COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Fiscal Year 2022-23 Annual Update



Behavioral Health Services

October 25, 2022

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

LIVEWELLSD.ORG

This report provides an update to the County of San Diego Health and Human Services Agency's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Year (FY) 2020-21 through FY 2022-23 (MHSA Three-Year Plan).

San Diego County Board of Supervisors



Nora Vargas
District One



Joel Anderson
District Two



Terra Lawson-Remer
District Three



Nathan Fletcher
District Four



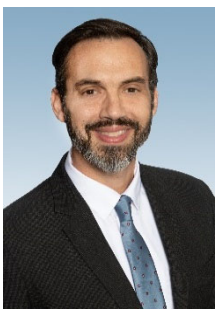
Jim Desmond
District Five



Helen N. Robbins-Meyer
Chief Administrative Officer



Nick Macchione
Agency Director/General Manager
Health and Human Services Agency



Luke Bergmann, Ph.D.
Director, Behavioral Health Services
Health and Human Services Agency

Table of Contents

A LETTER FROM THE BEHAVIORAL HEALTH SERVICES DIRECTOR 6

MHSA OVERVIEW 7

Background 7

Investments 8

Live Well San Diego 8

Advancing Diversity and Health equity 9

Homelessness and Housing 11

Collaboration with Justice, Courts, And Probation 12

The journey Ahead 12

DEMOGRAPHICS 14

COMMUNITY PROGRAM PLANNING PROCESS 15

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD 16

MHSA ACCOMPLISHMENTS AND CHANGES 17

Community Services and Supports (CSS) 17

CSS Programs for Children, Youth, and Families 18

CSS Programs for Transition Age Youth, Adults, and Older Adults 23

CSS Programs for All Ages (ALL) 30

Prevention And Early Intervention (PEI) 33

Innovation (INN) 36

Workforce Education and Training (WET) 38

Capital Facilities and Technological Needs (CFTN) 40

MHSA DATA COLLECTION AND ANALYSIS 41

Optum San Diego 41

Child and Adolescent Services Research Center 41

Health Services Research Center 41

APPENDICES 42

Appendix A: MHSA Expenditure Plan 42

Appendix B: Certifications and Minute Order 51

Appendix C: MHSA Program Summaries 52

Appendix D: MHSA Justice Involved Programs 72

Appendix E: County of San Diego Demographics 74

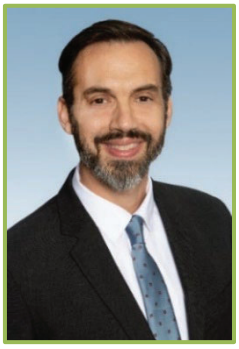
Appendix F: Community Engagement Report 2022 80

Appendix G: MHSA Issue Resolution Process 113

Appendix H: Community Supports and Services (CSS) Annual Report FY 2020-21.....117
Appendix I: Full-Service Partnership (FSP) Outcomes Report FY 2020-21 – children, youth, and families.....120
Appendix J: Annual System-wide Assertive Community Treatment (ACT) Report FY 2020-21.....130
Appendix K: Housing Update Executive Summary 141
Appendix L: Prevention and Early Intervention (PEI) System-wide Summary 144
Appendix M: Prevention and Early Intervention (PEI) Components and Priorities 158
Appendix N: Prevention and Early Intervention (PEI) Three Year Evaluation Report.....160
Appendix O: Innovation Reports 190
Appendix P: Glossary of Acronyms 311
Appendix Q: Glossary of Terms.....312
Appendix R: Stakeholder Comments 317

This page intentionally left blank.

A LETTER FROM THE BEHAVIORAL HEALTH SERVICES DIRECTOR



The Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2022-23 provides an opportunity for the County of San Diego (County) Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) department to inform stakeholders, partners, consumers, and community members of MHSA-funded programs, funding priorities, programmatic changes, and to highlight key accomplishments from FY 2020-21. The County Adopted Operational Plan for BHS for FY 2022-23 is $899.5 million, of which MHSA funding represents $224.3 million or nearly 25% of the total BHS budget.

In FY 2022-23, BHS will continue to focus work across the **behavioral health Continuum of Care** in key areas outlined below by leveraging a variety of funding sources including MHSA.

- To support **behavioral health treatment for adults**, BHS is adding services to ACTION Central and East hybrid mental health and substance use programs, biopsychosocial rehabilitation (BPSR) or outpatient programs, and Strengths Based Case Management with a transitional age youth component.
- To support **children, youth, and families**, investments will fund school-based outpatient treatment services for children, as well increased mental health services for youth with high acuity needs in foster home settings.
- The department is committed to funding enhancements within **Long-Term Care/Acute Care Services** for individuals with serious mental illness (SMI) in licensed residential care facilities to allow clients to be placed in the proper lower levels of care.
- Within **Crisis and Diversionary Services,** BHS will support the expansion of Mobile Crisis Response Teams (MCRTs) based on community need with further investments made in additional phases of the public messaging campaign, along with increased investments to crisis residential services.
- For **unserved and underserved populations**, investments will focus on integrated primary care and behavioral health care in rural communities, services for clients with justice involvement, programs for LGBTQIA+ youth, along with services to children who are victims of commercial sexual exploitation.
- BHS will also invest significantly in **Data and IT Infrastructure** to support the modernization and integration of our systems to adequately and efficiently support a healthcare organization of our size, and will bolster the **behavioral health workforce** to support Institutional Case Management, Strengths Based Case Management, Data Sciences, and Population Health Units and services outlined above.

BHS continues to press forward with our bold, population health approach to shift how residents access care for their behavioral health needs. We are transforming BHS from a system driven by crisis, to one rooted in chronic and continuous care, and prevention through the regional distribution of services, and integration with primary healthcare, to keep people connected, stable, and healthy. We make programmatic investment decisions with the goal of building an integrated, seamless, and outcome-oriented behavioral health system that advances health equity and ensures critical services are available to those in need.

Sincerely,

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

MHSA OVERVIEW

BACKGROUND

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

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

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

As required by the Welfare and Institutions Code, counties must complete a three-year plan and subsequent annual updates for MHSA-funded programs. The most recent MHSA Three-Year Plan for Fiscal Years (FY) 2020-21 through 2022-23 provided program and expenditure information for the five MHSA components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). This Annual Update provides an overview of the recent Community Planning Process (CPP), summarizes outcomes for FY 2020-21, and outlines adjustments to the three-year plan in FYs 2021-22 and 2022-23.

INVESTMENTS

The proposed MHSA spending plan for FY 2022-23 is $230.2 million as outlined in the chart below, reflecting an increase of nearly $36.8 million from the original MHSA Three-Year Plan budget for FY 2022-23. By the end of FY 2022-23, it is estimated that the County will have invested nearly $2 billion in MHSA programs since its inception.

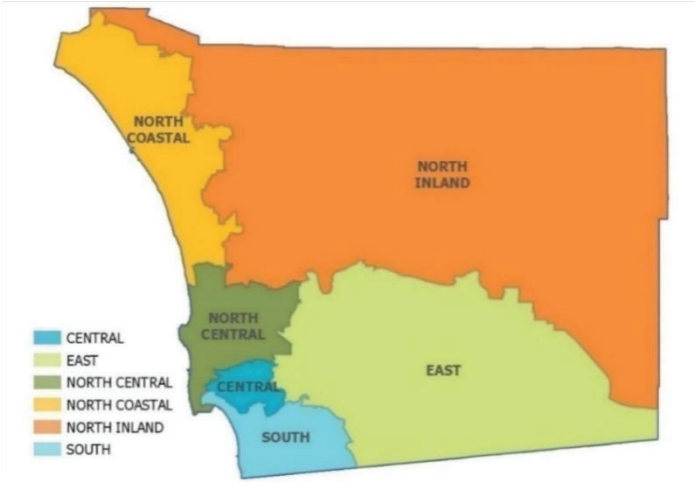
MHSA Component	*Three Year Plan FY 2022-23 Budget*	*Annual Update FY 2022-23 Budget*	*Variance*	*Percent of MHSA Budget*
Community Services and Supports (CSS)	$155,531,356	$190,890,025	$35,358,669	83%
Prevention and Early Intervention (PEI)	$26,323,724	$28,102,325	$1,778,601	12%
Innovation (INN)	$7,931,484	$7,299,401	($632,083)	3%
Workforce Education and Training (WET)	$3,605,648	$3,880,148	$274,500	2%
Capital Facilities and Technological Needs	$0	$0	$0	0%
Total	**$193,392,212**	**$230,171,899**	**$36,779,687**	**100%**

The MHSA budget and program adjustments for FY 2022-23 are based on priorities identified during the CPP in conjunction with staff recommendations.

A summary of programmatic and budgetary changes is available in the MHSA Accomplishment and Changes section of this report. An overview of the proposed expenditures by each MHSA component for FY 2022-23 is available in Appendix A. Summaries of all programs funded with MHSA dollars for FY 2022-23 are available in Appendix C.

LIVE WELL SAN DIEGO

Implementation of the MHSA demonstrates the County's commitment to the *Live Well San Diego* vision of achieving a healthy, safe, and thriving region. BHS is committed to providing accessible, community-based, and client-oriented services to all six Health and Human Services Agency (HHSA) service regions: North Coastal, North Inland, North Central, Central, East, and South. The MHSA enhances access to services, and encourages self-sufficiency, health, and well-being in children, adults, and families, as demonstrated by the personal stories embedded throughout this report. By collaborating with individuals, community partners, local government, schools, and others, the County continues its goal of achieving healthy, safe, and thriving communities through collective impact. In FY 2020-21, MHSA-funded programs provided services to nearly 60,000 clients including children, youth and families, transition-age youth, adults, and older adults in San Diego County, with an emphasis on individuals who were previously unserved or underserved.



ADVANCING DIVERSITY AND HEALTH EQUITY

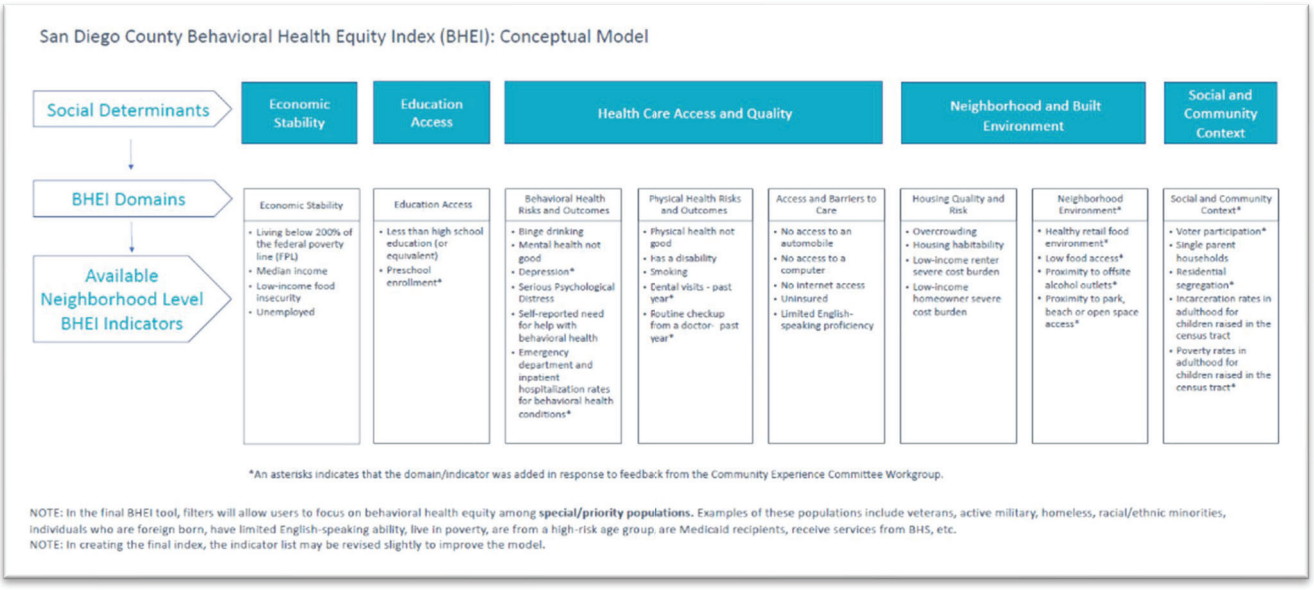
The vision of the MHSA is to build a system in which mental health services are equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals who are experiencing SMI or SED with timely access to quality behavioral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

The community need for behavioral health services continues to increase and has been compounded by the effects of the COVID-19 pandemic. According to the BHS Population Health Unit, the rate of fentanyl overdose deaths in San Diego County increased by 218% during the first year of the pandemic from March 2020 to February 2021 compared to the prior year. In the same time period, the rate of opioid overdose deaths increased by 106% and the rate of drug overdose deaths increased by 65% in San Diego County. Locally, these indicators signal the need for enhanced access to behavioral health services.

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). To advance equity and enhance community engagement, the CEP formed a workgroup consisting of community members that prioritized the domains to be included in the Behavioral Health Equity Index (BHEI). The BHEI is a quantitative measure of behavioral health needs and equity across the County to help determine where investments should be made. It combines census data, care utilization data, and community survey data with data collected in collaboration with communities and community coalitions through a Community Based Participatory Research Model.

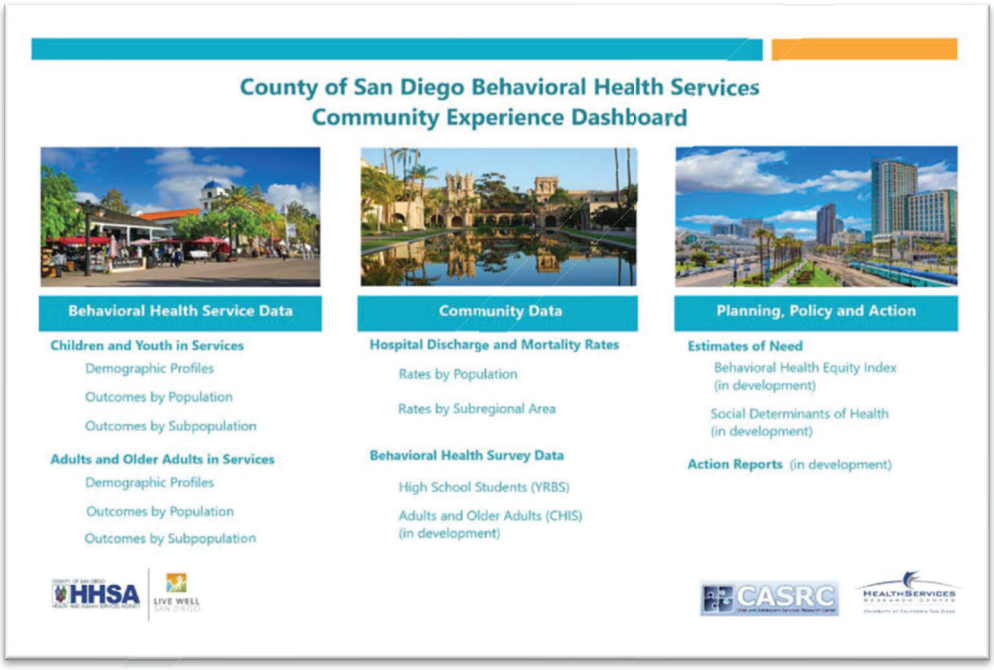
Major CEP accomplishments:

1. Created a **Behavioral Health Equity Index (BHEI)** conceptual model with the participation of community members to prioritize domains.



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

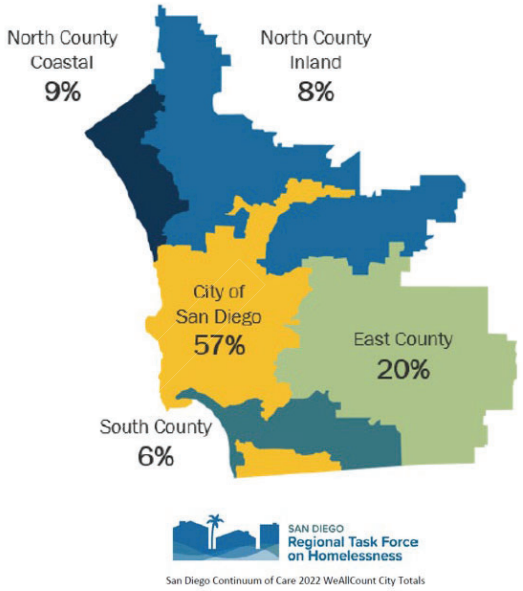
3. Developed an interactive **Community Experience Dashboard** that allows users to investigate behavioral health experiences by subpopulation (e.g., race/ethnicity, sexual orientation, etc.) and subregional area using timely community data sources to drive the decision-making process by BHS. A public version of the



dashboard was released in the Fall of 2022. For additional information, see the following videos: Community Experience Part 1, and Community Experience Part 2.

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

HOMELESSNESS AND HOUSING



Obtaining stable housing is critical in achieving health and wellness for individuals who are experiencing homelessness, or who are at risk of experiencing homelessness, and struggling with serious mental illness (SMI). The Point-in-Time Count is an annual effort to identify the number of persons experiencing homelessness that is conducted by hundreds of volunteers and outreach workers across San Diego County. Due to the pandemic and health and safety concerns, the Regional Taskforce on the Homeless (RTFH) did not conduct its annual Point-in-Time Count of unsheltered persons in 2021 but was resumed in February 2022. Compared to 2020, there was a 10% increase in overall homelessness (sheltered and unsheltered) and a 3% increase in unsheltered homelessness. According to the 2022 WeAllCount Report[1], an estimated 8,427 (4,321 sheltered and 4,106 unsheltered) men, women, and children were experiencing homelessness in San Diego County on the night of the count. For unsheltered persons, approximately 7 percent were veterans, 18 percent were chronically homeless, 8 percent were unsheltered youth, and 2 percent were families. MHSA programs continue to provide extensive outreach, engagement, treatment services, and permanent supportive housing to individuals with SMI who are experiencing homelessness. The map above outlines the homeless population, by region, identified in the 2022 WeAllCount Report. The HHSA has developed a framework to operationalize the County of San Diego Board of Supervisors' guiding principles on homelessness that align the existing work throughout the region to assist people experiencing homelessness or at-risk of experiencing homelessness, with the ultimate goal of ending homelessness. The Framework for Ending Homelessness (Framework) is anchored in five strategic domains: (1) Root Cause and Upstream Prevention, (2) Diversion and Mitigation, Services, (3) Treatment and Outreach, (4) Emergency/Interim Housing and Resources, and (5) Permanent Housing and Support. The Framework encompasses the County's ongoing work and provides a unified strategic approach to support forward, collaborative, and impactful progress. It was adopted by the Board of Supervisors on November 2, 2021.

PROJECT ONE FOR ALL (POFA)

In February 2016, the San Diego County Board of Supervisors implemented Project One for All (POFA) with a goal of connecting 1,250 individuals with SMI who are experiencing homelessness to housing and behavioral health services. POFA provides adults with SMI who are experiencing homelessness with fully integrated services, including outreach, case management, mental health treatment services, substance use disorder (SUD) services, referrals to primary health care, social services, and housing to ensure stability and live their best life. As of May 2021, 1,870 individuals experiencing homelessness were housed and received behavioral health services through POFA.

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM (SNHP)

The County has dedicated more than $53 million of MHSA CSS funds to the California Housing Finance Agency (CalHFA) for the Local Government Special Needs Housing Program (SNHP) and its predecessor, the MHSA Housing

[1] WeAllCount (PIT) 2022 San Diego Region: https://www.rtfhsd.org/reports-data/

Program. Upon completion, these programs will result in approximately 372 permanent supportive housing units. Of the 372 units, 354 units have been operationalized and 18 units are under construction or planned for development.

Status of Housing Units	# of Housing Units
Operationalized	354
Under Construction or Planned for Development	18
Total Housing Units	**372**

NO PLACE LIKE HOME (NPLH)

On July 1, 2016, Governor Jerry Brown signed the NPLH Act (SB 1206) into legislation. This program dedicates $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons with SMI who are experiencing homelessness or are at risk of experiencing homelessness. NPLH funds may be used to finance capital costs of rent-assisted units in rental housing developments, including costs associated with acquisition, design, construction, rehabilitation, or preservation. The bonds will be repaid with funds reallocated from MHSA funds.

On July 17, 2017, the State of California, Department of Housing and Community Development issued the final program guidelines for the NPLH program. According to the guidelines, the County is eligible to receive a total of approximately $125 million, resulting in an annual estimated MHSA revenue reduction of $11 million. Counties eligible to receive NPLH funding must commit to providing mental health services and help coordinate access to other community-based supportive services. In November 2018, Proposition 2, the ballot initiative to implement the NPLH Act of 2018 was approved by voters statewide. In FY 2018-19, MHSA funds were allocated to fund County staff dedicated to support the implementation and administration of the NPLH program. Beginning in FY 2019-20, funding for debt service is excluded from MHSA revenue received by the counties. As of April 2022, there are 11 developments, totaling 291 NPLH units, with conditional NPLH funding and services commitment, and the first two NPLH developments in the county were leasing up.

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION

Many MHSA programs provide access and support for individuals entering or exiting juvenile detention, jails, or courts. Programs collaborate with the courts, the San Diego County Sheriff's Department, the County Probation Department, and other law enforcement agencies to support successful reintegration of clients into the community through prompt and appropriate identification and treatment of behavioral health issues. The goal is to place people into the appropriate level of treatment and reduce recidivism. In FY 2022-23, the total estimated investment in justice-related MHSA programs will be $37.6 million. See Appendix D for a list of MHSA programs that serve justice-involved clients.

THE JOURNEY AHEAD

BHS continues to make forward progression in shifting how residents of San Diego County access care and support for behavioral health needs. We aim to successfully divert individuals from hospitalization through our regionally distributed crisis stabilization units. The County remains committed to making financial, staffing, and other resources available for behavioral health services, to meet the increasing demand due to stressors post-pandemic and economic uncertainty. BHS conducts ongoing and extensive planning to MHSA programming to mitigate large swings in funding projections and align services with MHSA revenues. In looking forward, we resolve to make critical investments in services, capacity, and workforce to:

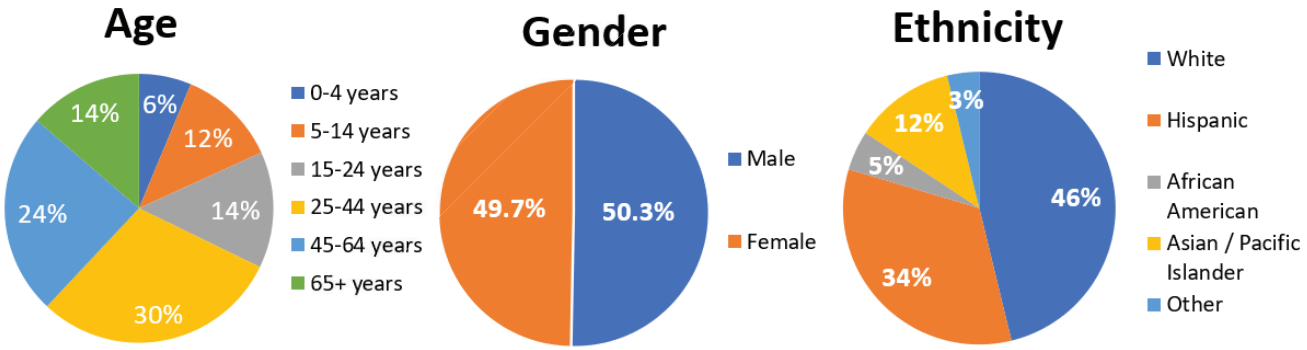
- Build out diversionary services, which includes planning efforts for an East Region Crisis Stabilization Unit, along with further expansion of Mobile Crisis Response Teams, including additional phases of the public messaging campaign.
- Remain focused on increasing long-term care capacity for individuals with serious mental illness (SMI) to allow clients to be placed in the proper lower levels of care.
- Expand services to unserved and underserved populations with behavioral health conditions, enhancements to our LGBTQ+ youth program, Our Safe Place, which offers mental health services and drop-in centers for LGBTQ+ youth up to age 21 and their families, and enhancements to programs that address the Commercial Sexual Exploitation of Children (CSEC).
- Offer a Parolee Assertive Community Treatment program and expand the Behavioral Health Court services program for individuals with justice involvement.
- Develop the new Screening to Care program for school-based screening for middle school youth in partnership with County school districts. With initial funding from the American Rescue Plan, services will use a multi-tiered approach, which includes universal screening of students regardless of the child's insurance status. This will complement the SchooLink program that provides school-based outpatient services across the County.

DEMOGRAPHICS

San Diego County, California is located near the Pacific Ocean in the far southwestern part of the United States, has nearly 70 miles of coastline, and shares an 80-mile international border with Mexico. It is among the nation's most geographically varied regions with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. According to the U.S. Census Bureau, San Diego County has an area of 4,526 square miles, of which 4,207 square miles are land and 319 square miles are water. San Diego County's population for 2020 was 3,298,634[2], making it the second-most populous county in California and the fifth-most populous county in the United States.

The culturally diverse region boasts robust technology and health industries, a business-friendly climate, green practices, and a high quality of life. It is home to world-class educational institutions and a large military presence. Over 217,188[3] veterans are estimated to reside in the region along with additional active military personnel and their families.

The estimated demographics for San Diego County based on 2015-2019 U.S. Census data from the American Community Survey 5-year estimates[4,5]:



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

Additional demographic data for San Diego County is in Appendix E.

[2] Based on U.S. Census Bureau, 2020 Census Redistricting Data (Public Law 94-171) retrieved on 3/3/2022 from https://data.census.gov/cedsci/table?g=0500000US06073&y=2020&tid=DECENNIALPL2020.P1

[3] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table S2101 retrieved on 3/3/2022 from <https://data.census.gov/cedsci/table?q=veterans&g=0500000US06073&tid=ACSST5Y2019.S2101>

[4] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table B01001 retrieved on 3/3/2022 from <https://data.census.gov/cedsci/table?q=b01001&g=0500000US06073&tid=ACSDT5Y2019.B01001>

[5] U.S. Census Bureau, 2015-2019 American Community Survey 5-Year Estimates, Table B03002 retrieved on 3/3/2022 from <https://data.census.gov/cedsci/table?q=b03002&g=0500000US06073&tid=ACSDT5Y2019.B03002&tp=false>

COMMUNITY PROGRAM PLANNING PROCESS

The Community Program Planning (CPP) process provides stakeholders with the opportunity to identify priorities, provide feedback, and make recommendations on how MHSA funds will be invested to best meet the needs of county residents. Throughout the year, BHS engages in open dialogue with the Behavioral Health Advisory Board (BHAB), System of Care (SOC) Councils, various stakeholders and stakeholder-led councils, organizations, and individuals in various settings to determine priorities, solicit feedback, and make recommendations for the utilization of MHSA funds. Additionally, on an annual basis as required by Welfare and Institutions Code, BHS facilitates behavioral health community engagement sessions that are open for the public to inform the MHSA Three Year Plan and subsequent Annual Updates.

Through the CPP, BHS works to ensure the vision of MHSA in which a system for mental health services is equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals experiencing Serious Mental Illness (SMI) or Social-Emotional Disturbance (SED) with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. BHS programs serve individuals of all ages, providing support to the County's most vulnerable, unserved, and underserved populations. To guide clinical service design and placement, and to ensure effective outcomes are achieved, BHS continues to enhance data integration and health equity work through the establishment of the BHS Data Sciences and Population Health units. The collaboration between BHS and UCSD to develop the Community Experience Partnership (CEP) will help identify and address unmet behavioral health needs within the region, and the systemic and regional inequities that lead to them.

BHS has created infrastructure to conduct ongoing community engagement as part of the MHSA Community Planning Process. BHS solicits feedback from the community inclusive of all stakeholders regarding behavioral health needs to gather input on how to better serve San Diego residents and meet the requirements of the MHSA. Community members are asked to discuss pressing behavioral health issues and ways to better engage and serve the community and include brainstorming sessions about new programs and services. Community Stakeholder members are inclusive of all stakeholder groups as identified in the MHSA. Input gathered from all stakeholders through various venues is used to inform the development of new programs and/or the expansion or modification of existing programs. Throughout the year, BHS engages in open dialogue with the BHAB, System of Care Councils, various stakeholders and stakeholder-led councils, organizations, and individuals in various settings to determine priorities, solicit feedback, and make recommendations for the utilization of MHSA funds.

In addition to the year-round BHAB and SOC Council engagement efforts as part of the Community Program Planning process, BHS has conducted engagement and outreach through other mechanisms in FY 21-22. Those efforts included engagement of BHS Program Mangers, teams, and leadership with various partners and stakeholder groups and through contracted providers. Six SOC Councils are explicitly designed to generate feedback from multiple stakeholder groups to inform the delivery of behavioral health services for the specific target populations. The Councils have cross-disciplinary membership and work with system partners to respond to gaps in access to care, to explore new opportunities for collaboration, and provide system and level of care recommendations to the BHS Director.

For the FY 21-22 community engagement process, the UC San Diego Health partnership with BHS began engagement efforts in May 2022, immediately upon commencement of the executed contract with UCSD. Working in collaboration with BHS, the UC San Diego Health partnership scheduled and facilitated two community MHSA training sessions held virtually in June of 2022. The MHSA training sessions were attended by 101 unique

individuals who represented all six HHSA regions. Training participants identified themselves as community members, consumers of behavioral health services, family members of consumers, current and former BHAB members, representatives and staff of community-based organizations and nonprofits, and academic and research organizations. The trainings were conducted in English, and participants had the opportunity to request Spanish translation. These sessions included the history, laws, specific components of the MHSA, and the CPP process. Interactive questions were asked during the training sessions. In the second half of the training, an open-ended question was presented to the audience: "What is the main behavioral health need of your community?" Answers from participants included housing, more support for the workforce, better access to services, and community engagement.

Participants were also asked to complete a training session satisfaction survey at the end of the training. Most respondents (84%) either somewhat or strongly agreed that the training improved their knowledge of California's MHSA, while 86% either somewhat or strongly agreed the training improved their knowledge of how MHSA funding is used in San Diego County. Respondents were also asked to indicate their preferred method of community input in the future. Answers included listening sessions, individual interviews, attending grassroots meetings, working with BHAB, focus groups, and working with stakeholders outside BHS. Finally, respondents were asked to identify the two to three most important issues that must be addressed, from their point of view, to improve the behavioral health of their communities. Overall, 95 unique issues were identified, which were reviewed and analyzed by the UC San Diego Health team. The issues were summarized by the following themes: (1) Strengthen the continuum of care; (2) Support for the workforce; (3) Outreach and community responsiveness; and (4) Housing supports. Overall, 90% of respondents were either somewhat or extremely satisfied with the MHSA trainings. Participants requested a copy of the training materials for their own review, and to share with others. Full details of the CPP can be found in the FY2021-22 Community Engagement Report in Appendix F.

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD

A draft of the FY 2022-23 MHSA Annual Update was posted on the BHS website from September 6 through October 6, 2022 for public review and comments. The 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's Behavioral Health Advisory Board (BHAB) is comprised of consumers, family members, prevention specialists, and professionals from the mental health and substance use disorder fields who represent each of the five County Supervisorial districts. BHAB held a public hearing on October 6, 2022, at the conclusion of the 30-day public review and comment period for the MHSA Annual Update.

Stakeholder comments on the FY 2022-23 MHSA Annual Update are available in Appendix R. The MHSA Issue Resolution Process for filing and resolving stakeholder concerns related to the Community Program Planning and ensuring consistency between program implementation and approved plans, is available in Appendix G.

MHSA ACCOMPLISHMENTS AND CHANGES

The section below summarizes programmatic accomplishments in FY 2020-21, and budgetary changes from the MHSA Three-Year Plan for programs in FYs 2021-22 and 2022-23. 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 2022-23, the estimated total budget for CSS programs is $190.9 million, reflecting a total increase of $35.4 million from the MHSA Three-Year Plan funding priorities for FY 2022-23.

Up to $3.9 million of CSS funds annually will be transferred to the Workforce Education and Training (WET) component to continue funding programs identified in the WET section of this report.

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

As required by the California Code of Regulations (CCR), Title 9, Division 1, Chapter 14, Article 6, Section 3620 (c), each county "*shall direct the majority of its Community Services and Supports funds to the Full-Service Partnership Service Category.*" FSP programs account for a majority of the MHSA CSS budget in FY 2022-23.

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

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

CSS Programs for Children, Youth, and Families



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

Children's FSP programs include school-based outpatient services, walk-in assessments, mobile assessment teams, medication support, intensive mental health services, case management, referrals and linkages, and assessments and interventions for people with co-occurring disorders. The FSP FY 2020-21 outcome report for children and adolescents is available in Appendix I.

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

In FY 2022-23, the estimated total MHSA budget for CY-FSP programs is $23,174,846 million. In FY 2022-23, the estimated annual cost per client served in CY-FSP programs is $7,697, inclusive of all funding, and the estimated number of clients to be served is 8,335. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

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. Most students started the 2020-21 school year in a remote learning environment due to the COVID-19 pandemic. Providers adjusted their service models to allow for telehealth as most school campuses were closed or did not allow service providers on campus. In FY 2020-21, 26 school-based FSP programs served 6,907 clients.

Incredible Years (CY-FSP)

Incredible Years provides a full range of family-focused, strength-based, comprehensive, and integrated mental health services to children up to age five and their families, using the Incredible Years evidence-based program. This evidence-based program is designed to teach positive interaction skills, social problem-solving strategies, anger management, and appropriate school behaviors to young children. The programs also strengthen parent-child relationships and help parents develop positive behavior guidance strategies. The program includes parent/teacher training and treatment services for children within a preschool setting. The program also offers a Promotora/Case Manager to provide case management and outreach in a way that reflects the culture, origins, and language of the community to be reached. Children and their families enrolled in the Incredible Years program report an increase in the child's functioning at home, in pre-school and grade school settings. Many in-person settings were closed due to COVID-19 safety precautions and the program

transitioned to telehealth platforms to maintain services through the year. In FY 2020-21, the program provided services to 111 clients.

THERAPEUTIC BEHAVIORAL SERVICES (TBS) (CY-FSP)

The TBS program provides intensive, individualized, one-on-one coaching to children and youth who are experiencing an emotional or behavioral challenge. TBS supports children/youth and families with learning new methods to increase successful behaviors and improve skills to manage challenging behaviors. In addition to the one-to-one coaching, the program provides family education and supports with events that promote family connections and resiliency building. TBS provided telehealth and in-person services due to the COVID-19 pandemic while recognizing that coaching services were more effective in person. In FY 2020-21, TBS served 655 clients.

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

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth involved with the County of San Diego Health and Human Services Agency, Child Welfare Services (CWS) or Probation, and their families. The program provides team-based care planning and coordination of needs and services to facilitate the youth in returning home from a group-care setting or staying in their home. An average of 95% of youth participating in the Wraparound program avoided psychiatric hospitalization or re-hospitalization during treatment, and 95% of youth enrolled in the program avoided placement in a higher level of care. Many Wraparound services were provided via telehealth during the start of COVID-19 pandemic which led to shorter client meetings, less progress in treatment, and "Zoom burnout" for both families and staff. By October 2020, the program focused on returning to in-person services and providing various supplies and personal protective equipment to help staff feel comfortable with the transition back into community work. Since June 2021, services were primarily provided in the field/in-person. During FY 2020-21, the program served 322 clients.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

CHILDREN'S FULL-SERVICE PARTNERSHIPS (FSP) (CY-FSP)

A countywide, community-based children's outpatient FSP mental health program is designed to serve youth and TAY who are experiencing homelessness. These comprehensive services are trauma-informed, data driven, integrated, and aimed to support the mental health needs of the youth while attending to their safety and housing needs. The program provides outreach services to locate and engage homeless and runaway youth within San Diego County. This program for FY 2022-23 has been recategorized from Children's School Based FSP to Children's FSP and the budget increased by $2,121,581 primarily due to restructuring within programs and services.

INCREDIBLE YEARS (CY-FSP)

Incredible Years provides a full range of family-focused, strength-based, comprehensive, and integrated mental health services to children up to age five and their families, using the Incredible Years evidence-based program. This evidence-based program is designed to teach positive interaction skills, social problem-solving strategies, anger management, and appropriate school behaviors to young children. The programs also strengthen parent-child relationships and help parents develop positive behavior guidance strategies. The program includes parent/teacher training and treatment services for children within a preschool setting. In FY 2022-23, the budget increased by $924,000 primarily due to restructuring the workplan from System Development (CY-SD) to Children's Full Service Partnership funding.

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

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth involved with the County of San Diego Health and Human Services Agency, Child Welfare Services (CWS) or Probation, and their families. The program provides team-based care planning and coordination of needs and services to facilitate the youth in returning home from a group-care setting or staying in their home. In FY 2022-23, the budget increased by $173,000 to provide enhanced after-care services to strengthen adherence to new program design requirements.

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

In FY 2022-23, the estimated total MHSA budget for CY-OE programs is $351,981 and the estimated cost per client is $2,514, inclusive of all funding, and the estimated clients served is 140. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

FAMILY & YOUTH PARTNERSHIP (CY-OE)

Family & Youth Partnership Program (FYPP) provides supportive behavioral health services to residents in the Southeastern region of San Diego County which includes case management, support and education groups, community resource fairs, and focus groups to learn about the community needs. They also provide linkage to behavioral health treatment and education services. By providing linkage to services, the program can prevent clients from entering higher levels of care by engaging youth and their families before mental health issues arise. During the COVID-19 pandemic, services were adjusted to virtual sessions as most school campuses and other community locations were closed. When campuses moved to hybrid models or community locations began to re-open, FYPP emphasized community outreach to promote referrals to care. In FY 2020-21, 140 youth received case management services.

FAMILY & YOUTH PARTNERSHIP
A PERSONAL STORY

A middle schooler and his family self-referred to the Family Youth Partner Program (FYPP) through a friend receiving FYPP services. The youth, being raised by a single mother, had behavioral issues and anger management challenges at school and home. For three months, FYPP worked with him on his self-confidence, feelings surrounding loss of a parent, behavioral management at school, understanding consequences of his behavior, and how it could impact his future. His mother expressed gratitude and highlighted that, "it is hard to find a male role model to trust and connect my son to this person. This program matched my son to a male partner with the same background and ethnicity for weekly sessions. This caused my son to trust and open up to him and change his behavior".

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

NON-RESIDENTIAL SUBSTANCE USE DISORDER (SUD) TREATMENT & RECOVERY SERVICES – WOMEN (CY-OE)

The non-residential SUD treatment and recovery services program for women, also referred to as the perinatal housing program, provides homeless outreach workers (HOWs) who conduct street-outreach to individuals experiencing homelessness. HOWs engage and assist homeless individuals with linkage to services and support. HOWs also coordinate with Homeless Outreach Teams, Regional Task Force on the Homeless (RTFH), Health and Human Services Agency Office of Integrative Services, and regional libraries with the primary goal of reducing homelessness. In FY 2021-22, the budget decreased by $1,235,400 due to the program ending and services are now provided by a new contract.

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

In FY 2022-23, the estimated total MHSA budget for CY-SD programs is $12,409,823; the estimated cost per client served in CY-SD programs is $6,169, inclusive of all funding; and the estimated number of clients to be served is 3,697. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

INCREDIBLE FAMILIES - CHILD WELFARE SERVICES (CWS) (CY-SD)

The Incredible Families program provides parenting support groups and outpatient mental health treatment services for children and families involved with CWS and promotes children to be reunited with their families in the home. The program enhances parenting skills and strengthens the bond between parent and child. During FY 2020-21, the program shifted parenting groups to telehealth resulting in smaller cohorts. Incredible Families receives all referrals from CWS and collaborative efforts include treatment planning and outreach to support the child/youth and family goal of reunification. In FY 2020-21, the program served 102 clients.

PLACEMENT STABILIZATION SERVICES (CY-SD)

Placement Stabilization Services provides case management and rehabilitation services, intensive care coordination, and crisis intervention services to foster youth with the goal of stabilizing their current placement and deterring them from placement in a higher level of care. The program goal is to provide supportive services to stabilize the youth's behavior in their current placement and support the transition back to their families. Within the Placement Stabilization Services program, the Comprehensive Assessment Stabilization Services (CASS) contract provides a full array of specialty mental health services for children/youth placed at County level foster homes, also known as Resource Family Homes. Program services aim to improve the child/caregiver relationship and stabilize the placement to reduce the impact and disruption that a change in placement would have on the child/youth. During FY 2020-21, a majority of services were provided via telehealth due to the COVID-19 pandemic; however, the program prioritized the needs of family and provided in-person services when requested. In FY 2020-21, the program served 166 clients.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

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

Optum San Diego serves as the Administrative Services Organization (ASO) for BHS, facilitating the County of San Diego's role in administering certain inpatient and outpatient Medi-Cal and realignment-funded specialty mental health services. Optum conducts ongoing quality review of therapy treatment plans and evaluation reports prepared for Child Welfare Services (CWS) cases and evaluation reports prepared for Juvenile Probation cases. It also operates a 24-hour Access and Crisis Line (ACL) for callers to access and navigate the behavioral health system of care. The ACL provides referrals and information for mental health and substance use disorders (SUD), access to emergency mental health services, and other services. In FY 2021-22, the budget increased by $1,855,986 for increasing provider rates needed for recruitment and retention efforts.

BHS CHILDREN, YOUTH AND FAMILIES (CYF) LIAISON (CY-SD)

The CYF Liaison collaborates with BHS administrative staff to ensure the needs of its children, youth, and their families are incorporated into service development, implementation plans, and service delivery. The liaison interacts with the community via trainings, meetings, and cloud-based applications to provide information on behavioral health services available in San Diego County while also providing collected information to the CYF administration about the communities' behavioral health needs. In FY 2022-23, the budget decreased by $550,000 due to the program ending as a result of consolidation of funding with a redesign of services to align with CalAIM and Peer Support Specialist Certification.

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 and or substance use recovery needs. Individuals have access to individual, group and/or family therapy with psychiatric medication management seven days a week. These drop-in centers offer supportive services such as caregiver support groups, internship programs, and youth peer partners. The program provides a safe place for youth to receive behavioral health and supportive services. In FY 2022-23, the budget increased by $240,000 due to increased service costs.

INCREDIBLE YEARS (CY-SD)

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 2022-23, the CY-SD budget decreased by $468,590 due to the transfer of the program to CY-FSP.

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 2022-23 the program will be transferred from INN funding to CSS (CY-SD) at the end of the INN project term and the transfer will be effective January 2023. The FY 2022-23 budget amount is $769,500 (6 months).

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

Our Safe Place provides individual, group, family therapy and medication management to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, and their families. The program also operates four drop-in centers with supportive services such as youth groups, social activities, and educational trainings in an environment that emphasizes acceptance for LGBTQ youth and their families. The program serves one of San Diego's most vulnerable populations, LGBTQ youth, to appropriately manage and overcome non-supportive environments in their homes, schools, and communities. In FY 2022-23, the budget increased by $440,000 to provide a fifth drop-in center site.

PLACEMENT STABILIZATION SERVICES (CY-SD)

Placement Stabilization Services provides case management and rehabilitation services, intensive care coordination, and crisis intervention services to foster youth with the goal of stabilizing their current placement and deterring them from placement in a higher level of care. The program goal is to provide supportive services to stabilize the youth’s behavior in their current placement and support the transition back to their families. For FY 2022-23 the budget increased by $290,000 primarily due to service enhancements and clinical redesign with additional staff for rehabilitation services and discharge care coordination.

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



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

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

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

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

In FY 2022-23, the estimated total MHSA budget for TAOA-FSP programs is $51,278,106 with estimated cost per client served in TAOA-FSP programs at $10,281, inclusive of all funding and the estimated number of clients to be served is 7,809. Refer to the table on page 32 for calculations on estimated cost per client served.

Highlights from FY 2020-21:

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 homeless or at-risk of homelessness. Programs offer an array of short-term, transitional, and permanent supportive- housing resources, including housing subsidies provided through partnerships with local housing authorities. Homeless-dedicated ACT programs have MHSA housing funds for rental and non-rental housing assistance, as well as dedicated housing coordinators and housing specialists to provide housing navigation and ongoing tenancy support services. In FY 2020-2021, the IMPACT program served 426 clients with 81% of clients showing clinical improvements or stabilizations and 80% of clients having functional improvement or stabilizations over the previous six-month period.

FSP/ ACT - Housing
A Personal Story

A 35-year-old male has been receiving services at IMPACT since 2012. The client has challenges with depression, high anxiety, impulsivity, anhedonia, and hopelessness. He experienced childhood trauma and family history of suicide, resulting in having post-traumatic stress symptoms. While at IMPACT, he has participated in individual therapy, learned skills to clearly convey his thoughts, and gained skills in getting and maintaining competitive employment. He has learned how to navigate public transportation to get to work and scheduled appointments. He has made great progress in treatment and presents with a wonderful sense of humor and kind demeanor, with desires to build interpersonal relationships and friendships.

Strengths Based Case Management (SBCM) (TAOA-FSP)

The SBCM programs provide case management services along with physical health referrals, peer counseling, linkage to services, and access to resources for persons who have SMI or SED. In FY 2022-23, the program served 461 clients representing a 15% increase from prior fiscal year.

Strengths Based Case Management
A Personal Story

A 57-year-old single female was referred by Big Sister's League, who was residing in temporary housing for persons challenged by severe mental illness (SMI), substance use disorder (SUD), and homelessness. The client was diagnosed with anxiety, bipolar disorder, and post-traumatic stress disorder (PTSD). In addition, she was in maintenance in the Stages of Change model with seven years in remission from alcohol dependence. The client's goals were to maintain sobriety, promote recovery from her SMI, and link to housing. The SBCM clinician assisted the client with maintaining her psychiatric care and referred her to a housing program that catered to seniors and/or persons challenged by disabilities. She was taking medications as prescribed, participating in therapy, and attending psychiatric services with Kaiser. She was successful in furnishing her apartment and was looking forward to getting an emotional support animal.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

Behavioral Health Court (TAOA-FSP)

Behavioral Health Court provides FSP/ACT services to adults who have been incarcerated, are misdemeanor or felony offenders, and who have been referred by the Collaborative Behavioral Court of the San Diego County Superior Court. The program provides intensive and community-based treatment for mental health and/or substance-induced psychiatric disorders, clinical case management, and specialized treatment. The program goal is to improve the overall quality of life and prevent recidivism into the criminal justice system. In FY 2022-23, the budget increased by $1,000,000 for additional services for justice-involved clients.

County of San Diego - Institutional Case Management (ICM) (TAOA-FSP)

Institutional Case Management provides funding to support five case management positions to a variety of County of San Diego-operated programs to provide stabilization and linkage to services for individuals with SMI or SED. In FY 2022-23, the budget increased by $196,744 for increases to support case management, stabilization, and/or linkage to services.

County of San Diego - Peer Support Services (PSS) (TAOA-FSP)

County of San Diego - Peer Support Services provides funding for the Medi-Cal Peer Support Specialist Certification Program to ensure that Peers Support Specialists meet state standards, qualifications, and core competencies required for certification. Peers use their lived experience to support engagement, education on recovery, advocacy, and assistance with navigating the service system and accessing needed services, and resources to behavioral health clients. In FY 2022-23, the budget for this new program is $253,283.

County of San Diego - Strengths Based Case Management (SBCM) (TAOA-FSP)

Strength Based Case Management (SBCM) is designed to provide continuity of care within the County-run behavioral health 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. In FY 2022-23, the budget increased by $782,067 for staffing increases to support SBCM.

Full Service Partnership (FSP) / Assertive Community Treatment (ACT) (TAOA-FSP)

FSP/ACT programs provide intensive community-based services for persons who are homeless or at risk of homelessness, have an SMI, and who may have a co-occurring substance use disorder. These programs

employ a "whatever it takes" model to help clients achieve success and independence and avoid the need for emergency services such as crisis stabilization, crisis outpatient, crisis residential, and services provided at the psychiatric hospital. ACT teams provide medication management, mental health services, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community. In FY 2022-23, the budget increased by $4,770,953 to provide for Parolee Assertive Community Treatment and increase staffing to for an additional 55 ACT slots to align with ACT fidelity.

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

The FSP/ACT transitional residential program provides ACT services to adult clients with SMI who are homeless or at risk of homelessness in 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 2022-23, the budget increased by $808,010 due to staffing ratio requirements set forth by Department of Health Care 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 homeless or at-risk of homelessness. Programs offer an array of short-term, transitional, and permanent supportive-housing resources, including housing subsidies provided through partnerships with local housing authorities. Homeless-dedicated ACT programs have MHSA housing funds for rental and non-rental housing assistance, as well as dedicated housing staff such as housing coordinators and housing specialists to provide housing navigation and ongoing tenancy support services. In FY 2022-23, the budget increased by $597,512 to provide 100 additional spaces for ACT services, substance use disorder, withdrawal management and/or Medication Assisted Treatment services.

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

In FY 2022-23, the estimated total MHSA budget for TAOA-OE programs is $1,991,960; the estimated cost per client served in TAOA-OE programs is $520, inclusive of all funding; and the estimated number of clients to be served is 4,782. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

NON-RESIDENTIAL SUBSTANCE USE DISORDER (SUD) TREATMENT & RECOVERY SERVICES – ADULT (TAOA-OE)

Non-residential SUD treatment and recovery centers provide services to adults with co-occurring disorders, to achieve recovery through screenings and linkage to services. These services include treatment groups, care coordination, and crisis counseling, which can reduce justice system involvement and use of emergency medical services. In FY 2020-21 the programs admitted 4,333 clients. Of the clients who completed treatment 99% had no new arrests within 30 days, 80% were housed, 86% were employed, or in a structured employment prep program, in a formal educational setting or enrolled in eligibility and benefits, and 56% were referred to Recovery Services.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

COUNTY HOMELESS OUTREACH (CHO) (TAOA-OE)

The County Homeless Outreach Program conducts outreach and engages persons 18 and older with serious mental illness and/or substance use conditions who are unsheltered to provide a Behavioral Health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources. In FY 2022-23, the budget for this new program is $2,470,801.

NON-RESIDENTIAL SUBSTANCE USE DISORDER (SUD) TREATMENT & RECOVERY SERVICES – ADULT (TAOA-OE)

Non-residential SUD treatment and recovery centers provide services to adults with co-occurring disorders, to achieve recovery through screenings and linkage to services. These services include treatment groups, care coordination, and crisis counseling, which can reduce justice system involvement and use of emergency medical services. These programs assist individuals to become and remain free of SUD problems addressing both disorders for adults experiencing co-occurring SUD and mental health problems. In FY 2022-23, the budget decreased by $1,235,400 due to new contract for County Homeless Outreach.

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

In FY 2022-23, the estimated total MHSA budget for TAOA-SD programs is $64,870,368; the estimated cost per client served in TAOA-SD programs is $3,912, inclusive of all funding; and the estimated number of clients to be served is 33,546. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

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

The South Region CSU provides critical treatment services in a hospital-based setting for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual needs. The CSU provides 24-hour services to vulnerable patients in a safe setting under the direct and constant supervision of behavioral health staff to reduce risk of a psychiatric hospitalization. Patients have access to emergency department services if medical crises arise. In April of 2021, the first and only CSU in the South Region opened. In the first three months, the CSU served 151 clients, with 88% of clients being discharged to the community. Of those discharged to the community, 88% remained stable in the community after 30 days.

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 2020-21 the program assisted over 195 individuals in seeking competitive employment. There were 2,796 supportive services, 2,492 job preparation, and 1,944 job placement activities facilitated. In addition, there were 1,597 post-placement contacts for individuals competitively employed.

Tenant Peer Support Services (TAOA-SD)

The Tenant Peer Support Services program provides housing support for homeless clients by linking them to the appropriate resources and assisting them with the tools to sustain housing. The program is dedicated to serving the homeless population. TPSS was named a 2022 National Association of Counties (NACo) Achievement Award winner, which recognizes programs for innovative approaches to providing new or needed services, improving administration of existing programs, or promoting intergovernmental cooperation and coordination. In FY 20-21, TPSS provided housing navigation and tenancy support services to 412 people and assisted 84 clients with completing and submitting housing applications.

Tenant Peer Support Services
A Personal Story

After experiencing homelessness for over a year, a 48-year-old male client found himself on the streets of Chula Vista, sleeping in front of a mortuary. The client was a criminal defense lawyer in Colorado, when the pressure of running a practice and his mental illness collided. Due to having untreated schizoaffective disorder, the client became street homeless. For a while, the client traveled the United States looking for help, panhandling to survive and take care of basic needs. He eventually ended up in Chula Vista and got connected to South Bay Guidance Center to start his journey to mental health recovery. Through the center, the client was referred to Alpha Project's Tenant Peer Support Services (TPSS) program. Despite the challenges of COVID-19, TPSS worked with the client to obtain a housing voucher which he subsequently received in September 2020. The client remains housed, enjoys cooking for neighbors, going to the beach, and is doing well.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

Augmented Services Program (ASP) (TAOA-SD)

ASPs provide additional services to individuals with SMI in licensed residential care facilities, also referred to as board and care facilities, to help them maintain or improve functioning in the community and to prevent or minimize institutionalization. These services are available at 12 licensed board and care facilities, with the primary goal of stepping down to a lower level of care. In FY 22-23, the budget increased by $4,125,000 for bed rate increases.

Bio-Psychosocial Rehabilitation (BPSR) (TAOA-SD)

BPSR recovery centers provide a wide variety of outpatient mental health services such as rehabilitation, medication management, care coordination, recovery services, and employment support at multiple locations throughout the county. The program offers specific programs dedicated to TAY and older adult geriatric specialists who provide culturally and age-appropriate services. These programs help improve the individual's level of functioning, quality of life, and housing status, as well as linkage to services, obtaining employment, and linkage to primary care services. In FY 2022-23, the budget increased by $7,065,355 to serve an estimated 740 additional clients.

Client Liaison Services (TAOA-SD)

The Client Liaison Services program increases participation and the consumer voice for adults through peer advocacy, participation, and partnership. The program coordinates increased involvement to develop and implement policies, practices, and programs to meet client needs. In FY 2022-23, the budget decreased by $364,268 due to the program ending as a result of consolidation of funding with a redesign of services to align with CalAIM and Peer Support Specialist Certification.

Client Operated Peer Support Services (TAOA-SD)

Client-operated peer support services include peer education, peer advocacy, peer counseling, peer support and referrals to support agencies. The program enables individuals to improve their mental health outcomes by decreasing isolation and increasing self-sufficiency. In FY 2022-23, the budget decreased by $748,400 due to consolidation of funding with a redesign of services to align with CalAIM and Peer Support Specialist Certification.

CONSUMER ADVOCACY (TAOA-SD)

The Consumer Advocacy program is designed to provide Advocacy Training to individuals with lived experience and family members for developing a Consumer Advocacy Council to assess system of care activities and providing recommendations. Program components include Advocacy Training for individuals interested in participating in the Consumer Advocacy Council, participants in the Augmented Services Program (ASP), or interested in increasing their self-advocacy skills. In FY 2022-23, this new program is budgeted for $997,445.

FAMILY EDUCATION (TAOA-SD)

The Family Education program is designed to provide curriculum-based education to family members of consumers who experience mental health and/or substance use conditions. A monthly support group provides additional support system for family members, which does not require participation in the curriculum-based training. In FY 2022-23, this new program is budgeted for $827,486.

FAMILY MENTAL HEALTH EDUCATION AND SUPPORT (TAOA-SD)

The Family Mental Health Education and Support program provides a series of educational classes using an established family education curriculum to provide education and support for persons who have relatives (or close friends) with mental illness. The program promotes increased family involvement, coping skills, and improved supportive relationships. In FY 2022-23, the budget decreased by $96,400 due to the program ending and consolidation of funding with a redesign of services to align with CalAIM and Peer Support Specialist Certification.

HOME FINDER (TAOA-SD)

The Home Finder program provides housing navigation and location, and tenancy-support services to individuals with SMI who are experiencing homelessness to identify and secure safe and affordable housing. Staff provide field-based services to engage clients and help them find housing. In FY 2022-23, the budget decreased by $757,587 due to the program ending and new contracts expanding Tenant Peer Support Services.

PEER WORKFORCE DEVELOPMENT (TAOA-SD)

This program supports Peer Support Specialists (PSS) who have already received certification with coaching and skill training to perform the PSS role in mental health and substance use programs. Program components for Peer Workforce Delivery services include weekly Digital Peer Support, individualized peer coaching, and education to PSS direct supervisors. In FY 2022-23, this program is budgeted for $1,082,424 for new contracts to expand the services and development of skills for PSS.

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

The Short-Term Acute Residential Treatment program provides 24-7 crisis residential services as an alternative to hospitalization or to step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have co-occurring substance use conditions, and are residents of San Diego County. In FY 2021-22, the budget increased by $4,274,502 for increased operating costs related to the execution of new contracts that includes a clinically appropriate redesign from crisis treatment model to continuous care model.

TENANT PEER SUPPORT SERVICES (TAOA-SD)

The Tenant Peer Support Services (TPSS) program provides housing support for persons experiencing homelessness to link them to the appropriate resources and assist them with the tools to sustain housing. In

FY 2022-23, the budget increased by $1,764,542 to expand the program county-wide and would serve approximately 200 or more clients per year.

WALK-IN ASSESSMENT (TAOA-SD)

The Walk-In Assessment Center provides treatment, rehabilitation, and recovery services to adults with SMI or SED. The program increases access to mental health services for its clients and helps them overcome barriers to services such as awareness of available services. In FY 2022-23, the budget decreased by $641,366 due to the program ending as a result of adequate regional capacity with expanded walk-in hours and in close proximity to absorb existing clients.

CSS Programs for All Ages (ALL)

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



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

In FY 2022-23, the estimated total MHSA budget for ALL-OE programs is $3,624,661; the estimated cost per client served in ALL-OE programs is $930, inclusive of all funding; and the estimated number of clients to be served is 3,920. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

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. In FY 2020-21, the program became Medi-Cal Certified and celebrates 25 years of serving the community and has provided services in 47 languages.

Victims of Trauma and Torture
A Personal Story

A rape survivor and refugee from Western Asia, left her home country with her family in 2011. She came to the program with various medical conditions that prevented her from working. She felt very isolated in her home being wheelchair-bound with limited English skills. She reported having disturbing nightmares, poor memory, and irritability. She had been to other clinics, but due to poor behavior and inconsistent participation, she was regularly discharged. Through treatment, the client was able to develop a strong support system to help her overcome her memory barriers. Her adult daughter has developed a highly communicative relationship with the program and helps her mom take her medications and attend appointments. For the first time since she became a client six years ago, she reported "feeling happy every other day" rather than depressed or irritated every day. She was noticeably cheery and patient, and reported her mood was improved. Program staff was intrigued with her improvement since they had not seen progress in over three years which shows that recovery is a process and can span years of a lifetime.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

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

The Behavioral Health Services and Primary Care Integration Services program facilitates the integration of care by providing evidence-based treatment of behavioral health interventions to individuals in primary care settings. A short-term, solution-focused treatment model is used to provide mental health services to primary care clients at multiple Federal Qualified Health Center sites throughout the county. In addition, a peer promotora program provides outreach to adults and older adults by linking them to mental health services at health centers as well as support groups. In FY 22-23, the program budget increased by $532,239 to provide additional services through a collaborative care model,

including Medication Assisted Treatment (MAT) prescriber support, psychiatric and addiction consultation services, and client support services.

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2022-23, the estimated total MHSA budget for ALL-SD programs is $8,289,582; the estimated cost per client served in ALL-SD programs is $1,297, inclusive of all funding; and the estimated number of clients to be served is 9,508. Refer to the table on page 32 for calculations on estimated cost per client served.

HIGHLIGHTS FROM FY 2020-21:

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 2020-21 the program exceeded key outcomes including 94% of clients showed clinical improvement or stabilization and 87% of clients showed functional improvement or stabilization over the previous six-month period.

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

The PERT program partners clinicians with specially trained police officers and deputies to ensure a more effective response to interactions involving law enforcement officers and individuals with mental illness. Teams are on-call and provide countywide services to individuals with a mental health crisis who have encounters with local law enforcement agencies and/or who need immediate mental health crisis intervention. In FY 2020-21, PERT provided a total of 33,723 contacts, including 21,764 community contacts and 11,959 crisis intervention contacts with 46% of the crisis interventions contacts being diverted from hospitalization.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

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 2022-23 the budget increased by $83,880 to provide services to recent immigrants from Afghanistan.

CSS Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2022-23, 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 2022-23 Proposed Budget (All Funding)	FY 2022-23 Estimated Number of Clients Served					FY 2022-23 Estimated Cost Per Client
		Children	TAY	Adult	OA	Total	
CY-FSP	$ 64,156,282	7,022	1,313			8,335	$ 7,697
CY-OE	$ 351,981	140				140	$ 2,514
CY-SD	$ 22,807,261	2,482	1,215			3,697	$ 6,169
TAOA-FSP	$ 80,283,454		937	5,232	1,640	7,809	$ 10,281
TAOA-OE	$ 2,486,120		335	4,304	143	4,782	$ 520
TAOA-SD	$ 131,240,735		5,703	24,153	3,690	33,546	$ 3,912
ALL-OE	$ 3,643,941	157	392	3,214	157	3,920	$ 930
ALL-SD	$ 12,330,475	1,331	1,331	5,229	1,616	9,508	$ 1,297
Total CSS	**$ 317,300,250**	**11,131**	**11,226**	**42,133**	**7,247**	**71,737**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included
- The FY 2022-23 estimated cost per client figures are based on the total proposed FY 2022-23 budget divided by the actual number of clients broken down by population served in FY 2020-21, plus the estimated new clients to be served in FY 2022-23. FY 2020-21 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figure will vary by service and contract based on the contracted rate, level of care, and a number of clients.
- The annual projected unique clients for FY 2022-23 will vary from the number of unique clients served in Appendix H, I, and J because some programs no longer exist, and new programs will be added in FY 2022-23. Additionally, clients may receive one or more different services, so there may be duplication of clients accross work plans
- CSS data collection and reporting may have been impacted starting March 2020 due to COVID-19

Prevention And Early Intervention (PEI)

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



In FY 2022-23, the estimated total budget for PEI programs is $28,102,325. 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 2022-23, this requirement will be met nearly 60 percent of the budget for PEI programs budgeted for programs serving persons less than 25 years of age. A detailed budget for PEI may be found in Appendix A. The FY 2020-21 PEI system-wide summary report can be found in Appendix L. A summary of the estimated cost per client is available at the end of the PEI section.

HIGHLIGHTS FROM FY 2020-21:

Caregiver Support For Alzheimer's & Dementia Patients (OA-06)

The Caregiver Support for Alzheimer's and Dementia Patients program provides education, training, and early intervention to prevent or decrease symptoms of depression and other mental health issues among caregivers of people suffering from Alzheimer's and dementia. The program raises awareness of the mental health needs of caregivers and encourages them to access County of San Diego-funded prevention and early intervention services to improve wellness. In FY 2020-21, the program provided PEI services to over 99,000 caregivers and older adults, highlighting the continued need for caregiver supports as the population of older adults grows.

Elder Multicultural Access & Support Services (EMASS) (OA-01)

EMASS convenes Promotores, members of the community who are leaders in social circles and who are experienced working with people experiencing SMI in underserved communities, including Filipino, Latino, African refugee, African American, and Middle Eastern. The Promotores are trained by professionals to provide outreach and engagement to older adults, and engage them in group and individual activities, including recreation, exercise, mental health education, and counseling to prevent mental illness. EMASS also provides referrals to multilingual mental health providers, transportation services, and translation services during medical and mental health appointments. In FY

Elder Multicultural Access & Support Services A Personal Story

EMASS was chosen in spring 2022 to represent San Diego in the "Ensuring Equity in Aging" webinar series produced by the California Department on Aging. In cooperation with the Office of Refugee Resettlement, EMASS provides services for more than 50 refugees in East San Diego County, using its Community Health Worker model to engage older adults in Farsi speaking communities. The program employs multi-cultural "promotores" in several non-refugee communities that focus on isolation, depression, and access to services. "Ensuring Equity in Aging" focuses on ways to work together to address inequities through culturally responsive policy, program, and service planning and delivery. The series has featured culturally informed policy and programs with and for Native Elders, LGBT Older Adults, People with Disabilities, Black Elders, Asian Pacific Islander Older Adults and Latino Older Adults.

2020-21, the EMASS program served 1,885 older adults and the program was selected as part of the California Master Plan for Aging webinar series.

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

The Positive Parenting Program is a training class which strengthens skills for parents with children in Head Start, Early Head Start and elementary school settings, who are exhibiting behavioral and/or emotional challenges. Families requiring specialty mental health services are linked directly to services and remain connected after completing the program and have the opportunity for individual consultations for up to six months. Through education and training, the program reduces child abuse, mental illness, behavioral and emotional problems, delinquency, and school failure. In FY 2020-21, the Positive Parenting Program provided services for over 1,600 parents and caregivers of over 3,500 children despite continued impacts of the pandemic and public health orders in place.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

COME PLAY OUTSIDE (PS-01)

The Come Play Outside program offers community-based programming inclusive of Parks after Dark curriculum to support the health and wellness of children, youth, and families. The program will aim to connect participants with outdoor activities within their community to increase prosocial interactions, promoting wellness, positive self-image while emphasizing confidence, respect, and a sense of responsibility. In FY 2022-23, the program received $500,000 in MHSA funding to serve 28,800 duplicated participants.

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

The Rural Integrated Behavioral Health and Primary Care Services program provides prevention and early intervention services through mobile outreach. The program increases access to services by providing assessments and education to individuals with SMI or SED living in the rural areas of San Diego County. The ROAM team has continued to provide medical, dental, and behavioral health services to Native Americans residing on reservations in rural San Diego County. In FY 2022-23, the budget increased by $136,565 for increased cost of services.

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

The School-Based PEI program utilizes a family-focused approach and evidenced-based curriculum to provide social-emotional support groups for children in preschool up to third grade who struggle with emotional and behavioral issues, and their parents. The services are provided in classrooms at four elementary schools in Oceanside and two elementary schools in Vista. Services include screening, child skill groups, parent skill groups, classroom skill lessons, community linkage and referrals, and outreach and engagement. The goal is to help each child improve in school, reduce parental stress, and reduce family isolation and stigma associated with seeking behavioral health services. In FY 2022-23, the budget increased by $268,712 due to funding adjustments for various contracts.

SUICIDE PREVENTION ACTION PLAN (PS-01)

The San Diego Suicide Prevention Council establishes the Suicide Prevention Action Plan to increase public awareness, increase understanding of suicide risks and warning signs, and reduce stigma and harmful outcomes. The plan has a special focus to reach some of the most vulnerable communities such as LBGTQ, TAY, veterans, and older adults. The program increases the number of individuals who able to recognize and prevent the immediate risk of suicide. In FY 2021-22, the budget increased by $75,000 to update the San Diego

County Suicide Prevention Action Plan published in October 2018, disseminate the Action Plan to increase understanding and awareness of suicide, and implement strategic initiatives for the prevention of suicide.

PEI Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2022-23, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA PEI Work Plan	Population Served	FY 2022-23 Proposed Budget (All Funding)	FY 2022-23 Estimated Number of Clients Served	FY 2022-23 Estimated Cost Per Client
CO-03 Integrated Peer & Family Engagement	ALL	$ 2,968,401	3,297	$ 900
DV-03 Alliance for Community Empowerment	Children, Youth	$ 402,480	641	$ 628
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$ 503,108	457	$ 1,101
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$ 1,106,820	5,174	$ 214
FB-01 Early Intervention for Prevention of Psychosis (Kick Start)	Children, TAY	$ 1,786,005	265	$ 6,740
NA-01 Native American Prevention and Early Intervention (Dream Weaver)	ALL	$ 1,755,819	4,770	$ 368
OA-01 Elder Multicultural Access & Support Services (EMASS)	OA	$ 572,682	1,885	$ 304
OA-02 Home Based Services - For Older Adults (Positive Solutions)	OA	$ 582,148	2,213	$ 263
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$ 1,087,461	75,000	$ 14
PS-01 Education and Support Lines	ALL	$ 5,349,740	14,016	$ 382
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$ 1,541,061	893	$ 1,726
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$ 301,860	-	$ -
SA-01 School Based Prevention and Early Intervention	Children, Youth	$ 6,609,438	13,498	$ 490
SA-02 School Based Suicide Prevention & Early Intervention (Here Now)	Children, Youth, TAY	$ 1,811,160	11,208	$ 162
VF-01 Veterans & Family Outreach Education (Courage to Call)	ALL	$ 1,287,936	3,210	$ 401
Total PEI		**$ 27,666,117**	**136,527**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs and PEI assigned funds are not included.
- The following program does not have client count data:
  - RE-01: Independent Living Association
- The FY 2022-23 estimated cost per client figures are based on the total proposed FY 2022-23 budget divided by the actual number of clients served in FY 2020-21, plus the estimated new clients to be served in FY 2022-23. FY 2020-21 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 2022-23 will vary from the number of unique clients served in Appendix L.
- PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.

INNOVATION (INN)



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

In FY 2022-23, the estimated INN expenditures will be $7,299,401. A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix N. A summary of the estimated cost per client is available at the end of this INN section.

HIGHLIGHTS FROM FY 2020-21:

PERIPARTUM PROGRAM (INN-18)

The Peripartum Program provides outreach and engagement to new or expecting parents with mood and anxiety disorders to reduce and manage postpartum depression and anxiety. The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) model identifies at-risk peripartum women for engagement and provides services for women and their partner. Referrals to ADAPT from public health nursing programs were substantially reduced as public health resources were largely diverted to address the COVID-19 emergency. ADAPT responded by expanding referral sources to include hospitals and birthing centers and transitioned to telehealth to maintain client access to services. In FY 2020-21, the program achieved positive outcomes that included significant decrease in depressive and anxiety symptoms, improved well-being, and a high level of client satisfaction to 66 unique clients.

PERIPARTUM PROGRAM
A PERSONAL STORY

A client who was actively engaged in ADAPT for 10 months shared significant improvement. She stated that compared to her time at intake, "I feel the difference. If I didn't have the support, COVID would've been a lot worse. I see the difference in my overall mood and attitude." She also had significant reduction in symptoms as evidenced by her score on Edinburgh Postnatal Depression Scale.

RECUPERATIVE SERVICES TREATMENT (REST) - RECUPERATIVE HOUSING (INN-21)

The ReST program engages TAY who are discharged from acute emergency mental health care and are experiencing homelessness or at risk of experiencing homelessness. The goal is to prevent future emergency care by providing short-term (up to 90 days) comprehensive, on-site services to link clients to permanent housing, ongoing mental health services, and other needed resources. In FY2020-21, Just Be You (JBU) continued to demonstrate high levels of success creating linkages to other BHS treatment programs with approximately 70% of youth participating in outpatient care while enrolled in JBU and almost 30% transitioning into ACT programs after completing the residential phase of JBU.

THE ROAM MOBILE SERVICES (INN-20)

Roaming Outpatient Access Mobile Services (ROAM) are mobile clinics that provide culturally appropriate mental health services to individuals living in rural areas. This program increases access to, and usage of, mental health services by providing services via mobile clinics on tribal lands to individuals that may be difficult to engage due to their lack of available services in the area. In FY 2020-21 the ROAM program provided nearly

1,000 behavioral health related services including cognitive behavioral therapy, trauma informed therapy, substance abuse counseling, and medication management to the rural Native American health population residing on reservations in the East Region of San Diego County.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

MEDICATION CLINIC (INN-22)

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 2022-23 the program will be transferred from INN funding to CSS (CY-SD) at the end of the INN project term and the transfer will be effective January 2023. The budget for FY 2022-23 decreased by $937,636 due the transfer to CSS.

The table below represents the estimated cost per client for FY 2022-23, 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 2022-23 Proposed Budget (All Funding)*	*FY 2022-23 Estimated Number of Clients Served*	*FY 2022-23 Estimated Cost Per Client*
INN-18 Peripartum Program	TAY, Adults	$ 1,070,093	300	$ 3,567
INN-19 Telemental Health	ALL	$ 1,130,052	250	$ 4,520
INN-20 ROAM Mobile Services	ALL	$ 1,891,951	200	$ 9,460
INN-21 ReST Recuperative Housing	TAY (ages 18-25)	$ 1,405,046	54	$ 26,019
INN-22 Medication Clinic	Children, Youth	$ 992,845	255	$ 3,894
INN-24 Early Psychosis Evaluation and Learning Health Care Network	Youth, TAY	$ 201,106	245	$ 821
Total INN		**$ 6,691,092**	**1,304**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included
- The FY 2022-23 estimated cost per client figures are based on the total proposed FY 2022-23 budget divided by the estimated proposed number of clients to be served in FY 2022-23, based on estimated from the programs.
- The estimated average cost per client is a summary of the work plan.

WORKFORCE EDUCATION AND TRAINING (WET)



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

In FY 2022-23, the estimated WET expenditures will be $3,880,148.

Annually, up to $3.9 million in CSS funds will be transferred to the WET component to continue funding programs. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually. A detailed budget for WET can be found in Appendix A.

HIGHLIGHTS FROM FY 2020-21:

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 2020-21 academic year, 54 students were enrolled in the Public Mental Health Academy (PMHA)/Mental Health Work Certificate program with 43 students completing their certificate, bringing the total to 355 total graduates since the program's inception. Over 589 academic counseling appointments were held to provide individuals with ongoing support and guidance.

PUBLIC MENTAL HEALTH ACADEMY A PERSONAL STORY

This program was awesome and everything down to the professors was perfect. I felt I had support the whole way through. Overall, I enjoyed my courses for the Mental Health Work Program and really appreciated the updates and announcements from Dawn Taft. Being able to have a direct line to Dawn was reassuring and knowing I had the support from her was very encouraging. The courses in this program were exactly what I thought helping professionals deal with on a daily basis. I would recommend this program to anyone curious in having a career as a helping professional.

ENHANCEMENTS AND CHANGES FOR FYS 2021-22 AND 2022-23:

COMMUNITY PSYCHIATRY FELLOWSHIP (WET-04) The UCSD Community Psychiatry Program places psychiatric mental health nurse practitioner (PMHNP) trainees side-by-side with psychiatry residents throughout the entire program. This program was created to address the shortage of psychiatrists working in public behavioral health. The goal is to engage psychiatry residents to continue their fellowship within public behavioral health. In FY 2022-23, the budget increased by $500,000 for supporting additional faculty and residents to the fellowship program.

CONSUMER & FAMILY ACADEMY (WET-03)

The Consumer & Family Academy provides training support to individuals with lived experience that work in, or plan to work in, the public behavioral health system. The Academy provides standardized training certifications for individuals working in public behavioral health programs. In FY 2022-23, the budget decreased by $245,091 due to the program ending as a result of consolidation of funding with a redesign of services to align with CalAIM and Peer Support Specialist Certification.

CULTURAL COMPETENCY ACADEMY (WET-02)

The Cultural Competency Academy (CCA) provides training to behavioral health and contracted behavioral health staff focused on multicultural populations. The goal of the CCA is to provide awareness, knowledge, and skill-based trainings, while ensuring the information provided is trauma informed. In FY 2022-23, the budget increased by $7,245 for increase in hourly rate for ASL interpreters.

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 and was created to address the shortage and lack of diversity in public mental health services. The program provides a career pathway in public behavioral health by offering coursework leading to a Mental Health Work Certificate of Achievement. In FY 2022-23, the budget increased by $18,750 for increasing access to academic counseling, advising, and trainings to strengthen the workforce pipeline.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)



Capital Facilities and Technological Needs (CFTN) funding is used for capital projects and technological capacity to improve mental illness service delivery to clients and their families. Capital Facilities funds may be used to acquire, develop, or renovate buildings, or to purchase land in anticipation of constructing a building. Expenditures must result in a capital asset, which permanently increases the San Diego County infrastructure. Technological Needs funds may be used to increase client and family engagement by providing the tools for secure client and family access to health information. The programs modernize information systems to ensure quality of care, operational efficiency, and cost effectiveness. CFTN funds were received as a one-time allocation that were fully spent in FY 2019-20.

MHSA DATA COLLECTION AND ANALYSIS

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

OPTUM SAN DIEGO

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

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

HEALTH SERVICES RESEARCH CENTER

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

HSRC works in collaboration with the BHS Quality Improvement team to evaluate and improve behavioral health outcomes for county residents. Aspects of the outcomes and service demographics are referenced throughout this MHSA Annual Update, and full reports are attached in Appendices H, I, J, and L.

