items, medication management and substance use maintained their positive intake levels (i.e., high functioning/less impairment), and other items achieved a gain of 0.4 to 1.2. Particularly notable were the ratings of symptom distress improving from 2.0 to 3.2, indicating participants went from being bothered "quite a bit" by their symptoms at intake to only "somewhat" at follow-up. These IMR-R results indicated the achievement of important improvements in minimizing symptom distress and impairment while also increasing knowledge, coping skills, and progress towards personal goals, which help to maintain benefits and minimize risk of future symptom recurrence.

Wellness Survey

The ADAPT Wellness Survey is a self-report tool administered to participants upon enrollment into ADAPT and then every 90 days thereafter. Survey items were rated on a scale from 1 to 5, with higher values representing better reported wellness. Participants reported improvement in multiple dimensions, with

statistically significant changes in areas including but not limited to quality of life, physical health, mental health/mood, satisfaction with social activities/relationships, improved sleep, and ability to carry out everyday activities. Notably, ratings of hopefulness about the future also improved substantially as well as the belief that they have the skills and resources needed to manage stress related to interpersonal conflicts. See Table 9 for more detailed information.

Table 9. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment (N=226)

Select Wellness Survey Item	n	Baseline Mean	Latest Follow Up Mean
		Scale of 1 to 5 where higher value = better condition	
In general, would you say your quality of life is:	225	3.2	3.5**
In general, how would you rate your physical health?	225	2.8	3.0**
In general, how would you rate your mental health, including your mood and your ability to think?	225	2.3	3.0**
In general, how would you rate your satisfaction with your social activities and relationships?	224	2.5	3.1**
In general, please rate how well you carry out your usual social activities and roles.	226	2.9	3.5**
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	226	3.9	4.4**
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	226	2.3	3.1**
My child(ren) had emotional and/or behavioral problems.	166	4.2	4.1
I felt hopeful about the future.	216	3.6	4.0**
I felt spiritually connected.	216	3.3	3.7**
I lived in a home that made me feel safe.	216	4.6	4.7^
I used substances (alcohol, illegal drugs, etc.) too much.	216	4.9	4.9
How would you rate your fatigue on average?	226	3.4	2.4**
I get the emotional help and support I need from supportive others.	144	3.4	3.8**
When I am in distress, I can identify supportive others and may use my supportive others.	142	3.6	4.0**
Conflict with my partner or supportive others interferes with my ability to respond to everyday life challenges.	143	3.6	3.7

Table 9. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment (continued)**.**

Select Wellness Survey Item	n	Baseline Mean	Latest Follow Up Mean
		Scale of 1 to 5 where higher value = better condition	
I have the skills and resources needed to manage stress stemming from conflict with my partner or supportive other.	144	3.2	4.0**
Select Wellness Survey Item	**n**	*Scale of 1 to 10 where higher value = worse condition*	
How would you rate your sleep?	144	6.0	4.5**
How would you rate your sense of rest?	144	6.3	4.7**
How would you rate your alertness?	144	4.0	3.2**
How would you rate your pain on average?	226	3.4	2.4**

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

Linkages to Community Resources

In addition to the therapy, education, and emotional support provided by ADAPT team members, the program also emphasized trying to address other needs of the mothers and their families either directly or through connections to other community resources. A review of the Linkage Tracker system (a tool designed to facilitate documentation of participant referral needs and outcomes), showed that 257 participants (61.2% of all ADAPT enrollees) had at least one referral for additional services, for a total of almost 1,000 unduplicated referrals (n=976). The most common referrals were for additional mental health-related services (i.e., 161 participants with 280 referrals), followed by referrals in the area of social health (i.e., 107 participants with 204 referrals to services such as support groups and/or, parenting classes, etc.), basic needs (i.e., 74 participants with 152 referrals for food, clothing, etc.), and financial/legal assistance (i.e., 71 participants with 120 referrals for legal counsel, direct financial assistance and/or assistance obtaining public benefits such as food stamps). Considering that the Linkage Tracker system likely does not include every referral or linkage facilitated by ADAPT (i.e., some referrals and linkages that occurred in practice may have been omitted from the additional data entry steps required to log them into the Linkage Tracker system), the true total number of referrals and linkages is likely even higher. As such, at least 85 ADAPT enrollees (i.e., 20.2% of the 420 total enrollees) successfully received one or more community benefit(s) facilitated through ADAPT, with basic needs as the most commonly recorded successful linkage.

ADAPT staff mentioned in feedback surveys how these linkages primarily serve to improve family well-being. Additionally, the process facilitates participant retention and engagement by removing stressors and providing opportunities to collaborate with families to meet their needs, especially considering the challenges associated with a rapidly changing system of care in the community. Even for referrals who were ineligible for ADAPT services, ADAPT implemented a “no wrong door” policy and attempted to facilitate connections to an appropriate service provider.

Staff reported the difficulty of making these connections given eligibility requirements, waitlists, and the overall limited availability of many services and resources, particularly related to housing and childcare. Staff also noted that some participants may have hesitancy to initiate and/or access services at a new organization given the uncertainties involved in forming new relationships as well as time pressures and not feeling capable of navigating a new care system, even with support of ADAPT team members.

Table 10. Types of Referrals and Successful Linkages to Resources

Linkage Tracker Dimensions of Wellness	Referrals		Successful Connections to Resources	
	# Actions	# Participants	# Actions	# Participants
Physical Health (e.g., primary care doctors, health/fitness classes, etc.)	66	43	12	8
Social Health (e.g., support groups, parenting classes, community events/activities, etc.)	204	107	31	16
Mental Health (e.g., connections to therapists, self-help groups, etc.)	280	161	27	22
Substance Use (e.g., connections to counselors, self-help groups, etc.)	21	7	<5[1]	<5[1]
Housing (e.g., assistance to maintain current housing, housing vouchers, etc.)	85	43	14	10
Occupation/Education (e.g., job readiness programs, job training, etc.)	29	23	<5[1]	<5[1]
Financial Assistance/Benefits & Legal (e.g., financial aid, public assistance such as CalFresh and Medi-Cal)	120	71	26	17
Transportation/ Identification (e.g., support for public transportation, repair assistance, ID applications, etc.)	19	17	<5[1]	<5[1]
Basic Needs (e.g., food, hygiene, clothing, etc.)	152	74	74	42
Total Unduplicated Across All Domains	**976**	**257[2]**	**189**	**85[2]**

[1] *Values were suppressed due to small n size.*
[2] *Will not sum to this value as participants may have referrals in multiple domain areas.*

Stakeholder Feedback

ADAPT Participant Feedback

Participant Feedback Survey

Every 90 days (and at discharge), ADAPT program participants were asked to complete a survey regarding their perceptions of the ADAPT program and the extent to which they thought participation in ADAPT resulted in achieving general objectives of knowing where to get help, increased comfort in seeking help (i.e., stigma reductions), and overall ability to handle things. Note, if multiple surveys were completed by a participant, the results from the last survey completed were included in the results reported below. Overall, ADAPT participants were very positive about their experiences. Nearly all participants (99.1%) felt staff were sensitive to their cultural background, and 98.2% reported they were satisfied with the services they received. More than 96% reported knowing where to get help when they needed it, that services were available at times that were good for them, and that they were able to get all the services they thought they needed. For more details, see Table 11. These findings, particularly as related to service availability and cultural support, indicate that the ADAPT program accomplished the goal of connecting with participants and meeting their needs in a manner which is convenient for and respectful of the participants.

Table 11. ADAPT Participant Feedback Survey (N=228)

Participant Feedback Survey Item	n	% that Agree/ Strongly Agree
As a result of participating in ADAPT:		
I know where to get help when I need it.	228	96.9%
I am more comfortable seeking help.	228	94.3%
I am better able to access services in the community.	226	88.9%
I am better able to handle things.	228	90.8%
Experiences with ADAPT services:		
Services were available at times that were good for me.	228	96.5%
I was able to get all the services I thought I needed.	227	96.9%
Staff were sensitive to my cultural background (race, religion, language, etc.).	228	99.1%
Overall, I am satisfied with the services I received here.	228	98.2%

Additionally, open-ended questions were presented to gather participants' thoughts about the most important benefits or services received through ADAPT, as well as recommendations for improving services. A review of the responses from both English- and Spanish-speaking respondents indicated the following six primary types of benefits received while participating in ADAPT services.

Learning about mental health issues and the techniques to better manage/prevent symptoms.

- "Felt like I changed completely in a positive way as a result of therapy."
- "I was in such a bad place when we started, I've learned my triggers, how to cope and talking with you has helped a lot."
- “I have learned so much and I would still be depressed if it wasn't for your support. My first time in therapy and it was so helpful."

Learning and utilizing exercises that promoted self-care and compassion.

- “Learned how I can manage my issues and about self-care and positive self-talk."
- “Learning compassion exercises, how to be caring about myself and fight for my self-worth."
- [I was able to] "open my heart and be real" [instead of] "having to be strong."
- [I could] "look at myself from different perspectives" [using mindfulness] "and be more compassionate with myself."

Learning new (co-)parenting strategies and skills.

- “For me and my child, feel more secure with being a mom.”
- "I realized I can't do everything alone, I need help...I can now ask my family/community for help."
- "I was able to see my partner's point of view from his own perspective. The activities, talk, skills we did and learned with our therapist has helped me to see things differently for better."
- "I learned so much. You taught me I'm my baby's advocate."

Receiving general emotional support/encouragement from therapists/peer support partners and always feeling “heard.”

- "My therapist was always there to listen and never judged me for whatever I had going on.”
- "Mis terapias, me es muy util e importante tener alguien con quien hablar y me ayude a plantear mejor mis ideas." (My therapy sessions, it is very useful and important for me to have someone who talks with me and helps me present my ideas better.)
- "Emotional support and guidance. Understanding life a little better. Love my therapist's passion and dedication to my individual needs."

Having positive social interactions and a sense of community/belonging.

- "I feel like I have a place, an identity since I've been in ADAPT. It's been very helpful. It helped me feel like I belonged."
- "The checking up on me in the beginning. I felt like I could pick up the phone at any time and someone will be there. It was so important! The feeling of not being alone."
- "Good connection with therapist."
- "Having someone else to talk to- social interaction."

Assistance with obtaining tangible community resources (e.g., food stamps).

- "It was great being given support with mental health and housing resources."
- "I liked everything about ADAPT. You listen to me, you helped me a lot, referred me to get clothes/diapers."
- "Just trying to get myself back on track physically. It's good to have someone to help me through going and getting my job and going through this in a pandemic."
- "All the local places that you guys direct me to."
- "Being referred to resources that can assist my family with basic needs."

Participants also identified two key factors that facilitated their engagement in the ADAPT services:

Positive and trusting relationships with ADAPT therapists and peer support partners.

- "I never saw myself doing therapy because I was scared to open up, but you made me feel safe and comfortable. I have grown so much, and I can't thank you enough for all your help."
- "The combo of therapy and peer support. I have someone who is listening to me and someone who grounds me."

Ease of participating in services via in-home visits or telehealth sessions at convenient times.

- "The resources, as there were so many and also the support and encouragement. So flexible and helpful to not leave [home]."
- "The most important benefit was having [the therapist] come into our home to provide therapy to the whole family. It really helped us connect with each other."
- "Being able to talk to someone and process life and know that having kids didn't limit me in my ability to do it because it was from home and I could make it around my schedule."

A "word cloud" was created to highlight the language commonly used by participants to describe the primary benefits received through ADAPT. The "word cloud" included all open-ended participant responses (i.e., over 400) and produced a graphic where words that were mentioned more frequently appeared larger than those that were less frequently mentioned. For ADAPT, the words most often used by participants included "therapy," "support," "coping," "learned," "helpful," and "resources" to describe the primary benefits of ADAPT. Given that these words accurately characterized key goals and components of ADAPT, it was a positive signal to see them reflected in the language of participants when describing their experiences with the program.

Figure 4. Participant "Word Cloud" of Words Commonly Utilized to Describe ADAPT Program Benefits

Respondents were asked about any issues they experienced connecting to services in the community after being referred by ADAPT program staff. The vast majority of respondents either did not respond or stated "no issues" when it came to accessing community service referrals. However, a few participants did share that they had longer than expected wait times for services or did not hear back after attempting to contact services.

When asked for recommendations to improve ADAPT program services, many indicated that they did not have recommendations since they were generally happy with the services they received. The most common feedback was the request to continue receiving ADAPT services for a longer period. Another request was to allow for additional forms of communication with the ADAPT team, such as texting and emailing. After the onset of the COVID-19 pandemic, some participants indicated that they wished they were able to have in-person meetings in addition to the remote contact options of telephone and video calls. As a whole, the feedback generally reflected an interest in extended and/or enhanced communication and interaction with ADAPT program team members.

Brief Participant Feedback Interview

At the end of FY 2021-22 and FY 2022-23, the UCSD evaluation team and ADAPT leadership developed a series of questions with BHS input to elicit additional feedback about the program from participants. A total of 38 individuals participated, sharing their perceptions of and experiences with the ADAPT program. From the collected data, the following themes emerged:

Positive Experiences with and Perceptions of the ADAPT Staff

Participants consistently identified the quality of the therapist and peer support staff as a factor that facilitated their engagement in ADAPT services. The positive and trusting relationships were highlighted as participants described:

- “I love my therapist's passion and dedication to my individual needs.”
- “My therapist was always there to listen and never judged me for whatever I had going on.”
- “I have had the best experience here. My therapist really cares and always advocates for me.”

Newfound Understanding of Depression and/or Anxiety

Participants mentioned that as a result of ADAPT, they have a new ability to understand their depression and/or anxiety and skills to help their day-to-day functioning and relationships. Participants shared:

- “I don't feel as crazy as I used to because now I have learned about [my disorder] and ways to deal with it. It helped me understand how my childhood impacted me so I can be a better mom than I had. Being part of the program, I was able to apply and enroll to college, find transitional housing for my baby and I, plus I know lots more resources.”
- “ADAPT helped me to improve and lessen anxiety and have been yelling less at others."
- “I have learned so many helpful tools to manage the extreme emotions from postpartum. This has helped my marriage immensely and given my husband and I the tools to work through our stress and be better partners and parents.”
- “Being part of the program helped me understand myself better which has improved my relationships. I learned about my attachment style, how to show myself self-compassion, and I feel like I have better skills as a mom with multiple children.”

Program Flexibility/Accessibility

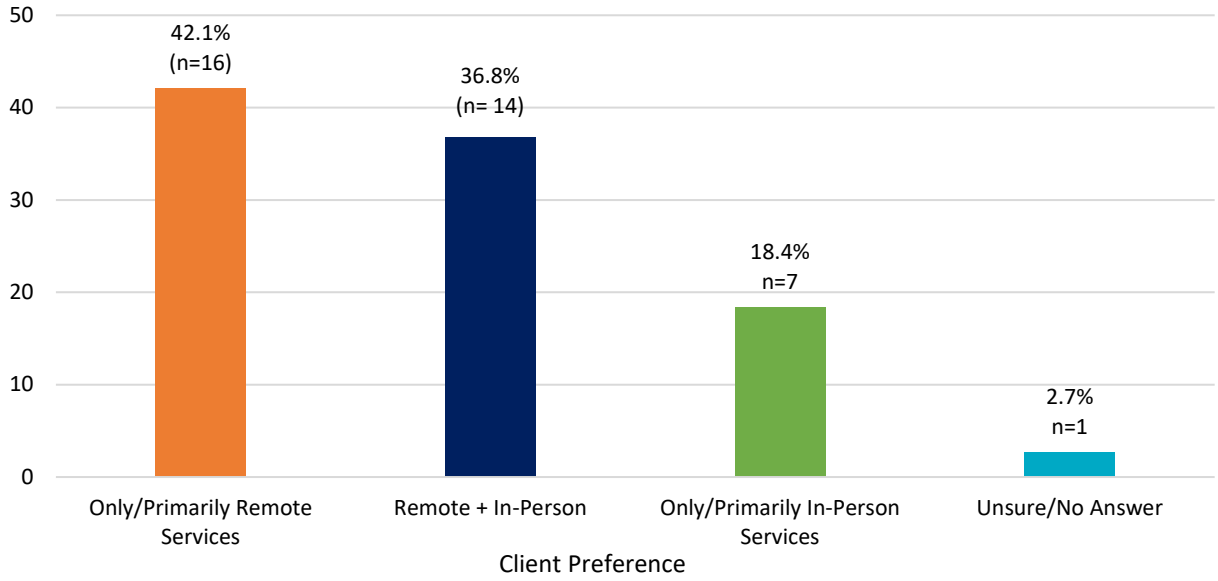
When ADAPT began in FY 2019-20, services were primarily provided in person. Participants appreciated the in-home option offered by ADAPT.