APPENDIX A

MHSA EXPENDITURE PLAN

FY 2022-23 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	Comments
A. Estimated FY 2022/23 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	$ 82,515,206	$ 40,871,430	$ 31,453,236	$ 1,544,497	$ -	$ 33,478,186	$ 189,862,555	
2. Estimated New FY2022/23 Funding*	$ 187,991,535	$ 46,997,884	$ 12,367,864	$ -	$ -	$ -	$ 247,357,283	
3. Transfers in FY2022/23a/	$ (3,900,000)	$ -	$ -	$ 3,900,000	$ -	$ -	$ -	
4. Access Local Prudent Reserve in FY2022/23							$ -	
5. Estimated Available Funding for FY2022/23	$ 266,606,741	$ 87,869,314	$ 43,821,100	$ 5,444,497	$ -	$ 33,478,186	$ 437,219,838	
B. Estimated FY2022/23 MHSA Expenditures	**$ 190,890,025**	**$ 28,102,325**	**$ 7,299,401**	**$ 3,880,148**	**$ -**		**$ 230,171,899**	
C. Estimated FY2022/23 Unspent Fund Balance	**$ 75,716,716**	**$ 59,766,989**	**$ 36,521,699**	**$ 1,564,349**	**$ -**	**$ 33,478,186**	**$ 207,047,939**	

* Estimated new funding based on average of FY 2020-21 and FY 2021-22 receipts

		Prudent Reserve Detail	
D. Estimated Local Prudent Reserve Balance	Total	*CSS*	*PEI*
1. Estimated Local Prudent Reserve Balance on June 30, 2022	$ 33,478,186	26,712,351	$ 6,765,835
2. Contributions to the Local Prudent Reserve in FY 2022/23	0	0	0
3. Distributions from the Local Prudent Reserve in FY 2022/23	0	0	0
4. Estimated Local Prudent Reserve Balance on June 30, 2023	$ 33,478,186	26,712,351	$ 6,765,835

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

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2022/23					
	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)	$ 3,140,935	$ 2,507,224	$ 348,991		$ 284,720	
Children's School Based Full Service Partnership (FSP)	$ 47,099,245	$ 13,472,859	$ 29,289,854		$ 4,336,532	
Family Therapy	$ 1,084,094	$ 1,084,094				
Incredible Years	$ 929,729	$ 368,991	$ 560,738			
Therapeutic Behavioral Services (TBS)	$ 4,895,163	$ 2,993,820	$ 1,901,343			
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 7,007,116	$ 2,747,857	$ 2,366,813		$ 1,892,446	
TAOA-FSP Full Service Partnerships for Children & Youth						
Adult Residential Treatment	$ 995,207	$ 995,207				
Assisted Outpatient Treatment (AOT)	$ 1,437,981	$ 978,551	$ 459,430			
Behavioral Health Court	$ 2,893,831	$ 1,923,620	$ 470,211		$ 500,000	
County of San Diego - Institutional Case Management (ICM)	$ 691,002	$ 486,557	$ 8,445		$ 196,000	
County of San Diego - Peer Support Services	$ 254,854	$ 254,854				
County of San Diego - Probation	$ 603,720	$ 243,044			$ 360,676	
County of San Diego - Strengths Based Case Management (SBCM)	$ 786,915	$ 786,915				
Crisis Residential Services - North Inland	$ 1,764,671	$ 1,147,375			$ 617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 47,758,439	$ 24,433,869	$ 19,771,339		$ 3,553,232	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 12,667,114	$ 12,241,480	$ 313,756		$ 111,878	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,025,473	$ 1,526,128	$ 499,345			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,122,139	$ 1,416,018	$ 706,121			
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 3,580,070	$ 3,066,064	$ 404,005		$ 110,000	
North Coastal Mental Health Center and Vista Clinic	$ 337,280	$ 152,519	$ 184,761			
Payee Case Management Services	$ 125,775	$ 125,775				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 749,070	$ 628,350	$ 120,719			
Strengths Based Case Management (SBCM)	$ 1,489,913	$ 871,779	$ 618,135			
Total Full Service Partnership (FSP) Programs	**$ 144,439,737**	**$ 74,452,952**	**$ 58,024,004**		**$ 11,962,780**	
Non-FSP Programs						
All-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 468,237	$ 468,237				
Behavioral Health Services and Primary Care Integration Services	$ 1,558,063	$ 1,558,063				
Behavioral Health Services for Deaf & Hard of Hearing	$ 367,263	$ 347,983	$ 19,280			
Clubhouse - Deaf or Hard of Hearing	$ 290,291	$ 290,291				
Psychiatric and Addiction Consultation and Family Support Services	$ 960,087	$ 960,087				
All-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 623,723	$ 330,565	$ 293,158			
EMT-MH Clinician Team	$ 258,593	$ 258,593				
Mobile Crisis Response Team (MCRT)	$ 2,012,400	$ 2,012,400				
Psychiatric Emergency Response Team (PERT)	$ 9,435,758	$ 5,688,023			$ 3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women						
Parent Partner Services	$ 351,981	$ 351,981				

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2022/23					
	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
CY-SD System Development for Children & Youth						
Administrative Services Organization (ASO) - TERM	$ 2,223,349	$ 1,295,356	$ 927,993			
Adolescent Day Rehabilitation	$ 100,620	$ 60,620	$ 0		$ 40,000	
BHS Children, Youth and Families (CYF) Liaison						
BridgeWays Program	$ 563,472	$ 181,339	$ 158,133		$ 224,000	
Commercially Sexually Exploited Children (CSEC)	$ 1,247,688	$ 241,007	$ 506,681		$ 500,000	
County of San Diego - Juvenile Forensic Services	$ 1,106,820	$ 1,106,820				
Crisis Action and Connection	$ 2,163,744	$ 1,497,309	$ 152,571		$ 513,864	
Emergency Screening Unit (ESU)	$ 5,881,981	$ 3,965,533			$ 1,916,448	
Incredible Families	$ 1,956,274	$ 994,342	$ 170,246		$ 791,686	
Incredible Years						
Med Clinics	$ 774,271	$ 274,096	$ 500,175			
Medication Support for Wards and Dependents	$ 852,251	$ 205,239	$ 308,212		$ 338,800	
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,952,028	$ 1,039,543	$ 312,485		$ 600,000	
Peer Mentoring	$ 80,496	$ 48,496			$ 32,000	
Placement Stabilization Services	$ 2,543,716	$ 671,970	$ 1,871,745			
Rural Integrated Behavioral Health and Primary Care Services	$ 125,775	$ 75,775			$ 50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 301,860	$ 181,860			$ 120,000	
Telemedicine	$ 21,300	$ 21,300				
Walk-In Assessment Clinic and Mobile Assessment Team	$ 911,617	$ 549,217			$ 362,400	
TAOA-OE Outreach & Engagement for Ages 18-60+						
Countywide Homeless Outreach Program	$ 2,486,120	$ 1,991,960			$ 494,160	
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult						
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 11,385,801	$ 7,787,022	$ 2,361,279		$ 1,237,500	
Behavioral Health Assessors	$ 689,247	$ 385,247			$ 304,000	
Bio-Psychosocial Rehabilitation (BPSR)	$ 40,076,283	$ 9,633,468	$ 23,079,548		$ 7,363,267	
Client Liaison Services						
Client Operated Peer Support Services						
Clubhouse	$ 5,010,904	$ 5,010,904				
Consumer Advocacy	$ 1,003,629	$ 604,651			$ 398,977	
Crisis Stabilization - North Coastal Oceanside	$ 7,647,120	$ 2,935,120	$ 4,712,000			
Crisis Stabilization - North Coastal Vista	$ 6,927,507	$ 1,672,157	$ 5,255,350			
Crisis Stabilization - North Inland	$ 10,218,852	$ 3,135,137	$ 5,849,574		$ 1,234,142	
Crisis Stabilization - South	$ 7,608,741	$ 5,140,717	$ 1,030,351		$ 1,437,672	
Faith Based Services	$ 1,483,613	$ 1,483,613				
Family Education	$ 832,616	$ 832,616				
Family Mental Health Education and Support						
Home Finder						
In-Home Outreach Teams (IHOT)	$ 4,277,223	$ 4,277,223				
Inpatient and Residential Advocacy Services	$ 570,746	$ 570,746				
Institutional Case Mgmt (ICM) - Older Adults	$ 506,140	$ 304,931			$ 201,208	
Justice System Discharge Planning	$ 930,735	$ 560,735			$ 370,000	

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2022/23					
	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
Mental Health Advocacy Services	$ 442,748	$ 442,748				
North Coastal Mental Health Center and Vista Clinic	$ 3,374,288	$ 1,031,759	$ 2,342,529			
North Inland Mental Health Center	$ 3,380,044	$ 1,343,423	$ 2,036,621			
NPLH BHS	$ 520,936	$ 312,562			$ 208,374	
NPLH Dept Pub Works Envir Svcs Unit	$ 27,500	$ 3,500			$ 24,000	
NPLH Housing & Community Dev Svcs	$ 1,199,155	$ 330,311			$ 868,844	
Peer Assisted Support Services	$ 902,623	$ 902,623				
Peer Workforce Development	$ 1,089,135	$ 710,287			$ 378,849	
Public Defender - Behavioral Health Assessor	$ 240,000	$ 144,000			$ 96,000	
San Diego Employment Solutions	$ 1,124,730	$ 669,562			$ 455,169	
San Diego Housing Commission	$ 120,744	$ 108,744			$ 12,000	
Short Term Acute Residential Treatment (START)	$ 14,273,992	$ 9,359,490	$ 2,137,251		$ 2,777,251	
Short-Term Bridge Housing	$ 1,200,231	$ 1,200,231				
Supplemental Security Income (SSI) Advocacy Services	$ 503,100	$ 503,100				
Telemedicine	$ 371,448	$ 324,439	$ 47,009			
Tenant Peer Support Services	$ 3,300,903	$ 3,149,301			$ 151,602	
Walk-In Assessment Center	$ (0)	$ (0)				
Total Non-Full Service Partnership (FSP) Programs	**$ 172,860,513**	**$ 91,538,374**	**$ 54,072,191**		**$ 27,249,948**	
CSS Administration	$ 24,898,699	$ 24,898,699				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	**$ 342,198,949**	**$ 190,890,025**	**$ 112,096,195**		**$ 39,212,728**	
FSP Programs as Percent of Total	75.7%					

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2022/23						
	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 - Next Steps	$ 2,968,401	$ 2,718,401			$ 250,000		P
2. DV-03 Alliance for Community Empowerment	$ 402,480	$ 402,480					P
3. DV-04 Point of Engagement	$ 503,108	$ 503,108					P
4. EC-01 Positive Parenting Program	$ 1,106,820	$ 666,820			$ 440,000		P
5. FB-01 Kick Start	$ 1,786,005	$ 300,211	$ 775,794		$ 710,000		EI
6. NA-01 Dream Weaver	$ 1,755,819	$ 1,057,819			$ 698,000		P
7. OA-01 Elder Multicultural Access & Support Services (EMASS)	$ 572,682	$ 345,021			$ 227,661		P
8. OA-02 Positive Solutions	$ 582,148	$ 582,148					P
9. OA-06 Caregiver Support	$ 1,087,461	$ 1,087,461					P
10. PS-01 Education and Support Lines							P / S&D / P
Breaking Down Barriers (BDB) Initiative	$ 440,514	$ 440,514					
Come Play Outside	$ 503,100	$ 503,100					
County of San Diego - Community Health Promotion Specialists (CHPS)	$ 620,703	$ 372,422			$ 248,281		
Family Peer Support Program	$ 199,791	$ 199,791					
Mental Health First Aid	$ 503,100	$ 503,100					
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 2,288,132	$ 2,060,729			$ 227,403		
Suicide Prevention Action Plan	$ 578,565	$ 578,565					
Supported Employment Technical Consultant Services	$ 215,835	$ 215,835					
11. RC-01 SmartCare	$ 1,541,061	$ 1,541,061					P / EI
12. RE-01 Independent Living Association	$ 301,860	$ 301,860					O
13. SA-01 School Based Program	$ 6,609,438	$ 6,609,438					P / EI
14. SA-02 Here Now	$ 1,811,160	$ 1,811,160					SP
15. VF-01 Courage to Call	$ 1,287,936	$ 1,287,936					A
PEI Categories **A** - Access to Treatment **EI** - Early Intervention **O** - Outreach **P** - Prevention **S&D** - Stigma & Discrimination **SP** - Suicide Prevention *Individual programs may serve more than one area*							
PEI Administration	$ 3,613,347	$ 3,613,347					
PEI Assigned Funds	$ 400,000	$ 400,000					
Total PEI Program Estimated Expenditures	**$ 31,679,464**	**$ 28,102,325**	**$ 775,794**		**$ 2,801,346**		

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2022/23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding *	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-18 Peripartum Services	$ 1,070,093	$ 1,070,093				
2. INN-19 Telemental Health	$ 1,130,052	$ 1,130,052				
3. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,891,951	$ 1,891,951				
4. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,405,046	$ 1,405,046				
5. INN-22 Medication Clinic	$ 992,845	$ 649,057	$ 343,787			
6. INN-24 Early Psychosis and Learning Health Care Network	$ 201,106	$ 201,106				
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 952,096	$ 952,096				
Total INN Program Estimated Expenditures	**$ 7,643,188**	**$ 7,299,401**	**$ 343,787**			

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2022/23					
	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	$ 1,823,727	$ 1,823,727				
2. WET-03 Mental Health Career Pathway Programs	$ 94,331	$ 94,331				
3. WET-04 Residency and Internship Program	$ 1,962,090	$ 1,962,090				
WET Administration	$ -	$ -				
Total WET Program Estimated Expenditures	**$ 3,880,148**	**$ 3,880,148**				

Appendix A
FY 2022-23 Annual Update Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2022/23					
	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						
CFTN Programs - Technological Needs Projects						
1. SD-3 Personal Health Record						
2. SD-5 Telemedicine Expansion						
3. SD-6 MH MIS Expansion						
4. SD-8 Data Exchange						
5. SD-9 Financial Management System						
CFTN Administration	$ -	$ -				
Total CFTN Program Estimated Expenditures	**$ -**	**$ -**				

APPENDIX B

CERTIFICATIONS AND MINUTE ORDER

APPENDIX C

MHSA PROGRAM SUMMARIES

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	ALL-OE	Behavioral Health Services - Victims of Trauma and Torture	Survivors of Torture International	Outpatient mental health services to Adults/Older Adults who are victims of trauma and torture with serious mental illness and children who suffer from a severe emotional disturbance	Improve access to mental health services, culture specific, outreach and education to persons with a serious mental illness or emotional disturbance who have been victims of torture and provide referrals for victims of trauma and torture who are indigent and do not meet medical necessity	All ages of uninsured, unserved individuals with SED and SMI who are victims of trauma and torture.	• Bio-psychosocial rehabilitation services recovery • Strength based, client and family driven and culturally competent programs	Survivors of Torture International (619) 278-2400	All
CSS	ALL-OE	Behavioral Health Services and Primary Care Integration Services	Behavioral Health Services and Primary Care Integration	Provides services and treatment to adult patients with behavioral health problems through the Enhanced Screening, Brief Intervention and Referral to Treatment model	Provide effective, evidence-based treatment for behavioral health interventions in a primary care setting	Adults 18 years and older	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network dba Health Quality Partners 3710 Ruffin Rd San Diego, CA 92123 (619) 542-4300	All
CSS	ALL-OE	Behavioral Health Services for Deaf & Hard of Hearing	Deaf Community Services	Adult outpatient mental health clinic provides video, secure email, and phone consultation in a mental health walk-in outpatient clinic within San Diego County	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Adult/older adults, transition age youth and children who are deaf and hard of hearing and who have a serious mental illness, including those with co-occurring substance disorders	• Outpatient mental health services • Case management • Integrated substance use disorder treatment and rehabilitation	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
CSS	ALL-OE	Clubhouse - Deaf or Hard of Hearing	Deaf Community Services Clubhouse	Recovery and skill center/clubhouse for the Deaf or Hard of Hearing	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning	Transition Age Youth, Adults/Older Adults, who are deaf or hard-of-hearing who have or are at risk of a serious mental illness or co-occurring disorder	• Member-operated recovery and skill development clubhouse program • Services include social skill development, rehabilitative, recovery, vocational and peer support	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
CSS	ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Psychiatric and Addiction Consultation and Family Support Services SmartCare	Provides psychiatric and addiction consultation and family support services for primary care, pediatric and obstetric providers who serve patients with Medi-Cal or who are uninsured, throughout San Diego County, Transition Age Youth, Adults/Older Adults	Improve the confidence, competence, and capacity of primary care pediatrics, and obstetricians in treating behavioral health conditions; increase identification of behavioral health issues, including suicide risk; provide education, referrals, and linkages to support families	Children, Transition Age Youth, Adults/Older Adults	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8825 Aero Dr, #315 San Diego, CA 92123 (858) 956-5906	All
CSS	ALL-SD	Chaldean and Middle-Eastern Social Services	Chaldean and Middle-Eastern Social Services	Outpatient mental health clinic provides treatment, rehabilitation, and recovery services to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	Provide culturally competent treatment, services and referrals for individuals of Middle Eastern descent who experience mental health issues or a serious mental illness	Adults 18 years and older and eligible for Medi-Cal funded services	• Outpatient mental health clinic which provides treatment, rehabilitation, and recovery services • Referrals and linkage support	Chaldean and Middle-Eastern Social Services 875 El Cajon Blvd. El Cajon, CA 92020 (619) 662-4100	2
CSS	ALL-SD	Mobile Crisis Response Team (MCRT)	Regional Mobile Crisis Response Team	The MCRT is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care.	The goal of the MCRTs is to respond to community (non-911calls) urgent/emergency calls and provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. These services are performed by trained clinicians and peers in the field.	Services to individuals experiencing a behavioral health crisis in the community including adults and older adults, as well as children, youth and families in the community.	Provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. The MCRTs are available 24 hours/7 days per week.	Breawna Lane Blane@telecarecorp.com 619-346-8484	1,2,3,4
CSS	ALL-SD	Psychiatric Emergency Response Team (PERT) EMT-MH Clinician Team	Psychiatric Emergency Response Team	Pairs law enforcement officers with licensed mental health clinicians to serve children and adults experiencing a behavioral health crisis and come have come in contact with law enforcement throughout the County	Improve collaboration between the mental health and law enforcement systems with the goal of more humane and effective handling of incidents involving law enforcement officers and mentally ill and developmentally disabled individuals	Children, Transition Age Youth, Adults/Older Adults, with a focus on veterans, homeless populations.	• Case coordination • Descalation and crisis intervention services • Training for law enforcement personnel	Community Research Foundation (CRF) 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0892	All
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	Provide outpatient diagnostic and treatment services for children and youth who require specialty mental health services who reside in County of San Diego Foster Family Agency (FFA) homes. Services includes the oversight of Therapeutic Foster Care (TFC) services, including the provision of specific Specialty Mental Health Services.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21, involved in Child Welfare Services and residing in Foster Family Agency homes, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children FFAST 8825 Aero Dr., Suite 110 San Diego, CA 92123 (858) 633-4102 North County 145 Vallecitos de Oro, Suite 210 San Marcos, CA 92069 (858) 633-4115	All
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Connections Community Counseling	Locates and engages homeless and runaway youth for the purpose of increasing access to mental health services and family reunification. Individual/group/family services provided at schools, community, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline Inc. NewLife Counseling 4180 Ruffin Rd Ste 295 San Diego CA 92123 (760) 842-6202	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland/North Coastal & Fallbrook 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, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235	2, 3, 5

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Vista Hill Foundation Learning Assistance Center	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill Foundation - Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation - North Inland Ramona 1012 Main St., Suite 101 Ramona, CA 92065 (760) 788-9724	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familias	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children up to age 6 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach and Engagement	Episcopal Community Services Para Las Familias 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner 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	Children and youth up to age 21 and their families who are underserved with a focus on Latino and Asian-Pacific Islanders	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	YMCA-TIDES 4394 30th St. San Diego, CA 92104 (619) 543-9850	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Counseling and Treatment Center - School Based Outpatient Children's Mental Health Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Homeless children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	4, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North 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, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Inland 2125 W. Citacado Pkwy., Suite 200 Escondido, CA 92025 (760) 294-9270	2,3,5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	School-Based Central-East-South	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-8471	1, 2, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Coastal Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co- occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Coastal 3605 Vista Way, Suite 258 Oceanside, CA 92056 (760) 758-1480	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	MHS - Community and School Based Counseling	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Crossroads Family Center	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	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 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 700 N. Johnson Ave, Suite P El Cajon, CA 92020 (619) 441-1907	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Douglas Young Youth and Family Services	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Douglas Young Youth and Family Services 7917 Ostrow St., Suite A San Diego, CA 92111 (858) 300-8282	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Nueva Vista Family Service	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	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 who meet medical necessity and serious emotional disturbance criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mobile Adolescent Services Team (MAST)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. Housing case management component for chidlren and families in the Monarch program.	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 who may be attending a Juvenile Court and Community School (JCCS) and meet medical necessity and serious emotional disturbance (SED) criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Mobile Adolescent Services Team 1260 Morena Blvd., Suite 200 San Diego, CA 92110 (619) 398-3261	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Youth Enhancement Services	Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Ysidro Health Center Youth Enhancement Services 3025 Beyer Blvd., Suite E-101 San Diego, CA 92154 (619) 428-5533	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Family Wellness Center - East County Outpatient Counseling Program	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children East Region Outpatient 6386 Alvarado Ct San Diego CA 92120 (619) 668-6200	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	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, family or youth partner support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	New Alternatives Inc 1529 Grand Ave. Suite A San Marcos CA 92078 (760) 798-0299	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle Central and East	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers - Logan Heights 2130 National Ave. San Diego, CA 92113 (619) 255-7859 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-5444	1,2,4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Pathways Cornerstone	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd., Suite 14 San Diego, CA 92115 (619) 640-3269	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Merit Academy Day School Services	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, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Behavioral Health Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services 1870 Cordell Ct., Suite 101 El Cajon, CA (619) 448-9700	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	School Based FSP Oceanside & Vista	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline - Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900 North County Lifeline - Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Multi-Cultural Community Counseling - Full Service Partnership (FSP)	Culturally specific individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. The focus of this program is to provide services to underserved Asian Pacific Islander (API) and Latino clients with Serious Emotional Disturbance with an emphasis on API clients.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	•Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) 5348 University Ave, Suite 108 San Diego, CA 92105 619-455-2108	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	SBCS Strengthening Communities - School Based Outpatient	Individual/group/family services provided at home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-FSP	Incredible Years	ChildNET Incredible Years North Coastal & North Inland	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management and family partner support	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 through five years old, and their families, using the Incredible Years evidence-based program.	Children through age 5 who meet medical necessity and serious emotional disturbance criteria, and their families	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 945 Vale Terrace Dr Vista CA 92084	2, 3, 5
CSS	CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services	Critical short term one-to-one behavioral intervention services for full Medi-Cal children up to 21 years old, and Full Service Partnership (FSP), who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children up to age 21 who are Medi-Cal eligible and who are receiving specialty mental health reimbursable services and experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	• One on one behavioral coaching	New Alternatives - TBS 8755 Aero Drive, Suite 230 San Diego, CA 92123 (858) 256-2180	All
CSS	CY-FSP	Wraparound Services (WRAP) - Child Welfare Services (CWS)	WrapWorks	Wraparound offers team based intensive and individualized case management to a child or youth within the context of their support system, leveraging both formal and informal supports	Return children/youth to their family or family-like setting, support permanency and enhance long-term success	Children and youth up to age 21 who are involved with Child Welfare Services or Probation	• Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	San Diego Center for Children 3002 Armstrong Street San Diego, CA 92111 (858) 569-2170 235 W 5th Avenue, Ste 130 Escondido, CA 92025 3322 Sweetwater Spring Blvd, Ste 104 Spring Valley, CA 929177	All
CSS	CY-OE	Parent Partner Services	Family/Youth Support Partnership Services	Provide case management, focus groups, support and education groups and community resource fairs provided by a Youth / Family Support Partner (YFSP) and linking them to needed behavioral health treatment and education.	Outreach and Engagement services for children, youth, up to age 21, and their families	Latino, Asian, and African American children and youth up to age 21	• Outreach and Engagement • Family Support Partners • Case management • Focus groups • Support and Education Groups • Community Presentations	Harmonium 5275 Market St, Ste E San Diego, CA 92114 (858) 226-1982	4
CSS	CY-SD	Adolescent Day Rehabilitation	San Diego Center for Children Residential Outpatient Children's Mental Health Services	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and youth up to age 18, residing at San Diego Center for Children, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CSS	CY-SD	BridgeWays Program	BridgeWays Program Services	Individual/group/family services provided at office/clinic, home, school or other community locations. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment	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 and serious emotional disturbance (SED) criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Home Based Services • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Substance use services	San Diego Youth Services BridgeWays 7364 El Cajon Blvd. Ste 209 San Diego, CA 92115 (619) 221-8600 x2503	All
CSS	CY-SD	Commercially Sexually Exploited Children (CSEC)	San Diego Youth Services - 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, family or youth partner support, and/or co-occurring substance treatment. Supportive services at drop-in center	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth and their families that are at risk for or are victims of commercial sexual exploitation	Children and youth up to age 21 who are at risk for or are victims of commercial sexual exploitation and who meet medical necessity and serious emotional disturbance (SED) criterial. Any at risk for or victim of commercial sexual exploitation who would benefit from supportive services at the drop-in center	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • GED preparation • Support groups • Youth Partners • Mentors	San Diego Youth Services I CARE 3660 Fairmount Ave. San Diego, CA 92105 (619) 521-2550 x 3816	All
CSS	CY-SD	County of San Diego - Juvenile Forensic Services	County of San Diego - Juvenile Forensics	Provides behavioral health services to youth transitioning out of the juvenile detention and rehabilitative institutions.	Prepare youth for transition back to the community and work with probation youth who have been released and are living in the community	Youth transitioning out of juvenile institutions	• Crisis intervention • Behavioral health assessment • Traditional psychotherapy • Psychiatric evaluation and medication management	Youth Transition Campus 2801 Meadlow Lark Drive 1st Flr. San Diego, Ca 92123-2711 (858) 298-6070 East Mesa Detention Facility 446 Alta Road San Diego, CA 92158 (619) 671-6558	All
CSS	CY-SD	Crisis Action and Connection	Crisis Action and Connection	Provides intensive support and linkage to services and community resources for children/youth who have had a recent psychiatric episode	Improve the ability of children and youth and their families to access and benefit from mental health services in order to divert or prevent readmission to acute services	Children and youth up to age 21 who meet medical necessity and meet set criteria	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services • Case Management	New Alternatives Inc. Crisis Action & Connection 730 Medical Center Crt. Chula Vista, CA 91911 (619) 591-5740	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	CY-SD	Emergency Screening Unit (ESU)	Emergency Screening Unit (ESU)	Provides crisis stabilization to children and youth experiencing a psychiatric emergency	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth under age 18 who are experiencing a psychiatric emergency	• Crisis stabilization services for high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Emergency Screening Unit 4309 Third Ave. San Diego, CA 92103 (619) 876-4502	All
CSS	CY-SD	Incredible Families	Incredible Families	Behavioral health outpatient services and other developmental appropriate clinical interventions to children and their families that are Dependents of the Juvenile Courts hence involved with Child Welfare Services (CWS).	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Families and their children 2-14 years old who are dependents of Juvenile Dependency Court due to abuse and/or neglect	• Weekly multi-family parent and child visitation event and meal for all family members • Utilization of the Incredible Years evidence-based curriculum • A primary therapist is assigned to each family • Clinical support during family visitation events, as well as, during individual and family therapy	New Alternatives Inc. Incredible Families Central 8765 Aero Dr Suite 310A, San Diego, CA 92123 (619) 207-0396 Incredible Families North 1020 S. Santa Ana Ave Suite D-1, Vista, CA 92084 Incredible Families South 730 Medical Center Court, Chula Vista, CA 91911	All
CSS	CY-SD	Med Clinics	Center for Child & Youth Psychiatry Medication Clinic	Outpatient psychiatric evaluation and medication support services utilizing face-to-face and telepsychiatry/telehealth practices for children and youth with complex psychiatric pharmacological needs inclusive of children and youth who may be involved in the juvenile justice or child welfare systems	Promote stabilization by providng psychiotropic medication support to children and youth, who require complex medication management.	Children and youth up to age 21 requiring on-going medicaiton support who have successfully completed a comprehensive mental health treatment with a system of care provider.	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	New Alternatives 8755 Aero Dr., Suite 306 & 320 San Diego, CA 92123 858) 634-1100	All
CSS	CY-SD	Medication Support for Wards and Dependents	Vista Hill - Juvenile Court Clinic	Provides short term (no more than three months) individual/family treatment, psychotropic medication and linkage to community-based provider for on-going treatment to children and youth who may be involved in the juvenile justice or child welfare systems	Assist the youth and family with stabilization, support, linkage and coordination to community provider for ongoing mental health services if needed	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria and who are in the juvenile justice or child welfare systems	• Individual/family treatment • Care coordination • Case management • Rehabilitative services • Medication services	Vista Hill Juvenile Court Clinic 8910 Clairemont Mesa Blvd San Diego, CA 92123 (858) 571-1964	All
CSS	CY-SD	Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	San Diego Youth Services - Our Safe Place	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, family or youth partner support, and/or co-occurring substance treatment. Supportive services at 4 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, youth who identify as LGBTQ and their families	LGBTQ children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria. 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 • Youth Partners • Mentors	San Diego Youth Services Our Safe Place 3427 4th Ave. Second Floor San Diego, CA 92103 (619) 525-9903	All
CSS	CY-SD	Peer Mentoring	San Pasqual Academy Children's Mental Health Services	Full day rehabilitation and peer mentor services to San Pasqual Academy residents who are dependents of the Court.	Provide full day rehabilitation and peer mentor services to San Pasqual Academy residents to ensure clients have a stable living environment in order to complete their schooling and eventually transition to a home-like enviornment.	Residents of San Pasqual Academy 12-21 years old who meet medical necessity and are dependents of the Court.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	New Alternatives Inc. San Pasqual Academy 17701 San Pasqual Valley Rd. Escondido, CA 92025 (760) 233-6003	All
CSS	CY-SD	Placement Stabilization Services	Comprehensive Assessment & Stabilization Services (CASS)	Outpatient mental health services including a comprehensive behavioral health assessment, individual and family therapy, casemanagement, individual rehab and psychiatric services/med management for children and youth placed by Child Welfare services in a resource family home and at risk of change of placement disruption.	Stabilize current placement, deter children and youth from placement in a higher level of care and support transition of children and youth back to their biological families	Foster children and youth up to age 18 who recently experience placement disruption and meet medical necessity and serious emotional disturbance criteria.	• Assessment • Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	New Alternatives Inc. 3517 Camino Del Rio South, Suite 407 San Diego, CA 92108 (619) 955-8905	All
CSS	CY-SD	Placement Stabilization Services	Polinsky Children's Center Outpatient Services (PCC)	Outpatient mental health services including a comprehensive behavioral health assessment and short-term individual therapy, case management, individual and group rehab and psychiatric services/med management for children and youth placed at County ten day assessment center, Polinsky Children's Center.	Return children and youth to their family or family-like setting, support permanency and link children, youth and families to support services when indicated	Children and youth up to age 18 who meet medical necessity and serious emotional disturbance criteria brought to Polinsky Children's Center by Child Welfare for a short assessment period	• Assessment • Case management and rehabilitative services • Intensive care coordination • Intensive home-based services • Crisis intervention • Medication management • Outreach at schools and the community	New Alternatives Inc. 9400 Ruffin Ct. San Diego, CA 92123 (858) 598-5035	All
CSS	CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Smart Care Integrated BHS	Paraprofessionals within rural community clinics provide behavioral health education to prevent development of serious mental illness or addiction. Services provided may also include short-term prevention services and community referrals to support early intervention.	Prevention and early intervention education to prevent development of serious mental health or addiction for children, transitional age youth and adults/older adults	Children, Transition Age Youth, Adults/Older Adults	• Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725	2, 5
CSS	CY-SD	Supplemental Security Income (SSI) Advocacy Services	San Diego Center for Children Residential Outpatient Children's Mental Health Services	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills services to Child Welfare Services youth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement	Children and youth up to age 18, residing at San Diego Center for Children, who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 277-9550	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Adult Residential Treatment	Changing Options	Residential facility for adults with serious mental disorders	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach to assist the client's recovery and return to independent living.	Adults 18 years and older with disabling psychiatric disorder requiring a 24-hour Mental Health Rehabilitation Center	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299	All
CSS	TAOA-FSP	Assisted Outpatient Treatment (AOT)	Assisted Outpatient Treatment (AOT)	Intensive community-based services for persons who establish an Assisted Outpatient Treatment court settlement agreement, persons who are court-ordered, persons who otherwise meet the eligibility criteria and voluntarily accept alternative services prior to an Assisted Outpatient Treatment petition being filed	Integrate behavioral health and rehabilitation treatment and recovery services for adults with a serious mental illness and have been identified as potential candidates by the In-Home Assessment Team, have agreed to an Assisted Outpatient Treatment court settlement, or have Assisted Outpatient Treatment status resulting from a contested court hearing	Adults 18 years and older meeting Title 9 criteria as established under Laura's Law	• Assertive Community Treatment with a rehabilitation and recovery focus	Telecare Corporation 1660 Hotel Circle N., Suite 101 San Diego, CA 92108 (619) 481-3840	All
CSS	TAOA-FSP	Behavioral Health Court	Collaborative Behavioral Health Court	Uses the Assertive Community Treatment model to enhance the lives of individuals experiencing a serious mental illness and co-occurring conditions through case management and mental health services	Integrate mental health, substance-induced psychiatric disorder rehabilitation treatment, and recovery services for adults with serious mental illness to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system	Underserved adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corporation 4930 Naples St. San Diego, CA 92110 (619) 276-1176	4
CSS	TAOA-FSP	Crisis Residential Services - North Inland	Esperanza Crisis Center	Twenty-four hours a day, seven days a week service provided as an alternative to hospitalization or step down from acute inpatient care within a hospital for adults with acute symptoms of serious mental illness, including those who may have a co-occurring substance use disorder	Provide alternative to hospital or acute inpatient care	Voluntary adults 18 years and older with acute and serious mental illness, including those who may have a co-occurring substance use disorder	• Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation 490 N. Grape Street Escondido, CA 92025 (760) 975-9939	All
CSS	TAOA-FSP	County of San Diego - Institutional Case Management (ICM)	Institutional Case Management	Provides 5 Full Time Equivalent positions of Institutional Case Management	Stabilization and linkage to services	Children, Transition Age Youth, Adults/Older Adults	• Case Management	County of San Diego	All
CSS	TAOA-FSP	County of San Diego - Peer Support Services	Peer Support Specialist (County - 4 FTEs)	County Operated Direct Service Program: Strength Based Case Management (SBCM) is designed to provide continuity of care within the behavioral health system in San Diego County. Services are delivered to adults, 18-59 years of age, living with serious and persistent mental health and co-occurring disorders who meet eligibility criteria for SBCM.	Obtain medical and psychiatric treatment, maintain housing, obtain financial assistance, case management services also help clients link with other community services, such as: education, work and social programs	Seriously and persistently mentally ill with co-occurring disorders, possibly on LPS Conservatorship, 18-59 years of age, living in the Central, North Central or East County community. Services are for SSI/Medi-Cal, SSA/Medicare and/or indigent populations.	• Strength 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	East County 1000 Broadway Suite 100 El Cajon, CA 92021 (619) 401-5424 North Central 1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715	2,3,4
CSS	TAOA-FSP	County of San Diego - Strengths Based Case Management (SBCM)	Strengths Based Case Management (County - 5 FTEs)						
CSS	TAOA-FSP	County of San Diego - Probation	Probation Officer for Behavioral Health Court	Probation Office for Behavioral Health Court	Stabilization and linkage to services	Transition Age Youth, Adults/Older Adults	• Transition services	County of San Diego	All
CSS	TAOA-FSP	County of San Diego - Probation	Probation-FSP-ACT Team	Interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re-offending while placed on probation by the courts	Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	Transition Age Youth and Adults who have a serious mental illness	• Mental health assessments • Interventions • Case Management • Outreach and engagement	Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice	24-hour community -based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness	Provides Assertive Community Treatment Services to persons with very serious mental illness	Adults 25 to 59 years old who have a serious mental illness and adults 18 years and older who may have been homeless	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. (MHS) 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Center Star ACT						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Pathways to Recovery	Assertive Community Treatment and In-Reach for adults in and discharged from long-term care	Provide Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialist, vocational specialist, housing specialists, nurses, physician's assistants, medical doctors, and substance use disorder specialists.	Adults 18-59 years old with serious mental illness and are, or recently have been, in a long-term care institutional setting	• Provide Assertive Community Treatment Team • Multidisciplinary, wraparound treatment and rehabilitation services for adults discharged from long-term care facilities who have a serious mental illness and needs that cannot be adequately met through a lower level of care • Includes an in-reach component for some persons served by the county institutional case management program • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Inreach to Long Term Care-Pathways to Recovery Member Housing II						

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Gateway to Recovery	Provides an Assertive Community Treatment, Full Service Partnership program for person 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness who may also have a co-occurring use disorder. This contract also serves persons who have been referred by Probation as AB109 Post Release Offenders (PROs) and Mandatory Supervision Offenders (MSOs) who have a serious mental illness.	Adults 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Probation-funded Assertive Community Treatment component • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION Central	The 100 Homeless Project is a collaborative effort between the County of San Diego and San Diego Housing Commission which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Integrate wrap-around services with accessible housing that supports the homeless population	Homeless Transition Age Youth, Adults/Older Adults who have a serious mental illness and may have a co-occurring diagnosis of substance use disorder	• Medication management and monitoring Individual therapy • Outpatient substance use disorder treatment • Intensive case management, Employment support • Peer counseling • Supportive housing component	Metal Systems Inc. (MHS) ACTION Central 6244 El Cajon Blvd., Suite 15-18 San Diego, CA 92115 (858) 380-4676	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION East	This homeless project is a collaborative effort between the County of San Diego and Housing and Community Development which provides a hybrid integrated service model to homeless individuals with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	Provide permanent supportive housing services integrated with serious mental illness (SMI) and substance use disorder (SUD) treatment services for the homeless in East Region. This hybrid program provides Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder.	Homeless Transition Age Youth, Adults/Older Adults with a serious mental illness who may have a co-occurring diagnosis of substance use disorder	• Mental health rehabilitation Treatment and recovery services for clients with substance use disorder • Integrated case management services with substance use disorder treatment and recovery services • Supportive housing component	Mental Health Systems Inc. (MHS) ACTION East 10201 Mission Gorge Rd., Suite O Santee, CA 92071 (619) 383-6868	2
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA - 100 City Star	Full Service Partnership Assertive Community Treatment team and recovery services program will use a "Housing First" approach	Provide Assertive Community Treatment Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff.	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnosis of substance abuse	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. (MHS) 8775 Aero Dr., Suite 132 San Diego, CA 92123 (858) 609-8742	4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Casa Pacifica	Transitional residential program serves abused and neglected children and adolescents, and those with severe emotional, social, behavioral, and mental health challenges	Increase independent living and reduce hospitalizations through educational and employment opportunities	Adults/Older Adults who are homeless with a serious mental illness	•Medication Support • Case management/Brokerage • Crisis intervention • Rehabilitative and recovery interventions in a transitional residential setting	Casa Pacifica 321 Cassidy St. Oceanside, CA 92054 (760) 721-2171	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Coastal ACT	Provides an Assertive Community Treatment, Full Service Partnership program for persons 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adult 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder	• Assertive Community Treatment intensive, multidisciplinary treatment services for persons who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes housing component	Mental Health Systems Inc. (MHS) 2122 El Camino Real #102 Oceanside, CA 92054 (760) 290-8170	5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Start ACT SBCM	Full Service Partnership/Assertive Community Treatment with supportive housing and Strengths-Based Case Management. Project-One-For-All (POFA) 100 Central/North Housing	Reduce homelessness and provide comprehensive ACT 'wraparound' mental health services for adults with most severe illness, most in need due to severe functional impairments, and who have not been adequately served by the current system	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless. Adults 18-59 years old who are eligible for Medi-Cal funded services or are indigent	• Strengths-based case management • Rehabilitation and mental health services with a focus on adults who meet eligibility criteria • Supportive housing component	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3,5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Star - Strengths Based Case Management (SBCM)	Program uses strength based case managment team approach to deliver comprehensive, community based servics and support for adults who are transitioning from higher levels of care.	Recovery-oriented strengths-based clinical case management services to persons with serious mental illness	Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless	• Strengths based case management	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3, 5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA - South Region (100 SMI Slots) Housing	Full Service Partnership Assertive Community Treatment team and recovery services Program will use a "Housing First" approach	Ensure clients are provided access to good quality housing in the South Region of San Diego County	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnoses of substance abuse	• Supportive Housing	Adelante (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 934-5770	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	POFA Homeless Project South - Adelante Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Hummingbird Healing House	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility. Program provides transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co-occurring disorders.	Provide transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co-occurring disorders.	Adults eighteen (18) years of age or older, with primary serious mental illness diagnosis	• Functional adaptation skills training; • Integrated co-occurring disorder services; • Wellness Recovery Action Plan; • Cognitive Behavioral Therapy and Dialectical Behavioral Therapy; • Problem solving • Independent living skills	Crestwood Behavioral Health, Inc. 5550 University Ave, Suite A San Diego, Ca 92105 (619) 481-5447	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	IMPACT Downtown IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or as-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults 18-59 who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central and North Central Regions of San Diego	• Linkage to food, housing and/or physical health services • Medication management •Vocational services • Substance use disorder services • Includes housing component	IMPACT 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156 Downtown IMPACT 995 Gateway Center Way, Suite 300 San Diego, Ca 92102 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Central IMPACT Housing						

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	IMPACT Downtown IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders	Improve the mental health and quality of life of adults in the community who have been or as-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults 18-59 who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central and North Central Regions of San Diego	• Linkage to food, housing and/or physical health services • Medication management •Vocational services • Substance use disorder services • Includes housing component	IMPACT 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156 Downtown IMPACT 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Downtown IMPACT Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Senior IMPACT	Offers intensive, comprehensive, community -based integrated behavioral health services	Increase timely access to services and supports to assist Older Adults and family/ caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes	Adults 60 years and older who are homeless or at risk of homelessness and have serious mental illness	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) - Senior IMPACT 928 Broadway San Diego, CA 92102 (619) 977-3716	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Senior Impact Supported Housing.						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Telecare Agewise	Strengths-Based Case Management, Full Service Partnership program for Older Adults in addition to having an Institutional case management component	Increased access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services plus assist clients in long term care to graduate and be placed in the community	Adults 60 years and older with a serious mental illness who may be on LPS Conservatorship or who have needs that cannot be adequately met by a lower level of care	•Care coordination and rehabilitation • Field-based services have a participant-to-staff ratio that is approximately 25 to 1 • Case management and supportive housing (when available)	Telecare Corporation Telecare Agewise 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Catalyst	Transition Age Youth Assertive Community Treatment Full Service Partnership. Services are team-based, available around the clock, are primarily delivered on an outreach basis, and have a participant-to-staff ratio that is approximately 10-12 to 1	Provide Assertive Community Treatment Team intensive, multidisciplinary, wraparound treatment and rehabilitation services for Transitional Age Youth who have a serious mental illness, may be on LPS Conservatorship, and have needs that cannot be adequately met through a lower level of care	Transition Age Youth with a serious emotional disturbance or serious mental illness (who may have a co-occurring mental illness and substance use disorder) that have been homeless or may be at risk of being homeless	• Assertive Community Treatment (ACT) mental health • Includes housing component	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Catalyst for TAY Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Vida ACT	Full Service Partnership/Assertive Community Treatment - Justice Involved	Provides Assertive Community Treatment Services to persons with serious mental illness who are justice involved	Adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and are misdemeanor or felony offenders	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Telecare Corporation 3491 Kurtz Street, Suite 150 San Diego, CA 92110	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Justice Involved Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Step Down from Long Term Care Housing	Full Service Partnership/Assertive Community Treatment	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from long term care (IMD, Skilled Nursing Facility, State Hospital)	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder and justice involved	• Assertive Community Treatment Services • Includes housing component	Telecare La Luz 3489 Kurtz, San Diego, CA 92110 619-320-2404	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	La Luz						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Step Down from Acute Care Housing	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility	Provide Assertive Community Treatment Services to persons with serious mental illness, who maybe have a substance use disorder, are homeless or at risk of homelessness, who are discharging from acute behavioral health hospital.	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	• Assertive Community Treatment Services • Includes housing component	Telecare Tesoro 489 Kurtz, San Diego, CA 92110 619-320-2404	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	Tesoro						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Uptown Safe Haven	Residential transitional housing program that provides supportive services for those who are experiencing homelessness and have a serious mental illness	Provide residential support, crisis intervention, and transitional housing services to clients experiencing homelessness who are enrolled in Assertive Community Treatment (ACT) services.	Adults/Older Adults with a serious mental illness 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	All
CSS	TAOA-FSP	North Coastal Mental Health Center and Vista Clinic	Vista/North Coastal TAY	BPSR recovery centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support at Wellness Recovery Centers (WRC) that are Short-Doyle Medi-Cal (SD/MC) certified Mental Health Clinics in the County of San Diego Health and Human Services Agency's North Coastal Region to serve residents 18+ who have serious mental illness (SMI) including those who may have co-occurring substance use.	The goal of the program is to provide integrated mental health and rehabilitation treatment and recovery services for TAY (age 18-25) adults who have SMI (including those with co-occurring substance use).	TAY (age 18-25)	Integrated mental health and rehabilitation treatment and recovery services for TAY age 18-25, adults age 26-59, and older adults age 60+ who have SMI (including those with co-occurring substance use) and who meet eligibility criteria. Access and services provided through culturally appropriate outreach, engagement, assessment, case management/brokerage, rehabilitation, y intervention, medication, therapy, mobile outreach and other indicated treatment, and include specialized components	(NC) Myesha Barton mbarton@mhsinc.org 760-712-3535 (Vista) Jennifer Osborn josborn@mhsinc.org 760-758-1092	5
CSS	TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Transition Team	Provides Short-term Intensive Transition Team to serve individuals who are or have recently been hospitalized	Provide Assertive Community Treatment Services to persons with very serious mental illness	Adults 18 years and older	• Short-term Intensive Transition Team	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Safe Connection Program	NHA Safe Connections delivers SC/MC certified Care Coordination/Short-term intensive case management services.	Provides Short-Doyle/Medi-Cal-certified care coordination and short-term intensive clinical case management services for clients with serious mental illness who have had high service use	Adults 18 years of age and older who are eligible for Medi-Cal funded services or are indigent, have a serious mental illness (including those with co-occurring substance use), and reside in San Diego County.	Provide care coordination/short-term intensive clinical case management. -Connect clients with appropriate behavioral health services and short term housing if the client is homeless	Safe Connections Neighborhood House Association 286 Euclid Ave. Ste. 104 San Diego, CA 92114 (858) 285-0979	4
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	South Bay Guidance Wellness and Recovery Center	South Region (Northern Area) strengths-based case management	Provide strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental clinic • Strengths-based case management	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661	1
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Maria Sardinas Center	South Region (Southern Area) strengths-based case management	Provide strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Transition Age Youth population and Probation-funded AB 109 component	• Outpatient mental clinic • Strengths-based case management	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
CSS	TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	North Coastal Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center for adults 18 years and older with substance use disorder including those who may have a co-occurring mental health disorder	Assist individuals to become and remain free of substance use disorder. For clients with co-occurring disorders, the goal is to ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders	Adults 18 years and older with substance use disorder(s), including those who may have co-occurring mental health and substance use	• Evidence-based treatment and recovery services approaches that incorporate both 12-step models (e.g., AA, NA) and non-12 step models (e.g., SMART Recovery, Rational Recovery, Secular Organizations for Sobriety) • Provide PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education 2821 Oceanside Blvd. Oceanside, CA 92054 (760) 721-2781	5
CSS	TAOA-OE	Countywide Homeless Outreach Program	Countywide Homeless Outreach Program	The program conducts outreach and engages persons 18 and older with serious mental illness and/or substance use conditions who are unsheltered to provide a behavioral health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	To assist persons experiencing homelessness by connecting them with housing, improving health and quality of life, and connection to community resources.	Persons served will be adults/older adults age 18 or older, with serious mental illness and/or substance use conditions and are homeless	The program shall outreach and engage the target population and provide a behavioral health screening and received short term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	PATH San Diego's Connections Housing 1250 Sixth Ave., San Diego, CA 92101 (619) 810-8600	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Carrolls Residential Care, Carrolls Community Care, Anthem Compassionate, Casa El Cajon, Orlando Residential Care and Fancor Guest Home	Augmented Services Program to provide additional therapeutic and support services in licensed residential care facilities	The goal of ASP is to maintain or improve client functioning in the community and to prevent or minimize institutionalization	Adults 18 years and older who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care	Carrolls residential: Bryan Meyers 619-444-3181 and 619-442-8893, Anthem: Charity Bailey 619-303-3717, Casa El Cajon Becky Rayo 619-440-1335, Orlando and Fancor: Cyra Manalot 619-444-9411 and 619-588-1761	All
CSS	TAOA-SD	Behavioral Health Assessors	Neighborhood House Association (Project Enable)	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long term vocational support	Provide transitional services to support youth to be released from detention	At risk African-American and Latino citizens who are incarcerated adults or Transition Age Youth at designated detention facilities and will be released in San Diego County	• Advocacy, assessment, engagement, and resource connection	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 207 San Diego, CA 92114 (619) 766-5994	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Bio-Psychosocial Rehabilitation (BPSR) (East - Heartland)	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery service	Provide outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery Probation-funded AB 109 component	Community Research Foundation (CRF) East Region Heartland Center 1060 Estes St. El Cajon, CA 92020 (619) 440-5133	2
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Areta Crowell Clinic	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older who have a serious mental illness including those who may have a co-occurring substance use disorder living in San Diego County	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults age 18 years and older who have serious mental illness • Services provided at a Bio-Psychosocial Rehabilitation Wellness Recovery center with Supported Housing	Areta Crowell BPSR Program 1963 4th Ave. San Diego, CA 92101 (619) 233-3432 ext. 1308	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Douglas Young BPSR Center	North Central Region Adults Region Adults/Older Adults Bio-Psychosocial Rehabilitation Wellness Recovery Center	Increase the number of Transition Age Youth with serious mental illness receiving integrated, culturally specific mental health services countywide	Adults/Older Adults who have a serious mental illness, including those with co-occurring substance use disorder, and Medi-Cal eligible or indigent	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, case management; and long-term vocational support	Community Research Foundation (CRF) - Douglas Young Clinic 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	3
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	South Bay Guidance Center BPSR-South Region	South Region (Northern Area) BPSR Wellness Recovery Center that is Short-Doyle/Medi-Cal-Certified (SD/MC) outpatient mental health center and Strengths-Based Case Management	Provide outpatient mental health services and strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Adult, older adult, and transitional age youth population	• Outpatient mental clinic • Strengths-based case management • Walk-in Services	South Bay Guidance Center 1196 3rd Ave Chula Vista, CA 91911 (619) 427-4661	1

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Maria Sardinas WRC BPSR	South Region (Northern Area) BPSR Wellness Recovery Center that is Short-Doyle/Medi-Cal-Certified (SD/MC) outpatient mental health center and Strengths-Based Case Management	Provide outpatient mental health services and strengths-based case management services to persons with serious mental illness	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Adult, older adult, and transitional age youth population	• Outpatient mental clinic • Strengths-based case management • Walk-in Services	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Project Enable Outpatient Program	Provides a Short-Doyle Medi-Cal certified Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage	Provide outpatient mental health rehabilitation, recovery services, an urgent walk-in component, and case management brokerage	Transition Age Youth, Adults and Older Adults with a serious mental illness, including those who may have a co-occurring substance use disorder; Adults/Older Adults who are low income or Medi-Cal eligible	• Provides outpatient mental health rehabilitation and recovery services, an urgent walk-in component, and case management brokerage	Neighborhood House Association Project Enable 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Bio-Psychosocial Rehabilitation (BPSR) & Co-Occurring Disorders (COD) - Adult & TAY (note: also funds under PEI CO-02)	Countywide Bio-Psychosocial Rehabilitation Services and DMC-ODS Outpatient Treatment	Outpatient Mental Health and Substance Use treatment.	Substance use disorder (SUD) and mental health treatment, recovery, and ancillary services to adults aged 18 years and above with substance use issues, including co-occurring mental health disorders	Individual and group counseling for Mental Health, and medication managment. Individual and group treatment for Substance Use.	Central (main site) 3539 College Ave. San Diego, CA 92115 619-818-3788 North 3998 Vista Way. Ste. E Oceanside, CA 92056 760-295-9830 South 865 Third Ave. Suite #112 Chula Vista CA 91911 619-271-7992	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Jane Westin Wellness & Recovery Center	Urgent Walk-In Services for Mental Health Evaluation	Provide short-termed services to include mental health evaluation, psychiatric consultation, and linkage in the community to assist clients on their path to recovery	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder	• Walk-In access and assessment • Treatment, rehabilitation, and recovery services	Community Research Foundation (CRF) Jane Westin Wellness & Recovery Center 1045 9th Ave San Diego, CA 92101 (619) 235-2600 ext. 201	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Counseling & Treatment Center (CTC - AOA & TA BPSR & Geriatric)	Central Region Bio-Psychosocial Rehabilitation Services	Outpatient Mental Health treatment.	BPSR and walk-in services to adults 18 years of age or older who have SMI including those with co-occurring substance use disorders and eligible for Medi-Cal funded services or are indigent.	Individual and group counseling, and medication managment.	CTC Mid-City 5348 University Avenue, Suite 101, San Diego, CA 92105 (619) 229-2999 CTC Serra Mesa 8745 Aero Drive, #330 San Diego, CA 92123 (858) 268-4933	3 & 4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Heartland Center	Provides Adults/Older Adults Bio-Psychosocial Rehabilitation clinical outpatient services that integrate mental health services and rehabilitation treatment and recovery service	Provide outpatient mental health services and AB 109 enhanced mental health outpatient services to persons with very serious mental illness	Adults/older adults with a serious mental illness, including those who may have a co-occurring substance use disorder	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery Probation-funded AB 109 component	Community Research Foundation (CRF) East Region Heartland Center 1060 Estes St. El Cajon, CA 92020 (619) 440-5133	2
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Alianza Wellness Center	Bio-Psychosocial Rehabilitation Wellness Recovery Center that provides outpatient mental health rehabilitation and recovery services, and case management services.	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge awareness or awareness of available services	Adult/Older Adults individuals who have serious mental illness/co-occurring disorder and are eligible for Medi-Cal or are indigent	• Bio-psychosocial rehabilitation wellness recovery center • Outpatient treatment, case management/brokerage, and peer support • Rehabilitative, recovery, and vocational services and supports	MHS Inc. Alianza Wellness Center 5555 Reservoir Dr. Ste. #204-A San Diego, CA 92120 (619) 822-1800	4
CSS	TAOA-SD	Clubhouse	The Corner Clubhouse - Areta Crowell (Central Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment service. Increase client's self-sufficiency through development or life skills	Adults/Older Adults 18 years and older who have a serious mental illness including those with co-occurring substance use disorders	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Corner Clubhouse 2864 University Ave. San Diego, CA 92104 (619) 683-7423	4
CSS	TAOA-SD	Clubhouse	Mariposa Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems (MHS), Inc. 1701 Mission Ave, Suite 120 Oceanside, CA 92058 (760) 439-2769	5
CSS	TAOA-SD	Clubhouse	Escondido Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems, Inc. (MHS) 474 W. Vermont Ave., Suite 105 Escondido, CA 92025 (760) 737-7125	3

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Clubhouse	Neighborhood House Application Friendship Clubhouse (Central Region)	Provides mental health-related recovery group counseling, social support services and employment development to members	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development or life skills	Adults/Older Adults 18 years and older who have a serious mental illness and who are eligible for Medi-Cal funded services or are indigent, including those with co-occurring substance use disorders	• Provides rehabilitation services • Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Neighborhood House Association 286 Euclid Ave. San Diego, CA 92114 (619) 266-9400	1, 4
CSS	TAOA-SD	Clubhouse	The Meeting Place & Warm Line	Provides mental health-related recovery group counseling, social support services and employment development to members. The program also offers a non-crisis phone service seven hours a day, seven days a week that is run by adults for adults who are in recovery from mental illness clubhouse also offers social security income advocates and peer support line	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills. The aim of the program is for the support line to be an essential support service for persons recovering from mental illness	Underserved Adults/Older Adults 18 years and older with a serous mental illness including those who may have a co-occurring substance use disorder	• Provides rehabilitative, recovery, health and vocational services and supports	The Meeting Place 2553 State St. San Diego, CA 92103 (619) 294-9582	4
CSS	TAOA-SD	Clubhouse	NAMI Connection 2 Community Clubhouse (Central Region)	Provides mental health-related recovery group counseling, social support services and employment development to members. In addition, the clubhouse provides street outreach to engage homeless adults with serious mental illness, including veterans, who may also have co-occurring substance use disorder	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills	Homeless Adults/Older Adults who have a serious mental illness; Services are in Central Region with an emphasis in downtown San Diego	• Group counseling Social support • Employment and education services • Support access to medical, psychiatric, and other services	National Alliance on Mental Illness (NAMI) San Diego 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	4
CSS	TAOA-SD	Clubhouse	East Region Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to members	Provide member-driven clubhouse services to individuals experiencing and/or recovering from serous mental illness	Adults 18 years and older who have a serious mental illness living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	East Corner Clubhouse 1060 Estes St., #104 El Cajon, CA 92020 (619) 631-0441	2
CSS	TAOA-SD	Clubhouse	UPAC EAST WIND Clubhouse	Provides mental health-related recovery group counseling, social support services and employment development to monolingual and/or limited English proficient Asian/Pacific Islander Adult members who have a serious mental illness, including those who may have a co-occuring substance use disorder.	• Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness. • Increase countywide social and community rehabilitation activities and employment services. • Increase client's self-sufficiency through development of life skills.	Monolingual and/or limited English proficient Asian/Pacific Islander adults who have a serious mental illness	• Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services • Group counseling • Social support • Employment and education services • Case management • Mobile outreach	UPAC East Wind Clubhouse 8745 Aero Dr., Suite 330 San Diego, CA 92123 (858) 268-4933	4
CSS	TAOA-SD	Clubhouse	Oasis Clubhouse	To provide mental health-related recovery group counseling, social support services and employment development to transition age youth members	Member-driven center that assists to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Transition Age Youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	• Provides clubhouse services to transition age youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	Pathways Community Services 3330 Market St. #A San Diego, CA 92102 (858) 300-0470	All
CSS	TAOA-SD	Crisis Stabilization - North Coastal Oceanside	Crisis Stabilization Unit North Region	Crisis Stabilization Unit 24 hours/7days a week for adult and older adults, including individuals who are Medi-Cal beneficiaries, indigent and/or underserved, and who are residents of San Diego County, who have serious mental illness and who are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug-induced problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting. CSU services shall last less than 24 hours (23.59 hours).	Services provided o transition aged youth (TAY) 18-25 years, 25-59 years and older adults aged 60 years and up, who have a serious mental illness including those with co-occurring substance use and who are eligible for Medi-Cal funded services or who are indigent Includes voluntary clients and those on WI 5150 hold who are experiencing a psychiatric crisis of such magnitude that it would place the health or safety of the individual or others.	• Psychiatric assessment • Transfer to inpatient services • Physical health assessment • Crisis intervention • Medication management • Linkage and care coordination • Transportation to short-term housing • Flex funds	Dennis Ewing Dewing@ExodusRecovery.com (760) 305-4848	5
CSS	TAOA-SD	Crisis Stabilization - North Coastal Vista	North County Walk in Assessment Center and Crisis Stabilization Unit	• Provide walk-in services assessment and referral services to individuals experiencing a mental health episode • Provide Telepsych Hub Telemedicine services on an on-demand basis • Provide 24/7 crisis stabilization services to individuals experiencing a psychiatric emergency	• Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services • Outpatient psychiatric prescriber services for children, and adult mental health consumers utilizing Telehealth practices and technology • Reducing the severity of a person's level of distress and/or need for a higher level of care	• WIAC and CSU: Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder • Telehealth: all ages	• Walk-in treatment center Rehabilitation and recovery services • Telehealth prescriber services • Crisis stabilization services	Exodus Recovery, Inc. North County Walk in Assessment Center 1520 South Escondido Blvd. Escondido, CA 92025 (760) 871-2020 Vista Walk In Assessment Center 524 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Crisis Stabilization - North Inland	Crisis Stabilization Unit	Crisis Stabilization Unit in the North Inland Region for San Diego County residents who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems	Impact unnecessary and lengthy involuntary inpatient treatment, as well as to promote care in voluntary recovery oriented treatment settings	Voluntary and involuntary adults with a serious mental illness	• Provide a twenty-four hour, seven days a week hospital-based Crisis Stabilization Unit (CSU) for adult and older adult Medi-Cal beneficiaries.	Palomar Health 2185 Citracado Parkway Escondido, CA 92029 (760) 480-7901	3, 5
CSS	TAOA-SD	Crisis Stabilization - South	Bayview Crisis Stabilization Unit	South Region 24-hour hospital based crisis stabilization unit for Adults who are experiencing a psychiatric emergency.	Impact unnecessary and lengthy involuntary impatient treatment, as well as promote care in voluntary recovery oriented treatment settings.	Voluntary and involuntary adults and older adults with a serious mental illness.	• 24-hour, seven days a week, hospital-based crisis stabilization as an alternative to emergency room services. • Behavioral Health Assessments • Medication management • Case management • Linkage to community services	Prime Health Paradise Valley Bayview Crisis Stabilization Unit 330 Moss Street Chula Vista, Ca. 91911 (619) 426-6310	1
CSS	TAOA-SD	Faith Based Services	Health & Wellness 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	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 209 San Diego, CA 92114 (619) 737-2639	All
CSS	TAOA-SD	Faith Based Services	Faith Based Behavioral Health Training and Education Academy & Ccommunity Education (Formerly INN-13 Faith Based Initiative)	Provides training and education to FBBHEA participants using the developed curriculum for both faith leaders and behavioral health providers. The program outreaches, engages, and provides educational opportunities for faith-based leaders and behavioral health providers to participate in FBBHEA combined trainings. This includes creating educational materials to address faith/spirituality principles and values, wellness, behavioral health conditions, and resource information to the African-American and Latino communities in designated regions.	Increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health. The FBBHEA and its community education trainings will facilitate behavioral health awareness and connection to resources within their community. Identify Faith-Based and Behavioral Health Champions (faith leaders and behavioral health professionals who have successfully completed FBBHEA), who together provide Community Educational Presentations. These champions form a Cadre of Facilitator Trainers within the HHSA North Coastal and North Inland Regions.	Faith-based leaders, behavioral health providers, provide resource information to African American and Latino communities in designated regions. Faith-based organizations, churches, synagogue, temples, mosques and other places of worship, to support them and establish a ministry or group, designed and created by its members, to assist their membership in the area of behavioral health.	Faith-based behavioral health training and community education	Mary Ferro, Director of Outreach and Education Phone: 760-204-2025 x120 Email: mferro@interfaithservices.org	3, 5
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team IHOT Central/East/ South	Mobile In-Home Outreach Teams for a serious mental illness	Reduce the effects of untreated mental illness in individuals with serious mental illness and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment	• In-Home Mobile Outreach	Telecare Corporation - IHOT 1080 Marina Village Pkwy,. Suite 100 Alameda, CA 94501 (619) 961-2120	1, 2, 4
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team IHOT - North Inland, North Central	Mobile In-Home Outreach Team for serious mental illness	Reduce the effects of untreated mental illness in individuals with serious mental illness and their families, and to increase family member satisfaction with the mental health system of care	Adults/Older Adults reluctant to seek treatment.	• In-Home Mobile Outreach	Mental Health Systems - IHOT 365 Rancho Santa Fe Rd., Suite 100 San Marco, CA 92078 (760) 591-0100	5
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	UCSD-IHOT/AOT Evaluation	Outcome and program evaluation of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services by: a) conducts client, family and staff focus groups; b) evaluates program and outcome data; and c) prepares and submits to County periodic and final reports of findings and recommendations for potential future system-wide implementation.	Consultant conducts outcome and program evaluation of In-Home Outreach Teams (IHOT) and Assisted Outpatient Treatment (AOT) services	N/A	Evaluation Services	Regents of the University of California San Diego 9500 Gilman Drive La Jolla, CA	All
CSS	TAOA-SD	Inpatient and Residential Advocacy Services	Patient Advocacy Services	Patient Advocacy Services for mental health clients will be expanded to County-Identified Skilled Nursing Facilities	Provide on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities. Expands services for County-Appointed Patient Advocate	Children, Transition Age Youth, Adults/Older Adults	• Provides inpatient advocacy services for adults and children/adolescents receiving mental health services in any covered 24-hour facility • Provides client representation at legal proceedings where denial of client rights are concerned • Handles client complaints and grievances for clients in these facilities	Jewish Family Service 8788 Balboa Ave. San Diego, CA 92123 (619) 282-1134	All
CSS	TAOA-SD	Institutional Case Mgmt (ICM) - Older Adults	Institutional Case Management	Provides 5 Full Time Equivalent positions of Institutional Case Management	Stabilization and linkage to services	Children, Transition Age Youth, Adults/Older Adults	• Case Management	Institutional Case Management 6160 Mission Gorge Road, Suite 108, San Diego, CA 92120 (619) 481-5200	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Justice System Discharge Planning	Project In-Reach (aka Project Enable)	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 207 San Diego, CA 92114 (619) 766-5994	All
CSS	TAOA-SD	Mental Health Advocacy Services	Adult SSI Advocacy	Supplemental Security Income Advocacy services. Responsible for the submission of applications to the Social Security Administration and further follow-up as needed	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC) (Vista)	BPSR recovery centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support with Short-Doyle Medi-Cal certified Mental Health Clinics in the North Coastal Region to serve residents 18+ who have serious mental illness (SMI) including those who may have co-occurring substance use.	The goal of the program is to provide integrated mental health and rehabilitation treatment and recovery services for Adult (age 26-59) and older adults (age 60+) who have SMI (including those with co-occurring substance use).	Adults, Older Adults	Outreach, walk in services, assessment, crisis intervention, case management, rehabilitation, crisis intervention, medication management, therapy, mobile outreach, and other indicated treatment	Jennifer Osborn josborn@mhsinc.org 760-758-1092	5
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	North Coastal Mental Health Center (N. Coastal MHC)	BPSR recovery centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support Wellness Recovery Centers (WRC) that are Short-Doyle Medi-Cal (SD/MC) certified Mental Health Clinics in the North Coastal Region to serve residents 18+ who have serious mental illness (SMI) including those who may have co-occurring substance use.	The goal of the program is to provide integrated mental health and rehabilitation treatment and recovery services for Adult (age 26-59) and older adults (age 60+) who have SMI (including those with co-occurring substance use).	Adults, Older Adults	Outreach, walk in services, assessment, crisis intervention, case management, rehabilitation, crisis intervention, medication management, therapy, mobile outreach, and other indicated treatment	Myesha Barton mbarton@mhsinc.org 760-712-3535	5
CSS	TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Center	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Adults 18 years and older	• Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	Mental Health Systems, Inc. (MHS) 125 W. Mission Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Escondido, CA 92025 (760) 480-2255 Kinesis North WRC--Ramona 1521 Main St. Ramona, CA 92065 (760) 736-2429 MHS-WRC with MHSA and Satellite North Inland 474 West Vermont Suite 101 Escondido, CA 92025 (760) 480-2255	3

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Peer Assisted Support Services	Peer Assisted Support Services (Formerly INN-15 Peer Assisted Transitions)	A culturally competent, recovery-focused Peer Assisted Support Services program for adults with serious mental illness who are not connected to County operated or Contracted Behavioral Health Services (BHS) and present at Behavioral Health Units or Crisis Residential programs in the Central region. The Peer Assisted Support Services program engages with individuals in inpatient or crisis residential programs and continues engagement with these individuals after discharge from these programs to ensure they are connected to BHS. The program provides linkages and a warm handoff to needed mental health, substance use, and social services with the goal of decreasing hospitalization and crisis residential acute care by increasing connections to ongoing behavioral health services.	The goal of the Peer Assisted Support Services project is to increase the depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are unconnected with Mental Health services, Substance Use Disorder services or community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.	Transition Age Youth, Adults/Older Adults with serious mental illness. Adults diagnosed with a serious SMI, including co-occurring Substance Use Disorder and are not currently connected to County Operated Outpatient Clinics or contracted mental health or substance use programs and who are present at the designated 24/7 programs in the Central Region: Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as County designated Crisis Residential facilities.	• Peer specialist coaching • Connecting participants to relevant services	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6586	4
CSS	TAOA-SD	Public Defender - Behavioral Health Assessor	Public Defender Discharge	Licensed mental health clinicians will provide discharge planning, care coordination, referral and linkage, and short term case management to persons with a serious mental illness who have been referred by the Court for services	Public Defender Treatment Unit will reduce untreated mental illness by ensuring persons are connected to system of care	Adults 18 years and older with a serious mental illness who are incarcerated or Transition Age Youth at designated detention facilities who will be released in San Diego County	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender 450 B St., Ste 1100 San Diego, CA 92101	All
CSS	TAOA-SD	San Diego Employment Solutions	San Diego Employment Solutions	Supported employment services and opportunities for Transition Age Youth, Adults and Older Adults with serious mental illness	Increase competitive employment of adults 18 and older who have a serious mental illness and who want to become competitively employed	Adults 18 years and older who have a serious mental illness and need assistance with employment	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness obtain competitive employment • Use a comprehensive approach that is community-based, client and family-driven, and culturally competent	Mental Health Systems, Inc. (MHS) Employment Solutions 10981 San Diego Mission Rd. # 100 San Diego, CA 92108 (619) 521-9569	All
CSS	TAOA-SD	San Diego Housing Commission	Housing Subsidy program	Administrative support for 180 San Diego Housing Commission subsidies	Provide support for housing	Adults 18 years and older who have a serious mental illness and are experiencing homelessness in the city of San Diego.	• Housing Vouchers/subsidies	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400	1, 2, 3, 4
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	START Vista Balboa, New Vistas, Halcyon, Crisis Center, Turning Point, Jary Barreto, Isis Crisis Center	Provide crisis residential services to individuals with serious mental illness and may have co-occurring substance use disorder	Provide urgent services in North Coastal, Central, East and South Regions of San Diego to meet the community-identified needs	Voluntary adults 18 years and older who may have a serious mental illness and who may have a co-occurring substance use disorder that are experiencing a mental health crisis, in need of intensive, non-hospital intervention and are residents of San Diego County	• 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 (619) 233-4399 CRF New Vistas Crisis Center (619) 239-4663 CRF Halcyon Crisis Center (619) 579-8685 CRF Turning Point (760) 439-2800 CRF Jary Barreto Crisis Center (619) 232-4357 CRF Del Sur Crisis Center (619) 575-4687	All
CSS	TAOA-SD	Short-Term Bridge Housing	Urban Street Angels (Transitional Shelter Beds for Transition Age Youth)	Short-term & Bridge Housing for Transitional Age Youth (TAY) with serious mental illness or serious emotional disturbance who are experiencing homelessness	The provision of housing and support services to TAY with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients	Transitional Age Youth, 18 to 24 years of age, who have a serious emotional disturbance or a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Emergency shelter and transitional beds • Case Management	Urban Street Angels, Inc. 1404 Fifth Ave San Diego, CA 92101 (619) 415-6616	4

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CSS	TAOA-SD	Short-Term Bridge Housing	United Homes	Residential transitional housing program that provides supportive services for adult men who are experiencing homelessness and have a serious mental illness.	• The provision of housing and support services to adult men with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. • Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adult men, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	United Homes 515 North Horne St. Oceanside, CA 92054 (760) 612-5980	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Ruby's House Independent Living	Residential transitional housing program that provides supportive services for adult women who are experiencing homelessness and have a serious mental illness.	• The provision of housing and support services to adult women with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. • Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adult women, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	4
CSS	TAOA-SD	Short-Term Bridge Housing	Interfaith Community Services	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Interfaith Community Services 550 W. Washington St., Suite B Escondido, CA 92025 (760) 489-6380	3, 5
CSS	TAOA-SD	Supplemental Security Income (SSI) Advocacy Services	Supplemental Security Income (SSI) Advocacy Services	Supplemental Security Income Advocacy services. Responsible for the submission of applications to the Social Security Administration and further follow-up as needed	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
CSS	TAOA-SD	Tenant Peer Support Services	Alpha Project for the Homeless	Housing navigation and support for persons with SMI who are experiencing homelessness.	On-going support for clients experiencing homelessness who are connected to permanent supportive housing resources. Services include housing navigation and tenant support services. Includes nonclinical services for MHSA developed units, such as NPLH units.	Adults 18 years and older with serious mental illness who are experiencing homelessness. Small number of families who are accessing family MHSA units will also be served.	• Support identifying and securing safe and affordable housing • Provides flex funds to support resident retention. • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project 2667 Camino Del Rio South, Suite 204 San Diego, CA 92108 (619) 542-1877	All
INN	INN-24	Early Psychosis Evaluation and Learning Health Care Network	Early Intervention for Prevention of Psychosis; Kickstart	Provide a collaborative Learning Health Care Network to support quality improvements, consumer engagement and provide use of measurement-based care in early psychosis (EP) programs.	Develop an Early Psychosis LHCN software app to support ongoing collaborative data-driven learning and program development to evaluate the effect of San Diego provider on consumer and program level outcomes.	Individuals served by Pathways Community Services' Kickstart program (contract 552662)	This is a software development contract	University of California, Davis 4701 X St. #1207 Sacramento, CA 95817 (916) 734-3247	All
INN	INN-22	Med Clinics	Center for Child and Youth Psychiatry (CCYP)	Outpatient psychiatric evaluation and medication support services utilizing face-to-face and telepsychiatry/telehealth practices for children and youth with complex psychiatric pharmacological needs.	Promote stabilization by providng psychiotropic medication support to children and youth, who require complex medication management.	Children and youth up to age 21 requiring on-going medicaiton support who have successfully completed a comprehensive mental health treatment with a system of care provider.	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	New Alternatives 8755 Aero Dr., Suite 306 & 320 San Diego, CA 92123 858) 634-1100	All
INN	INN-18	Peripartum Program	Accessible Depression and Anxiety Peripartum Treatment (ADAPT)	Identifies at-risk peripartum women for engagement and provides services for women and spouses	Reduce incidence and impact of postpartum depression and anxiety	Peripartum women and partners, especially in underserved	• Outreach and engagement through public health nurses • Trauma-infromed Interventions to treat and reduce negative consequences of postpartum depression and anxiety.	Vista Hill Foundation 6070 Mission Gorge Road San Diego, CA 92120 (858) 514-5100	All
INN	INN-21	ReST Recuperative Housing	Recuperative Services Treatment (ReST)	Provides post-institutionalization recuperative residential services, includes wrap-around services, case management, and permanent housing help	Prevent re-institutionalization and homelessness; encourages successful re-integration following institutionalization	Transition Age Youth	• Wrap-around services • Case management • Voluntary residential services • Employment and permanent housing support	Urban Street Angels, Inc. 3304 Idlewild Way San Diego, CA 92117 (619) 255-1842	All
INN	INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Southern Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the East Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN	INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the North Inland Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Indian Health Council, Inc. 50100 Golsh Road Valley Center, CA 92082 (760) 749-1410	2, 5
INN	INN-19	Telemental Health	BH Connect	Outpatient mental health services including crisis intervention, individual and family therapy, individual rehab,case management services utilizing tele-therapy/technolgy platform for children, youth and adults discharging from an emergency psychiatric service setting who are unconnected to a mental health provider.	Prevent re-hospitalization and psychiatric emergency services with follow up mental health services for successful connection to mental health treatment following a psychiatric emergency	Children, Transition Age Youth, Adults/Older Adults who have accessed psychiatric emergency services but are unconnected.	Follow-up mental health treatment and stabilization via tele-therapy including; • individual/family treatment • care coordination • case management • rehabilitative services • outreach and engagement	Vista Hill Foundation 8825 Aero Dr., Suite 315 San Diego, CA 92123 (858) 877-0179	All
PEI	CO-03	Integrated Peer & Family Engagement Program	Next Steps	Provides comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and/or substance use disorders. Services aim to engage clients by linking them to appropriate treatment and support services spanning the entire continuum of care, including behavioral health and primary care clinics to reduce the need for hospitalizations.	The program assists participants with increases resiliency and self-care, reduced consumption of alcohol and drugs, improved medication adherence, decreased depression and anxiety, reduced problems commonly associated with SUD, and improved mental and physical wellness. The program also links to participants to treatment and other community resources as needed.	Adults 18 years and older	• Walk-in center and services in community clinics and SDCPH • Screening, brief treatment, and referrals and linkages to resources and services in the community	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	DV-03	Community Violence Services - Alliance for Community Empowerment	Alliance for Community Empowerment	Provides trauma informed, community centered, family driven and evidenced based Community Violence Response services, support, referrals and linkages to care countywide	Increase in resilience; increased knowledge of services; increased problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma	Community members including middle-school age youth boys and girls affected by community violence	• Immediate support and assistance, referrals and linkages to care after an incidence of community violence. • Grief counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities (UPAC) 5348 University Ave., Suites 101 and 102 San Diego, CA 92105 (619) 232-6454	All
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF - South Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF Central & North Central Regions	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Social Advocates for Youth 8755 Aero Dr., Suite 100 San Diego, CA 92123 (858) 565-4148	4
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF East Region	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Establish a community safety net to ensure the safety and well being of children and their families	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Home Start 5005 Texas St., Suite 203 San Diego, CA 92108 (619) 629-0727	2
PEI	DV-04	Community Services for Families - Child Welfare Services	CSF - North Coastal/North Inland	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Provides family preservation, family support, and family reunification services to children and families in the CWS system	Children 0 to 17 years old and their families at a high risk of child abuse and neglect	• Case management • In-Home Parent Education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	3, 5
PEI	EC-01	Positive Parenting Program (Triple P)	Positive Parenting Program (Triple P)	Provides mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum	Specialized culturally and developmentally appropriate mental health PEI services to promote social and emotional wellness for children and their families	Countywide parents and families; parents and guardians of children enrolled in Head Start, Early Head Start, elementary school and community center locations	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Service 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3000 ext. 3006	All
PEI	FB-01	Early Intervention for Prevention of Psychosis	Kickstart	Provides Prevention and Early Intervention (PEI) services for persons who have emerging 'prodromal' symptoms of psychosis	Reduce incidence and severity of mental illness and increase awareness and usage of services	Countywide youth 10 to 25 years old in San Diego County and their families & substantial public component on psychosis	• Prevention through public education • Early intervention, through screening potentially at risk youth • Intensive treatment for youth who are identified as at-risk and their families	Pathways of California Kickstart Program 6160 Mission Gorge Rd., Suite 100 San Diego, CA 92120 (858) 637-3030	All
PEI	NA-01	Native American Prevention and Early Intervention	Southern Indian Health Council, Inc.	Provides PEI and substance use disorder prevention and treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in South and East County	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PEI	NA-01	Native American Prevention and Early Intervention	Indian Health Council, Inc.	Provides PEI and substance use disorder prevention and treatment services for Native Americans	Increase community involvement and education through services designed and delivered by Native American communities	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; North Regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services • Child abuse prevention case management to Native Americans in North County	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	5
PEI	NA-01	Native American Prevention and Early Intervention	San Diego American Indian Health Center	Provides PEI services for Native American Indian/Alaska Native urban youth	Increase community involvement and education through services designed and delivered by Native American communities	At risk and high risk urban American Indian and Alaska Natives children and Transitional Age Youth	• Specialized culturally appropriate prevention and early intervention services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center	San Diego American Indian Health Center 2602 1st Ave., Ste. 105 San Diego, CA 92103 (619) 234-1525	4
PEI	OA-01	Elder Multicultural Access & Support Services (EMASS)	Elder Multicultural Access & Support Services (EMASS)	Provides outreach and support to older adults, especially non-Caucasian/non-English speaking	Reduce ethnic disparities in service access and use. Increases access to care	Multicultural Seniors, refugees, 60 years and older who are at risk of developing mental health problems	• Outreach and education • Referral and linkage • Benefits advocacy • Peer counseling • Transportation services • Home and community based services	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	All
PEI	OA-02	Home Based Services - For Older Adults	Positive Solutions	Provides outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduces stigma associated with mental health concerns and disparities in access to services	Homebound older adults 60 years and older who are at risk for depression or suicide	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	1, 4, 5
PEI	OA-06	Caregiver Support for Alzheimer & Dementia Patients	Caregivers of Alzheimer's Disease and Other Dementia Clients Support Services	Provides caregiver education, training, and early intervention services to prevent or decrease symptoms of depression and other mental health issues among caregivers	Reduce incidence of mental health concerns in caregivers of patients that have Alzheimer's and other types of dementia. Improve the quality of well-being for caregivers and families. Provides services to an underserved/unserved population	Adult Caregivers 18 years and older	• Outreach • Information dissemination • Early intervention • Prevention Education	Southern Caregiver Resource Center 3675 Ruffin Rd. San Diego, CA 92123 (858) 268-4432	All
PEI	PS-01	Breaking Down Barriers (BDB) Initiative	Breaking Down Barriers	Outreach, engagement and community organizing across all communities to reduce the stigma associated with mental illness and improve mental health well-being	Reduce mental health stigma to culturally diverse, unserved and underserved populations	Unserved and underserved populations; Latino; Native American; African; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); African-American	• Outreach and education to reduce mental health stigma to culturally diverse, unserved and underserved populations • Collaboration with community based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Jewish Family Services of San Diego 8804 Balboa Ave San Diego., CA 92123 (858) 637-3000	All
PEI	PS-01	Come Play Outside	Come Play Outside	Offers community-based programming inclusive of Parks After Dark curriculum to support the health and wellness of children, youth, and families.	The program aims to connect participants with outdoor activities within their community to increase pro-social interactions, promoting wellness, positive self-image while emphasizing confidence, respect, and a sense of responsibility.	• Children, youth and their families	• Outreach and engagement	City of San Diego Parks & Recreation Department 202 C W St. San Diego, Ca 92101 (619) 525.8211	All
PEI	PS-01	Family Peer Support Program	Family Peer Support Program (In Our Own Voice & Friends in the Lobby)	Provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes	Family members and friends of psychiatric inpatients	• Resources and support to family and friends visiting loved ones in psychiatric inpatient units in San Diego area • Public education	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	PS-01	Mental Health First Aid	Mental Health First Aid	Mental Health First Aid is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis	Provide county-wide community- based mental health literacy education and training services	Adults/Older Adults who work with youth	• Interactive class that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All
PEI	PS-01	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	Suicide Prevention & Stigma Reduction Media Campaign	Countywide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increases awareness of available mental health services	Countywide individuals with mental illness; families of individuals with mental illness; general public	• Public media campaign to education and promote mental health awareness • Print, radio, and TV ads • Printed materials	Rescue Agency Public Benefit, LLC 2437 Morena Blvd San Diego, CA 92110 (619) 231-7555	All
PEI	PS-01	Suicide Prevention Action Plan	Suicide Prevention Action Plan	Provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies.	Reduce the number of suicides in San Diego County. Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	General population, mental health service consumers, local planners, and mental health organizations.	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives • Facilitate Suicide Prevention Council and workgroups	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
PEI	PS-01	Supported Employment Technical Consultant Services	Supported Employment Technical Consultant Services	Provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Services are coordinated and integrated through BHS to develop new employment resources	Supported Employment TA will develop 5-Year Strategic Plan and implement strategies within BHS programs that include Supported Employment. TA will also operate as sub-committee of the BHS Adult Council.	Service providers, employers, agencies, government organizations, and other stakeholders	• Promote employment opportunities for adults with serious mental illness	San Diego Workforce Partnership, Inc. 9246 Lightwave Ave. #210 San Diego, CA 92123 (619) 228-2900	All
PEI	RC-01	Rural Integrated Behavioral Health and Primary Care Services	Integrated Behavioral Health and Primary Care Services in Rural Communities	Provides for prevention and early intervention services. Program works in partnerships with various primary care clinics in rural areas and utilizes a Screening, Brief Intervention and Referral to Treatment (SBIRT) model to identify persons at risk for behavioral health issues. Treatment services are strengths-based, time limited and embrace the concepts of resilience and recovery for adults and children with severe emotional disturbance (SED), and their families.	Program staff provide health education and community engagement events, brief behavioral health interventions, psychiatric consultations, case management services, wellness screenings and referrals to treatment.	Children, Transition Age Youth, Adults/Older Adults	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725	All
PEI	RE-01	Independent Living Association (ILA)	CHIP Independent Living Association (ILA)	Provide and manage an Independent Living Association and Recovery Residence Association, which are a resource to identify, promote, and develop independent living, build their capacity, and direct those individuals in need of such services to available resources in the community.	Promote the highest quality home environments for adults with severe mental illness and other disabling health conditions. Serve residents that do not need medication oversight, are able to function without supervision, and live independently	Member operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources countywide	• Education and training to member operators and residents. • Website listings • Resources to support clients • Resources to develop their business • Marketing tools • Advocacy support	Community Health Improvement Partners 5059 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	SA-01	School Based Prevention and Early Intervention	San Diego Unified School District - School Based PEI Central and North Central	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public 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 public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	3, 4
PEI	SA-01	School Based Prevention and Early Intervention	San Diego Unified School District - School Based PEI Central and Southeastern	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public 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 public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	4
PEI	SA-01	School Based Prevention and Early Intervention	Vista Hill - School Based PEI North Inland	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public 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 public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation 1029 N. Broadway Escondido, CA 92026 (760) 489-4126	5
PEI	SA-01	School Based Prevention and Early Intervention	Palomar Family Counseling - School Based PEI North Coastal Region	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public 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 public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
PEI	SA-01	School Based Prevention and Early Intervention	San Diego Youth Services - School Based PEI East	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public 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 public schools. Refugee children pre-school through 3rd grade who struggle with transitioning and would benefit from small groups	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement • Assimilation groups for refugee children/parents.	San Diego Youth Services 3845 Spring Dr. Spring Valley, CA 91977 (619) 258-6877	2
PEI	SA-01	School Based Prevention and Early Intervention	SBCS Corp - School Based PEI South	Early intervention services utilizing a family focused approach and evidenced based curriculum to provide social-emotional groups to parents and children as well as identified classrooms in designated public 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 public schools	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	SA-02	School Based Suicide Prevention & Early Intervention	HERE Now	Provides school based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth	Reduces suicide ideation, suicides, bullying and the negative impact of suicide in schools. Increases education of community and families.	Middle school, high school, and Transition Age Youth	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600	All
PEI	VF-01	Veterans & Family Outreach Education	Courage to Call	Provides confidential, peer- staffed outreach, education, referral and support services to the Veteran community & families and its service providers	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors and/or stressors. Improves access to mental health and PEI services, information and support	Veterans, active duty military, Reservists, National Guard, and family members	• Education • Peer counseling • Linkage to mental health services • Mental health information • 7/24/365 Support hotline	Mental Health Systems, Inc. (MHS) 9445 Farnham St., Suite 100 San Diego, CA 92123 (858) 636-3604	All

Component	Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
WET	WET-02	Behavioral Health Training Curriculum (BHTC)	Behavioral Health Training Curriculum	The Behavioral Health Training Curriculum provides training and technical assistance to County and County contracted behavioral health staff on best practices that incorporate principles of trauma informed care, cultural competency, and mental health/substance use co-occurring disorders and primary care/behavioral health integration. Training is provided in all mediums: in-person, eLearning, and webinar.				San Diego State University Research Foundation 5250 Campanile Dr. San Diego CA 92182 (619) 594-1900	All
WET	WET-02	Cultural Competency Academy	Cultural Competency Academy	The Cultural Competency Academy (CCA) provides training to BHS and BHS contracted staff with trainings focused on clinical and recovery interventions for multicultural populations. The goal of CCA is to provide awareness, knowledge and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications.				San Diego State University Research Foundation 5250 Campanile Dr. San Diego, CA 92182 (619) 594-1900	All
WET	WET-02	Training and Technical Assistance	Training and Technical Assistance	Provide administrative and fiscal training support services to County of San Diego Health and Human Services, Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop and execute training contracts between RTC and trainers/consultants, coordinate with BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs.				Regional Training Center 6155 Cornerstone Ct., Suite 130 San Diego, CA 92121 (858) 550-0040	All
WET	WET-03	Public Mental Health Academy	Public Mental Health Academy - Academic Counselor	Provide an academic counselor to support student success in the community based public mental health certificate program. This certificate program assists individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be matriculated into an Associates and/or Bachelor Degree program to assist in the career pathway continuum				San Diego Community College District 3375 Camino Del Rio South San Diego, CA 92108 (619) 388-6555	All
WET	WET-04	Community Psychiatry Fellowship	The Residency and Internship Program (Community Psychiatry Program)	Programs are for physicians and public mental health nurse practitioners with one program for adult psychiatry residents and fellows and another program for child and adolescent psychiatry residents and fellows and up to seven public mental health nurse practioners who are studying at local universities. Programs foster the development of leaders in Community Psychiatry and provide exposure to the unique challenges and opportunities, and targeted approaches to ethnically and linguistically diverse populations.				Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All

APPENDIX D

MHSA JUSTICE INVOLVED PROGRAMS

Population Served	*Program Name and Description*	*FY 2022-23 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.	$ 2,000,000	CSS
All Ages	The **Psychiatric Emergency Response Team (PERT)** provides mental health consultation, case coordination, linkage to services and limited crisis intervention services for individuals with mental illness who come in contact with law enforcement officers.	$ 9,377,617	CSS
Youth	The **Bridgeways** program is a newly redesigned juvenile justice program that provides comprehensive services to address the behavioral health needs of justice involved youth or youth at risk of justice involvement. The program provides outpatient clinical services, field supportive services, and institutional services with the primary goal of establishing a unified continuum of care that allows for coordination of services within and outside the detention facilities.	$ 560,000	CSS
Youth	The **County of San Diego Juvenile Forensics** team provides mental health and case management services to children and youth in juvenile detention facilities to ensure they are able to successfully reintegrate into the community and to reduce recidivism.	$ 1,100,000	CSS
Youth	**Mobile Adolescent Service Team (MAST)** is an outpatient treatment program that serves children and youth in the community who are involved with the justice system. The program enhancement allows for increased psychiatry coverage.	$ 2,165,000	CSS
Youth	**Juvenile Court Clinic** provides assessment, medication management services and case management for juveniles involved in the Court system.	$ 847,000	CSS
Transitional Age Youth	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) program for Transition Age Youth (TAY)** provides services to TAY who are homeless, may have been referred by jail services, are experiencing serious mental illness (SMI), and who may also have a co-occurring substance use disorder.	$ 5,250,116	CSS
Adults	The **Faith Based Wellness and Mental Health Inreach Ministry** program focuses on adults diagnosed with SMI while in jail and also engages individuals with schizophrenia or bipolar disorders to provide spiritual support, wellness education for physical and mental health, and linkages to community- based resources for reintegration into the community.	$ 949,690	CSS
Adults	The **Justice Integrated Full Service Partnership (FSP) Assertive Community Treatment (ACT)** program provides services to homeless adults with a SMI who may also have a co-occurring substance use disorder. Clients served are system involved and have received mental health services while in detention. An array of housing options is provided to enrolled clients. Includes new program rows added to Center Star.	$ 5,693,167	CSS
Adults	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) for Persons with High Service Usage and Persons on Probation** program provides multidisciplinary, wraparound treatment and rehabilitation services, along with housing.	$ 3,055,060	CSS
Adults	The **Collaborative Behavioral Health Court and Assertive Community Treatment** program focuses on adults in the Central Region who are referred by the Court for services as an alternative to custody.	$ 2,876,000	CSS
Adults	The **Public Defender Discharge and Short Term Case Management Service** adds two licensed mental health clinicians to provide discharge planning, care coordination, referral and linkage to services, and short term case management for persons with SMI who have been referred by the Court for services.	$ 240,000	CSS
Adults	**Justice System Discharge Planning**, or Project Enable, provides in-reach services to assist with discharge planning and short- term transition services for clients who are in jail and identified to have SMI, to assist in connecting clients with community- based treatment once released.	$ 925,000	CSS
Adults	**Probation Officers for BH Court and FSPs** are dedicated to specific Assertive Community Treatment teams to provide support and case management of individuals with SMI who are on probation.	$ 600,000	CSS
Adults	The **Behavior Health Assessor** is a program within the Lemon Grove Family Resource Center that provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 250,000	CSS
Adults	The **BH Assessor** is a program for Courts in South and Central Regions the provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 435,000	CSS
Adults	The **Veterans & Family Outreach Education** program, or Courage to Call, is a veteran peer-to-peer support program staffed by veteran peers. The program provides countywide outreach and education to address the mental health conditions that impact veterans, active duty military, reservists, National Guard, and their families (VMRGF), and provides training to service providers of the VMRGF community. This program includes navigator assistance in Veterans' Court for those involved with the justice system.	$ 1,280,000	PEI
Grand Total		**$ 37,603,650**	

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

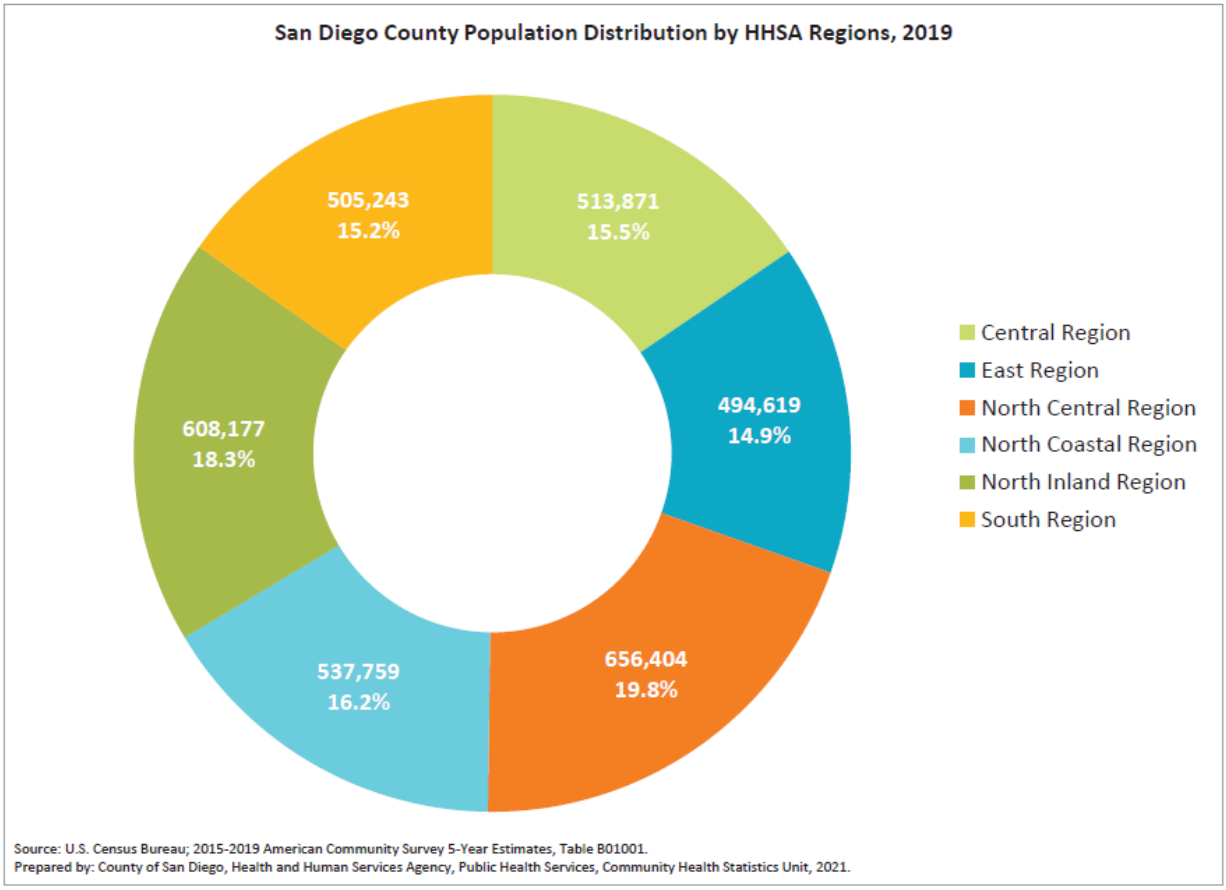
APPENDIX E

COUNTY OF SAN DIEGO DEMOGRAPHICS

POPULATION

HHSA Region	Population	%
Central Region	513,871	15.5%
East Region	494,619	14.9%
North Central Region	656,404	19.8%
North Coastal Region	537,759	16.2%
North Inland Region	608,177	18.3%
South Region	505,243	15.2%
San Diego County	3,316,073	100.0%

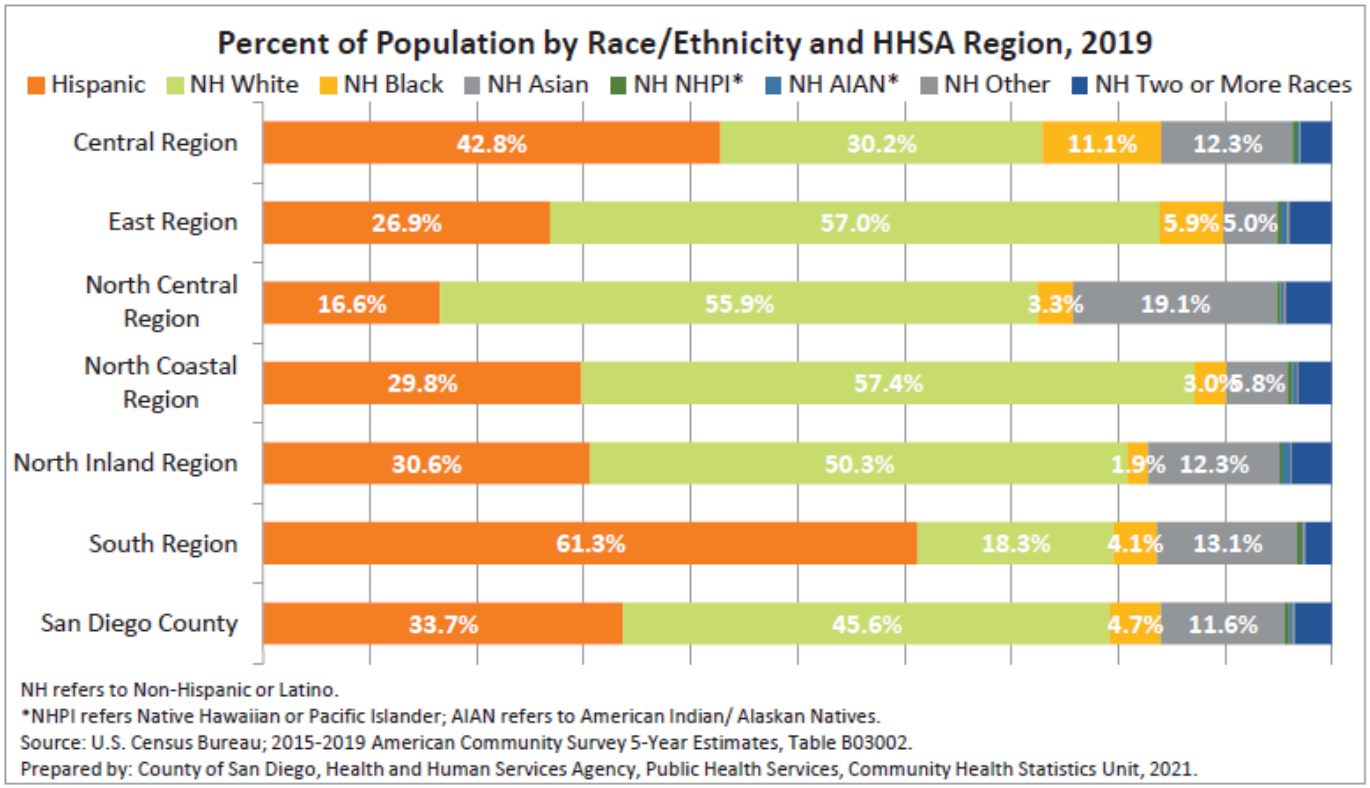
Source: U.S. Census Bureau; 2015-2019 American Community Survey 5-Year Estimates, Table B01001.



RACE/ETHNICITY

HHSA Region	Hispanic	Non-Hispanic White	Non-Hispanic Black	Asian Alone	Native Hawaiian/ Pacific isalnder	American Indian/ Alaskan Native	Some Other Race Alone	Two or More Races
Central Region	219,785	154,985	57,157	63,089	2,106	1,070	742	14,937
East Region	132,952	282,044	29,322	24,829	2,256	2,697	1,152	19,367
North Central Region	108,802	366,972	21,652	125,268	2,124	1,661	1,900	28,025
North Coastal Region	160,262	308,468	16,047	30,946	2,220	2,153	914	16,749
North Inland Region	186,153	305,893	11,378	75,094	1,718	4,316	1,014	22,611
South Region	309,563	92,394	20,528	66,431	2,323	577	838	12,589
San Diego County	1,117,517	1,510,756	156,084	385,657	12,747	12,474	6,560	114,278

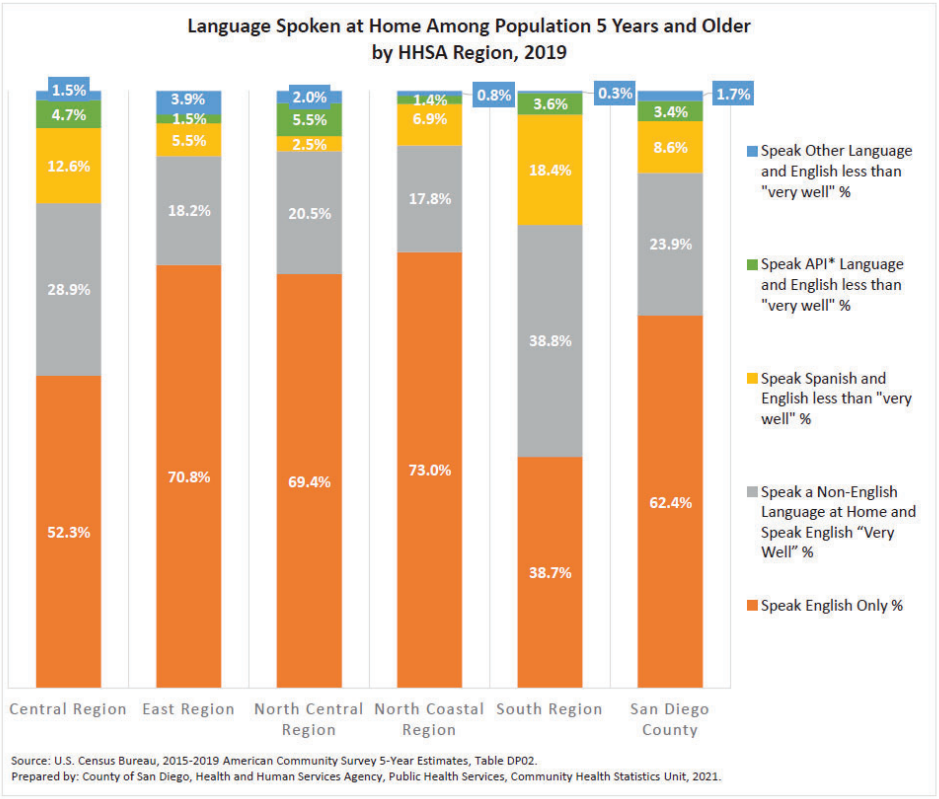
Source: U.S. Census Bureau; 2015-2019 American Community Survey 5-Year Estimates, Table B03002



LANGUAGE SPOKEN (5 YEARS OLD AND GREATER)

HHSA Region	Population Age 5+	Speak English only	Speak a non-English language at home and English "Very Well"	Speak Spanish Speak English less than "Very Well"	Speak Asian and Pacific Islander languages and Speak English less than "Very Well"	Speak Other Language and Speak English less than "Very Well"
Central Region	483,695	52.3%	28.9%	12.6%	4.7%	1.5%
East Region	460,674	70.8%	18.2%	5.5%	1.5%	3.9%
North Central Region	619,618	69.4%	20.5%	2.5%	5.5%	2.0%
North Coastal Region	501,671	73.0%	17.8%	6.9%	1.4%	0.8%
North Inland Region	567,724	66.9%	20.6%	7.9%	3.2%	1.4%
South Region	473,011	38.7%	38.8%	18.4%	3.6%	0.3%
San Diego County	3,106,393	62.4%	23.9%	8.6%	3.4%	1.7%

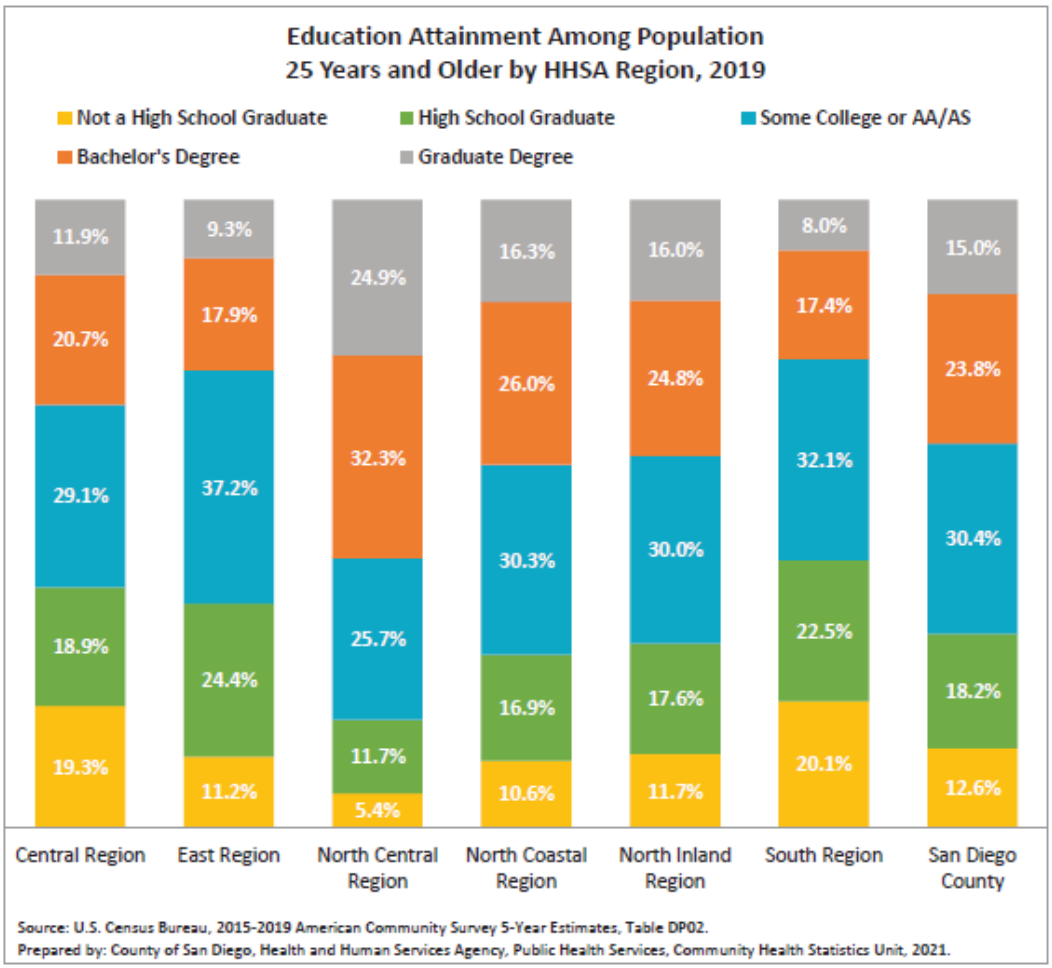
Source: U.S. Census Bureau; 2015-2019 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.



LEVEL OF EDUCATION

HHSA Region	Population Age 25+	Not a High School Graduate	High School Graduate	Some College or AA	Bachelor's Degree	Graduate Degree
Central Region	351,180	19.3%	18.9%	29.1%	20.7%	11.9%
East Region	337,713	11.2%	24.4%	37.2%	17.9%	9.3%
North Central Region	459,104	5.4%	11.7%	25.7%	32.3%	24.9%
North Coastal Region	356,015	10.6%	16.9%	30.3%	26.0%	16.3%
North Inland Region	411,255	11.7%	17.6%	30.0%	24.8%	16.0%
South Region	331,304	20.1%	22.5%	32.1%	17.4%	8.0%
San Diego County	2,246,571	12.6%	18.2%	30.4%	23.8%	15.0%

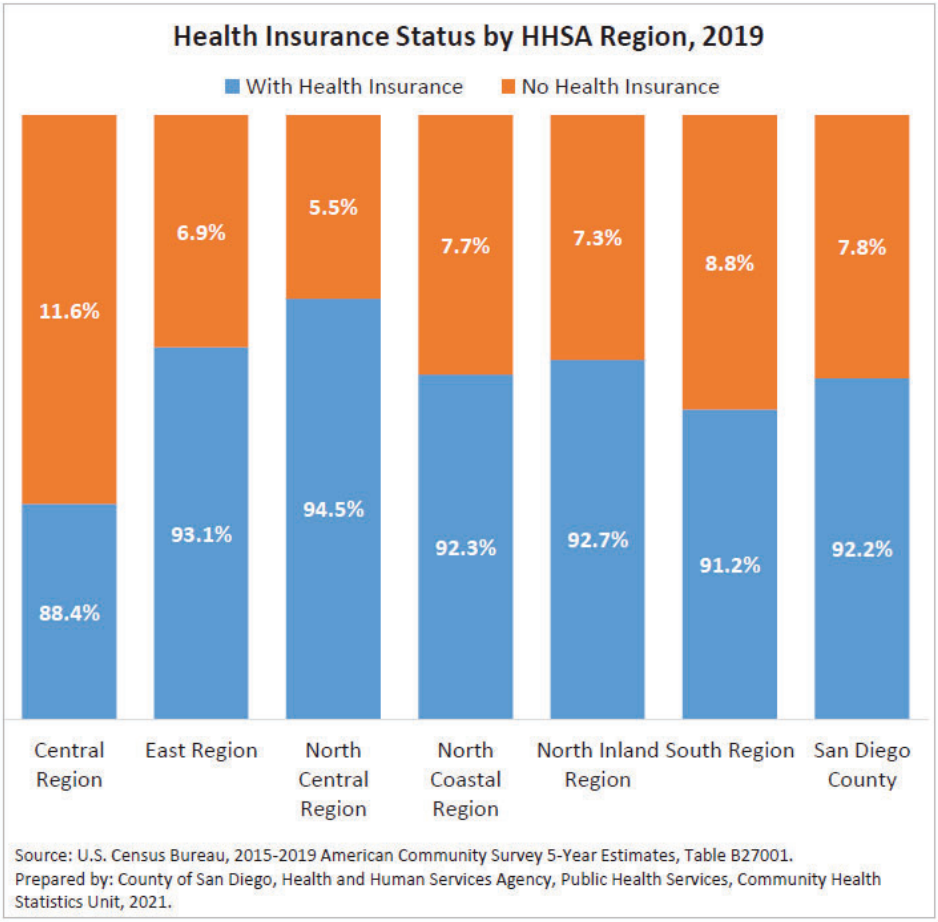
Source: U.S. Census Bureau; 2015-2019 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.



INSURED AND UNINSURED

HHSA Region	With Health Insurance	No Health Insurance	0-18 w/ Health Insurance	19-25 w/Health Insurance	26-44 w/Health Insurance	45-64 w/Health Insurance	65+ w/Health Insurance
Central Region	88.4%	11.6%	95.5%	83.9%	83.0%	86.9%	98.6%
East Region	93.1%	6.9%	95.6%	88.7%	89.0%	93.2%	98.9%
North Central Region	94.5%	5.5%	97.3%	92.0%	91.6%	94.6%	99.1%
North Coastal Region	92.3%	7.7%	96.4%	87.2%	86.9%	91.3%	98.8%
North Inland Region	92.7%	7.3%	96.7%	86.2%	86.9%	92.6%	99.0%
South Region	91.2%	8.8%	95.4%	86.1%	86.6%	90.2%	97.9%
San Diego County	92.2%	7.8%	96.2%	87.6%	87.5%	91.7%	98.8%

Source: U.S. Census Bureau; 2015-2019 American Community Survey 5-Year Estimates, Table B27001.
Note that percentages may not add up to 100% due to rounding.



APPENDIX F

COMMUNITY ENGAGEMENT REPORT 2022

County of San Diego Health and Human Services Agency
Behavioral Health Services

Community Engagement Report

MHSA Community Program Planning



Mental Health Services Act (MHSA)
Fiscal Year 2021-2022 Annual Update

LIVE WELL SAN DIEGO

UC San Diego

Contents

Introduction 3

COVID-19 Impacts 3

Advancing Diversity and Health Equity 3

Chapter 1 Background and Purpose 4

Chapter 2 4

Behavioral Health Advisory Board and System of Care Councils 4

Additional Community Engagement Events Hosted by COSD BHS 7

Key Stakeholder Findings 9

Breaking Down Barriers (BDB) 9

County of San Diego: Involving Stakeholder Input through Diverse Efforts 11

Chapter 3 – Community Experience Partnership 13

Overview 13

Community Experience Dashboard (CED) 13

Behavioral Health Equity Index (BHEI) 14

Community Profiles and Action Reports (CP/AR) 15

Chapter 4 New Engagement Strategies 16

Chapter 5 MHSA Stakeholder Training 17

Appendices 18

Appendix 1: MHSA Stakeholder Training Summary 18

Introduction

The Mental Health Services Act (MHSA) provides a substantial amount of the funding for the County of San Diego (COSD) Health and Human Services Agency (HHSA) Behavioral Health Services (COSD BHS) Department. The fiscal support of the MHSA offers critical resources to support the San Diego County region's historically marginalized populations and serves all ages, including children, youth, transition-age youth, adults, older adults, and families. MHSA funding supports prevention and early intervention, treatment services, and the development of critical infrastructure, technology, and training to support the public mental health system. The MHSA aims to increase access to the unserved, and the underserved individuals and families by reducing disparities in the service delivery system for children presenting with Social Emotional Disturbance (SED), adults, and older adults with Serious Mental Illness (SMI). Integral to the MHSA is a required Community Program Planning (CPP) process, through which counties gather input from a diverse range of stakeholders as to the needs and priorities of community members. The community engagement process is designed to identify and gather information regarding the needs of regional unserved and underserved populations. In addition, the COSD BHS maintains regular contact with the public through interactive councils and advisory boards and stakeholder engagement throughout the year to inform program planning and development of the COSD BHS continuum of care.

COVID-19 Impacts

The COVID-19 pandemic greatly impacted the delivery of behavioral health services within the community; however, the COSD BHS continued to make forward progression in shifting how residents of San Diego County access care and support for behavioral health needs. In Fiscal Year 2021-22 (FY 21-22), the County infused additional financial, staffing, and other resources into behavioral health services, which are more critical than ever post pandemic. Although the delivery of behavioral health services has been impacted by the pandemic in FY 21-22 and outreach has been challenging, engagement efforts continue, incorporating stakeholder perspectives in multiple aspects of planning and service delivery.

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 (SMI) or Social-Emotional Disturbance (SED) with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. These programs serve individuals of all ages, providing support to the County's most vulnerable, unserved, and underserved populations.

The community need for behavioral health services continues to increase, especially among the most vulnerable populations and in the wake of the COVID-19 pandemic. To guide clinical service design and placement, and to ensure effective outcomes are achieved, the COSD BHS continues to enhance data integration and health equity work through the establishment of the COSD BHS Data Sciences and Population Health units. Additionally, COSD BHS is partnering with the University of California San Diego (UC San Diego), to develop the Community Experience Partnership (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs.

The COSD BHS further demonstrates its commitment to implementing health equity, diversity, and inclusion initiatives through procurements and contracting, specifically requiring outreach and engagement with underserved, unserved, and historically hard-to-reach communities.

Chapter 1

Background and Purpose

The COSD BHS has created infrastructure to conduct ongoing community engagement as part of the MHSA Community Program Planning (CPP) Process. The COSD BHS solicits feedback from the community inclusive of all stakeholders about behavioral health needs to gather input about how to better serve San Diego residents and meet the requirements of the MHSA. Community members are asked to discuss pressing behavioral health issues and ways to better engage and serve the community; they also brainstorm ideas about new programs and services. Community Stakeholders (members) is inclusive of all stakeholder groups as identified in the MHSA. Input gathered from all stakeholders through various venues is used to inform the development of new programs and/or the expansion or modification of existing programs.

In FY 21-22, the COSD BHS prioritized further enhancement of data integration, and advancement of diversity and health equity work by expanding data sciences and population health capacities within BHS. BHS partnered with UC San Diego to develop the Community Experience Partnership (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and systemic and regional inequities. Another priority of the COSD BHS was to move ahead with the transformation of the behavioral health continuum of care and address urgent behavioral health needs of our communities through the expansion of crisis services such as Mobile Crisis Response Teams (MCRTs) and new crisis stabilization units (CSUs).

The purpose of the County of San Diego Behavioral Health Advisory Board (BHAB) is to review and evaluate the community's behavioral health needs, services, programs, facilities, and procedures used to ensure stakeholder (inclusive of all MHSA stakeholders) involvement in the planning process. BHAB identified following priority areas of focus for 2022, with an emphasis on enhancing BHAB's value to the community: criminal justice, alcohol and other drug prevention, behavioral health workforce challenges, and building community and stakeholder engagement.

Throughout the year, the COSD BHS engages in open dialogue with the BHAB, System-of-Care (SOC) Councils (SOC), various stakeholders and stakeholder-led councils, organizations, and individuals in various settings to determine priorities, solicit feedback and make recommendations for the utilization of MHSA funds.

Chapter 2

Behavioral Health Advisory Board and System of Care Councils

The engagement efforts of the COSD BHS system of care are centered on intentional and meaningful outreach. The primary council is the Behavioral Health Advisory Board (BHAB), which serves as the primary oversight and engagement board for the COSD BHS system. BHAB is elevating its commitment to optimization of its utility, strategic planning over the next five years, actively identifying improved

communication channels from the County of San Diego Board of Supervisors (BOS) to COSD BHS, COSD BHS to BHAB, direct correspondence from members to their elected officials, and cultivating provider and other stakeholder engagement.

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

1. The Cultural Competence Resource Team (CCRT) serves as an advisory body to the COSD BHS Director. The CCRT is composed of multi-agency stakeholders, consumers and community-based organizations. Input, feedback and recommendations are provided to the MHSA Annual Update, health equity and other major BHS initiatives in alignment with the FY 21-22 priorities of the COSD BHS.

2. The Adult System of Care Council in their advisory capacity to BHS participate in system and programmatic planning and development efforts for systemwide needs for the public adult system of care for San Diego County.

3. The Children, Youth, and Families Behavioral Health System of Care Council (CYF) vision is wellness for children, youth, and families throughout their lifespan. The mission is to advance systems and services to ensure that children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families. The CYF SOC Council relies on 10 principles, ranging from collaboration and integration to ensuring that services and programs are child, youth, and family driven. It is grounded in a four-sector partnership inclusive of family/youth, private, public, and education.

4. The Housing Council facilitates design, implementation, and evaluation of housing for individuals with serious mental illness by providing feedback and recommendations to the COSD BHS Director and Executive Team. The Housing Council provided input, feedback and recommendations to the development of the 5-year BHS Strategic Housing Plan through extensive stakeholder participation to address the behavioral health needs of individuals at risk of or experiencing homelessness or housing insecurity.

5. The Older Adult Council's role and function include: 1) making recommendations related to the development of the Older Adult System of Care; 2) provide consultation and feedback to help understand what is and what is not working for older adults; 3) facilitate the exchange of information across all sectors of the system of care; 4) provide community representation and input for the integrity of all services and advancement of all aspects of the SOC; and 5) provide recommendations and feedback to the COSD BHS Director regarding the progress and future expansion of all OA Behavioral Health programs and services. The membership shall include up to 30 voting members. It is led by the Chair and Chair-Elect. The Chair-Elect is nominated by the Nominating Committee. Each position is held for one year with the Chair-Elect becoming the Chair the following year.

6. The Transitional Age Youth Behavioral Health Services Council (also known as TAYBHSC) provides feedback and recommendations regarding Transitional Age Youth (TAY-ages 16 to 25) services in the Children, Youth and Families (CYF) and the Adult and Older Adult (AOA) systems of care. Additionally, TAYBHSC provides community representation and input for the integrity of all TAY services and advancement of all TAY related aspects of the systems of care.

SOC Councils promote the *Live Well San Diego* Vision and COSD Board of Supervisors Framework for Our Future, recognizing the Pandemic and Racial Justice context, while considering population health and social determinants of health. Councils evaluate the SOC and advocate for needed adjustments with recognition of the economic effects of the pandemic and impacts to the community. Councils provide input for MHSA Community Engagement events and COSD BHS Forums.

As one example, the CYF SOC Council, as part of integration of the comprehensive Harm Reduction Strategy, facilitated a panel discussion which highlighted some of the key opportunities, strategies, and considerations needed regarding the Harm Reduction initiative. Open discussion included a diverse range of stakeholders – youth, National Alliance on Mental Illness (NAMI) representatives, local health clinic and substance use disorder services providers, adult consumers, among others, and responded to a wholistic discussion centered on:

1. How does integrating a Harm Reduction philosophy and practice affect your work?
2. What is the impact on clients by utilizing a Harm Reduction model of service?
3. What challenges are you experiencing/anticipating while moving towards a Harm Reduction approach? How are you addressing them?
4. What successes have you experienced by introducing Harm Reduction strategies?
5. What changes do you hope to see in the System of Care as a result of the Harm Reduction Strategy?

Stakeholder Engagement Workgroup

In FY 21-22 the BHAB continued hosting a stakeholder engagement ad hoc workgroup whose primary objective is equitable representation of stakeholders to best address issues related to how the COSD BHS and the community engage in relation to behavioral health challenges. Workgroup recommendations include the COSD BHS and BHAB working together to realign responsibilities related to the budget planning process outlined in the MHSA Three-Year Plan and Annual Update, as well as the Community Program Planning Process, and collaboration with the County to improve engagement by developing a public facing website and utilizing social media outlets to disseminate information. Priorities for this workgroup include workforce development and diversity, culturally responsive practices, timely scheduling of reports and data, and stakeholder engagement funding opportunities. The Stakeholder Engagement Workgroup's strategic goals include: 1) Being fully engaged in the Community Program Planning (CPP) Process; 2) Engaging workforce to include identifying scholarships and/or grants for advanced degree students in behavioral health, diversifying workforce, and creating innovative incentives to recruit and maintain professionals in the County; and 3) Continuum of Care (COC) improvements such as reducing barriers to care, streamlining prescription processed at pharmacies, monitoring contractor outcomes, and building new programs.

Additional Community Engagement Events Hosted by COSD BHS

In addition to the year-round BHAB and SOC Council engagement efforts as part of the Community Program Planning process, the COSD BHS has conducted engagement and outreach through other mechanisms in FY 21-22. Those efforts included:

- The Community Harm Reduction Team Implementation (C-HRT): Developed in partnership with the City of San Diego and the San Diego Housing Commission, the C-HRT is a clinical team that focuses on outreach and engagement of homeless individuals, particularly those with substance abuse issues.

- The CalAIM Community Forum (September 2021) was a forum that hosted over 200 participants to provide an overview on Medi-Cal and CalAIM. The forum afforded an opportunity for community feedback, and participants were encouraged to attend a future event.

- Ongoing efforts centered on gathering stakeholder feedback about the plan to build a Psychiatric Health Facility in Oceanside (i.e., North San Diego County), which will be operated by Tri-City Medical Center. A public meeting was held to provide information and answer questions from the public and included the participation of the local Board of Supervisors representative.

- San Diego Housing Federation (SDHF) Roundtable Series (housingsandiego.org) where the SDHF hosted several educational seminars throughout FY 21-22 on relevant, timely topics to keep members and the general public informed and enhance their professional impact in affordable housing or a related field. Topics in FY 21-22 included: actualizing diversity, equity, and belonging, housing accountability unit, and financing affordable housing.

- The *Live Well San Diego* (LWSD) Youth Sector in collaboration with CYF hosted the Amplifying Voices: "What You(TH) Want Mental Health Professionals to Know" virtual Town Hall (December 2021). The Amplifying Voices Series: Supporting Youth Mental Health was held on December 3, 2021. Of the 38 attendees at the event, the majority (73.7%) were 25 years and older, 15.8% were between the ages of 18-24, 5.3% were between the ages of 13-17 and only 2.6% were under 12 years of age. Almost half of attendees (48.6%) identified as White or Caucasian, about one-third (31.4%) identified as Hispanic or Latinx, 8.6% as Black or African American, 5.7% as Asian or Pacific Islander and 5.7% selected "prefer not to say." About three-quarters (75.7%) identified as female, 13.5% as male, 8.1% as non-binary and 2.7% as transgender male.

  The youth-identified areas of improvement included: lack of personalized engagement, issues often downplayed, unsupportive systems, and stigma and misinformation. The experiences youth reported were that they do not always feel they are being included in the development of their treatment plan and that their caregivers sometimes overlook the issues they face. Youth expressed that they struggle with attaining a diagnosis and treatment, that they can get stuck in a loop of referrals and providers and feel as though providers have preconceived ideas of them and their situations. Youth shared hearing from other youth or adults that behavioral health treatment is not helpful.

  Possible solutions proposed by attendees were to work with youth to build genuine connections as well as personalized treatment plans and to hold youth accountable during their treatment. Furthermore, attendees suggested having diverse providers with lived experiences that relate to

what youth are experiencing and create a safe space that ensures the youths' privacy. Other solutions proposed were to provide education and resources for family and friends. The second phase of the Town Hall focused on delivering this information to the System of Care to promote the youth voice, experiences, and recommendations for action. Services providers and administrators created space to learn from the youth and look for opportunities to infuse practices that promote safe spaces and emphasis on connections.

- Workforce Engagement: The COSD BHS also makes vital efforts to include its provider workforce as stakeholders. Like nationwide workforce shortages across the safety net system of care, COSD BHS is facing a "workforce crisis." The COSD BHS engaged the workforce community by establishing the San Diego Workforce Partnership. The Workforce Partnership represented the diverse system-of-care components and collaboratively identified five different work streams for supporting the workforce for improved morale and retention:
    1. Understanding the Needs
    2. Competitive Compensation
    3. Homeowner Incentives
    4. Tuition assistance, Loan Forgiveness and Stipends
    5. Expanding and Diverse the Pipeline

  Currently, there are 29 recommendations, with the top emergent priorities being increasing the diversity and representation of individuals within the COSD BHS workforce and quality of life, such as flexible schedule and childcare.

- The COSD BHS hosted multiple countywide outreach events in FY 21-22. The county creates visibility for engagement activities happening in the community through media campaigns and social websites. These events include:
    - Recovery Happens: Annual community event celebrating individuals in recovery and those who support them, hosted by the COSD BHS (September 2021)
    - NAMI Walk (April 2022)
    - Annual CYF System of Care Conference (May 2022)
    - Annual Youth Mental Health Well Being Celebration (May 2022)

MOBILE CRISIS REPONSE TEAM (MCRT) PILOT PROJECT

The COSD BHS department on January 2021 launched a Mobile Crisis Response Team (MCRT)program designed to help people who are experiencing a mental health or substance use crisis by dispatching behavioral health experts to emergency calls instead of law enforcement, when appropriate. MCRT are non-law-enforcement clinical teams that will respond to crises due to either mental health or substance use. MCRT services are available countywide serving individuals of all ages.

In collaboration with the San Diego County Sheriff's Department and the 10 San Diego Police Department jurisdictions, eligibility referral criteria have been developed to deploy response teams with the goal to provide the following:

- Response to individuals in a behavioral health crisis, de-escalate, and stabilize individuals in the community
- Coordination with Access and Crisis Line (ACL) and law enforcement jurisdictions for appropriate referrals to MCRT

- Linkage and coordination of services for the individual in crisis
- Reduction in unnecessary utilization of acute services
- Providing Care Coordination to link individuals to behavioral health and supportive services
- Community and stakeholder education and media campaign development
- Community input and feedback to identify needs and how to best socialize the program

Evidence of the community engagement process and bidirectional sharing of communication and feedback, the MCRT Strategic Communication Plan was shared with BHAB for feedback and dialogue on messaging strategies.

- Stakeholder focus group feedback and MCRT data were integrated into the campaign and used to refine messaging.
- BHAB members provided feedback on all components presented including narrative scripts, social media platforms, and suggestions on billboard wording, graphics, MCRT team images, and placements.
- The rollout included raising community awareness of MCRT as a new service line, stakeholder engagement, service provision in multiple languages (i.e., COSD threshold languages including Farsi, Arabic, Tagalog, Vietnamese, and Spanish), and countywide messaging including out-of-home placements such as advertisements, billboards, bus bench ads, and posters in specific geographic areas. In addition, utilization of local media platforms such as radio advertisements, digital advertisements, and the County Communications Office.

The Phase II campaign developed targeted messaging to engage underserved communities and for individuals who are difficult to engage.

Key Stakeholder Findings

Breaking Down Barriers (BDB)

Program description

Breaking Down Barriers (BDB) is an outreach campaign that engages distinct, underserved communities, including Latinx, African American, Native American, African immigrants/refugees, Lesbian, Gay, Bisexual, Transgendered and Questioning (LGBTQ) individuals, Asian-Pacific Islanders (API) and Middle Eastern individuals, to increase access to mental health services. The campaign's Cultural Broker strategy builds community acceptance through organized group presentations, individual one-to-one resource sharing and conversation, and participation at community events, fairs, or celebrations. Cultural Brokers serve as mediators between groups or persons of different cultural backgrounds to bridge understanding. Cultural brokering is an ancient practice traced to the earliest recorded encounters between cultures.

The program reduces stigma and discrimination through increased awareness and acceptance of mental illness and treatment choices, increased access, and use of available services, especially in previously unserved and underserved communities, and development of a knowledge base for best practices of outreach and engagement.

Breaking Down Barriers: Feedback to COSD BHS

The BDB contractor conducted multiple outreach activities to the target communities. Some themes shared back to the COSD BHS include:

- Latinx: Need for visibility and transparency around the conversation of medication to support one's mental health via an Instagram Live event "Experiences with Medication."
- African American: Appreciation for outreach efforts and programs
- LGBTQ: workshops and group discussions add validation and created a great and safe community vibe (workshop on Boundaries with Voices of Love)
- African-Refugee: Participants shared how they learned that their bodies can pass down trauma in the form of genetics (workshop African Refugee Population topic historical trauma and resiliency, Somali Bantu Association of America). Participants shared awareness of stigmas tending to isolate individuals experiencing mental health crises and discussed how those who are unhoused are greatly impacted by mental health but are not given compassion. Participants expressed positive feedback about the BDB presentation.
- Middle Eastern: Feedback included that these important conversations to have and are often not discussed in the medical field (Cultural humility presentation on Afghan culture for the Philippine Nurses Association of San Diego (PNASD)).
- Asian-Pacific Islanders (API): Content is affirming and appreciated (Cultural humility presentation about API in the United States for Advanced North).
- Native American Community: Feedback from community meeting emphasized the importance of increasing culturally aware service providers who speak various languages and reflect the community.

FY 21-22 Community Feedback on Breaking Down Barriers (June 2022)

Consistent with the COSD BHS commitment to stakeholder engagement and consideration of feedback to address service program and planning, a feedback session was conducted with BDB constituents. General feedback noted a long duration of time for accessing services, specifically intake appointments in federally qualified health centers, and a lack of providers that are available for Spanish-speaking communities (resulting in consumers obtaining services outside of San Diego/in Tijuana, Mexico). Additionally, the LGBTQ+ community expressed challenges related to long wait lists and mostly short-term services. Formerly incarcerated youth and other community members are often unaware about services at-large (e.g., food, housing, mental health, clinics, community programs, etc.). Many have been glad to hear about MCRT. Additionally, youth express having a lack of input regarding health and well-being and that community providers need to incorporate youths' ideas and feedback. In the Refugee community, people are struggling to get case management services. Community members express feeling unsupported and that they experience racism with providers that are supposed to be serving them.

Moreover, there is a need for more collaboration with community programs. Communities share they often do not hear about County events and that increased importance should be placed with community workers for "sharing the word out." Community members shared that more programs like BDB should exist, and community programs should receive more staff that are mental health professionals. Finally, community members mentioned that services are very fragmented even though they are part of a whole.

Comments, questions, and suggestions from the community regarding outreach and MCRT are considered throughout.

County of San Diego: Involving Stakeholder Input through Diverse Efforts

The COSD obtains stakeholder input throughout the year through a variety of community councils, feedback activities, and outreach efforts. In FY 21-22, these efforts included more than twenty different events over the year, ranging from efforts on substance use to homelessness and housing insecurity, and the need to reach TAY, among others. Highlights are summarized below.

Event Highlights

RFI (Industry Day) for Substance Use OTP (January 2022)

The intended purpose of industry day obtaining feedback from behavioral health providers and collecting information about the landscape of the industry.

Opioid Treatment Programs (OTP) provider feedback was utilized to inform Request for Proposal (RFP) and Statement of Work (SOW) development. Specifically, the inclusion of recovery residences and case management. Long-term engagement in OTP treatment results in better outcomes; no limits placed on client treatment period, client-centered treatment. Improved care coordination and corresponding OTP SOW sections. Continued integration of recovery resident association and programs providing medication-assisted treatment, importance of "housing first" approach.

Oak Park Community Council and Webster Community Council - FY21-22

The Community Councils provided updates on a stakeholder question (posed at previous month's meeting) regarding independent living "facilities," homelessness, localized drug use, perceptions of increased crime, and trash in the area. These negative community concerns were directly attributed to the behavioral health contractor's clients. The Local Opioid Treatment Authority (LOTA) began attending to seek input on the development on OTP community-centric metrics to operationalize SAMHSA community guidelines. LOTA continued attendance is aimed at maintaining open lines of communication with the community and ensuring a bidirectional flow of information – stakeholder input regarding new concerns related to the behavioral health contractor are incorporated into OTP workstreams and other COSD BHS systems of care and feedback is provided to the community.

Direct results from the Community Councils included the (a) development of local OTP metrics focusing on homelessness, clinic cleanliness and safety, clinic security, and the clinic positive presence as a community member; (b) ongoing subject matter expertise invitations with COSD BHS AOA team to speak to Independent Living Association and Homeless Outreach efforts; and (c) collaboration with Homeless Solutions and Community (HSEC) to address COSD homelessness efforts.

Homeless Storage Neighborhood Advisory Committee (HSNAC) – FY 21-22

Intended purpose of the HNSNAC is to receive stakeholder input related to homeless storage facilities in Sherman Heights and to provide the community with COSD responses, when feasible and appropriate. Stakeholder feedback received included specific community concerns about siting of handwashing

stations provided by AOA SME. In addition, the LOTA attends or receives the summary from AOA SME for Oak Park and Webster community concern cross-threading.

Healthy San Diego Behavioral Health Subcommittee

The Healthy San Diego Behavioral Health Subcommittee meets monthly with health plans to discuss impacts to the behavioral health system. When there is a need to bring a topic to a smaller group to brainstorm, these topics are brought to the Healthy San Diego Behavioral Health Operations Workgroup, which also meets monthly.

East County Homeless Task Force

The intended purpose of the task force is obtaining feedback from community providers on needs in the East Region specific to homelessness and services available. Community input included the need for more services in the region and a lack of current resources. These concerns were documented and are intended to be included in program design for the upcoming Crisis Stabilization Unit.

TAY Substance Use Treatment Focus Group

Stakeholder input about substance use treatment for the TAY population was obtained from a focus group with two programs of TAY participants. In response to the question – what types of services would be important – the TAY participants shared residential services (“firm but sweet assistance) were vital. Specific valuable components include (a) offering “guides” to help TAY through the process; (b) allowing program flexibility – no "one size fits all;” (c) cannot force services – doing so can create new issues for TAY; (d) “Tough love but need to earn trust first” from individuals before moving forward with treatment; and (e) exercise, healthy living, and music therapy were mentioned as helpful.

Youth Leadership Meeting

The COSD BHS Deputy Directors and COR convened a Youth Leadership meeting to gather input and feedback about what components are necessary for TAY substance use services. The youth shared several elements considered important for using substance use services including (a) flexibility (i.e., do not get “kicked out” of program if they slide or otherwise break a rule; (b) more harm reduction tactics (i.e., offer naloxone, reduce fear of punishment, work with schools); (c) peer conversations; (d) offer youth positions of leadership; and (d) social media outreach (i.e., Instagram stories).

North County Faith Based Partnership Council (bi-monthly)

The North County Faith Based Partnership Council meets to share information about the status of the faith-based academies and discuss the creation of community events with themes of faith and behavioral health. The Council disseminates new information, gains feedback from providers, and allows community presenters to inform the group of current events, programs, and new services.

Quarterly Dreamweaver Consortium Meetings

Quarterly gatherings of the Consortium in which staff from each Consortium member entity presented on several activities that took place. Examples of activities shared include Table Talk, a series of mental health topics hosted on Facebook Live and hosting a Suicide Prevention Walk.

Outreach Event - Talent Show/Poetry Slam

A talent show and poetry slam event consisted of an open mic forum for youth and their families to share. A COSD BHS representative observed this event to better understand youth and family perspectives on behavioral health.

Pathways Focus Group

Pathways to Well-Being services are an effort to ensure that the mental health needs of the youth involved in Child Welfare Services are met with the goals of safety, permanency, and well-being. To learn more about The Child and Family Team (CFT) member experience in CFT meetings conducted virtually, in-person and/or hybrid, three distinct focus groups were held – one each with youth, caregivers, and providers. Participants were invited through their mental health treatment program via the COSD BHS Pathways to Well-Being team.

Learnings from the focus groups included (a) having the option of virtual CFT meetings increases CFT member attendance and provides more flexibility to accommodate to CFT member schedules; (b) it is important that decision to have CFT meetings in person or virtual should be youth and family driven; and (c) when meetings are held virtually it is essential to utilize methods for engaging all CFT members.

Chapter 3 – Community Experience Partnership

Overview

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

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

Community Experience Dashboard (CED)

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

In FY 21-22, the second development phase of the CED was completed which included finalizing suppression methodology and applying data suppression for confidentiality and reliability, data enhancements (i.e., diagnosis, co-occurring substance use, and social determinants of health. Successes including the creation of CEP web portal (Dashboards | Community Experience (communityexperiencepartnership.com)) and the launch of public-facing dashboards.

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

- BHS Quality Improvement Performance Improvement Team (QI-PIT)
- Executive Quality Improvement Team (EQIT)
- Quality Review Council (QRC)
- Behavioral Health Advisory Board (BHAB) Stakeholder Engagement Workgroup
- Community Experience Committee (CEC) Workgroup

Response to the CED was overwhelmingly positive. Constructive feedback included addition of substance use disorder (SUD) system data, definition of acronyms, and use of accessible terminology.
FY 22-23 efforts around the CED include accessibility enhancements, including soliciting community input to enhance ease of use and interpretability and generating a "How-To" video demonstration. Further, additional data enhancements are being considered on the following topics:

- Addition of FY 20-21 service data for adults/older adults
- Expand adult population health indicators
- Emergency department and inpatient discharge and mortality rates utilizing data processed by the COSD BHS's Population Health epidemiologists
- Priority data as identified by County and community partners

Behavioral Health Equity Index (BHEI)

Working in collaboration with the COSD BHS's Community Experience Committee (CEC) and contracted community facilitators, UC San Diego, developed a Behavioral Health Equity Index (BHEI) model for the County of San Diego. BHEI indicators were selected and sorted into domains, aligned with social determinants of health established by the U.S. Department of Health and Human Services.

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

BHEI Community Engagement

The BHEI is a service planning tool that compiles data about the root causes, or social determinants, of behavioral health into a single index. The index can then be used to help identify neighborhoods and populations that could benefit from additional resources, supports, and services. The BHEI is one component of a larger COSD BHS initiative to advance behavioral health equity. The first step in creating the BHEI was to develop a conceptual model to identify the social determinants, domains, and indicators that will comprise the index. The model was developed in collaboration with community experts, representatives from COSD BHS, and UC San Diego researchers (the Community Experience Committee (CEC Workgroup) during a four-part workgroup series conducted between January and April 2022 and aligned with social determinants of health established by the U.S. Department of Health and Human Services (https://health.gov/healthypeople/priority-areas/social-determinants-health).

The CEC Workgroup provided input on selection of indicators and categorization of those indicators within eight domains. Primary feedback from the CEC Workgroup was regarding how the BHEI would be presented to communities, and how it would (or would not) be used by the COSD BHS. Community experts respectfully challenged the development of a needs-based model that might further alienate marginalized communities. A strong recommendation to augment or supplement the model with strengths-based variables was issued. This valuable dialogue led to a critical shift in the broader engagement and implementation plan. Rather than leverage the BHEI to engage the broader community, it was determined to collect weighting data from the sample of experts, utilizing the budget allocation process (BAP), a participatory weighting method. In the BAP, a group of expert decision makers distribute points to domains based on their value or importance. The scores are then averaged to get an "expert weight."

As it is assumed that not every domain is an equally important determinant of behavioral health equity in San Diego County, domains should be weighted according to their relative importance towards determining equity. There are various methods available to select weights when creating indices. UC San Diego has adopted a process that prioritizes feedback from experts familiar with the social determinants of health and their influence on achieving behavioral health equity in San Diego County. The next step in the BHEI construction will be to gather, finalize, standardize, and aggregate the neighborhood level BHEI indicators to form eight domain scores. The scores will then be weighted and summed to develop a single index.

BHEI Next Steps

- Establish a diverse focus group consisting of community subject matter experts to gather feedback
- Gather, standardize, and aggregate the neighborhood level BHEI indicators to form eight domain scores
- Finalize weights and calculate BHEI
- Integrate BHEI map and indicators into Power BI (revise as needed based on expert review and community feedback)
- Support the new COSD BHS community engagement contract in the development of a strengths-based survey, if needed

Community Profiles and Action Reports (CP/AR)

This Community Profiles and Action Reports (CP/AR) component will be initiated in the next phase of the CEP in FY 22-23.

UC San Diego and the COSD BHS will collaborate to engage community members and key stakeholders in the development of plans for action. Community engagement procedures will likely include partners' meetings and online surveys and will be ongoing throughout the life of the project. Reports and community profiles will be developed to meet needs at the service, administrative, and community levels.

Community Experience Partnership videos

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

Chapter 4

New Engagement Strategies

The MHSA Stakeholder Engagement Activities and Community Program Planning (CPP) process will be led by the UC San Diego team, whose community engagement contract was awarded in May 2022, in partnership with the COSD BHS. UC San Diego is partnering with two community organizations to facilitate community engagement and outreach. Relying on principles of community organizing and participatory research and evaluation, the team will employ an outreach approach consistent with Community-Based Participatory Research (CBPR) methods used to integrate key constituencies in the development and implementation of the comprehensive community engagement activities. Involving the community and collaborating with its members are cornerstones of efforts to improve public health. CBPR is the most recognized form of health-focused, community-engaged research, integrating community partners throughout the process, with the goal of promoting equity and reducing health disparities. CBPR approaches are committed to principles of co-learning and health equity actions, with goals to equalize power between the academic institution and community participants. As such, while the UC San Diego Health Partnership provides a strong foundation from which to start this initiative, to truly accomplish the overall project goals of identifying persons from a wide range of underserved and unserved communities throughout San Diego County and creating safe, accessible, and supportive opportunities for sharing their behavioral health needs, experiences, and recommendations, it will ultimately require the involvement of many different community members and representatives from large and small behavioral health and non-behavioral health services, advocacy, and faith-based organizations.

The partnership brings an extensive network of "first-order" community connections to the engagement process (i.e., organizations whom at least one of the partners has worked with previously and could place a call to talk with a contact). In addition to involving community connections to help with outreach about stakeholder engagement events (e.g., including listening sessions, focus groups, and interviews) to their members and clients to inform the CPP, the team will work with the COR to develop a Community Partnership Council. The Community Partnership Council will expand the efforts of the Community Experience Committee, center equity and community involvement in the CPP. The Community Partnership Council will meet with the UC San Diego Health Partnership team (4-6x annually) to deliberate outreach plans and identify feasible and appropriate strategies for connected with currently unrepresented groups, centering community voice, and utilizing CBPR principles as the cornerstones of our Community Engagement Process.

Specific community engagement activities to inform the Community Program Planning process and the development of the three-year plan will commence in late Fall 2022 and continue through the fiscal year. Activities will include community listening sessions, focus groups, and key stakeholder interviews. In addition, the UC San Diego Health Partnership is actively engaging grassroots community events, conducting community-facing outreach efforts in all regions of San Diego to engage stakeholders in the CPP.

Chapter 5

MHSA Stakeholder Training

For the FY 21-22 community engagement process, the UC San Diego Health partnership began engagement efforts in May 2022, immediately upon commencement of the contract being awarded to UC San Diego. Working in collaboration with the COSD BHS, the UC San Diego Health partnership scheduled and facilitated two community facing MHSA training sessions in June of 2022. This year, events were conducted virtually considering the local COVID-19 context.

Flyers advertising the training sessions were distributed in both Spanish and English in a variety of spaces, including the COSD BHS mailing lists, UC San Diego Health first order contacts, and COSD 211 calendars. The flyers included date, time, and a brief description of the MHSA training topics and intended learning outcomes. Registration instructions, including a registration link and a QR code, were provided on the flyers.

The MHSA training sessions were attended by 101 unique individuals, who represented all six HHSA regions. Training participants identified themselves as community members, consumers of behavioral health services, family members of consumers, current and former BHAB members, representatives and staff of community-based organizations and nonprofits, and academic and research organizations. The trainings were conducted in English, and participants had the opportunity to request Spanish translation.

The training sessions were introduced by Nadia Privara Brahms, Assistant Director, Chief Strategy & Finance Officer for the COSD BHS. The presenters discussed history, laws, specific components of the MHSA as well as the CPP process. Interactive questions were asked during the training sessions. In the back half of the training, an open-ended question was presented to the audience: What is the main behavioral health need of your community? Answers from participants included housing, more support for the workforce, better access to services, and community engagement.

Participants were asked to complete a training session satisfaction survey at the end of the training. The majority of respondents (84%) either somewhat or strongly agreed that the training improved their knowledge of California's MHSA, while 86% either somewhat or strongly agreed the training improved their knowledge of how MHSA funding is used in San Diego County. Respondents were also asked to indicate their preferred method of community input in the future. Answers included listening sessions, individual interviews, attending grassroots meetings, working with BHAB, focus groups, and working with stakeholders outside of COSD BHS. Finally, respondents were asked to identify the two to three most important issues that must be addressed, from their point of view, to improve the behavioral health of their communities. Overall, 95 unique issues were identified, which were reviewed and analyzed by the UC San Diego Health team. The 95 ideas were summarized by the following themes: (1) Strengthen the

continuum of care; (2) Support for the workforce; (3) Outreach and community responsiveness; and (4) Housing supports.

Overall, 90% of respondents were either somewhat or extremely satisfied with the MHSA trainings. Participants requested a copy of the training materials for their own review, and to share with others.

Detailed summary of the trainings, as well as the training presentation are provided in Appendix 1.

Appendices

Appendix 1: MHSA Stakeholder Training Summary

County of San Diego Health and Human Services Agency
Behavioral Health Services

Community Engagement Report

Appendix 1 MHSA Stakeholder Training Summary

Executive Summary

As part of the FY 21-22 Community Program Planning (CPP) process, the UC San Diego Health partnership initiated engagement efforts in May 2022, immediately upon commencement of the contract being awarded to UC San Diego. Working in collaboration with the COSD BHS, the UC San Diego Health partnership scheduled and facilitated two community facing MHSA Training sessions in June of 2022. Events were conducted virtually considering the local COVID-19 context.

Flyers advertising the training sessions were distributed in both Spanish and English in a variety of spaces, including the COSD BHS mailing lists, UC San Diego Health first order contacts (e.g., community health centers, community-based organizations, university public health researchers), COSD 211 calendars, and physical community buildings (e.g., YMCA). The flyers included date, time, and a brief description of the MHSA Training topics and intended learning outcomes. Registration instructions, including a registration link and a QR code, were provided on the flyers.

The MHSA Training sessions were attended by 101 unique individuals, who represented all six HHSA regions. Training participants identified themselves as community members, consumers of behavioral health services, family members of consumers, current and former BHAB members, representatives and staff of community-based organizations and nonprofits, and academic and research organizations. The trainings were conducted in English, and participants had the opportunity to request real-time Spanish translation.

The training sessions were introduced by the Assistant Director, Chief Strategy & Finance Officer for the COSD BHS, Nadia Privara Brahms. The training included discussion of MHSA history, regulations, specific components, and the CPP process. Interactive questions were asked during the training sessions. During the second half of the training, an open-ended question was presented to the audience: “What is the main behavioral health need of your community?”. Answers from participants included housing, more support for the workforce, better access to services, and community engagement.

Participants were asked to complete a training session satisfaction survey at the end of the training. The majority of respondents (84%) either somewhat or strongly agreed that the training improved their knowledge of California’s MHSA, and 86% somewhat or strongly agreed the training improved their knowledge of how MHSA funding is used in San Diego County. Respondents were also asked to indicate their preferred method of community input in the future. Answers included listening sessions, individual interviews, attending grassroots meetings, working with BHAB, focus groups, and working with stakeholders outside of COSD BHS. Finally, respondents were asked to identify the two to three most important issues that must be addressed, from their point of view, to improve the behavioral health of their communities. Overall, 95 unique issues were identified, which were reviewed and analyzed by the UC San Diego Health team. The 95 ideas were summarized by the following themes: (1) Strengthen the continuum of care; (2) Support for the workforce; (3) Outreach and community responsiveness; and (4) Housing supports.

Overall, 90% of respondents were either somewhat or extremely satisfied with the MHSA trainings. Participants requested a copy of the training materials for their own review and to share with others.

Introduction

In an effort to expand and transform California’s behavioral health system, the Mental Health Services Act (MHSA) was passed by California voters in 2004. To better serve individuals and their families, MHSA

addresses a broad array of prevention, early intervention, and service needs. In May 2022, the COSD BHS contracted with the UC San Diego partnership to oversee and conduct the community engagement requirements specified in the MHSA. As part of this, the UC San Diego partnership developed and conducted two MHSA training sessions open to the San Diego public.

Process and Methodology

Collaborative Planning

In collaboration with the COSD BHS, dates for the training sessions were chosen and relevant topics to be included in the presentation were discussed.

Special Considerations

Due to the consistent local case-rate of COVID-19, it was determined that the best reach of the trainings would occur by using a virtual platform. Zoom was selected as the optimal platform for the MHSA Training sessions. To maximize efficiency and focus for the training, the webinar version of Zoom was utilized to prevent distractions (e.g., attendees on camera, accidentally removing themselves from mute, etc.). In addition, the Zoom webinar chat function allowed for two-way communication between attendees and panelists. This allows participants to have a way to communicate confidentially with facilitators while limiting external discussion among participants that could distract from the MHSA Training content. A survey following the trainings session asked if individuals would like to be contacted for community engagement activities in the future.

Engagement Approach

Due to a recent rise in local COVID-19 cases, Zoom was determined to be the best platform for the training sessions. Zoom was selected due to its security features and the ability to conduct the training in a webinar format, hosting up to 1000 people.

The Zoom Question & Answer (Q&A) feature for webinars allows attendees to ask questions during the webinar and for panelists to answer their questions. At the conclusion of the webinar, Zoom provides a Q&A report for further analysis. This report was used to submit questions to the COSD BHS if the panelists were unable to answer the questions in real time.

Topics

Topics included in the training sessions were MSHA history, laws, specific components, and the CPP process (see Appendix A).

Scheduling

The team decided evening and daytime sessions were necessary to accommodate different schedules of community members. It was determined the trainings would be beneficial to all members of the San Diego community: BHS employees, contractors, consumers, families of consumers, etc. and this would allow for more individuals to attend.

The sessions were held on:

- Friday, June 24, 2022, 12:00 – 1:15pm
- Wednesday, June 29, 2022, 6:00 – 7:15pm

Language Availability

For the initial trainings, the COSD BHS and UC San Diego Health teams determined it optimal to provide Spanish translation due to the large Spanish-speaking community in San Diego. Approximately 25% of San Diego residents speak Spanish in their homes, making it the most spoken language after English in San Diego. The Zoom webinar functionality provides an additional channel with simultaneous Spanish translation of the presentation. In the future, the aim will be to include additional threshold languages availability via translation.

Staffing

UC San Diego Health employees, including doctorate and masters level professionals staffed the trainings. A professional translator was hired for the simultaneous Spanish translation of the training. Student interns helped creating the flyer as well as the registration and satisfaction survey.

Participant Recruitment

Promotional Flyers

Promotional flyers were created in Spanish and English. The flyer included date, time, and a brief description of the training topics and learning outcomes. Registration instructions, including the registration link and QR code were provided. Flyers were approved by BHS and then distributed in a manner detailed below.

One-on-One Personal Recruitment

The UC San Diego Health team utilized their first order networks in order to distribute the promotional flyers. These networks included, but were not limited to:

- Community health centers
- Community-based organizations
- University public health researchers

Public Calendars

The 211 Community calendar, an online public calendar, was utilized as a community wide advertising method to promote the MHSA Training sessions.

Email Blasts

- An email blast was sent by BHS to all funded program directors, all administrative staff, and other people on the BHS list of relevant stakeholders.
- Providers who currently use San Diego County data collections systems for behavioral health services
- Members of San Diego County Suicide Prevention Council which includes community members, leaders of non-county funded organizations, providers, clinicians, people involved in suicide prevention initiatives, faith-based community leaders, people who have been impacted by suicide.

Social Media

The UC San Diego partnership reached out to UC San Diego's social media team. Unfortunately, the turnaround time meant the posts were not approved prior to the training dates. However, this channel of recruitment will be utilized in the future.

Event Process

Registration

Participants could register through a link or QR code on Qualtrics, all detailed on the promotional flyers. This registration form was available in Spanish and English. Participants could select if Spanish interpretation service was needed.

Registrants were asked to provide basic information, including ZIP code, and association with listed community groups. A total of 192 individuals registered for two trainings. The North Central region of San Diego County was most represented by registrants, however individuals from each of the six HHSA regions registered for the trainings. Nearly 20% of registrants identified as community members (19%), followed by CBO or other community providers. Other community groups represented by registrants included nonprofit employees, County of San Diego staff, BHS consumers, and family members of consumers. A summary of the registration information is available in Figures 1 and 2.

Figure 1. Regions Represented by Registrations

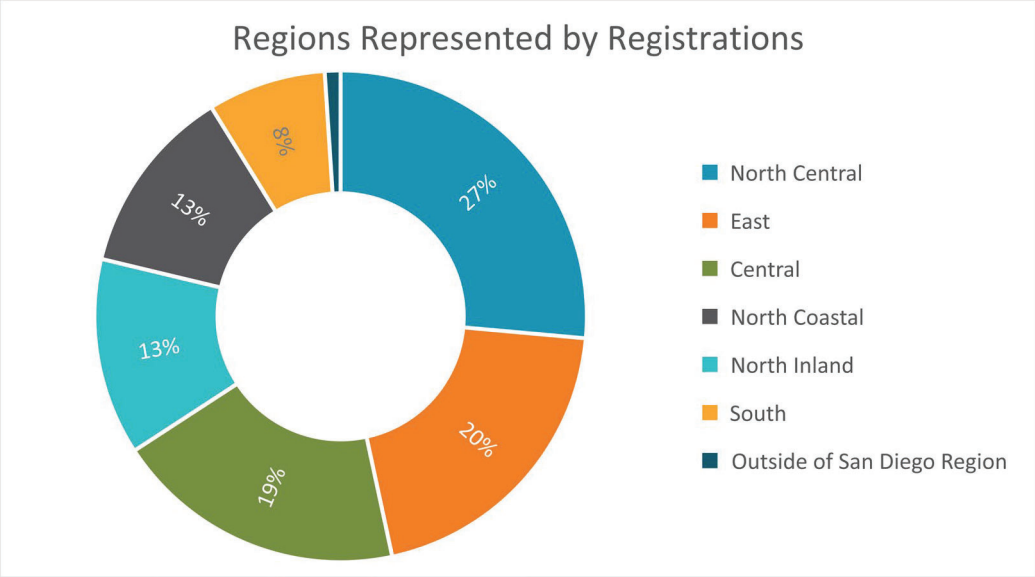
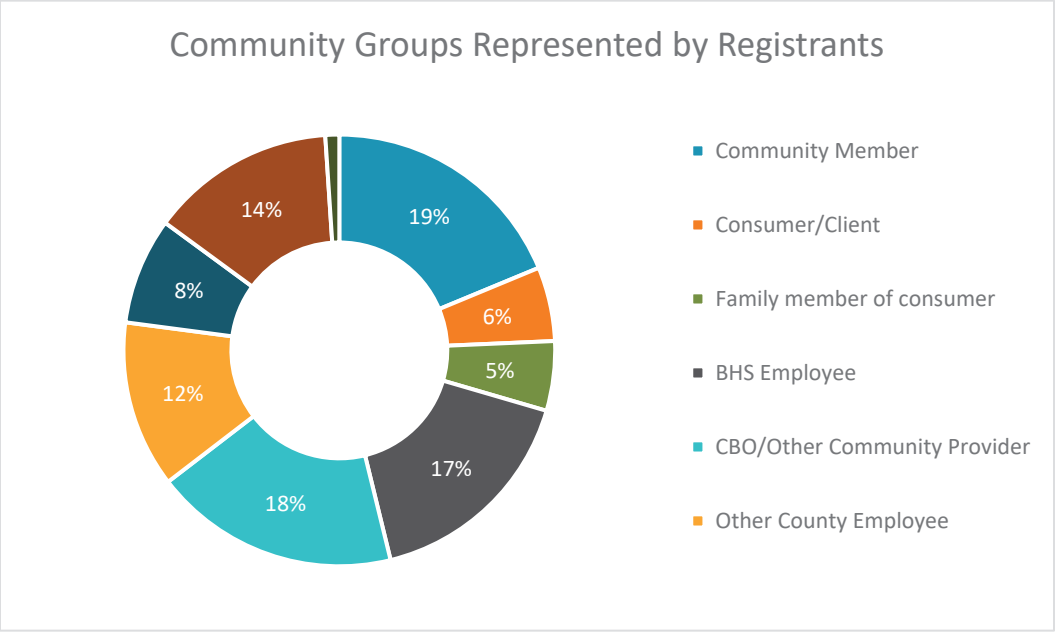


Figure 2. Community Groups Represented by Registration



After registering to attend one of the training sessions, an email was sent to the registrant with the Zoom meeting link.