- “The most important benefit was having [the therapist] come into our home to provide therapy to the whole family. It really helped us connect with each other.”
- “The resources, as there were so many and also the support & encouragement. So flexible and helpful to not leave [home].”

Due to the onset of COVID-19, there was a rapid shift to remote services (i.e., telephone or telehealth). In the FY 2020-21 survey, some participants indicated that they wished they were able to have in-person meetings in addition to the remote contact options of telephone and video calls. As safety demands of the pandemic decreased, there became more opportunities for in-person visits when desired.

In the FY 2021-22 and FY 2022-23 surveys, participants were asked about their preference between the available options (i.e., in-person vs. remote), respondents answered as follows:

Figure 5. Participant Preference for Therapy Modality



Reasons for preferring remote services included social anxiety or considering themselves an "introvert." Others preferred telehealth due to the flexibility and/or having other obligations ("I have 4 kids and it would be almost impossible for me to do it in person"). Participants who appreciated the choice between in-person and remote services shared that "in-person would be nice to go to but remotely allows me flexibility as a mom" and "video calls are convenient when I'm busy. It's also nice seeing my peer support partner in person."

In FY 2021-22, participants who preferred in-person services commented on technological difficulties and the quality of the interaction over video. In this regard, improved capacity to engage successfully in telehealth sessions was needed to increase the number of participants who preferred telehealth as an option to receive ADAPT services. It seems that some of these hurdles resolved with time and experience, as in FY 2022-23 any preference for in-person services was attributed to the ability to be more attentive and engaged: "I find meeting with someone in person more personable and it's also easier for me not to get distracted."

The ADAPT Program was Different from Prior Treatment Experiences

Participants consistently shared feedback that ADAPT was different than experiences they had in other treatment programs. A selection of comments are as follows:

- "ADAPT has more quality treatment and I feel more comfortable with ADAPT providers."
- "[ADAPT is] more intensive and tailored to my needs."
- "The consistency of meeting with someone weekly was super helpful. Also, I would not have been able to afford care like this on my own. I am so grateful to have gotten this counseling at no cost!"
- "ADAPT staff cares. My therapist went above and beyond. The support felt different."
- "The postpartum specialization is different, and I've never had the option for the peer support aspect. I also like the ability to call my therapist if I needed to."

Given that only approximately 10% of ADAPT participants participated in the more detailed feedback discussion, a potential limitation of the findings presented is that they may not reflect the perceptions of the entire ADAPT program participant population. Additionally, it should be noted that the interviews were conducted by ADAPT program staff and therefore could be positively biased. However, many of the findings were similar in both years and consistent with data collected via other feedback mechanisms such as the Participant Feedback Survey administered throughout the year, which increases confidence in their generalizability to the overall ADAPT program. The consistently positive feedback and the resounding emphasis on the quality of care and positive impact of services is highly encouraging that ADAPT was successful in their goals of assisting participants with peripartum struggles. While many participants shared the progress they made with ADAPT, one respondent's statement about ADAPT stood out in its significance: "ADAPT helped me get out of the dark deep hole I felt at start of postpartum. Thanks to this program I am no longer there."

Referral Partner Feedback

At the end of each fiscal year, PHNs and other referral partners were asked to complete a brief online survey to obtain feedback regarding their experiences with the ADAPT program. The UCSD evaluation team, in collaboration with ADAPT leadership and BHS, developed a series of questions exploring referral partners' understanding of the ADAPT program and recommendations for program improvement. Participants were given a short script explaining the qualitative data collection process and instructed that providing feedback was voluntary.

A total of 242 referral partners (e.g., PHNs and representatives from seven other service providers) completed the online survey. While the response rate for individuals may warrant some caution when interpreting the results, the core themes were consistent with feedback received in prior years and from other feedback mechanisms such as PHN consultations and roundtable discussions. While the sample sizes were too small for detailed comparisons and conclusions, in general, the feedback was similar between the types of referral partners. Of note, some referral partners use the term "clients" when describing the persons served by their program and/or those referred to ADAPT. In this manner, the words "clients" and "participants" can be viewed interchangeable in the following referral partner quotes. Several themes emerged from the referral partners' feedback.

Bilingual services are important.

Referral partners highlighted the importance of Spanish-speaking clinicians. One referral partner indicated that when ADAPT staff turnover inhibited access to a bilingual clinician for their region for a period of time, they did not refer as many participants.

- "ADAPT has been able to assist with my Spanish speaking participants by having bilingual therapists. This is so important and I am so happy to finally have this needed support in my region. Speaking the language is so crucial when you need mental health services."

Electronic communication is beneficial.

Coordination and communication activities between ADAPT and the PHNs evolved throughout the years of the program, with a particular emphasis on improving the initial referral process. In FY 2019-20, initial referral efforts by PHNs were reported to be challenging. Substantial effort was made by PHNs, ADAPT

staff, and San Diego County BHS to build a sustainable partnership. Recommendations from PHNs included additional options for submitting referrals, such as via secure email. This effort paid off; by FY 2021-22 survey, over half of the respondents (60%) described the ease and efficiency of referring participants to ADAPT.

- "BHS ADAPT has been extremely fast to follow up with a referral, which is something that is really lacking in the mental health field. I also like the fact that they will come to the facility and meet with the [patient], instead of waiting for the [patient] to come to them."

In FY 2020-21, referral partners requested additional communication methods with participants. At the time, ADAPT clinicians did not have the ability to text with participants or email referral partners regarding participant treatment. Referral partners felt the ADAPT team would benefit from "having the ability to text participants regarding their upcoming appointments or if they need to reschedule." Additional recommendations included the creation of a signed participant consent that would allow for electronic communication to address ADAPT's liability. Where feasible, these types of efficiency improvements have been incorporated into the ongoing ADAPT program operations.

Referral partners desired expanded eligibility criteria.

In FY 2020-21, many referral partners expressed a desire to have wider eligibility requirements for the program. Often referral partners see participants who would benefit from ADAPT-style services from other community partners. One referral partner remarked:

- "Many clients were just referred back to their provider not qualifying for clinician visits. These clients are really needing a clinician in the home. When a mom is depressed, it is very difficult to get her out of the home with a newborn."

In FY 2021-22 and FY 2022-23, this theme emerged again with at least a third of survey respondents each year mentioning private insurance as a barrier to services. One referral partner remarked:

- "Having only Medi-Cal patients qualify for services is limiting. There are underinsured and insured patients that would benefit from this program."

Participants benefit from ADAPT.

Through the years, referral partners reported overwhelmingly positive outcomes for participants who engaged in ADAPT services. In the FY 2019-20 survey, PHNs indicated they often observed participant improvements such as increased confidence and hope, better decision-making and overall mental well-being, and additional connections to needed community resources. In later years, positive feedback was plentiful:

- "The ADAPT program has been a tremendous help to each of my clients that I have referred. The ADAPT services have allowed my clients to have focused, in-home mental health services that they truly need. Each of my clients that have completed the program have nothing but positive things to say about their experiences."

- "Every single client who has participated in the program has reported to me how helpful the program has been to them. I have had clients with suicidal ideation who have become more stable

using coping skills provided by the ADAPT clinician, and will hopefully use the resources provided at closing of the program to continue mental health services."

The positive feedback continued in the FY 2022-23 survey. The majority of referral partners highlighted "care coordination" (71.4%; n=30) followed by "communication with ADAPT providers," (52.4%; n=22) and "the referral pathway" (52.3%; n=22) as aspects of the ADAPT program that were working particularly well. Referral partners shared that their participants have had positive feedback about ADAPT. One stated, "My clients who stick with the program find it very helpful with managing symptoms of anxiety and depression."

ADAPT has improved the system of care in the community.

Referral partners have consistently reported how the ADAPT program benefits the system of care, both directly by providing necessary services and indirectly by making the jobs of the PHNs easier.

The ADAPT program has reduced the waitlist for services in the community.

- "Whereas many outpatient programs in the community have a waitlist ranging from 3 months to 18 months, [ADAPT] has done such a great job of meeting the needs of client and families and not having a waitlist. [ADAPT] has been able to successfully link with clients referred to them and we are so grateful to have a program like this in the community."

Further, referral partners mentioned that the ADAPT program has helped to ensure that their patients are connected to appropriate mental health services. Respondents described how "ADAPT has made it easy to refer participants who need peripartum mental health services" and "without this program there isn't much concrete I can do to get them help."

Referral partners also shared what they perceived as potential negative impacts of **not** having a program like ADAPT available:

- "Negative impact on clients, some may be able to get care through their medical provider, but the ability to offer a resource specific to their needs in relation to maternal-child health and interactions is a comfort on its own. If their provider isn't able to assist, having ADAPT is an additional safety net for them and gives them some comfort just knowing its available to them."

- "If ADAPT services were no longer available, it would be very difficult to find an accessible resource for our clients. It is challenging to find and contact other local resources in a timely manner regarding service availability and eligibility, the partnership that ADAPT has with our programs has been such a big help."

Notably, over the years the PHNs mentioned how ADAPT has helped to make their job duties more manageable.

- "I have not had a lot of available time during COVID-19 to be available for my clients. ADAPT has really helped by caring for their mental health needs when I'm not consistently able to take a phone call."

- "It helps me so much to be able to provide a mental health option that is available rather than to meet multiple dead ends and long waits for services through other organizations."

ADAPT Staff Feedback

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ADAPT Staff Survey. The stakeholder meetings were held throughout the years with representatives from BHS, ADAPT, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ADAPT Staff Survey was conducted at the end of each fiscal year. Staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program.

Over the years, 52 staff survey invitations were distributed (note: staff could participate in multiple years) with a total of 46 completed surveys for an overall response rate of 88.5%. Open-ended survey question responses were coded by a member of the UCSD evaluation team and reviewed by at least one other evaluator to identify the following emergent themes.

Staff Experiences with Using Telehealth Services as Primary Treatment Modality

With the onset of the COVID-19 pandemic, ADAPT was required to shift from providing services primarily in-person to interacting only via telehealth. Initially, there were some issues with being able to consistently utilize telehealth due to problems with internet connectivity and/or other technical challenges managing video calls. Additionally, participant preference was a factor: even when video calls were possible, staff estimated that approximately 10-20% of participants preferred telephone (i.e., no video) sessions.

However, staff reports of these issues generally diminished by the end of FY 2019-20 as comfort and expertise on the part of both participants and providers increased. In FY 2020-21, staff reported an increase in participant engagement in services with telehealth (as compared to in-person sessions), a reduction in no-show rates, and an increase in participant willingness to schedule services. Providers indicated telehealth was an effective and quality communication method, and reported a high level of confidence in their ability to provide services via this modality. A key benefit of the telehealth system was the substantial amount of time saved when staff travel was eliminated. Additionally, the switch to telehealth services facilitated a more efficient allocation of staffing resources to meet participant needs throughout San Diego County rather than maintaining primarily region-based service teams, as was in the original design of the program. Staff highlighted the importance of setting clear expectations about how to conduct telehealth sessions and establishing a pre-arranged plan with the participant for if and when a connection was lost (i.e., telephone follow-up). By FY 2022-23, staff were reporting numerous benefits of providing telehealth service options to participants; for instance, one staff member shared that delivering “services via telehealth has allowed the participants to meet more consistently with their therapist for sessions.”

Program Strengths

Team and Leadership

When reflecting on program strengths, staff members consistently mentioned the quality of the team at ADAPT. In the FY 2020-21 survey, a staff member highlighted “the communication, perseverance, diligence, passion, intelligence, desire to serve others, dedication [of ADAPT staff] to the support of mental health as a whole and serving an underrepresented population in San Diego County.” In the FY 2021-22

survey, nearly every staff member mentioned the team as a primary strength of the program. The team was described as “highly committed, passionate and empathetic" and the “collaboration, coordination, compassion, and camaraderie among the team members” was credited for the success of the program. Similarly, in FY 2022-23 the staff member responses focused on the characteristics of the team. Staff described the team as “dedicated" and highlighted the team’s willingness to “adapt to the individual and nuanced needs of our participants.”

Leadership was also consistently emphasized and credited as a primary strength of ADAPT. Staff surveys in FY 2020-21 mentioned “our supervisor is very supportive and transparent” and the following year the “commitment and clinical integrity of program leadership” was highlighted. This theme continued into FY 2022-23, where staff noted that “the ADAPT program has great supervision provided to the clinicians and the team is very supportive of personal growth and learning. The team also supports participants and ensures continuity of care.”

Referral Processing

A crucial aspect of ADAPT program coordination involved the process of receiving and processing referrals of PHN participants identified as potential ADAPT candidates. Key steps in the referral process included the development of referral documents that met the needs of both ADAPT staff and PHNs as well as protocols to guide the process of submitting and tracking status of referrals. As a result of ongoing discussions, the referral documents and process were revised multiple times during FY 2019-20, which facilitated more efficient and effective communication. In January 2020, ADAPT implemented a shared referral tracker that provided the disposition of referrals to each public health region. ADAPT staff designed training to increase PHN awareness and understanding of mental health issues. Coupled with ongoing review and feedback, this helped to substantially improve the fit between PHN referrals and ADAPT program eligibility criteria. By June 2020, 75% of PHNs reported that they felt confident they could identify appropriate referrals for ADAPT. ADAPT staff attempted to assist each referral received by trying to find alternative community resources and referrals even if the person ultimately was not eligible for ADAPT or otherwise did not enroll.

Flexibility and Accessibility

Over the years of staff surveys, staff recognized the unique way in which ADAPT is tailored to meet individual participant needs. During the most critical times of the COVID-19 pandemic, ADAPT staff found unique ways to meet with participants while also ensuring safety of all parties. Appointments were set up via telehealth, outdoors with social distancing, or via the phone. ADAPT staff arranged times to drop off tangible items such as diapers, formula, and other necessities without face-to-face contact.

Even once pandemic restrictions were lessened, ADAPT staff worked to meet participant needs including “requests about meeting in-person or face-to-face, offering various times to schedule appointments, letting participants know about expectations for example how long appointments will be and the length of treatment.” Offering both telehealth and in-person services has been beneficial to both staff and participants. Staff credited this accessibility as a key component of program success and a contributing factor in their ability to reach more participants. Staff mentioned the uniqueness of ADAPT in this respect; the flexibility offered is not typically characteristic of mental health service agencies. The culture of going “above and beyond” for participants is something ADAPT staff consistently recognized and appreciated.

At the inception of ADAPT, referrals had to come from a select set of approved referral partners. In FY 2021-22, eligibility criteria was expanded such that anyone who met criteria throughout San Diego County (i.e., Medi-Cal/Medi-Cal eligible with evidence of experiencing peripartum depression or anxiety) could be referred to ADAPT. This allowed ADAPT to receive the non-PHN originating referrals and enrollees discussed in earlier sections of the report.

An additional key component of successful recruitment and retention was the bilingual services offered by ADAPT, both from clinicians and peer partners. As one survey respondent remarked, "Flexibility and availability to meet participant needs including but not limited to efforts to hire and recruit Spanish-speaking clinicians, and advocating for both internal forms and partnerships to include Spanish-speaking participants."

Program Challenges

Collaboration with PHNs

As with many new initiatives, especially those with multiple organizational partners, mutual learning between the ADAPT program and the PHNs was required in order to develop, implement, and refine the coordination of information and services. Two components of the relationship between PHNs and ADAPT that were of particular importance during the life of the program were: 1) the identification of potential ADAPT referrals and 2) communication of referrals from PHNs to the ADAPT program.

In the early years of the program, staff indicated some communication and coordination challenges between ADAPT and PHNs. Staff reported that periodic face-to-face interactions with PHNs best facilitated the referral stream and coordination of activities. When the COVID-19 pandemic and related safety practices emerged, this became challenging to accomplish if not explicitly prohibited. However, due to ongoing efforts by both groups including increased e-mail communication, regularly scheduled meetings, involvement of PHN leadership, and increased education about ADAPT to reduce ineligible referrals, staff characterized the collaboration between themselves and PHN as positive and helpful in participant engagement.