Agendas and Facilitation

The training started with an Introduction by Nadia Privara Brahms, Assistant Director, Chief Strategy and Finance Officer for Behavioral Health Services. The presenters discussed history, laws, specific components of the MHSA as well as the Community Program Planning (CPP) process. Interactive questions were asked during the training sessions. Two Zoom polls were conducted, the first aimed to get a sense of who is in the audience and for participants to also know the breadth of audience. The second poll elicited participants' familiarity with the MHSA. In the second half of the training, an open-ended question was presented to the audience: ***What is the main behavioral health need of your community?*** Participants were encouraged to respond using the online Mentimeter platform. Participants could submit multiple responses. Responses were shared in live time as participants shared their perceived community behavioral health needs.

Throughout the training, participants could address questions to the panelists through the Zoom chat and Q&A feature:

- Overall: Participants requested access to the training material
- Content questions were about MHSA funding specific services participants think are needed as well as regarding wait times and increasing capacity so waitlists would be reduced

Engagement Activity

Participants were invited during the training to share, via the online Mentimeter platform, what they think is the main behavioral health need of their community. Participants could enter multiple responses. The June 24th MHSA Training session participants shared 52 responses. The June 29th MHSA Training session participants shared 22 responses. The five top behavioral health needs identified by participants were related to:

- Housing (long term housing for women and children)
- Providers/workforce (diversity, more providers, and increase salaries)
- Access to services
- Behavioral health services (children 0-5 ages, veterans, and prevention)
- Community engagement

Image 1 portrays a word cloud developed from the responses of the engagement activity across both training sessions.

Image 1. Top San Diego Community Behavioral Health Needs as Identified by MHSA Stakeholder Training Participants



Satisfaction Survey Results

Participants

A total of 101 unique participants attended across the two trainings. Of those participants, just over half (n=54) completed a participant satisfaction/feedback survey. Of those, approximate 20% did not complete one or more of the demographic questions. The following results summarize the opinions and experiences of those who completed the survey, hereafter referred to as respondents.

Based on successful outreach efforts, more than 50% of respondents learned of the trainings from a co-worker or colleague. Respondents also learned of the trainings through flyer distribution, social media, and emails from various individuals and organizations.

Respondents indicated they belonged to the following community groups (more than one could be selected, so for example an attendee could be a both a family member and County staff). See Figure 1 for more information on the community representation at the trainings.

Figure 3. Community Groups Represented by MHSA Training Survey Respondents

Community Representation	n	%
Community Member	16	30%
CBO staff/Behavioral Health Provider	15	28%
Other Nonprofit organization	11	20%
County of San Diego BHS Staff	10	19%
Consumer of BHS Services	7	13%
Other County of San Diego Staff	7	13%
Family Member of Consumer	5	9%
Current or Former BHAB Member	5	9%
Other	3	6%

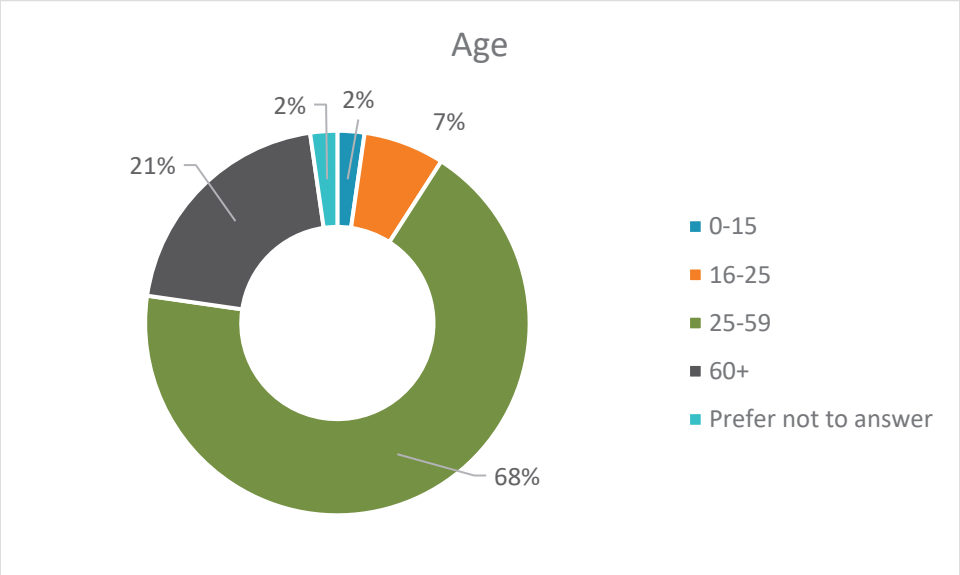
Respondents were able to select more than one community representation response, so figures may total to more than 100%.

Demographics

Age

The majority of respondents (68%, n=30) were between the ages of 25-59 years.

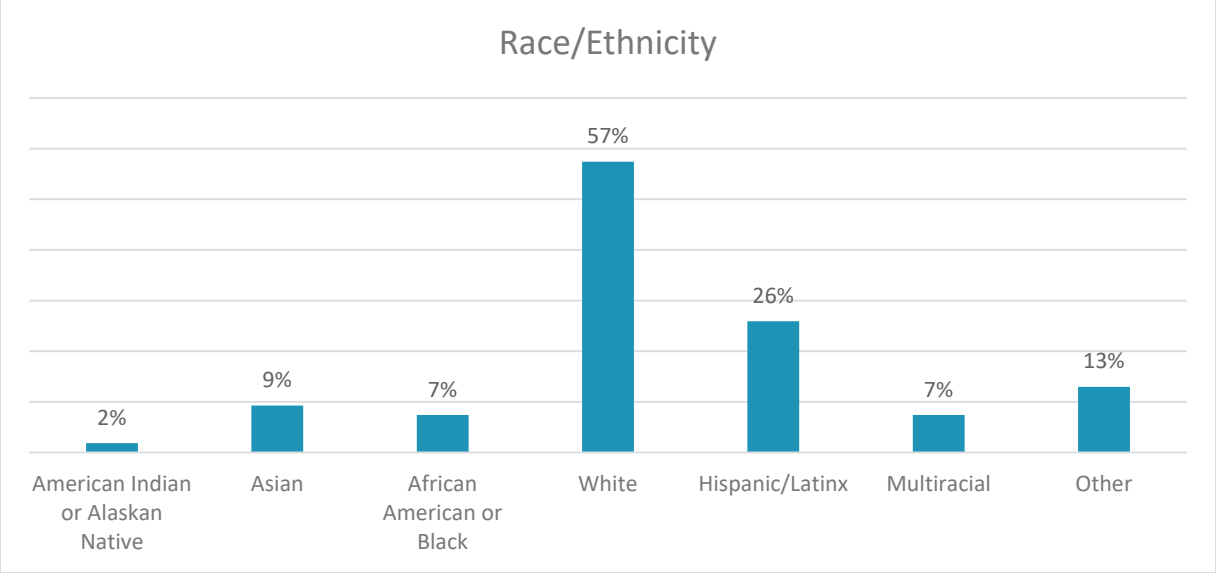
Figure 4. Age of MHSA Training Survey Respondents



Race/Ethnicity

More than half of respondents identified as White (57%), around three-quarters of respondents identified as Hispanic/Latinx (26%), 13% of respondents as Other Non-Hispanic, 9% of respondents as Asian, 7% respondents as African American/Black, and 2% of respondents as American Indian/Alaskan Native. There were 7% of respondents who selected more than one race. None of the respondents identified as Native Hawaiian/Pacific Islander.

Figure 5. Race/Ethnicity of MHSA Training Survey Respondents



Respondents were able to select more than one racial or ethnic response, so figures may total to more than n=54.

The majority of respondents (71.4%) who identified as Hispanic indicated they were of Mexican/Chicano origins. The race/ethnicity category of "Other" represented non-Hispanic individuals and included Eastern European and Middle Eastern identities, among others.

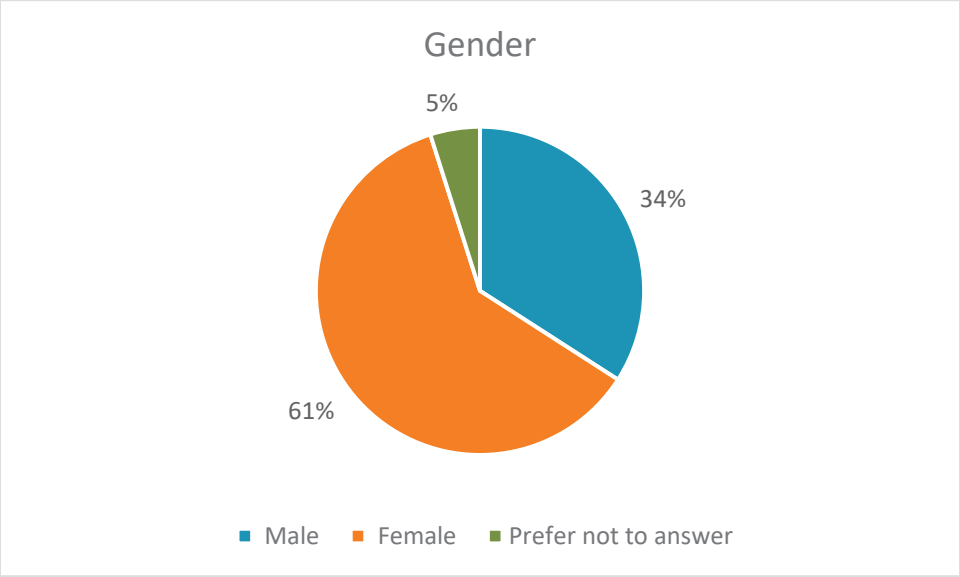
Primary Language

Most respondents (82.9%) speak English at home as their primary language, although 14.6% indicated they speak Spanish, and 2.4% indicated they speak Farsi.

Gender

The majority of respondents identified as female. Slightly more than a third of participants (34%) identified as male, while 5% preferred not to answer.

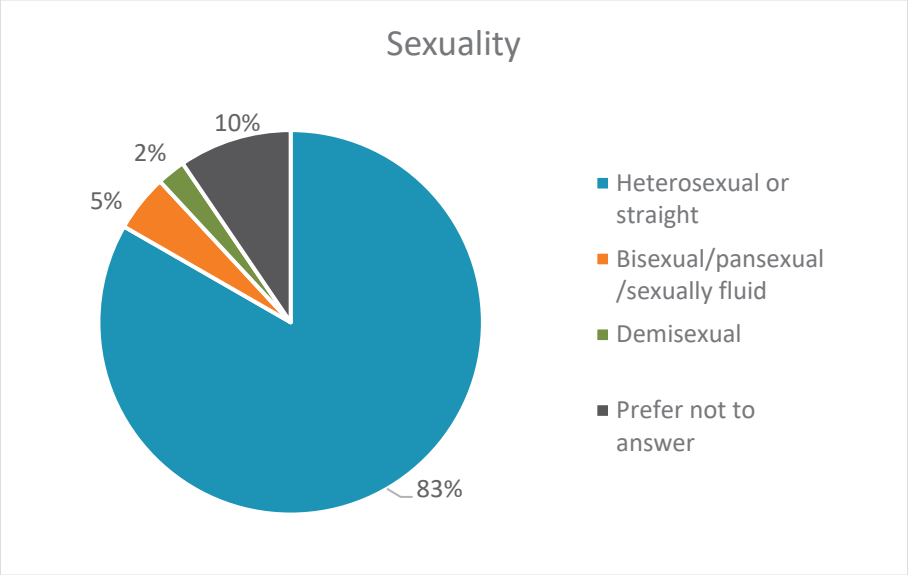
Figure 6. Gender of MHSA Training Survey Respondents



Sexuality

The majority of respondents indicated they identified as heterosexual or straight (83%). More than 20% of respondents did not respond to this demographic question. Of those who responded, 10% preferred not to answer the question regarding their sexuality.

Figure 7. Sexuality of MHSA Training Survey Respondents



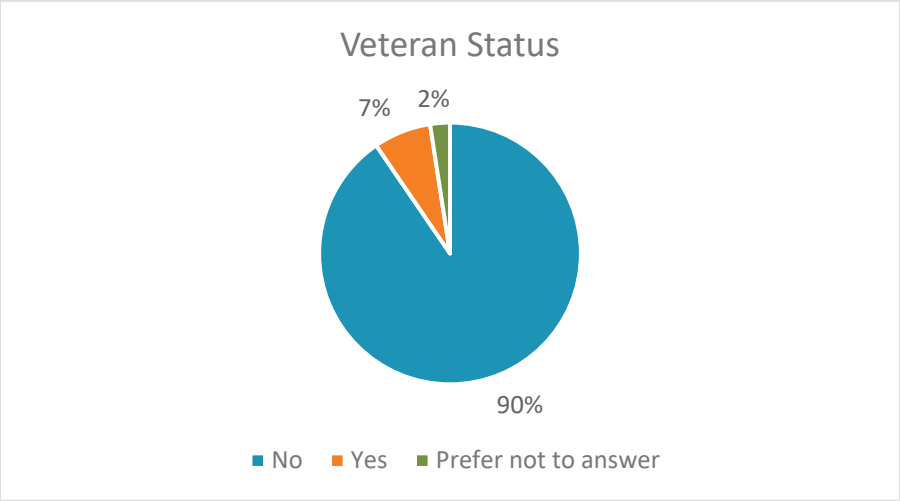
Disability

More than 70% of MHSA Training Survey respondents (72%) did not consider themselves to be disabled. Respondents who indicated having a disability selected disabilities related to vision, hearing, physical or mobility issues, or chronic health conditions.

Veteran Status

Approximately 7% of respondents indicated they were military veterans. In San Diego County, military veterans make up more than 15% of the population, due in large part to the multiple military bases housed here.

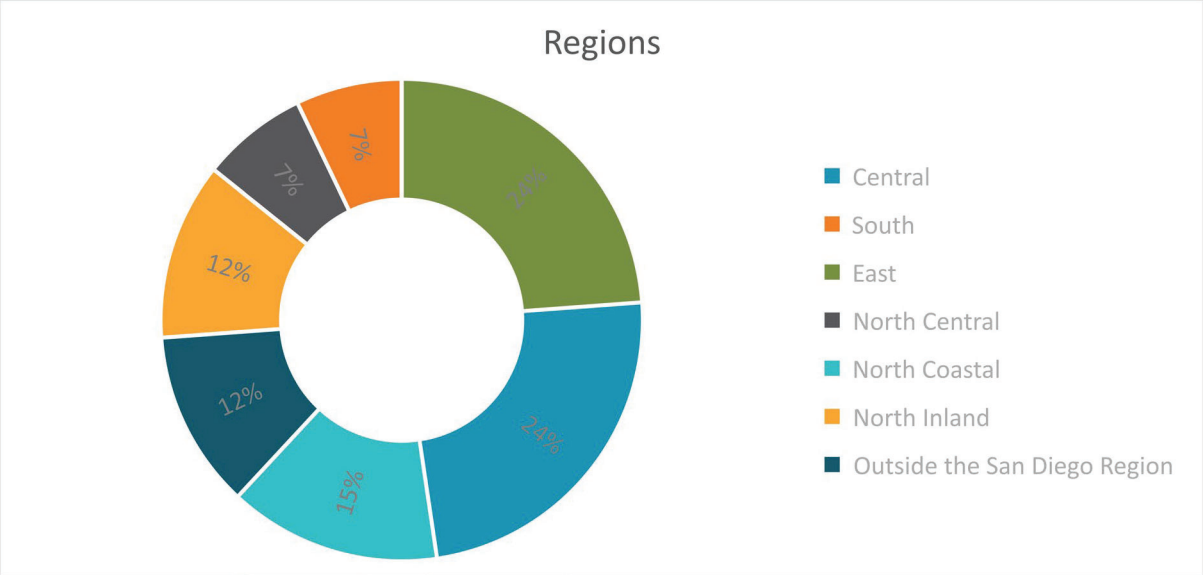
Figure 8. Veteran Status of MHSA Training Survey Respondents



Regions

Respondents indicated they represented all six of the HHSA Regions, almost half of respondents attending from the East and Central Regions. Regional representation of respondents is similar to the information gathered during registration, except for the North Central region. North Central region represented 27% of registrants, but only 7% of respondents.

Figure 9. HHSA Regions Represented by MHSA Training Survey Respondents



Survey Findings

The satisfaction survey asked respondents to provide a variety of feedback on the MHSA Training, how they would like to provide input in the future, and issues they felt were necessary to address to improve the behavioral health of their communities. The following sections detail the findings.

Schedule of Training Sessions

Overall, respondents thought the training times worked well for their schedules. A majority of respondents strongly agreed (48%) or somewhat agreed (28%) that the day of the week worked well for their schedules. Additionally, a majority of the respondents indicated that they strongly agreed (48%) or somewhat agreed (26%) the time of day (one at lunchtime, one held in the evening) worked for their schedules. In the future, the UC San Diego Health team will work to ensure a variety of scheduling options are available to individuals in order to best meet the needs of San Diego residents.

Suggestions for future input

Respondents indicated they would be open to a variety of options for future input sessions. While the majority of respondents (70%) indicated that virtual events, a third of respondents (33%) indicated their preference would depend on COVID-19 conditions.

Respondents also provided feedback on the best strategy to collect stakeholder input on how MHSA funding should be utilized in the future. Forums and Listening Sessions, Focus Groups, and Individual Interviews were offered as pre-filled suggestions, and respondents had the opportunity to enter in other suggestions as well. Respondents could select more than one response. Table 1 provides a summary of responses and suggestions.

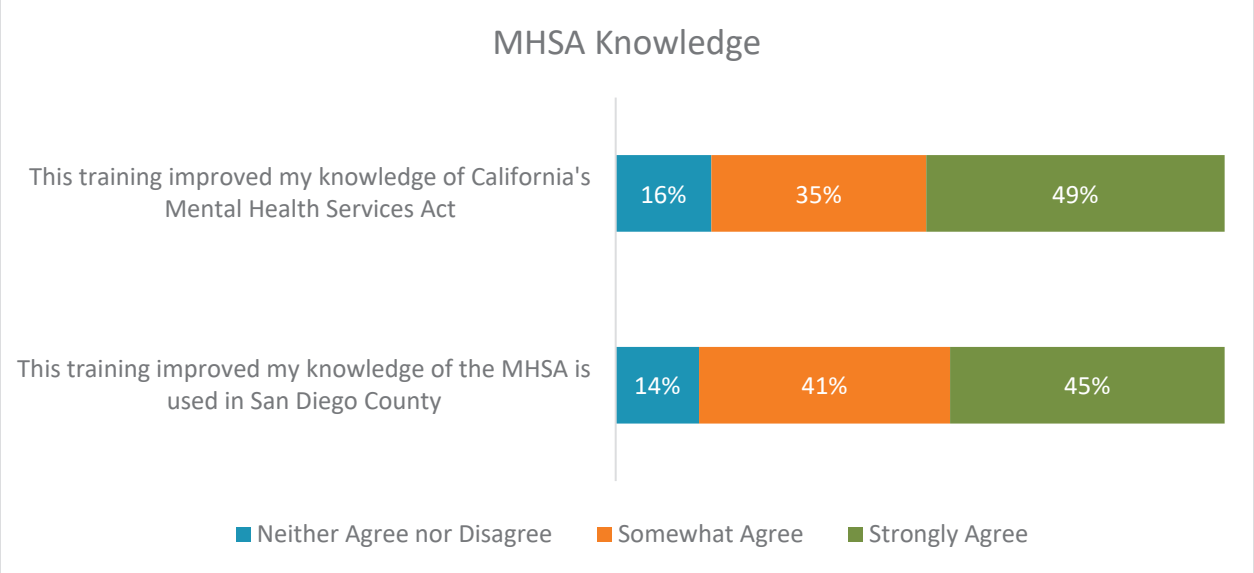
Table 1. Suggestions for future input

Suggestion	n	%
Forum/Listening Session	35	65%
Focus Groups	33	61%
Individual Interviews	18	33%
Other: Direct interaction with service providers	3	6%
Other: Work with current efforts happening in the community	3	6%
Other: Work with other COSD departments	2	4%
Other: Evaluation Efforts	2	4%
Other: Written opportunities	1	2%
Other: Web-based survey	1	2%
Other: Work with stakeholders outside of BHS (judges, primary care, etc.)	1	2%
Other: BHAB involvement	1	2%

Knowledge of MHSA

An overwhelming majority of respondents agreed the training improved their knowledge of the MHSA and how the MHSA is used in San Diego County. None of the respondents indicated the training did not increase their knowledge.

Figure 10. MHSA Knowledge



Identified Important Issues

Respondents were asked to identify the two to three most important issues that must be addressed to improve the behavioral health of their communities. Overall, 95 unique issues were identified ranging from the types and quantities of services available to the system organization. The top issues identified by respondents are summarized thematically below.

Strengthening the Continuum of Care

The largest identified concern was that of strengthening the continuum of care. This was reflected in multiple comments, some of which are detailed here:

- "More dedicated resources for CWS-involved children, or appointments/providers who specialist working with CWS/trauma cases and who also specialize in early childhood. We need to intervene early before the mental health or developmental issues worsen."
- "Veterans mental health and wellness"
- "Additional young adult appropriate outpatient treatment services"
- "More social services support such as housing, housing navigation, trauma informed care in shelters, financial assistance for clients not eligible for general relief or SSI. And more withdrawal management programs since there are only 4 in the county that work with Medi-Cal."

The idea of the continuum of care was highlighted by the wide variety of populations and needs that were specifically identified as requiring more support in the community. Substance use disorders, treatment beds, services for infants, services for veterans, and services for young adults were all specifically identified as important issues for the continuum of care to address. Additionally, suggestions were made to improve internet connectivity and provide more services through telehealth to increase access to care for those who face transportation challenges.

Support for the Workforce

After strengthening the continuum of care, support for the workforce was the next largest identified issue to improve the behavioral health of San Diego's communities. Concerns over annual salaries, worker burnout, quality of staff and their training, as well as staffing shortages were all reported by respondents. One individual commented, "… Current programs seem to be over capacity and cannot provider quality care to clients. I hear clients say they feel these programs are not helpful or are constantly getting new [staff] assigned." Another remarked that San Diego needs "multiple strategies to build additional staffing." Other commentors focused on the salary limitations of current staff, noting higher salaries for behavioral health staff are necessary "in order to be able to hire and retain qualified staff to be able to serve the community."

Outreach and Community Responsiveness

Survey respondents also identified the need for greater community engagement as well as more targeted outreach efforts. Community responsiveness included suggestions such as developing a more diverse workforce to meet the cultural and linguistic needs of patients, as well as understanding the unique barriers that face marginalized communities in San Diego. Participants also identified the need to provide resources for education and outreach to marginalized communities, families with members experiencing severe mental illness, and general awareness of the services provided in San Diego.

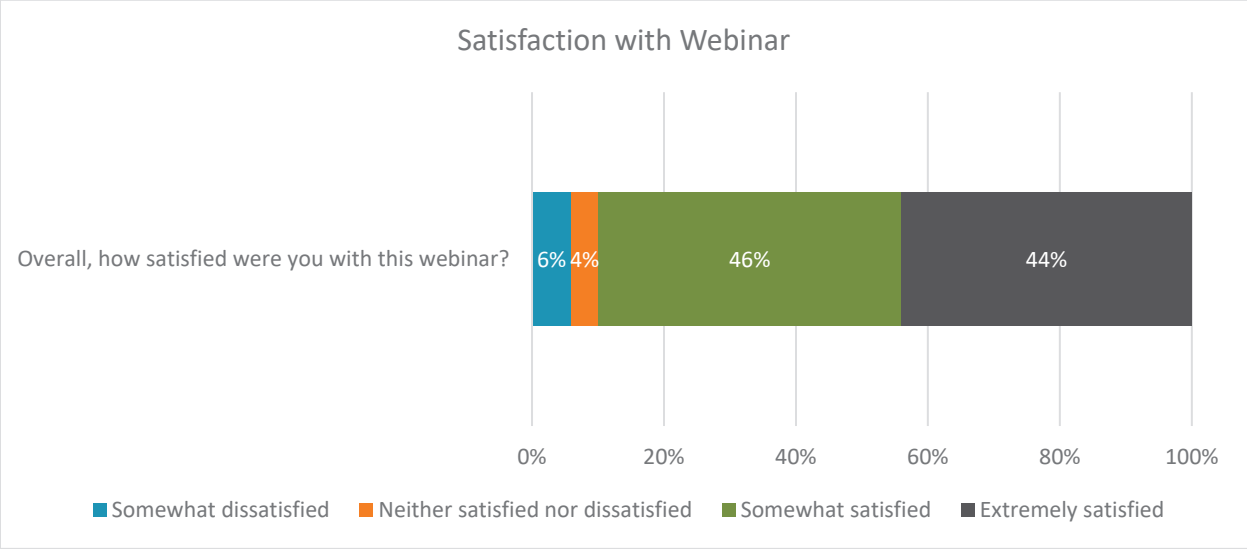
Housing Supports

Finally, housing was an issue identified as being important for the behavioral health of our communities. This ranged from short-term options such as over-night shelters, to longer, more permanent options such as permanent supportive housing. In addition to housing specifically, the needs of individuals facing homelessness was highlighted in the survey responses. This may include employment services, behavioral health services, and transportation options to those who are experiencing housing instability.

General Satisfaction

Overall, respondents were satisfied with the webinar training, with 90% of respondents indicating they were either extremely or somewhat satisfied with the training.

Figure 11. Satisfaction



In the open-ended comments, some respondents indicated they would appreciate a copy of the slides to share with others. The UC San Diego Health team and BHS are currently working on an approved method to share slides after future trainings. Comments also indicated attendees were enthusiastic about participating in the CPP process and looked forward to future opportunities to provide feedback. Respondents would also like more information on how the MHSA funds are intended to be spent, and how they are spent here in San Diego County.

Other comments expressed the need for stakeholder feedback to be meaningful not just to BHS, but to the stakeholders themselves. As such, 65% (n=35) of respondents indicated they would like to receive e-mails regarding future training and engagement opportunities. The UC San Diego Health team, along with community partners, will utilize these comments and various feedback to improve stakeholder trainings going forward.

APPENDIX G

MHSA ISSUE RESOLUTION PROCESS

Mental Health Services Act (MHSA) Issue Resolution Process
Updated July 2022

Purpose:

This procedure supplements the Beneficiary and Client Problem Resolution Policy and Process, which provides detailed guidelines for addressing grievances and appeals regarding services, treatment, and care, by providing a process for addressing issues, complaints and grievances about MHSA planning and process.

The Department of Health Care Services (DHCS) requires that the local issue resolution process be exhausted before accessing State venues such as the Mental Health Services Oversight and Accountability Commission (MHSOAC) or the California Mental Health Planning Council (CMHPC) to seek issue resolution or to file a complaint or grievance.

The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) has adopted an issue resolution process for filing and resolving issues related to the MHSA community program planning process, and consistency between program implementation and approved plans.

BHS is committed to:

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

Types of MHSA issues to be resolved in this process:

- Appropriate use of MHSA funds
    - Allegations of fraud, waste, and abuse of funds are excluded from this process. Allegations of this type will be referred directly to the County Compliance Office for investigation.
- Inconsistency between approved MHSA Plan and implementation;
- San Diego County Community Program Planning Process.

Process:

- An individual may file an issue at any point and via any avenue within the system. These avenues include but are not limited to the BHS Director, BHS Assistant Directors, BHS Deputy Directors, BHS Councils, County of San Diego Compliance Officer, Consumer and Family Liaisons, Patient Advocacy Program, and BHS providers.
- The MHSA issue shall be forwarded to the Consumer and Family Liaisons, RI International and NAMI San Diego, for review within three (3) business days of receipt.
- Consumer and Family Liaisons (CFL) shall provide the Issue Filer a written acknowledgement of receipt of the issue, complaint, or grievance within two (2) business days.
- CFL shall notify the BHS MHSA Coordinator of the issue received while maintaining anonymity of the Issue Filer within two (2) business days.
- CFL will investigate the issue.
    - CFL may convene the MHSA Issue Resolution Committee (MIRC) whose membership includes unbiased, impartial individuals who are not employed by the County of San Diego.
    - CFL will communicate with the Issue Filer every seven (7) days while the issue is being investigated and resolved.
- Upon completion of investigation, CFL/MIRC shall issue a committee report to the BHS Director.
    - Report shall include a description of the issue, brief explanation of the investigation, CFL/MIRC recommendation and the County resolution to the issue.
    - CFL shall notify the Issue Filer of the resolution in writing and provide information regarding the appeal process and State-level opportunities for additional resolution, if desired.
- The BHS Director will provide a quarterly MHSA Issue Resolution Report to the Behavioral Health Advisory Board.

Contact:

Consumer Center for Health, Education & Advocacy – CCHEA
Carol Neidenberg
110 S Euclid Ave.
San Diego, CA 92114
(877) 534-2524

This page intentionally left blank.

APPENDIX H

COMMUNITY SUPPORTS AND SERVICES (CSS) ANNUAL REPORT FY 2020-21

FY 2020-21 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

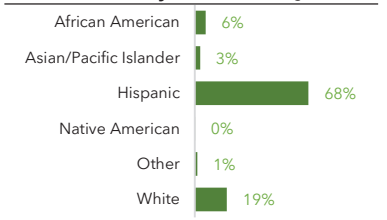
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Children & Youth – Full-Service Partnership (CY-FSP; n=7,327)

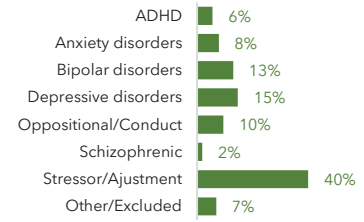
Living Situation	%
Correctional Facility	1%
Foster Home	1%
Group Home	0%
Homeless	1%
House/Apartment	96%
Children's Shelter	0%
Other/Unknown	1%

Language	%
English	88%
Spanish	12%
Arabic	0%
Vietnamese	0%
Tagalog	0%
Farsi	0%
Other/Unknown	0%

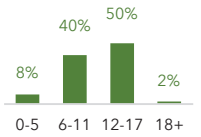
Race/Ethnicity (excludes missing/unknown)



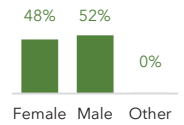
Diagnosis (excludes missing/invalid)



Age



Gender



CY-FSP **20%** (7,327)

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

CY-OE programs were not active in FY 2020-21

Total CSS Clients (unduplicated) N = 36,677

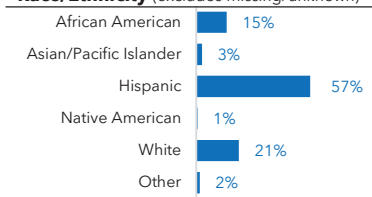
Children & Youth – System Development (CY-SD; n=3,246)

CY-SD **9%** (3,246)

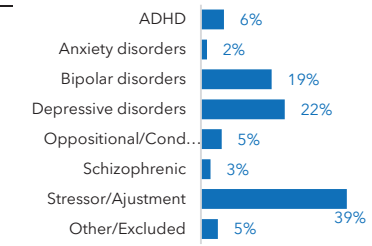
Living Situation	%
Correctional Facility	15%
Foster Home	10%
Group Home	3%
Homeless	1%
House/Apartment	60%
Children's Shelter	4%
Other/Unknown	7%

Language	%
English	93%
Spanish	97%
Arabic	0%
Vietnamese	0%
Tagalog	0%
Farsi	0%
Other/Unknown	0%

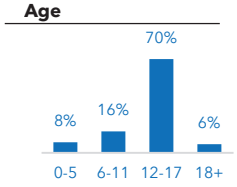
Race/Ethnicity (excludes missing/unknown)



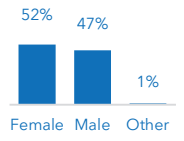
Diagnosis (excludes missing/invalid)



Age



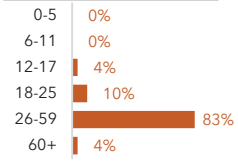
Gender



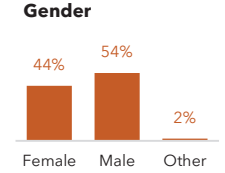
ALL-OE **<1%** (110)

All CSS – Outreach and Engagement (ALL-OE; n=110)

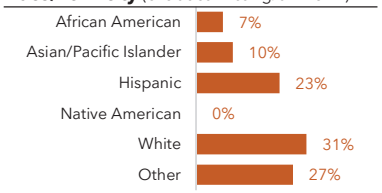
Age



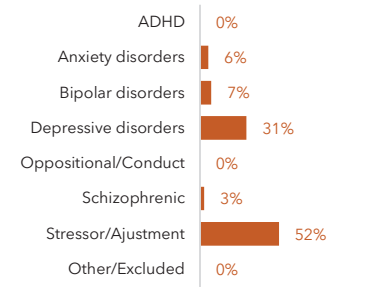
Gender



Race/Ethnicity (excludes missing/unknown)



Diagnosis (excludes missing/invalid)



Living Situation	%
Board & Care	4%
Foster Home	0%
Group Home	0%
Homeless	6%
House/Apartment	91%
Children's Shelter	0%
Other/Unknown	0%

Language	%
English	10%
Spanish	18%
Arabic	8%
Vietnamese	1%
Tagalog	0%
Farsi	6%
Other/Unknown	57%

CSS Report | Source: Optum | Data Source: Optum Monthly data extracts. Data may be impacted starting March 2020 due to COVID-19.
Note: Clients may have received services from >1 CSS category within the fiscal year. Only CSS programs that enter data into CCBH are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. Percentages may not add up to 100% due to rounding.

Report Date: 05/02/2022

FY 2020-21 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

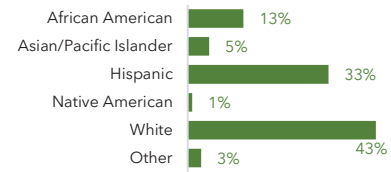
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

TAY, Adult, Older Adult – Full-Service Partnership (TAOA-FSP; n=10,352)

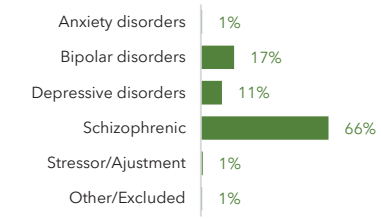
Living Situation	%
Board & Care	10%
Correctional Facility	1%
Homeless	15%
House/Apartment	58%
Institutional	9%
Other/Unknown	8%

Language	%
English	89%
Spanish	7%
Arabic	0%
Vietnamese	0%
Tagalog	0%
Farsi	0%
Other/Unknown	3%

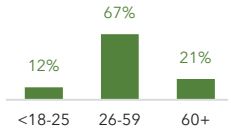
Race/Ethnicity (excludes missing/unknown)



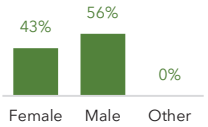
Diagnosis (excludes missing/invalid)



Age



Gender



TAOA-FSP **28%** (10,352)

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

TAOA-OE programs were not active in FY 2020-21

Total CSS Clients (unduplicated) N = 36,677

TAOA-SD **36%** (13,107)

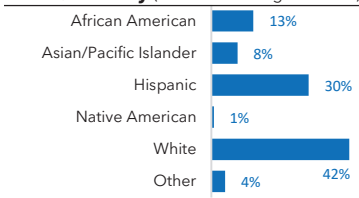
ALL-SD **25%** (9,308)

TAY, Adult, Older Adult – System Development (TAOA-SD; n=13,107)

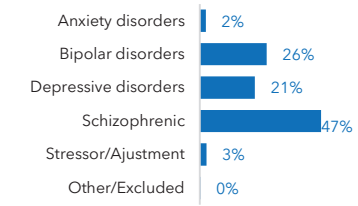
Living Situation	%
Board & Care	6%
Correctional Facility	1%
Homeless	17%
House/Apartment	67%
Institutional	8%
Other/Unknown	1%

Language	%
English	87%
Spanish	5%
Arabic	2%
Vietnamese	2%
Tagalog	0%
Farsi	0%
Other/Unknown	3%

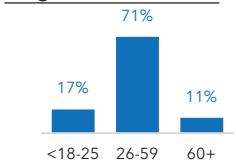
Race/Ethnicity (excludes missing/unknown)



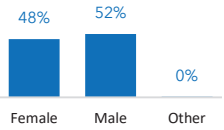
Diagnosis (excludes missing/invalid)



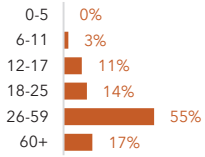
Age



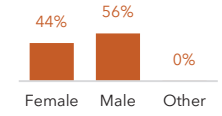
Gender



Age

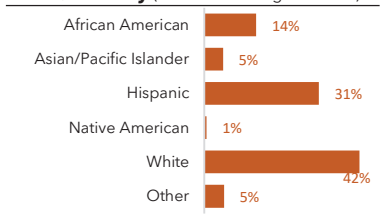


Gender

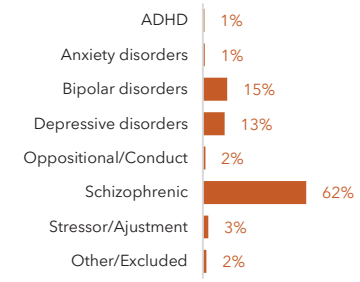


All CSS – System Development (ALL-SD; n=9,308)

Race/Ethnicity (excludes missing/unknown)



Diagnosis (excludes missing/invalid)



Living Situation	%
Board & Care	3%
Correctional Facility	1%
Group Home	0%
Homeless	20%
House/Apartment	69%
Institutional	2%
Other/Unknown	4%

Language	%
English	92%
Spanish	4%
Arabic	2%
Vietnamese	0%
Tagalog	0%
Farsi	0%
Other/Unknown	1%

CSS Report | Source: Optum | Data Source: Optum Monthly data extracts. Data may be impacted starting March 2020 due to COVID-19.
Note: Clients may have received services from >1 CSS category within the fiscal year. Only CSS programs that enter data into CCBH are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition Shelter Beds, Board & Care facilities, and Regional Recovery Centers. Percentages may not add up to 100% due to rounding.

Report Date: 05/02/2022

APPENDIX I

FULL-SERVICE PARTNERSHIP (FSP) OUTCOMES REPORT FY 2020-21

Full Service Partnerships OUTCOMES REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Children, Youth & Families FSP Summary ***FY 2020-21***

What Is This?

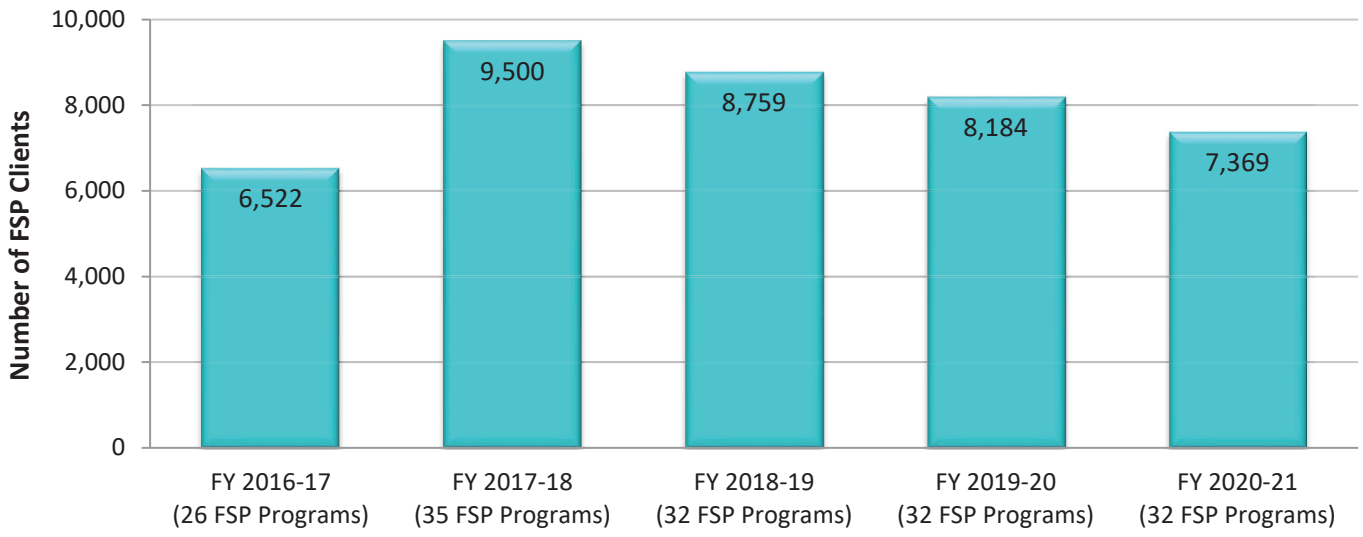
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals and treatment plan, and clients can access designated staff 24 hour/7 days a week. FSP services comprehensively address client and family needs through intensive services, supports, and strong connections to community resources with a focus on resilience and recovery. An FSP offers ancillary support(s), when indicated, by case managers, Substance Use Disorder (SUD) counselors addressing co-occurring conditions, rehabilitation specialists, and/or family/youth partners. Services offered are trauma informed and promote overall wellbeing. Emphasis on partnership with the family, natural supports, primary care, education, and other systems working with the family is a recognized core value.

Why Is This Important?

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

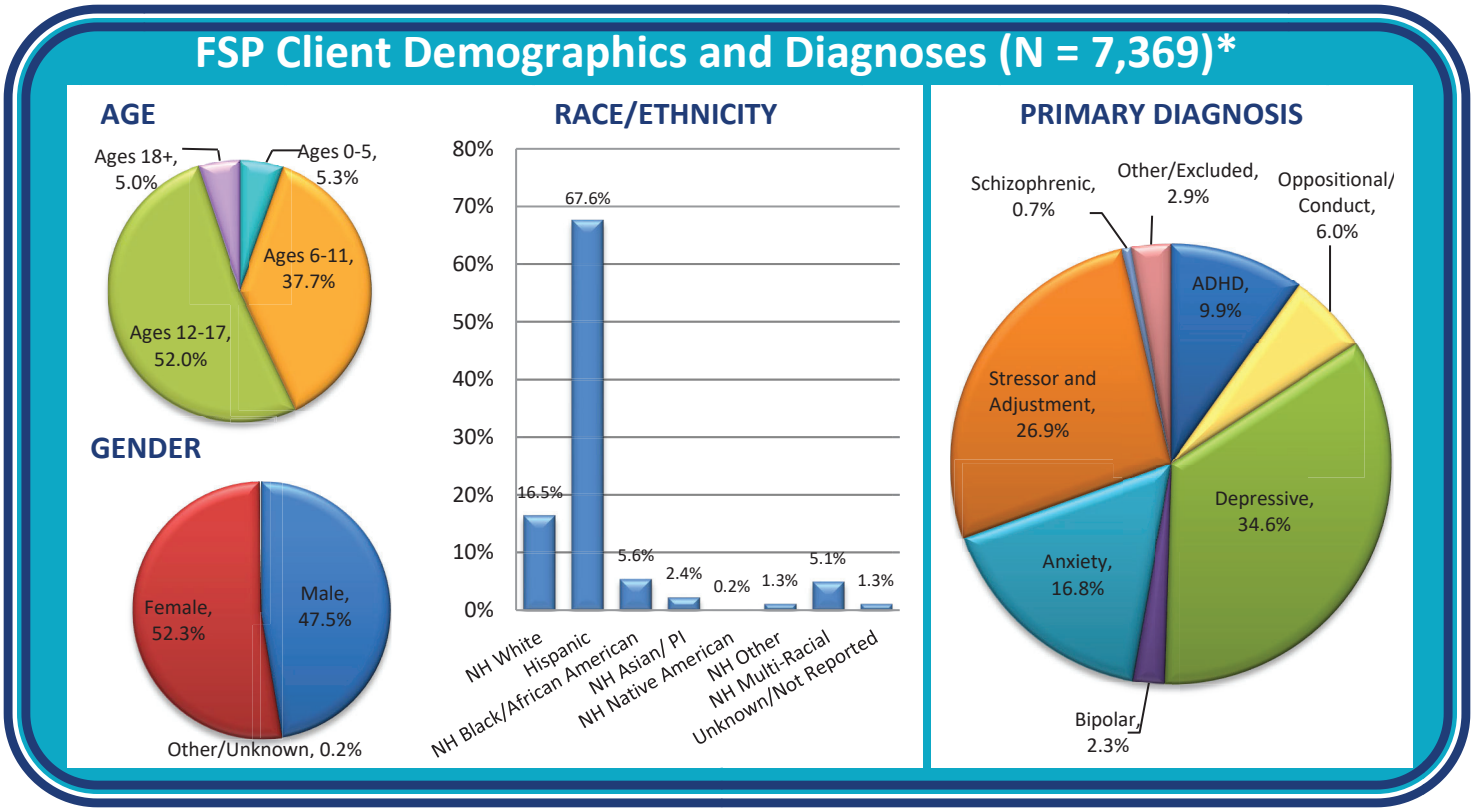
Who Are We Serving?

In Fiscal Year (FY) 2020-21, a total of 7,369 unduplicated clients received services through 32 CYF FSP programs, a 10% decrease from 8,184 FSP clients served in 32 CYF FSP programs in FY 2019-20.



Who Are We Serving?

In FY 2020-21, FSP clients were more likely to be female and Hispanic. The most common diagnosis among FSP clients was Depressive disorder.



**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 2020-21.

Referral Sources (N = 3,680)

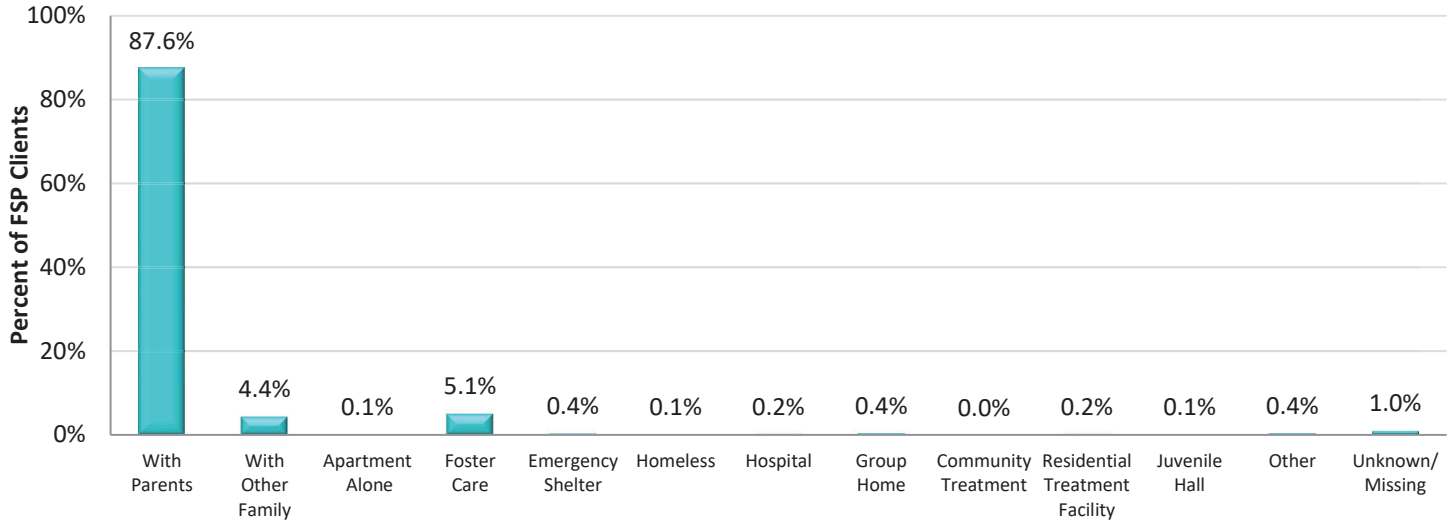
FSP referrals for clients with an intake assessment in FY 2020-21 were as follows (in order of frequency): school system (29%), family member (25%), primary care physician (13%), mental health facility (10%), social service agency (7%), self-referral (7%), other county agency (3%), Juvenile Hall (2%), acute psychiatric facility (1%), emergency room (1%), friend (1%), homeless shelter (<1%), faith-based organization (<1%), substance abuse facility (<1%), and street outreach (<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 2020-21.

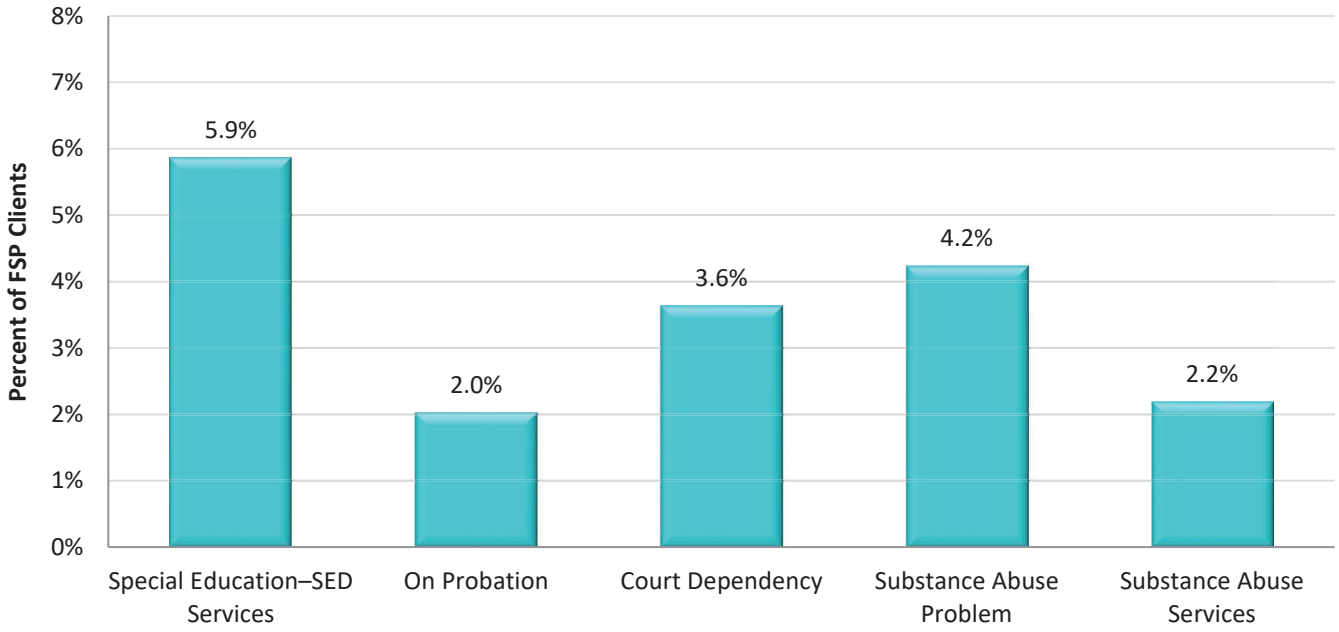
Living Arrangement at Intake (N = 3,680)*

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



Risk Factors at Intake (N = 3,680)*

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 3,111 (85%) of clients did not have a risk factor identified on the intake form. Clients with identified risk factors may have had more than one risk factor endorsed.



**Clients with intake assessment in the DCR within FY 2020-21.*
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 2020-21, a total of 9 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of 7,369 unduplicated clients who received services from an FSP program in FY 2020-21, 141 (1.9%) had at least one inpatient (IP) episode and 273 (3.7%) had at least one Emergency Screening Unit (ESU) visit during the treatment episode. These numbers show increases from 1.3% of FSP clients who had at least one IP and 2.3% of FSP clients who had at least one ESU in FY 2019-20, respectively.

Are Children Getting Better?

FSP providers collected outcomes data with the California Child and Adolescent Needs and Strengths (CANS and CANS-EC) and the Pediatric Symptom Checklist (PSC and PSC-Y). Scores were analyzed for youth discharged from FSP services in FY 2020-21 who were in services at least 60 days and who had both initial assessment and discharge scores completed. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP programs augmented with a Substance Use Disorder (SUD) component in FY 2020-21, who were in services for at least one month.

FSP PSC Scores

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

Amount of Improvement

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

Reliable Improvement

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

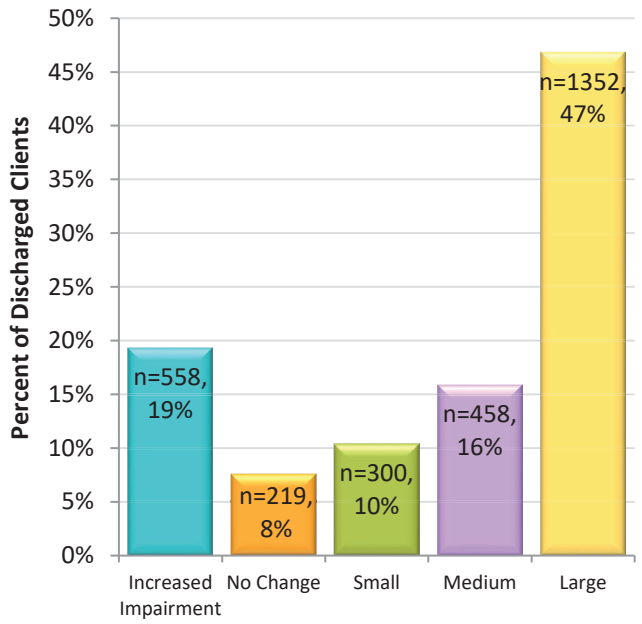
Clinically Significant Improvement

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

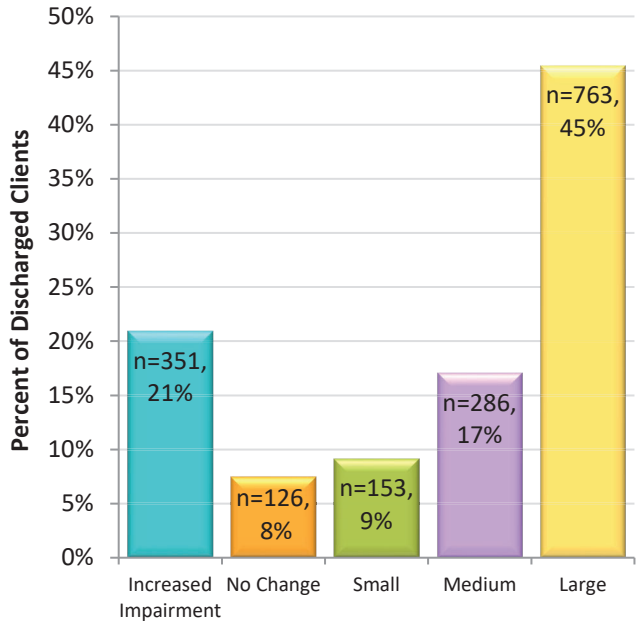
Are Children Getting Better? (continued)

PSC Amount of Improvement from Intake to Discharge

FSP Parent/Caregiver (N = 2,887)

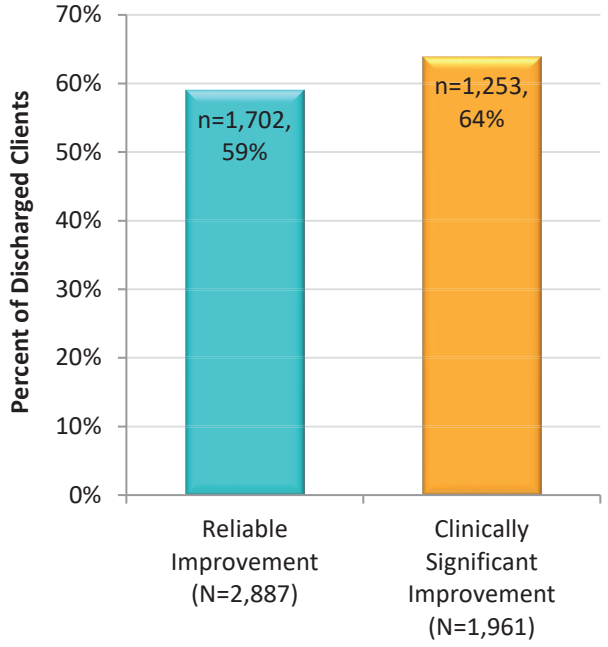


FSP Youth (N = 1,679)

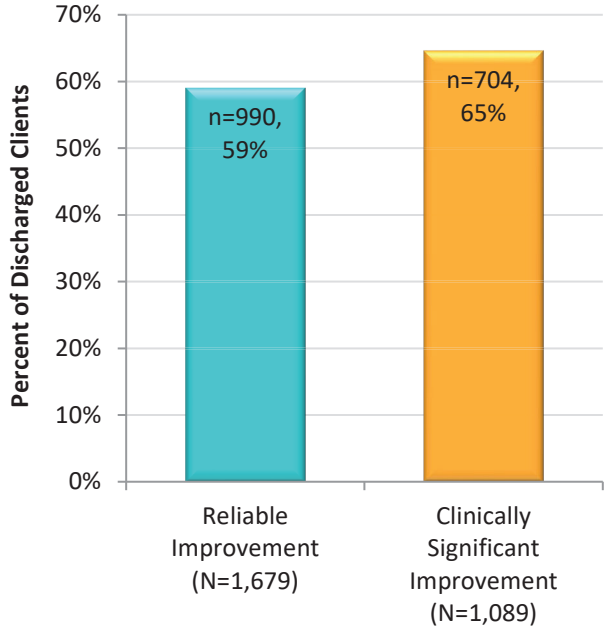


PSC Reliable and Clinically Significant Improvement from Intake to Discharge

FSP Parent/Caregiver



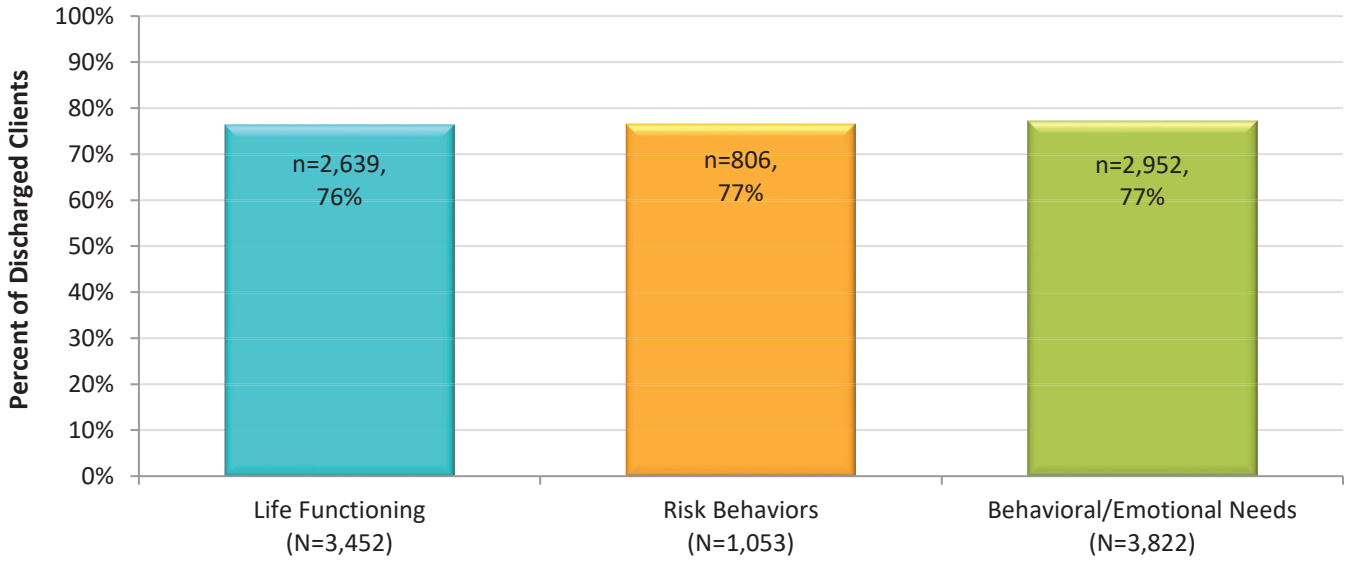
FSP Youth



Are Children Getting Better? (continued)

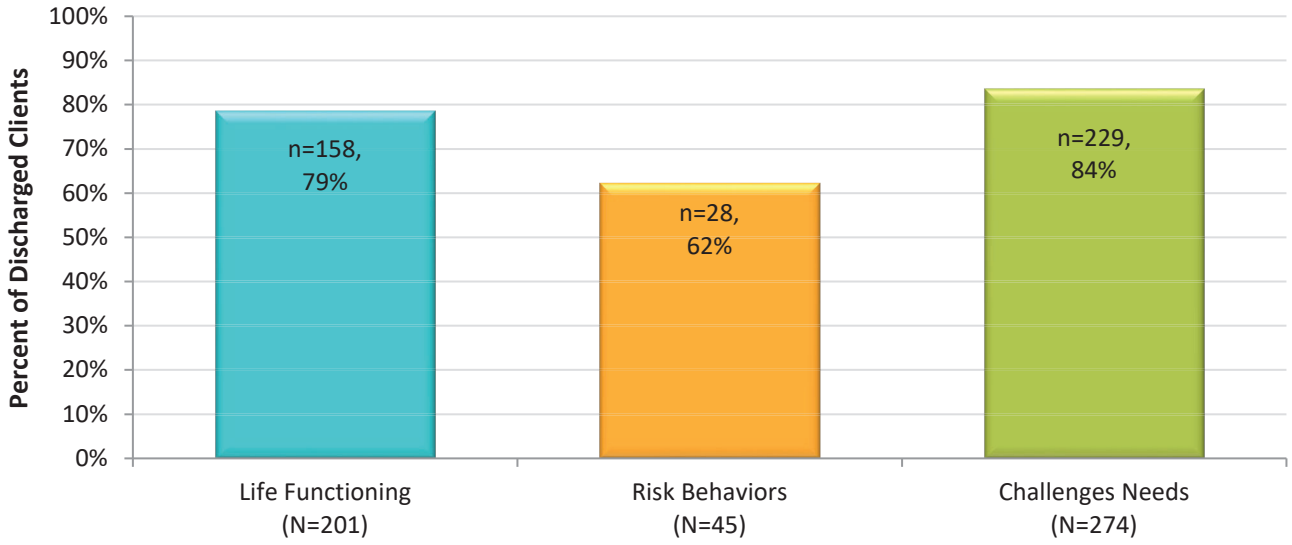
FSP CANS Scores

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



FSP CANS-EC Scores

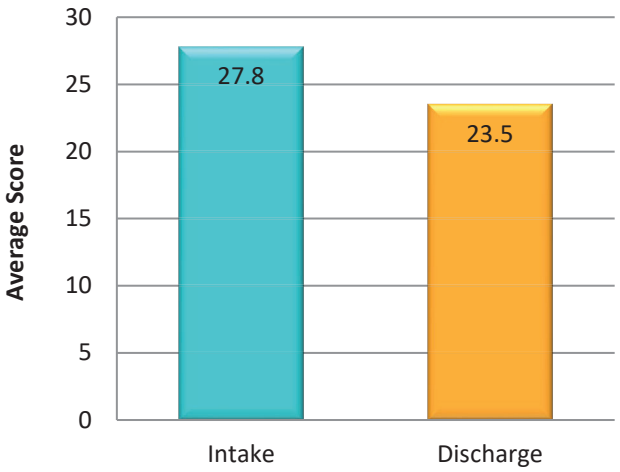
The CANS-EC is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 0 through 5. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors,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



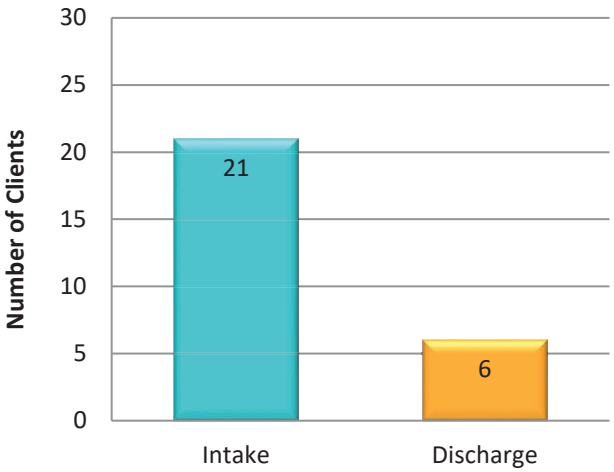
FSP PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their Substance Use Disorder (SUD) counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 60 discharged clients in FY 2020-21.

PESQ Severity Scale (N = 60)



PESQ Clinical Cutpoint



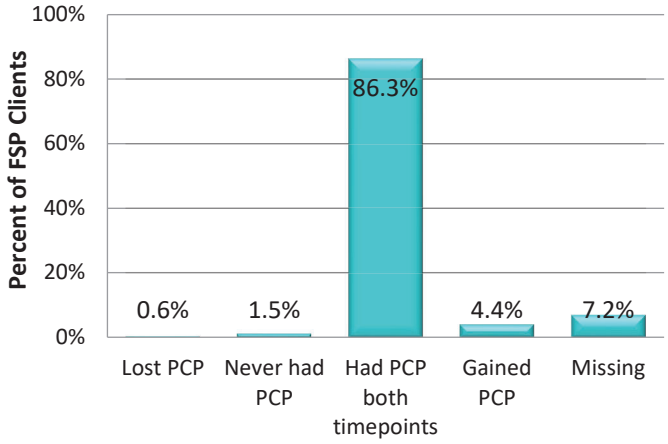


Are Children Getting Better? (continued)

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

Primary Care Physician (PCP) Status (N = 4,987)

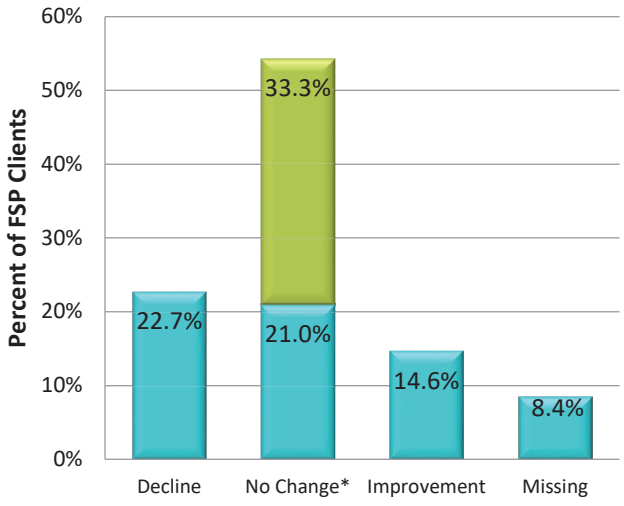
86% of FSP clients had and maintained a PCP.





School Attendance (N = 4,987)

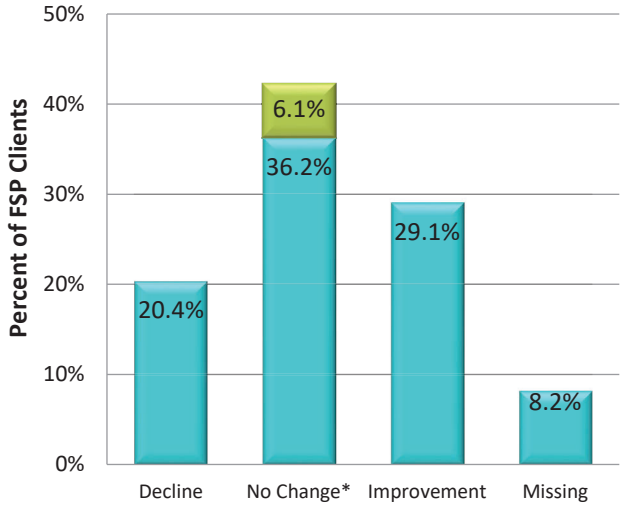
48% of FSP clients either improved (15%) or maintained excellent (33%) school attendance at follow-up assessment as compared to intake.



**Of the 54% of clients for whom no change was noted, 33% (green portion of bar) had consistently excellent attendance (intake and discharge assessments indicated the most positive category for school attendance).*

Academic Performance (N = 4,987)

35% of FSP clients either improved (29%) or maintained excellent (6%) grades at follow-up assessment as compared to intake.



**Of the 42% of clients for whom no change was noted, 6% (green portion of bar) had consistently excellent grades (intake and discharge assessments indicated the most positive category for school grades).*

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

What Does This Mean?

- **Data may be impacted starting March 2020 due to COVID-19.** This may, in part, account for the lower number of clients served and poorer attendance ratings in FY 2020-21 as compared to FY 2019-20.
- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms and reductions in needs, according to client, parent, and clinician report. The CANS-EC data show that a majority of clients ages 0 through 5 also showed reductions in needs between intake and discharge.
- On average, children and youth who received treatment by SUD counselors showed improvement in their risk for substance abuse problems.
- The majority of youth FSP clients had, and maintained, a PCP during their participation in FSP programs.
- Nearly half of youth FSP clients either improved or maintained excellent school attendance during their participation in FSP programs.

Next Steps

- Continued collaboration between FSP programs and schools to improve or maintain FSP clients' academic performance and school attendance.



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

The Child & Adolescent Services Research Center (CASRC) is a consortium of over 100 investigators and staff from multiple research organizations in San Diego County and Southern California, including: Rady Children's Hospital, University of California San Diego, San Diego State University, University of San Diego, and University of Southern California. The mission of CASRC is to improve publicly funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders. For more information please contact Amy Chadwick at aechadwick@health.ucsd.edu or 858-966-7703 x247141.

APPENDIX J

ANNUAL SYSTEM-WIDE ASSERTIVE COMMUNITY TREATMENT (ACT) REPORT FY 2020-21



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

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

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

Drawing from multiple data sources, this report presents a system-level overview of service use and recovery-oriented treatment outcomes for those who received FSP services from the 19 ACT programs* in San Diego County during fiscal year (FY) 2020-21.

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

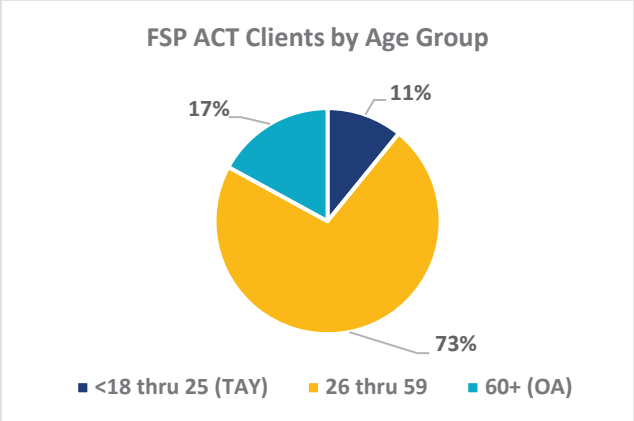
  were retrieved from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) system used by FSP programs across the State of California.
- Recovery outcomes and progress toward recovery were obtained from the County of San Diego's Mental Health Outcomes Management System (mHOMS).

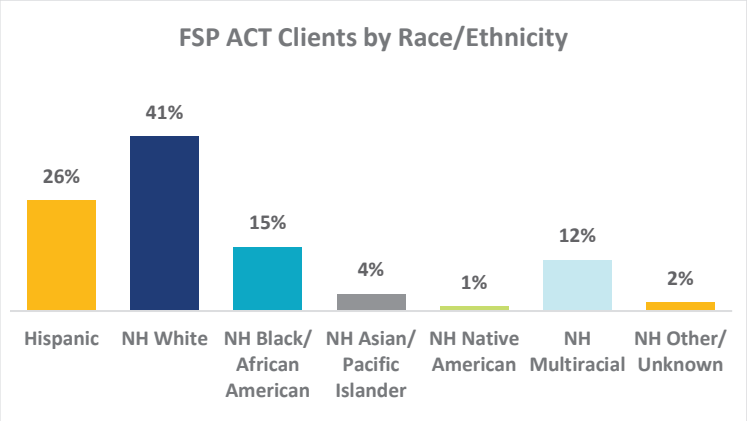
*Data from the following programs are included in this report (program name and sub-unit): CRF Downtown IMPACT (3241, 3244, 3245), Telecare Gateway to Recovery (3312, 3315), Telecare LTC (3331), MHS North Star (3361, 3364), CRF IMPACT (3401, 3404), MHS Center Star (3411, 3413, 3414), CRF Senior IMPACT (3481, 3482), Telecare PROPS AB109 (4192), Telecare MH Collaborative Court (4201, 4203), Telecare Assisted Outpatient Treatment (4211), MHS City Star (4221), MHS Action Central (4242), MHS Action East (4251), Pathways Catalyst (4261, 4264), CRF Adelante (4341), MHS North Coastal (4351), Telecare Vida (4401), Telecare La Luz (4421) and Telecare Tesoro (4411).

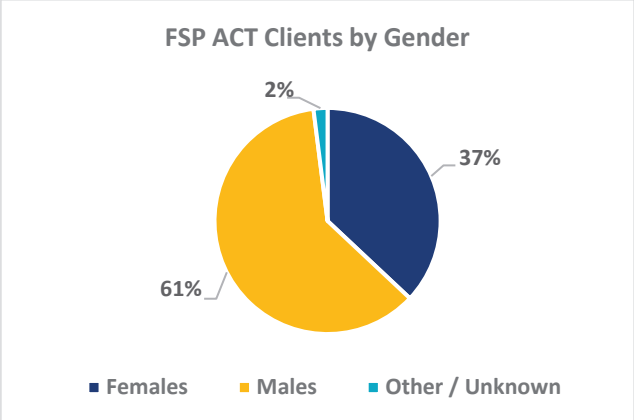
Note: Due to rounding, percentages in this report may not sum to 100%.

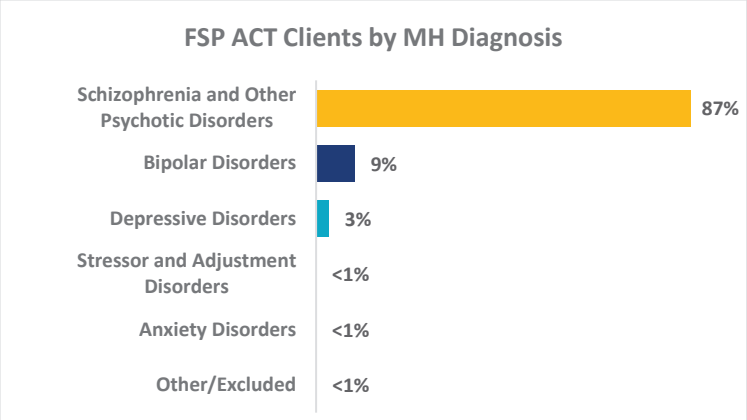
Demographics and Diagnoses

During FY 2020-21, 3,312 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (73%), a majority were male (59%), and the vast majority had a primary mental health diagnosis of schizophrenia or a psychotic disorder (87%). The next most common primary mental health diagnosis among FSP ACT clients served during the fiscal year was bipolar disorders (9%). In addition to their primary mental health diagnosis, 83% of FSP ACT clients served during FY 2020-21 had a history of substance use disorder. Almost half of FSP clients who received services from ACT programs during this period were Non-Hispanic (NH) White (41%), nearly one-fourth were Hispanic (26%) and nearly one-fifth were NH African American (15%).

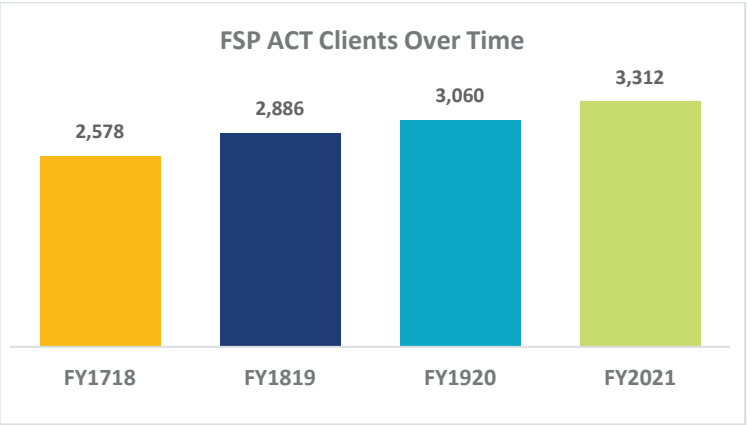








Since FY 2017-18, there have been nearly 750 additional FSP clients served by ACT teams each year. These additional clients reflect a 28% increase in the number of FSP clients served by ACT programs since FY 2017-18. The distribution of the key demographics highlighted above among FSP ACT clients served during FY 2020-21 is similar to the demographics of the clients served by these programs during the previous two fiscal years.