Engagement of Family Members

A goal of the ADAPT program was to involve family and/or key support persons (i.e., close friend, co-parent, partner) to participant services. Staff highlighted the importance of including family members in "a variety of case management and counseling avenues" and explaining to key support persons the "many facets of pregnancy and motherhood physically and emotionally." This model has the potential to bring benefits to the broader family unit, including improved communication skills, and so efforts of the ADAPT team to involve family members in services were substantial. However, it was a challenging goal to accomplish. Family members can be a source of conflict for participants, and not all participants have family members willing to participate. Even when family is willing, the participants may not be interested in including them in therapy either due to strained relationships or because they want the time to focus on themselves. Staff mentioned Motivational Interviewing was useful in helping participants to identify which family members would be most helpful to engage. Also, explaining "the importance of having family support … when we talk to them about their participant plan." In terms of engaging the identified family members, staff suggested offering family or couples' therapy, employment assistance, and the option of a male therapist to increase motivation to participate.

Resource Awareness

Each survey, staff mentioned the challenge of keeping up-to-date on a rapidly evolving system of care in the community. When ineligible referrals were received, ADAPT implemented a "no wrong door" policy where those referrals would be connected with an appropriate service provider. To do this effectively, staff members emphasized the challenges of keeping current on available community programs.

- "We need more resources and more up to date resources and programs happening in San Diego. I feel like there has to be hundreds of more programs or resources for participants regarding childcare and housing, but it feels like we can't connect to them or find them."

Although the team did their best to "[pull] from one another's knowledge regarding resources in San Diego" it was not always sufficient. Staff reported that "connection with housing, childcare, and employment/school resources," was a major challenge in providing and continuing services. In the FY 2022-23 survey, one staff member shared:

- "San Diego County programs are impacted heavily so it is very difficult for people to get the resources that they need. Housing is impacted. Childcare is impacted or costs too much and financial assistance is very difficult to maneuver and obtain. Low-income housing is still too expensive for mothers who don't have jobs and don't have anyone to watch their children to get jobs."

Changes from Initial Program Design

COVID-19-Related Changes

In FY 2019-20 and FY 2020-21, the ADAPT program needed to make changes related to the COVID-19 pandemic. As discussed earlier in the report, the program was primarily designed to provide services in person but the onset of the pandemic forced a transition to primarily telehealth and/or telephone services. When the pandemic became more manageable for the health care system in general, and safety concerns lessened, ADAPT re-introduced in-person services while continuing to provide telehealth and some telephone-based services. When an ADAPT clinician thought that an in-person visit would be beneficial, and such a visit was feasible and appropriate, efforts were made to identify a safe location such as outdoors or another location convenient for the participant. The greater flexibility associated with telehealth led it to be not only sufficient, but potentially a superior way to support participants throughout all San Diego County regions, rather than having region-specific clinicians and staff. Participants became generally more comfortable with telehealth and many even came to prefer it over in-person services.

Allowing Eligible Referrals from Throughout San Diego County

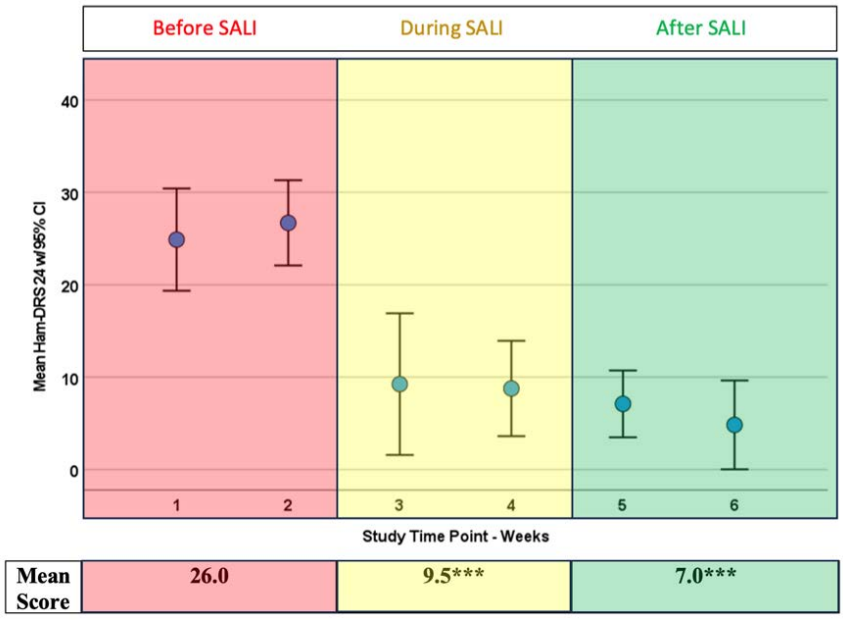
Initially, only PHN programs could send referrals to ADAPT. During FY 2020-21, additional referral partners were added including Sharp Mary Birch, Best Start Birth Center, and the Sudden Infant Death Syndrome (SIDS) program. In FY 2021-22, the options were expanded further to allow referrals from throughout San Diego County. Anyone can refer participants directly to ADAPT, and self-referrals are also accepted. This brought two issues to light: 1) the need for additional community outreach to increase awareness about ADAPT, and 2) the need for effectively communicating eligibility criteria (i.e., Medi-Cal/Medi-Cal eligible with evidence of experiencing peripartum depression or anxiety) in order to encourage appropriate

referrals. In FY 2022-23, the ADAPT program continued to engage in community outreach activities to expand the number of potential community referral partners and increase the network of organizations that can provide additional supplemental resources for ADAPT participants.

Sleep and Light Intervention Study (SALI)

SALI is a brief, non-pharmacological, in-home intervention for perinatal depression. Participants engage in a one-night sleep timing and duration adjustment, coupled with two weeks of 30-minute per day lightbox exposure at a specific time based upon whether pregnant or postpartum. This protocol is meant to reset the individual's circadian rhythm, and has demonstrated high levels of fast-acting and durable effectiveness at treating perinatal depression in research settings. As part of an effort to move SALI into community settings, a pilot research study led by Drs. Barbara Parry and David Sommerfeld from the UCSD Department of Psychiatry was designed to test the feasibility, acceptability, and effectiveness of training community providers to deliver SALI. The pilot study was reviewed and approved by the UCSD Institutional Review Board (IRB) and the BHS Research Committee.

Figure 6. Average Hamilton Depression Score Ratings Before, During, and After SALI



*** statistical significance at p< 0.001.

The primary outcome measure for assessing depression in the SALI pilot study was the Hamilton Depression Rating Scale with Atypical Depression Supplement (HAMDRS), which was administered weekly during: 1) the two weeks preceding, 2) the two weeks during, and 3) at least two weeks after completing SALI.

HAMDRS scores of 0-7 are considered "normal" with no depression, 8-16 suggest "mild depression," 17-23 "moderate depression" and scores over 24 are evidence of "severe depression". Figure 6 presents the average HAMDRS scores across the six primary study time points for the ADAPT participants (n=9) that enrolled and completed the 2-week SALI intervention. Paired sample t-tests comparing average scores before and during SALI, as well as before and after SALI, were both statistically significant at $p < .001$. The results demonstrated clinically meaningful reductions in depressive symptoms as the average HAMDRS

scores improved from 26 (severe depression) before SALI to 7 (no depression) in the two weeks after SALI. While caution is warranted given the small sample size, the results suggesting rapid and substantial reductions in depression symptoms by those completing SALI is consistent with prior research (Parry et al., 2023).

Figure 7. First Page of the SALI "Mom's Night In!" Handout of Potential Pleasant Activities

Feedback from participants indicated some concerns with the first night of SALI, which requires an expectant or new mother to adjust and restrict sleep during a specific time of the night. While most indicated that this was not as challenging as initially expected, to help minimize uncertainty and unease about the night with the sleep adjustments, we created a "Mom's Night In" handout (see Figure 7) with a wide range of potential activities that focused on self-care and pleasant things that could be done during the night either by themselves or together with someone else.

ADAPT team members generally reported SALI as feasible to integrate into services, due to its appropriateness for populations served by ADAPT and appeal to the clinicians. Even with general positive perceptions, enrollment into the SALI study was less than originally anticipated, which indicates that implementation barriers to utilizing SALI within "real world" treatment environments persist. Identifying and attempting to reduce those barriers continues to be an emphasis of the ongoing SALI pilot study.

Conclusion

Based on the experiences of the ADAPT program and outcomes achieved, primarily that of reduced depression and anxiety among peripartum populations, the ADAPT program will be incorporated as an ongoing program into the overall BHS system of care. During the Innovations-funded phase of ADAPT, a total of 420 participants enrolled into the program. Most participants (89.5%; n=376) were involved in Level 1 services, which included therapy from licensed clinicians as well as general support, education, and linkages to other care services provided by peer support partners and other ADAPT team members. Initially, ADAPT was designed to accept only referrals from select County PHN programs; however, due in large part to the onset of the COVID-19 pandemic, the number of eligible referrals originating from these PHNs was substantially less than expected. This contributed to the BHS decision to allow ADAPT to accept both referrals from other community organizations who provided services to peripartum populations as well as self-referrals from mothers who initiated contact with ADAPT to seek assistance. PHNs remained the largest single source of referrals throughout the Innovations-funded pilot phase and will continue to

be a primary referral partner as ADAPT transitions to become a specialized ongoing service provider within the overall BHS system. Even with the expanded network of referral partners, enrollment into the ADAPT program was about 100 participants per year—lower than anticipated (i.e., original plans called for 300 participants served each year, 200 in Level 1 and 100 in Level 2). To better reflect actual enrollment levels, the ongoing ADAPT program aims to serve 100 participants each year.

Overall, clinician and participant assessments indicated that after participating in ADAPT, individuals experienced substantial reductions in depression and anxiety-related symptoms and improved their ability to manage their emotional well-being. Scores on the EPDS demonstrated substantial improvements from baseline values, with 42.6% exhibiting a clinically meaningful treatment response rate of at least a 50% reduction between their baseline and follow-up EPDS scores. This type of treatment response is consistent with other psychosocial and/or pharmacological evidence-based treatments for peripartum depression and anxiety. With a few exceptions, the average reductions in EPDS scores and treatment response rates were similar across several different population groups defined by race/ethnicity, language, age, or ADAPT enrollment period. Those who were pregnant when they enrolled into ADAPT appeared to have slightly better outcomes than those who enrolled postpartum, with treatment response rates of 52.7% and 42.2%, respectively. Additionally, both Spanish-speaking and non-Spanish-speaking Hispanics showed nearly identical outcomes with treatment response rates above 45%, which were similar to those of African Americans (44%), but substantially higher than those who identified as White/Caucasian (26.7%). These results indicate that ADAPT was successfully able to achieve desired treatment outcomes with many who enrolled into the ADAPT program, particularly with populations of emphasis such as participants identifying as Hispanic and/or those who speak Spanish.

Additional feedback from participants suggested that ADAPT contributed to improvements in sleep, better ability to interact with family members and handle social responsibilities, improved capacity to manage symptoms, as well as other beneficial outcomes. Participants also highlighted the importance of connections to additional community resources that allowed families to better care for their children and address basic needs related to food, clothing, shelter, and employment. High levels of satisfaction were reported by participants and echoed by PHNs, who reported substantial benefits for their ADAPT-enrolled participants such as improvements in their mental health and enhanced ability to manage life challenges.

Both participants, PHNs, and other referral partners highlighted the importance of having a community program like ADAPT that specializes in the unique needs of pregnant and postpartum women experiencing depression. Due to the positive outcomes achieved by the ADAPT program, BHS decided to incorporate these specialized services into the overall system of care as an ongoing program. However, based on the program's lower-than-anticipated enrollment, it was decided to discontinue Level 2 services as well as adjust the overall enrollment goal to 100 participants per year. Core features that will continue to be emphasized in the ongoing ADAPT program include the provision of culturally and linguistically appropriate services, facilitating connections to additional community resources, and reduction of barriers to treatment engagement by offering accessible at-home services in-person or via telehealth.

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Appendix A

Characteristics of ADAPT Participants

Characteristic	Participants (N=420)	
Pregnancy Status	**n**	**%**
Pregnant	81	19.3
Postpartum	339	80.7
Total	**420**	**100**
Age	**n**	**%**
18 – 25	156	37.1
26 – 35	206	49.1
36 or Older	58	13.8
Total	**420**	**100**
Gender	**n**	**%**
Male	7	1.7
Female	410	97.6
Another gender identity	2	0.5
Unknown/Missing	1	0.2
Total	**420**	**100**
Primary Language	**n**	**%**
English	313	74.5
Spanish	87	20.7
Other (i.e., Arabic, Cambodian, Mandarin, Portuguese, Tagalog, Other)	20	4.8
Total	**420**	**100**
Race/Ethnicity[1]	**n**	**%**
African American	57	13.6
American Indian	14	3.3
Asian	30	7.1
Hispanic/Latino	278	66.2
White	128	30.5
Multiple	78	18.6
Other	6	1.4
Missing/Unknown	2	0.5
Total[1]	-	-

Appendix (continued).

Characteristic	Participants (N=420)	
Mental Health Diagnosis	**n**	**%**
Depressive Disorders	139	37.0
Bipolar Disorders	24	6.4
Anxiety Disorders	63	16.8
Stressor and Adjustment Disorders	111	29.5
Other/Missing	39	10.3
Total[2]	**376**	**100**
Substance Use Disorder (SUD) Diagnosis	**n**	**%**
Yes, has SUD Diagnosis	40	10.6
No, does not have SUD Diagnosis	336	89.4
Total[2]	**376**	**100**
Sexual Orientation	**n**	**%**
Heterosexual or straight	375	89.3
Bisexual/Pansexual/Sexually Fluid	32	7.6
Another sexual orientation	<5[3]	<1.2[3]
Missing/Prefer not to answer	<5[3]	<1.2[3]
Total	**420**	**100**
Disability	**n**	**%**
Has a disability	73	17.4
Does not have a disability	343	81.7
Declined/Prefer not to answer	4	0.9
Total	**420**	**100**
Type of Disability[4]	**n**	**%**
Communication (i.e., seeing, hearing)	17	4.1
Learning or other Mental Disability	24	5.7
Physical Disability	9	12.3
Chronic Health	24	5.7
Other Disability	26	6.2
Total	-	-

[1] *Total may exceed 100% since participants could select more than one response.*
[2] *Diagnosis related information is only available for participant who enrolled in Level-1 ADAPT services.*
[3] *Values were suppressed due to small n size.*
[4] *Total may exceed the number of participants with a disability since participants could select more than one response.*

BHCONNECT INNOVATIONS-19

Final Report

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

v.4.30.2024

Table of Contents

Introduction

The County of San Diego Health and Human Services Agency's (HHSA), Behavioral Health Services (BHS) Telemental Health program (commonly known as BHConnect) was funded as a pilot study through the Innovations (INN) component of the Mental Health Services Act (MHSA). BHConnect focused on persons who have received crisis-oriented psychiatric care services, but were otherwise unconnected to behavioral health treatment services and identified as likely having barriers to accessing traditional outpatient services. The goal was to reduce the recurrence rate for psychiatric crisis services among these individuals by offering an alternative method of care that relied primarily on telehealth treatment. BHConnect provided clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access. The BHConnect service provider team was comprised of 1) licensed and associate clinicians who provided therapeutic care services, and 2) health navigators who supported the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed. BHConnect provided services to children, youth and families (CYF), and adults/older adults (AOA).

While recognizing the positive benefits of the treatment services provided to BHConnect clients with the many competing demands for funding, BHS decided the BHConnect program would not continue past the conclusion of the MHSA Innovations (INN)-funded pilot study phase on 10/31/2023. Primary reasons for not continuing BHConnect included 1) lower than expected enrollment, particularly for AOA clients, and 2) the overall increased availability of telehealth services throughout the network of other BHS-funded treatment service providers, which lessened the uniqueness of the BHConnect program compared to when it started (i.e., before the pandemic).

This report highlights the successes and challenges of the BHConnect program during the INN-funded pilot study. Despite difficulties with initial uptake of BHConnect services, as evidenced by low enrollment of AOA clients, the results from the pilot study generally provided "proof of concept" for the original objectives by demonstrating that a telehealth-based service delivery model could successfully engage with and provide behavioral health treatment to youth and adults who recently received crisis services but were otherwise unconnected to ongoing treatment. This connection to treatment was associated with a reduced utilization of emergency/acute care services, particularly for those who had a prior psychiatric hospitalization. Key benefits of the telehealth service delivery model identified by participants, referral partners, and staff focused on the convenience and flexibility of participating in services that did not

require in-person/in-clinic interactions. The ability to offer treatment services without requiring any in-clinic sessions was particularly beneficial for engaging certain populations including persons with mental health conditions such as agoraphobia and depressive symptoms that contributed to significant self-isolation tendencies.

Program Description

The County BHS BHConnect program was funded through the INN component of the MHSA. Services were provided through the Vista Hill community-based organization. BHConnect was developed to increase access and connection to follow-up behavioral health services after a San Diego County resident utilized a psychiatric hospital, emergency screening, and/or crisis response services but was otherwise unconnected to behavioral health treatment. The aim was to overcome barriers to follow-up care with the goal of reducing recurrence rates of psychiatric crises. As such, specialized supports were provided almost exclusively via telehealth to reduce barriers to accessing ongoing care. San Diego County residents of all ages were eligible for BHConnect, and services were tailored to be culturally and developmentally appropriate. The BHConnect service provider team was comprised of licensed and associate clinicians who provided therapeutic care services. The team also included health navigators who supported the clinical team by maintaining engagement and communication with clients and providing other care management and supports as needed. After an initial evaluation by a case manager, services were offered on a telehealth platform. To facilitate better access to care services, BHConnect provided clients with the technology necessary to maintain contact with telehealth professionals. Clients could either install a telehealth app on an existing personal device, or the program provided a phone/tablet that was equipped with built-in internet access and the telehealth app to use while receiving BHConnect services. Clients received a full tutorial on how to use the technology, as well as assistance with in-home setup prior to being connected with a behavioral health professional.

Assessment of Primary Program Objectives

The main goals of the BHConnect project included the following:

1. ***To learn if telehealth will lead to increased engagement in outpatient behavioral health services for clients who access emergency services yet are not connected to outpatient care and are therefore at risk for a secondary emergency service.***

   The MHSA INN-funded BHConnect pilot study was designed to expand opportunities for engaging in treatment by offering telehealth services for persons who recently utilized behavioral health-related emergency services but were otherwise unconnected to outpatient care. As discussed in more detail in this report, the results were somewhat mixed in that enrollment into BHConnect, particularly for AOA populations, did not meet expectations. Low AOA enrollment was especially pronounced during the early years of the BHConnect program, which coincided with and was likely negatively impacted (at least initially) by the onset of the COVID pandemic in 2020. The pandemic created challenges throughout the BHS system and disrupted efforts to develop referral partners. In more recent years, the network of referral partners expanded substantially with a corresponding increase in enrollment among AOA participants (approximately 20% more during Fiscal Year (FY) 2022-23 as compared to the prior year), but the initial goal of serving 175 AOA clients annually was not achieved.

Results generally indicated that BHConnect was able to retain the majority of clients in treatment services using a telehealth-based model of service provision and engagement. Approximately half of both CYF and AOA clients received services for at least four months, with around 10% receiving services for more than a year. For each month (i.e., 30 days) enrolled in BHConnect, CYF and AOA clients received an average of 3.5 and 4.2 respective services with therapy as the majority of those contacts. In the last full year of program operations (FY 2022-23) CYF and AOA clients, respectively, received on average a total of 9.4 and 12.5 total hours of therapy.

BHConnect also facilitated linkages to other treatment providers if BHConnect services were not preferred or were not the best fit for client needs. Approximately 20% of clients transitioned to other care providers, with less than 5% needing to transition to a higher level of care. In this regard, BHConnect prioritized quickly engaging with clients, and if a different treatment option was needed, facilitated a connection to another provider.

Both CYF and AOA clients who participated in BHConnect demonstrated a reduced need for emergency and crisis-oriented care services after 90 days of program involvement. Based on available data from the BHS service system, the number of CYF clients and AOA clients experiencing an inpatient hospitalization decreased 76.9% (from 39 to 9) and 82.1% (from 67 to 12), respectively. The data was based on available data from the BHS service system, comparing clients who were enrolled 90 days before and 90 days after enrolling in BHConnect. Crisis stabilization visits also reduced substantially for CYF and AOA clients. Where baseline and follow-up data were available (i.e., Child and Adolescent Needs and Strengths and Pediatric Symptoms Checklist for CYF clients, and Illness Management and Recovery and Recovery Markers Questionnaire for AOA clients), the results were generally consistent with the level of improvements identified in the overall BHS system of care.

In support of the basic concept motivating the creation of BHConnect, qualitative feedback from participants, referral partners, and staff highlighted the benefits of the telehealth-based service model to reduce barriers to accessing care and providing flexible and rapid scheduling of services to meet the needs of interested participants. Overall, telehealth-based mental health treatment services may not be preferred by or work for everyone, but the results of the BHConnect pilot study suggest that with the identification and development of sufficient numbers of referral partners, a telehealth only/telehealth primary model represents a viable strategy to engage a portion of the population who may not otherwise enroll in care.

2. ***To learn if telehealth decreases the utilization of crisis/hospital services within 30 days of discharging from psychiatric hospitalization.***

For CYF and AOA clients who had a BHS psychiatric hospitalization within 30 days prior to BHConnect, hospitalization readmission rates were calculated and compared to the overall BHS 30-day readmission rates as reported in Appendix A of the FY 2021-22 CYF and AOA BHS Systemwide Annual Report. For those BHConnect CYF clients who had a psychiatric hospitalization within 30 days prior to enrolling into BHConnect, only 10.7% (3 out of 28) were readmitted within 30 days of discharge. This was slightly lower than the BHS CYF systemwide average of 14.0%. For BHConnect AOA clients, only 1.9% (1 out of 52) had a readmission within 30 days as compared to a BHS AOA systemwide average of 22.3%. While the total number of BHConnect participants included in these analyses was relatively small, the results suggest that engagement with outpatient care services such as BHConnect shortly

after discharge from a psychiatric hospitalization contributed to lower readmission rates, particularly among adults.

3. To determine how telehealth meets specific needs or diminishes barriers to treatment for clients.

As reflected in Figure 3 (pg. 24; Implementation Findings) and in the stakeholder staff feedback, telehealth services were generally viewed as an effective strategy for delivering mental health treatment services. Telehealth expanded access to care by eliminating specific barriers such as transportation, and by reducing others such as child care and the overall amount of time needed to participate in services as compared to in-person/in-clinic treatment. Telehealth also allowed for more flexible scheduling/rescheduling of appointment times, increasing convenience and feasibility for both clients and treatment providers. Additionally, stakeholders identified an unanticipated benefit of telehealth in that it allowed persons with certain mental health conditions such as agoraphobia or depression-related self-isolating tendencies the opportunity to access treatment services without requiring any in-office appointments. Near the end of the INN-funded pilot study, BHConnect began to strategically integrate some in-person visits if needed for client engagement, achieving treatment goals, and/or client safety. In this manner, treatment was further customized to address the needs and preferences of the client.

While telehealth eliminated or reduced many barriers to accessing care, it was important to address the following key telehealth requirements/needs: ensuring the client had an acceptable and operational device, ensuring they were comfortable using the device, verifying they had access to sufficient internet strength, and identifying a private space to conduct their treatment sessions. BHConnect staff would specifically attend to these essential components (e.g., providing them with a WIFI-enabled device and/or setting up an existing personal device to access telehealth services based on client preference) when enrolling someone into BHConnect. If challenges persisted that BHConnect could not address, BHConnect would explore transitioning the client to another care option.

Similar to in-person/in-clinic treatment, barriers affecting therapeutic engagement also needed to be addressed in the telehealth service delivery context. Examples include treatment ambivalence/lack of motivation, difficulty focusing, presence of other co-morbidities including substance use disorder, as well as the potential for mental health treatment stigmas. In addition to utilizing strategies applicable to both in-person and telehealth services, such as training staff in Motivational Interviewing techniques and encouraging “warm hand-offs” with the previously involved emergency service providers, BHConnect staff dedicated time to finding and incorporating technology-enabled tools such as online art therapy, educational videos, therapeutic games, and psychoeducational applications to engage with their clients. Also, the existing technology-based relationship between clients and BHConnect staff facilitated more frequent contact through messaging and other forms of brief virtual check-ins.

As discussed in more detail below, at the start of the BHConnect program there was another barrier that affected the utilization of BHConnect services, particularly for AOA clients. Prior to the onset of the COVID pandemic in March of 2020, use of telehealth to provide mental health treatment services was not commonly practiced throughout the BHS service system. Telehealth was a novelty, particularly among organizations providing crisis and emergency mental health care services to the AOA population. Based on provider feedback, there appeared to be some hesitancy to refer clients to BHConnect as it relied exclusively on telehealth to treat patients. As such, initial AOA referral numbers

were very low. Through the experience of responding to the pandemic, telehealth services became much more widespread and incorporated as a regular service option in many different mental health programs, which likely contributed to the growth in AOA referrals to BHConnect in more recent years.

4. ***To determine which subpopulations respond best to technology-driven services.***

   The experiences of BHConnect suggest that as long as the core technological requirements are addressed, telehealth services can be utilized by participants with a wide range of personal characteristics spanning age, gender, race/ethnicity, etc. However, BHConnect participants exhibited some variability from typical BHS outpatient participants. This trend was likely due, at least in part, to the focal population of BHConnect (i.e., those recently receiving behavioral health crisis/emergency services) and the telehealth orientation of their service delivery strategy. There were enrollment and utilization patterns that suggested some tendencies regarding who may be most interested in receiving mental health care exclusively/primarily via telehealth services. In particular, BHConnect participants tended to be "older" youth and "younger" adults, with approximately half (49.9%) aged between 15 and 30 years old. This trend suggests that the telehealth approach to providing treatment services may be most appealing to persons who were "old enough" to manage treatment services on their own via a telehealth device, and "young enough" to be familiar with and comfortable with interacting primarily via technology (i.e., video and phone). Feedback from staff supported this interpretation with some suggesting that a primarily telehealth-health based treatment program might be most appropriate and feasible with older teens and younger adults (and not younger children).

   Females also appeared to be somewhat more receptive to the BHConnect service delivery approach as they comprised approximately 60% of CYF and AOA enrollees, which is a larger percentage than found in the overall BHS CYF (52%) and AOA (43%) service system. BHConnect successfully served a racially and ethnically diverse client population; however, a lower percentage of BHConnect CYF clients identified as Hispanic (51%) as compared to other BHS CYF outpatient (67%) and emergency services (60%). These findings suggest that potentially a larger proportion of Hispanic families may have been hesitant to utilize a technology-based approach for mental health service delivery and/or were not offered it as consistently as a treatment option. This would need to be explored further in any future investigations into potential differences in utilization of telehealth treatment approaches by population groups. Similarly, although BHConnect provided treatment services to persons with a wide range of mental health diagnoses, depression was the most common for both CYF and AOA clients. This finding, combined with BHConnect team member feedback, highlights the fact that a technology-based approach to providing treatment services may be particularly appealing to persons for whom an in-person/on-site session may be a significant barrier to engaging in needed care to not only to logistical concerns, but those for whom their mental health symptoms inhibit interpersonal interactions.

Future Directions

With many competing demands for funding, BHS discontinued the BHConnect program on 10/31/2023, at the end of the MHSA INN-funded pilot study phase. The program stopped enrolling new clients as of 6/30/2023 and then either successfully concluded treatment or transitioned persons needing ongoing care to alternative treatment options throughout the BHS system by 10/31/2023. While recognizing the

benefits of the treatment services provided by BHConnect, the main reasons for not continuing the program included lower-than-expected enrollment (particularly for AOA clients) and the increased availability of telehealth services throughout the network of other BHS-funded treatment service providers.

Based on the experiences of the BHConnect program it appears there is a portion of the population, albeit of unknown size, receiving crisis and acute care behavioral health services who would benefit from having the opportunity to engage in treatment primarily or exclusively via telehealth. While most outpatient behavioral health treatment providers now regularly offer telehealth treatment services, BHConnect was unique in that it combined an outpatient treatment program with licensed clinicians who provide ongoing therapy with an outreach/linkage program (such as the BHS-funded In-Home Outreach Team [IHOT] or PeerLINKS programs) that meets with individuals at their preferred location (i.e., home or crisis/inpatient facility) to form connections and facilitate interactions.

This outreach orientation of BHConnect removed significant barriers to accessing treatment by enabling prompt and low burden initiation of services to literally and figuratively, "meet the client where they are at." The telehealth approach of BHConnect then helped to keep people in treatment by offering a convenient and relatively barrier-free option to participate in therapy, which other outpatient treatment programs are now generally able to replicate given the proliferation of telehealth services that occurred during the COVID pandemic. While BHConnect is no longer a standalone program, there are aspects of BHConnect that could be incorporated into existing outpatient programs. The following is a list of suggestions focused on minimizing barriers to starting treatment services and expanding opportunities for engaging "unconnected to care" populations who have recently received crisis-oriented behavioral health services:

- Establish referral partnerships/relationships with crisis/acute care behavioral health service providers and/or BHS-funded outreach and linkage organizations.
- Enhance pathways to initiating treatment services without needing any in-clinic, in-person visits to remove that as a potential barrier to engaging in care.
- Utilize peers, health navigators, community health workers/promotoras, and/or other trained professionals at the outpatient clinics to engage in virtual and/or in-person outreach with persons identified as having barriers to connecting to traditional outpatient treatment services. Examples include utilizing a "warm-handoff" process while client is still located at a crisis/acute care provider and/or meet with the person at home/another convenient location to establish telehealth service delivery capabilities).
- Ensure that all persons interested in receiving telehealth services have the technological capability and knowledge to do so successfully. For example, provide phones (or tablets for those who would benefit from a larger visual format) along with training/practice, if needed, for how to successfully access and engage in telehealth sessions.
- Encourage development of outpatient clinician expertise and utilization of online resources and tools to incorporate into telehealth treatment sessions.
- Future standalone programs like BHConnect should emphasize younger adults and/or specifically TAY.
- Incorporate psychiatric care directly into the program or develop a specific partnership to provide needed medication management services.

BHConnect Enrollment and Referrals

As shown in Table 1, a total of 391 unique persons were enrolled into the BHConnect program throughout the MHSA INN-funded phase of the program that ended on 10/31/2023. Of the enrollees, 58.1% (n=227) were enrolled as CYF clients and 41.9% (n=164) were enrolled as AOA clients. Enrollment was not uniform across the years, particularly among AOA clients. More AOA clients enrolled during the final two years of BHConnect operations (78.6%; n=129) than the first two years (21.4%; n=35).

Table 1. BHConnect Enrollment and Total Served by Year

	Youth (N=227)			Adult (N=164)			Combined Total Served[3]
	First Enrollment	Total Enrolled[1]	Total Served[2]	First Enrollment	Total Enrolled[1]	Total Served[2]	
FY 2019-20	37	37	37	17	17	17	**54**
FY 2020-21	69	71	98	18	18	31	**129**
FY 2021-22	51	54	81	59	60	67	**148**
FY 2022-23	70	73	105	70	73	101	**206**
Total	227	235	321	164	168	216	**537**

[1]*Includes persons re-enrolled from a prior year.*

[2]*Include persons receiving services during the year who enrolled in the previous year.*

[3]*Includes all CYF and AOA persons served in the respective FY.*

Total enrollment into BHConnect did not meet original expectations, particularly among AOA clients. It was estimated that 250 persons (75 youth and 175 adults) would be served annually. While this goal was consistently met or exceeded for CYF clients in all but the first year, for AOA clients this threshold was not achieved. As discussed in more detail below, additional outreach efforts focused on AOA referral sources during recent years produced substantial growth in total AOA clients enrolled and served. Although still not meeting expectations, the increased number of AOA clients served during FY 2022-23 suggests that a sufficient level of systemwide interest in a BHConnect-type program may exist. However, to fully identify and engage this population, extensive referral networks must be established among service providers.

In the last full year of BHConnect operations (FY 2022-23) a total of 13 different organizations referred CYF clients to BHConnect. Consistent with prior years, Rady Children's Hospital was the primary referral source with 77 referrals coming from either the emergency department or behavioral health urgent care. Other prominent CYF referral sources included the SmartCare and Child and Adolescent Psychiatry Services with 27 and 18 referrals, respectively. Similarly, a total of 20 organizations referred AOA clients to BHConnect with over 35% (37.2%; n=74) originating from Sharp Mesa Vista. Additional sources with at least 10 referrals included Adult Protective Services, SmartCare, Paradise Valley Hospital/Bayview, and Strength Based Case Management-Central/North.