Meeting FSP ACT Clients' Basic Needs*

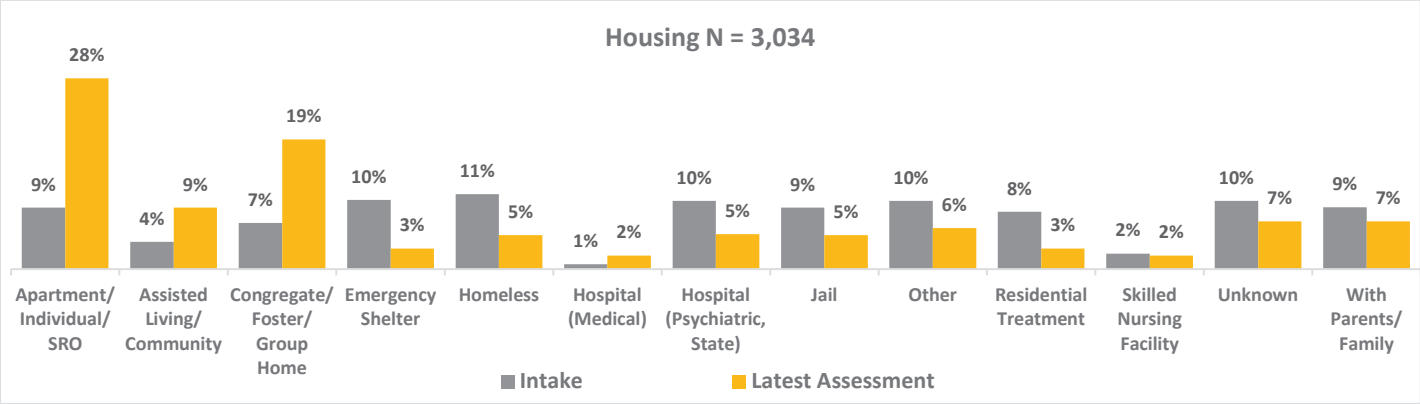
Housing

During FY 2020-21, FSP clients served by ACT programs showed progress in several areas of basic needs. Compared to intake, more than three times as many clients were living in an apartment/individual/single room occupancy (SRO) setting at the time of their latest assessment (9% at intake versus 28% at the latest assessment). Similarly, the proportion of clients living in a congregate, foster, or group home setting almost tripled from intake (7%) to the latest assessment (19%) and the proportion of clients living in an assisted living or community setting more than doubled from intake (4%) to the latest assessment (9%).

Notable decreases in the proportion of clients living in specific housing settings were also observed from intake to latest assessment. The proportion of clients housed in an emergency shelter decreased from 10% to 3%, the proportion of clients reporting a psychiatric hospital as their current living situation decreased from 10% to 5%, and the proportion of homeless clients decreased by over three-fifths from intake (11%) to latest assessment (5%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment/individual/single room occupancy** (SRO) setting more than **tripled** from intake (9%) to latest assessment (28%).
- The proportion of **clients** housed in an **emergency shelter decreased** from 10% at intake to 3% at the latest assessment.
- The proportion of **homeless clients decreased** by more than **three-fifths** from intake (11%) to latest assessment (5%).



Employment

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

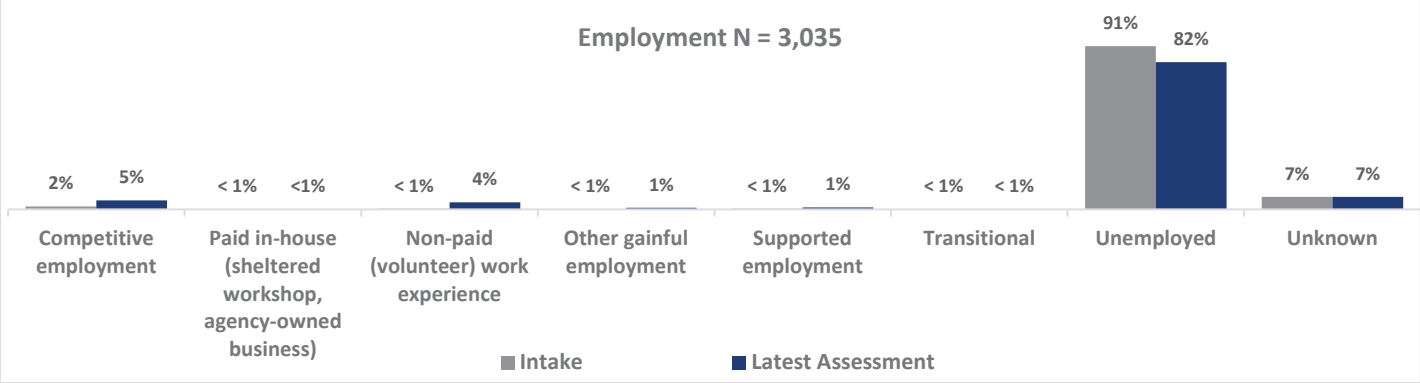
While most clients remained unemployed at the time of the latest assessment (82%), there was a 9% reduction in the number of clients that were unemployed at the latest assessment (2,497 clients) compared to intake (2,748 clients). The most notable increase in employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (6 clients at intake compared to 127 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 (161 clients) compared to the number employed at intake (57 clients). Similarly, there were five times as many FSP ACT clients working in supported employment settings at the time of the latest assessment (20 clients) compared to intake (4 clients).

*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2020-21, as of the 12/2020 DHCS DCR download.

Lastly, while only three clients were employed in another gainful employment setting at intake, 17 clients were employed in this setting at the time of the latest assessment.

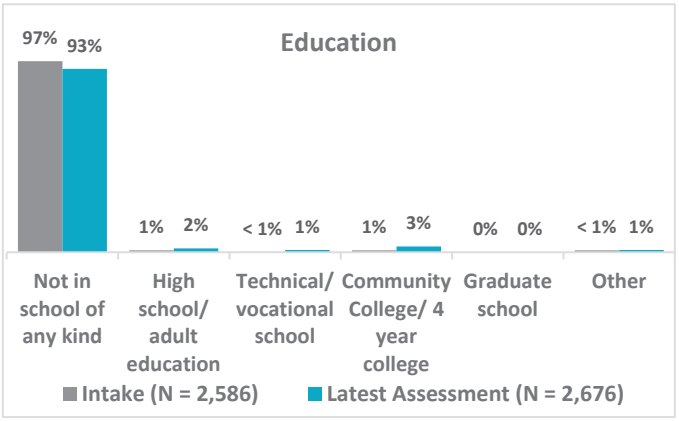
Key Findings: Employment

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



Education

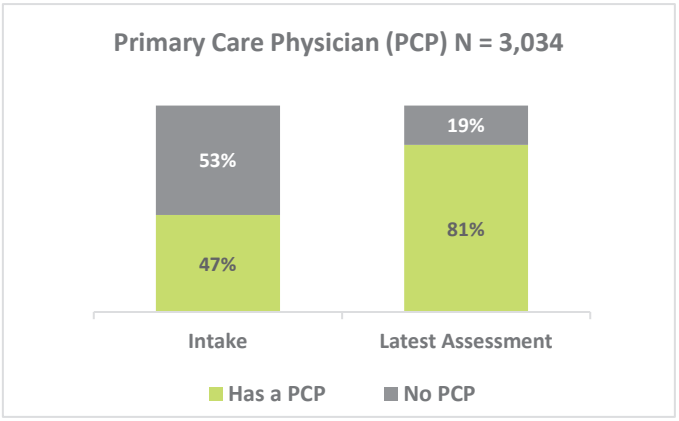
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 2,586 FSP ACT clients with education information available at intake[†], 86 (3%) were enrolled in an educational setting. At the time of the latest assessment, 196 of the 2,676 FSP ACT clients with educational information available (7%) were enrolled in an educational setting[†]. The largest increases from intake to latest assessment were observed in the proportion of clients enrolled in a community or four-year college (1% at intake versus 3% at the latest assessment for both settings) compared to other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2020-21, 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 (47%; 1,419 clients) had a primary care physician at intake, while a majority (81%; 2,443 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 2020-21 were similar to those observed during previous fiscal years.



[†]Education information was missing for 448 clients at intake, and 358 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, 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 2020-21. 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 (75% and 63%, respectively, compared to reductions of 41% and 42%).

Similar to the reduction in overall emergency service utilization, there was a 48% 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 (70%) and services at the psychiatric hospital (54%). The number of clients who received a PERT service or a CS service decreased by 46% from pre to post assessment and the number of clients who received a UO service decreased by 44%, 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 (14%). Some of the most notable reductions observed among those receiving services from the CR (15%) and psychiatric hospital LOCs (20%).

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2020-21 were similar to reductions in utilization observed among this population during FY 2018-19 and FY 2019-20. CO was renamed to UO in FY 2018-19 to more accurately reflect the types of services provided at that level of care.

Key Findings: Use of Inpatient and Emergency Services

- Utilization of **all emergency services 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.
- The mean number of **UO, PERT,** and **CS** services per client **remained relatively stable** among FSP ACT clients 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	521	337	-35%	259	158	-39%	2.01	2.13	6%
UO†	572	393	-31%	285	188	-34%	2.01	2.09	4%
PERT	701	419	-40%	410	251	-39%	1.71	1.67	-2%
Crisis Residential	728	164	-77%	401	104	-74%	1.82	1.58	-13%
Psychiatric Hospital	1,645	580	-65%	622	269	-57%	2.64	2.16	-18%
Overall	**4,167**	**1,893**	**-55%**	**861**	**444**	**-48%**	**4.84**	**4.26**	**-12%**

**The overall number of clients at Pre (n=1,051) and Post (n=542) 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=1,573) had an enrollment date ≤ 7/1/2020 and discontinued date (if inactive) > 7/1/2020. 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 10/2020 CCBH download. The 12/2021 DHCS DCR download was used to identify active clients, and for Post period data.

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

Similar to previous fiscal years, there were overall decreases from pre to post assessment in the mean number of days spent (57% 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 hospital (82% reduction) and the number of clients who resided in a state hospital (69% reduction). Notable reductions were also observed in the number of days (59% reduction) and the number of clients (49% reduction) residing in long-term care settings from pre to post assessment.

The residential status of individuals receiving FSP services is changed to "Acute Medical Hospital" when admission to a medical hospital setting occurs for a physical health reason such as surgery, pregnancy/birth, cancer, or another illness requiring hospital-based medical care. Data pertaining to placements in acute medical care settings are reported separately in the table below. Compared to pre assessment, there was nearly over a two and a third time increase (235%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 60% 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 2020-21 the rates of change between pre and post assessment for each type of restrictive setting mirrored the rates observed for these settings during the previous fiscal year. One change from last fiscal year is that the mean number of days per FSP ACT client in the state hospital only decreased by 8% from pre to post during FY 2019-20, but decreased by 42% during FY 2020-21. Also, to note, is the observed 24% increase in the mean number of days per client spent in a jail or prison setting, a trend consistent with the increase observed during FY 2019-20.

Key Findings: Placements in Restrictive and Acute Medical Settings

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

	# OF DAYS			# OF CLIENTS*			MEAN # OF DAYS PER CLIENT		
Type of setting	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change****
Jail/Prison	38,897	21,061	-46%	385	169	-56%	101.03	124.62	23%
State Hospital	9,172	1,477	-84%	57	10	-82%	160.91	147.70	-8%
Long-Term Care	69,587	24,030	-65%	249	106	-57%	279.47	226.70	-19%
Overall	**117,656**	**46,568**	**-60%**	**768**	**342**	**-55%**	**176.27**	**170.33**	**-3%**
Acute Medical Hospital	4,202	9,336	122%	182	234	29%	23.09	39.90	73%

**The overall number of clients at Pre (n=768) and Post (n=342) 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 12/2021 download; 12-month pre-enrollment DCR data rely on client self-report.

Measuring Progress Towards Recovery**

Overall Assessment Means for Assessments 1 and 2

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

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

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

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

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

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

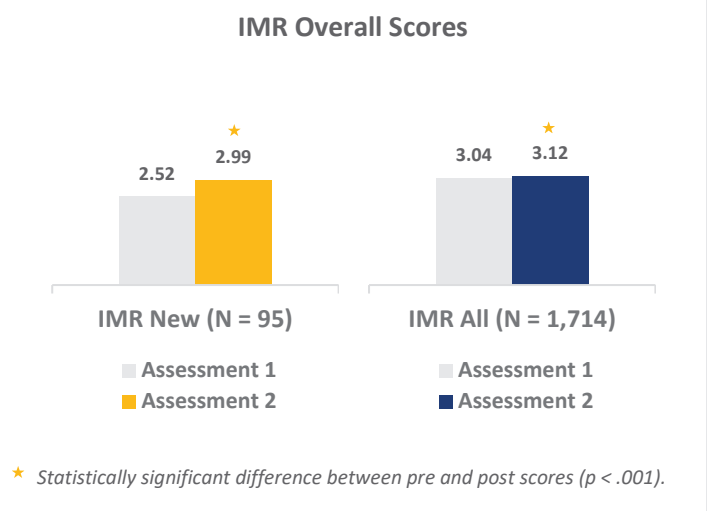
- **New** clients are defined as those who:
  1. began receiving ACT services in 2020 or later,
  2. had two IMR or RMQ assessments during FY 2020-21 (assessments 1 and 2), and
  3. had a first service date within 30 days of their first IMR assessment.
- **All** clients include every FSP ACT client with at least two IMR or RMQ assessments during FY 2020-21 (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.

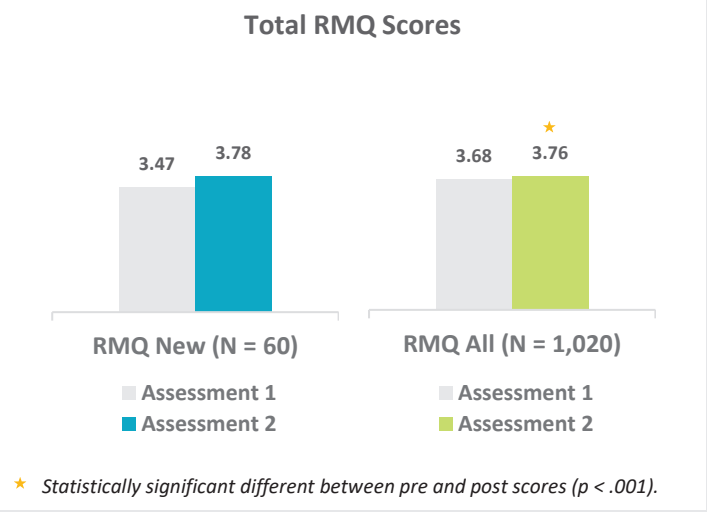
As expected, overall IMR and RMQ assessment 1 mean scores for New clients were lower than assessment 1 mean scores for All clients. For both groups overall IMR assessment 2 mean scores were significantly higher than overall IMR assessment 1 mean scores ($p < .001$).

The mean assessment 1 score from All clients was relatively high compared to mean scores among New clients, suggesting that clients enrolled in ACT services for a longer period of time may have reached a point in their recovery where they are maintaining their current recovery and improvement is no longer expected.

Overall RMQ mean scores were slightly higher at assessment 2, compared to assessment 1 for both New and All clients, but this increase only reached statistical significance for the group of All clients. RMQ assessment scores for New and All clients were higher than their IMR scores indicating that both groups of clients rated their progress higher than clinicians did.



★ *Statistically significant difference between pre and post scores ($p < .001$).*



★ *Statistically significant different between pre and post scores ($p < .001$).*

**Outcomes data are sourced from mHOMS FY 2020-21; Data include all mHOMS entries as of 3/10/2021 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2020-21, 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 subscale scores ($p < .001$) 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. Only New FSP ACT clients had significantly higher mean Management subscale scores ($p < .001$) at assessment 2 than they did at assessment 1.

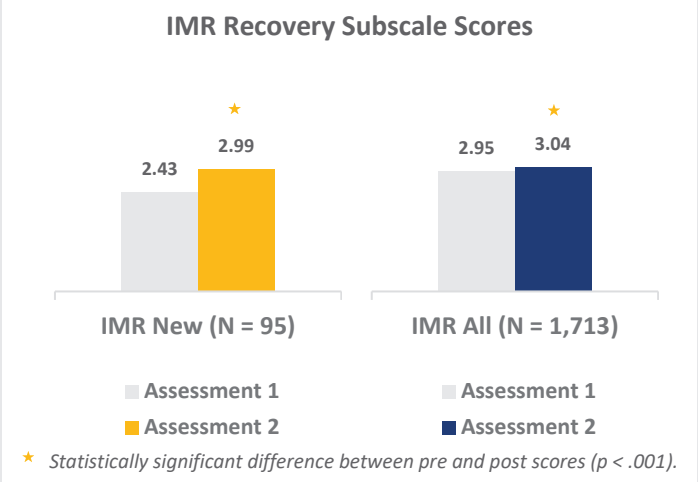
Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or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

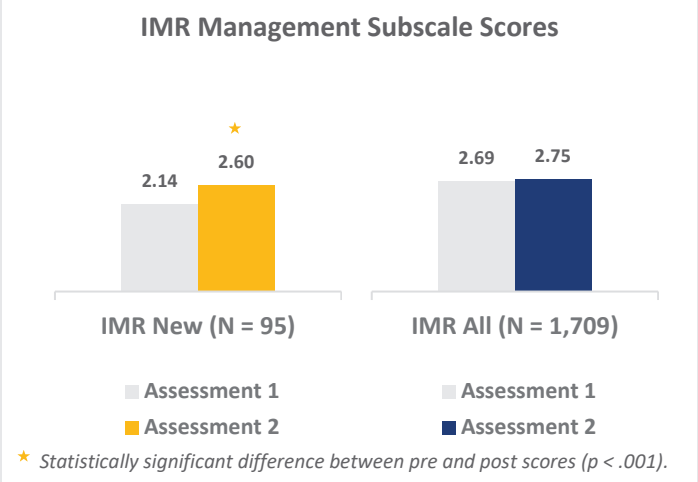
Both New and All FSP ACT clients had slightly higher mean Substance Use scores at assessment 2 compared to assessment 1, however this difference in mean scores was not statistically significant.

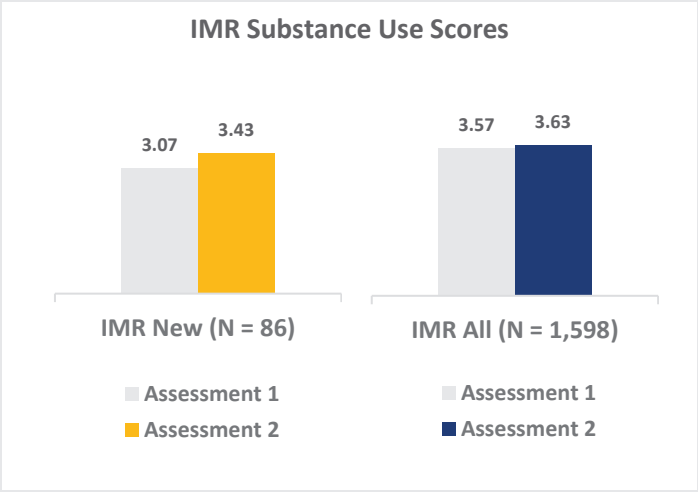
Key Findings: Assessment Outcomes

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

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

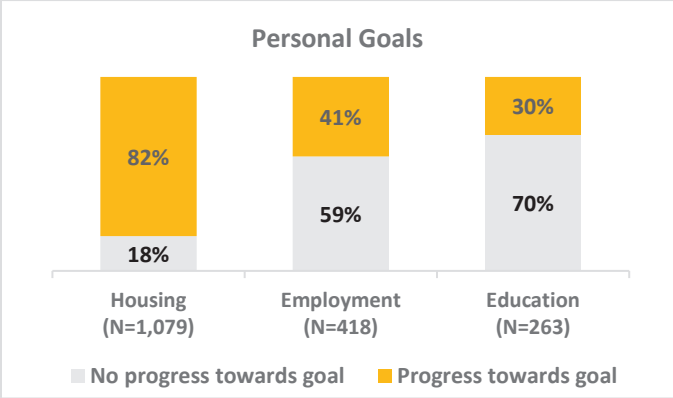






Progress Towards Key Treatment Goals

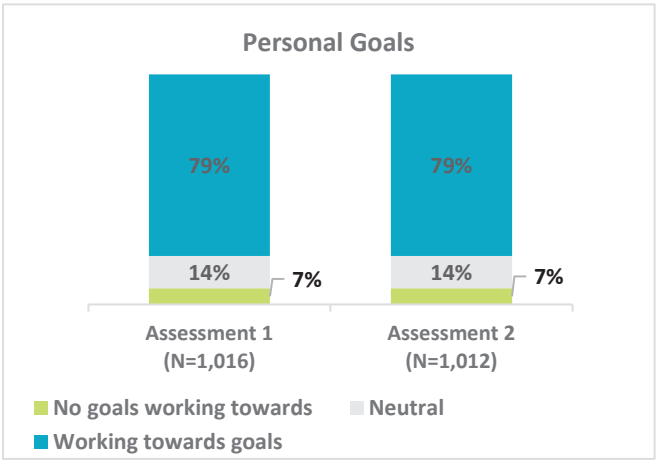
At the time of their follow-up IMR assessments, clinicians also noted client progress towards goals related to housing, education, and employment. Similar to trends observed during FY 2019-20, most FSP ACT Clients served during FY 2020-21 with a completed Goal assessment had a goal related to housing (1,079 clients; 90%) on their treatment plan. Of these clients, clinicians reported that 82% made progress towards their individual housing goal at the time of the latest assessment. Fewer FSP ACT clients had goals related to employment (418 clients; 35%) or education (263 clients; 22%) on their treatment plan, compared to the number with housing related goals. Additionally, over two-fifths of clients with goals related to employment (41%) and less than one-third of clients with goals related to education (30%) made progress towards their goals at the time of the most recent assessment. These results may reflect a



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

Personal Goals

One of the items in the RMQ assessment asks clients if they have goals which they are working towards achieving. More than three-quarters of FSP ACT clients at assessment 1 (79%) and assessment 2 (79%) 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. Only 74 FSP ACT clients (7%) 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 four clients at assessments 1 and eight 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:

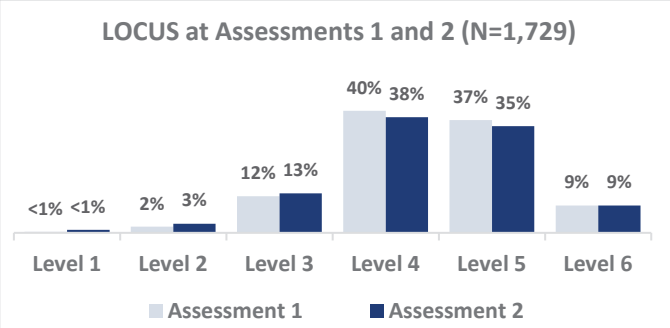
1. risk of harm,
2. functional status,
3. medical, addictive, and psychiatric co-morbidity,
4. recovery environment,
5. treatment and recovery history, and
6. engagement and recovery status.

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 non-residential services (Level 4) was observed from assessment 1 to assessment 2, and a similar proportion of clients recommended for medically monitored residential services (Level 5) was observed between assessments.



Note: Percentages are rounded.

Key Findings: Goals and LOCUS

- **Majority** of FSP ACT clients (90%) had a **housing related goal** on their treatment plan.
- Of the clients with a housing goal on their treatment plan, a **majority** (82%) **made progress** towards that goal by assessment 2.
- **Most** clients (79%) agreed or strongly agreed that they were **working towards a treatment goal** at assessment 2.
- Clients were most likely to be recommended for a **Level 4** or **Level 5** treatment setting at both times points.

Conclusion

With the addition of several new FSP ACT programs within the San Diego County Behavioral Health System of Care during the past few years, there has been increased interest in learning more about the impact of these programs on clients' service use and outcomes. The FSP ACT model aims to serve homeless clients with severe mental illness, as evidenced by the vast majority of clients served during FY 2020-21 with 1) a housing-related goal (90%), 2) a diagnosis of schizophrenia or psychotic disorder (87%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 86% at intake).

Similar to trends reported from previous fiscal years, FSP ACT clients served during FY 2020-21 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/individual/ single room occupancy setting tripled from intake (9%) to latest assessment (28%), the proportion housed in an emergency shelter decreased from 10% at intake to 3% at the latest assessment, and the proportion of homeless clients decreased from 11% at intake to 5% at the latest assessment. There was also a 9% reduction in the number of clients unemployed at the latest assessment compared to intake and an 34% 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 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 (57% 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 2020-21, mirroring improvements observed among this population during previous fiscal years and demonstrating a positive effect of services on the lives of clients served by the ACT programs.

APPENDIX K

HOUSING UPDATE
EXECUTIVE SUMMARY

COUNTY OF SAN DIEGO
Behavioral Health Services

Five Year (2022-2027) Strategic Housing Plan

2022 is a year of opportunity following a seismic shift in how we all think about the importance of home and what it means to be healthy. Now, more than ever, there is a shared understanding of the critical importance of housing and agreement that housing is fundamentally important to being healthy and having a strong platform to achieve goals.

This Five-Year Plan envisions ***Creating Homes With Intention, Purpose, and Collaboration*** and outlines guiding principles and targeted responses that will maximize a range of housing options for people with behavioral health issues (people with serious mental illness/ serious emotional disorders and/or substance use disorder) and limited resources through policy decisions, funding commitments, and programmatic initiatives. The Plan's approach is rooted in principles of equity and inclusion and the goals are driven by the voices of people with lived expertise. The Plan aims to maximize opportunities for community integration as well as choice in housing and services options that best meet individual needs and recovery goals.

>>>



SUMMARIZING THE FIVE-YEAR STRATEGIC HOUSING PLAN

Three key goals have been identified with ten focus areas that call for purposeful action in the first two years in order to recognize the urgent need for housing and maximize the impact of significant new resources.

GOAL #1 Opening More Doors

- ***Focus Area #1*** *Diversity of Housing Options*
- ***Focus Area #2*** *Housing Equity and Supporting Community Integration*
- ***Focus Area #3*** *Priority Populations*
- ***Focus Area #4*** *Geographic Diversity and Regional Distribution of Housing*

GOAL #2 Driving Collaboration Through Active Connectivity

- ***Focus Area #5*** *Effective Collaboration and Integrating Systems*
- ***Focus Area #6*** *Ongoing Pandemic Response*

GOAL #3 Expanding Services Approaches

- ***Focus Area #7*** *Recovery and Retention Supports*
- ***Focus Area #8*** *Flexibility in Service and Housing Models*
- ***Focus Area #9*** *Bring Moving On Opportunities to Scale*
- ***Focus Area #10*** *Increase Wraparound Service Supports*

USE THIS QR CODE TO DOWNLOAD THE FULL REPORT OR LEARN MORE, OR VISIT:
https://www.sandiegocounty.gov/content/sdc/bhsa/programs/bhs/mental_health_services_act/mhsa_housing.html

UNDERSTANDING THE CHALLENGES

Corporation for Supportive Housing (CSH) and San Diego National Alliance on Mental Illness (NAMI) designed an input process in partnership with people with lived expertise as well as the Behavioral Health Housing Council and County of San Diego Behavioral Health Services. Throughout the input process, they identified key stakeholders in order to develop and refine the questions and key areas of discussion. An extensive variety of opportunities for participation in the development of the Plan were offered throughout the first half of 2021 in order to engage with a broad range of stakeholders, including:

- **14 Focus Groups with people with lived expertise,**
- **2 focus groups with service and housing providers**
- **Client Surveys (online in English and Spanish; paper copy for in-reach)**
- **13 input/listening Sessions**
- **Online Input Form**

Guided by the BHS multi-sector system of care transformational goals of continuous care and prevention, and providing coordinated resources to keep people connected, stable and healthy, the Housing Council members used all of the valuable feedback to identify the following top three priority goals and corresponding actionable strategies.

GOAL #1 Opening More Doors

The County of San Diego has prioritized the creation of new housing for over two decades, and the inventory of dedicated supportive housing for people with serious mental illness with limited resources has successfully increased from 241 units to 584 units. The need remains high, however, and focused effort needs to continue, especially for very low and extremely low income households; there is a shortfall of 68,959 homes in these income categories. The Housing Council is particularly focused on increasing a diversity of housing options and geographical locations by:

- Maximizing and accelerating unit creation by fully committing the first 3 years of No Place Like Home Funding by February, 2023.
- Maximizing ongoing rent subsidies by aligning with support services, such as Emergency Housing Vouchers.
- Identify opportunities to create "tiny home" villages with wrap-around supports that are not time limited and which have an emphasis on community building, particularly on parcels of land that can't support larger multifamily housing projects.
- Establish a dedicated flexible housing subsidy pool for people with behavioral health issues.
- Increase inventory of shared housing by exploring feasibility of developed shared housing opportunities, converting more single family homes into co-living or communal living situations, and expanding independent living and recovery residence association member homes by 25%.
- Explore other housing production alternatives and innovative housing types in addition to tiny homes to include, but not limited to 3D printed homes, new prefabricated housing types that meet state and local building code standards, conversion of vacant commercial or industrial buildings to affordable housing. This includes deepening collaboration with Department of Homeless Solutions & Equitable Communities to address system, service & housing needs for people experiencing homelessness who have identified behavioral health needs.
- Expand understanding and implementation of quality in housing and services, including Housing First and Supportive Housing fidelity models which emphasize community integration principles.
- Address systemic disparities by reviewing and incorporating recommendations from the County of San Diego Behavioral Health Equity Index, the San Diego Cultural Competency Plan, and the Ad Hoc Committee Addressing Homelessness among Black San Diegans.

GOAL #2 Driving Collaboration Through Active Connectivity

Stakeholder feedback indicated that purposeful collaboration is needed and also desired among the various industries – health care, mental health care, law enforcement, public defender's office, district attorney, service providers and more that work every day to assist BHS clients experiencing homelessness to ultimately access housing and keep it. More effective, collaborative working relationships would result in more housing opportunities, and more successful outcomes once people are housed. The Housing Council is focused on supporting:

- Payment reform efforts, including Medi-Cal CalAIM planning, which prioritizes care and provides incentives for collaboration and continuous system improvement instead of cost-based reimbursement which includes burdensome documentation requirements.
- Engage in collaborative data-sharing efforts by seeking out opportunities to align systems and databases with BHS housing planning efforts, building on cross-sectoral referral capacities with housing & service partners.
- Address the digital divide by expanding access to computers and internet access.
- Further develop and promote quality telehealth, phone app based, and 24/7 phone based behavioral health options as well as connections to public health supports (including access to vaccines/boosters).
- Continue to develop services in housing which accommodate for social distancing while maintaining community connection.
- Focus on increasing income and basic supports.

GOAL #3 Expanding Service Approaches

Homeless individuals struggle with a wide range of housing needs, including understanding how to apply for a variety of affordable housing and how to navigate the system once they are able to access affordable housing. Many stakeholders also shared that it is often traumatic to move from homelessness to a new home and BHS clients struggle in making that adjustment. Priorities for Housing Council include:

- Further develop peer based programs to support tenants who are connected to BHS services as they make a transition into housing.
- Identify opportunities to expand services and housing eligibility criteria to more broadly serve people with behavioral health issues through intentional partnerships.
- Expand Moving On opportunities through training and additional housing subsidies.
- Increase BHS client access to Social Security work incentives, Housing Authority "Family Self Sufficiency" programs, and other partner program opportunities that offer financial literacy programs as well as financial incentives to increase earnings and savings.
- Expand employment supports for people accessing housing opportunities.
- Increase the evidence-based and best practice service supports that assist in enhanced access to housing and housing retention, including income and benefit supports, harm reduction strategies, mental health support and linkage to physical health care and housing retention supports.

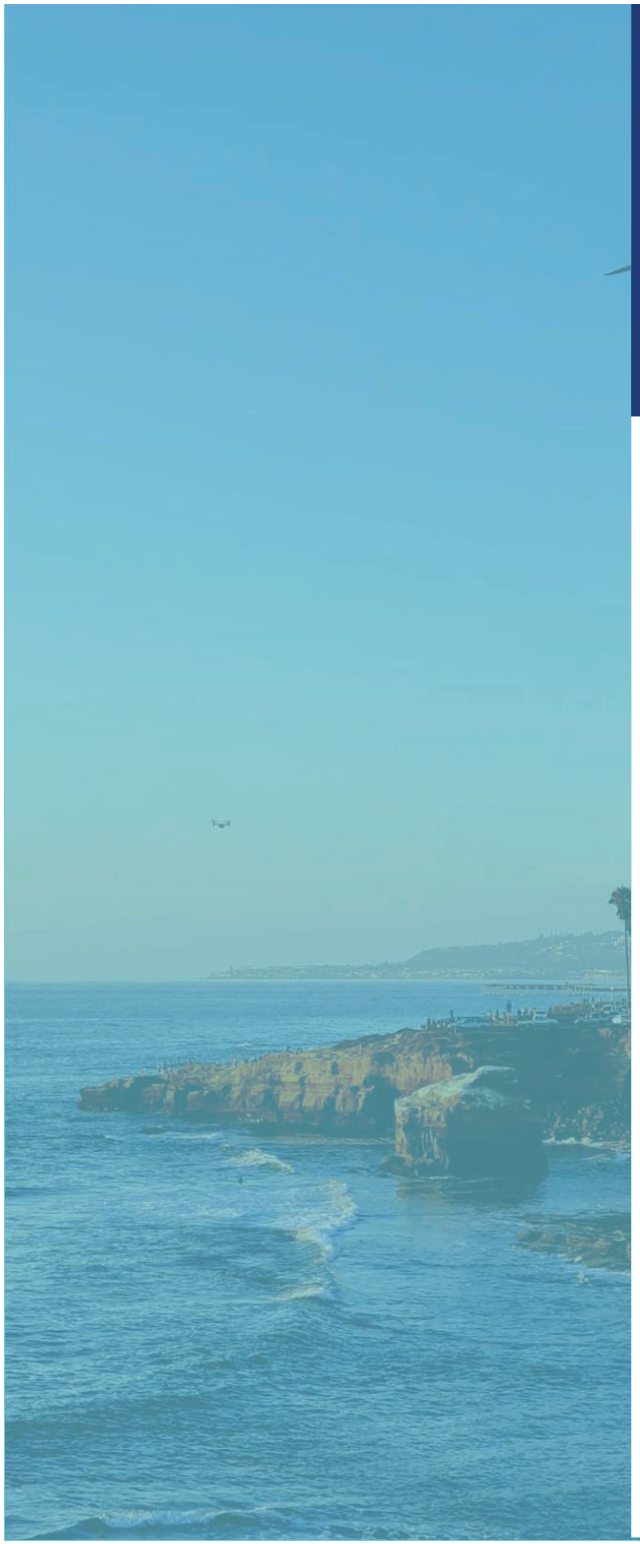
APPENDIX L

PREVENTION AND EARLY INTERVENTION (PEI) SYSTEM-WIDE SUMMARY

CHILD & ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2020-21 ANNUAL REPORT



REPORT CONTENTS

03 Background

04 Systemwide Demographics

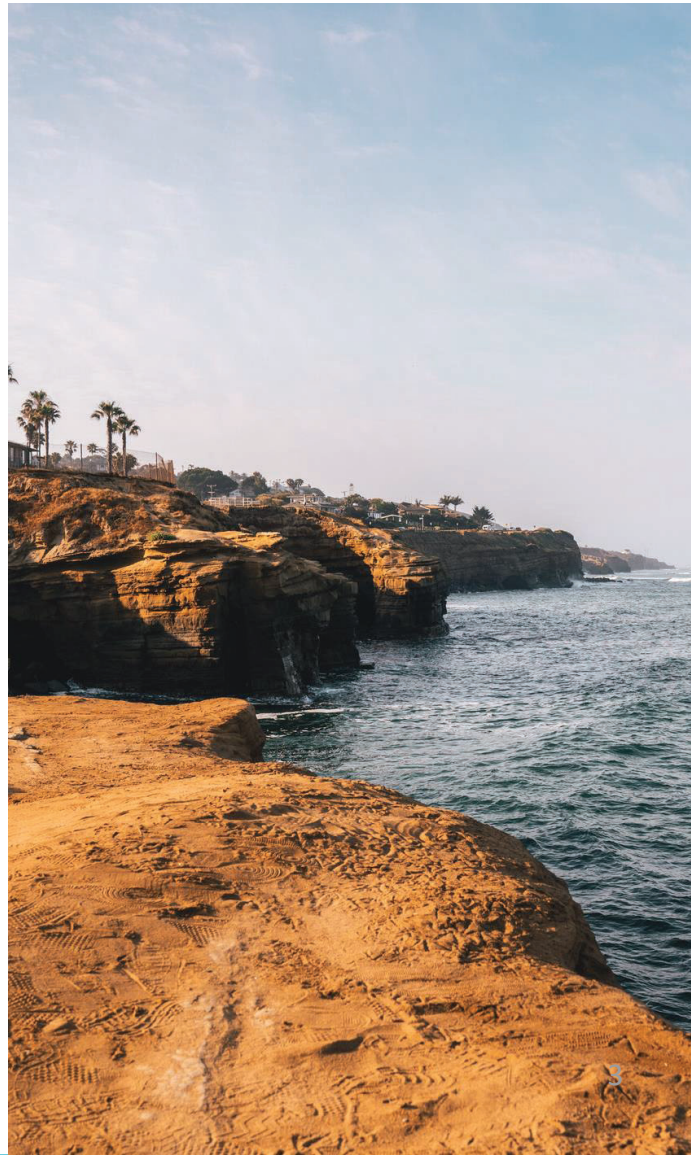
12 Systemwide Outcomes and Referrals

13 About the Research Centers

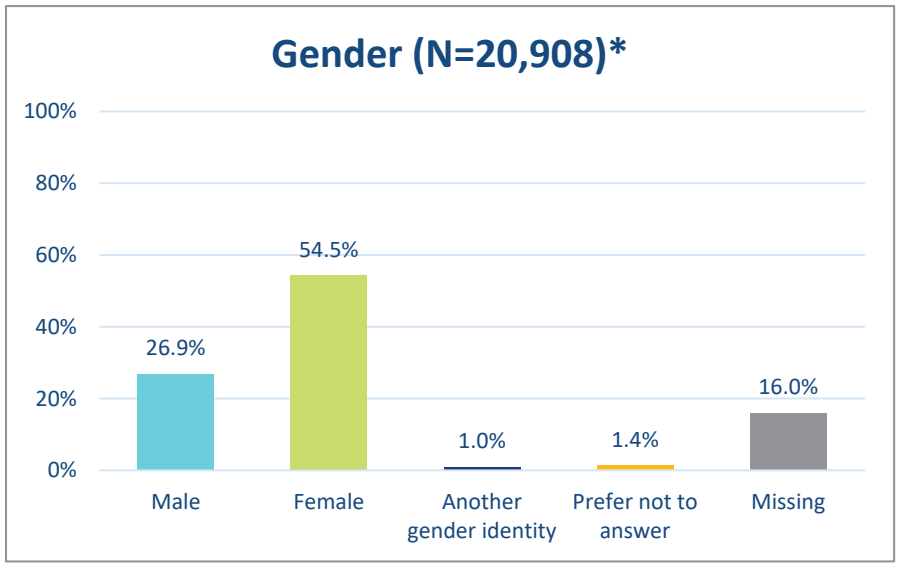
CHILD & ADULT PEI PROGRAMS: BACKGROUND

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. With this funding source, the County of San Diego contracted with providers for PEI programs for adults and older adults, youth and transition age youth (TAY), and their families. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by the program via outreach efforts, including but not limited to: presentations, community events, and fairs. PEI data collection and reporting may have been impacted starting March 2020 due to COVID-19.

DATA: Child and Adult PEI Programs
REPORT PERIOD: 7/1/2020-6/30/2021
NUMBER OF PARTICIPANTS WITH DATA IN FY 2020-21: 20,908 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=20,908 vs. N=13,606).* *†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.*

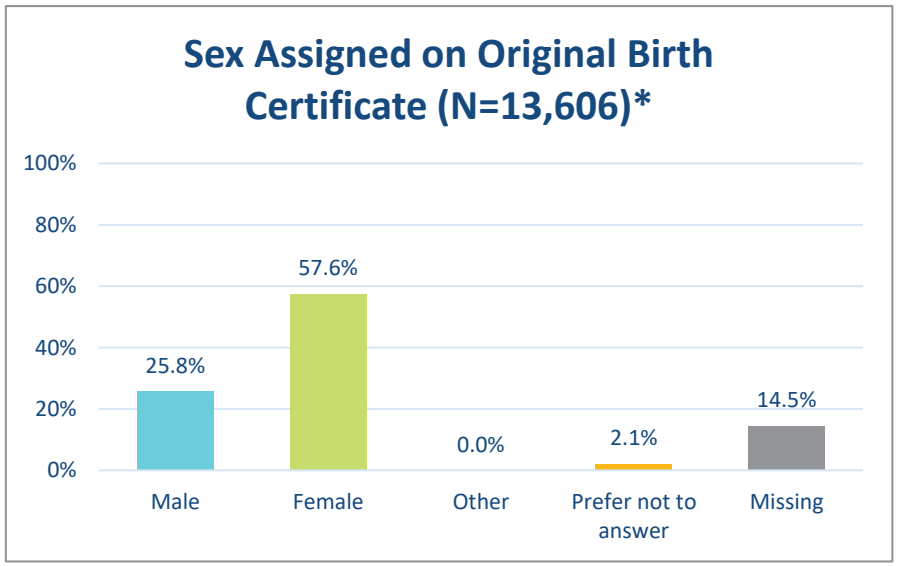


SYSTEMWIDE DEMOGRAPHICS



Almost 55% of participants identified as female. One percent of participants identified as another gender identity. One percent of participants preferred not to answer this question.

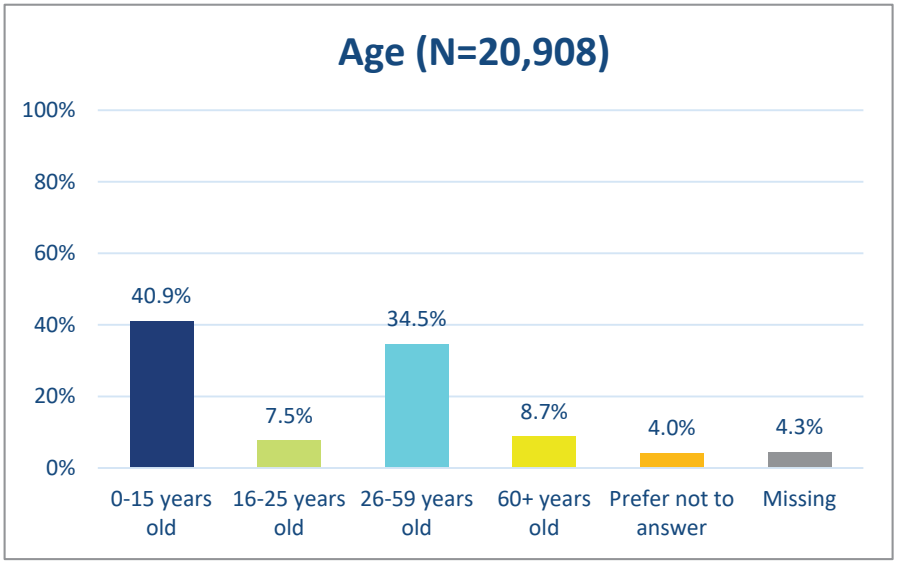
**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*



Almost 58% of participants reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =13,606 vs. N=20,908).*

SYSTEMWIDE DEMOGRAPHICS continued



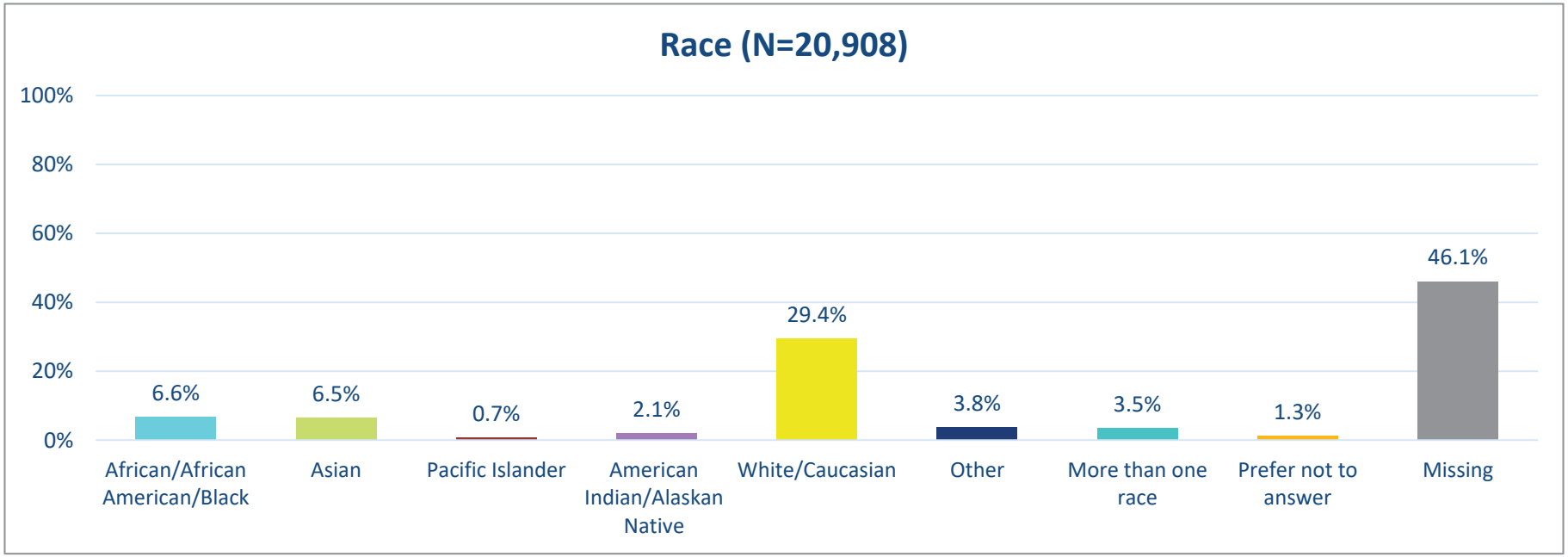
Primary Language (N=13,606)*	Count	%
Arabic	368	2.7%
English	6,345	46.6%
Farsi	53	0.4%
Spanish	3774	27.7%
Tagalog	148	1.1%
Vietnamese	31	0.2%
Prefer not to answer	125	0.9%
Missing	1,896	13.9%

Nearly 41% of participants were 15 or younger. Approximately 35% of participants were between the ages of 26 and 59.

Almost 28% of participants identified their primary language as Spanish. About 47% of participants identified their primary language as English.

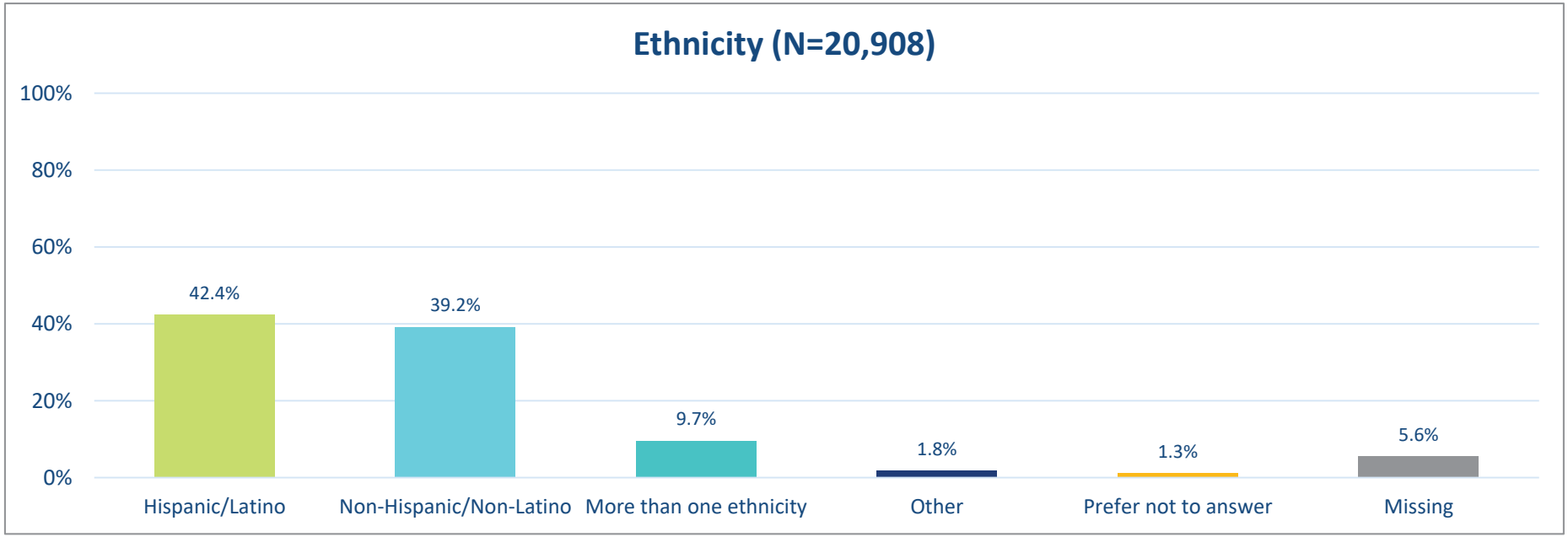
**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,606 vs N=20,908).*

SYSTEMWIDE DEMOGRAPHICS continued



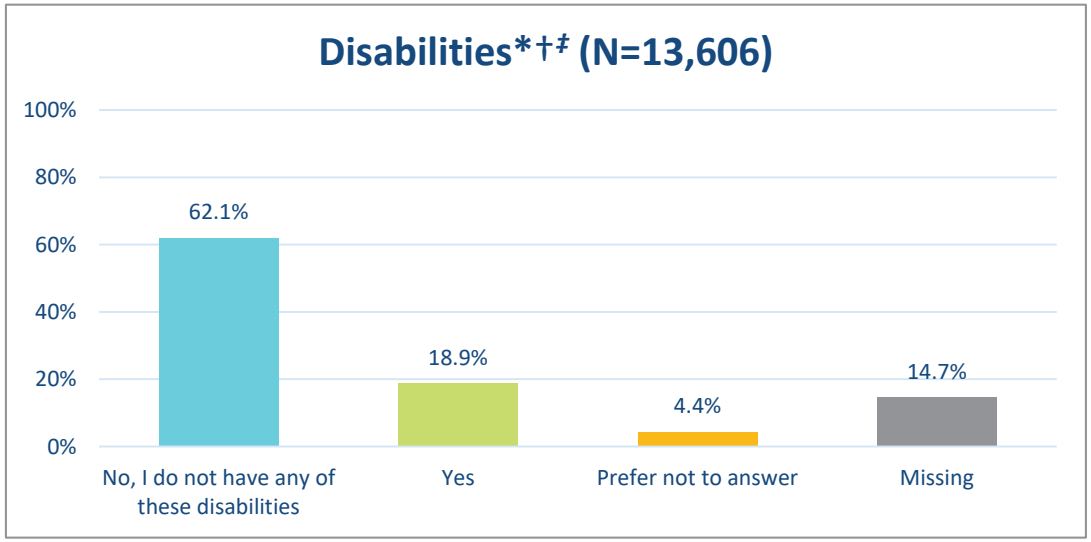
Twenty-nine percent of participants identified their race as White/Caucasian. Nearly 7% identified as African, African American or Black and approximately 7% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

SYSTEMWIDE DEMOGRAPHICS continued



Forty-two percent of participants identified their ethnicity as Hispanic/Latino, and 39% of participants identified their ethnicity as non-Hispanic/non-Latino.

SYSTEMWIDE DEMOGRAPHICS continued



Sixty-two percent of participants indicated no disability. Nearly 19% of participants reported having a disability, with approximately one in ten reporting a chronic health condition or chronic pain. Four percent preferred not to answer this question.

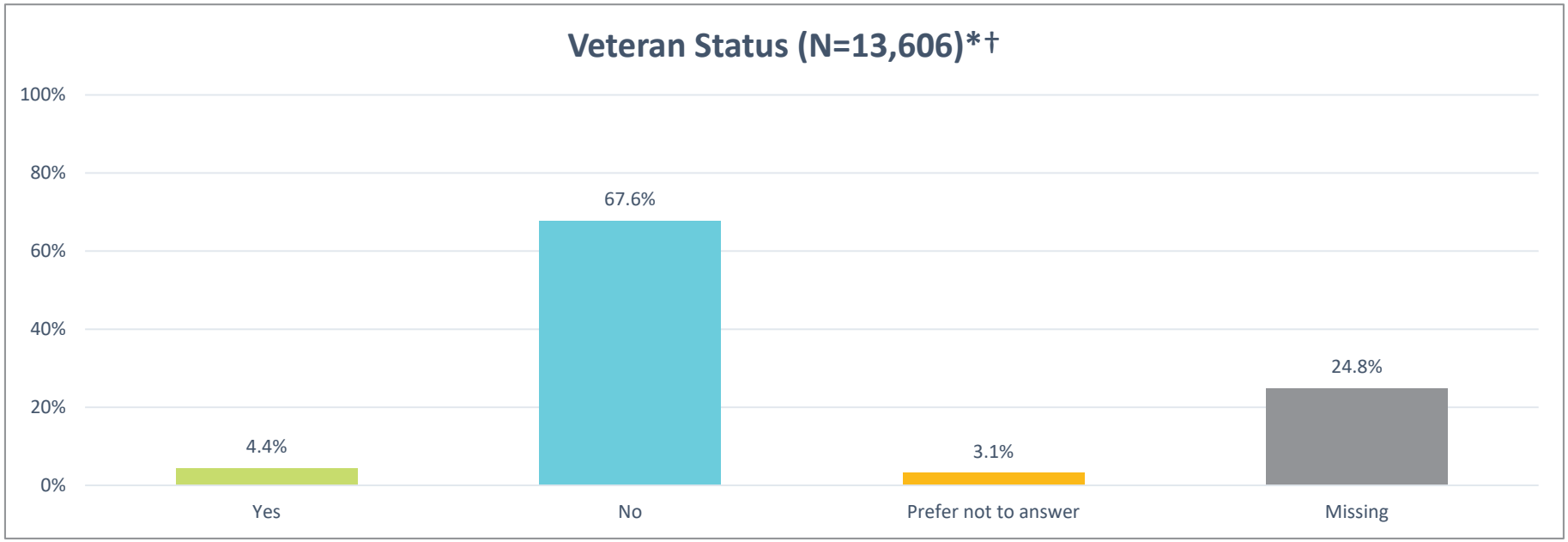
Disabilities*†‡ (N=13,606)	Count	%
Difficulty seeing	419	3.1%
Difficulty hearing or having speech understood	183	1.3%
Other communication disability	37	0.3%
Mental disability not including a mental illness	449	3.3%
Learning disability	229	1.7%
Developmental disability	64	0.5%
Dementia	29	0.2%
Other mental disability not related to mental illness	127	0.9%
Physical/mobility disability	572	4.2%
Chronic health condition/chronic pain	1,417	10.4%
Other	443	3.3%
Prefer not to answer	595	4.4%
Missing	1,997	14.7%

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

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

‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,606 vs N=20,908).

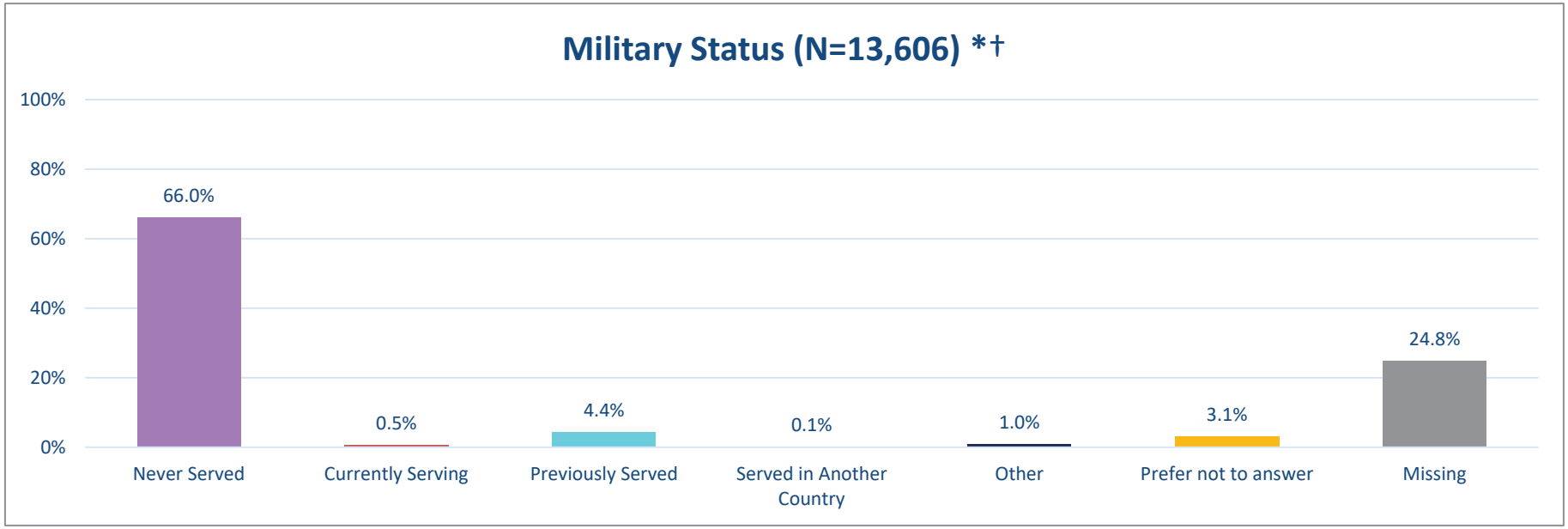
SYSTEMWIDE DEMOGRAPHICS continued



Information on veteran status indicated that about 4% of participants had served in the military. Additionally, 0.5% of participants reported that they are currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,606 vs N=20,908).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."

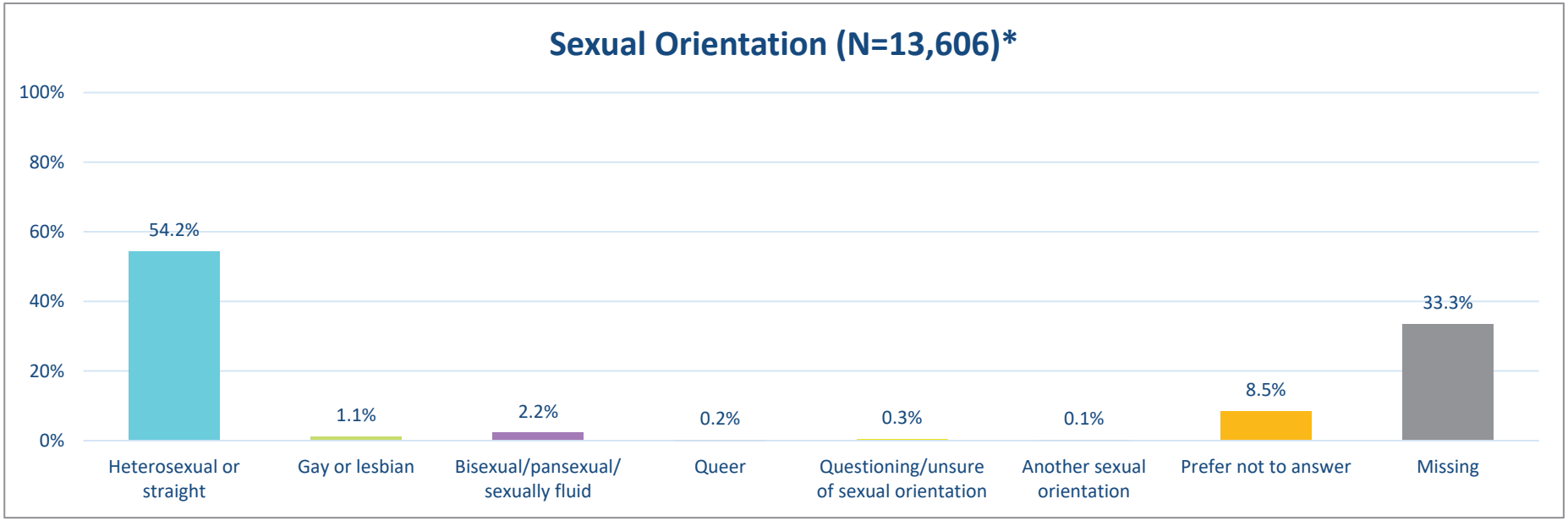
SYSTEMWIDE DEMOGRAPHICS continued



Sixty-six percent of participants had never served in the military. One half of one percent of participants indicated that they are currently serving in the military and 4% indicated that they had previously served in the military.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,606 vs N=20,908).*
† Military status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."

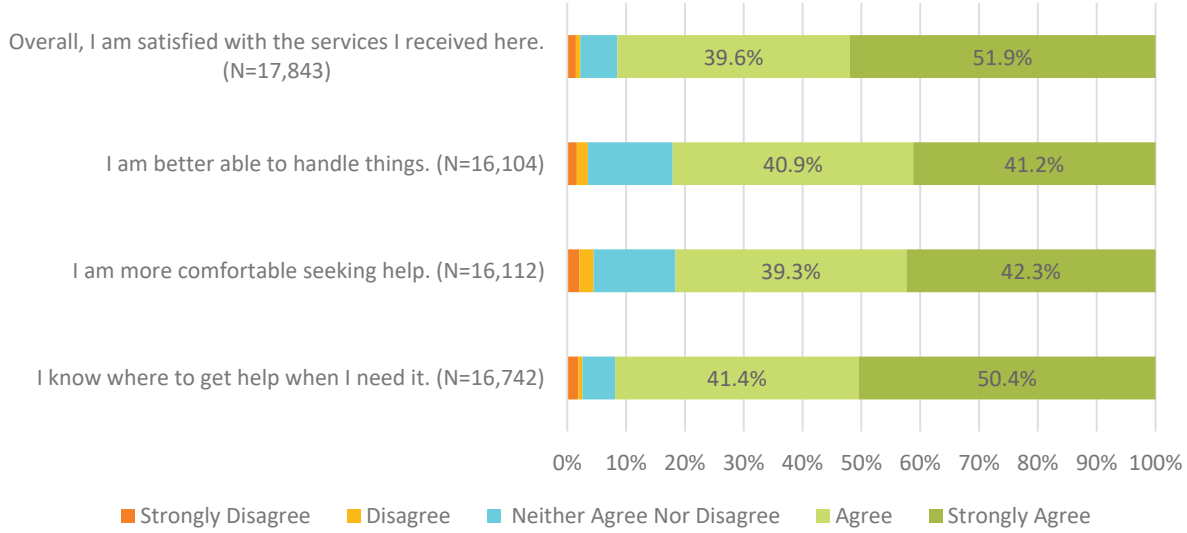
SYSTEMWIDE DEMOGRAPHICS continued



Fifty-four percent of the participants identified their sexual orientation as heterosexual or straight. Two percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Almost 9% of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=13,606 vs N=20,908).*
† Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."

SYSTEMWIDE SATISFACTION AND OUTCOMES*†



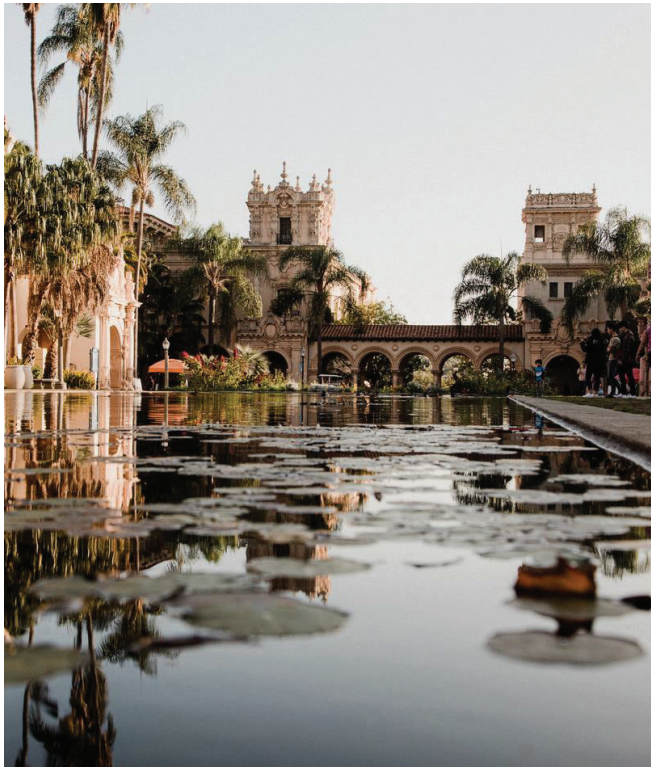
Satisfaction and outcome data are not available for all participants.
† Satisfaction data may include duplicate participants.

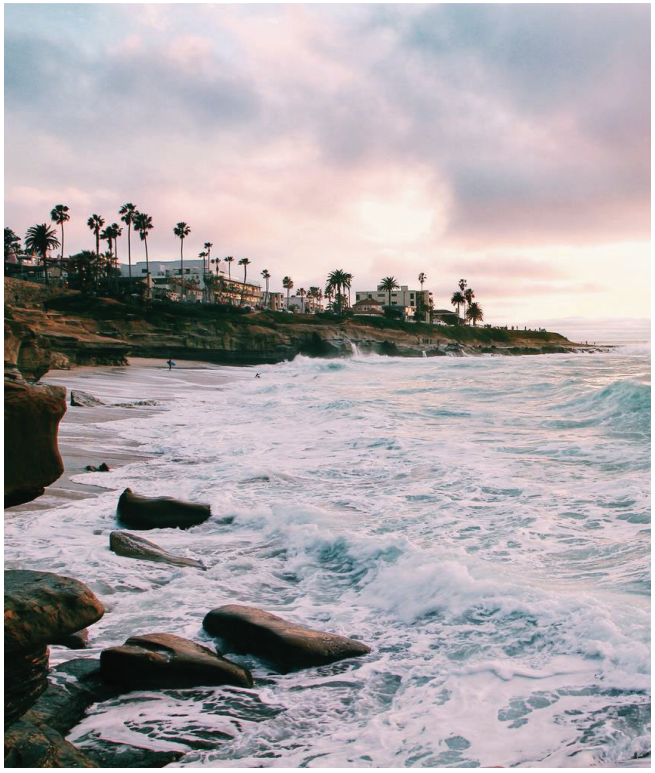
Nearly 92% of participants agreed or strongly agreed that they were satisfied with the services they received and that they knew where to get needed help as a result of the program. Eighty-two percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Nearly 82% 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 2020-21, a total of 533 participants received a mental health referral, and 218 of these participants received a mental health service as a result of the referral (Linkage Rate = 40.9%)
- A total of 233 participants received a substance use referral, and 133 of these participants received a substance use service as a result of the referral (Linkage Rate = 57.1%)
- The average time between referral and linkage to services was eleven days.

Not all PEI programs make referrals.





HEALTH SERVICES RESEARCH CENTER

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

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

APPENDIX M

PEI COMPONENTS AND PRIORITIES

Prevention and Early Intervention Priority Areas Fiscal Year 2022-23

Work Plan	Contractor	Name of Program	1-Child Trauma PEI	2-Early Psychosis	3-Youth Outreach	4-Culturally Comp	5-Older Adults	6-Early ID Symptoms
CO-03	National Alliance for Mental Illness, San Diego	Integrated Peer & Family Engagement - Next Steps						x
DV-03	Union of Pan-Asian Communities	Community Violence Services	x					
DV-04	Home Start	Community Services for Families-East Regions	x					
DV-04	North County Lifeline	Community Services for Families-N Coastal/N Inland	x					
DV-04	Social Advocates for Youth, San Diego	Community Services for Families-Central	x					
DV-04	South Bay Community Services	Community Services for Families-South Region	x					
EC-01	Jewish Family Service of San Diego	Positive Parenting Program (Triple P)	x					
FB-01	Pathways Community Services, LLC	Early Intervention for Prevention of Psychosis - Kickstart		x				
NA-01	Southern Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x	
NA-01	Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x	
NA-01	San Diego American Indian Health Center	Native American Prevention and Early Intervention			x	x		
OA-01	Union of Pan-Asian Communities	Elder Multicultural Access Support Services (EMASS)				x	x	
OA-02	Union of Pan-Asian Communities	Home Based Services - Positive Solutions				x	x	
OA-06	Southern Caregiver Resource Center	Caregiver Support for Alzheimer & Dementia Patients				x		x
PS-01	City of San Diego	Come Play Outside			x			
PS-01	Rescue Agency Public Benefit, LLC	Suicide Prevention and Stigma Reduction Campaign - Its Up to Us				x		
PS-01	Mental Health America	Mental Health First Aid				x		
PS-01	San Diego Workforce Partnership	Supported Employment Technical Consultant Services				x		
PS-01	Mental Health Association in San Diego County	Father 2 Child				x		
PS-01	Jewish Family Service of San Diego	Breaking Down Barriers				x		
PS-01	National Alliance for Mental Illness, San Diego	Family Peer Support Program				x		
PS-01	Community Health Improvement Partners	Suicide Prevention Action Plan				x		
RC-01	Vista Hill Foundation	Rural Integrated Behavioral Health & Primary Care		x				x
RE-01	Community Health Improvement Partners	Independent Living Association (ILA)				x		
SA-01	South Bay Community Services	School Based PEI - South	x					
SA-01	Vista Hill Foundation	School Based PEI - North Inland	x					
SA-01	Palomar Family Centers	School Based PEI - North Coastal	x					
SA-01	San Diego Unified School District	School Based PEI - Central and North Central	x					
SA-01	San Diego Unified School District	School Based PEI - Central and Southeastern	x					
SA-01	San Diego Youth Services	School Based PEI - East	x					
SA-02	San Diego Youth Services	School Based Suicide Prevention & Early Intervention - HERE Now			x			x
VF-01	Mental Health Systems, Inc	Veteran & Family Outreach Education - Courage to Call				x		

PRIORITY AREAS

1 - Childhood Trauma Prevention and Early Intervention
2 - Early Psychosis and Mood Disorder Detection and Intervention
3 - Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program
4 - Culturally Competent and Linguistically Appropriate Prevention and Intervention
5 - Strategies Targeting the Mental Health Needs of Older Adults
6 - Early Identification Programming of Mental Health Symptoms and Disorders

APPENDIX N

PREVENTION AND EARLY INTERVENTION (PEI) THREE YEAR EVALUATION REPORT

COUNTY OF SAN DIEGO

PREVENTION AND EARLY INTERVENTION THREE-YEAR EVALUATION REPORT

June 2022

County of San Diego Health and Human Services Agency

Behavioral Health Services

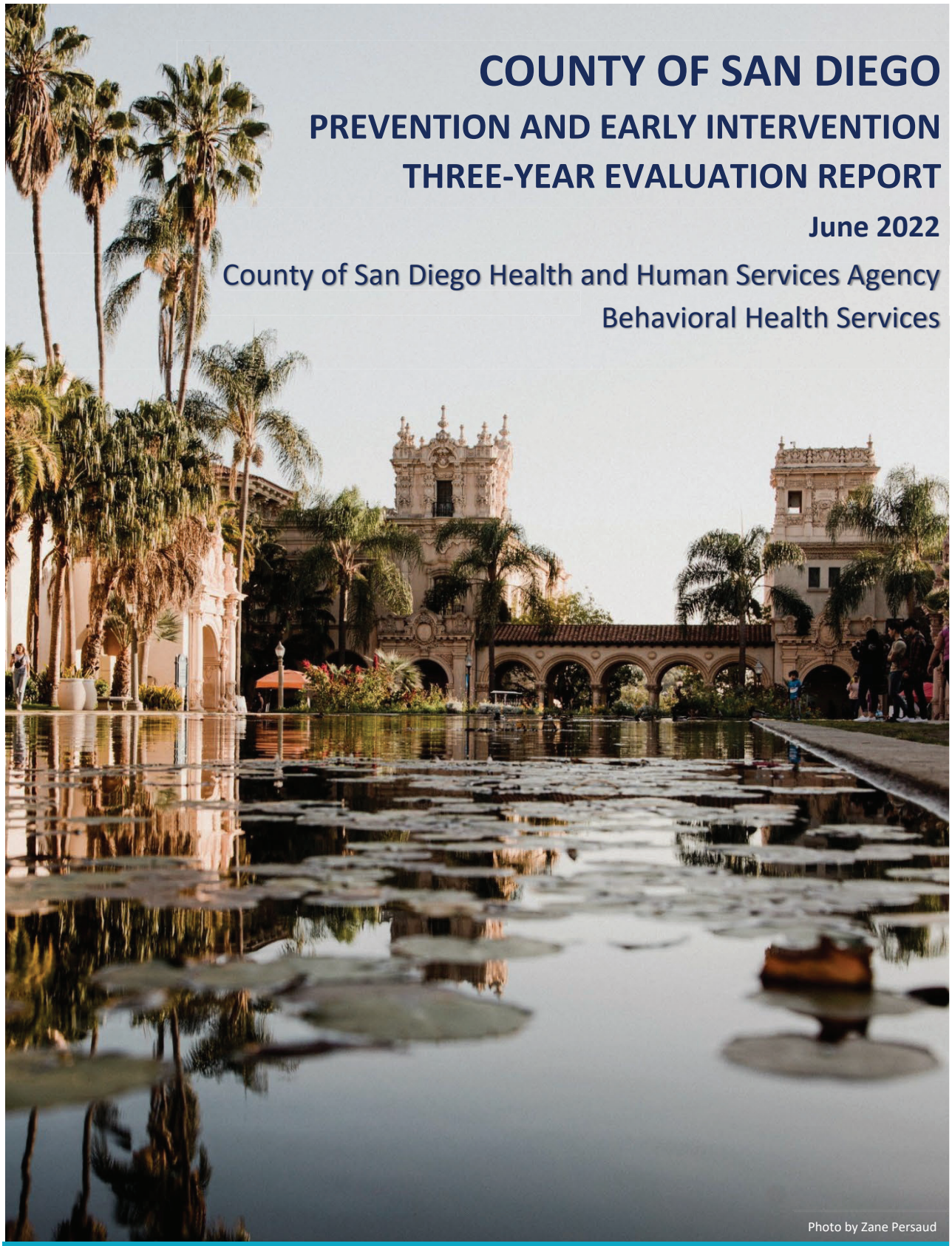


Photo by Zane Persaud

This page intentionally left blank

Table of Contents

Background 4
Senate Bill 1004 (SB1004) Priorities 4
Childhood Trauma Prevention and Early Intervention 4
Early Psychosis and Mood Disorder Detection and Intervention 5
Youth Outreach and Engagement Strategies 5
Culturally Competent and Linguistically Appropriate Prevention and Intervention 5
Older Adults 6
Early Identification Programming of Mental Health Symptoms and Disorders 7
How Were the PEI Outcomes Chosen? 7
Research Methods 8
PEI Outcome Results 9
Conclusion 10
Appendix 11

This page intentionally left blank

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.

Senate Bill 1004 (SB1004) Priorities

In 2018, California Senate Bill 1004 (SB1004) was passed, which revised the structure of PEI programming by revising the funding focus to include 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 Prevention and Early Intervention (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 and the corresponding local County of San Diego program names are provided in the following section.

Childhood Trauma Prevention and Early Intervention

(Alliance for Community Empowerment (ACE), Community Services for Families (CSF), Positive Parenting Program, and 5 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.

Positive Parenting Program (Triple P): This program promotes social and emotional wellness for children and their families by providing free parenting workshops along with referrals and linkage to services while utilizing the Triple P education curriculum.

Early Psychosis and Mood Disorder Detection and Intervention

(Kickstart, Rural Integrated Behavioral Health and Primary Care – SmartCare)

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 objects 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.

KickStart: In the effort of reducing the severity of mental illness while increasing awareness and usage of services, the Kickstart program focuses on persons who have emerging 'prodromal' symptoms of psychosis for Countywide children, teens, and transitional-aged youth ages 10 to 25 years old, as well as their families. Kickstart's success can be attributed to their advocacy of prevention through public education, early intervention, screening, and intensive treatment for youth who have been identified as at-risk.

Youth Outreach and Engagement Strategies

(Dream Weaver Consortium, HERE Now)

The youth outreach and engagement priority targets secondary school and transition age youth by partnering with college mental health programs that educate and engage students and provide either on-campus, off-campus, or linkages to mental health services not provided through the campus to students who are attending colleges and universities, including, but not limited to, public community colleges.

HERE Now: This outreach program to youth specifically focuses on education and outreach, crisis response training, screening, and short-term early intervention to middle school, high school, and transitioning youth with the aim to reduce suicides as well as their impact within schools. The educational information provided aims at helping students understand mental health, explains that suicide is preventable, assists students in identifying potential suicidality in a friend or loved one, addresses bullying and bystander roles, and includes mental health resources and suicide prevention tools.

Culturally Competent and Linguistically Appropriate Prevention and Intervention

(Dream Weaver Consortium, Elder Multicultural Access Support, Positive Solutions, Reach2Caregivers, Supported Employment Technical Assistance, Suicide Prevention and Stigma Reduction Campaign and 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.

Dream Weaver Consortium: The Dream Weaver Consortium offers three different children, youth, and family PEI programs provided by the Urban Youth Center, Indian Health Council, and Southern Indian Health Council. Operating on reservations and in urban areas, these providers offer prevention 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. Each program provides information on available culturally appropriate behavioral health services and increases involvement in child abuse prevention activities.

Older Adults

(Dream Weaver Consortium, Elder Multicultural Access Support, Positive Solutions, REACH2Caregivers)

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.

Elder Multicultural Access Support: This multiculturally focused program provides outreach, education, advocacy, peer counseling support, and transportation services to older adult Hispanic/Latino, African refugee, African American and Filipino seniors through health promotion and community health workers (Promotoras). These Promotoras are trained to provide outreach and engagement to older adults. The program seeks to identify and prevent mental health issues amongst older adults, reduce inappropriate utilization of services (such as emergency room visits), and increase access to healthcare services.

Early Identification Programming of Mental Health Symptoms and Disorders

(REACH2Caregivers, Rural integrated Behavioral Health, and Primary Care – SmartCare, 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.

REACH2Caregivers: The REACH2Caregivers is operated by the Southern Caregiver Resource Center and provides an evidence-based educational series for caregivers of individuals with Alzheimer's disease or related dementias. Classes are offered in group settings with other caregivers and focus on helping caregivers cope with their caregiving situation, take better care of themselves, learn stress management techniques, and develop effective family communication skills.

How Were the PEI Outcomes Chosen?

Outcome 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.

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 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 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, youth, and families. HSRC is responsible for the evaluation of the adult and older 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 PEI survey to participants, which includes the MHSA required demographic items and the four outcome questions 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.

A small number of PEI programs meet with participants more than once and administer the PEI survey at two points in time. The initial survey includes the demographics and is given to the participant upon entry to the program. The outcome questions are administered to participants at discharge or a standard follow-up interval (e.g., three or six months) for programs that work with clients over longer durations.

Programs have the option to use one of a few 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. Other programs use Teleforms, which are scanned into a database using the Teleform System. Teleforms are used by some of the children's programs. 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 service 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.

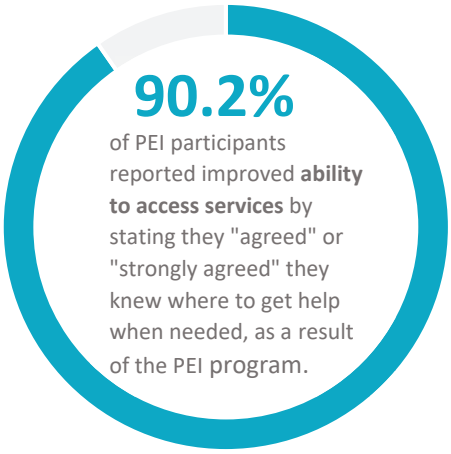
The programs that use mHOMS also have access to automated reports that aggregate demographic and outcome data based on date range. These reports provide for timely review of outcomes and demographics. They are used by programs to share feedback to program staff and improve services to underrepresented populations. Other programs run the automated report for outcomes monthly to share the aggregated responses with staff and provide them with positive feedback on the percentage of participants satisfied with the program. 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 Outcome Results

This section provides the results of the County of San Diego's four PEI outcomes combined for fiscal years 2018-19, 2019-20 and 2020-21. Sometimes participants did not answer all the survey questions thus, in this section, the total number of responses is shown for each outcome question.

The most significant outcome 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. Of the nearly 81,000 respondents, 90 percent stated they "agreed" or "strongly agreed".

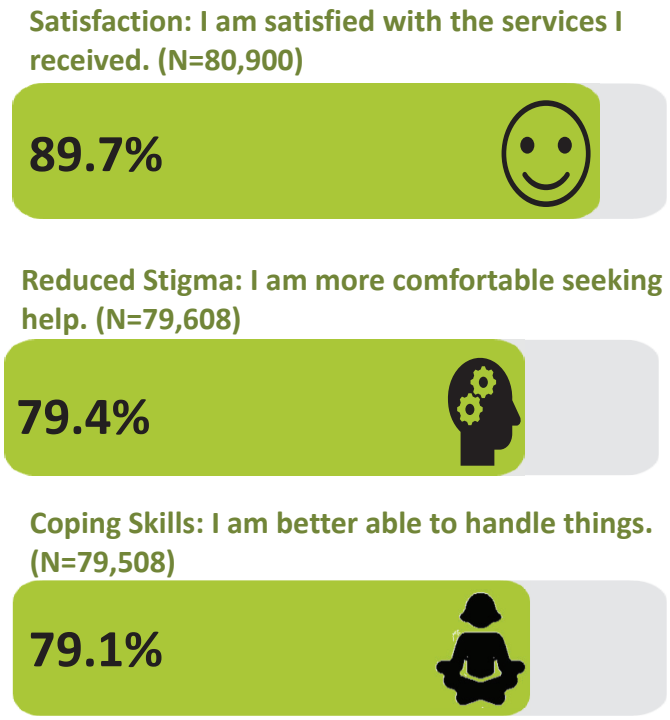
Figure 1: Participant-reported Access to Services Outcomes (N=80,954)



The high positive response rate for this outcome may have been due to Countywide PEI referral tracking that was implemented July 1, 2016 that aligned PEI program goals with reporting processes.

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. Nearly 90 percent stated they "agreed" or "strongly agreed" they were satisfied with the PEI program. Likewise, 79 percent reported they "agreed" or "strongly agreed" that they were more comfortable seeking help and better able to handle things as a result of the PEI program.

Figure 2: Participant-reported Outcomes for Satisfaction, Reduced Stigma, and Coping Skills



These positive outcomes help demonstrate the effectiveness of the PEI programs and strategies in supporting children, youth, families, 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.	80,954	4.0%	5.8%	90.2%
Reduced Stigma: I am more comfortable seeking help.	79,608	6.9%	13.6%	79.4%
Coping Skills: I am better able to handle things.	79,508	6.1%	14.7%	79.1%
Satisfaction: Overall, I am satisfied with the serviced I received here.	80,900	3.2%	7.1%	89.7%

**Percentages may not sum to 100 percent due to rounding.*

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 Community County-Wide Violence Response Team (CCVRT) provides needed supports and services to victims of, and witnesses to, community violence. CVRT interventions are designed to build community resilience and combat the negative effects of violence in a culturally appropriate manner. Supportive services include therapeutic support, short-term system navigation assistance, case management, crisis intervention, grief counseling, linkages and referrals to community partners, and other needed services. CVRT also aims to enhance the skills of providers, schools, and community and faith-based organizations to ensure coordinated neighborhood responses to gang/community violence. Most of the program's clients are referred in-house because the program has an in-house therapist available. The program also has certified Grief Specialists to handle internal referrals for bereavement counseling for victims of violent loss. Additionally, the program organizes 16 community events to engage participants and outreach to address the effects of community violence by providing resources and a system of meaningful support. Program staff have weekly meetings with advocates to discuss case management needs, where initial mental health or substance use referrals are also made. Since COVID-19 began, CVRT has encouraged access to services through a mandatory protocol plan to execute visits and counseling sessions remotely through video conference or phone conference. In instances where in-person interactions are necessary (i.e., severe cases), face-to-face interactions are executed in accordance with safety and health recommendations.

County of San Diego PEI Programs	
Program Name	**Program Description**
Community Services for Families (DV04)	Family Support Clinicians work within San Diego's Child Welfare System to enhance parents' abilities to create stable and nurturing home environments for their children. Clinicians work with families who have had contact with the child welfare system and qualify for Family Preservation Services. 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 shared with families and their social workers so that families can be linked with needed services such as therapy or parenting classes. Through the assessment process, Family Support Clinicians work to engage families in the process of determining the needs of their family, gain an understanding of how services may benefit them, and encourage families to follow up on recommended referrals. Clinician services are short-term, often limited to one visit and currently being provided in a telehealth format due to COVID-19. Because of this, clinicians do not follow up on referrals. Clinicians do, however, recommend services aimed at providing the support families need to connect to additional resources, and are currently providing COVID-19 related resources.
The Triple P - Positive Parenting Program (EC01)	The Triple P - Positive Parenting Program serves Head Starts (HS), Early Head Starts (EHS), preschools, elementary schools, and community centers to strengthen the skills of parents, childcare staff, and educators to promote the development, growth, health, and social competence of young children. Services are designed to benefit the child by teaching caregivers and childcare staff specific parenting skills and techniques for managing misbehavior. This Triple P program provides both group-based trainings and individual treatment. Staff are also trained to provide ongoing support to the family/caregiver once the Triple P curriculum is completed. This program serves all of San Diego County. The Positive Parenting program recognizes the unique position of prevention services in connecting at-risk families to mental health care. When an individual is identified as needing a higher level of service, staff link them to mental health services inside our organization (Jewish Family Services) or, if at capacity, link them to outside community resources. Staff also fill out a referral form which is tracked by our data specialist. After 3 weeks, staff follows up with a referred individual to assess if need was met. If necessary, another referral will be provided.

County of San Diego PEI Programs	
Program Name	**Program Description**
Kickstart Program (FB01)	Kickstart provides 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. The early intervention component of the program includes a comprehensive assessment. Based upon the results of the assessment, youth and their families may be referred and linked to outside community resources. Youth who screen into the program participate in a variety of services including 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. As a part of the PIER model, the program emphasizes the integration of health in all areas of life: mental, emotional, physical, social, spiritual, etc. Throughout services, starting from the first evaluations with youth and families, the team communicates and educates families on the importance of reaching out for support, availing oneself of community resources, and improving total health to improve functioning and wellbeing. We find that families are receptive to this for the most part and tend to follow recommendations when connecting/transferring them to outside resources.

County of San Diego PEI Programs	
Program Name	**Program Description**
Dreamweaver Program (NA01)	The Dream Weaver Consortium offers three different PEI programs provided by the Urban Youth Center, Indian Health Council, and Southern Indian Health Council. These providers offer prevention 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 traditional health gatherings, cultural programs that maintain language, knowledge of basket weaving (a local tradition for many tribes), nutrition programs, self-esteem activities, elder outreach services, male involvement strategies, positive parenting, exercise programs, and the promotion of overall increased medical and dental health. All these services are intended to prevent the onset of serious mental health problems. The program encourages access to services by striving to reduce stigma and discrimination of either being diagnosed with a mental illness or seeking mental health services. The program does this by offering outreach, prevention education, support groups, intergenerational activities and events, wellness workshops and community nights, Mental Health First Aid trainings, Question, Persuade and Refer (QPR) trainings, linkage, and integration to community resources (e.g., early intervention through onsite trauma-informed counseling), and therapeutic and case management services.

County of San Diego PEI Programs	
Program Name	**Program Description**
School-Based Programs (SA01)	The six school-based PEI programs provide culturally appropriate, multi-level prevention and intervention services to children and families. The programs utilize Incredible Years (IY), an evidence-based curriculum. Services include screening of children and families for prevention and early intervention services, classroom trainings that focus on increasing the social and emotional skills of the students, and child small groups where students learn and practice age-appropriate social skills. Additionally, parent groups are open to family members of enrolled children and are designed to foster positive parenting skills. The programs also provide culturally appropriate, family-based outreach activities that focus on family wellness, strengthening resilience, increasing protective factors, reducing stigma in accessing mental health services, and providing community referrals. The school-based PEI programs actively seek to encourage families to access services using multiple techniques. Staff conduct outreach efforts throughout the year that include program presentations at school sites and within the community; collaboration with community agencies and school personnel; distribution and posting of program information; distribution and collection of family and community needs screenings; and outreach to specific families who demonstrate need through screening and/or referral to the program. In the event the request and/or need for services is beyond the scope of program services, the staff will seek to work closely with the family to encourage and assist in the receipt of requested and/or needed services. The staff identifies appropriate community agencies to meet the requests/needs of the family and provide referral services. Staff follow up with referred families within 30 days to determine if services have been received and if necessary, assist the family with additional linkage services. As a results of the pandemic, and subsequent school closures, the school-based PEI programs utilized a combination of telephonic, email, Facebook, and/or YouTube outreach efforts for provision of referrals.

County of San Diego PEI Programs	
Program Name	**Program Description**
HERE Now (SA02)	The Helping, Engaging, Reconnecting and Educating (HERE) Now Program focuses on preventing youth suicide and suicidal ideation, reducing stigma around help seeking, and creating a safer place to learn in San Diego County. The program educates youth (7th through 12th grade) and their families on the risk factors of 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 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. During the HERE Now presentation at schools, facilitators talk with students about the many types of treatment options available. The HERE Now program updates their regional resource list at least annually or as needed to reflect clinic and counseling options near students' schools. Each student who attends a presentation completes a Response Card afterwards, which asks them about any concerns or questions they may have. The students who mark, "I need to talk to someone about a safety concern for myself," "I would like to talk to someone about myself," "I need to talk to someone about a friend," or "I have a question about the video, presentation, and/or discussion" are met with individually for an assessment to determine level of need. In addition, students may also be assessed if they are "flagged" by a friend or school staff. If a student is identified as needing additional services, HERE Now staff will inform school staff and contact the student's parent or guardian to begin the referral process to the appropriate resource. Youth who have been assessed one-on-one with HERE Now staff are referred for outpatient mental health services with their school's EPSDT provider or through their non-Medi-Cal insurance as needed. Due to COVID-19, the HERE Now team is now connecting students to tele-health services and in person services as appropriate for the referral source. HERE Now 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.

County of San Diego PEI Programs	
Program Name	**Program Description**
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 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. Next Steps receives referrals from the Emergency Room and Inpatient units at San Diego County Psychiatric Hospital (SDCPH). In addition, the program receives referrals from all four County DUI Clinics, Jane Westin Walk-in Center, and the three County-operated outpatient specialty mental health clinics, East County Mental Health Center, North Central Mental Health Center, and Southeast Mental Health Center. Every patient is seen by program staff while in the hospital or emergency room unless they have a “do not see” status. All community referrals are contacted by phone and encouraged to come into the program office to meet with a staff member. If the client prefers to meet in the community, the staff member will meet with the individual in a public location on a day and time of their choice. The Walk-In Clinic is open on weekdays from 9 am to 4 pm. Anyone can come in and receive resource information from staff. During the challenges of COVID-19, the program continued to provide in-person engagements in the hospital units, walk-in clinic, and in the community. This year, the program enrolled all clients referred from any Clubhouses located in San Diego and North County and the program removed the eligibility requirement for clients to have contact information to increase engagements and enrollments. Staff also provided telehealth services and mailed “Caring Letters” to clients to improve engagement and access to services.

County of San Diego PEI Programs	
Program Name	**Program Description**
Elder Multicultural Access and Support Services (OA01)	The Elder Multicultural Access and Support Services (EMASS) program provides outreach, education, advocacy, peer counseling support, and transportation services to older adult Hispanics, African refugees, African American, and Filipino seniors by promotoras and community health workers. The program seeks to identify and prevent mental health issues, reduce inappropriate utilization of services (such as emergency room visits), and increase access to healthcare services. The EMASS Program was impacted by the COVID-19 restrictions and work was migrated remotely. The program continues to encourage access to services and follow-through on referrals via telehealth. Contact with them is either by phone or via a virtual platform. EMASS continues to offer the following: •Bilingual Community Health Workers (CHWs) call outreached participants to assess their pressing needs, give them the current information on COVID-19 restrictions, and assess their mental health challenges. •Bilingual CHWs have virtual discussions about the clients' priorities and facilitate an action plan. If the participant is already seeing a psychiatrist but not receiving psychotherapy or counseling service, the participants are educated on the importance of counseling and/or psychotherapy in their treatment plan using the motivational interviewing technique. •Using a "hand holding" strategy, CHWs follow up with a phone call to clients who are in the pre-contemplation stage of change and who refuse to accept professional help. The CHWs provide continued virtual peer education to clients not willing to engage. When the person finally accepts a referral for professional help, the CHW makes the referral and facilitates the telehealth appointment either by helping the participant connect on their own or by bringing the person to the office to provide the access to the telehealth appointment. Note that this process takes weeks, months, or years, and EMASS will continue to engage the client if the client is willing.

County of San Diego PEI Programs	
Program Name	**Program Description**
Positive Solutions (OA02)	The Positive Solutions program provides psychoeducation, linkages to services, prevention, and short-term early intervention mental health services to underserved older adults who are racially, ethnically, and culturally diverse who report signs and symptoms of depression. This program seeks to increase knowledge of mental health warning signs and reduce stigma and disparities in mental health services access. Positive Solutions utilizes an evidence-based therapeutic modality called PEARLS, which is 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. The Positive Solutions program has two dedicated Bicultural/Bilingual Senior Community Workers (SCW). Apart from the outreach team, the entire staff, interns, and volunteers attend different community events and perform outreach presentations at the places where seniors congregate, such as senior housing communities, senior centers, community clinics, hospitals, social events, health fair, churches, food banks, etc. During the presentations, the attendees are informed about the available resources for mental health, and we endeavor to create awareness about mental health and promote help-seeking behavior. This also helps aid in reducing stigma around mental health. Stigma related to mental health plays a significant role and deters community members from seeking mental health services. The outreach team is trained to talk about the basic issues and symptoms related to mental health/depression, health care behavior, and how to improve overall well-being and health-related quality of life. The referral process is simple without any intrusive questions in it. The program's policy is that anybody can refer clients to Positive Solutions. Referrals are screened for their appropriateness, then services are provided accordingly. Clients are linked to other mental health providers as needed to provide ongoing continuation of care. Two follow-up phone calls are made after the clients discharge from the program. During this call, we ascertain that the clients are doing well, inquire about their practicing of the skills learned during therapy, and/or follow-up with other long-term providers and services. The goal is to provide services within two weeks of referral to UPAC Positive Solutions. Due to the ongoing pandemic situation, Positive Solutions is providing services only via telehealth that includes video or telephone sessions. Additionally, the program is mailing via USPS the literature, service agreement forms, and other relevant materials utilized during the therapeutic processes.

County of San Diego PEI Programs	
Program Name	**Program Description**
Southern Caregiver Resource Center's REACH Program (OA06)	Resources for Enhancing Alzheimer's Caregiver Health (REACH) 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. Through a four-class series, the program 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. SCRC has employed master's level clinicians skilled in performing comprehensive psychosocial caregiver assessments. This includes assessing current mental health status and screening for high-risk indicators (e.g., suicidal, and homicidal ideation, history of mental health conditions, substance abuse) that may necessitate specialty mental health services. Caregivers identified to benefit from specialty mental health services, during initial assessment or upon follow-up, are referred to appropriate mental health services, including the 24-hour Access and Crisis Line (888-724-7240), regional outpatient mental health clinics, adult and older adult MHSA-funded programs (e.g., Mental Health Systems, Inc.), fee-for-services providers, integrated mental health and primary care programs for adult and older adults, and emergency services.

County of San Diego PEI Programs	
Program Name	**Program Description**
Family Adult Peer Support Program (PS01)	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 a meeting format. They 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 Family Adult Peer Support Program is now offered completely digitally. The speaker series "In Our Own Voices" continues to grow and expand. This education series is on platforms such as Zoom, WebEx, and GotoMeeting. This innovation has increased and diversified participation across San Diego County and the region. This year, 137 presentations were viewed by 2,274 people. The program uses a bilingual team, and the series has become more interactive via Qualtrics surveys and PowerPoint presentations, which are integrated into the series. The Friends in the Lobby, which was renamed The Friends Resource Helpline when lobbies were closed to visitors has increased hours, diversified methods of service delivery, and has developed a team of highly skilled peer support specialists. Friends Resource Helpline supported 5,323 live phone calls and returned 2,200 emails this year. NAMI San Diego, the agency directing the Family Adult Peer Support Program, is responding to an increase in demand for prevention and intervention services for mental health. The program is now available to provide support to family and friends live via telephone 9am to 5pm Monday through Friday. Teams of two people with lived experience answer calls in two hour shifts on a cloud-based phone system which has a public 1-800 number and local San Diego phone number that is promoted digitally and is also widely distributed across San Diego County on printed materials by thousands of NAMI community partners. A team of peers provided support and information, behavioral health system navigation, and prevention and early intervention in a more private, confidential, comprehensive way via the telephone and computer for over thousands of participants each year.

County of San Diego PEI Programs	
Program Name	**Program Description**
Father2Child Program (PS01 F2C)	Father2Child is a program provided by Mental Health America of San Diego County (MHASD). It is a free court-approved 12-week program for fathers of all ethnicities, offering them new parenting techniques and skills, and encouraging them to improve their awareness of the importance of a father in the life of a child to create stronger bonds with their children. The program targets seven priority populations including 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. This program 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. Father2Child asks participants which resources they may be looking for or are lacking at the time of enrollment. Our population tends to need resources geared towards employment such as: job leads, interview clothes, transportation, resume building, and education. Current F2C funding allows us to assist with the interview clothes and transportation issues. We work with the workforce partnership of San Diego, The Urban League, and other organizations to connect participants with resume and job assistance. Many of our community partners have had to shift to Zoom or other digital platform due to COVID-19, but there has not been any gap in services. Father2Child has begun offering online and hybrid classes. We currently still offer in-person meetings but in small group settings which allow for social distancing. Father2child periodically would have guest speakers from local organizations come in and share information regarding mental health resources. Currently the program has guest speakers from Mental Health First Aid Program and shares flyers/information regarding available community resources. When a participant is referred to a resource, we email a program representative so they are aware of the referral and can expect the participant. Our Father2Child outreach facilitator informs the participant that a representative of the program is expecting them and when possible, connects them via email, text, or phone call.

County of San Diego PEI Programs	
Program Name	**Program Description**
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. Breaking Down Barriers aims to reduce mental health stigma in unserved and underserved communities by providing educational opportunities for providers as well as community members. To ensure cultural competency, Breaking Down Barriers has a program advisory group for each of the seven priority populations to better reach and engage members of these communities and to direct individuals, families, and priority population communities to mental health services. At the end of each educational activity, staff distribute resource lists of local services that can support participants' mental health, physical health, and other needs. For individuals who do provide their contact information and are seeking referrals and connections to other services, Breaking Down Barriers staff follow-up with a phone call and ask if they received the help and assistance they needed.
Mental Health First Aid San Diego (PS01H)	Mental Health First Aid provides a free certification training that gives participants the tools they need to respond to psychiatric emergencies until professional help arrives. This program provides outreach for increasing recognition of early mental illness and aims to improve mental health literacy for people who do not have clinical backgrounds. Classes are provided in-person and virtually through Mental Health America and throughout San Diego County. Settings in which responders were engaged included community rooms, libraries, churches, universities, high schools, medical centers, non-profit organizations, city agencies, county agencies, hospitals, youth camps, neighborhood and community clinics, military behavioral health departments, clubhouses, amusement parks, fire departments, Police Cadet Academy, Indian Health Clinics, and community reservations. The trainings are continuously provided to social workers, front line mental health staff, managers, students, nursing students, first responders, community members, caregivers, parents, Tribal Sovereign Nations, the District Attorney's office, security guards, amusement park employees, human resource personnel, medical staff, and San Diego City & County employees.

County of San Diego PEI Programs	
Program Name	**Program Description**
Supported Employment Technical Consultant Services (PS01)	The San Diego Workforce Partnership program provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Services are coordinated and integrated with SDCBHS and operate through collaboration with behavioral health providers, regional collaboratives, local employers, employment agencies, workforce partnerships, local government employment agencies, and other groups to develop new employment resources for individuals with serious mental illness. Services are provided to the program staff who serve clients, utilizing the Program Manager and Employment Specialists as points of contact. There are two meetings open to this audience monthly: Work Well Meetings to address supported employment strategies, and Individualized Placement & Support (IPS) Advisory Meeting, to address specific components of the IPS model. The program staff are working directly with the behavioral health clients enrolled at the respective treatment and non-treatment programs. Non-treatment programs are engagement opportunities to support connection to mental health treatment as guided by the request and need of individuals.

County of San Diego PEI Programs	
Program Name	**Program Description**
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. RIBH promotes de-stigmatization of mental illness through educating their patients and communities in intervention focused, short-term counsel settings, longer termed therapy, and health and wellness events/groups. Community groups and events have been halted due to the pandemic, and our public health and engagement efforts have been refocused to our social media platforms and virtual forums. Our social media platforms and website have been a way to provide public health information, wellness tips, and resources. Patients of the medical clinic are encouraged by their providers to meet with the program consultants and educators at their visits. Patients can also access educational mental health information while in the waiting room awaiting appointments. The program welcomes walk-ins at the clinic sites. The RIBH program provides resource guides for housing, shelter, food, legal aid, school aid, mental health, and wellness. They also inform people how to access care through hotlines, 211, and local resource centers. The program quickly switched and adapted to telehealth across all sites at the start of the COVID-19 pandemic. The teams remained connected with the providers at their clinics to ensure referrals are received and addressed in a timely fashion. Referrals and triaging are done via warm hand-offs, to ensure all patients feel comfortable, welcome, and understood. RIBH continues to work with their clinic sites to ensure safe patient care as they resume services on-site and through telehealth.

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). The ILA provides a number of resources to independent living operators to assist them with referring their tenants with mental health needs to the appropriate resources. This includes training on recognizing when tenants are experiencing mental health crises, as well as accessing both crisis-response and ongoing mental health services. Training courses that address recognizing mental health needs and accessing resources include: The Operations Course, The Art of Conversation, ILA 101 Presentation, Serving Sex Offenders Struggling with Mental Disorders and Homelessness, and ILA 101 w/ Metropolitan Area Providers of Social Services (MAPSS). The ILA also makes resources available through their website, including general information on mental illness, a Behavioral Health Emergency Response Plan (ERP) form that can be completed by tenants, and a link to 2-1-1, which provides linkage to behavioral health and homelessness-response resources. Newly approved member homes also receive a packet of resources, which includes information about ongoing education and trainings. In addition, the availability of quality housing for people experiencing homelessness who have mental health conditions is a crucial component of client recovery, allowing clients to pursue mental health treatment and supportive services, educational and employment goals, and renewed connections with loved ones. The ILA serves to increase access to this quality housing in the San Diego region, increasing clients' ability to focus on their recovery.

County of San Diego PEI Programs	
Program Name	**Program Description**
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 and 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. At Courage to Call, the peer-to-peer specialists provide resource information to veterans, active military, reservists, guard, and their families. If a situation arises where the veteran or their family is not able to access a service due to mental health concerns or a combination of traumatic life events, the peer-to-peer specialist refers the client "up" to the veteran peer navigator. The navigator then contacts the client and validates efforts, listens to dilemmas, and helps the client problem solve. Short-term goals of seeking tailored resources are established and continuous encouragement and motivational calls are made to help the client contact the resources.

APPENDIX O

INNOVATION REPORTS



ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT)

INNOVATIONS-18

Annual Report
Year 2 (7/1/2020 - 6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

Table of Contents

Executive Summary....1
ADAPT Program Description....3
Service Changes Due to COVID-19....4
Participant Characteristics....4
Utilization of Program Services....6
Primary Program Outcomes....8
ADAPT Participant Feedback Survey....12
Referral Partner Feedback Survey....14
Additional Program Activities....15
Primary Implementation Findings....17
Changes from Initial Program Design....20
Program Recommendations....20
Conclusion....21
Appendix....22

Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The ADAPT program was designed to improve access to treatment and address the negative health outcomes of perinatal mood and anxiety disorders, with a focus on women and families from underserved communities. A key component of the ADAPT program is the partnership with HHSA's Nurse Family Partnership (NFP) and Maternal Child Health Home-Visiting (MCH) programs to provide mental health services to clients. ADAPT provides therapeutic treatment, peer support, and linkage to community resources and support for the entire family in an in-home setting. With the onset of the COVID-19 pandemic, the ADAPT program has had to substantially reduce the practice of providing in-home assessments and clinical sessions and had transitioned to providing these services primarily via telehealth video sessions. This allowed the ADAPT team to maintain continuity of care with minimal disruption to services; however, the number of referrals received from NFP and MCH has decreased substantially as public health nurses were redirected to other COVID-19-related priorities. To help address the lower-than-expected number of referrals from public health, the ADAPT program established additional referral partners.

Primary Findings for Fiscal Year (FY) 2020-21

1. The ADAPT program achieved substantial reductions in depression and anxiety symptoms and improved well-being among ADAPT participants. Additionally, the participants expressed high levels of satisfaction with ADAPT services.
2. Relative to both in-person and telephone-based services, the ADAPT team substantially increased the amount of ADAPT services delivered via telehealth with video during FY 2020-21, likely due to the ongoing COVID-19 pandemic.

3. Total ADAPT enrollment was less than the initial goal (i.e., 65 unduplicated persons compared to a target of 300). The ongoing COVID-19 pandemic continued to substantially reduce referrals from the NFP and MCH public health nursing programs. During FY 2020-21 new referral partnerships were established with Best Start Birth Center, Sharp Mary Birch Hospital, and the Public Health SIDS (Sudden Infant Death Syndrome) Program. The addition of new referral partners coupled with the potential for public health nurses (PHNs) to have more time for non-COVID-19-related priorities is expected to increase referrals during FY 2021-22.
4. Good communication and coordination between ADAPT and PHNs remained critical to effective operations. PHNs expressed recognition of the value of ADAPT services to their clients and indicated they wish the ADAPT program was available to more of their clients beyond the target population of Medi-Cal recipients, Medi-Cal-eligible individuals, and those who are low income and uninsured. In contrast, PHN eligibility exceeds these eligibility requirements, leading to PHNs reporting a gap in behavioral health services for their clients who may not meet these criteria.
5. The ADAPT program was designed with long-term sustainability in mind and has continued to make progress satisfying the requirements needed to allow for Medi-Cal insurance reimbursement billing. ADAPT anticipates beginning to submit Medi-Cal claims by the end of the first quarter of calendar year 2022.
6. ADAPT partnered with USCD researchers to develop and obtain approval from BHS for assessing the feasibility, acceptability, and effectiveness of using the innovative brief (two-week), fast-acting, non-pharmacological, in-home Sleep and Light Intervention (SALI) to treat perinatal depression. SALI has demonstrated the capacity to reduce depressive symptoms quickly and safely when administered by research clinicians to reset circadian rhythms by having participants engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session. During FY 2021-22, SALI will be implemented within ADAPT to examine whether the intervention can be successfully utilized by community providers to obtain reductions in perinatal depression.

Conclusion

During FY 2020-21, the ADAPT program was able to successfully navigate ever-changing public health recommendations to provide services safely and effectively throughout the ongoing COVID-19 pandemic. ADAPT staff continued to process referrals, screen clients, establish care, and provide continuing services via telehealth, as well as through socially distanced, outdoor, in-person sessions. The ADAPT program responded to the shifting priorities for PHNs by including multiple referral sources during FY 2020-21. While overall enrollment was less than anticipated, those receiving services demonstrated substantial reductions in symptoms of distress as well as improvements in domains such as illness management, functioning, and quality of life. High levels of satisfaction were reported by participants and echoed by public health nurses, who reported substantial benefits for their ADAPT-enrolled clients. The ADAPT program increased the role of the peer support partner throughout FY 2020-21 and will focus on additional ways to enhance the peer support aspect of ADAPT in FY 2021-22.

Primary Recommendations for FY 2021-22

1. Increase support and collaboration with PHNs by offering additional case consultations and roundtable discussion opportunities.

2. Identify practices to increase utilization of the ADAPT peer partners, potentially expanding their roles during screening and assessment so that ADAPT participants can interact with peer partners early in their engagement with the ADAPT program.
3. Identify additional referral sources to increase the number of persons enrolling into the ADAPT program.
4. Identify additional allowable communication methods with clients with regard to scheduling.
5. Identify barriers to engagement after admission into ADAPT.

Program Description

The County of San Diego BHS ADAPT program is funded through the INN component of the MHSA, with services provided by clinicians and staff from Vista Hill, a community-based nonprofit organization. ADAPT provides mental health services to clients of HHSA's public health NFP and MCH home visiting programs who have, or are at risk of, perinatal mood or anxiety disorders. NFP is a free, voluntary program that provides at-home nurse visitation services to qualifying first-time mothers prior to their 28th week of pregnancy and continuing through the child's second birthday, many of whom are low-income. Through NFP, PHNs provide support, education and counseling on health, behavioral and self-sufficiency issues. MCH is also a free, voluntary prevention program that provides at-home nurse visitation to at-risk, pregnant, and postpartum women and their children from birth to five years old. Similar to NFP, PHNs in the MCH program provide support, health and parenting education, address bonding issues, medical, and mental risks.

The ADAPT program was developed in response to concerns about the high prevalence of unmet treatment needs for perinatal anxiety and depression among the women served by the MCH and NFP programs and the desire to prevent the negative consequences often related to perinatal mood disorders, including challenges to the family unit, difficult infant temperament, and emotional and cognitive delays in children of mothers with perinatal mood disorders. ADAPT provides therapeutic treatment, peer support, and linkage to community resources and support for the entire family, as well as other therapeutic interventions including skill building education, case management, and facilitating collateral supports. Services are evidence-informed and include care coordination and case consultation. To facilitate better access to care services, the program was designed primarily to provide in-home visiting. As discussed in more detail below, the COVID-19 pandemic required ADAPT to shift their treatment approach from in-person visits to telehealth sessions. A key innovative component of the ADAPT program is the partnership between PHNs, the ADAPT mental health clinicians, and the peer support partners. Given the reduced number of referrals from PHNs during the COVID-19 pandemic, new referral partners were added during FY 2020-21.

The ADAPT program was designed to provide two tiers of services. Level-1 participants included those who met criteria for Title IX specialty mental health services and peripartum criteria, evidenced in significant functional impairments, including but not limited to clinically significant depression and/or anxiety. The persons in Level-1 received ongoing therapy as well as other supportive services. Level-2 participants did not meet full criteria for specialty mental health services but demonstrated being at risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors, and also demonstrated some impairments in functioning. These participants may have presented

with less acute symptoms but were able to demonstrate risk and need for intervention to prevent development of functional impairments and maintain current functioning. Additionally, Level-2 included participants who would meet BHS eligibility for Level-1 services yet were receiving services from another mental health provider or reported not being interested in receiving mental health services at the time of initial assessment. Persons in Level-2 could also include family members of Level-1 participants. ADAPT attempts to enhance the role of fathers/partners in therapeutic interventions as a way to reduce the symptoms of both maternal and paternal mental health disorders.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected 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 remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they serve continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

For the ADAPT program, a major effect on services was the greatly reduced capability to provide in-home assessments and clinical sessions for much of FY 2020-21. These services initially transitioned to being provided via telephone, but then throughout FY 2020-21 most service contacts were shifted again to be completed via telehealth with video capability so that ADAPT participants and service providers could see each other. As conditions allowed, ADAPT reinstated efforts to meet in person with ADAPT participants (if desired by the ADAPT participant), with these visits typically occurring in outdoor settings conveniently accessible to the ADAPT participant. The number of referrals received from PHNs remained lower than originally planned due to the ongoing COVID-19 pandemic, which prompted the ADAPT team, in collaboration with BHS to establish additional partners who were able to refer clients to ADAPT as long as those clients also were concurrently referred to PHN services as well. These disruptions to referral flows contributed to the lower-than-expected FY 2020-21 enrollment totals (i.e., 65 unique persons newly enrolled compared to a target of 300 persons). A more detailed discussion of ADAPT experiences with providing telehealth services and the impact of COVID-19 on staff is included in other sections of the report.

Participant Characteristics

A brief overview of ADAPT participant characteristics is presented here with a more complete listing in the appendix. As shown in Table 1, a total of 65 unique persons enrolled in the ADAPT program during FY 2020-21 (46 initial enrollments into Level-1 and 19 initial enrollments into Level-2). In addition to the 19 persons who enrolled directly into Level-2, four persons transitioned from Level-1 to Level-2 during FY

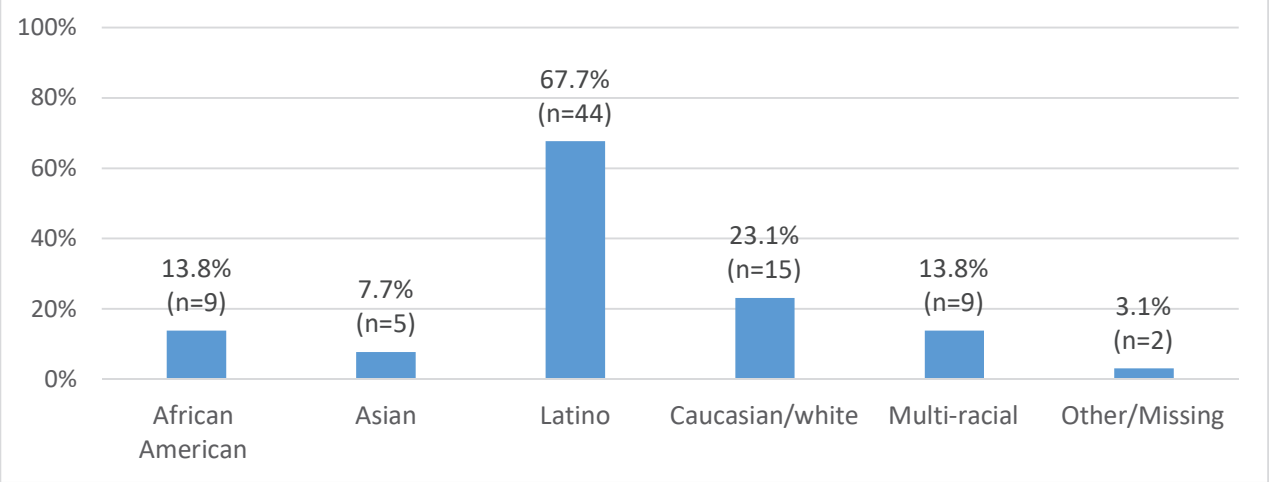
2020-21 when they no longer had a need for ongoing clinical therapy services but still wanted the education and support services provided by ADAPT. Similarly, four people transitioned from Level-2 to Level-1 once it was determined that more intensive services were appropriate. These 65 people enrolled into ADAPT during FY 2020-21 represent 64 different families with a total of 104 children in the households (including those not yet born at the time of ADAPT program enrollment).

Table 1. ADAPT Program Enrollment for FY 2020-21 (N=65 unique persons)

	FY 2020-21
Enrollment By ADAPT Service Level	**N**
Level-1 services (i.e., ongoing therapy services)	46
Level-2 services (i.e., education and support services)	19
Total unique ADAPT enrollees	**65**

Across both service levels, 96.9% of participants identified as female (n=63). While the majority of participants indicated English as their primary language (70.8%; n=46), almost one quarter (24.6%; n=16) indicated Spanish as their primary language and were served by Spanish-speaking ADAPT staff. More than 90% of participants (90.8%; n=59) identified as heterosexual or straight. Participants were overwhelmingly between the ages of 16-35 (n=58; 89.2%), with only 10.8% (n=7) over the age of 36. As shown in Figure 1, the ADAPT program served a racially and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (67.7%).

Figure 1. Race/Ethnicity of ADAPT Participants (N=65)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

ADAPT participants also completed the Adverse Childhood Experiences (ACE) questionnaire at program intake. The ACE seeks to quantify a person's exposure to specific types of childhood trauma at home. A higher score is associated with numerous negative social and health outcomes. The mean ACE score (scored 0 to 10) among ADAPT participants was 4.5 while the median was 6.0. The majority of ADAPT

participants (56.9%) had an ACE score of 4.0 or greater, which is associated with a greater risk of developing health and mental health problems in adulthood.

Utilization of Program Services

Level-1 Services

Based on data from the San Diego County BHS electronic health record system, Table 2 indicates the number and type of services provided by licensed and license-eligible clinicians on the ADAPT team for persons enrolled in Level-1 during FY 2020-21. The information indicates that during each 30 days enrolled in ADAPT, participants typically received approximately 5.0 ADAPT services (comprised primarily of an average of 0.8 assessment visits, 1.7 therapy visits, and 1.0 case management visits per each 30 days enrolled in ADAPT). ADAPT offers family services for participants; however, the majority of participants in Year 1 did not utilize family therapy. ADAPT services were also expected to benefit the family unit directly and indirectly through case management and resource support. Of note, ADAPT team members were available to respond to crisis events and did so on three occasions during FY 2020-21. This highlights the importance of having a program like ADAPT connected with these persons to address potentially serious situations, while the rarity of such events also suggests that the ADAPT team was generally able to provide support and services that prevented the need for crisis care for almost all ADAPT participants.

Table 2. ADAPT Level-1 Services during FY 2020-21 (N=68)

ADAPT Service Type	Persons with at least one service		Total ADAPT services provided	Average number of services per person, per 30-day period
	N	%		
Any ADAPT service	66	97.1%	1,214	5.0
Assessment/Tx. plan development	57	83.8%	191	0.8
Individual/Family therapy (i.e., by licensed clinician)	52	76.5%	419	1.7
Individual/Family rehab. (i.e., by peer support or other professional)	38	55.9%	174	0.7
Crisis	<5	<7.6%	3	<0.1
Case management	47	69.1%	241	1.0
Other services (e.g., Collateral)	55	80.9%	186	0.8

The average time in the ADAPT program was 190.3 days, with a median time of 177 days for the 41 persons who had been discharged from Level-1 services during FY 2020-21; however, a quarter of ADAPT participants were in the program for at least 259 days (with maximum program duration of over one year). These findings indicate that while the typical ADAPT program duration was approximately six months, there was a substantial number of participants who required a longer period of time. Often the request for extended time stemmed from a desire for additional support due to the pandemic.

As shown in Table 3, the method used to deliver ADAPT services fundamentally changed between FY 2019-20 and FY 2020-21 due to the onset of the COVID-19 pandemic. Prior to the pandemic, ADAPT services were almost exclusively provided face-to-face, which then shifted to primarily telephone-based service delivery during the initial months of the pandemic at the end of FY 2019-20. At that time, only a small number of services were conducted as telehealth visits that included a video component since the ADAPT program had never offered telehealth previously and many staff did not have equipment for this type of service delivery. Throughout FY 2020-21, Vista Hill was able to update policies allowing for telehealth and made efforts to ensure staff were comfortable and equipped with the necessary technological tools to provide telehealth services. These changes contributed to a substantial shift in how ADAPT services were delivered with 59.3% conducted via telehealth with video, reflecting an increased capacity for and comfort of both staff and participants in engaging in telehealth.

Table 3. Type of ADAPT Service Contact

	FY 2019-20		FY 2020-21	
Contact Type	**N**	**%**	**N**	**%**
Telehealth with video	150	9.4%	720	59.3%
Telephone	426	26.7%	368	30.3%
Face to face	1011	63.5%	112	9.2%
Other	6	0.4%	14	1.2%
Total Services	**1,593**	**100%**	**1,214**	**100%**

Telephone continued to be utilized for a substantial number of visits (i.e., when telehealth visits were not feasible) with only a limited number of face-to-face visits (9.2%). It is expected that face-to-face visits will increase when COVID-19 safety concerns diminish.

Level-2 Services

A total of 24 persons enrolled directly into Level-2 services, including four persons who "stepped down" in care from Level-1 as they no longer needed the more intensive therapy services. Four additional persons enrolled from the prior FY were still active during FY 2020-21, for a total of 28 participants in Level-2 services. These 28 persons received a total of 300 different Level-2 ADAPT service contacts during FY 2020-21, representing a substantial increase in the provision of Level-2 services compared with FY 2019-20 (i.e., 14 persons with 73 services). Level-2 participants received an average of 10.7 ADAPT services (median = 9 services), provided by peer support partners on the ADAPT team. Table 4 highlights the most common types of services provided during Level-2 service contacts, which typically focused on educational/skill-building opportunities or assistance with basic needs. Both staff and participants noted the importance of being able to help address basic needs (e.g., food insecurity, housing assistance, etc.) as this can alleviate a major source of family distress. Additional types of supports provided to some Level-2 ADAPT participants addressed a wide range of other issues including employment services, navigating public benefit or legal issues, or assistance with obtaining needed physical health care.

Table 4. Most Common Types of FY 2020-21 ADAPT Level-2 Service Encounters

	ADAPT Level-2 Service Encounters			
	Total persons (N=28)		Total services (N=300)	
	Number of Persons with service	Percent of persons with service	Number of services	Percent of total services*
Mental Health Education	14	50.0	39	13.0%
Goal Setting Skills	14	50.0	41	13.7%
Basic Needs	12	42.9	29	9.7%
Mindfulness Skills	12	42.9	45	15.0%
Self-Regulation Skills	11	39.3	38	12.7%
Organization Skills	10	35.7	18	6.0%
Housing	6	21.4	23	7.7%
Parenting Skills	5	17.9	10	3.3%

** Total may exceed 100% as multiple services could be provided during an encounter*.

For the 16 persons who discharged from Level-2 ADAPT services during FY 2020-21, the average time in the ADAPT program was 104.0 days (median of 92 days). These findings suggest that Level-2 participation was typically shorter than that for persons receiving Level-1 services with very few requiring services beyond the standard 6-month program duration.

Primary Program Outcomes

Due to the small number of Level-2 participants enrolled during FY 2020-21 and their differing service needs, participant outcomes referenced in this section only include the Level-1 participants.

Edinburgh Postnatal Depression Scale

The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item self-report scale developed to identify individuals who may have postpartum depression in outpatient, home-visiting settings, or at the 6-8 week postpartum examination in a physician's office. Individuals indicate which response comes closest to how they have felt over the previous seven days. Each item is scored on a 0 to 3 scale with higher scores reflecting worse condition/more distress. The maximum score is 30 and scores over 10 are considered to indicate likely depression. The EPDS was administered upon entry into ADAPT and then regularly thereafter as part of clinical assessment and treatment planning (i.e., re-administration of the EPDS was done more frequently than other evaluation measures discussed below due to its direct use as part of treatment).

As shown in Table 5, during FY 2020-21 the average EPDS score at intake was 12.7, which reduced to 8.9 at the last EPDS follow-up assessment. This represents a statistically significant change in the total EPDS score and reflects an overall reduction in symptoms as reported by ADAPT program participants. A total

of 75.8% of all participants demonstrated at least some reduction in depression symptoms at follow-up. A statistically significant reduction of similar magnitude was also identified during FY 2019-20 (i.e., from 13.5 at intake to 9.7 at follow-up). Additional analyses that compared the FY 2020-21 EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 10.1. This finding suggests that, on average, approximately half of the improvement in EPDS scores occurred within the first 30 days, with continued treatment leading to further improvements.

Table 5. Change in EPDS Scores from Initial Assessment to Last Follow-up Assessment by FY

	FY 2020-21			FY 2019-20		
		Initial EPDS	Last available EPDS		Initial EPDS	Last available EPDS
EPDS Item *(Note: higher value = worse condition)*	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
I have been able to laugh and see the funny side of things	62	0.7	0.4**	70	0.7	0.6
I have looked forward with enjoyment to things	62	1.0	0.6**	70	0.9	0.6^
I have blamed myself unnecessarily when things went wrong	62	1.9	1.5**	70	2.0	1.4**
I have been anxious or worried for no good reason	62	2.0	1.5**	70	2.1	1.5**
I have felt scared or panicky for no very good reason	62	1.4	0.8**	70	1.7	1.1**
Things have been getting on top of me	62	1.7	1.3*	70	1.7	1.4*
I have been so unhappy that I have had difficulty sleeping	62	1.3	1.0*	70	1.4	1.0*
I have felt sad or miserable	62	1.4	1.0**	70	1.5	1.2^
I have been so unhappy that I have been crying	62	1.2	0.7**	70	1.2	0.8**
The thought of harming myself has occurred to me	62	0.2	0.1	70	0.3	0.1*
EPDS Total Score	**62**	**12.7**	**8.9****	**70**	**13.5**	**9.7****
Likely Depression (i.e., score >=10)	**-**	**45 (72.6%)**	**27 (43.5%)**	**-**	**54 (78.3%)**	**34 (48.6%)**

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

An examination of the individual EPDS items indicates that improvements were generally evident across all dimensions. The items from FY 2020-21 with the largest changes from intake consist of reductions in self-blame, anxiousness, panic, and unhappiness (i.e., average EPDS differences of at least 0.5). While not statistically significant, thoughts of harming oneself were rare at intake and even less prevalent at follow-up. The pattern of reductions across the individual items matches closely to the changes observed in FY

2019-20. Overall, the findings demonstrated that ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

Illness Management and Recovery Scale-Reduced

To measure clinician perceptions of client recovery and improved illness management, a shortened version of the Illness Management and Recovery-Reduced (IMR-R) scale was completed by ADAPT providers. The IMR-R included nine of the 15 items from the full IMR that were determined to be most relevant to the ADAPT program services and the focal service population (via review and consensus between representatives from ADAPT, BHS, and the evaluation team). Each item on the scale has a 5-point behaviorally defined response option tailored to that specific domain. Items are rated from 1 to 5, with higher values indicating less impairment/better functioning. The IMR-R was administered upon entry into ADAPT and then at 90-day follow-up intervals, documenting the amount of potential initial impairment and the extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians.

As shown in Table 6, the initial IMR-R ratings varied substantially across the individual items. For FY 2020-21, average ratings for many items were between 2-3 (generally indicative of moderate impairment) with symptom distress being the lowest rated item at 1.9, which was indicative of fairly high levels of mental health-related distress upon entry into ADAPT. Conversely, medication management and substance abuse were rated as areas of less concern (i.e., intake ratings between 4 and 5). The pattern of FY 2020-21 intake IMR-R scores was similar to that observed during FY 2019-20 with an overall IMR-R score of 3.1 during both FY 2020-21 and FY 2019-20.

Table 6. Change in IMR Scores from Initial Assessment to Last Follow-up Assessment

	FY 2020-21			FY 2019-20		
(Note: higher value = better condition)		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
IMR Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
Progress towards personal goals	39	2.4	3.5**	44	2.7	3.6**
Knowledge about symptoms, treatment, coping strategies, and medication	39	2.6	3.6**	48	2.8	3.5**
Involvement of family and friends in his/her mental health treatment	39	3.2	3.4	48	3.2	3.7**
Symptom distress	39	1.9	2.9**	48	1.7	2.7**
Impairment of functioning	39	2.3	3.2**	48	2.2	3.1**
Coping with mental or emotional illness from day to day	39	2.6	3.7**	48	2.6	3.5**
Effective use of psychotropic medication	7	3.4	4.3	8	4.1	4.2
Impairment of functioning through alcohol use	39	4.9	4.9	45	5.0	4.9
Impairment of functioning through drug use	39	4.9	5.0	45	5.0	5.0
Overall	**39**	**3.1**	**3.8****	**48**	**3.1**	**3.7****

***statistical significance at p < 0.01*

During FY 2020-21 the overall IMR-R score increased from 3.1 to 3.8, indicating a statistically significant change and evidence of clinically meaningful improvements within the participant population. Among the individual items, medication management and substance use maintained their high intake levels (i.e. high functioning/less impairment), and many of other items approached or achieved a gain of 1.0. Particularly notable are the ratings of symptom distress, improving from 1.9 to 2.9, indicating clients went from being bothered "quite a bit" by their symptoms at intake to only "somewhat" at follow-up. The IMR-R results indicate the achievement of important improvements to minimize symptom distress and impairment, while also increasing knowledge, coping skills, and progress towards personal goals to help maintain benefits and minimize risks of future recurrence of symptoms.

Wellness Survey Questionnaire

The ADAPT Wellness Survey is a self-report tool administered to participants upon enrollment into ADAPT and then every 90 days thereafter. Survey items were rated on a scale from 1 to 5, with higher values representing the better or more desirable response. During FY 2020-21, self-reported improvements occurred across multiple dimensions with statistically significant changes occurring for ratings of mental health/mood, hopefulness for the future, and feeling spiritually connected (see Table 7). The findings from FY 2020-21 were generally similar to those identified during FY 2019-20. Staff feedback regarding the findings in both FYs of increased self-rated spirituality at follow-up was interpreted to reflect ADAPT staff efforts to encourage ADAPT participants to utilize their personal resources and beliefs to develop their own strengths and sense of well-being. These areas of self-reported improvement were consistent with the primary areas of emphasis within the ADAPT program. Of note, in both FYs, participants reported an increase in emotional/behavioral problems from intake to follow-up. ADAPT staff attributed these ratings to two explanations: 1) Participants may be better able to recognize emotional/behavioral problems in their children after receiving psychoeducation that is part of ADAPT and 2) Participants have more capacity to notice challenging family dynamics as their personal mental health improves.

Table 7. Change in Wellness Survey Scores from Initial to Last Follow-up Assessment

	FY 2020-21			FY 2019-20		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items *(Note: higher value = better condition; Scale of 1 to 5)*	N	Mean	Mean	N	Mean	Mean
In general, would you say your quality of life is:	39	3.3	3.3	47	3.1	3.4*
In general, how would you rate your physical health?	40	2.9	3.0	48	2.8	2.9
In general, how would you rate your mental health, including your mood and your ability to think?	40	2.5	3.0**	48	2.4	2.7**
In general, how would you rate your satisfaction with your social activities and relationships?	40	2.8	3.0	48	2.5	2.9*
In general, please rate how well you carry out your usual social activities and roles.	40	3.1	3.2	48	2.9	3.2^
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	40	3.8	4.0	48	3.9	4.4**
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	40	2.6	2.9	48	2.3	2.7*
My child(ren) had emotional and/or behavioral problems.	35	4.7	4.2*	36	4.6	4.3
I felt hopeful about the future.	40	3.5	4.2**	38	3.3	3.9**
I felt spiritually connected.	40	3.1	3.6*	38	3.0	3.5^
I lived in a home that made me feel safe.	40	4.5	4.7	38	4.3	4.6
I used substances (alcohol, illegal drugs, etc.) too much.	40	4.9	5.0	38	4.8	4.9
How would you rate your fatigue on average?	40	2.9	3.1	48	3.1	3.2

*^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

ADAPT Participant Feedback Survey

Every 90 days and at discharge, ADAPT participants were asked to rate the extent to which they were achieving specific ADAPT objectives. For FY 2020-21, 95% of participants indicated they knew where to get help and 86% indicated they were better able to handle things because of participating in ADAPT (see Table 8). Further, ADAPT participants were extremely positive about their experiences. For FY 2020-21, over 90% of participants indicated that services were available at convenient times, 95.3% reported they were able to receive all needed services, 100% reported that staff were sensitive to cultural background, and 95.3% were satisfied with ADAPT services. A similar pattern of participant responses was identified during FY 2019-20. These findings, particularly as related to service availability and cultural support,

indicate that the ADAPT program has accomplished the goal of connecting with participants and meeting their needs in a manner which is convenient for and respectful of the participants.

Table 8. ADAPT Participant Feedback Survey

	FY 20-21 (N=43)	FY 19-20 (N=52)
ADAPT Participant Feedback Survey Item	**Agree/ Strongly Agree**	**Agree/ Strongly Agree**
As a result of participating in ADAPT:	**%**	**%**
I know where to get help when I need it.	97.7%	94.2%
I am more comfortable seeking help.	97.7%	90.4%
I am better able to handle things.	86.0%	84.6%
Experiences with ADAPT services:	**%**	**%**
Services were available at times that were good for me.	100%	94.2%
I was able to get all the services I thought I needed.	95.3%	92.3%
Staff were sensitive to my cultural background (race, religion, language, etc.).	100%	100%
Overall, I am satisfied with the services I received here.	95.3%	96.2%

Participants were also asked what they thought were the most important benefits or services received through their participation in ADAPT. A review of the responses indicated the following themes:

Learning about mental health issues and the techniques to better manage/prevent symptoms.

1. "Most important benefit was learning how to cope and it's okay to feel my feelings"
2. "I learned not to be so hard on myself. It's ok to ask for help. Use resources that are there."

Learning and utilizing exercises that promoted self-care and compassion.

1. “Learned how I can manage my issues and about self-care and positive self-talk."
2. “Learning compassion exercises, how to be caring about myself and fight for my self-worth."

Receiving general emotional support/encouragement from therapists/peer support partners and always feeling “heard."

1. "My therapist was always there to listen and never judged me for whatever I had going on.”

Having positive social interactions and a sense of community/belonging.

1. "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."
2. "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."

Assistance with obtaining tangible community resources (e.g., food stamps).

1. "It was great being given support with mental health and housing resources."
2. "I liked everything about ADAPT. You listen to me, you helped me a lot, referred me to get clothes/diapers."
3. "Just trying to get myself back on track physically. Its good to have someone to help me through going and getting my job and going through this in a pandemic."
4. "All the local places that you guys direct me to."

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 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 for extended and/or enhanced communication and interaction with ADAPT program team members.

Referral Partner Feedback Survey

A brief online survey was conducted with PHNs and other Referral Partners to obtain feedback regarding their experiences with the ADAPT program. The questions were largely open-ended and served to explore referral partners' understanding of the ADAPT program and elicit recommendations for program improvement. Several themes emerged from the referral partners' feedback.

Eligibility

Given the overall success of clients who engage with ADAPT services, many referral partners expressed a desire to have wider eligibility requirements for the program. Often referral partners see clients 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."

While ADAPT services are limited to individuals enrolled in Medi-Cal, Medi-Cal-eligible, or underinsured, the program's focus on perinatal mood disorders could potentially be replicated by other programs who serve a wider client base.

> "It would be wonderful if ADAPT clinicians could also see clients that do not fit the current criteria. There are times when a client has seen a mental health clinician within their insurance group in the past but stopped going to appointments (they didn't like the clinician; too overwhelmed to make an appointment; lack reliable transportation...). One of the wonderful qualities of the ADAPT program is being able to meet the client where they are at or in their home."

Bilingual Clinicians

Referral partners also 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 clients.

Electronic Communication

Referral partners felt ADAPT could benefit from additional communication methods with clients. Currently ADAPT clinicians do not have the ability to text with clients or email referral partners regarding client treatment. Referral partners felt the ADAPT team would benefit from "having the ability to text clients regarding their upcoming appointments or if they need to reschedule." Additional recommendations included the creation of a signed client consent that would allow for electronic communication to address ADAPT's liability.

Program Benefits

Overwhelmingly, referral partners reported positive outcomes for clients who engage in ADAPT services. One referral partner reported:

> "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."

PHNs also reported significant assistance from ADAPT staff, given the PHN focus on COVID-19 pandemic responses:

> "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."

The peer support program was also specifically highlighted as a program benefit:

> "When my clients are eligible for services they enjoy having the peer support person and the clinician visit them in person. The staff have been amazing."

Additional Program Activities

Community Resources and Engagement

Partnership Presentations

ADAPT welcomed the following external presenters in staff meetings to increase knowledge of community resources and enhance partnerships with other community organizations: Adoption Center of San Diego, San Diego Breastfeeding Coalition, Steven A. Cohen Military Family Clinic, Safe Families for Children, and La Maestra Community Services. These efforts to enhance community partnerships directly support the ADAPT scope of work.

Connection to Community Resources

ADAPT was able to offer and deliver holiday gifts to clients in need who wished to participate in December 2020. ADAPT also collaborated with Gently Hugged, a resource that makes personalized and homemade baby blankets for families to request and deliver these blankets to families who are interested. This resource is offered to all clients who give birth. Additionally, ADAPT finalized a partnership with Yasukochi Farms to deliver fresh produce to families in need, who are enrolled in ADAPT for the duration of three months. A total of 18 deliveries were made to families from September to November 2020 with educational resources to link to similar services as well as nutrition and its impact on overall development and mental health.

Education and Outreach

Early Childhood Mental Health Virtual Conference

ADAPT staff attended the Early Childhood Mental Health Virtual Conference which included participation in breakout sessions and instruction on trauma-informed practices which contribute to their roles. Additionally, ADAPT was featured in a breakout session titled, “Hope from the Beginning: Supporting Peripartum Mental Health Within the Community." The presentation included a review and education of Perinatal Mood and Anxiety Disorders. The ADAPT Clinical Supervisor presented a review of the ADAPT program and highlighted the intention of ADAPT services in instilling “hope from the beginning” through service delivery and program model. The presentation highlighted ADAPT’s partnership with public health and included a presentation from a partnering nurse from a Maternal Child Health unit based in San Diego's North Central Region. Additionally, an ADAPT clinician from the Central Region and a Peer Support Partner from the North Central and Central Regions presented on their unique roles and responsibilities regarding the services they deliver.

Marcé of North America Annual Conference

ADAPT, in partnership with the UC San Diego evaluation team, had an abstract, “Access to Perinatal Depression and Anxiety Treatment: Addressing Social Inequities through the ADAPT Program,” accepted for a presentation at the Marcé of North America (MONA) annual conference. MONA is the North American branch of the International Marcé Society for Perinatal Mental Health (https://marcesociety.com/). The presentation occurred in October 2021.

ADAPT Participation in UCSD Research to Improve Perinatal Depression Treatment: The Sleep and Light Intervention (SALI) Study

During FY 2020-21, the ADAPT program, with review and approval by County BHS, agreed to participate in a research study led by Drs. Barbara Parry and David Sommerfeld from the UCSD Department of Psychiatry to test the feasibility, acceptability, and effectiveness of community providers delivering the Sleep and Light Intervention (SALI) previously developed and tested by Dr. Parry in academic settings. SALI is a brief (two-week), non-pharmacological, in-home intervention that utilizes a one-night adjustment in the timing and duration of sleep coupled with two weeks of a 30-minute per day lightbox session at a specific time to reset circadian rhythms and reduce perinatal depressive symptoms. This research has demonstrated high levels of fast-acting and durable effectiveness at treating perinatal depression when

administered by research personnel. The partnership with ADAPT will provide an opportunity to transition SALI from an academic setting to a community-based care program to assess the capacity of community providers to successfully provide SALI to community participants. The study was developed and approved during FY 2020-21 and will be implemented during FY 2021-22. The information learned from this study is expected to inform future wide-spread dissemination of SALI to other community care providers and programs that treat perinatal depression.

Preparing for Medi-Cal Billing to Promote Program Sustainability

The ADAPT program was designed with sustainability in mind, and thus, from the onset, has made concerted efforts to develop a pathway to Medi-Cal billing. During FY 2020-21, the ADAPT program initiated a fire clearance, which is scheduled to be completed in FY 2021-22. All other items required for Medi-Cal billing application have been completed, including obtaining a National Provider Identifier (NPI). ADAPT continued to actively review updates to required policies and procedures in order to be Medi-Cal compliant. While ADAPT has made considerable progress toward the goal of Medi-Cal billing, some barriers remain. Level-2 services are provided to participants who identify as "at risk of perinatal mood and anxiety" as outlined in the scope of work. Thus, these individuals may not meet criteria for specialty mental health services (Title IX), which would not be Medi-Cal billable. ADAPT anticipates beginning to submit Medi-Cal claims by the end of the first quarter of calendar year 2022.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ADAPT Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ADAPT, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ADAPT Staff Survey was conducted at the end of FY 2020-21. ADAPT program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 12 respondents from the 14 ADAPT staff invited to participate in the survey, a response rate of 85.7%. For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Program Strengths and Challenges

ADAPT staff reported having strong leadership, accessible services for clients, and a program that offers flexibility for individual client needs. The reported quality of communication between ADAPT staff and clients has improved since FY 2019-20, as well as perceptions of client's willingness to schedule sessions, client engagement during sessions, and rates of no-shows. ADAPT staff reported confidence in their ability to provide services via telehealth. When reflecting on program strengths, one staff member remarked, "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 addition to the frontline and support staff, the ADAPT team recognized the importance of having a dedicated and involved leader: "Our supervisor is very supportive and transparent, and I think this is super helpful" noted one staff member.

ADAPT staff reported the following issues becoming more challenging since FY 2019-20: the PHN referral process, documentation burden, issues with staff turnover, and client engagement in ongoing ADAPT services. A staff member suggested, "Reducing the number of assessment tools and using some of them when needed would be helpful because this would reduce time spent on intake process and it would be spent on building rapport with clients." Despite the challenges of the referral process and communication with PHNs, ADAPT staff continue to focus on "improving communication with programs, as well as regional Public Health Nursing office managers and nurses." Finally, as with many behavioral health programs during the pandemic, staff turnover has also been a challenge.

Accessibility of Services

ADAPT staff recognized the unique way in which the program is tailored to meet individual client needs. In reflecting on what sets ADAPT apart from other services, one staff member wrote, "The adaptability and flexibility of staff to changes of policies and procedures to better ensure clients' needs are met." ADAPT staff also recognized individual efforts to meet the needs of clients. In discussing different approaches to meeting client needs, a staff member responded, "Being flexible with client requests about meeting in person or face to face, offering various times to schedule appointments, letting clients know about expectations for example how long appointments will be and the length of treatment. Also being able to offer services in Spanish."

ADAPT staff found unique ways to meet with clients while also ensuring safety during the ongoing COVID-19 pandemic. 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. The culture of going above and beyond for clients is something ADAPT staff recognized and appreciated.

PHN and ADAPT Program Coordination

The responsibilities of PHNs continued to focus on COVID-19 pandemic-related tasks during FY 2020-21. It is expected this pandemic focus will continue for PHNs for the foreseeable future. Some PHNs continue to reach out to ADAPT, even when clients do not qualify for ADAPT services. In these cases, ADAPT staff have tried to provide linkages to other, more appropriate, programs. While PHNs can identify referrals to ADAPT, they continue to express the need for additional programs like ADAPT, so that more PHN clients can receive ADAPT-style services. Other, non-Medi-Cal insurance providers and community behavioral health programs may benefit from developing services specifically addressing perinatal mood disorders for their clients. ADAPT staff have utilized multiple methods of communication to engage with PHNs. During one Program Advisory Group, PHNs provided feedback on the ADAPT program. From this feedback, ADAPT developed a program flier, which can be distributed to potential clients by PHNs.

ADAPT Participant Engagement and Retention

Efforts by ADAPT staff to keep clients and referral partners engaged in the ADAPT program are substantial. Staff reported frequent and consistent communication as necessary not just with clients, but with family members and referral partners as well. One staff member remarked on timing: "Not leaving a large gap of time between services and being over with calling clients more often to remind them of their sessions."

Staff have developed effective methods to engage with clients, including frequent phone calls to remind them of session, limiting the time between sessions, and providing tangible resources such as diapers and food. Regarding family engagement, ADAPT staff reflected that often family members are a source of conflict for clients, and that would need to be addressed individually before a family member is brought into client sessions. Additionally, staff reported that specific accommodations for family members may increase family engagement, such as having male therapists, resume support, and job connections. Finally, staff reported that continued communication with PHNs was necessary to coordinate services.

ADAPT staff have increased engagement during FY 2020-21 through concerted efforts to educate clients and referral sources about the benefits of peer support and the various ways peers can help. ADAPT has also provided additional training and education on best practices for utilizing peer support, when needed. Finally, peer partners were included in the Level-1 intakes, which gave clients the opportunity to understand the role of the peer partner.

Experiences with Telehealth Services

ADAPT staff saw increasing success with telehealth during FY 2020-21. Staff reported having a higher quality of communication between staff and clients than during FY 2019-20. ADAPT also saw an increase in client engagement in services with telehealth (as compared to in person sessions), a reduction in no-show rates, and an increase in client willingness to schedule services. ADAPT staff are overwhelmingly confident in their ability to provide services via telehealth, and generally felt their agency has done a good job supporting the shift to increased telehealth services. ADAPT staff agreed that providing telehealth services should continue to be a high priority, even after in-person services become safe and available.

Impact of COVID-19 on ADAPT Staff

The flexibility afforded by telehealth has proven beneficial but has also created challenges for ADAPT staff. As compared to FY 2019-20, staff reported a decreasing sense that their work tasks and personal life had changed due to the pandemic. One ADAPT staff member stated, “I enjoy working remotely and have found that quite satisfying.” While staff appreciated the ability to be more open and flexible with scheduling, they also reported difficulties with working from home. Loss of co-worker support and organizational challenges were cited as difficulties of working remotely. One staff member reflected, “I don't have enough space at home, and it can be challenging to keep documents like assessment tools organized at home.”

ADAPT staff are conscientious of their need for self-care and reported several methods of ensuring they were attending to their own mental health needs during the pandemic. When asked how they are reducing pandemic related stress in their personal life, one ADAPT staff reflected, “Finding things that make me joyful. Still making time to be out of the house, with friend, family, and safely adventuring.”

According to ADAPT staff, fewer clients are expressing a non-telehealth preference (less than 5%), as compared to FY 2019-20, but more clients experience some difficulties utilizing telehealth services (approximately 10%).

Recommendations and Additional Feedback

ADAPT staff would like more opportunities for county-funded training—particularly in topics that are evidence-based in their population of focus. Specifically mentioned were “adverse childhood effects specific with postpartum depression. All around suicide information including ideation, intent, plans, and how to do an effective safety plan.” Another staff member requested “more training in motivational interviewing, CBT, couples, and family therapies to support the clients' layered needs.” This focus on evidence-based training highlights the dedication ADAPT staff have to meeting their clients’ unique and specific needs.

Staff felt that expanded referral sources would help the program, as well as reach more at-risk individuals in San Diego County. “For example, I think referrals can come from programs like First 5 First Steps, from schools, directly from OBGYN doctors and staff, from different facilities like Sharp HealthCare, from Family Health Centers and not just the Nurses." Another suggestion was to allow clients to self-refer into the program. Staff felt that self-referral may decrease program attrition.

Finally, as mentioned above, staff felt the ability to text clients to remind them of their appointments would help facilitate attendance and engagement in the program. “It would be extremely beneficial to be able to text clients to schedule appointments at least. Extremely helpful.”

Changes from Initial Program Design

Establishing New Referral Partners

During FY 2020-21, the ADAPT Program Manager worked on improving programmatic referral process to reduce challenges reported by both ADAPT staff and PHNs. The Program Manager collaborated with IT to create a referral email and communicated relevant changes with Nurse Managers in all regions. The intention of changing referral procedures in this way will assist PHNs with more efficient access to sending referrals and streamline the way ADAPT receives referrals, allowing for more timely contact and screening. Additionally, ADAPT established new referral partnerships with Best Start Birth Center, Sharp Mary Birch Hospital, and the Public Health SIDS Program to increase the number of referrals for ADAPT services.

COVID-19-Related Changes

The ADAPT program has utilized the greater flexibility associated with telehealth capabilities to support clients throughout all County of San Diego regions rather than having region specific clinicians and staff. Additionally, even when offered in-person services, many clients refused as they were uncomfortable with receiving in-person services due to COVID-19-related safety concerns. Where feasible and appropriate, efforts were made to identify safe alternatives, such as meeting outdoor at a location convenient for the ADAPT participant when an ADAPT clinician thinks that an in-person visit would be beneficial.

Program Recommendations

1. Increase support and collaboration with PHNs by offering additional case consultations and roundtable discussion opportunities.

2. Identify practices to increase utilization of the ADAPT peer partners, potentially expanding their roles during screening and assessment so that ADAPT participants interact with peer partners early in their engagement with the ADAPT program.
3. Identify additional referral sources to increase the number of persons enrolling into the ADAPT program.
4. Identify additional allowable communication methods with clients.
5. Identify barriers to engagement after admission into ADAPT.

Conclusion

During FY 2020-21, the ADAPT program achieved substantial reductions in depression and anxiety symptoms and improved well-being among ADAPT participants. The results were similar to the previous year (i.e., FY 2019-20), which indicates that the program has adjusted to the service delivery changes brought about by the COVID-19 pandemic (i.e., minimizing/eliminating in-person service contacts) and was still able to meet core program objectives. While some challenges remain with consistently being able to utilize video-based telehealth sessions with all participants (e.g., not all participants had sufficient internet connectivity), the ADAPT program has substantially increased their telehealth capabilities such that most services during FY 2020-21 were delivered via telehealth, with telephone used primarily as a "back-up" when telehealth visits were not feasible.

The ADAPT program has expanded the use of Level-2 services during FY 2020-21 and has increased the role of the peer support partners to engage with and provide additional assistance to ADAPT participant. Feedback from ADAPT participants about their experiences with the ADAPT program indicated that they felt well supported by the ADAPT team members, learned new skills for managing their mental health, and were very satisfied with services overall.

The ongoing COVID-19 pandemic continued to substantially reduce referrals from the NFP and MCH public health nursing programs. To help increase referrals into the ADAPT program, new partnerships were established with Best Start Birth Center, Sharp Mary Birch Hospital, and the Public Health SIDS Program. The addition of new referral partners coupled with the potential for PHNs to have more time for non-COVID-19-related priorities is expected to increase referrals during FY 2021-22.

ADAPT partnered with USCD researchers to develop and obtain approval from BHS for assessing the feasibility, acceptability, and effectiveness of using the innovative brief (two-week), fast-acting, non-pharmacological, in-home Sleep and Light Intervention (SALI) to treat perinatal depression. SALI has demonstrated the capacity to reduce depressive symptoms quickly and safely when administered by research clinicians to reset circadian rhythms by having participants engage in one night of adjusted sleep timing and duration followed by two weeks of a 30-minute per day lightbox session. During FY 2021-22, SALI will be implemented within ADAPT to examine whether the intervention can be successfully utilized by community providers to obtain reductions in perinatal depression.

For more information about this Innovation program and/or the report please contact:

David Sommerfeld, Ph.D. (dsommerfeld@health.ucsd.edu)

Appendix

Characteristics of Participants who Enrolled during FY 2020-21

	FY 2020-21		FY 2019-20	
Characteristic	Total Participants (N=65)		Total Participants (N=91)	
Gender	N	%	N	%
Female	63	96.9%	89	97.8%
Another Gender Identity/ Missing/Prefer not to answer	2	3.1%	2	2.2%
Total	65	100%	91	100%
Age Group	N	%	N	%
16-25	22	33.8%	34	37.4%
26-35	36	55.4%	46	50.5%
>=36	7	10.8%	11	12.1%
Total	65	100%	91	100%
Primary Language	N	%	N	%
English	46	70.8%	63	69.2%
Spanish	16	24.6%	22	24.2%
Other/Missing/Prefer not to answer	3	4.6%	6	6.6%
Total	91	100%	91	100%
Race/Ethnicity	N	%	N	%
African American	9	13.8%	16	17.6%
Asian	5	7.7%	-	-
Latino	44	67.7%	57	62.6%
Caucasian/white	15	23.1%	27	29.7%
Multi-racial	9	13.8%	17	18.7%
Other/Missing/Prefer not to answer	2	3.1%	9	9.9%
Total[1]	-	-	-	-
Sexual Orientation	N	%	N	%
Heterosexual or straight	59	90.8%	81	89.0%
Bisexual/Pansexual/Sexually fluid	3	4.6%	6	6.6%
Missing/Prefer not to answer	3	4.6%	4	4.4%
Total	65	100%	91	100%
Military Status	N	%	N	%
Never served in the military	64	98.5%	88	96.7%

	FY 2020-21		FY 2019-20	
Characteristic	**Total Participants (N=65)**		**Total Participants (N=91)**	
Other/Missing/Prefer not to answer	1	1.5%	3	3.3%
Total	65	100%	91	100%
Disability	**N**	**%**	**N**	**%**
Yes, Has a disability	20	30.8%	15	16.5%
No disability/Declined/Prefer not to answer	45	69.2%	76	83.5%
Total	65	100%	91	100%
Type of Disability	**N**	**%**	**N**	**%**
Learning Disability	5	7.7%	-	-
Physical Disability/Chronic Health	12	18.5%	9	9.9%
Other	9	13.8%	8	8.8%
Total[2]	-	-	-	-

[1] Total may exceed 100% since more than one race/ethnicity could be selected.

[2] Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.



BHCONNECT INNOVATIONS-19

Annual Report
Year 2 (7/1/2020- 6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

Table of Contents

Executive Summary....1
Program Description....4
Service Changes Due to COVID-19....4
Participant Characteristics....5
Referrals for BHConnect Services....5
Utilization of Program Services....5
Primary Program Outcomes....7
Additional Program Activities....12
Primary Implementation Findings....12
BHConnect Participant Feedback....15
Changes from Initial Program Design....16
Program Recommendations....17
Conclusion....17
Appendix....19

Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Telemental Health program (commonly known as BHConnect) focuses on persons who have received crisis-oriented psychiatric care services, but are otherwise unconnected to behavioral health treatment services and identified as likely having barriers to accessing traditional outpatient services. The goal is to reduce the recurrence rate for psychiatric crisis services among these persons by offering an alternative method of care that relies exclusively on telehealth treatment. BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access. Maintaining engagement with clients is an important component of BHConnect activities. Initially, Welcome Home Health (WHH) was subcontracted to provide 24 hours a day/7 days a week telehealth technical support, treatment scheduling reminders, and to direct any crisis requests to appropriate services. During fiscal year (FY) 2020-21, BHConnect transitioned to providing such services and support directly via BHConnect staff. Since the initial design of BHConnect already relied exclusively on the provision of mental health treatment services via telehealth technologies, BHConnect has experienced minimal disruptions to treatment services due to the COVID-19 pandemic.

Primary Findings for FY 2020-21

1. A total of 89 persons enrolled in BHConnect during FY 2020-21 (i.e., 71 persons enrolled in the Children, Youth, and Family (CYF) BHS system and 18 persons enrolled in the Adult and Older Adult (AOA) BHS system). An additional 24 persons who had enrolled in the prior year continued services into FY 2020-21.
2. To address concerns with lower-than-expected enrollment, BHConnect continued to seek out and develop referral partners throughout FY 2020-21. These efforts contributed to the substantial increase in persons served (i.e., 113 during FY 2020-21 compared to 54 persons served during the initial FY 2019-20 start-up year), with expectations for continued growth during FY 2021-22.

3. BHConnect received a total of 169 referrals (131 CYF and 37 AOA) during FY 2020-21. Rady Children's Hospital Urgent Care was the primary referral source with 113 referrals. Overall, approximately 55% of CYF and AOA referrals enrolled in BHConnect with 20% declining services and 25% lost to contact.
4. Of those who participated in therapy services, the average number of sessions received was 12.0 and 15.1, respectively, for youth and adults (a substantial increase in the average number of treatment sessions from the prior year). Almost 65% of the enrolled youth and 45% of adults participated in at least 3 therapy sessions during FY 2020-21.
5. Persons enrolled in BHConnect as of 6/30/2021 had median service durations of 143.0 days and 208.0 days, respectively, for youth and adults. This indicates that a substantial portion of the active BHConnect caseload had been receiving BHConnect services for 5-7 months or more. These findings indicate that BHConnect is frequently able to maintain persons in treatment once they have established an initial therapeutic relationship.
6. Preliminary findings suggest that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services.
7. For clients with assessment data at both an intake and a follow-up, improvements in well-being and symptom management were generally identified. This was true for both clinician and self-reported assessments among both youth and adult client populations.
8. BHConnect decided to phase out the subcontract with WHH and shift those outreach, engagement, and scheduling responsibilities directly to BHConnect staff, particularly the Field Health Navigators. This decision was made to facilitate better communication and continuity of care between clients and all members of the BHConnect team. It also served to minimize confusion on the part of clients by eliminating a second entity (WHH) involved in their care services. This required BHConnect staff to develop and implement new practices to replace the 24/7 access previously provided by WHH, as well as establish strategies to initiate and maintain engagement in BHConnect services. As the transition away from WHH occurred near the end of FY 2020-21, the implications for service delivery will be examined throughout FY 2021-22.