Typically, if enrollment was unsuccessful, the primary reason was that BHConnect staff were not able to locate/contact the person based on the referral information. This was true for 25.6% of CYF and 42.7% of AOA referrals. Further, during FY 2022-23, an additional 21.9% of CYF and 11.1% AOA referrals declined

to enroll, indicating that barriers to participating in recommended treatment services remained even if burdens associated with accessing care were minimized by offering telehealth services.

Participant Characteristics

An overview of key BHConnect participant characteristics is presented here with a complete listing in Appendix A. In the descriptions below, comparison data comes from the BHS CYF and AOA Systemwide Annual Reports or the BHS Databook from FY 2021-22, the most recent published versions.

The BHConnect program provided mental health outpatient treatment to clients of all ages. As the focal service population was persons with a recent crisis behavioral health contact, BHConnect clients tended to be "older" youth and "younger" adults than those found in other BHS outpatient treatment programs. For example, 12-15 year old youth comprised 49.3% of BHConnect clients but only 34% of other BHS outpatient programs. Clients aged 16-18 were 33.1% of those served by BHConnect, as compared to 22% of the larger BHS outpatient system. The BHConnect AOA group also differed substantially from the larger BHS outpatient population: in BHConnect, TAY (i.e., aged 18-25) comprised a larger share of the service population (28.7%) than was served in BHS outpatient programs (17%). However, when we focus on emergency behavioral health services (i.e., crisis stabilization), the BHConnect client age distribution was much more similar to the larger BHS outpatient system. A closer examination of the age distribution indicated that the majority (51.1%) of CYF BHConnect clients were age 15-18 and approximately half (48.2%) of AOA BHConnect clients were age 18-30.

Figure 1. Age Distribution of CYF Clients

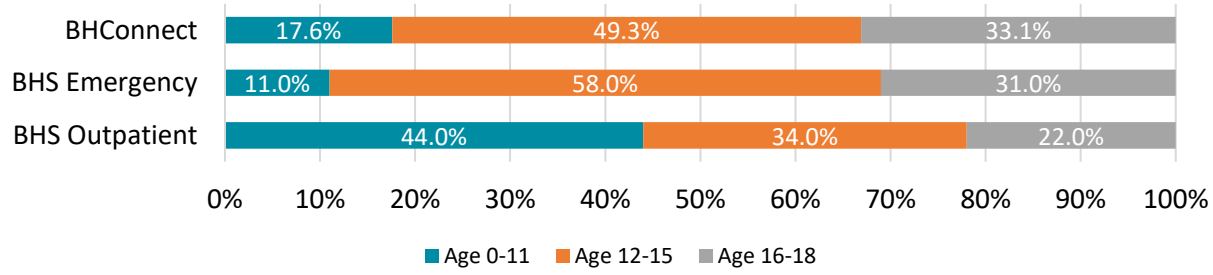
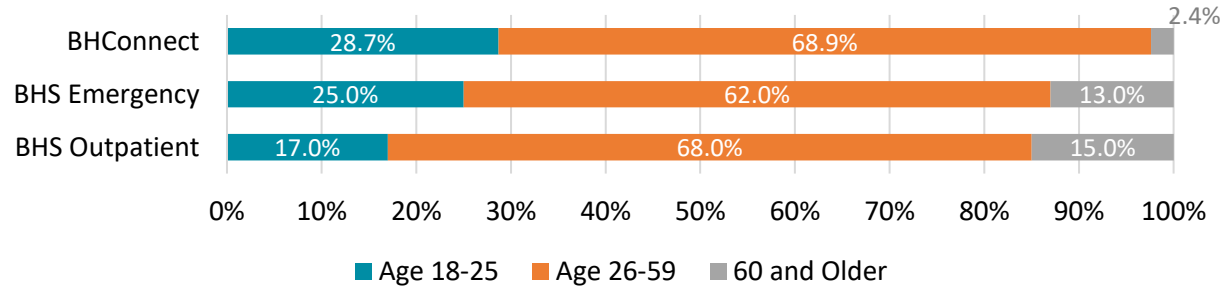


Figure 2. Age Distribution of AOA Clients



As shown in Table 2, for both the BHConnect CYF and AOA service populations, approximately 60% of participants identified as female (59.9% and 60.4%, respectively). For CYF clients, this is slightly more than

in BHS outpatient programs (53%), but slightly less than found in BHS emergency services (66%). Among AOA clients, the proportion of females served exceeded that found in BHS outpatient programs (53%) and even more so than BHS emergency services (43%).

English was the primary language for over 90% of CYF and AOA BHConnect clients, with approximately 5% of CYF and AOA BHConnect clients reporting Spanish as their primary language. While the majority of CYF BHConnect clients identified as Hispanic (51.1%), this was less than found in both BHS outpatient programs (67%) and emergency services (60%). Among AOA BHConnect clients, approximately one-third identified as Hispanic (32.3%), which is similar to that found in BHS outpatient programs (36%) and BHS emergency services (31%).

Table 2. BHConnect Participant Characteristics

Characteristic	Youth (N=227)		Adult (N=164)	
Gender	**n**	**%**	**n**	**%**
Male	72	31.7	61	37.2
Female	136	59.9	99	60.4
Transgender male/Trans man	5	2.2	-	-
Another gender identity/Questioning	10	4.4	4	2.4
Prefer not to answer	4	1.8	-	-
Total	**227**	**100**	**164**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	208	91.6	153	93.3
Spanish	13	5.7	8	4.9
Other	6	2.7	3	1.8
Total	**227**	**100**	**164**	**100**
Race/Ethnicity[1]	**n**	**%**	**n**	**%**
African American	39	17.2	36	22.0
American Indian	5	2.2	5	3.0
Asian	17	7.5	13	7.9
Hispanic/Latino	116	51.1	53	32.3
Pacific Islander	4	1.8	-	-
White	91	40.1	68	41.5
Multiple	46	20.3	18	11.0
Other	3	1.3	1	0.6
Missing/Unknown	5	2.2	8	4.9
Total[1]	**-**	**-**	**-**	**-**

[1]Total may exceed 100% since participants could select more than one response.

As shown in Table 3, for both CYF and AOA BHConnect clients, depressive disorder was the most common mental health diagnosis (47.6% and 39.6%, respectively). The next most common diagnoses for CYF clients

were anxiety (19.4%) and stressor/adjustment disorders (16.3%). For AOA clients, it was bipolar disorder (23.8%) and schizophrenia/other psychotic disorders (20.1%).

Table 3. BHConnect Participant Behavioral Health Diagnostic Characteristics

Characteristic	Youth (N=227)		Adult (N=164)	
Mental Health Diagnosis	**n**	**%**	**n**	**%**
ADHD	7	3.1	<5[1]	<3.0
Oppositional/Conduct Disorders	5	2.2	N/A	N/A
Depressive Disorders	108	47.6	65	39.6
Bipolar Disorders	8	3.5	39	23.8
Anxiety Disorders	44	19.4	11	6.7
Stressor and Adjustment Disorders	37	16.3	9	5.5
Schizophrenia and Other Psychotic Disorders	5	2.2	33	20.1
Other/Missing	13	5.7	<5[1]	<3.0
Total	**227**	**100**	**164**	**100**
Substance Use Disorder (SUD) Diagnosis	**n**	**%**	**n**	**%**
Yes, has SUD Diagnosis	22	9.7	66	40.2
No, does not have SUD Diagnosis	205	90.3	98	59.8
Total	**227**	**100**	**164**	**100**

[1]*Values were suppressed due to small n size.*

For the CYF population, the prevalence of depressive disorders among BHConnect clients (47.6%) was more similar to BHS emergency services (50%) than the BHS outpatient programs (30%). In the AOA population, BHConnect clients reported higher rates of depressive disorders (39.6%) than BHS emergency services (15%) and outpatient programs (22%), but lower rates of schizophrenia/other psychotic disorders (20.1%) than BHS emergency (49%) and outpatient populations (47%).

BHConnect staff indicated that the emphasis on telehealth and remote delivery of services was particularly appealing to persons with mental health challenges such as agoraphobia and some depressions that inhibit in-person participation in treatment.

For CYF populations, the prevalence of substance use diagnoses was similar for BHConnect clients (9.7%), emergency services (11%) and outpatient programs (8%). The prevalence of substance use disorder was higher for BHConnect AOA clients (40.2%) than CYF clients, but less than BHS outpatient programs (50%).

Overall, the characteristics of BHConnect participants exhibited some differences from typical BHS outpatient participants, likely due to the focal population of BHConnect (i.e., those recently receiving behavioral health crisis/emergency services) and the telehealth orientation of their service delivery strategy. As mentioned earlier, BHConnect participants tended to be “older” youth and “younger” adults, with the majority aged between 15 and 30 years old. This trend suggests that the telehealth approach to providing treatment services may be most appealing to persons “old enough” to manage treatment services on their own via a telehealth device, and “young enough” to be familiar with and comfortable with interacting primarily via technology (i.e., video and phone).

Females also appeared to be somewhat more receptive to the BHConnect service delivery approach as they comprised approximately 60% of enrollees. While BHConnect successfully served a racially and ethnically diverse client population, a lower percentage of CYF BHConnect clients identified as Hispanic as compared to other BHS CYF outpatient and emergency services, which suggests that at least some proportion of Hispanic families were hesitant to utilize a technology-based approach for mental health service delivery. Similarly, although BHConnect provided treatment services to persons with a wide range of mental health diagnoses, depression was the most common for both CYF and AOA BHConnect clients. This finding, combined with BHConnect team member feedback, highlights the fact that a technology-based approach to providing treatment services that can be initiated without needing to attend any in-person onsite sessions may be particularly appealing to persons for whom such an interaction may pose a significant barrier to engaging in needed care.

Utilization of Program Services

BHConnect Services – Duration and Discharge Status

Table 4. BHConnect Program Participation Duration

	Youth (N=227)	Adult (N=164)
Mean (days)	177.2	160.9
Median (days)	123.0	109.5
Treatment longer than 1 year	11.5% (n=26)	13.4% (n=22)

Both CYF and AOA clients receiving BHConnect services were typically enrolled for approximately four months (i.e., median duration of 123.0 and 109.5 days, respectively). Approximately 10-15% of CYF and AOA clients were engaged in longer-term therapeutic relationships with BHConnect clinicians and received services for more than a year, influencing the mean duration of BHConnect program to be substantially higher than the median (177.2 for CYF and 160.9 for AOA clients) (see Table 4).

BHConnect Services – Type and Amount

In an average month (defined as 30 days), BHConnect CYF clients received an average of 3.5 services while AOA clients received 4.2 (see Table 5). For both groups, therapeutic sessions were the primary type of service. For CYF clients, psychotherapy represented 60.2% of contacts with an average of 2.1 sessions per month. For AOA clients, psychotherapy was 62.4% of contacts averaging 2.6 sessions per month. Conducting assessments and providing case management services were the other primary forms of interactions.

Table 5. Mean Number of BHConnect Services Provided Per Month during Life of Program

	Youth (N=227)	Adults (N=164)
Type of BHConnect Service	Average Number of Services per 30 Days	
Any BHConnect service	3.5	4.2
Psychosocial assessment	0.5	0.5
Therapy	2.1	2.6
Rehabilitation	<0.1	0.2
Case management	0.4	0.7
Other services (e.g., collateral)	0.5	0.2

An additional examination of service utilization patterns revealed that CYF and AOA clients averaged 9.4 and 12.5 hours, respectively, of therapy during FY 2022-23. For CYF clients, this was nearly identical to the average of 9.5 hours of therapy reported in the BHS CYF Systemwide FY 2021-22 Annual Report. No comparable value has been published for AOA clients. BHConnect services were flexible and customizable to meet the clinical needs of their clients, such as by providing services that would last longer than the typical 45-minute therapy session if needed and/or offering therapy or rehabilitation services multiple times per week.

Behavioral Health Service Utilization Patterns

Utilization of BHS Crisis and Acute Oriented Services

As evidenced by a review of BHS electronic health records, individuals utilized BHS-funded crisis and acute care services less often after enrolling in BHConnect than prior to enrollment. This improvement was particularly evident for AOA clients, as 40.9% had at least one inpatient psychiatric hospitalization in the 90 days prior to enrolling in BHConnect while only 7.3% utilized these services during the 90 days afterward. Reductions in hospitalizations, crisis stabilization visits, and PERT/MCRT contacts were also evident for youth participating in BHConnect.

Table 6. Utilization of BHS Crisis and Acute Oriented Services Before and After Enrolling in BHConnect

	Youth (N=227)				Adult (N=164)			
	90 days before enrolling in BHConnect		90 days after enrolling in BHConnect		90 days before enrolling in BHConnect		90 days after enrolling in BHConnect	
	n	%	n	%	n	%	n	%
Inpatient Psychiatric Hospitalization	39	17.2	9	4.0	67	40.9	12	7.3
Crisis Residential	0	-	0	-	6	3.7	<5[1]	<3.0
Crisis Stabilization	50	22.0	17	7.5	22	13.4	13	7.9
Urgent Outpatient	0	-	<5[1]	<2.2	23	14.0	15	9.1
PERT/MCRT[2]	25	11.0	10	4.4	13	7.9	12	7.3

[1]*Due to the small number of persons experiencing this service the exact number is masked.*
[2]*PERT = Psychiatric Emergency Response Teams; MCRT = Mobile Crisis Response Team*

Of note, a limitation of these analyses is that they only include BHS-funded services, so any crisis services received outside the BHS system are not reflected. As such, the results presented in Table 6 should be interpreted cautiously as they do not reflect all services received, particularly for the youth population given that many received behavioral health-related care at Rady Children's Hospital Urgent Care which would not be reflected in BHS electronic health records.

Additional analyses focused on psychiatric hospitalization readmission rates for the CYF and AOA clients who had an occurrence within 30 days prior to enrolling into BHConnect. These rates (see Table 7), were compared to the 30-day psychiatric hospitalization readmission rates for CYF and AOA populations in the broader BHS system, as reported in the CYF and AOA BHS Systemwide Annual Report FY 2021-22, Appendix A.

Table 7. Comparison of 30-day Psychiatric Hospitalization Readmission Rates

Characteristic	Youth		Adult	
	%	n	%	n
Enrolled in BHConnect within 30 days of discharge	10.7	(3 of 28)	1.9	(1 of 52)
Average BHS systemwide 30-day psychiatric hospital readmission rate FY 2019-20 to FY 2021-22	14.0		22.3	

For the 28 CYF clients who had a hospitalization within 30 days pre-BHConnect, 10.7% (n=3) were readmitted within 30 days post-enrollment. This was lower than the BHS CYF systemwide average of 14.0%. For AOA clients, only 1.9% (1 out of 52) had a psychiatric hospital readmission post-enrollment as compared to the BHS systemwide average of 22.3%. Notably, the total number of BHConnect participants included in these analyses was relatively small and may not be representative of all BHConnect clients served. Further, analyses include BHS services only and may not reflect all crisis services received. However, the results suggest that engagement with outpatient treatment services shortly after a psychiatric hospitalization contributed to lower recurrence of hospitalization, particularly among adults.

Linkages to Other Treatment Programs

While providing direct treatment and support services to clients, the BHConnect team also continually evaluated client needs and preferences to determine if other treatment approaches and/or levels of care may be appropriate. Approximately 20% of both youth and adult BHConnect clients were linked to other treatment programs (see Table 8). Most were connected to programs offering a similar intensity or level of care. Less than 5% needed to be referred to a program that could provide a higher level of care to address more serious concerns.

Table 8. Linkages to Other Treatment Programs

Characteristic	Youth (N=227)		Adult (N=164)	
Type of Treatment Linkage	n	%	n	%
Equivalent Level of Care	44	19.4	29	17.7
Higher Level of Care	9	4.0	4	2.4

BHConnect Treatment Outcomes

Child/Youth Assessments

Child and Adolescent Needs and Strengths (CANS)

The CANS assessment is a structured tool used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In BHConnect, the CANS is completed by providers at initial intake, six-month reassessment, and discharge. A total of 146 clients were enrolled at least six months and had a follow-up or discharge CANS completed to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a “2” or “3” indicating a specific area that could potentially be addressed in the particular service or treatment plan. Table 9 shows the mean number of needs at initial and last available assessments for the following domains: child behavioral and emotional needs, life functioning, and risk behaviors. Overall, the findings indicated statistically significant improvement in all three domains.