Conclusion

During FY 2020-21, BHConnect increased enrollment to 89 persons (71 youth and 18 adults), a substantial increase from the prior year, particularly among youth (i.e., 54 persons, 37 youth and 17 adults). The number of therapy services provided also substantially increased with youth receiving an average of 16 services (as compared to an average 9.6 services in FY 2019-20) and adults receiving an average of 15.3 services (as compared to an average 11.8 services in FY 2019-20). The increase in enrollees and provided services is a program success likely due in part to the program entering their second full year of operations and overcoming startup challenges. However, even though the program has grown, FY 2020-21 enrollment was still below initial expectations. In light of this, staff have reported continued interest in generating referrals from additional referral partners.

Services provided by BHConnect include psychosocial assessments, treatment plans, therapy, rehabilitation, and case management. Out of all the enrollees, 64.8% of youth (n=57) and 44.0% of adults (n=11) received at least three therapy sessions from BHConnect clinicians. Once enrolled in the program and receiving services, youth and adults will stay engaged with the program anywhere from a few weeks to six months or more. Of those who were still involved with BHConnect services as of 06/30/2021, youth had a median enrollment duration of 143 days and adults had a median enrollment duration of 208 days.

BHConnect provided essential behavioral health services for both youth and adults as indicated by their respective assessments. A comparison between baseline and follow-up Child and Adolescent Needs and Strengths (CANS) assessment, and the Pediatric Symptoms Checklist (PSC) for youth, shows significant reductions (i.e., improvements) in behavioral and emotional needs, life functioning, risk behaviors, and clinical concern. Of the children and youth served by BHConnect, 60-65% experienced at least one reduction in a need item identified during the initial assessment. Alternatively, some youth showed an increase in impairment between their baseline PSC and follow-up. This same increase is also seen in the overall CYF BHS system and is indicative of the substantial variability of behavioral health needs and changes within this population. Similarly to the youth, a comparison of the Recovery Markers Questionnaire (RMQ) and Illness Management and Recovery (IMR) assessments for adults showed improvements in the desired direction, but unlike the youth, the changes were not statistically significant.

Overall, BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services throughout FY 2020-21; however, a primary challenge for BHConnect was the difficulty generating the desired number of client referrals from other crisis-oriented mental health service provider organizations. BHConnect decided to phase out the subcontract to WHH in order to increase communication and continuity of care with the BHConnect team. This required BHConnect staff to develop and implement new practices to replace the 24/7 access previously provided by WHH as well as establish strategies to initiate and maintain engagement in BHConnect services. The transition away from WHH occurred near the end of FY 2020-21 and changes will be examined throughout FY 2021-22.

Primary Recommendations for FY 2021-22

1. Continue to diversify referral sources to increase referrals for youth, adult, and geriatric patients. In particular, expand referral sources to include adult crisis centers throughout all regions of San Diego, and add PERT and CPS as approved referral partners.
2. Maintain ongoing and close relations with hospitals to potentially provide more integrated care, with on-site onboarding/warm hand-offs, and inevitably, more continuity of care and engagement with BHConnect services.
3. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care.
4. Continue collaborating with psychiatry providers and primary care providers to provide coordinated, integrated care, and to assist clients in navigating the healthcare system.
5. Consider adding in-house psychiatry services or identifying a community partner to help meet the medication management needs for adults.
6. Increase San Diego Change Agents Developing Recovery Excellence (CADRE) and co-occurring capability through incorporating this integrated approach in program literature (website and brochure), clinical approach, and to always consider modifications to the clinical staff annual training plan to include trainings such as “Harm Reduction.”
7. Continue to provide clinical support and training to all staff so that they can feel effective and productive in their role.
8. Refine screening process and explore best practices to increase client engagement from the moment referral is received.
9. Provide in-home services when clinically indicated to further engage clients in treatment.

Program Description

BHConnect is funded through the Innovations (INN) component of the Mental Health Services Act. BHConnect was developed to increase access and connection to follow-up behavioral health services after a psychiatric emergency in which a San Diego resident utilized a psychiatric hospital, emergency screening, and/or crisis response services. Services are provided through Vista Hill.

BHConnect services focus on persons who have received crisis-oriented psychiatric care services, but who are otherwise unconnected to behavioral health treatment services. The goal is to reduce recidivism rates for psychiatric crisis services among these persons by providing specialized supports through elemental treatment services that reduce barriers to accessing ongoing care. San Diego County residents of all ages are eligible for BHConnect services. Services are culturally and developmentally appropriate and aim to overcome current barriers when clients attempt to connect to care following a psychiatric crisis.

Offering services entirely through a telehealth platform, after an initial onsite evaluation by a case manager, is a key innovative component of the BHConnect program. To facilitate better access to care services, BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as tablet or phone equipped with built-in internet access. Clients receive a full tutorial of how to use the technology, as well as assistance with in-home set up prior to being connected with a behavioral health professional. Initially, Welcome Home Health (WHH) was subcontracted to provide 24 hours a day/7 days a week telehealth technical support, treatment scheduling reminders, and to direct any crisis requests to appropriate services. During FY 2020-21, BHConnect transitioned to providing such services and support directly via BHConnect staff.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the San Diego community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected 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 remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19 related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

The initial design of BHConnect, which already relied exclusively on the provision of mental health treatment services via telehealth technologies, allowed BHConnect to adjust to the new practice realities with essentially no disruption to ongoing treatment services. The main changes for BHConnect due to the pandemic 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 now occurs at the client's home).

However, the COVID-19 pandemic changed initial client recruitment and engagement practices as BHConnect staff were no longer physically co-located at crisis sites to meet with potential clients at the time when they were at the crisis facility. This inhibited the ability to have "warm-handoffs" where BHConnect staff would be able to meet in-person with the clients and that staff they were receiving care from at the crisis facility prior to transitioning care solely to BHConnect. A more detailed discussion of BHConnect experiences with providing telehealth services and the impact of COVID-19 on staff is included in other sections of the report.

Participant Characteristics

A brief overview of the BHConnect participant characteristics is presented here with a more complete listing in the report appendix. The BHConnect program provided mental health outpatient treatment services to clients of all ages through both the CYF and AOA BHS service systems. During FY 2020-21, a total of 71 persons enrolled in CYF services and 18 enrolled in AOA services. This represents a near doubling of CYF clients entering BHConnect as compared to the prior year (i.e., FY 2019-20 CYF enrollment was 37 persons), however, enrollment remained below initial expectations and efforts were ongoing throughout FY 2020-21 to increase program awareness and expand the number of referral partners. During FY 2020-21, CYF clients ranged in age from 7-17 with the majority (60.6%; n=43) younger than 15. AOA clients ranged in age from 21-72, with 22.2% (n=4) as Transitional Age Youth (TAY) between the ages of 18-25. Approximately two-thirds (64.8%; n=46) of the CYF clients and almost 80% (77.8%; n=14) of AOA clients were female.

Referrals for BHConnect Services

BHConnect received a total of 169 referrals from community referral partners during FY 2020-21. The primary referral source for CYF was Rady Children's Hospital Urgent Care with 113 referrals. Of these referrals, 65 youth (57.5%) enrolled in BHConnect. All other community providers only referred a total of 18 youth to BHConnect. For AOA clients, the BHS-funded In Home Outreach Team (IHOT) and the San Diego County Psychiatric Hospital (SDCPH) were the primary BHConnect referrals sources with 20 and 11 referrals, respectively. The enrollment rate was 60.0% for IHOT referrals and 45.5% for SDCPH referrals. Other community organizations provided a total of seven additional referrals for AOA clients. For both CYF and AOA clients, approximately 55% of all referrals ended up enrolling in BHConnect. Of the 169 total referrals to BHConnect, 20.1% (n=34) declined services and 26.0% (n=44) were lost to contact.

Utilization of Program Services

BHConnect Services – Type and Amount

Often, there was a brief period of time (typically 2-4 days), between enrolling into BHConnect (following an acute care treatment episode) and receiving initial BHConnect services. During this time, the WHH team and/or BHConnect staff attempt to maintain daily contact with the newly enrolled BHConnect clients until their first therapy session. Despite these outreach and engagement activities, a portion of BHConnect enrollees (14.8% of youth and 20.0% of adults) did not participate in any BHConnect services during FY 2020-21. BHConnect stakeholders and evaluators will continue to examine this group of enrollees in the future to identify any potential characteristics or needs this group has that may inform enhanced

engagement strategies. Table 1 shows the overall service utilization patterns for persons who enrolled in BHConnect services during FY 2020-21. On average, youth and adults enrolled and receiving BHConnect services had more than 15 total services (16 and 15.3, respectively) as of 6/30/2021. Of those that participated in at least one BHConnect therapy session, the mean number of therapy sessions received by youth and adults was 12.0 and 15.1, respectively. Out of all BHConnect enrollees, 64.8% of youth (n=57) and 44.0% of adults (n=11) received at least three therapy sessions from BHConnect clinicians.

Table 1. BHConnect Service Utilization during FY 2020-21

	Youth (N=88)			Adult (N=25)		
	Persons with at least one svc.		Mean number of services (of persons with svc.)	Persons with at least one svc.		Mean number of services (of persons with svc.)
Type of Service	n	%		n	%	
Any BHConnect service	75	85.2%	16.0	20	80.0%	15.3
Psychosocial assessment provided	66	75.0%	1.3	16	64.0%	1.5
Treatment plan session	68	77.3%	1.3	15	60.0%	1.1
Therapy sessions provided	71	80.7%	12.0	16	64.0%	15.1
Case management sessions provided	15	17.0%	2.1	7	28.0%	1.3
Other services provided (e.g., collateral contacts)	49	55.7%	3.0	8	32.0%	1.9
Received at least three therapy sessions	57	64.8%	-	11	44.0%	-

BHConnect Services – Duration and Discharge Status

As shown in Table 2, of the 88 youth and 25 adults who were enrolled in BHConnect services during FY 2020-21, there were 31 youth and 8 adults still active in the program as of 6/30/2021. These persons were typically enrolled for approximately 5-7 more months (i.e., median duration of 143.0 days and 208.0 days, respectively) than those who had already discharged. Of the persons who discharged from BHConnect prior to 6/30/2021, the duration times were typically shorter, particularly for adults, which reflects the fact that a portion of the BHConnect enrollees were only in the program for a brief period of time. The program duration patterns suggest some initial "sorting out" of client preferences and interest levels during the early weeks of BHConnect involvement; some closed out of services within a month or less, but many others connected with and maintained treatment for 6 months or more. These duration patterns will continue to be monitored in future years to better understand factors that promote engagement with BHConnect services.

Table 2. BHConnect Program Participation Duration and Discharge

	Youth (N=88)		Adult (N=25)	
	Still in program	Discharged	Still in program	Discharged
N (persons)	31	57	8	17
Mean (days)	205.3	141.7	243.8	95.0
Median (days)	143.0	113.0	208.0	52.0

Primary Program Outcomes

Utilization of BHS Crisis and Acute Oriented Services

An examination of the BHS crisis and acute care service utilization patterns before and after enrolling in BHConnect can help identify the extent to which participation in BHConnect was associated with a reduced need for such services. The following analyses were accomplished by reviewing the electronic health record that documents participation in county-funded BHS crisis and acute care oriented services during the 90 days before and after enrolling in BHConnect. To ensure equal 90-day observation periods for all persons, only clients enrolled at least 90 days prior to 6/30/2021 were included in the analysis. Of note, a limitation of these analyses is that they only include BHS-funded services, so any crisis services received outside the BHS system are not reflected. As such, these results presented in Table 3 should be interpreted cautiously as they do not reflect all services received, particularly for the youth population given that many received behavioral health-related care at Rady Children's Hospital Urgent Care.

Table 3. Utilization of BHS Crisis and Acute Oriented Services Before and After Enrolling in BHConnect

	Youth (N=98)				Adult (N=31)			
	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	14	14.3%	5	5.1%	15	48.4%	<5	<16.2%
Crisis Residential	0	-	0	-	<5	<16.2%	<5	<16.2%
Crisis Stabilization	14	14.3%	9	9.2%	13	41.9%	<5	<16.2%
Urgent Outpatient	0	-	<5	<5.1%	13	41.9%	7	22.6%
PERT*	8	8.2%	3	3.1%	<5	<16.2%	<5	<16.2%

*PERT = Psychiatric Emergency Response Teams

Overall, the service utilization pattern for both youth and adult BHConnect participants suggested a reduced need for crisis and acute care services after enrolling in BHConnect. This improvement was particularly evident among adult clients: clients with at least one inpatient psychiatric hospitalization decreased from almost 50% (48.4%) before BHConnect to approximately 10% (12.9%) during the 90 days after enrolling in BHConnect. These results should be considered preliminary given the relatively small

sample sizes, especially for the adult population, and the limitation that the analyses only included BHS services; however, initial indications suggest that participation in BHConnect helped to reduce the need for crisis and acute care services.

Child/Youth Baseline Assessments

Child and Adolescent Needs and Strengths

The CANS is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In BHConnect, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 54 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2020-21 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0-3, with a "2" or "3" indicating a specific area that could potentially be addressed in the particular service or treatment plan. Table 4 shows the mean number of needs at initial assessment and last available assessment for the domains of child behavioral and emotional needs, life functioning, and risk behaviors. These findings show statistically significant reductions for all three CANS domains.

Table 4. CANS Average Change from Initial Assessment (N=54)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	1.80	1.24**
Life Functioning	1.59	1.41
Risk Behaviors	0.63	0.39*

**statistical significance at $p < 0.05$; **statistical significance at $p < 0.01$*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). As shown in Table 5, for each CANS domain, 60-65% of the children and youth served by BHConnect experienced at least one reduction in a need item identified during the initial assessment.

The percent of persons with an improvement across these three domains was slightly lower than what was reported in the FY 2019-20 Systemwide Annual Report for the overall County of San Diego Children, Youth, and Families BHS for discharged clients (i.e., at least one improvement was evident in approximately 70-75% of discharged clients across each domain). This difference is likely due, in part, to the nature of the population served by BHConnect, which is comprised of youth who have had difficulty engaging in traditional outpatient treatment programs. In this regard, the fact that the majority of the BHConnect population exhibited progress on the CANS suggests that the BHConnect team was successfully able to connect with these children, youth, and their families via telehealth and facilitate improvements in well-being at rates almost as high as those observed across the broader CYF service system.

Table 5. Persons with CANS Improvement at Follow-up (N=54)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Behavioral/Emotional	51	32	62.7%
Life Functioning	35	21	60.0%
Risk Behaviors	25	16	64.0%

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 6.

In FY 2020-21, the PSC-35 was administered at initial entry into BHConnect, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 24 caregivers and 30 youth in FY 2020-21 completed both a baseline and follow-up assessment. Table 6 shows that the majority of both parents and youth reported PSC scores (58.3% of parents and 63.3% of youth) at entry into BHConnect that met or exceeded the PSC total score cut point for clinical concerns[1]. At follow-up, this had reduced to approximately one-third of parents and youth (37.5% of parents and 36.7% of youth). Likewise, an examination of mean score changes show statistically significant reductions (i.e., improvement) in total PSC scores for both parents and youth. Among the PSC subscales, there were indications of improvements from initial Internalizing scores for both caregivers and youth. With the reduced sample sizes for completed self-report PSC assessments, the findings should be interpreted cautiously as they may not reflect the broader experiences of the full BHConnect youth population.

Table 6. PSC Average Change from Baseline

	Parent/Caregiver Report (N=24)					Child/Youth Report (N=30)				
		% Above clinical cutoff[1]		Mean			% Above clinical cutoff[1]		Mean	
Composites:	N	Baseline %	Post %	Baseline	Post	N	Baseline %	Post %	Baseline	Post
PSC Score	24	58.3%	37.5%	31.1	24.9**	30	63.3%	36.7%	30.4	22.3**
Attention Subscale	24	33.3%	29.2%	5.2	4.9	30	33.3%	23.3%	5.6	4.6*
Internalizing Subscale	24	70.8%	37.5%	6.4	4.3**	30	80.0%	43.3%	6.6	4.0**
Externalizing Subscale	24	25.0%	12.5%	4.2	3.5	30	13.3%	3.3%	3.4	2.5^

*[1]PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7; ^statistical significance at p < 0.10; *statistical significance at p < 0.05; **statistical significance at p < 0.01*

To better understand the distribution of PSC change scores within the BHConnect client population and to facilitate comparisons with the overall CYF BHS system, analyses were also conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2019-20 Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and a large improvement (9+ point reduction).

Table 7. Distribution of FY 2020-21 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=24)		Child/Youth Report (N=30)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	6	25.0%	6	20.0%
No improvement (i.e., 0-1 point reduction)	2	8.3%	3	10.0%
Small improvement (i.e., 2-4 point reduction)	5	20.8%	4	13.3%
Medium improvement (i.e., 5-8 point reduction)	0	0.0%	2	6.7%
Large improvement (i.e., 9+ point reduction)	11	45.8%	15	50.0%

As shown in Table 7, approximately half of the parents/caregivers (45.8%) and children/youth (50.0%) in BHConnect reported a large improvement from their initial PSC assessment. Alternatively, 25.0% caregivers and 20.0% of children reported a higher PSC score at follow-up, indicating some increased impairment. These findings suggest substantial variability among BHConnect clients and their self-reported experiences of behavioral health changes. Substantial variability and similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2019-20 Systemwide Annual Report. Approximately 40% of caregivers and children/youth reported large improvements and about 20-25% reported increased impairment from initial PSC assessment.

Adult Baseline Assessments

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks persons to answer questions as it is "true for you now."

The total mean RMQ score for the seven adult participants who completed it at intake and at a follow-up assessment during FY 2020-21 was 3.0 at baseline and 3.3 a follow-up. While in the desired direction, the magnitude of the change was not statistically significant. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and TAY residential programs) was 3.3 with a follow-up RMQ of 3.6. It appears

that BHConnect participants self-report generally similar assessments of their recovery status and outlook on life as do clients in other BHS programs.

Illness Management and Recovery

To measure clinician perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by BHConnect staff. The IMR scale has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement. Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery. Seven participants completed an intake and a follow-up assessment in FY 2020-21 (see Table 8). The mean overall IMR score at intake was 2.3 and increased to 3.4 at last available follow-up. Primary areas of improvement included reductions in psychiatric hospitalization as well as improved ratings for recovery and management of symptoms.

As reported in the mHOMS Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8, which increased to 3.3 at most recent follow-up. While definitive conclusions are not possible with the small number of BHConnect participants, clinicians assessed BHConnect participants to have slightly more impairment and/or worse recovery/management skills at program intake compared to participants in other BHS programs.

Table 8. IMR Assessments for BHConnect Adult Clients (N=7)

		Intake	Follow-up
IMR Assessment Item/Subscale	**N**	**Mean**	**Mean**
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?	7	2.6	3.4
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?	7	1.6	2.1
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	7	1.6	3.4*
Using medication effectively: How often does s/he take his/her medication as prescribed?	7	3.6	4.4
Recovery subscale	7	2.2	3.3*
Management subscale	7	1.3	3.0*
Substance abuse subscale	7	4.8	4.8
Overall IMR	**7**	**2.3**	**3.4***

**statistical significance at $p < 0.05$*

Additional Program Activities

Establishing Referral Sources

Per the initial design of the BHConnect program, potential clients are identified at crisis-oriented mental health service programs such as the Emergency Stabilization Unit (ESU), Child and Adolescent Psychiatry Services (CAPS), and the San Diego County Psychiatric Hospital (SDPH). Establishing a network of referral sites throughout FY 2020-21 required ongoing BHConnect outreach efforts that involved meeting with representatives of potential partner organizations to educate them about BHConnect services and develop processes for identifying and screening potential clients. Additionally, BHConnect gave presentations at multiple community service provider meetings to increase awareness of BHConnect services.

BHConnect also formed partnerships with other County BHS service programs such as the IHOT where BHConnect could provide the treatment services to the population of treatment unconnected persons that the IHOT teams worked to engage in services. Weekly meetings with another County BHS "Innovation" program, the Center for Child and Youth Psychiatry (CCYP), were established to discuss shared cases and mutual support approaches between the two programs, particularly with CCYP providing psychiatric support for CYF BHConnect clients.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual BHConnect Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, BHConnect, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual BHConnect Staff Survey was conducted at the end of FY 2020-21. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. All BHConnect staff invited to participate in the survey did so, for a 100% response rate (n=7). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes.

Program Strengths

Staff engagement with BHConnect is an overwhelming strength of the BHConnect program, according to annual survey feedback. BHConnect staff report working together to collaborate on client treatment plans, work on communication strategies, and supporting each other.

One staff member captured the lengths to which the BHConnect team goes to meet the needs of clients:

> "We have provided training for clinicians on how to assess for the need of case management or rehabilitation services to support the clients in achieving their mental health goals. We hold a weekly meeting with therapist and FHN's to collaborate on cases and discuss how FHN's can support clients more. We have started discussing with clinicians on how to increase service delivery when clinically indicated, such as twice a week individual session for clients that are first referred and also family therapy

engagement when working with children clients. In addition, we have discussed strategies to increase engagement such as reminder calls, calling clients right away after a missed appointment, rescheduling missed sessions within the same week, utilizing motivational interviewing strategies to increase motivation for participation in treatment."

BHConnect staff also reported increased referrals from Rady Behavioral Health Urgent Care, IHOT, and Center for Child and Youth Psychiatry as program strengths during FY 2020-21. BHConnect is also seeing increased referrals from SDPH as well.

Program Challenges

BHConnect staff identified staff turnover as one of the biggest challenges to reaching program goals during FY 2020-21, as well as the lack of referrals from identified partners. During FY 2020-21, the BHConnect program began to make plans to move away from the WHH platform and transfer the outreach and engagement responsibilities to the Field Health Navigators. A detailed assessment of the strategies used by BHConnect staff to support this service structure change will be an ongoing evaluation activity during FY 2021-22.

Client engagement and attrition were additional difficulties faced by staff. One staff member remarked, "Clinicians have expressed frustration with this being a disengaged population. Many clients no show, don't reschedule during the week for missed appointments, and will be hard to reach and connect with to provide services." Other comments from staff highlighted the ways in which client disengagement reduces morale and enthusiasm among staff.

BHConnect Participant Engagement and Retention

As a program designed to work with clients who have experienced a mental health-related crisis but were otherwise unconnected to outpatient services, ambivalence or resistance to treatment among some clients was anticipated. BHConnect staff recommended structured roles for staff in the client treatment process, from a standardized screening process to the incorporation of case management, and finally a whole-team approach to maintaining client engagement. BHConnect staff were also cognizant of the need to have a client-centered approach to communication, understanding that each client may require a different frequency of communication and outreach.

BHConnect staff also recognized the need to effectively address co-occurring substance abuse issues with BHConnect participants. Efforts to support participants include additional trainings, completing the Compass-EZ assessment, and inviting SUD programs and strengths-based case management programs to present to BHConnect staff. Staff also recommended including a screening tool for assessing client needs prior to admission to BHConnect.

The accessibility of BHConnect staff and services was seen as a positive feature of the program.

Experiences with Telehealth Services

Technical difficulties with both the telehealth platform and devices were reported as the most common difficulties when attempting to provide telehealth with video services. BHConnect staff recommended incorporating the development of an alternative contact method during the screening process, so that

providers and clients would have a back-up method of communication should disruption occur during a session.

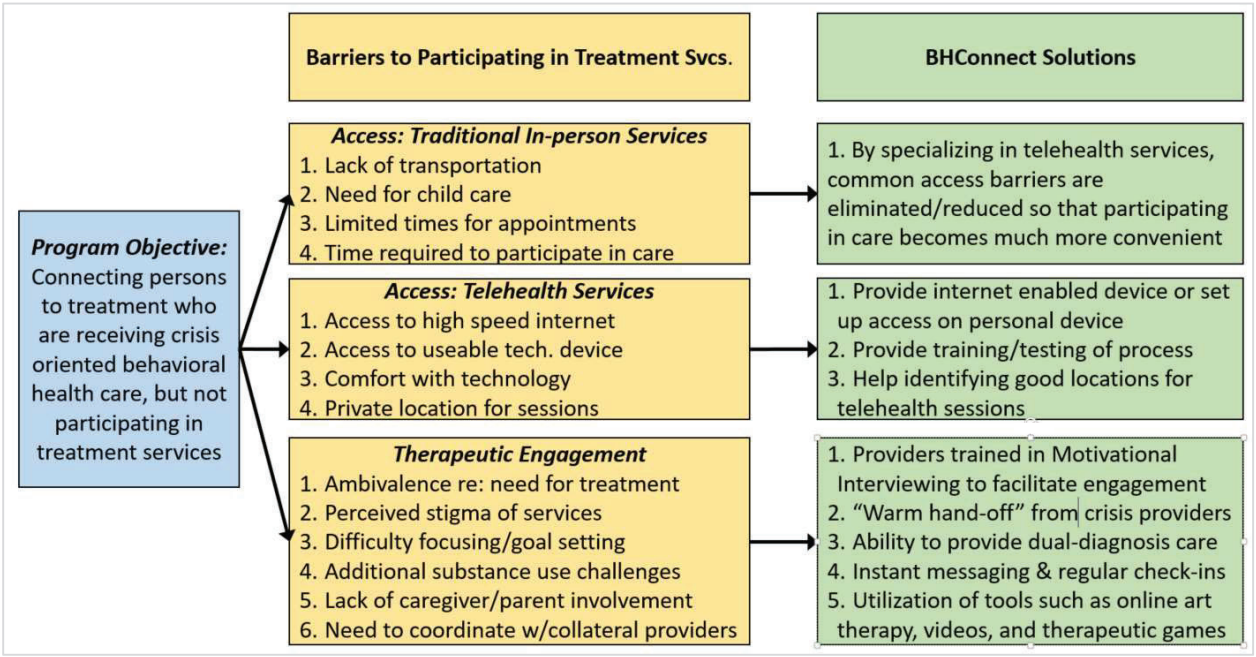
Impact of COVID-19 on BHConnect Staff

Staff reported productivity and communication as the primary issues impacted by COVID-19. BHConnect staff report utilizing routine schedules, exercise, and opportunities to be outdoors as ways to manage or reduce COVID-19-related stress or anxiety.

BHConnect Strategies to Connect Persons to Telehealth Care

Based on feedback from BHConnect staff and participants, the following model (as shown in Figure 1) 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 has successfully implemented to facilitate connection to ongoing care.

Figure 1. Summary of BHConnect Strategies to Connect Persons to Ongoing Telehealth Care



The barriers for connecting to care are conceptually split into two domains pertaining to factors that affect 1) treatment "access" and 2) treatment "engagement" as they represent related, but distinct aspects of maintaining participation in treatment services. Access was separated between in-person services and telehealth services to identify the unique challenges relevant to each type of treatment modality. Key barriers for participating in traditional in-person services include transportation, need for child care, difficulty finding a time to match availability of service provider, and the overall time commitment needed to attend an in-person treatment session on a regular basis. Given the telehealth orientation of BHConnect, all these barriers are either eliminated or substantially reduced.

Participating in telehealth services has its own unique access barriers such as the need for sufficient quality internet capable of video-based communication, having a device that can access telehealth services, being comfortable navigating the device and initiating telehealth sessions, as well as needing to

find an appropriate space that allows for private, focused conversations. BHConnect has had success addressing these telehealth access barriers by providing clients with internet enabled devices and offering clients the option of setting up the connection to BHConnect telehealth services on clients' own personal device (i.e., personal smartphone). Additionally, BHConnect has identified the importance of providing training and support to clients so they can practice using their device to access services and prepare for how to have successful sessions such as finding appropriate locations that are quiet and private (e.g., an empty bedroom, their car, or an outside location).

Mostly independent of the access barriers, the extent to which clients engage in the therapeutic process also affects ongoing connection to services and the potential to receive the benefits of participating in services. Common engagement barriers to telehealth services seen in BHConnect clients include ambivalence to participating in services, resistance to services due to perceived stigma of engaging in behavioral health care, difficulty focusing on treatment objectives, particularly if mental health is substantially impaired or if there are other substance use issues present. For youth clients, the extent to which caregiver/parents are invested in supporting the process is critical, as is the ability to coordinate and communicate with other collateral providers (e.g., primary care doctors, social service providers). BHConnect team members focus on quickly building a positive rapport with clients and are trained in Motivational Interviewing techniques, an evidence-based practice to encourage treatment engagement. The telehealth-based orientation of the BHConnect program supports flexibility so that clinicians and other team members can engage with clients at convenient times when they are more open to receiving care. The online, telehealth approach also facilitates regular communication such as "messaging" to maintain brief interactions with clients and send reminders for upcoming treatment sessions. To promote engagement and retention in services, the BHConnect team also incorporates other tools to connect with participants such as online art therapy, watching and sharing appropriate informational and discussion videos, and engaging in therapeutic online games.

Overall, the experiences with 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 has developed and continues to refine strategies to promote ongoing engagement in treatment services once the initial access barriers have been addressed. However, there will be some persons for whom a telehealth-based approach may not be the appropriate strategy given ongoing difficulty utilizing the device (e.g., frequently forgetting to charge device and not having regular capability to do so) or challenges maintaining focus and developing relationship via the device. BHConnect will continue 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 is determined that telehealth is not the optimal modality for providing care.

BHConnect Participant Feedback

During June of 2021, BHConnect providers asked participants to engage in a short qualitative survey to elicit feedback on the program. Clients were asked a series of questions which had been developed by the 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 the feedback was completely voluntary and would not impact participation in the program. Of the 38 clients invited to participate, 21

agreed and 17 declined for a response rate of 55%. Given the response rate, a limitation of the findings presented is that they may not fully reflect the perceptions of BHConnect participant population. From the collected data, the following themes emerged:

Referrals from familiar sources helped clients to feel comfortable engaging in BHConnect services

1. "With the Rady's Children Hospital connection I was more confident in the program."
2. "I was just coming out of a mental hospital and they gave me your contact info for support with outpatient programs."

Clients appreciated the ease of referral and availability of appointments

1. "We were desperate to enroll him in therapy and it seemed that you guys could get him in quickly."
2. "Never had a therapist that genuinely cares about her clients and it is easier to get a hold of the therapist when you are in need."

BHConnect clients appreciated BHConnect staff

1. "More comfortable because the therapist is approachable and openness in services and topics and resisted therapy but has grown from therapy."
2. "There [sic] super friendly and welcome you with open arms."
3. "I needed someone to talk other than family, I needed a professional."

Clients enjoyed being able to access BHConnect services at home

1. "The convenience and comfort of being in our home."
2. "She likes that she doesn't have to leave the house and I like that I don't have to travel."
3. "Having access to a person from my home."

Changes from Initial Program Design

During FY 2020-21 BHConnect expanded the options that clients could utilize to connect with BHConnect services. Originally, all clients were issued an electronic device that they would utilize solely for communicating with the BHConnect and WHH team members. During FY 2020-21, BHConnect began to allow clients the option to choose whether they would like to utilize their personal smartphone to receive BHConnect service (and get the relevant programs installed on their phone) or if they would rather receive a device from BHConnect to use for interacting with the care team.

A substantial programmatic change that occurred during FY 2020-21 was the decision to phase out the subcontract with WHH and shift those outreach, engagement, and scheduling responsibilities directly to BHConnect staff, particularly the Field Health Navigator. This decision was made to facilitate communication and coordination between all members of the BHConnect team and the clients and to minimize confusion on the part of clients by 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 the client's phone and monitored 24/7. After-hours calls were answered by specially trained medical answering service personnel who can either triage for immediate crisis care or deliver messages to the BHConnect team for less urgent matters. Clients who were issued a BHConnect device (rather than using personal phone) could confidentially message their therapist and Field Health Navigator during business hours. Additionally, the

Field 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. The transition away from WHH occurred near the end of FY 2020-21, so the implications for service delivery will be examined throughout FY 2021-22.

Program Recommendations

1. Continue to diversify referral sources to increase referrals for youth, adult, and geriatric patients. In particular, expand referral sources to include adult crisis centers throughout all regions of San Diego, and add PERT and CPS as approved referral partners.
2. Maintain ongoing and close relations with hospitals to potentially provide more integrated care, with on-site onboardings/warm hand-offs, and inevitably, more continuity of care and engagement with BHConnect services.
3. Increase family therapy and family rehabilitation services and continue to engage parents as a critical component of client-care.
4. Continue collaborating with psychiatry providers and primary care providers to provide coordinated, integrated care, and to assist clients in navigating the healthcare system for improved mental health outcomes.
5. Consider adding in-house psychiatry services or identifying a community partner to help meet the medication management needs for adults.
6. Increase San Diego Change Agents Developing Recovery Excellence (CADRE) and co-occurring capability through incorporating this integrated approach in program literature (website and brochure), clinical approach, and to always consider modifications to the clinical staff annual training plan to include trainings such as “Harm Reduction.”
7. Continue to provide clinical support and training to all staff so that they can feel effective and productive in their role.
8. Refine screening process and explore best practices to increase client engagement from the moment referral is received.
9. Provide in-home services when clinically indicated to further engage clients in treatment.

Conclusion

During FY 2020-21, BHConnect enrolled 89 persons (71 youth and 18 adults), successfully increasing the number of people engaged in the program as compared to the 54 persons (37 youth and 17 adults) enrolled during FY 2019-20. The number of services provided also substantially increased with youth receiving an average of 16 services (as compared to an average 9.6 services in FY 2019-20) and adults receiving an average of 15.3 services (as compared to an average 11.8 services in FY 2019-20). The increase in enrollees and provided services is a program success likely due in part to the program entering their second full year of operations and overcoming startup challenges.

Challenges still remain for providing BHConnect services because even though the program has grown, enrollment remained below initial expectations. Staff reported a lack of referrals as one of the main barriers to achieving enrollment goals. BHConnect received a total of 169 referrals (131 CYF clients and 37 AOA clients) during FY 2020-21. Rady Children’s Hospital Urgent Care was the primary referral source

with 113 referrals. Overall, approximately 55% of CYF and AOA referrals enrolled in BHConnect with 20% declining services and 25% lost to contact.

Services provided by BHConnect include psychosocial assessments, treatment plans, therapy, case management and mental health rehabilitation. Out of all the enrollees, 64.8% of youth (n=57) and 44.0% of adults (n=11) received at least three therapy sessions from BHConnect clinicians. Once enrolled in the program and receiving services, youth and adults will stay engaged with the program anywhere from a few weeks to 6 months or more. Of those who were still involved with BHConnect services as of 06/30/2021, youth had a median enrollment duration of 143 days and adults had a median enrollment duration of 208 days. Preliminary findings suggest that participation in BHConnect services was associated with a reduction in the need for crises and acute care services.

BHConnect provided essential behavioral health services for both youth and adults as indicated by the CANS, PSC, RMQ, and IMR assessments. A comparison between baseline and follow-up CANS and PSC assessments for youth shows significant reductions (i.e., improvements) in behavioral and emotional needs, life functioning, risk behaviors, and clinical concern. Of the children and youth served by BHConnect, 60-65% experienced at least one reduction in a need item identified during the initial assessment. Alternatively, some youth showed an increase in impairment between their baseline PSC and follow-up. This same increase is also seen in the overall CYF BHS system and is indicative of the substantial variability of behavioral health needs and changes within this population. Similarly to the youth, a comparison of the RMQ and IMR assessments for adults showed improvements in the desired direction, but unlike the youth, the changes were not statistically significant.

Overall, BHConnect engaged in extensive outreach and educational activities to increase awareness of BHConnect services throughout FY 2020-21; however, a primary challenge for BHConnect was the difficulty generating the desired number of client referrals from other crisis-oriented mental health service provider organizations. The decision to move away from the WHH platform has implications for changing the roles and responsibilities of BHConnect team members, particularly the Field Health Navigators. This change is expected to create improved communication and coordination with BHConnect clients and additional opportunities for BHConnect staff to encourage and support ongoing engagement with treatment services.

For more information about this Innovation program and/or the report please contact:

David Sommerfeld, Ph.D. (dsommerfeld@health.ucsd.edu)

Appendix

Characteristics of Participants who Enrolled during FY 2020-21

Characteristic	Child/Youth (N=71)		Adult (N=18)	
Gender	N	%	N	%
Male	20	28.2%	4	22.2%
Female	46	64.8%	14	77.8%
Another gender identity	5	7.0%	-	-
Total	71	100%	18	100%
Primary Language	N	%	N	%
English	67	94.4%	18	100%
Other	4	5.6%	-	-
Total	71	100%	18	100%
Race/Ethnicity	N	%	N	%
African American	9	12.7%	-	-
Hispanic/Latino	28	39.4%	2	11.1%
Caucasian/White	35	49.3%	6	33.3%
Multi-racial	14	19.7%	-	-
Asian	7	9.9%	-	-
Other	5	4.9%	2	11.1%
Missing/Unknown	5	4.9%	10	50.0%
Total[1]	-	-	-	-
Sexual Orientation	N	%	N	%
Heterosexual or straight	48	67.6%	9	50.0%
Another sexual orientation	6	8.5%	-	-
Prefer Not to Answer/Missing	17	23.9%	9	50.0%
Total	71	100%	18	100%
Disability[2]				
Has a disability	14	19.7%	-	-
Does not have a disability	52	73.2%	-	-
Declined/Preferred not to answer	5	7.0%	-	-
Total	71	100%	-	-

Characteristic	Child/Youth (N=71)		Characteristic	Adult (N=18)	
Age Group	N	%	Age Group	N	%
5 to 14	43	60.6%	18 to 25	4	22.2%
15 to 18	28	39.4%	26 to 65 (or older)	14	77.8%
Total	71	100%	Total	18	100%

[1] *Total may exceed 100% since more than one race/ethnicity could be selected.*

[2] *Values were suppressed due to small n size.*



ROAMING OUTPATIENT ACCESS MOBILE (ROAM) INNOVATIONS-20

Annual Report
Year 3 (7/1/2020 - 6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

Table of Contents

Executive Summary 1
Program Description 3
Service Changes Due to COVID-19 4
Participant Characteristics 5
Utilization of Program Services 5
Primary Program Outcomes 7
Additional Program Activities 10
Primary Implementation Findings 11
Changes from Initial Program Design 15
Program Recommendations 18
Conclusion 18
Appendix 20

Executive Summary

Program Overview

The Roaming Outpatient Access Mobile (ROAM) program was designed to increase access to and utilization of culturally competent mental health services in rural American Indian populations to decrease the effects of untreated mental health and co-occurring conditions. Two organizations, the Indian Health Council (IHC) and Southern Indian Health Council (SIHC), were selected to provide ROAM services. To facilitate access to care and to help treat the typically underserved American Indian population, the ROAM program adopted the use of mobile health units (MHU) to provide effective health services in areas that may be typically hard to reach as well as offering telehealth and telepsychiatry services to lessen the need for in-person clinic visits. For both the IHC and SIHC ROAM programs, the ongoing effect of the COVID-19 pandemic throughout fiscal year (FY) 2020-21 and the required safety precautions led to periodic suspension of in-person behavioral health service provision, except for crisis situations. This also prevented the consistent use of mobile health units for delivering behavioral health care services.

Primary Findings for FY 2020-21

1. During FY 2020-21 more persons participated in ROAM services (i.e., 323 in FY 2020-21 as compared to 242 unique persons in FY 2019-20) and total services provided increased substantially (i.e., 2,852 services in FY 2020-21 as compared to 1,874 in FY 2019-20).
2. Of those persons for whom initial and follow-up data were available, PHQ-9 and MORS scores improved at follow-up assessment indicating a reduction in depression symptoms and improved recovery and management of symptoms.
3. Participants reported that they highly valued ROAM services and noted they likely would not be in services if not for the accessible, trusted, and private ROAM services.
4. COVID-19 initially prevented use of the mobile health units, but during FY 2020-21 both ROAM programs used their mobile health units to distribute COVID-19 vaccines, help with promoting awareness of the ROAM program and behavioral health more generally, and SIHC restarted regular provision of ROAM services on the mobile health unit.

5. Feedback from ROAM staff and participants indicated that where technologically feasible, telehealth with video was an acceptable, and in many instances desirable, mode for delivering behavioral health care services for Native community members due to convenience and privacy.
6. Tribal, organizational, and program efforts were important for increasing the capacity to provide telehealth with video behavioral health services in Native communities.
7. Based on the experiences of the ROAM programs, a multi-level model was created to illustrate and summarize the foundational community-, organizational-, provider- and patient-level factors necessary to support widespread utilization of telehealth services.
8. Challenges remain for providing telehealth services throughout remote regions; however, additional infrastructure investments are expected to continue during FY 2021-22 that should expand opportunities to provide telehealth services, especially in areas served by IHC ROAM.
9. ROAM services were utilized to help address COVID-19 by providing education, testing, and vaccinations, particularly to those living in remote areas with limited access to those resources.

Conclusion

Collectively, IHC and SIHC ROAM programs substantially increased the number of people enrolled in the program (i.e., 323 in FY 2020-21 as compared to 242 unique persons in FY 2019-20) and the amount of ROAM services provided (i.e., 2,852 services in FY 2020-21 as compared to 1,874 in FY 2019-20). The ROAM services were particularly important as persons eligible for ROAM typically have barriers that inhibit participating in standard clinic-based outpatient behavioral health treatment.

ROAM provided essential behavioral health services as indicated by baseline PHQ-9 and MORS scores showing many persons in the service population experienced mild/moderate depression or were not coping well with their mental health symptoms. When measured again at follow-up, there was a reduction in depression symptoms and improved recovery and management of symptoms. In addition to providing needed behavioral health services, ROAM was able to help address COVID-19 through education, testing, and vaccinations. While challenges remain for providing telehealth services throughout remote regions, the importance of tribal, organizational, and program efforts to reach Native communities and provide services has become even more apparent during FY 2020-21.

ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services in a flexible and private manner, stating that without the program they likely would not be in therapy. Unfortunately, due to the pandemic and safety concerns, the mobile health unit was not able to deliver services consistently and contributed to the low utilization of in-person visits during FY 2020-21. However, the program's efforts at location and modality flexibility were substantial with approximately two-thirds of ROAM services provided to participants who were in their home (i.e., via phone or telehealth), with 62.1% of services at IHC provided via telephone and 57% of services at SIHC provided via telehealth.

A key factor allowing SIHC ROAM to provide more telehealth services was the additional infrastructure and organizational technical support to increase access to the internet that could support video telehealth interactions. Additional infrastructure investments are expected during FY 2021-22 that will increase the capabilities of the ROAM programs, particularly IHC, to offer telehealth services to persons in certain areas where that is not currently feasible.

Overall, the ROAM programs successfully served as a link between the clinical setting and their local communities to facilitate access to services and improve the cultural competence of service delivery for

persons who likely would not have received needed care. Both programs are continuing to plan for how best to utilize the mobile health units and improve their capabilities to provide telehealth services during FY 2021-22.

Primary Recommendations for FY 2021-22

1. Continue to identify and address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
2. Develop and refine plans for how best to provide "hybrid" behavioral health care services that integrate in-person and remote service provision to keep participants engaged and benefiting from services.
3. Increase ROAM's participation in large-scale community outreach events to educate the community about behavioral health and physical health challenges as well as promote ROAM services as an option for those tribal and community members who cannot easily access services at the clinic.
4. Increase the number of psychoeducation events at local community centers with both community members and community center staff.
5. Increase group-oriented services within SIHC ROAM to facilitate community building and increase ROAM's impact.

Program Description

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) ROAM program is funded through the Innovations (INN) component of the Mental Health Services Act. ROAM was developed to provide fully mobile mental health clinics to American Indians of all ages in the North Inland and East County regions of San Diego. The ROAM teams at both IHC and SIHC included licensed therapists and psychiatrists, and the IHC ROAM team also included a licensed substance use disorder (SUD) counselor. The majority of ROAM staff at both IHC and SIHC identified as American Indians. This representative staffing is part of an effort to provide culturally competent services that are sensitive to the needs of American Indians.

Efforts by ROAM are intended to improve access to and utilization of mental health services for American Indian children, transitional age youth (TAY), adults, and older adults residing on tribal reservations and in rural communities in San Diego County. A key eligibility criterion for ROAM services is whether barriers are identified that would inhibit participation in standard clinic-based outpatient behavioral health care services. ROAM services aim to decrease behavioral health symptoms and improve level of functioning for participants, while also improving care coordination and access to physical health care. Each ROAM team is staffed with culturally competent licensed and unlicensed professionals who can provide a variety of care services. In addition, the ROAM program will use telehealth for addressing ongoing mental health needs to decrease burdens for accessing needed services. The usage of telehealth in conjunction with, rather than in lieu of, face-to-face services was expected to be a key factor in minimizing barriers to treatment and furthering mental health engagement. To facilitate better access to care services, the program will provide at least some night and/or weekend services to better match availability of participants.

The ROAM program staff are also expected to participate in community events and meetings to provide education about behavioral health issues, reduce stigma often associated with behavioral health concerns, and make the community aware of ROAM services.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the San Diego community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected 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 remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to and greater utilization of telehealth service delivery approaches.

For the IHC and SIHC ROAM programs, the onset of the COVID-19 pandemic and the required safety precautions led to the initial suspension of all in-person service provision, except for crisis situations. During FY 2020-21, both ROAM programs resumed offering in-person services when community conditions, such as the relative prevalence of COVID-19 cases, allowed. Where feasible and appropriate, in-person visits were conducted in a manner to promote safety of ROAM staff and participants such as by conducting the visit outdoors and/or maintaining other safety protocols such as wearing masks and distancing. The ongoing effects of the COVID-19 pandemic throughout FY 2020-21 and associated concerns for safety inhibited the consistent use of the MHU for the delivery of mental health services. However, as described in more detail below, the MHUs were utilized to extend efforts to address COVID-19 by providing testing and vaccinations (when they became available in the fall of 2020) to persons living in remote areas. Both IHC and SIHC relied extensively on providing ROAM behavioral health services remotely using telephone and telehealth (i.e., video) technologies.

While the initial design of the ROAM program anticipated and encouraged providing services remotely as a way of increasing service accessibility, the impact of COVID-19 throughout FY 2020-21 also likely contributed to the low utilization of in-person visits. Overall, the ROAM programs endeavored to offer flexibility in location and communication modality to allow participants to engage in services however they preferred and felt safe doing. As such, during a typical day ROAM clinicians provided services in a variety of physical locations (e.g., at community centers, remote clinics, or on the MHU) and methods of communication (e.g., in-person, phone, or telehealth with video) to meet the engagement preferences of ROAM participants. A more detailed discussion of the experience with telehealth services is provided below.

The COVID-19 pandemic also limited the ability of the ROAM programs to be involved in more large-scale outreach events during FY 2020-21 as almost all annual in-person tribal gatherings were canceled due to safety concerns. Among the events which ROAM program staff would typically participate in would be

Pow Wows, tribal gatherings, health fairs, wellness events and Native youth conferences. ROAM anticipates a return to more in-person community outreach events during FY 2021-22 to allow for more community education regarding mental health awareness and the opportunity to engage in services provided by ROAM.

Where relevant, findings and recommendations in this report indicate aspects potentially related to the unique challenges that COVID-19 posed within the local community and health care environment throughout FY 2020-21.

Participant Characteristics

A brief overview of the ROAM participant characteristics is presented here with a more complete listing found in the report appendix. In general, the characteristics of the enrollees in the respective ROAM programs were similar. A total of 323 persons received at least one ROAM service during FY 2020-21 (80 from IHC and 243 from SIHC). Of the 198 participants who entered the ROAM program during FY 2020-21 (40 from IHC and 158 from SIHC), the majority (53.0%) identified as female, spoke English (98.0%) and indicated their race/ethnicity to be American Indian (78.3%). Approximately one-quarter (22.7%) of ROAM participants indicated having a disability that was not the result of a serious mental illness (SMI) with 18.2% indicating their disability was a chronic health condition. One area in which the two programs differed in the composition of their new ROAM enrollees was that males comprised the majority of IHC enrollees (70.0%), but only 40.5% of enrollees at SIHC. Additionally, a larger proportion of new enrollees at SIHC were children or youth (26.0% at SIHC as compared with 10.0% at IHC).

Utilization of Program Services

ROAM Behavioral Health Service Provision

During FY 2020-21 there were 80 persons active in IHC ROAM who received a total of 1,070 services (average of 13.4 services per person) and 243 persons active in SIHC ROAM who received a total of 1,782 services (average of 7.3 services per person). As shown in Table 1, one key area of difference between the two programs was the provision of substance abuse counseling, with over half (66.3%) of IHC participants receiving at least one such service compared to the 2.5% of SIHC participants. This difference reflects the composition of the respective ROAM teams at IHC and SIHC and the inclusion of a SUD counselor at IHC. Another key area of difference was that medication management services were received by about twice as many participants at SIHC (52.7%) as compared to IHC (22.5%) due to the direct involvement of a psychiatrist on the SIHC ROAM team.

Similar percentages of participants from IHC and SIHC received cognitive behavioral therapy (43.8% and 44.9%, respectively), however psychoeducation was more prevalent among IHC participants (26.3% and 13.2%, respectively). While there were some differences between the IHC and SIHC programs, most notably the emphasis on substance abuse counseling evident at IHC and medication management at SIHC, the overall findings highlight the wide range of service activities that were provided to persons who may have had difficulty accessing needed behavioral health care through traditional outpatient clinic settings.

Table 1. Number and Type of ROAM Service Contact by Program

	IHC				SIHC			
	Total persons (N=80)		Total services (N=1,070)		Total persons (N=243)		Total services (N=1,782)	
	Number of persons with service	Percent of persons with service	Number of services	Percent of total services	Number of persons with service	Percent of persons with service	Number of services	Percent of total services
Assessment	27	33.8%	32	3.0%	142	58.4%	179	10.0%
Psychoeducation: Individual	21	26.3%	123	11.5%	32	13.2%	182	10.2%
Psychoeducation: Group	<5	<6.2%	<5	<0.5%	0	-	0	-
Therapy-Cognitive Behavioral: Individual	35	43.8%	376	35.1%	109	44.9%	942	52.9%
Therapy-Cognitive Behavioral: Group	0	-	0	-	<5	<2.1%	<5	<0.4%
Therapy-Trauma Informed: Individual	18	22.5%	135	12.6%	39	16.0%	182	10.2%
Therapy-Family Involved	0	-	0	-	29	11.9%	97	5.4%
Substance Abuse Counseling	53	66.3%	471	44.0%	6	2.5%	19	1.1%
Referral to Substance Abuse Counseling	<5	<6.2%	<5	<0.5%	<5	<2.1%	<5	<0.4%
Case Management	<5	<6.2%	<5	<0.5%	56	23.0%	121	6.8%
Medication Management	18	22.5%	73	6.8%	128	52.7%	545	30.6%
Traditional Healing-BH related	<5	<6.2%	<5	<0.5%	0	-	0	-
MAT	0	-	0	-	24	9.9%	113	6.3%

The wide range of service activities provided by both ROAM programs were delivered either in person, over the phone, or via telehealth. As shown in Table 2, the majority of services were provided remotely. At IHC 62.1% of the service contacts were provided via telephone whereas most services provided by SIHC were via telehealth (57.0%). While both programs provided at least some in-person services during FY 2020-21, demand for in-person service delivery was likely diminished due to the ongoing effects of the COVID-19 pandemic.

Table 2. Method of Contact

	IHC		SIHC	
Contact Type	**N**	**%**	**N**	**%**
In Person	345	32.2%	260	14.6%
Telehealth	59	5.5%	1,016	57.0%
Telephone	664	62.1%	508	28.5%
Other	2	0.2%	3	0.2%

The difference between IHC and SIHC utilization of telehealth services (5.5% and 57.0% of ROAM services, respectively), reflected the challenges that IHC experienced during FY 2020-21 with attempting to offer such services. A primary factor that limited the use of telehealth services at IHC was that many persons did not have internet connectivity that could support a video-based telehealth session. Where internet services were available, communication disruptions (i.e., dropped calls) and video/audio distortions interfered with the ability to consistently engage in the therapeutic discussions needed by the ROAM participants. This prompted a greater reliance on delivering services via phone. Additional difficulties emerged during portions of FY 2020-21 with integrating IHC information technology systems and the virtual platforms needed to securely conduct telehealth sessions. The information technology systems issues were resolved at IHC and new community-wide infrastructure investments that will enhance the capability to provide telehealth services are expected during FY 2021-22. These factors should contribute to greater utilization of telehealth services at IHC in future years.

Since many services were provided remotely, this allowed participants more flexibility regarding where they were located when receiving ROAM services. While approximately two-thirds of ROAM services were provided while the participant was at home (i.e., via phone or telehealth), other common locations for participants included: 1) the home of friend/family member, 2) in a car, 3) at work, or 4) while located in another inpatient or residential treatment program. The ongoing effects of the COVID-19 pandemic limited the programs' ability to consistently provide ROAM services using the MHU during FY 2020-21. However, offering services via the MHU represented another approach used to extend the reach of ROAM into the community and make services as accessible as possible.

Primary Program Outcomes

Patient Health Questionnaire

The Patient Health Questionnaire (PHQ) is a well-validated, brief tool for identifying depression. The two-item PHQ-2 is often used as a depression screener while the PHQ-9 is used for a more complete assessment of depression symptoms. As shown in Table 3, a total of 32 persons at IHC and 41 persons at SIHC completed a PHQ-9 at the time of enrollment into ROAM and at least one FY 2020-21 follow-up assessment. The average intake PHQ-9 scores were 10.4 and 11.9 for IHC and SIHC participants, respectively, indicating moderate depression at initial assessment. However, there was substantial variability in the initial PHQ-9 scores with approximately 45% of participants from both programs who completed initial and follow-up PHQ-9 assessments demonstrating symptoms of a likely depressive disorder.

Both ROAM programs showed a decrease in depression symptoms between their participants' initial and last PHQ-9 assessment, with SIHC showing statistically significant decreases. Likewise, the percentage of persons exhibiting signs of likely depressive disorder reduced substantially for both programs. At IHC, 14 people (43.8%) qualified at their initial assessment as likely having a depressive disorder, whereas at their last follow-up assessment that number decreased to 10 people (31.2%). Similarly, for SIHC, 20 people (48.8%) qualified for a depressive disorder at their initial assessments, which decreased to 9 people (22.0%), at their last available follow-up assessment.

Table 3. Change in PHQ-9 Scores from Initial Assessment to Last Follow-up Assessment

	IHC (N=32)			SIHC (N=41)		
(Note: higher value = worse condition; scale of 0 to 3 that corresponds to "not at all" to "nearly every day" over the past few weeks)		**Initial PHQ-9**	**Last available PHQ-9**		**Initial PHQ-9**	**Last available PHQ-9**
PHQ-9 Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
1. Little interest or pleasure in doing things	32	1.2	1.1	41	1.6	0.8**
2. Feeling down, depressed, or hopeless	32	1.5	1.1	39	1.5	0.8**
3. Trouble falling or staying asleep, or sleeping too much	32	1.6	1.2	41	1.8	1.3*
4. Feeling tired or having little energy	32	1.4	1.4	41	1.8	1.4*
5. Poor appetite, weight loss, or overeating	32	1.2	0.8	41	1.1	0.6*
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	32	1.2	0.8	41	1.4	1.0*
7. Trouble concentrating on things, such as reading the newspaper or watching television	32	1.3	0.8	41	1.6	1.1*
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	32	0.8	0.5	41	0.7	0.3*
9. Thoughts that you would be better off dead, or of hurting yourself in some way	32	0.2	0.2	41	0.4	0.1*
PHQ-9 Total Score	**32**	**10.4**	**7.9**	**41**	**11.9**	**7.5****
Likely Depressive Disorder (i.e., at least 4 items scoring 2 or 3)	**-**	**14 (43.8%)**	**10 (31.2%)**	**-**	**20 (48.8%)**	**9 (22.0%)**

**statistical significance at p < 0.05; **statistical significance at p < 0.01*

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) captures recovery as assessed by staff using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

As shown in Table 4, there were 36 persons at IHC and 39 persons at SIHC who had a follow-up MORS completed during FY 2020-21 and an initial intake MORS from which to conduct a change assessment comparison. The average MORS score upon intake was nearly identical for IHC and SIHC (i.e., 5.3 and 5.2, respectively), which corresponds most closely to "not coping, engaged." The initial MORS score distribution differed to some extent between the two programs; SIHC participants exhibited a broader range of values relative to IHC, demonstrated by a higher proportion of their participants falling in both the lowest and highest MORS ratings categories.

Table 4. Change in MORS Scores from Initial Assessment to Last Follow-up Assessment

		IHC (N=36)				SIHC (N=39)			
		Intake		Follow-Up		Intake		Follow-Up	
Value	MORS Rating Category	N	%	N	%	N	%	N	%
1-4	Extreme risk; High risk, not engaged; High risk, engaged; Not coping, not engaged	3	8.3%	2	5.6%	9	28.2%	3	7.7%
5	Not coping, engaged	19	52.8%	7	19.4%	12	30.8%	4	10.3%
6	Coping/rehabilitating	11	30.6%	19	52.8%	8	20.5%	16	41.0%
7-8	Early recovery; Advanced recovery	3	8.3%	8	22.2%	8	20.5%	16	41.0%
	Mean MORS	**5.3**		**6.0****		**5.2**		**6.2****	

***statistical significance at p < 0.01*

As of the last available follow-up assessment completed during FY 2020-21, the average MORS score increased for both IHC and SIHC participants. Scores were 6.0 and 6.2, respectively, corresponding most closely to "coping/rehabilitating". For both programs, these changes reflected statistically significant and clinically meaningful improvements in recovering and management of symptoms.

ROAM Participant Feedback

During June of 2021, ROAM providers asked participants to engage in a short qualitative survey to elicit feedback on the program. Providers were given a short script that explained the qualitative data collection process and that their feedback was completely voluntary and would not impact participation in the program. The 16 ROAM clients who participated were asked a series of questions which had been developed by the evaluation team in collaboration with ROAM leadership and BHS. The following themes emerged from the qualitative data collection effort:

Clients would not be in therapy without ROAM

1. "I would feel like there is no help. I wouldn't go and be seen by anybody. I would feel at a loss that there would be no programs to deal with mental health issues."
2. "I wouldn't be meeting with anyone. I have tried and it has not been good."
3. "I would probably go to the clinic because I needed support. I wouldn't have liked that option though. This has been convenient and private."

Word of mouth and community presence are important for program success

1. "I heard from someone I know that you guys were doing telehealth."
2. "I was going through difficulties at the time. I saw the bus come out every week and one day I decided to come over. I have anxiety about meeting new people so it helped to have said hello to you (therapist) a few times."
3. "Because I knew [the ROAM therapist], I felt comfortable with you and ROAM. Plus, I had no choice I needed some support at the time. Then when I met you I felt even more comfortable because I knew you were cool."

Combination of behavioral health and medical services is helpful

1. "I like how ROAM is set up. I can be close to my home and get medical care and therapy. It's convenient and private."
2. "I would add (additional medical) services and be more consistent… there are lots of ways to help the community out here."
3. "Maybe do more medical services for the elders or people that don't make it to the clinic."

Clients value flexibility in appointment types and locations

1. "I liked in-person with ROAM because I was given the option to meet outside. It's hard for me to sit in a room for an hour."
2. "If we hadn't started talking on the phone and you hadn't been so nice I never would have started this. The phone helped me with my anxiety. There is no way I would have come and met with you face to face right away."
3. "I met with a psychiatrist at another clinic but it was too hard to keep appointments. Transportations was the problem."

Clients appreciate ROAM culturally appropriate and private services

1. "The fact that it is Native American culture, and plus you are on the reservation."
2. "I don't trust counselors. I felt you were different. It seemed like you actually listened and cared. You weren't trying to be better than me."
3. "There is no way I would be getting (behavioral health) services if ROAM didn't come out here. I don't feel comfortable at the clinic because everyone knows your business. This feels private."

Additional Program Activities

Supporting Community Efforts to Address the COVID-19 Pandemic

In addition to providing mental health services, ROAM program resources, particularly at SIHC, were utilized to address the COVID-19 pandemic during FY 2020-21. SIHC utilized the ROAM program to assist with the goal of expanding COVID-19 testing and vaccination efforts to the local Native community. The ROAM RN provided COVID-related services at SIHC clinics, at large-scale community events, as well as by utilizing the ROAM MHU to extend outreach, education, and COVID-19 testing and vaccination services to those living in remote areas. A total of 1,523 COVID-19 vaccination doses were administered through SIHC ROAM during FY 2020-21. Additionally, the ROAM mobile unit at IHC was used to administer 1,148 COVID-19 vaccination doses throughout the community.

Reducing Opioid Overdose Risks in the Community

During FY 2020-21, SIHC ROAM led efforts to educate the community about Narcan use and distributed Narcan as an emergency treatment option in an effort to reduce the risk of opioid overdose deaths. To do this, ROAM used their network of tribal contacts to set up meetings with tribal leaders and hosted SIHC's Medication Assisted Treatment (MAT) nurse on the ROAM bus on select days throughout the month. Additionally, ROAM set up Narcan education courses for leaders at the community centers on the reservation and collaborated with the SIHC MAT nurse to provide education and distribute the Narcan. Narcan distribution and education efforts were conducted in response to concern from local law enforcement and health care organizations regarding the opioid crisis and overdose deaths on tribal lands.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ROAM Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ROAM, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ROAM Staff Survey was conducted at the end of FY 2020-21. IHC and SIHC ROAM program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 14 respondents from the 14 IHC and SIHC ROAM staff invited to participate in the survey (i.e., a response rate of 100%). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses and any discrepancies were discussed to arrive at a consensus on the key response themes. Information included in the following sections is applicable to both the IHC and SIHC programs unless otherwise indicated.

Community, Organizational, and Program Efforts to Support Telehealth

While telehealth was included as part of the original design of the ROAM programs, the emergence of the COVID-19 pandemic and the tribal, organizational, and ROAM program response to it substantially increased the capabilities and feasibility to provide a high level of these services. For example, during FY 2020-21, the majority of SIHC ROAM program services were provided using telehealth that allowed for video interaction between provider and participant (more than 1,000 telehealth service sessions). The

following were identified by the SIHC ROAM team as instrumental to support the widespread utilization of telehealth ROAM services:

1. **Community Efforts:**
    a. Where possible, local tribes provided cell phones, tablets, and upgrades on connectivity for tribal members.
2. **Organizational Efforts:**
    a. SIHC set up Wi-Fi zones at each clinic and in locations throughout the region such as at community centers.
    b. SIHC hired a part-time driver who drove hotspots and tablets to community members' homes on request.
    c. SIHC Information Technology (IT) department focused on thoroughly training SIHC staff to navigate OTTO Health (the virtual platform used by SIHC to deliver telehealth services), using collective learning sessions, supervisor learning sessions, helpful handouts, and consistent follow up conversations to troubleshoot challenges that emerged.
3. **ROAM Efforts:**
    a. ROAM clinicians educated clients at the start of each session about potential connectivity issues and established backup plans such as changing location, restarting the OTTO Health session, or if necessary, moving to phone if the telehealth session was disrupted.
    b. ROAM clinicians were flexible about appointment times and locations. When connectivity was disrupted, ROAM providers tried changing their location whenever possible such as moving from the bus to the clinic, or from the community center to SIHC's substance use center.

Favorable Staff Perspectives Regarding the Value of Remote Sessions

During FY 2020-21, staff from both ROAM programs indicated developing a more favorable view on the role of remote visits (i.e., telephone and telehealth) to provide behavioral health services. Overall, ROAM clinicians thought they were able to accomplish much more in their therapeutic interactions via remote sessions than originally expected. The following observations were provided regarding the change in staff perspectives about utilizing telehealth with video services:

1. Many ROAM clinicians initially had doubts that the Native community would engage in telehealth services regularly. However, after utilizing telehealth they report a significant drop in no-show rates and that Native clients were engaged with services at similar levels to those observed for in-person sessions.
2. ROAM clinicians also had concerns that the lack of person-to-person contact may prevent significant rapport building. However, after extensively utilizing telehealth, clinicians shared that rapport building was effective in most, although not all, telehealth cases.
3. ROAM clinicians thought that technological problems due to remote locations on the reservation would prevent widespread utilization of telehealth services. However, we found that most people living on the reservations were able to find a location where they could engage in a successful telehealth meeting without technical issues, especially after the tribal and organizational investments to expand connectivity options following the onset of the COVID-19 pandemic.

While ROAM staff were generally impressed with what could be accomplished via remote service provision, there was recognition that remote services were not ideal for some persons and that being able to offer at least some in-person services was still essential.

Staff Experiences with COVID and Telehealth Services

The COVID-19 pandemic had a substantial impact on the Native American communities served by ROAM. Community buildings were empty for much of the year, making outreach challenging. Contactless events made developing connections and relationships with community members and leaders even more challenging. In an attempt to address community needs due to the COVID-19 pandemic, many ROAM staff were reassigned to pandemic-related jobs, which decreased consistency and halted the process of building relationships with the community.

The flexibility afforded by telehealth has proven beneficial for ROAM staff but has also created challenges. Staff reported logistical challenges such as inadequate PPE, plastic barriers on the MHU, and difficulty finding privacy with clients as the greatest impacts of COVID-19 on their work. Other impacts include decreased in-person interaction, and a greater emphasis on telehealth and program flexibility. ROAM staff are conscientious of their need for self-care and reported several methods of ensuring they were attending to their own mental health needs during the pandemic, including an intentional self-care practice and dedicated time with friends and family. Compared to FY 2019-20, staff reported a decreasing sense that their work tasks and personal life were changed due to the pandemic. This is likely due, in part, to the "normalization" of new work activities and routines during the ongoing COVID-19 pandemic.

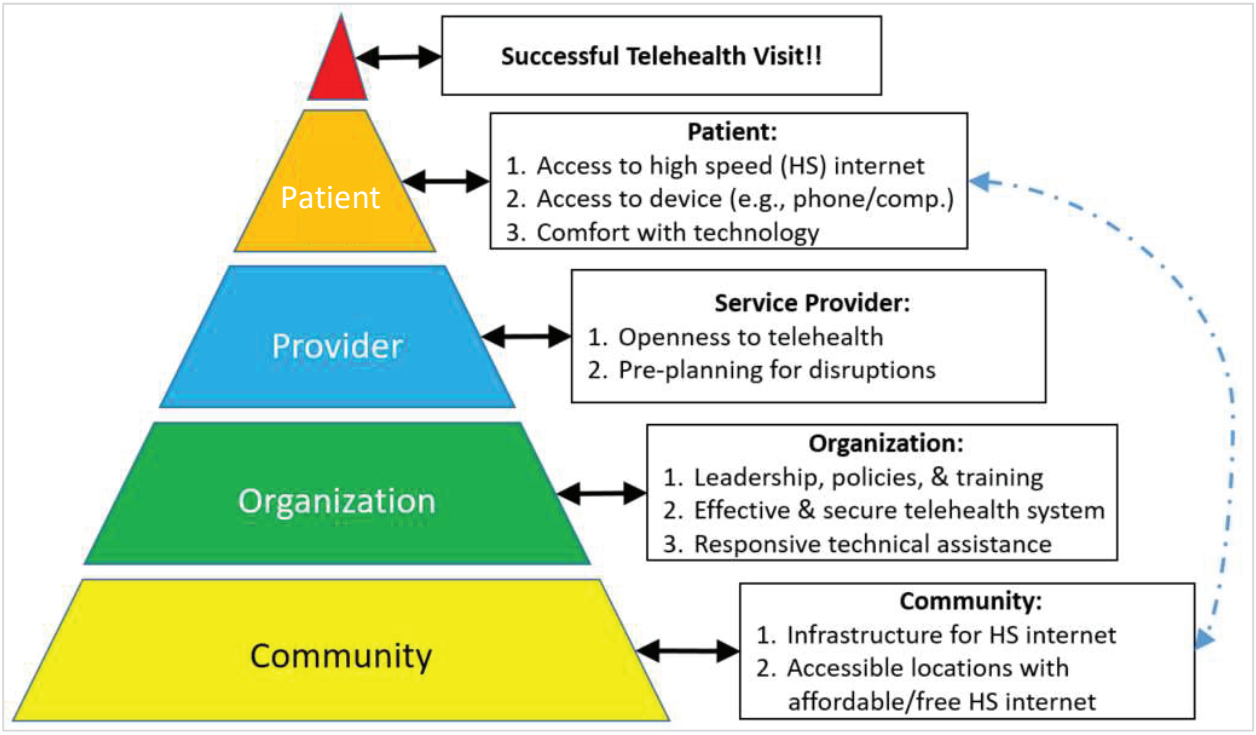
According to ROAM staff, as compared to FY 2019-20, more clients are expressing a preference for non-telehealth services as in-person services become more viable. While clients reported appreciating the flexibility of ROAM services, technological issues such as functional devices and appropriate internet services continue to be a barrier to telehealth for some clients living on reservations.

In addition, ROAM staff indicated that the difficulties experienced while trying to comprehensively provide behavioral health care via telehealth services throughout the community helped identify the geographic areas where such services were not feasible (i.e., areas where internet connectivity was nonexistent or not strong enough to support the upload speeds needed to seamlessly conduct video-based telehealth sessions). An increased awareness of the need for improved rural information technology infrastructure that can support telehealth services was not unique to the County of San Diego. ROAM program staff were aware of federal funding sources that will create opportunities for rural and Native communities to enhance the capacity to provide telehealth services. It is expected that these investments will increase the availability of telehealth services for the ROAM programs, particularly for IHC ROAM.

Establishing a Multi-Level Foundation for Successful Delivery of Telehealth Services

Based on the experiences of both ROAM programs and feedback from ROAM participants and staff, the following model was developed to summarize and illustrate the foundational factors needed to successfully deliver telehealth services in the communities served by ROAM. As shown in Figure 1, key foundational elements across multiple levels were identified as necessary to create the context for widespread delivery of telehealth visits.

Figure 1. Multi-Level Foundation for Successful Delivery of Telehealth Services



The overall foundation, upon which everything else is dependent, is community-level infrastructure needed to provide the widespread high-speed internet capable of seamlessly and consistently handling video-based interactions between patients and providers. While the goal is for all community members to have their own personal high-speed internet access, or at least have a local friend or family member who does, there are areas where this is not feasible. In that case, locations such as community centers, clinics, etc. should offer secure and free Wi-Fi in private settings so that telehealth options are accessible close to a person's home.

At the organization level, three key factors are needed: 1) organizational support in terms of leadership, provision of staff training, and developing policies and protocols to guide telehealth practice are critical to encourage and champion use of telehealth, especially when it was initially considered not part of standard practices; 2) the adoption of a telehealth platform that integrated well with clinic workflows and data systems; 3) and the importance of a responsive technical assistance team who can help with guiding providers through the telehealth platform and quickly ("real-time" is preferred) addressing questions and problems that arise when delivering telehealth care.

At the provider level, essential factors were 1) a general openness to trying to provide telehealth care services (which can be greatly facilitated by the organizational-level factors discussed above), as well as 2) pre-emptively developing a plan for how to handle the eventuality that a telehealth visit will get disrupted due to technological issues and communicating that with the patient (e.g., attempting to reconnect via video or switch to a phone call).

At the patient level, two logistical access issues much be addressed: 1) accessibility of high-speed internet and 2) a device capable of accessing the telehealth platform.

As discussed above, community investment into availability of affordable high speed internet access is crucial. Additionally, where a patient does not have their own device (e.g., phone, tablet, or computer) or ability to easily access one via friends and family or at a local resources such as community center or clinic, health care organizations should consider providing such a device to patients. A final step, and often one of the easiest, is to ensure (and increase where needed) patient knowledge and comfort with using telehealth technologies (e.g., how to access the internet, start the telehealth session, etc.). Feedback from the ROAM team members indicated that many patients quickly learned how to utilize telehealth technologies, felt comfortable communicating with providers in this manner, and appreciated the flexibility and convenience that it allowed. In this regard, once the multi-level foundation was prepared, successful telehealth visits with patients were feasible and common.

Outreach and Recruitment of ROAM Participants

ROAM staff indicated the following primary goals in the Annual Survey: increasing access to mental health care for historically underserved Native American populations, increasing engagement with local Native American communities, and addressing drug and alcohol use. Staff indicated that positive coordination and communication with community partners led to successful outreach and recruitment, and more potential ROAM clients could be recruited using community/cultural events. Additionally, the flexibility and increased accessibility of the ROAM program were seen to be facilitating factors in reaching program goals. The following themes emerged from the qualitative data collection effort:

Staff are committed to the goals and mission of the ROAM program

1. "The communication, perseverance, diligence, passion, intelligence, desire to serve others, dedication [of ROAM staff] to the support of mental health as a whole and serving an underrepresented population in San Diego County."
2. "Our supervisor is very supportive and transparent, and I think this is super helpful."

Services flexibility

1. "The adaptability and flexibility of staff to changes of policies and procedures to better ensure clients' needs are met."
2. "Adaptability, flexibility, and organization. We are able to meet client needs and adjust to the new requirements and the ever-changing needs of our clientele."

Connection to the community and culture are a key component of ROAM services

1. "The program spent the first year building relationships with community organizations on the reservation. This created an increased sense of trust with ROAM which led to more referrals and a greater confidence to seek treatment."
2. "[One factor that helped the ROAM program achieve its goals was] open conversation with the Tribal Councils about the availability of the services provided."

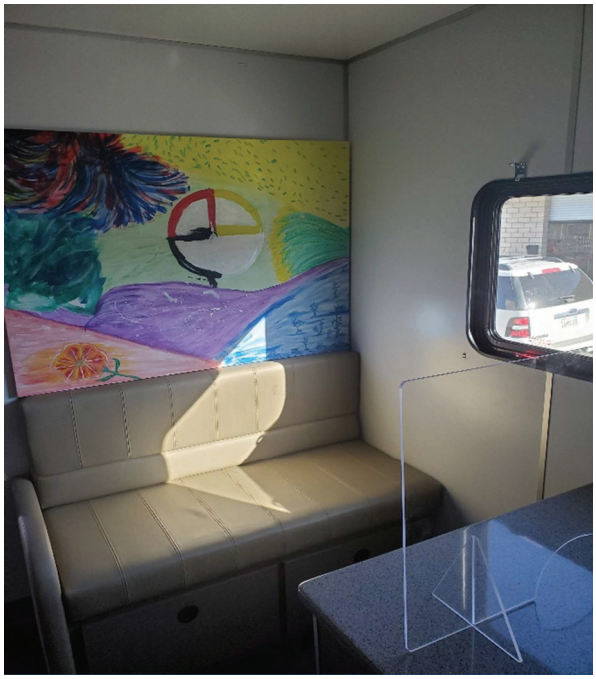
Role of Mobile Health Unit to Support ROAM Operations and Outreach

While the ROAM programs initially stopped utilizing the mobile health units during March 2020 due to the onset of the COVID-19 pandemic and the associated health and safety concerns, SIHC ROAM was able to restart regular "ROAM Bus" mobile health services during FY 2020-21. A total of 65 persons (26.7% of

SIHC ROAM clients) received 299 SIHC ROAM services (16.8% of all SIHC ROAM services) via the ROAM mobile health unit. This allowed ROAM to expand their reach and provide services to persons who would otherwise have difficulty accessing services, particularly if there was a desire or need for in-person sessions.



Photo 1: Outside view of SIHC mobile health unit



Picture 2: Clinician's office



Picture 3: Substance counselor's office

Additionally, both SIHC and IHC reported using their mobile health units to promote awareness of their respective programs in the community via the logos and other information on the units themselves to encourage engagement. The ROAM mobile health units were invited to community events to provide

education, behavioral health services, as well as contribute efforts to provide COVID-19 related testing and vaccination services.



Photo 4: Outside view of IHC mobile health unit

Even though the utilization of the mobile health units was affected by the COVID-19 pandemic the ROAM staff from both IHC and SIHC viewed the mobile health units as a particularly important part of the ROAM programs, as can be seen in some example feedback from the staff survey.

MHU Flexibility is a strength of the ROAM program

1. "This program is excellent for the rural clients/patients without transportation. It aides in providing services in getting the much needed help for them."
2. "With the ROAM Bus [i.e., the MHU] acting as a central hub in the community ROAM could potentially expand to include more staff who go out into the community each day to meet needs of community members who cannot make a trip to the clinic."

Changes from Initial Program Design

The primary changes from initial program design included the adaptations required in response to the ongoing COVID-19 pandemic. The pandemic has limited the availability of in-person sessions and increased reliance on remote interactions for both ROAM programs. However, since the ROAM programs were specifically developed to provide a range of options for delivering behavioral health services, the COVID-19-related changes do not represent a completely new approach to service provision. Instead, the adaptations were a shift in emphasis such that remote services via telephone and telehealth have become more common and normalized than initially expected. In addition, the initial ROAM program design anticipated the use of "cultural brokers" as part of the ROAM staff in order to facilitate connections to and engagement with the American Indian communities intended to be served by the ROAM programs. The decision to utilize organizations already established within these communities (i.e., IHC and SIHC) essentially eliminated the need for maintaining a specific "cultural broker" role on the ROAM teams given that many IHC and SIHC staff identified as American Indians and the organizations had a long history of

working with and serving American Indians. In this regard, by embedding the ROAM program within IHC and SIHC, the original goal of promoting engagement with American Indians was achieved without the need for designating specific staff as "cultural brokers."

Program Recommendations

1. Continue to identify and address technological barriers related to conducting telehealth services (e.g., issues with internet connectivity, availability of suitable devices).
2. Develop and refine plans for how best to provide "hybrid" behavioral health care services that integrate in-person and remote service provision to keep participants engaged and benefiting from services.
3. Increase ROAM's participation in large-scale outreach events to educate the community about behavioral health and physical health challenges as well as promote ROAM services as an option for those tribal members who cannot easily access services at the clinic.
4. Increase the number of psychoeducation events at local community centers with both community members and community center staff.
5. Increase group-oriented services within SIHC ROAM to facilitate community building and increase ROAM's impact.

Conclusion

Both IHC and SIHC ROAM programs successfully implemented all their service approaches and substantially increased the number of people enrolled in the program (i.e., 323 in FY 2020-21 as compared to 242 unique persons in FY2019-20) and the quantity of services provided (i.e., 2,852 services in FY 2020-21 as compared to 1,874 in FY 2019-20). Enrollees were eligible to receive ROAM services because they had barriers that inhibited them from participating in standard clinic-based outpatient behavioral health treatment.