Table 9. CANS Average Change from Initial Assessment (N=146)

Key CANS Domain	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	2.2	1.4*
Life Functioning	2.1	1.8*
Risk Behaviors	0.7	0.5*

*^statistical significance at p < 0.1; *statistical significance at p < 0.05*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a "2" or "3" at initial assessment to a "0" or "1" on the same item at the discharge assessment). For each CANS domain, approximately 65% of the children and youth served by BHConnect experienced at least one reduction in a need item identified during the initial assessment (see Table 10).

Table 10. Persons with CANS Improvement at Follow-up (N=50)

Key CANS Domain	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Behavioral/Emotional	134	91	67.9
Life Functioning	100	63	63.0
Risk Behaviors	68	44	64.7

This is slightly lower than the overall County CYF BHS system, where it is reported in the FY 2021-22 CYF BHS Systemwide Annual Report that 75% of discharged clients reported at least one reduction in a need item. This difference is likely due, at least in part, to the nature of the population served by BHConnect: youth who have had difficulty engaging in traditional outpatient treatment programs and have recently experienced a crisis event.

Overall, client improvement on the CANS suggests that the BHConnect team was generally successful at engaging children, youth, and their families and achieving improvements in well-being at rates almost as high as those observed across the broader CYF service system.

Pediatric Symptoms Checklist (PSC)

The PSC is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below in Table 11.

The PSC was administered at initial entry into BHConnect, six-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 89 caregivers and 86 youth completed both a baseline and follow-up assessment.

Table 11. PSC Average Change from Baseline

	Parent/Caregiver Report (N=89)					Youth Report (N=86)				
Subscales	N	% above clinical cutoff[1] at baseline	% above clinical cutoff[1] at follow-up	Mean Score at Baseline	Mean Score at Follow-up	N	% above clinical cutoff[1] at baseline	% above clinical cutoff[1] at follow-up	Mean Score at Baseline	Mean Score at Follow-up
Attention	89	21.3	20.2	4.8	4.4*	86	41.9	23.3	5.8	4.8**
Internalizing	89	70.8	41.6	6.0	4.4**	86	82.6	47.7	6.7	4.3**
Externalizing	89	25.8	25.8	4.4	4.1	86	11.6	4.7	3.0	2.2**
Total Score	**89**	**61.8**	**37.1**	**30.8**	**25.7****	**86**	**70.9**	**34.9**	**31.7**	**22.7****

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

[1]Score above clinical cutoff. Note: PSC clinical cutoff scores by subscale (higher scores indicate worse condition): Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28

To better understand the extent to which PSC scores changed within the BHConnect client population and to facilitate comparisons with the overall CYF BHS system, analyses were also conducted that examined the level of change from initial PSC assessment, which is consistent reporting from the CYF BHS Systemwide Annual Report.

Table 12. Distribution of Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=89)		Youth Report (N=86)	
Amount of Change	n	%	n	%
Increased impairment (i.e., 1+ point increase)	24	27.0	17	19.8
No improvement (i.e., 0-1 point reduction)	7	7.9	9	10.5
Small improvement (i.e., 2-4 point reduction)	18	20.2	5	5.8
Medium improvement (i.e., 5-8 point reduction)	11	12.4	13	15.1
Large improvement (i.e., 9+ point reduction)	29	32.6	42	48.8

There was substantial variability among BHConnect clients and their self-reported experiences of behavioral health changes. As shown in Table 12, while a third of parents/caregivers (32.6%) and half of children/youth (48.8%) in BHConnect reported large improvements from their initial PSC assessment, 27.0% of caregivers and 19.8% of children reported increased impairment. Similar variability and distribution patterns in PSC change score analyses were also evident in the overall CYF BHS system as reported in the FY 2021-22 CYF BHS Systemwide Annual Report where 41% and 45% of caregivers and children/youth, respectively, reported improvements while 23% and 22%, respectively, reported increased impairment from initial PSC assessment.

When comparing BHConnect clients to the overall BHS system, BHConnect caregivers were less likely to report large improvements (i.e., 32.6% compared to 41%); however, BHConnect youth reported large

improvements at approximately the same rate as the overall BHS system of care (i.e., 48.8% compared to 45%). Of note, since approximately only 40% of clients had both a baseline and follow-up PSC completed, the results reported above may not reflect the experiences of the overall population served by BHConnect.

Adult Assessments

Recovery Markers Questionnaire (RMQ)

The RMQ is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The RMQ is administered at initial entry into BHConnect, at six-month reassessment, and at discharge. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks respondents to answer questions as it is "true for you now."

The total mean score for the 65 adult participants who completed the RMQ at intake and at a follow-up assessment during was 3.4 at baseline and 3.7 at follow-up. This change was in the desired direction and was statistically significant. An important individual item from the RMQ was "My symptoms are bothering me less since starting services here," for which mean scores increased from 3.1 (i.e., neutral) to 4.0 (i.e., agree) - also statistically significant and clinically meaningful.

As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, Assertive Community Treatment (ACT), case management, and TAY residential programs) was 3.3 with a follow-up score of 3.7. It appears that BHConnect participants self-report generally similar assessments of their recovery status and outlook on life as do clients in other BHS programs. Of note, since approximately only 40% of clients had both a baseline and follow-up RMQ completed, the results reported above may not reflect the experiences of the overall population served by BHConnect.

Illness Management and Recovery (IMR)

To measure clinician perception of client recovery, the IMR scale was completed by BHConnect staff at initial program entry, at six-month reassessment, and at discharge. The IMR scale has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement. Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery.

Table 13. IMR Assessments for BHConnect Adult Clients (N=82)

		Intake	Follow-Up
Individual Assessment Items	**n**	**Mean[1]** *Scale of 1 to 5 where higher value = better functioning*	**Mean[1]** *Scale of 1 to 5 where higher value = better functioning*
Involvement of family and friends in his/her mental health treatment: How much are family members, friends, boyfriends or girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his or her health treatment?	82	2.9	3.0
Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment?	79	2.5	3.2**
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	82	3.0	3.9***
Using medication effectively: How often does s/he take his/her medication as prescribed?	48	4.1	4.4
IMR Subscales	**n**	**Mean[1]**	**Mean[1]**
Recovery	82	2.8	3.5***
Management	81	2.1	3.0***
Substance Abuse	71	4.2	4.5**
Overall IMR	82	2.9	3.5***

***statistically significant at p < 0.01; ***statistically significant at p < 0.001;*
[1]IMR scores range from 1 to 5, where 5 = highest level of recovery

A total of 82 participants completed an intake and a follow-up assessment (see Table 13). The mean overall IMR score significantly improved from intake (2.9) to last available follow-up (3.5). Improvements were observed in terms of greater recovery (i.e., reduced impairment due to symptoms), better management of their illness, and reduced substance abuse. Clinicians reported a substantial decrease in psychiatric hospitalizations, as the value for this item increased from 3.0 to 3.9 with the average last psychiatric hospitalization occurring more than six months ago (i.e., not while enrolled in BHConnect).

As reported in the mHOMS Annual Outcomes Report for FY 2021-22, the average overall IMR intake score for other outpatient programs was 2.8, which increased to 3.4 at most recent follow-up. This pattern indicates that BHConnect adult clients have similar levels of impairment and recovery/management skills at program intake as other BHS programs and can achieve similar or greater improvements at follow-up.

BHConnect Stakeholder Feedback

BHConnect Participant Feedback

At the end of FY 2020-21, FY 2021-22, and FY 2022-23, BHConnect providers asked participants to engage in a short qualitative interview to elicit feedback on the program. Clients were asked a series of questions, which had been developed by the University of California San Diego (UCSD) evaluation team in collaboration with BHConnect leadership and BHS input. Providers were given a short script explaining the qualitative data collection process, and explained that providing feedback was voluntary and would not impact participation in the program. A total of 61 participants (24 adults, 22 youth, and 15 parents/caregivers) volunteered to complete the brief qualitative interview. From the collected data, the following themes emerged across all years:

BHConnect clients appreciated the emphasis on telehealth to reduce burdens

> "Easier to access, via in person would be more of a challenge to make it to sessions."
>
> "This has been so much better for me because I don't have to figure out how to get there [sessions]. I don't have to figure out who is going to take care of the kids."
>
> "I like that I can go minutes before the session and don't have to ask mom to give me a ride or go on the bus to make it to session."

Respondents in FY 2021-22 and FY 2022-23 noted that youth clients may struggle more than adults with telehealth. The potential for lack of privacy and distractions can pose a barrier to engagement in sessions. Special considerations should be made in the future to accommodate youth clients who may struggle with telehealth services.

The BHConnect program model improved service flexibility

> "It's more flexible for me to be able to connect with my therapist when needed. I had to miss a few appointments with my therapist but luckily they were able to be flexible with my schedule so I could make up the missed sessions."
>
> "We were desperate to enroll him in therapy and it seemed that you guys could get him in quickly."

The BHConnect experience differed, in a positive way, from prior treatment experiences

> "Since starting services, my trust level with mental health workers has improved."
>
> "More experienced people working there."
>
> "It's a more personal connection."
>
> "I like that my privacy is kept private with [BHConnect], I didn't really feel the same way with my previous program."
>
> "I feel like I am getting better care than I have from past providers."

Given that only approximately 12% (n=46) of the 391 unduplicated BHConnect clients participated in a feedback survey, a potential limitation of the findings presented is that they may not reflect the perceptions of the entire BHConnect program participant population. Additionally, it should be noted that the interviews were conducted by BHConnect program staff and therefore could be positively biased. However, the core theme of telehealth improving the ability to engage in treatment is consistent with expectations and the reduced barriers to treatment participation that telehealth services offer.

BHConnect Referral Partner Feedback

At the end of FY 2021-22 and FY 2022-23, BHConnect providers asked referral partners to engage in a short survey to elicit feedback on the program. Referral partners were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with BHConnect leadership and BHS input. Referral partners were given a short script explaining the qualitative data collection process, and explained that providing feedback was voluntary and would be used only to inform recommendations for program improvements. Combining both years, 124 invitations were issued and 54 surveys were completed for a response rate of 43.5%. Given the response rate, a limitation of the findings presented is that they may not fully reflect the perceptions of the BHConnect referral partner population. From the collected data, the following themes emerged from the qualitative data feedback across both years:

BHConnect offered timely services to clients in need

> "I love how responsive the team has been when referrals are submitted. The partnership we have with BHConnect is phenomenal."
>
> "The expediency in getting clients serviced has been of great value."
>
> "… there is minimal waitlist, they are responsive, and they are a good lifeline for patients that are coming out of a crisis."

BHConnect reduced barriers to therapy

> "There are other referral options, but they come with longer waitlists and other barriers (transportation, not set up to treat severe concerns)."
>
> "Clients that are interested in receiving therapy but are impacted by different barriers that make it difficult for them to receive traditional therapy. I often refer clients that self-isolate or are agoraphobic, due to their difficulty in public settings."
>
> "For patients with [serious mental illness], psychotic disorder, it would be extremely difficult to find other referral options."

BHConnect filled a gap in services in the community

> "[BHConnect] fills a gap in services and overcomes barriers that already exist in which services delivery is compromised. For all the reasons listed in previous answers... transportation, waiting lists..."
>
> "We believe that it has improved the quality of care for patients transitioning from the hospital and are hoping that it would prevent patients needing to return to the hospital."

BHConnect Staff Feedback

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) annual BHConnect staff surveys. The stakeholder meetings were held throughout the year with representatives from BHS, BHConnect, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual BHConnect staff survey was conducted at the end of each FY. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. The response rate was 100% for all but one year (i.e., FY 2022-23) when it was 92.3%. Open-ended survey question responses were coded by a member of the UCSD evaluation team and reviewed by at least one other evaluator to identify the following emergent themes.

Staff Experiences with Using Telehealth Services as Primary Treatment Modality

Over the years, when BHConnect staff were asked about the most common difficulties they encountered when providing telehealth, the primary answers were regarding the technology: internet connectivity issues (in both rural and urban settings), problems with devices, and user error in accessing the telehealth system. BHConnect had success addressing many telehealth access issues by providing clients the choice between setting up telehealth on their own personal device or utilizing a device provided by the program. Additionally, BHConnect provided training on session preparation for clients: practice using their device to access services, identification of a quiet, private location and ensure an alternate contact method (i.e., a telephone) in case of issues.

Notably, by FY 2022-23 the feedback shifted from focus on challenges to the relative ease and convenience of providing telehealth services.

> "Telehealth/Virtual Sessions have been an instrumental opportunity for use in assisting the population we serve, which has various challenges in obtaining services. The populations that we serve include, but are not limited to those with physical health challenges whom are unable to leave the home, those with multiple children whom are unable to attend in person appointments due to lack of childcare resources, and those with agoraphobia, and have extreme fear of leaving the home."

There were some clients for whom a telehealth-based approach was not the most appropriate strategy given ongoing difficulty utilizing the device (e.g., frequently forgetting to charge device or not having regular capability to do so) or challenges maintaining focus and developing rapport via the device. BHConnect worked to innovate and adapt in their effort to meet the needs of as many persons as possible and then facilitate connection to other forms of treatment services if it was determined that telehealth was not the optimal modality for providing care.

Program Strengths

Program Flexibility

Staff emphasized program flexibility in FY 2021-22 and FY 2022-23 in their survey responses. BHConnect staff described their ability to accommodate clients in terms of therapy modality (i.e., offering telehealth when in-person sessions are not possible), scheduling, and location. Staff members captured the lengths to which the BHConnect team went to meet the needs of clients:

> "…the option to receive services remotely anywhere and anytime for the most part and provides the device that they might not otherwise have to participate in other remote services."

> "BHConnect is a program that meets them where they are at, during a time of significant crisis and an option to get the support they might not otherwise receive in traditional programs and traditional settings."

> "Therapists and health navigators are flexible in scheduling and providing clients with session times that work for them. Therapists make several attempts to engage and re-engage clients who have disconnected from therapy."

Engagement and Retention

Program successes were attributed to the capability of BHConnect to reduce treatment burden via easy-to-access telehealth services and 24/7 availability, but still subject to client motivation and interest to participate in services. In this regard, the telehealth approach of BHConnect may represent a necessary, but not entirely sufficient, condition to keep some persons in treatment. Notably, as a program designed to work with clients who have experienced a mental health-related crisis but were otherwise unconnected to outpatient services, ambivalence or resistance to treatment among some clients was anticipated.

Over the years, staff recognized the need for regular contact with clients. However, the frequency of communication and outreach must be client-centered and personalized to individual needs and/or life circumstances.

> "When clients are affected by stressors such as pandemic, inflation, and life stressors we notice the change in their engagement with services."

Health navigator visits, reminder calls and care packages were mentioned as helpful methods to maintain contact between appointments.

Through the years, BHConnect staff also recognized the need to effectively address co-occurring substance abuse issues with BHConnect participants. Efforts to support participants included providing additional trainings, completing the Compass-EZ assessment (i.e., an organizational assessment of capacity to provide integrated recovery oriented co-occurring treatment services), and inviting substance use disorder (SUD) programs and strengths-based case management programs to present to BHConnect staff.

Health Navigator Role

In the early stages of the program, Welcome Home Health (WHH) organization provided health navigation support services to BHConnect clients including device management, crisis intervention/safety planning,

appointment scheduling, and reminders/follow-up. During FY 2021-22, the role of field health navigator (FHN) was added to the BHConnect service provider team. This change allowed for greater coordination and integration of health navigation and service engagement activities with the rest of the BHConnect care team.

Program Challenges

Establishing a Referral Network

Establishing a strong referral network was not without challenges, as noted in the staff surveys. In the first staff survey, respondents mentioned that organizations expressed interest in having BHConnect as a new outpatient resource to offer clients following crisis episodes. However, the number of resulting referrals was substantially less than anticipated. Feedback from program leaders indicated that prior to the onset of the COVID pandemic, there appeared to be some reluctance to send referrals to programs that primarily utilized telehealth to deliver treatment services. Referrals increased over the past two years, which was due to both the ongoing efforts of the BHConnect team as well as the increased interest in telehealth-based mental health services more generally.

Engagement and Retention

Even once referrals are made, establishing services with referred individuals remained a challenge through the life of the BHConnect program.

> "Some are homeless and lose contact due to moving around or they lose or damage their devices. Also, with the high-needs population, many have severe mental health issues or they are addicts and have difficulty with follow through and consistency in meeting with their provider. Some lose track of the day of the week, or the time that their appointment was scheduled for."

Staff Turnover and Role Changes

Particularly in the early years of the BHConnect program, staff identified turnover as one of the biggest challenges to reaching program goals. Clinician burnout was a significant factor in turnover. Staff mentioned various ways in which client disengagement reduces morale and enthusiasm among staff.

> "Morale is always a work in progress at BHConnect because our population is chronically unconnected and difficult to engage. Our clients tend to no-show frequently, and this can contribute to clinician burnout or feeling like they are not doing a good job."

During the FY 2021-22 transition from the WHH platform to health navigators, many respondents noted the "learning curve" and increased need for training with new staff.

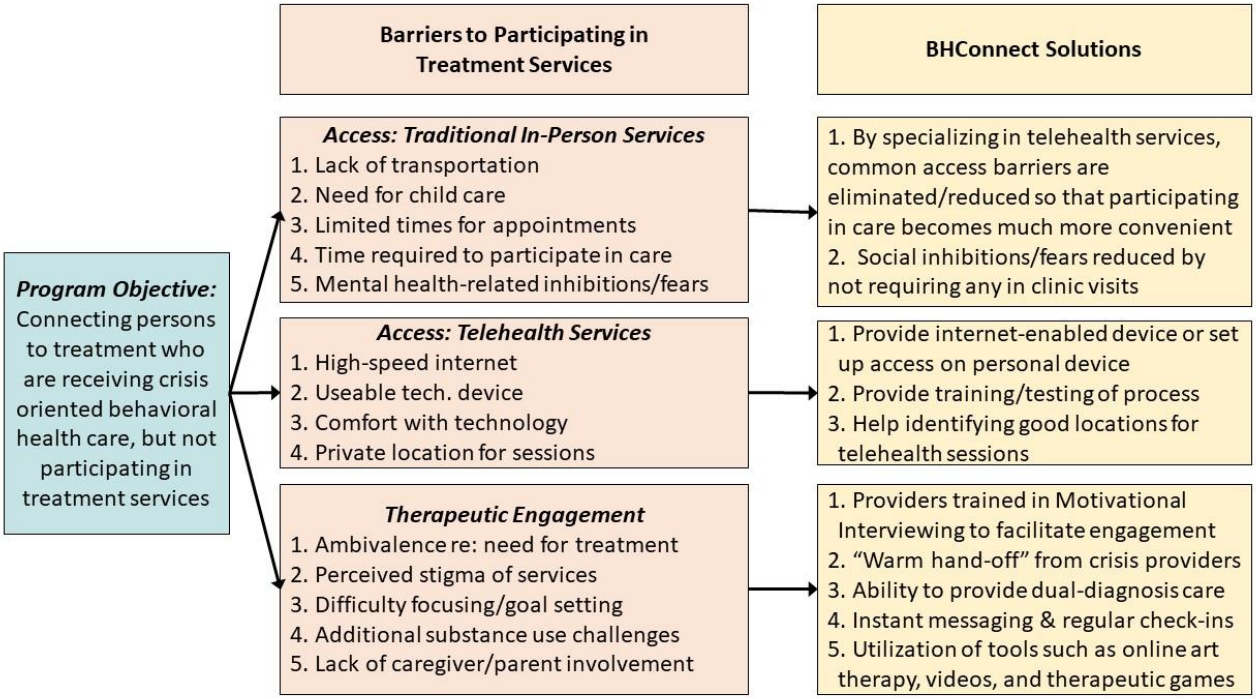
> "The transition from WHH to FHNs providing support to clients has been a difficult transition. The FHNs required a great deal more training than clinicians on service delivery and how to capture, bill and document the services being delivered under their role. In addition, we had to train the clinicians to consider more case management and rehab."

Primary BHConnect Implementation Findings

The BHConnect Approach to Connecting Persons to Telehealth Care

Based on feedback from BHConnect staff, participants and referral partners, the following model was developed to summarize and illustrate both the common barriers experienced when attempting to connect people to needed behavioral health treatment services and the strategies that BHConnect was able to successfully implement to facilitate connection to ongoing care (see Figure 3).

Figure 3. Summary of BHConnect Strategies to Connect Persons to Ongoing Telehealth Care



Barriers to treatment were conceptually split into two domains, as they represent related but distinct aspects of maintaining participation in treatment services: 1) treatment access and 2) treatment engagement.

Treatment access was further separated into in-person services and telehealth services to distinguish the unique challenges relevant to each type of treatment modality. Key barriers included transportation, need for child care, difficulty finding a time to match availability of a service provider, and the overall time commitment needed to attend an in-person treatment session on a regular basis. In addition, for persons with certain mental health disorders (i.e., agoraphobia and some forms of depression) requiring in-person sessions can lead to substantial hesitancy or even refusal on the part of the individual to engage in treatment. The telehealth platform of BHConnect substantially reduced or even eliminated many of these barriers. The flexibility of telehealth allows for sessions to occur at a time and location that is most comfortable and convenient for the individual, removing the need for transportation or child care and the social demands of in-person interactions.

However, participating in telehealth services has its own unique access barriers. Telehealth requires a sufficient quality internet connection, a device that is capable of managing the platform, user comfort and knowledge in utilizing the device, as well as an appropriate space that allows for private and focused conversations. BHConnect had success addressing these barriers by offering clients the option to use their own personal device or providing an internet-enabled device for the client to use while enrolled in BHConnect. Additionally, BHConnect provided training and support to clients so they could practice using their device to access services and prepare for sessions by finding an appropriate location that was quiet and private (e.g., an empty bedroom, their vehicle, or an outside location).

A second barrier faced by BHConnect clients was accessing needed medication management (i.e., psychiatric) services. This barrier became apparent during the pilot study, and to address it BHConnect formed a partnership with another BHS-funded program, the Center for Child and Youth Psychiatry (CCYP; another primarily telehealth program), to ensure that CYF clients had access to needed care. For AOA clients with medication needs that could not be addressed by a primary care doctor, the issue remained. In this case, BHConnect staff worked to connect the client with another behavioral health treatment provider who could also provide psychiatric services.

An additional barrier domain was treatment engagement, which affected ongoing connection to and thereby the potential benefit of participating in services. Common engagement barriers included ambivalence, resistance to services due to perceived stigma of engaging in behavioral health care, and difficulty focusing on treatment objectives, particularly if mental health was substantially impaired or if there were substance use issues present. For youth clients, the extent to which parents/caregivers were invested in supporting the process was critical, as was the ability to coordinate and communicate with other collateral providers (e.g., primary care doctors, social service providers). BHConnect staff attempted to quickly build a positive rapport with clients and were trained in Motivational Interviewing techniques, an evidence-based practice to encourage treatment engagement. The flexibility of the telehealth platform allowed clinicians and team members to engage with clients at convenient times when they were more open to receiving care. The telehealth approach also opened up alternative communication methods such as “messaging” in order to maintain frequent interactions and send reminders for upcoming appointments. To further promote service engagement and retention, the BHConnect team incorporated creative ways to connect with participants such as online art therapy, watching and sharing informational and discussion videos, engaging in therapeutic online games, and mental health apps (e.g., ACT coach, CBT-I Coach, Mindfulness Coach, and PTSD Coach).

Overall, the BHConnect program demonstrated that it was possible to eliminate or greatly reduce barriers for accessing behavioral health treatment by providing services in a convenient, telehealth-based approach, as long as specific attention is devoted to addressing access barriers unique to this form of treatment modality. Additionally, BHConnect developed strategies to promote ongoing engagement in treatment services once the initial access barriers had been addressed. However, a telehealth-based approach is not an appropriate treatment strategy for everyone given ongoing difficulty utilizing the device (e.g., frequently forgetting to charge device or not having regular capability to do so) or challenges maintaining focus and developing a therapeutic relationship via the device. If it was determined that telehealth was not the optimal modality for providing care, BHConnect facilitated connection to other forms of treatment. As reported above, approximately 20% of BHConnect CYF and AOA clients were linked to other treatment services. In this regard, BHConnect was able to act as a “rapid-response” treatment

provider and then facilitate connections for persons who needed alternative treatment options for ongoing care.

Impact of COVID Pandemic on the BHConnect Program

The COVID pandemic affected the San Diego area in a substantial manner from March 2020 through the suspension of the State of California state of Emergency on February 28, 2023. BHS programs, including BHConnect, were impacted by various State and County public health orders as to whether and how organizations were allowed to maintain in-person staffing as well as the extent to which in-person services were feasible. These official guidelines, coupled with overall concerns for the safety of staff and community members, resulted in a substantial reliance upon remote work and interactions with service recipients via telehealth or telephone. Most COVID-related County of San Diego official public health orders were ended as of June 15, 2021, however, some service provider agency protocols continued to promote safety. For many BHS programs, responding to and navigating changes brought about by COVID substantially impacted how services were provided.

The initial design of BHConnect, which already relied exclusively on the provision of mental health treatment services via telehealth, allowed BHConnect to adjust to the new practice realities with essentially no disruption to ongoing treatment services. The main pandemic-related changes for BHConnect were staff and client safety-related practices such as social distancing, use of personal protective equipment, and implementing new cleaning protocols for the initial recruitment interactions and/or when providing the telehealth device to the client (which often occurred at the client's home). Client recruitment and engagement practices were also revised as BHConnect staff were no longer physically co-located at crisis sites and therefore unable to conduct "warm handoffs" where BHConnect staff met with potential clients in person to facilitate transition to BHConnect. In addition, the onset of the pandemic disrupted efforts to engage in outreach with community partners to develop new referral networks during the time that BHConnect was getting started. This created organizational challenges and strain on staff for both the potential referral partners and for BHConnect as everyone adapted to the new service delivery environment.

An unanticipated impact of the pandemic on BHConnect was the transformative change in attitudes regarding the provision of mental health care via telehealth. Prior to the pandemic, BHConnect experienced difficulty convincing potential partners to refer clients to a service provider who exclusively utilized telehealth for treatment delivery. However, the collective learning experience throughout the pandemic created a normative shift resulting in a more favorable perception of using telehealth to provide behavioral health treatment. While the more favorable attitudes toward telehealth contributed to an expansion of the BHConnect referral partner network during the final two years of the program, the expanded availability of telehealth services throughout the entire BHS system eroded some of the perceived uniqueness of the BHConnect program. Initially, BHConnect was perceived as "too novel" by some and struggled to develop referral partners, particularly for adult clients, but by the end of the INN-funded phase of the pilot study, BHConnect was perceived as "not novel enough" to continue as a separate, ongoing outpatient program given that other BHS outpatient programs had also added telehealth services to their treatment options.

Changes from Initial Program Design

A substantial programmatic change that occurred during FY 2021-22 was the transition to phase out the subcontract with WHH. WHH had been providing client scheduling and engagement support, and those outreach, engagement, and scheduling responsibilities were shifted to the FHNs on the BHConnect staff. This decision was made to facilitate communication and coordination between all members of the BHConnect team, and to minimize potential for client confusion with having a separate entity (i.e., WHH) also involved in their care services. To promote engagement and maintain the 24/7 availability previously provided by WHH, the BHConnect program established an Access Line that was pre-programmed into client phones and monitored 24/7. After-hours calls were answered by specially trained medical answering service personnel who could either triage for immediate crisis care or deliver messages to the BHConnect team for less urgent matters. Additionally, the health navigator and therapists offered services on evenings and weekends to better match the availability of clients and reduce overall burdens for engaging in BHConnect services.

During FY 2021-22, BHConnect also expanded the options that clients could utilize to connect with BHConnect services. Originally, all clients were issued an electronic device that they would utilize solely for communicating with BHConnect and/or WHH team members. BHConnect began to allow clients the option to choose whether they would like to utilize their personal smartphone to receive BHConnect services or if they would rather receive a device from BHConnect to use for interacting with the care team. When provided the option, approximately 40% of CYF clients and 50% of AOA clients chose to have an application installed on an existing personal device to participate in BHConnect telehealth services instead of receiving a separate device from BHConnect.

BHConnect was not designed to include psychiatric care needed to provide medication management services. To address this emergent limitation among CYF clients, BHConnect formed a partnership with the Center for Child and Youth Psychiatry (CCYP), which also operates using a primarily telehealth model of service provision. CYF clients were able to stay in BHConnect and receive supplementary medication management from CCYP. Unfortunately, for AOA clients, there is no comparable program to CCYP. For adult clients with complex medication needs that could not be addressed in primary care, BHConnect worked to transition care to another behavioral health treatment provider that also offered psychiatric services.

While the BHConnect program was initially designed to provide treatment services exclusively via telehealth, it was determined that for some clients, strategic use of a limited number of in-person treatment services was useful to support engagement, accomplish goals, and/or promote client safety. Clients needing or preferring ongoing in-person treatment were transitioned to other service providers.

Conclusion

A total of 391 unduplicated persons enrolled in BHConnect (227 CYF and 164 AOA clients) during the life of the program. BHConnect efforts to expand their referral partner network contributed to increased enrollment, particularly among AOA clients, during the past two years. Despite recent increases in enrollment, the number of persons served remained below the initial program goal of 250 persons each year. Given many competing demands for resources, the lower-than-expected enrollment, coupled with increased availability of telehealth services throughout the BHS System of Care, contributed to a

determination by BHS to not continue the BHConnect program after the end of the INN-funded phase of the pilot program, which concluded on 10/31/2023.

For those enrolled in BHConnect, most CYF and AOA clients typically engaged with the program for at least four months, with approximately 10-15% receiving treatment services for more than a year. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. However, the focal population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remained a challenging population to serve with many demonstrating a need for further behavioral health improvements. Common challenges included homelessness, symptom complexity, and co-morbid substance use. An examination of BHS service utilization patterns indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services with both youth and adults experiencing fewer inpatient psychiatric hospitalizations. Youth also exhibited substantially fewer crisis stabilization visits and PERT/MCRT contacts after enrolling in BHConnect.

Overall, the telehealth-based approach to providing behavioral health services was perceived by participants, referral partners and staff to have successfully reduced barriers to engaging in treatment services. While the BHConnect program will not be incorporated into the BHS System of Care as an ongoing service, it is expected that the lessons learned during the INN-funded phase of the pilot project will help inform other BHS efforts to ensure continuity of care and the provision of appropriate and accessible treatment options for persons receiving crisis and acute care services but who are not connected to treatment services. In particular, the experiences from BHConnect highlighted the benefits of including more of an outreach component within outpatient treatment programs to help promote connections to ongoing care after receiving crisis and acute care services. This outreach orientation of BHConnect removed significant barriers to accessing treatment by literally and figuratively “meeting the client where they are at” and initiating treatment services with minimal burden.

The following are potential strategies, where feasible, for how aspects of the BHConnect program could be integrated into existing outpatient programs to minimize barriers to starting treatment services and expand opportunities for engaging persons who have recently received crisis-oriented behavioral health services, but are not connected to treatment:

- Establish referral partnerships/relationships with crisis/acute care behavioral health service providers and/or BHS-funded outreach and linkage organizations.
- Enhance pathways to initiating treatment services without needing any in-clinic, in-person visits to remove that as a potential barrier to engaging in care.
- Utilize peers, health navigators, community health workers/promotoras, and/or other trained professionals at the outpatient clinics to engage in virtual and/or in-person outreach with individuals identified as having barriers to connecting to traditional outpatient treatment services. Examples include utilizing a “warm-handoff” process while client is still located at a crisis/acute care provider, or meeting with them at their home or another convenient to establish telehealth service delivery capabilities.
- Ensure that all persons interested in receiving telehealth services have the technological capability and knowledge to do so successfully. For example, provide phones (or tablets for those who would benefit from a larger visual format) along with training/practice, if needed, for how to successfully access and engage in telehealth sessions.

- Encourage development of outpatient clinician expertise and utilization of online resources and tools to incorporate into telehealth treatment sessions.
- Future standalone programs like BHConnect should emphasize younger adults and/or specifically TAY.
- Future programs should incorporate psychiatric care directly into the program or develop a specific partnership to provide needed medication management services.

Based on the experiences of the BHConnect program, implementing the strategies listed above would address some of the existing "gaps" that occur when persons are exiting crisis and acute care behavioral health services but have difficulty transitioning to additional needed treatment services. Such increased connections to treatment are then expected to contribute to improved personal well-being and reduced need for further crisis and acute care services.

For more information about this Innovations program and/or the report please contact:

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Appendix A

Characteristics of BHConnect Participants

Characteristic	Child/Youth (N=227)		Characteristic	Adult (N=164)	
Age Group	n	%	Age Group	n	%
0 to 11	40	17.6	18 to 25	47	28.7
12 to 15	112	49.3	26 to 64	113	68.9
16 to 18	75	33.1	65+	4	2.4
Total	**227**	**100**	**Total**	**164**	**100**

Characteristic	Child/Youth (N=227)		Adult (N=164)	
Gender	n	%	n	%
Male	72	31.7	61	37.2
Female	136	59.9	99	60.4
Transgender male/Trans man	5	2.2	-	-
Another gender identity/Questioning	10	4.4	4	2.4
Prefer not to answer	4	1.8	-	-
Total	**227**	**100**	**164**	**100**
Primary Language	n	%	n	%
English	208	91.6	153	93.3
Spanish	13	5.7	8	4.9
Other	6	2.7	3	1.8
Total	**227**	**100**	**164**	**100**
Race/Ethnicity[1]	n	%	n	%
African American	39	17.2	36	22.0
American Indian	5	2.2	5	3.0
Asian	17	7.5	13	7.9
Hispanic/Latino	116	51.1	53	32.3
Pacific Islander	4	1.8	-	-
White	91	40.1	68	41.5
Multiple	46	20.3	18	11.0
Other	3	1.3	1	0.6
Missing/Unknown	5	2.2	8	4.9
Total[1]	-	-	-	-

[1]*Total may exceed 100% since participants could select more than one response.*

Appendix A (continued).

Characteristic	Youth (N=227)		Adult (N=164)	
Mental Health Diagnosis	**n**	**%**	**n**	**%**
ADHD	7	3.1	<5[2]	<3.0
Oppositional/Conduct Disorders	5	2.2	N/A	N/A
Depressive Disorders	108	47.6	65	39.6
Bipolar Disorders	8	3.5	39	23.8
Anxiety Disorders	44	19.4	11	6.7
Stressor and Adjustment Disorders	37	16.3	9	5.5
Schizophrenia and Other Psychotic Disorders	5	2.2	33	20.1
Other/Missing	13	5.7	<5[2]	<3.0
Total	**227**	**100**	**164**	**100**
Substance Use Disorder (SUD) Diagnosis	**n**	**%**	**n**	**%**
Yes, has SUD Diagnosis	22	9.7	66	40.2
No, does not have SUD Diagnosis	205	90.3	98	59.8
Total	**227**	**100**	**164**	**100**
Sexual Orientation	**n**	**%**	**n**	**%**
Heterosexual or straight	139	61.2	107	65.2
Gay or Lesbian	5	2.2	6	3.7
Bisexual/Pansexual/Sexually Fluid	19	8.4	18	11.0
Queer/Questioning/Unsure	7	3.1	5	3.0
Missing/Prefer not to answer	57	25.1	28	17.1
Total	**227**	**100**	**164**	**100**
Disability	**n**	**%**	**n**	**%**
Has a disability	50	22.0	58	35.4
Does not have a disability	146	64.3	86	52.4
Declined/Prefer not to answer	31	13.7	20	12.2
Total	**227**	**100**	**164**	**100**
Type of Disability[2]	**n**	**%**	**n**	**%**
Communication (i.e., seeing, hearing)	11	4.8	10	6.1
Learning Disability	18	7.9	18	11.0
Physical Disability/Chronic Health	8	3.5	32	19.5
Other Mental Disability	25	11.0	9	5.5
Other	-	-	-	-

[2]Values were suppressed due to small n size.
[3]Sum of disabilities may exceed the number of persons who indicated having a disability since participants could select more than one response.

APPENDIX Q

GLOSSARY OF ACRONYMS

Glossary of Acronyms

ACEs – Adverse Childhood Experiences
ACL – Access and Crisis Line
ACT – Assertive Community Treatment
ASP – Augmented Services Program
ASO – Administrative Services Organization
API – Asian/Pacific Islander
AOA – Adults and Older Adults
B&C – Board & Care
BHAB – Behavioral Health Advisory Board
BHS – County of San Diego Health and Human Services Agency, Behavioral Health Services
BHBH – Behavioral Health Bridge Housing
BPSR – Bio-psychosocial Rehabilitation
CalMHSA – California Mental Health Services Authority
CalWORKs – California Work Opportunity and Responsibility to Kids
CASRC – Child and Adolescent Research Center
CCRT – Cultural Competency Resource Team
CFTN – Capital Facilities and Technological Needs
CHW – Community Health Workers
CLAS – Culturally and Linguistically Appropriate Services
CSEC - Commercially Sexually Exploited Children
CPP – Community Planning Process
CSU – Crisis Stabilization Unit
CSS – Community Services and Supports
CYF – Children, Youth, and Families
DMC/ODS – Drug Medi-Cal Organized Delivery System
EMASS – Elder Multicultural Access and Support Services
ESU – Emergency Screening Unit
FSP – Full Service Partnership
FY – Fiscal Year
HHSA – Health and Human Services Agency
HCDS – County of San Diego Health and Human Services Agency, Housing and Community Development Services
HOW – Homeless Outreach Workers
HSRC – Health Services Research Center
ICM – Institutional Case Management
IHOT – In-Home Outreach Team
ILA – Independent Living Association
IMAR – Illness Management and Recovery
INN – Innovation
LGBTQ + – Lesbian, Gay, Bisexual, Transsexual, Questioning

MDT – Multidisciplinary Team
MHFA – Mental Health First Aid
MHSA – Mental Health Services Act
MHSOAC – Mental Health Services Oversight and Accountability Commission
MIS – Management Information System
NPLH – No Place Like Home
OE – Outreach and Engagement
PERT – Psychiatric Emergency Response Team
PEI – Prevention and Early Intervention
POFA – Project One for All
QI – Quality Improvement
RER – Revenue and Expenditure Report
ReST – Recuperative Services Treatment
ROAM – Roaming Outpatient Access Mobile Services
RMQ – Recovery Markers Questionnaire
SATS-R – Substance Abuse Treatment Scale, Revised
SBCM – Strengths-Based Case Management
SBIRT – Screening, Brief Intervention and Referral to Treatment
SD – System Development
SDCPH – San Diego County Psychiatric Hospital
SDHC – San Diego Housing Commission
SED – Serious Emotional Disturbance
SMI – Serious Mental Illness
SSI – Supplemental Security Income
SEL – Social and Emotional Learning
START – Short-Term Acute Residential Treatment
SUD – Substance Use Disorder
TAOA – Transition Age Youth, Adults and Older Adults
TAY – Transition Age Youth
TN – Technological Needs
UCSD – University of California, San Diego
WET – Workforce Education and Training
WIC – Welfare and Institutions Code
WRAP – Wellness Recovery Action Plan

APPENDIX R

GLOSSARY OF TERMS

Glossary of Terms

Aftercare: a program of outpatient treatment and support services provided for individuals discharged from an institution, such as a hospital or mental health facility, to help maintain improvement, prevent relapse, and aid adjustment of the individual to the community. Aftercare may also refer to inpatient services provided for convalescent patients, such as those who are recovering from surgery.

Assertive Community Treatment (ACT): a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address every aspect of their life, whether it is medication, therapy, social support, employment, or housing.

California Advancing and Innovating Medi-Cal (CalAIM): a multi-year initiative by the California Department of Health Care Services to improve the quality of life and health outcomes of Medi-Cal members through broad delivery system, program, and payment reform across the Medi-Cal program.

Case Management: a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

Cognitive Training: a term that reflects the theory that cognitive abilities can be maintained or improved by exercising the brain, in an analogy to the way physical fitness is improved by exercising the body.

Complex Behavioral Health Conditions: can include serious mental illness (e.g., schizophrenia, bipolar disorder, or major depressive disorder) or other mental health conditions, with or without co-occurring substance use disorders that, individually or in combination, have an impact on one or more functional abilities. Functional limitations can impede an individual's ability to live independently at home and engage in the community.

Crisis Intervention: is the brief 'first-aid' use of psychotherapy or counseling to persons who have undergone a highly disruptive experience, such as an unexpected bereavement or a disaster. Crisis intervention may prevent more serious consequences of the experience, such as post-traumatic stress disorder. It is also a psychological intervention provided on a short-term, emergency basis for individuals experiencing mental health crises, such as an acute psychotic episode or attempted.

Culturally Appropriate: community interventions that are defined as meeting each of the following characteristics: (a) The intervention is based on the cultural values of the group, (b) the strategies that make up the intervention reflect the subjective culture (attitudes, expectancies, norms) of the group, and (c) the components that make up the strategies reflect the behavioral preferences and expectations of the group's member.

Family Engagement: a family-centered and strengths-based approach to making decisions, setting goals, and achieving desired outcomes for children and families. It encourages and empowers families to be their own champions, working toward goals that they have helped to develop based on their specific family strengths, resources, and need.

Family Groups: a therapeutic method that treats a family as a system rather than concentrating on individual family members. The various approaches may be psychodynamic, behavioral, systemic, or structural, but all regard the interpersonal dynamics within the family as more important than individual intrapsychic factors.

Full Service Partnership (FSP): a collaborative relationship between the County of San Diego and the client, and when appropriate the client's family, through which the client may access a full spectrum of community services to achieve identified goals.

Outreach: an activity of providing services to any populations who might not otherwise have access to those services. In addition to delivering services, outreach has an educational role, raising the awareness of existing services.

Peer Support: counseling or support by an individual who has experience and/or status equal to that of the client.

Personal Health Record (PHR): an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorized, in a private, secure, and confidential environment. A PHR includes health information managed by the individual. The clinician's record of patient encounter, a paper- chart or electronic health record (EHR) is managed by the clinician and/or health care institution.

Primary Care: basic or general health care a patient receives when they first seek assistance from a health care system provided by licensed general practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians.

Psychiatric Assessments: evaluations based on present problems and symptoms, of an individual's biological, mental, and social functioning, which may or may not result in a diagnosis of a mental illness.

Serious Emotional Disturbance (SED): a condition that affects persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental,

behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): a condition that affects persons who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation.

Stigma: includes prejudicial attitudes and discriminating behavior directed towards individuals with mental health problems or the internalizing by the mental health sufferer of their perception of discrimination.

Strengths Based Approach: a specific method of working with and resolving problems experienced by the presenting person. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person’s resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems.

Substance Use Disorder (SUD): recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Suicide Prevention: an umbrella term used for the collective efforts of local community-based organizations, health professionals and related professionals to reduce the incidence of suicide; reduce factors that increase the risk for suicidal thoughts and behaviors; and increase the factors that help strengthen, support, and protect individuals from suicide.

Supplemental Security Income benefits (SSI): pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. SSI is a federal income supplement program funded by general taxes. It is designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

Supportive Housing: an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wraparound supportive services for people experiencing homelessness, as well as other people with disabilities.

Trauma Informed Care: a style of care that accounts for the widespread impact of trauma and the understanding of potential paths for recovery. It includes the recognition of the signs and symptoms of trauma in clients, families, staff, and others. Organizations that are trauma informed fully integrate knowledge about trauma into policies, procedures, and practices and actively avoid re-traumatization.

Warning signs: behaviors that may be signs that someone is thinking about suicide, examples include:

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated, behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

APPENDIX S

STAKEHOLDER COMMENTS

Fiscal Year 2025-26 Mental Health Services Act Annual Update Stakeholder Comment Log

#	DATE	SOURCE	COMMENT	RESPONSE
1	4/15/25	Online Public Comment Feedback Form	"Hello, thank you for allowing comments. I really think SUD programs do not need funding due to Medi-Cal (as long as there are no Medi-Cal cuts) but we do need Recovery Residence funding for SUD Outpatient Treatment. Thank you."	Noted
2	4/16/25	Online Public Comment Feedback Form	"We are facing a serious budget deficit in San Diego that will directly impact the services we are providing for children and their families. At Healthy Development Services, a program funded by First 5 San Diego, we are looking at a 35% overall budget cut which will significantly reduce the behavioral interventions we provide to families. The work we provide for children 0-5 is unparalleled, not just in this community, but in the nation. Specializing in Infant and Early Childhood Mental Health, we not only focus on prevention and psychoeducation, we are one of only a few that provides specific intervention and care for even the youngest of the population undergoing trauma or healing from past trauma. Understanding a whole-child, whole-family approach, we work with the dyadic pair to support attachment, bonding, nurturing, and healing. The Return on Investment is unquestionable. We see the ripple effect not only in the dyad but also the immediate family, extended family, neighbors, schools, etc. Halting or reducing this groundbreaking work will devastate the landscape San Diego has so carefully built. We need more money and support for the 0-5 population and their mental health needs so that we can provide early intervention and triage prior to mental health crises as older children or adults. We also provide one of the fastest and easiest screening opportunities for families to look at potential ASD diagnosis. We support families through navigating the complex system in order to receive long-term support, if needed, or provide treatment and care if a child is having concerns that will not warrant a diagnosis and they are ineligible for care. This can be through a variety of services such as support with Speech, Occupational Therapy, and their global Development. I urge you to consider the landscape of San Diego, the way we have broken ground on the incredible work we have done for our youngest and sustain our funding to continue building a healthy, thriving future with healthy, thriving adults."	Noted
3	4/22/25	Online Public Comment Feedback Form	"Our program Vista Hill Parent Care needs more funding for housing."	Noted

4	**4/22/25**	**Online Public Comment Feedback Form**	"Most San Diego residents and providers are well aware of the lack of safe, affordable and stable housing, yet housing itself is not always the solution to address the complex needs and developmental trauma of those engaged in our System of Care, or is adding more services for individuals and families to try and engage with... For perinatal families, families with SUDs and child welfare involvement, establishing housing that mirrors a therapeutic milieu, where support services can be offered in a home-based setting seems interesting to consider. The current SUD Recovery Residences provide an alternative to remaining unhoused and exposed to the elements, and for a few, this is quite helpful, yet for many, Recovery Residences do not feel safe, and more often continue to perpetuate a highly stressful living environment. Placing individuals with significant trauma (and their children) in shared housing, with no therapeutic oversight, rarely has a healing effect. Individuals with SUDs, and complex co-occurring conditions need housing environments that can better attend to their biopsychosocial functioning. For individuals in SUD treatment, a 90-day paid for stay in Recovery Residence is rarely long enough to prepare for employment and locate other housing, while attempting to engage in early SUD recovery, and perhaps reunify with children. Onsite Clinical Care Managers, Family Partners, etc. who support the individuals and families onsite and coordinate care with external providers seems interesting to imagine. Access to healthy eating, prenatal and parenting groups at the Recovery Residences or other Healing Homes, etc., where wellness, prevention and early intervention is emphasized seems important and an opportunity to pair these services with easily accessible home-based residency activities. What is happening to and with families is enormous and attempting to help or put supports in place that will feel effective and meaningful is quite difficult, yet if we imagine all services and supports to be developmentally-informed and trauma-responsive, collectively we may all begin to speak the same language regardless of professional discipline or community support service. Thank you so much."	**Noted**
5	**5/01/25**	**BHAB Meeting - Speaker 1**	The speaker has been a part of the Behavioral Health Advisory Board (BHAB) for five years prior and stated that the MHSA plan was created for the community but not by the community. The speaker stated that BHAB has not been given the time to review and approve the Community Planning Process (CPP) plan and has not done so in the past 10 years. The speaker indicated that Los Angeles County has held 19 meetings (they meet twice a month) with 100-160 people to create the plan and now they are deploying the plan, showing the complexity of their planning process. The speaker stated that time and resources are needed, separate from BHAB meetings, to ensure the community gets an opportunity to participate in the design of the plan and resources. The speaker also noted that in 2021, the County declared racism as a Public Health Crisis and would like to see a program to address this issue.	**Noted**
6	**5/01/25**	**BHAB Meeting – Speaker 2**	The speaker spoke about the lack of a Countywide approach for people with behavioral health disabilities to have reasonable accommodation requests provided. The speaker stated it is legally required to provide accommodations. The speaker urged the BHAB Board to look into this as a workplan and to ensure there is a process given for reasonable accommodations for those with behavioral health disabilities.	**Noted**