Behavioral health services provided by ROAM were necessary, as evidenced by baseline PHQ-9 and MORS scores showing many persons in the service population were experiencing mild/moderate depression or were not coping well with their mental health symptoms. When measured again at follow-up, there was a reduction in depression symptoms and improved recovery and management of symptoms. In addition to providing needed behavioral health services, ROAM was able to help address COVID-19 through education, testing, and vaccinations. While challenges remain for providing telehealth services throughout remote areas, the importance of tribal, organizational, and program efforts to reach Native communities and provide services has become even more apparent during FY 2020-21. Feedback from ROAM staff and participants indicated that when technologically feasible (e.g., having sufficient internet connectivity and a convenient device), telehealth with video was viewed positively as a method to provide behavioral health services due to convenience and privacy.

ROAM was designed to provide expanded access to care through two primary mechanisms: 1) a mobile health unit that would bring behavioral health care teams to remote areas of San Diego County with limited availability of behavioral health care services, and 2) expanded use of telehealth and telepsychiatry to connect behavioral health professionals with persons who need services via telephone and video sessions. ROAM participants reported great appreciation for the provision of culturally informed and culturally relevant behavioral health services, stating that without the program they likely would not be

in therapy. Unfortunately, due to the pandemic and safety concerns, the MHU was not able to deliver services consistently and contributed to the low utilization of in-person visits. However, the program's efforts at location and modality flexibility were not lost; approximately two-thirds of ROAM services were provided while the participant was at home (i.e., via phone or telehealth), with 62.1% of services at IHC provided via telephone and 57% of services at SIHC provided via telehealth. A key factor for allowing SIHC ROAM to provide more telehealth services was the additional infrastructure and organizational technical support to increase access to the internet that could support video telehealth interactions. Additional infrastructure investments are expected during FY 2021-22 that will increase the capabilities of the ROAM programs, particularly IHC, to offer telehealth services to persons in areas where that is not currently feasible.

Overall, the ROAM programs successfully served as a link between the clinical setting and their local communities to facilitate access to services and improve the cultural competence of service delivery for persons who likely would not have received needed care. Both programs are continuing to plan for how best to utilize the mobile health units and improve their capabilities to provide telehealth services during FY 2021-22.

For more information about this Innovation program and/or the report please contact:

David Sommerfeld, Ph.D. (dsommerfeld@health.ucsd.edu)

Appendix

Characteristics of Participants who Enrolled during FY 2020-21

Characteristic	Total Participants (N=198)	
Gender	N	%
Male	92	46.5%
Female	105	53.0%
Missing/Prefer not to answer	1	0.5%
Total	198	100%
Age Group	N	%
<16	14	7.1%
16-25	31	15.7%
26-45	87	43.9%
46-65	51	25.8%
>65	15	7.6%
Total	198	100%
Primary Language	N	%
English	194	98.0%
Missing/Prefer not to answer	4	2.0%
Total	198	100%
Race/Ethnicity	N	%
American Indian	155	78.3%
Latino	13	6.6%
Caucasian	30	15.2%
Multi-racial	9	4.5%
Other	5	2.5%
Missing/Prefer not to answer	4	2.0%
Total[1]	-	-
Sexual Orientation	N	%
Heterosexual or straight	88	52.5%
Gay/Lesbian/Bisexual/Pansexual	6	3.0%
Missing/Prefer not to answer	104	44.5%
Total	198	100%
Military Status	N	%
Never served in the military	189	95.5%
Other/Missing/Prefer not to answer	9	4.5%
Total	198	100%

Characteristic	Total Participants (N=198)	
Disability	**N**	**%**
Yes, Has a disability	45	22.7%
No, Does not have a disability	146	73.7%
Declined/Preferred not to answer	7	3.6%
Total	198	100%
Type of Disability	**N**	**%**
Learning/Developmental/Other Mental	7	3.5%
Physical	8	4.0%
Chronic Health	36	18.2%
Total[2]	-	-

[1] Total may exceed 100% since more than one race/ethnicity could be selected.
[2] Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.



JUST BE U INNOVATIONS-21

Annual Report
Year 3 (7/01/2020-6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

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

Table of Contents

Executive Summary 1
Program Description 3
Program Model 4
Service Changes Due to COVID-19 5
Program Outreach and Enrollment 5
Participant Characteristics 6
Utilization of Program Services 7
Key Evaluation Findings – BHS Outcome Measures 8
Key Evaluation Findings – Additional Outcome Measures 12
BHS Utilization Patterns 14
Youth Perspectives on JBU Services 16
Photovoice Project 16
Composite of JBU Youth Experiences 21
Program Implementation Findings 23
Additional Program Activities 25
Program Changes from Initial Design 26
Status Update on Prior Year Program Recommendations 26
New Program Recommendations 27
Conclusion 27
Appendix 28

Executive Summary

Program Overview

The Just Be U (JBU) program was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY; age 18-25; referred to as "youth" throughout this report) with serious mental illness (SMI) who are homeless or otherwise at risk of homelessness and repeatedly utilize acute or emergency mental health services, but are otherwise unconnected to services. JBU provides short-term housing for youth in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions coupled with occupational therapy supports to help teach skills needed to accomplish personal goals. Throughout these interactions with youth, JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on youth-centric, whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging youth.

As a residential program serving a population at considerable risk for exposure to disease (i.e., homeless youth), JBU staff maintained in-person operations throughout the COVID-19 pandemic by implementing CDC and San Diego County public health guidelines. While JBU's residential component continued without interruption, the availability of holistic services was more limited during fiscal year (FY) 2020-21 except those that could be socially distanced or completed via remote technologies, and community-based educational and enrichment events shifted to primarily outdoor, nature-based activities (e.g., hiking, trips to beach, etc.).

Primary Findings for FY 2020-21

1. To help expand enrollment, Behavioral Health Services (BHS) approved JBU to accept referrals from other service provider organizations for youth who met the core eligibility criteria. Previously, only youth identified by BHS as potentially eligible based upon their service utilization patterns of receiving in-crisis services while not connected to treatment could enroll in JBU.
2. During FY 2020-21, JBU staff were able to successfully locate and contact 50.4% (n=113) of the 224 potentially eligible TAY and enrolled approximately 80% (n=45) of the youth determined to still be eligible for JBU services (i.e., not housed).
3. TAY with completed baseline and follow-up assessments demonstrated improvements across many domains including symptom management, recovery orientation, sense of well-being, and impairment due to substance use.
4. Occupational therapy (OT) services were comprehensively incorporated into JBU practices via both individual and group interactions. Structured OT assessments helped youth to identify, develop and take steps to achieve their goals. Initial outcome data indicate improvements in TAY capabilities to perform and derive satisfaction from completing desired tasks.
5. After participating in JBU, TAY typically increased their utilization of BHS outpatient and Assertive Community Team (ACT) program services as evidenced by approximately 70% of JBU youth connecting with outpatient mental health treatment services while enrolled in JBU and almost 30% receiving ACT services following discharge from the residential phase of JBU.
6. Participation in JBU was also associated with reduced need for crisis and acute care BHS services (i.e., crisis stabilization, urgent outpatient visits, and PERT interactions). Fewer youth accessed such services during the 180 days after JBU discharge as compared to the 180 days prior to enrolling in JBU.
7. The Photovoice Project generated youth feedback regarding their perceptions of the JBU program. Key emergent themes included the following: 1) Housing was the most important part of JBU, 2) JBU provided a sense of stability, 3) Community can be uncomfortable for JBU youth, but they recognize its importance, 4) A sense of control was important while youth work towards independence, and 5) Participation in JBU gets youth to independence faster than if they tried on their own.

Conclusion

Although the COVID-19 pandemic continued to disrupt normal operations during FY 2020-21, the JBU program provided residential care and support services to enrolled youth throughout the year while abiding by relevant safety protocols. In fact, no COVID-19 cases were identified among JBU youth. JBU expanded their services in FY 2020-21 to include comprehensive assessment and individualized goal planning with occupational therapists. These OT services provided another mechanism to engage with youth and help support efforts to improve wellbeing and facilitate connections to needed behavioral health care services.

JBU continued to demonstrate high levels of success creating linkages to other BHS treatment programs with approximately 70% of youth participating in outpatient care while enrolled in JBU and almost 30% transitioning into ACT programs after completing the residential phase of JBU. JBU has also established relationships with organizations that provide substance use disorder (SUD) treatment services as SUD remained a primary barrier to successfully achieving program objectives with JBU youth.

Primary Recommendations for FY 2021-22

1. Develop additional connections to outside providers for TAY-appropriate mental health care in the San Diego region.
2. Incorporate more intensive case management for JBU youth.
3. Evaluate opportunities for an increased transportation budget to mitigate the need for additional transportation assistance associated with moving the JBU program from downtown San Diego to a residential neighborhood.
4. Increase attention to post-discharge follow-ups.

Program Description

Using County of San Diego BHS Electronic Health Record (EHR) data, BHS personnel identify youth (age 18-25) who appear eligible for JBU services (i.e., multiple acute/crisis-related BHS service contacts, SMI diagnosis, and unconnected to behavioral health services) and who are homeless or at-risk of homelessness. After JBU receives the list of eligible names from BHS, intensive outreach efforts are made by JBU staff to locate and contact each youth using available contact information provided by County databases, street searches, and coordination with other County and support agencies. During FY 2020-21, a BHS-approved change was made to allow for "open" referrals as well so that JBU was allowed to enroll youth who were referred from other organizations if they met the core criteria (i.e., multiple acute/crisis related BHS service contacts, SMI diagnosis, and unconnected to behavioral health services, all while experiencing homelessness or being at-risk of homelessness).

Once eligible youth have been contacted, given an explanation about the program's offerings, and agreed to enroll in the program, JBU provides short-term housing that incorporates support services, smart device-based apps and biometric technology, integrative medicine, and holistic health care in one central, urban location. With dormitory-style housing, JBU youth can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same housing unit in central San Diego. During their time in the program youth will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, chiropractic care, and meditation, as well as mindfulness education, nutritional counseling, individual case management, peer support, group outings, and various in-house community-building trainings and events.

The overarching goal of JBU is to engage and stabilize youth by offering short-term housing (typically around 120 days) while providing holistic youth-centric recuperative services. Throughout their residence at JBU, youth are linked with ongoing treatment, housing, and supportive services, thereby improving their mental health and quality of life in the community. Ideally, JBU programming breaks the cycle of homelessness early in the process, avoiding youth hardening in identity as homeless and mentally ill. This has the additional benefit of minimizing the tendency of this population to repeatedly utilize inappropriate and financially burdensome levels of emergency and mental health services.

The program's emphasis on community-building, destigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation, self-regulation training, and engagement

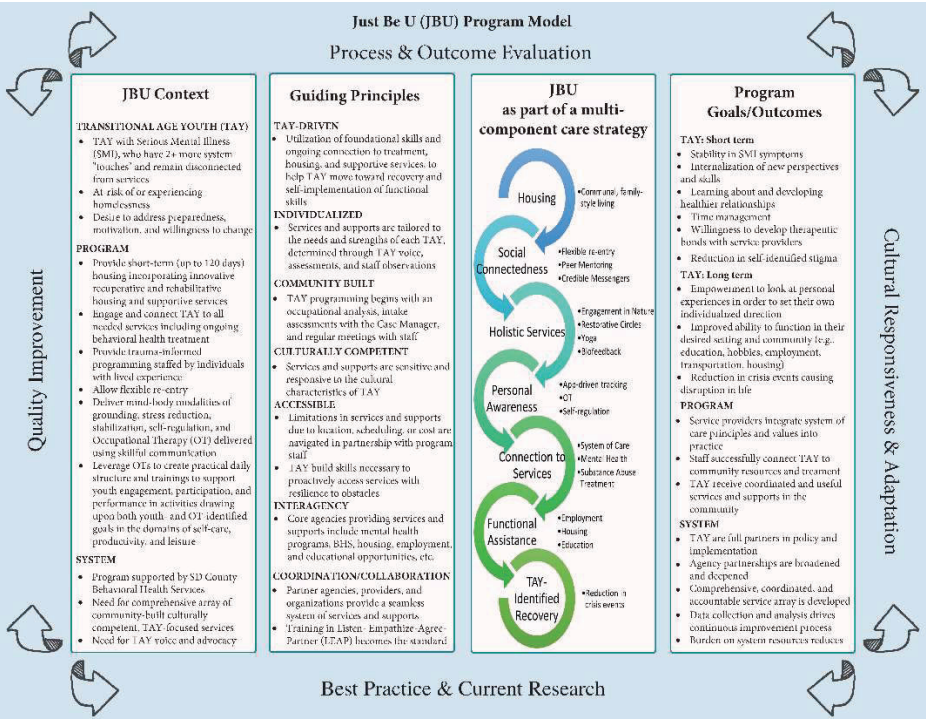
with holistic and integrative therapies both attracts and retains this historically difficult-to-reach cohort of the homeless population.

It is particularly salient that the program aims to intervene early in the cycle of homelessness, before youth self-identify as homeless and/or helpless, and before the personal and societal costs escalate and become more intractable. Further, the program's emphasis on destigmatization, community, and well-being provides a model of care and continuity that is characteristic of a well-functioning family, the historical foundation for ensuring safety, growth, and wellness in a well-functioning human society.

Program Model

Throughout FY 2020-21, the UCSD evaluation team, JBU leadership, and BHS County representatives met monthly to review JBU evaluation practices, get updates on the program, and better understand the general practice experiences of JBU as an innovative and evolving program. To define JBU's multi-faceted service approach more clearly within a broader strategy of care for these youth, the team endeavored to develop a JBU Program Model. Through these discussions a model was created in which JBU's context, guiding principles, role as a single component in a multi-component care strategy, and goals/outcomes were defined across multiple levels (individual, program, and system-based levels).

Figure 1. JBU Program Model



Understanding the complex context in which a program such as JBU operates is critical to understanding how improvements may be made and where successes are truly occurring.

Programmatically, JBU relies on individual youth to engage in services and outside providers to have accessible treatment options reliably available for youth. Within the JBU program, there remains a commitment to using current research, engaging in culturally-informed responses, and improving quality of care. The JBU Program Model is presented in Figure 1. A full-size rendering of the Program Model is available to review in the appendix.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected 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 remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

As a residential program serving homeless youth, a population at considerable risk for exposure to disease, JBU implemented a number of policies and procedures that allowed staff to continue providing in-person services while complying with CDC and San Diego County public health guidelines. These policies and procedures included: holding staff safety procedure trainings, providing quarantine and isolation plans, increasing security and protocols for building entry, posting COVID-19 safety education materials, implementing staff and youth mask requirements and rigorous sanitation procedures, and complying with the "stay-at-home" order to prevent opportunities for exposure. Of note, JBU's safety practices contributed to an environment in which there have been no identified COVID-19 cases. While the basic residential component continued without interruption, JBU suspended all in-person holistic services except those which could be socially distanced or completed via remote technologies (i.e., yoga, fitness, mindfulness, and biofeedback). Public outings to promote education, enrichment, and/or growth with peers were more limited during FY 2020-21 due to COVID-19. Sessions with behavioral health providers (e.g., from Areta Crowell Center) continued, but were transitioned to telehealth platforms. JBU staff facilitated sessions by setting up a computer for private video sessions with therapists and other external service providers.

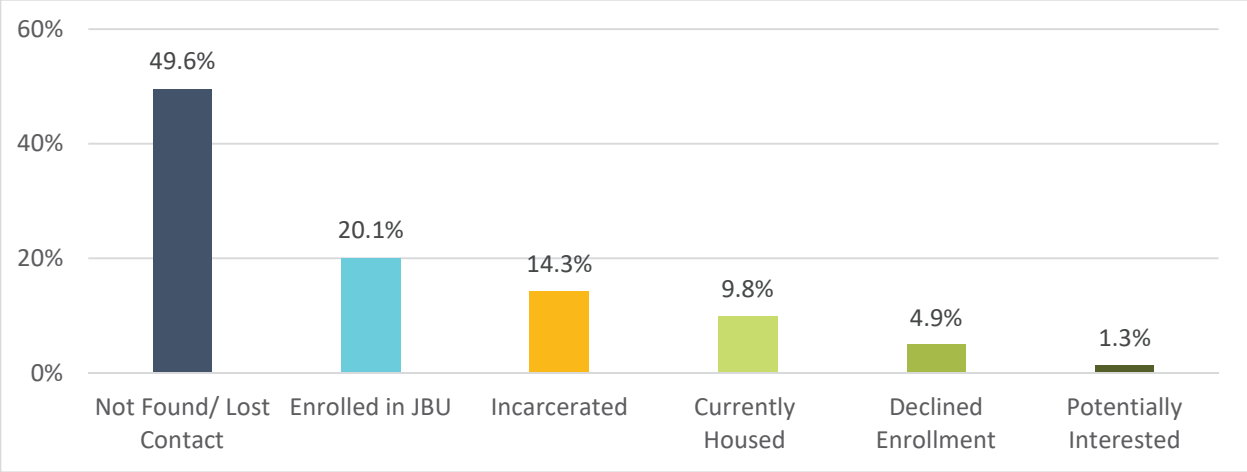
Where relevant, findings and recommendations in this report underscore issues potentially related to the unique challenges that COVID-19 poses within the local community and healthcare environment.

Program Outreach and Enrollment

Based on the BHS CO-19 report (i.e., a BHS listing of youth appearing to meet eligibility criteria) and the open referral sources, a roster of 224 individuals potentially eligible for JBU services was generated throughout FY 2020-21. Extensive efforts were made by JBU's Outreach Coordinator to locate and contact youth identified as eligible for JBU services. JBU works closely with a variety of individuals and organizations (e.g., PERT, parole officers, District Attorney's office, family members, etc.) to locate eligible JBU youth. However, despite these active outreach efforts, many youths identified by the CO-19 report cannot be located by the time JBU receives their names. Alerts may be listed in the BHS EHR for youth to indicate eligibility for JBU services while they access acute care services; however, these alerts are only visible if the staff at the hospital or other crisis facility access the BHS EHR, which may not occur prior to

the discharge of the youth. As shown in Figure 2, JBU outreach staff were unable to contact nearly half (49.6%; n= 111) of youth identified as eligible for JBU services. Another approximately 25% were ineligible for JBU due to either being incarcerated (14.3%; n=32) or having housing with family/friends/programs (9.8%; n=22) throughout FY 2020-21. Only 11 people (4.9%) indicated that they were not interested in JBU services while 45 youth (20.1%) agreed to enroll. This distribution of JBU outreach outcomes highlights: 1) the challenges of locating potentially eligible youth who frequently have transient living situations and limited options for establishing communication, 2) a relatively high proportion of potentially eligible youth who were unable to participate due to extended periods of incarceration (i.e., not just a few days or weeks), and 3) the high levels of interest in JBU participation (i.e., among youth who were contacted and determined to be eligible, only 18.6% declined JBU services).

Figure 2. Status of Potential JBU Youth According to Outreach Efforts during FY 2020-21 (N=224)

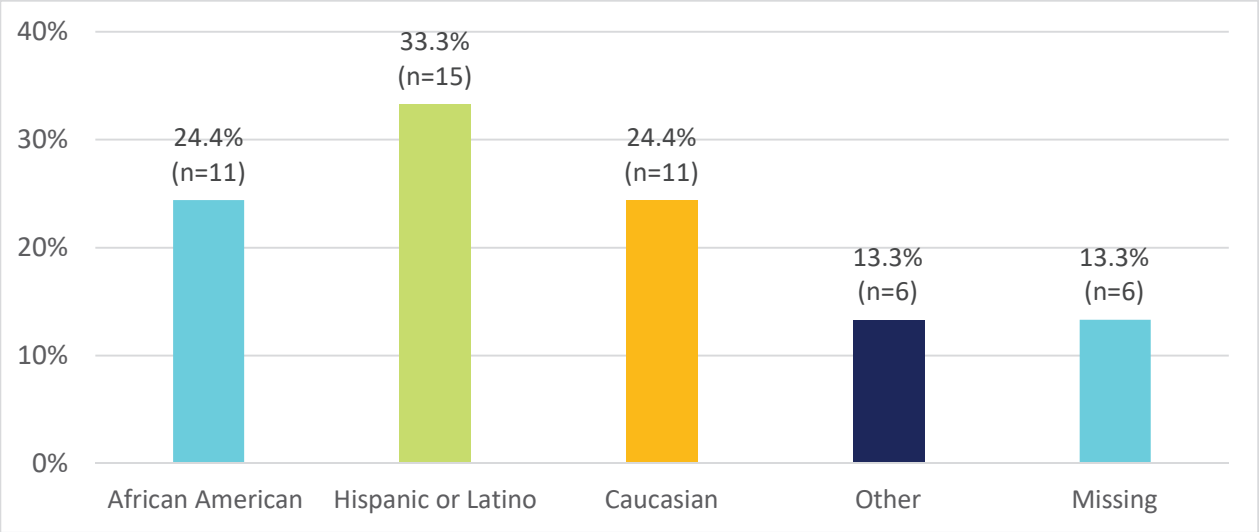


Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. Of the 45 youth enrolled during FY 2020-21, 15 originated from the BHS CO-19 report and 30 were from other referral sources. The demographic profiles were similar for both types of referrals. JBU program eligibility criteria required that participants are youth between the ages of 18 and 25. Of the 45 youth who enrolled in JBU during FY 2020-21, the majority (n=30; 66.7%) identified as male. Almost all JBU youth, 91.1% (n=41), spoke English as their primary language, and 64.4% (n=29) identified as heterosexual or straight, with 11.1% (n=5) identifying as bisexual, pansexual, or sexually fluid. None of the JBU youth indicated they had served in the military. The most common diagnoses for JBU youth included depressive disorders (n=16; 35.6%), schizophrenia/psychotic disorders (n=12; 26.7%) and bipolar disorders (n=10; 22.2%).

As shown in Figure 3, JBU youth were racially and ethnically diverse with no single population group representing more than 50% of the population. Approximately one-third identified as Hispanic or Latino (33.3%; n=15), followed equally by African American (24.4%; n=11) and Caucasian (24.4%; n=11).

Figure 3. Race/Ethnicity of Youth Who Enrolled in JBU during FY 2020-21 (N=45)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

Utilization of Program Services

Engagement in JBU Activities

Holistic Services

Throughout FY 2020-21, yoga and fitness classes were reduced to 1x per week and social distancing was applied. Attendance averages were 3-6 youth per class. Holistic services (e.g., chiropractic, acupuncture, massage) were suspended March 2020 through the beginning of FY 2021-21. Chiropractic and acupuncture services restarted September 2020. Massage services did not occur during FY 2020-21. Biofeedback was suspended indefinitely due limited availability of the practitioner and variable levels of participation by youth in this service activity.

Group Outings

JBU youth participated in one overnight trip to Harrison Serenity Ranch on Mount Palomar 10/21/20. Due to statewide shutdowns and stay at home orders, many indoor activities were no longer an option throughout much of FY 2020-21. As a result, JBU staff initiated more outdoor activities with youth such as group hikes at local trails, walks by the bay, and trips to local beaches.

Occupational Therapy at JBU

Throughout FY 2020-21 there were seven occupational therapy (OT) "interns" at JBU who were graduate students enrolled in both the master's and Doctorate programs in OT at the University of St. Augustine for Health Sciences, California campus. Collectively, they provided over 2,500 hours of service to the JBU program. The interns worked under the supervision of Dr. Bianca Doherty, the Director of Occupational Therapy, who was onsite at JBU a minimum of one day per week.

OTs developed an intervention plan to include individualized long-term and short-term goals related to enhancing participation in activities of: 1) self-care (e.g., grooming and hygiene, community mobility,

sleep hygiene, health management), 2) productivity (e.g., work, financial management, school, volunteering), and 3) leisure (e.g., social activities, activities for fun). This OT intervention plan was based on an initial interview with the youth to develop an occupational profile (e.g., client history, strengths, interests, goals, and barriers) as well as standardized and non-standardized assessments to measure client factors impacting performance skills and patterns (e.g., time-use, cognitive, sensory, and goal-focused assessments).

In collaboration with the JBU team, OTs would determine a uniquely tailored service delivery method and outcome measurement approach. The OTs conducted individual client intervention sessions every 1-3 weeks to address identified client needs and goals, as well as running as-needed weekly group interventions addressing topics such as: leisure exploration, social participation, time management and organization, employment seeking and maintenance, pursuing volunteer opportunities, managing finances, home maintenance, meal preparation, community exploration and engagement, medication management, and self-care.

Throughout a youth's time at JBU, OTs would conduct observations and activity analyses during a client's transition into the program and their participation in services. These observations served to identify barriers to occupational participation (i.e., being able to do the activities or tasks they want and/or need to do). Youth would review their personal intervention plan with OTs every month and modify as needed. OT services at JBU also provided consultation to the JBU team regarding supporting client with additional needs including cognitive challenges, neurological or sensory differences, physical disabilities, and/or significant mental health challenges.

Additionally, OT interns supported participation of JBU youth in program and organization-wide activities including Mental Health Awareness Month art activities, trips to Oasis Clubhouse for socialization, haircuts, etc., and a "mural project" in collaboration with Urban Beats at the downtown Urban Street Angels site location. This involved driving approximately six interested youth to the downtown site weekly for 5-6 weeks and supporting their participation in the mural project from design to implementation.

Key Evaluation Findings – BHS Outcome Measures

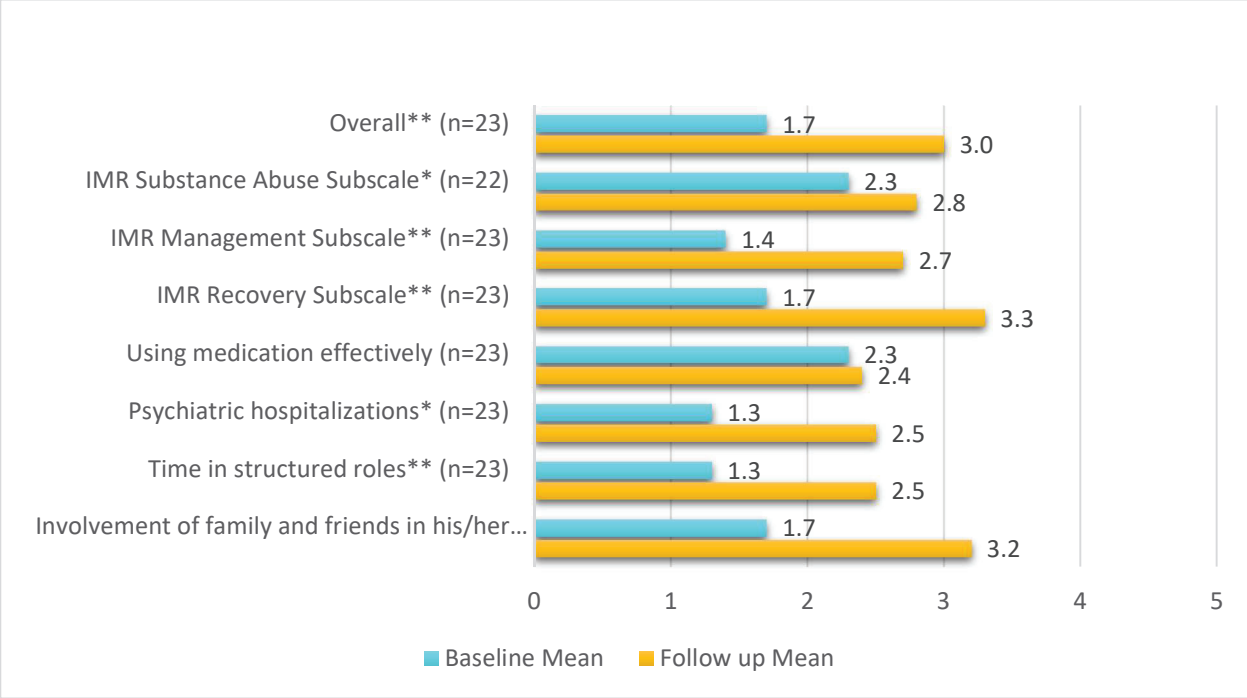
The following sections highlight outcomes for youth gleaned via assessment tools completed upon intake into the JBU program and at least one follow-up time point (e.g., the monthly assessments administered during the residential phase of JBU). In situations where a youth may have multiple completed follow-up assessments, the most recently completed assessment prior to end of FY on 6/30/2021 was used in the analysis. The requirement to have at least two data points allows for examinations of change that might occur while enrolled in JBU, however, this also reduces the sample size included in the analyses as not all participants completed follow-up assessments. There were two primary reasons for incomplete follow-ups: 1) youth may decline to complete self-assessment tools and 2) youth may leave the program prior to the follow-up assessment. Further, in some cases there may also be insufficient information for staff to complete the staff-reported measures. These data collection challenges are not unique to JBU as evidenced by the Mental Health Outcomes Management System's (mHOMS) Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), which indicates that less than one-third of clients in BHS programs throughout San Diego County have completed both the standard client self-reported and staff-reported outcome measures. The primary implication of this circumstance is that the findings presented below may not generalize to the subset of JBU participants for whom follow-up data

is unavailable. Investigations into the generalizability of the findings to all JBU participants will be examined in future reports as the cumulative number of JBU participants increases and allows for more definitive conclusions.

Illness Management and Recovery Scale

To measure staff perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by JBU staff. The IMR 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: Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery.

Figure 4. IMR Results for JBU Youth with Follow-up during FY 2020-21 (N=23)



**Statistically significant change with a p-value less than 0.05; **Statistically significant change with a p-value less than 0.01*

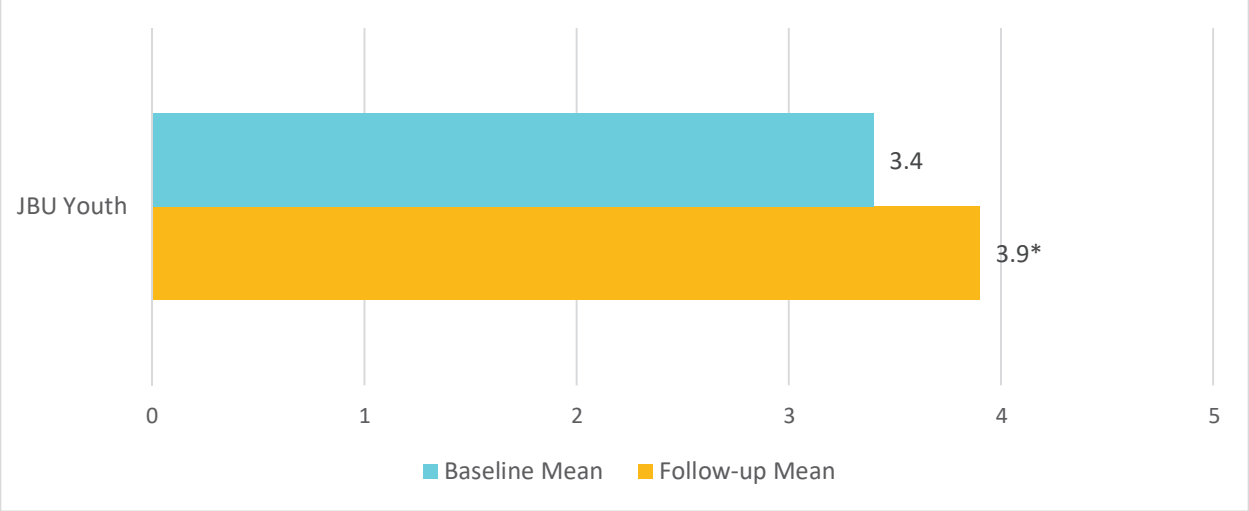
Scores of participants entering JBU reflected more overall impairment (1.7) than participants entering other BHS programs (2.8) as reported in the mHOMS Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison). These differences were evident across each of the IMR subscales. The average Management subscale scores for JBU youth were lower (1.4 at intake and 2.7 at follow-up) than other BHS programs (2.0 at intake and 2.9 at follow-up), as were the average intake Recovery subscale scores (1.7) as compared to other BHS programs (2.3). Notably, however, the average Recovery subscale follow-up score for JBU participants was higher (3.3) than other BHS programs (2.9), suggesting that JBU was able to obtain substantial improvements among participants who were generally less recovery-oriented at intake when compared to participants in other BHS programs.

The greatest area of difference between JBU and other BHS program participants was found within the IMR Substance Abuse subscale at intake (2.3 and 4.6, respectively). This demonstrates the high prevalence of and substantial levels of impairment due to substance abuse among JBU participants, which is consistent with ongoing staff reports. Improvements in substance abuse was evident at follow-up (2.8), but remains well below the system-wide average of 4.8. The overall pattern of JBU IMR results indicated that positive changes were typically achieved – across multiple illness management and recovery domains – while receiving JBU services.

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements relevant to mental health recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure of personal recovery. The results listed below are scaled from 1-5 with higher values corresponding to higher levels of well-being. The RMQ asks youth to answer questions from the perspective of what is "true for you now."

Figure 5. RMQ Results for JBU Youth with Follow-up during FY 2020-21 (N=13)



**Statistically significant change at a p-value less than 0.05*

As shown in Figure 5, average RMQ scores improved from baseline to follow-up (3.4 to 3.9). According to the mHOMS Annual Outcomes Report for FY 2019-20, the average RMQ at intake for other BHS treatment programs (e.g., outpatient, ACT, case management, and youth residential programs) was 3.3 and increased to 3.6 at follow-up, suggesting that, at intake, JBU participants self-report similar assessments of their recovery status and outlook on life as do clients in other BHS programs. However, the average follow-up RMQ score for JBU participants (3.9) was higher than the average follow-up RMQ scores reported by other BHS programs (3.6).

Figure 6. IMR and RMQ Results for JBU Youth with Follow-up during FY 2020-21

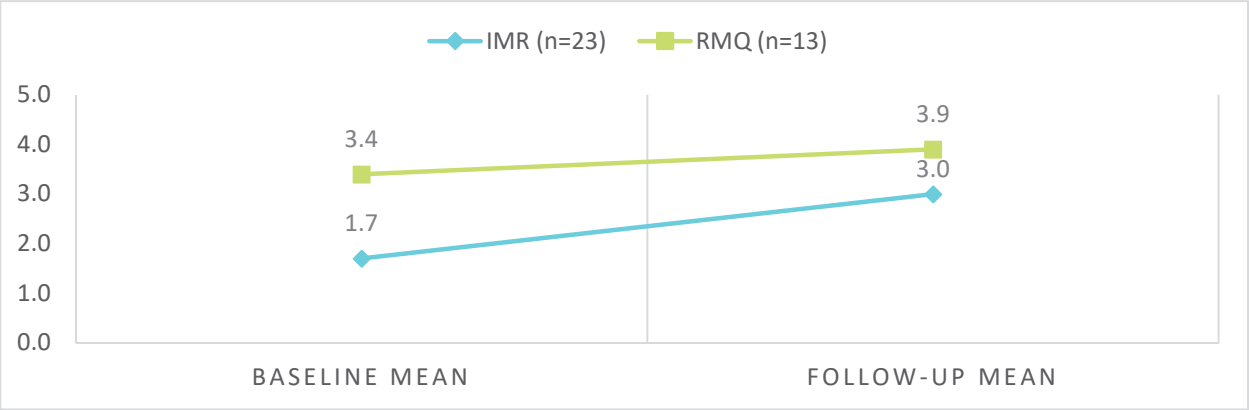


Figure 6 highlights a similar trend line in recovery reporting from both youth and staff reported measures, an indication of the reliability and validity of the data.

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) captures the stage of mental health recovery, as assessed by staff, using a single-item recovery indicator. Participants were placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

Table 1. MORS Results for JBU Youth with Follow-up during FY 2020-21 (N=23)

		Baseline		Last Follow-Up	
Value	MORS Category	N	%	N	%
1	Extreme risk	0	-	0	-
2	High risk, not engaged	≤5	≤21.7%	0	-
3	High risk, engaged	≤5	≤21.7%	0	-
4	Not coping, not engaged	12	52.2%	≤5	≤21.7%
5	Not coping, engaged	0	-	≤5	≤21.7%
6	Coping/rehabilitating	≤5	≤21.7%	13	56.5%
7	Early recovery	0	-	0	-
8	Advanced recovery	0	-	0	-
	Mean MORS	**3.4**		**5.3****	

***statistical significance at p < 0.01*

The results indicate substantial changes in recovery status at follow-up. At intake, less than 22% of youth were considered as coping or in recovery, whereas more than 50% were doing so at follow-up and none of the youth were in one of the "high risk" categories. Overall, the average MORS score increased from 3.4 at intake (corresponds to "high risk, engaged") to 5.3 at follow-up (corresponds to "not coping,

engaged"). The change in average MORS score for JBU youth was similar to prior JBU results (i.e., MORS score increased from 3.4 at intake to 5.5 at follow-up during FY 2019-20).

As reported in the mHOMS Annual Outcomes Report for FY 2019-20 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.4 at intake and 4.9 at follow-up. The findings from JBU indicate that youth typically entered the program with a lower-than-average MORS score (i.e., more impaired/less engaged in treatment), but had a higher-than-average MORS score at follow-up (i.e., less impaired/more engaged in treatment). The lower-than-average MORS score at intake was consistent with the JBU focal population (i.e., youth with serious mental illness who were not currently in or seeking treatment), with the substantial positive change in MORS score suggesting a high capability of the JBU team to support and connect with youth and get them linked to appropriate levels of treatment.

Key Evaluation Findings – Additional Outcome Measures

Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is a widely used (e.g., translated into more than 35 languages), individualized, client-centered, evidence-based outcome measure designed to document a client's self-perception of performance in everyday living at multiple time points. The COPM is a standardized instrument, in that there are specific instructions and methods for administering and scoring the test. It is designed as an outcome measure, with a semi-structured interview format and structured scoring method. The COPM asks individuals to identify everyday activities that they want or need to do, but are currently unable to do or are dissatisfied in the way they are doing them, across all areas of life, including self-care, leisure, and productivity. The assessment then asks clients to rate these activities on a 1-10 scale for importance, performance, and satisfaction with performance with "1" representing not important/not able to do it/not satisfied at all. Typically, differences of two points or more between the pre- and post-OT intervention scores are considered clinically important.

A total of 8 JBU youth had baseline and follow-up COPM assessments completed during FY 2020-21. Figure 7 shows that that average performance assessment increased from 3.9 to 6.6 at follow-up and the satisfaction score increased from 4.1 to 6.7. Both the performance and satisfaction domains had average change scores higher than 2.5 (2.7 and 2.6, respectively) indicating clinically important changes for youth.

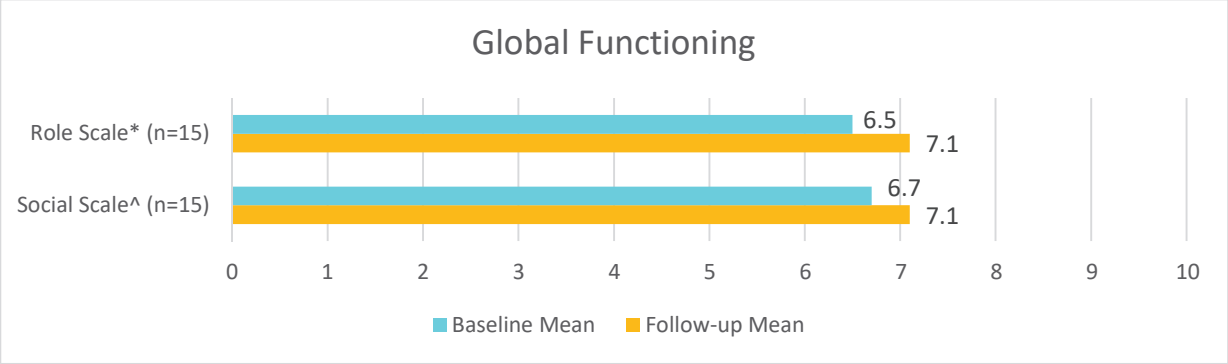
Figure 7. COPM Mean Scores for JBU Youth with Follow-up during FY 2020-21 (N=8)



Global Functioning

Following a semi-structured interview, the provider rated the Role and Social Functioning of JBU youth on a 10-point scale (1 = Extreme Dysfunction; 5 = Serious Impairment; 10 = Superior Functioning).

Figure 8. Global Functioning Results for JBU Youth with Follow-up during FY 2020-21



*^Statistically significant change at a p-value less than 0.1; *Statistically significant change at a p-value less than 0.05*

For both scales, baseline mean values were typically around 6.5 range (indicative of moderate impairment). Follow-up mean values increased to over 7.0, which is indicative of moderate/mild impairment). The improvements were statistically significant for JBU youth.

Perceptions of Mental Health Challenges and Mental Health Services

The Mental Health Perceptions survey was introduced during FY 2020-21 as a shorter tool with items that focused more directly on mental health perceptions likely to be affected by participation in JBU. The 10-item questionnaire asks participants to rate various aspects of mental health wellness and challenges on a 5-point scale with 1 representing strongly disagree and 5 representing strongly agree. As shown in Table 2, results were mixed across the individual items, but generally a trend towards more favorable perceptions, particularly regarding the efficacy of mental health services and feeling more comfortable talking with mental health professionals.

Table 2. Youth Perceptions of Mental Health Challenges and Mental Health Services (N=11)

#	*Note: questions 2,7,9 were reverse scored so that higher values equal better condition/lower level of stigma.*	N	Baseline Mean	Follow-up Mean
1	I can have a good, fulfilling life, despite my mental health challenges.	11	3.9	4.4
2	I rarely share my mental health challenges with others.	11	3.4	3.2
3	Acceptance of my mental health challenges can help me better manage them.	11	3.7	4.3^
4	It is possible to manage and/or recover from mental health challenges.	11	3.8	4.3
5	I would feel comfortable talking with a mental health professional.	11	3.6	4.3^
6	I have not had any trouble from people because of my mental health challenges.	11	3.0	2.9
7	I feel ashamed or embarrassed about having had mental health challenges.	11	2.8	2.6
8	Participating in mental health services can effectively improve my mental well-being.	11	3.5	4.4*
9	I feel the need to hide my mental health challenges from others.	11	3.1	2.8
10	Like any life challenge, mental health challenges can improve with understanding, skill development, and/or help from others.	11	3.8	4.5^

*^Statistically significant change at a p-value less than 0.1; *Statistically significant change at a p-value less than 0.05*

BHS Utilization Patterns

San Diego County BHS Services Utilized Before, During, and After JBU

BHS utilization patterns before, during, and after leaving the residential portion of JBU can help identify the extent to which participation in JBU is associated with a fundamental shift in the mix of service utilization (i.e., increased engagement in treatment and reduced interaction with crisis/acute care). The following analyses were accomplished by reviewing the electronic health record that documents county-funded BHS services provided throughout San Diego County to identify other mental health services received by JBU participants. Given the variable length of time that a youth might be in the residential portion of the JBU program, a standardized metric was created to enable equivalent comparisons for the three time periods of interest. The standardized metric for the "during JBU" period reflects the average amount of services JBU youth would be expected to receive during a 180 day stay with JBU. This metric facilitates comparisons to the 180 day period immediately preceding JBU enrollment and the 180 day period after leaving the residential phase of the JBU program.

The standardized "during JBU" metric was computed by summing the total number of BHS services (by service type) that occurred while the youths were enrolled in JBU and dividing that by the total number of days that all youth were enrolled in JBU. The resulting values represents the average number of each specific BHS service that a JBU youth received per day, which is then multiplied by 180 to generate the

estimate of BHS services that JBU youth would receive if they were enrolled in JBU for 180 days. For the 180 days prior to JBU, all BHS services (by service type) were summed and then divided by the total number of JBU clients to generate an estimate of the average number of BHS services received by JBU clients prior to enrolling in JBU. A similar calculation was made for the 180 day period after youth left the residential phase of the JBU program.

The analyses presented in Table 3 include JBU participants who enrolled after 7/1/2020 if they had been discharged at least 180 days before the end of FY 2020-21 to ensure full and equivalent 180-day "post-JBU" observation periods for all persons.

As shown in Table 3, the 49 JBU youth included in these analyses had either no or limited involvement with BHS outpatient treatment services in the 180 days prior to entering JBU (average of 0.9 outpatient sessions across all youth). However, that changed substantially during their time enrolled in JBU as almost 70% of the youth (69.4%) linked to outpatient care and the 180 day average number of outpatient sessions increased to 16.4. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 2.3 sessions per youth. This apparent reduction in outpatient services 180 days post-JBU is likely partially explained by the linkages to ACT programs that many JBU youth made while in the program. Fully 28.6% (i.e., 14 out of 53) of JBU youth had ACT visits post-JBU, with the average of 7.1 sessions compared to 0.1 pre-JBU and 0.9 during JBU.

Table 3. BHS Service Utilizations Patterns Before, During, and After JBU Participation (N=49)

	180 Days Prior to JBU Enrollment			Standardized 180 Days During JBU Residential Phase			180 Days After Leaving JBU Residential Phase		
	% of youth	# of visits/ episodes	Average per JBU youth	% of youth[1]	# of visits/ episodes[1]	Stdzd. average per JBU youth	% of youth	# of visits/ episodes	Average per JBU youth
Outpatient	10.2%	43	0.9	69.4%	264	16.4	40.8%	114	2.3
ACT	2.0%	7	0.1	14.3%	15	0.9	28.6%	350	7.1
Urgent Outpatient	28.6%	26	0.5	49.0%	26	1.6	26.5%	17	0.4
PERT	22.4%	16	0.3	6.1%	3	0.2	18.4%	17	0.4
Crisis Stabilization	24.5%	24	0.5	4.1%	2	0.1	12.2%	18	0.4
Inpatient	34.7%	26	0.5	10.2%	7	0.4	26.5%	30	0.6
Crisis Residential	26.5%	22	0.5	8.2%	5	0.3	18.4%	16	0.3

[1]*The number of persons and number of visits/episodes is not directly comparable to the other time periods since the average length of time in JBU was less than 180 days (mean = 59.3 days). Only the average is directly comparable across all three time periods.*

The patterns evident among acute/crisis-oriented type BHS services were more nuanced. Interestingly, the average number of urgent outpatient visits was similar before and after JBU (0.5 and 0.4, respectively), but was substantially higher during JBU (1.6). This can be explained by the fact that JBU staff facilitate access to needed urgent outpatient care, in an effort to avoid situations escalating into the need for a

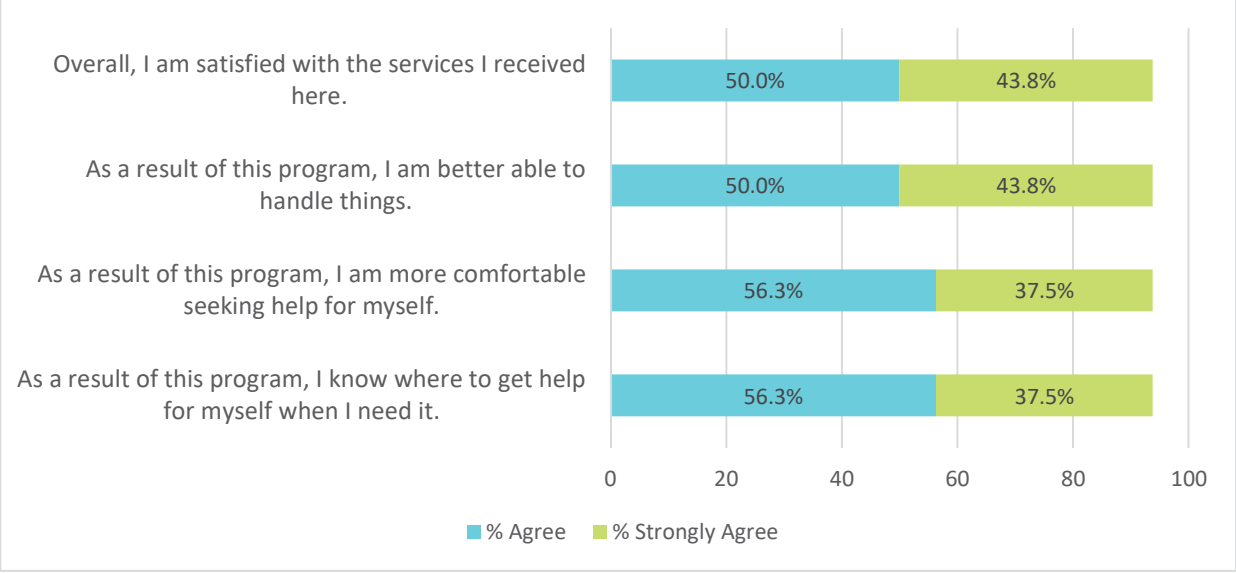
crisis stabilization visit or inpatient hospitalization (both of which occurred less frequently during JBU than pre-JBU).

Overall, the percentage of youth accessing crisis-oriented BHS services was lower during the 180 days post-JBU than during the 180 days pre-JBU. This was most evident for crisis stabilization services which reduced from 24.5% of youth having at least one crisis stabilization visit during the 180-days before JBU compared to only 12.2% in the 180 days after leaving JBU. However, the average number of crisis stabilization visits only reduced slightly before and after JBU (0.5 to 0.4, respectively) since the total number of crisis stabilization visits did not decrease as much (24 to 18, respectively). With the relatively small sample sizes caution is warranted when interpreting findings, however it is evident that JBU substantially increased engagement with outpatient treatment services and facilitated connections to ACT programs (a preferred discharge destination for many JBU youth).

Youth Perspectives on JBU Services

A total of 16 youth completed feedback surveys at one of the follow-up time periods during FY 2020-21. As shown in Figure 9, over 90% of youth agreed/strongly agreed that because of participating in JBU they knew where to get help when needed (93.8%), were more comfortable seeking help (93.8%), were better able to handle things (93.8%) and were satisfied with the services they received from JBU (93.8%). Overall, these findings suggest that among youth who completed a follow-up assessment, there was widespread acknowledgement of achieving key JBU program outcomes of increasing youth knowledge of how to access services, reduced stigma associated with accessing services, and an increased sense of being better able to manage themselves.

Figure 9. JBU Services Feedback Questions for FY 2020-21 (N=16)



Photovoice Project

Photovoice is a visual research method employed with the intention of addressing social issues and fostering change. It is defined as a process where "people can identify, represent, and enhance their

community through a specific photographic technique." Photovoice provides the opportunity for community members to creatively document their concerns and simultaneously act as "catalysts for change."

Additionally, it ignites interest in important topics that are relevant within a community and allows a community to express themselves through photography. Photovoice breaks past language and traditional communication barriers that often prevent members of a group from expressing their concerns. Photovoice is a highly customizable community-based intervention and is an excellent tool to use when there is a need to create awareness around a certain issue or concern, particularly when the issue of concern is one that is traditionally difficult to address or discuss. As such, it was determined by JBU leadership and BHS that Photovoice would be an appropriate method of evaluation in partnership with JBU youth.

Youth were invited to participate during a house meeting in May 2021. In collaboration with 11 JBU youth, the evaluation question was identified: "How does participation in JBU affect my life?"

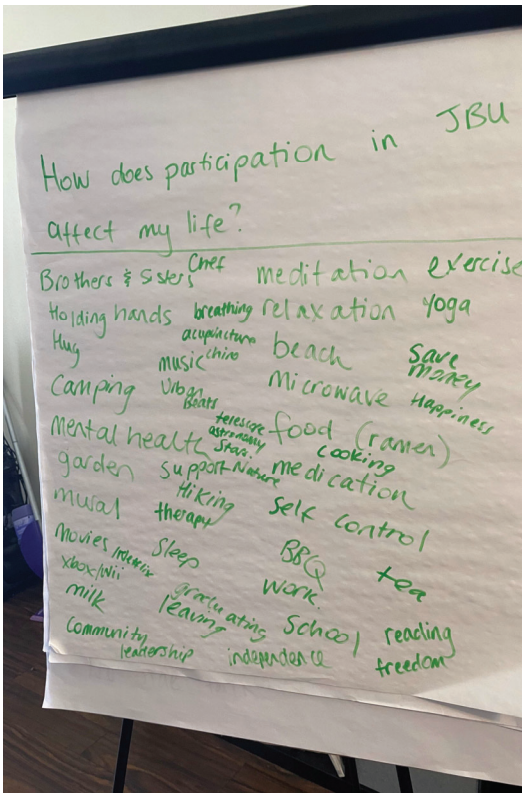


Photo 1: Notes during JBU brainstorming session

Photos (n=48) were taken by nine unique JBU youth during the month of June 2021. In four separate analysis sessions, seven of the photos were analyzed by ten JBU youth. These analysis sessions were recorded and reviewed by the evaluation team. The following themes emerged:

JBU provides housing, so youth can someday have a home

JBU youth overwhelmingly identified housing as the most important component of the JBU program. In addition to housing, however, JBU youth routinely expressed a desire to have a "home" and not just

housing. Youth mentioned ideas such as painting the rooms assorted colors or having themed rooms to create a place that reflects the people inhabiting JBU. Other youth remarked on the personal connection to staff and youth that the vegetable garden has and discussed how their goal was to have something like that in their own home someday. Youth understood that participation in JBU required them to learn skills such as chores, responsibility to the community, and stabilizing their mental health so that they can eventually sustain independent living. One thread that was apparent in all the analysis sessions was the idea of independence. JBU youth recognized the importance of being pushed outside their comfort zones, particularly when it comes to group or community activities. However, youth frequently expressed a desire to have more control over their immediate surroundings, as well as the activities in which they participate.

Youth Quotes

"I am here to have a place to live and that's it. I just don't want a lot of extra activities to be mandatory because I'm here to have a roof over my head and not anything else."

"I have never been interested in watering plants, but when I am here [in this] living situation, I want to better myself."



Photo 2: Garden boxes being watered by a JBU Youth

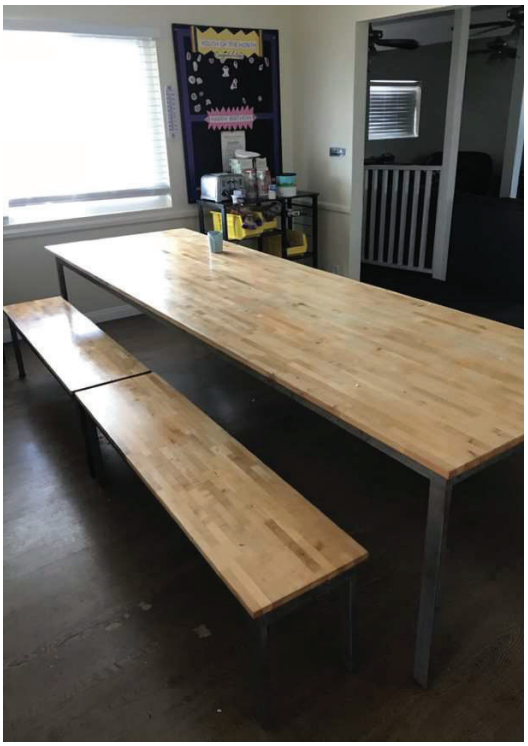


Photo 3: Dining table at JBU

JBU gives youth a chance to become comfortable with being uncomfortable

JBU youth reported enjoying JBU activities, even when the activities pushed them to expand beyond their comfort zone. They often used skills from holistic activities like yoga to "make it" through the week, using breathing techniques to calm down and center themselves in stressful situations. Youth felt that activities

built a sense of community at JBU—a sense that was often missing in their lives prior to JBU. Gardening, camping trips, movie nights, and nature walks were all examples of group activities that youth enjoyed, even when they were initially apprehensive about participating.

JBU youth also analyzed the difficulty of learning to live with other people, while also maintaining a home. Group outings, chores, and JBU activities give youth a chance to practice living with other people while also completing undesirable tasks. Youth remarked that while they were not always comfortable being in a shared space with other people, they understood how important it was to practice being around others without getting annoyed, irritated, or frustrated. Youth also shared insight on how to handle those inevitable negative emotions, citing yoga practice as one way to help them choose healthy responses to feelings of dismay or agitation.

Youth Quotes

"[W]hen you allow yourself to go out of your comfort zone… I mean, I haven't been camping since I was eight years old."

"This gives you a chance to go out and be comfortable with being uncomfortable… have the opportunity to get out of your room, out of your house… build relationships that maybe some of us haven't had before."

"It's like a break for the whole house… I mean, I can give myself a break, but this is an opportunity to go out with the other people here. Yeah, I live here, but I am not always at the house, so I am not always seeing people here. It's different when we aren't doing chores."



Photo 4: Poster for upcoming camping trip for JBU youth

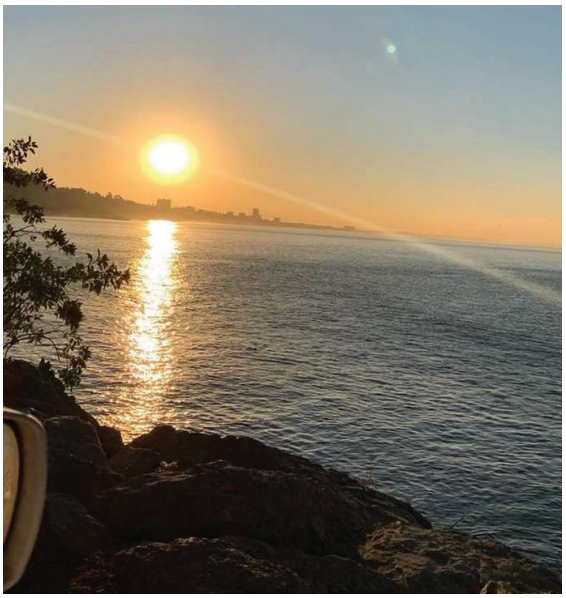


Photo 5: Sunset, taken during a JBU outing

JBU provides security

Social/Emotional Security: Youth reflected on the ability to make mistakes and know that they can return to the JBU program. During analysis sessions, youth discussed how a main component of the safety they felt at JBU was knowing they could return even after. Watching other youth leave and return was also impactful, as youth felt they contributed to that sense of safety for others as well.

Physical Security: In addition to the re-entry policy, a sense of security came from the actual physical neighborhood. While they did note that the downtown location provided more job opportunities, the house setting provided a sense of stability and structure that was not present downtown. Having a physical space to leave their items was important for the youth. They discussed the simple behavior of going for a walk and leaving their belongings on their beds, knowing they could return and nothing would be disturbed.

Personal Security: Finally, youth analyzed the efforts at JBU to ensure personal, holistic security. Youth identified weekly yoga practices as a source of personal security. Youth discussed the safety they felt with the instructor, who has a history of his own lived experiences with homelessness, as well as the mindfulness and grounding that came along with a routine practice of yoga.



Photo 6: Yoga mat during JBU practice

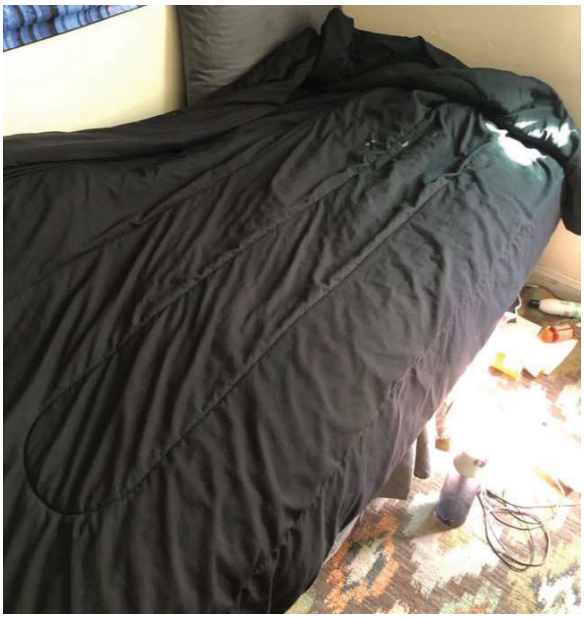


Photo 7: Bed at JBU



Photo 8: Neighborhood during dusk

Youth Quotes

"I do have family, but my mental issues are really not their first priority. So having a place to put my head at every day or every night is really nice to look forward to, and not have to worry about. We make sure there is a place where homeless youth have a place to return to."

"I haven't always had a safe place to eat my food, so that table is something I don't take for granted. I was here before and got kicked out, and out there it isn't always safe… just knowing that I won't be starving."

"Thinking back to how bad my mental health issues were, before I didn't even want to go outside."

Overall Key Takeaways

1. Housing was the most important part of JBU.
2. JBU provided a sense of stability.
3. Community can be uncomfortable for JBU youth, but they recognized its importance.
4. A sense of control was important while youth worked towards independence.
5. Youth believed that participation in JBU gets them to independence faster than if they tried on their own.

"We are all here to better our lives. We aren't where we want to be, so we don't leave because we are here trying to get our lives together. We aren't just going to throw that away. We've put the effort in to be here."

Composite of JBU Youth Experiences

JBU youth have a variety of experiences and needs when they arrive at the program. The following is a composite infographic, derived from multiple youth accounts. While all examples are from JBU youth, it is important to recognize youth entering and exiting the program will have a variety of experiences.

A JOURNEY THROUGH JBU

The following example is a composite of multiple JBU youth, who have successfully engaged with JBU programming.



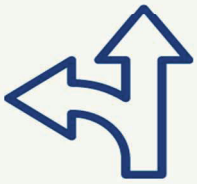
COMING TO JBU

Often, when youth come to JBU, they have been in and out of many programs and failed to stick with any. Many youth come from other programs where they have struggled with issues such as personal hygiene, sobriety, or mental health conditions. Youth are often unconnected to their community and family of origin.

GOALS AT JBU

Once settled at JBU, youth work with the JBU team to determine goals. These goals are highly specific to the individual, and may include obtaining legal custody of children, establishing sobriety, maintaining employment, obtain a driver's license, and securing housing.





ENGAGEMENT AT JBU

Youth who successfully complete the JBU program are often engaged in JBU programming. However, JBU staff understand this is not a linear process. Occasionally, youth need to exit JBU and receive outside services before returning to successfully complete the program.

INDICATION OF JBU SUCCESS

JBU staff see successful youth as committed to their goals, such as taking the bus independently, or seeking out leadership roles with their peers. Other indications of success may include a sense of "grit"-- where youth are determined to accomplish their goals despite setbacks such as SUD relapse, legal issues, or interpersonal conflict.





BEYOND JBU

Successful JBU youth are currently housed and continue to pursue the goals they set in the program. Often these youth have reunified with their children, are gainfully employed, purchased personal vehicles, or have completed rehab programs. Youth typically remain in contact with JBU through the peer support program.

While the journey for JBU is **unique** and **personalized** to each individual youth, it is not uncommon for youth to transition from *living on the streets* or other *unstable housing arrangements* to *engaging in treatment* and *making progress* on personal goals regarding employment, housing, and relationships.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual JBU Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, JBU, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual JBU Staff Survey was conducted at the end of FY 2020-21. JBU program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 11 respondents from the 14 JBU staff invited to participate in the survey (i.e., a 79% response rate). For the open-ended survey questions, at least two evaluators reviewed and coded the individual survey responses, and any discrepancies found were discussed to arrive at a consensus on the key response themes.

JBU staff identified two main goals for FY 2020-21: 1) providing secure housing and 2) supporting youth to stabilize mental health. Connections with San Diego County BHS providers and programs as well as JBU staff and peer support were identified as having helped JBU achieve their goals. Conversely, JBU youth resistance to change and lack of follow-through were identified as inhibiting factors.

Connections to Treatment

Finding available and appropriate treatment options for JBU youth continues to be cited as a challenge for JBU staff. One JBU staff reported, “We lack resources/availability for inpatient or outpatient services all over the county. No emergency services for youth interested in SUD support.” Maintaining a positive relationship with outside providers is seen as an effective strategy to successfully connect youth with needed services. Staff also reported significant effort on their end to support and encourage youth to remain engaged in treatment.

> “We must be aggressive and proactive. It's not easy. Too few SUD inpatient beds. Too little skill or time or flexibility in mental health providers. We need complete and consistent access in a rapid timeframe. And we need providers who follow up. If we don't drive it as staff, it doesn't happen.”

This support comes in tangible ways such as transportation and assistance with scheduling, and less tangible ways, such as partnering with youth in a strengths-based perspective.

> “Mental Health partners (or on-site professionals) to flexibly and aggressively make appointments with TAY for SMI and SUD counseling [are needed supports]. They need special training, e.g., LEAP, to connect well with the TAY, not in a hurry or dismissive or seen to "push" medications without explanation or deep engagement. They need time and savvy. Same for SUD challenges.”

JBU staff also recognized the need to collaborate with each other, so that staff members are all aware of a youth’s status toward goals and treatment and any concerns regarding behavioral health or substance use. The most cited recommendation for program success was faster, more secure community referrals to housing and treatment.

Engagement of JBU Participants

Youth engagement and willingness to participate in JBU programming also remains a challenge. One staff member cited “the inability to enforce or require connection to mental health services as part of the

agreement to continue with the program" as a consistent barrier to program success. JBU staff recognize the unique difficulties facing JBU youth, and work to train providers to also understand these difficulties. "Successful integration into society is complex and unique to each individual. This makes it challenging but is an inherent part of working with mental health clients." Many of the mental health conditions dealt with by JBU youth prevent youth from accepting or addressing their mental health. In explaining this, a staff member commented, "Youth not being receptive to certain types of services [is a challenge]. The frequency of services offered may be 'too much' or 'too overwhelming'." These barriers were often cited as factors that inhibited JBU from achieving program objectives.

Rapport with JBU Participants

JBU staff highlighted rapport with youth as one of the great strengths of the program. When reflecting on this strength, a staff member remarked:

> "Rapport and genuineness of staff who truly care and the TAY see and feel this. It's real. Also, our services are loving and supportive. We are flexible and show tough love, such that early exits for cause are followed up and TAY are welcomed back after doing something to remediate e.g., SUD or SMI issues that led to early exit"

While creating connections with youth can be challenging, JBU staff see their ability to make the youth feel at home, safe, and accountable as one of the main reasons JBU remains a successful program. Staff highlighted practices such as texting youth to encourage engagement in JBU activities, even though it might feel "silly" when they are in the same house. "This program is effective in diminishing the gap between "us and them" which makes the youth feel comfortable and more related to staff." Practices such as these, to "meet the youth where they are," help to cultivate a culture of partnership and empowerment for youth. Staff also reflected on the practice of offering incentives to youth to meet their personal goals, citing it as another effective way to maintain engagement.

Substance Use Disorder (SUD) Challenges

As is the case for many behavioral health programs, SUD continues to be a challenge for JBU youth. In addressing SUD, JBU staff reported needing LEAP-trained mental health providers in the community to appropriately address the unique mental health needs of JBU youth.

> "MH providers who are hip, savvy, can connect with TAY (or a specialist communicator who does this). They need the time to explain all Rx's and therapy approaches, address concerns, adjust regimens based on reports and observations of TAY... all much more like an informed partnership, not a hierarchy of over-worked providers in a hurry and dismissive or unable to communicate well. Best would on-site at JBU… We need immediate access to inpatient SMI and SUD programs, to stabilize TAY who need this, before the holistic services or follow-thru on linkages can have much effect. We must stabilize before we optimize."

Additionally, JBU staff reported difficulties in connecting with SUD providers who had availability to admit new clients. While the Access & Crisis Line (ACL), a service in San Diego County which screens for substance use needs, crisis intervention, and mental health referrals, is available for JBU to utilize, JBU staff felt that additional resources for TAY oriented SUD services could benefit youth.

Occupational Therapy

The use of Occupational Therapy (OT) to assist youth in their goals and treatment plan is seen as a great strength for the JBU program. OTs aid their clients with vocational pursuits, leisure pursuits, social engagements, financial management, medication management, community mobility, etc., and they bridge the gap between clinicians and peer support specialists. A staff member commented, "Inclusion of occupational therapy [is a key program strength and] has allowed for an increased focus on needed life skill development (e.g., self-care, meal prep, social participation, leisure exploration, daily routine-building, community mobility)."

OT benefits JBU youth in a variety of ways, including with their occupational engagements and with successful transitions into the community. According to one JBU youth:

> "Occupational therapy was very helpful during my time with the program. I worked with the occupational therapist once a week and could have benefited from more one-on-one sessions. I feel like the one-on-one sessions were more beneficial than the occupational therapy groups."

Impact of COVID-19 on JBU Staff

Overall, staff members indicated there were aspects of their lives, both related and unrelated to work, which changed due to the COVID-19 pandemic. In the work setting, the public health measures necessary to keep staff and youth safe were the most cited ways JBU needed to adapt in the era of COVID-19 during FY 2020-21. JBU staff indicated they experienced an increase in stress or anxiety due to COVID-19 and the response to the pandemic. Staff members reported coping with this increase in stress by using yoga, meditation, mindfulness, and healthy sleep practices as well as becoming vaccinated. Of note, these are many of the services JBU staff provide to youth as part of the holistic service delivery. Staff also reported other changes in their roles and work-related tasks due to COVID-19, however, not to the degree in which they reported change during FY 2019-20.

Additional Program Activities

App Development

To further support achieving JBU objectives (and with BHS approval), JBU partnered with a software development firm to create a unique TAY-oriented software application (i.e., an "app") that would enable JBU youth to: 1) actively monitor their health and wellness in real-time, 2) access health and wellness educational information, 3) develop and track personal goals, and 4) interact and engage with JBU program staff through either an iOS or Android platform, both while enrolled in the JBU program and potentially afterward during a specified follow-up period of care.

The app development process has encountered difficulties and delays related to multiple developer changes and the complexities associated with the ambitious nature of the desired product. A prototype of the app was completed during the end of FY 2020-21, but further testing and refinement will be required during FY 2021-22 prior to any actual utilization by JBU youth.

Program Changes from Initial Design

Beginning in September 2020, JBU was approved to accept direct referrals from other service providers if they met all standard eligibility criteria and were approved by BHS. This allowed for the identification and enrollment of eligible youth who were not included on the BHS CO-19 lists provided to JBU.

The availability of OT services was expanded during FY 2020-21, with OT services becoming an essential component of how JBU engages with and supports youth. Through interactions with the OT personnel, youth are encouraged to develop and then act on achieving personal goals.

Status Update on Prior Year Program Recommendations

Recommendation 1: Focus program activities on improving youth awareness of their own mental health needs and increasing openness to engaging in mental health treatment.

FY 2020-21 Update: With addition of OT interns and onsite OT supervisor one day per week, youth have access to additional staff members with whom to build rapport and open up to in order to better understand the barriers to engaging in activities to support their mental health and wellbeing. The JBU program also conducted a "Listen & Learn" session in partnership with NAMI and UCSD researcher Dr. Annick Borquez. Originally this was intended to understand youth experiences about marijuana use, but ultimately raised discussion around previous negative experiences with mental health providers.

Recommendation 2: Proactively address factors that inhibit engagement in program services through holistic and other supportive services.

FY 2020-21 Update: Engagement proved to be particularly challenging during FY 2020-21 due to the ongoing issues associated with the COVID-19 pandemic. JBU expanded the delivery of individual and group OT services during FY 2020-21 with regular staffing by OT interns. These services were well-received by youth and the OT interactions provided additional support and information to JBU staff by developing a greater understanding of client factors potentially affecting engagement (e.g., cognition, sensory differences) and creating ideas for task or environment adaptation to support successful youth participation in JBU. Additionally, text messaging was found to be best method for maintaining contact with clients, so texting was utilized to send reminders before activities and meetings.

Recommendation 3: Develop additional strategies to improve JBU effectiveness among youth who have co-occurring SUD.

FY 2020-21 Update: Youth were connected to SUD counseling through a partnership with SAY San Diego and a new SUD service partnership with Vista Hill. Given the importance of this issue to the JBU population, JBU anticipated ongoing efforts to expand SUD service referral options further.

Recommendation 4: Relocate program to a neighborhood with fewer negative environmental opportunities for engaging in undesired behaviors (e.g., less access to drugs).

FY 2020-21 Update: This recommendation was achieved, and client feedback has generally been positive (see findings from Photovoice project discussed above), despite more difficulties with transportation.

New Program Recommendations

1. Develop additional connections to outside providers for TAY appropriate mental health care in the San Diego region.
2. Incorporate more intensive case management for JBU youth.
3. Evaluate opportunities for an increased transportation budget to mitigate the need for additional transportation assistance associated with moving JBU program from downtown San Diego to a residential neighborhood.
4. Increase attention to post-discharge follow-ups.

Conclusion

During FY 2020-21, JBU was able to successfully contact and enroll 45 youth who met all eligibility requirements (a level of enrollment similar prior years). Coupled with having SMI, many of the youth also had substance use and abuse issues. JBU staff provided daily encouragement and support throughout the residential phase of the program, primarily through the addition of extensive OT support services as well as offering group and individual sessions for various holistic services and educational/enrichment activities. In addition to the emphasis on increasing awareness and practices of wellness among JBU youth, the program was successful at creating linkages to other BHS treatment programs, with approximately 70% of youth participating in outpatient care while enrolled in JBU and almost 30% transitioning to ACT programs after completing the residential phase of JBU. While access to external holistic providers was more limited as a direct response to the COVID-19 pandemic, the JBU staff continued to provide residential care services and facilitated telehealth connections to outpatient treatment providers.

For youth with baseline and follow-up outcome assessment data, both the staff self-report and the youth self-report measures indicated positive changes related to numerous domains such as: improved symptom management, greater recovery orientation, increased sense of well-being, and reductions in impairment due to substance use. Staff feedback indicated that for youth who were not successfully engaged in JBU services, substance abuse was a primary factor that impeded their efforts. These experiences prompted the JBU program to create additional community connections and develop internal resources to better address substance abuse issues among youth enrolled in the JBU program.

The Photovoice Project generated youth feedback regarding their perceptions of the JBU program. Key emergent themes included the following: 1) Housing was the most important part of JBU, 2) JBU provided a sense of stability, 3) Community can be uncomfortable for JBU youth, but they recognized its importance, 4) A sense of control was important while youth work towards independence, and 5) Youth believed that participation in JBU gets them to independence faster than if they tried on their own.

Overall, the findings from FY 2020-21 indicated that the JBU program was able to achieve key objectives of contacting and engaging with their target youth population, creating linkages to appropriate mental health and substance use treatment, and improving the general well-being of the youth who participated in JBU services. The program also continued to evolve to address emerging issues to better meet the behavioral health and wellness needs of the youth they are serving.

For more information about this Innovation program and/or the report please contact:

David Sommerfeld, Ph.D. (dsommerfeld@health.ucsd.edu)

Appendix

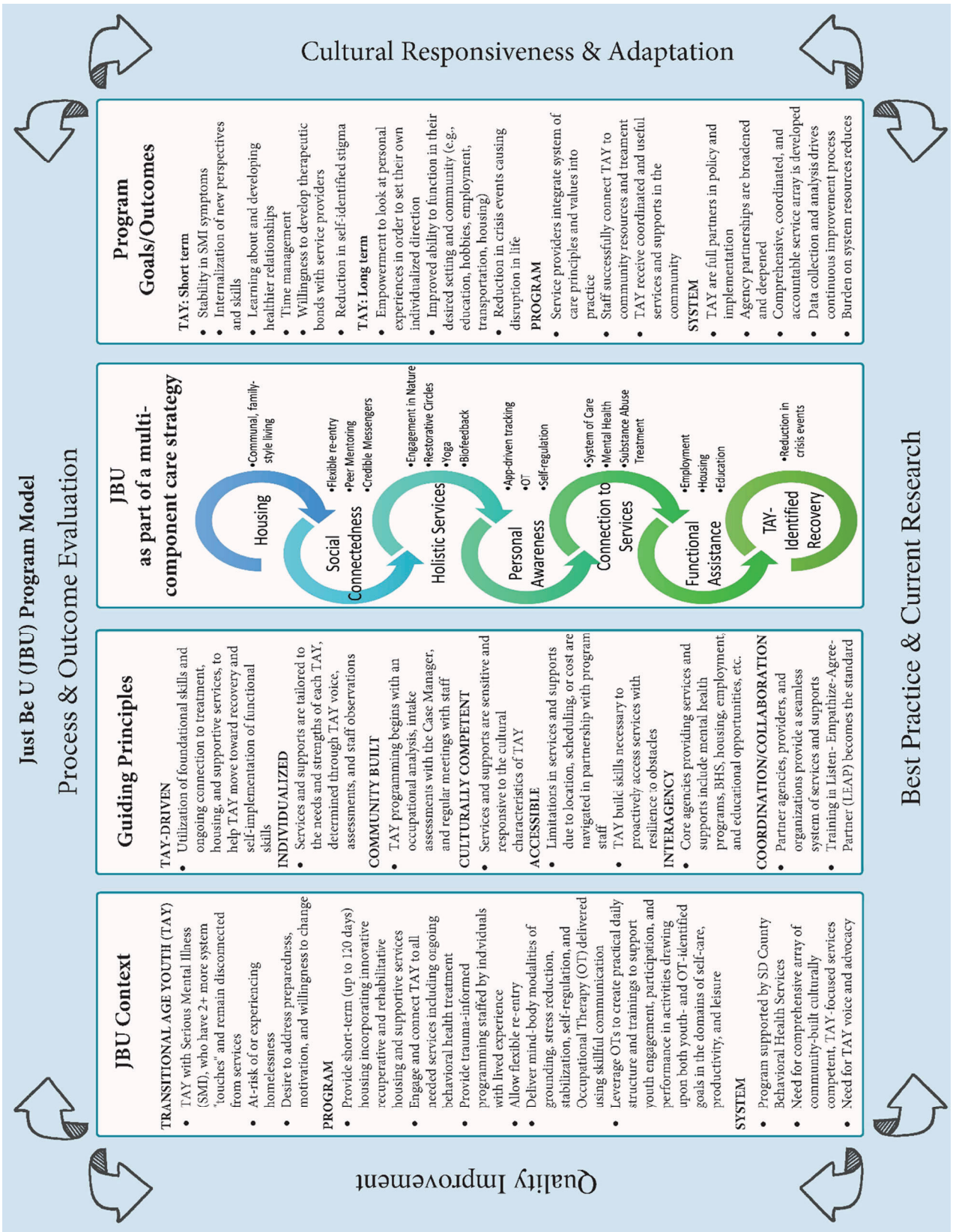
Characteristics of Participants who Enrolled during FY 2020-21

Characteristic	Total Participants (N=45)	
Gender	**N**	**%**
Male	30	66.7%
Female	13	28.9%
Another Gender Identity/Missing	2	4.4%
Total	45	100%
Age Group	**N**	**%**
18-21	26	57.8%
22-25	19	42.2%
Total	45	100%
Primary Language	**N**	**%**
English	41	91.1%
Other/Missing	4	8.9%
Total	45	100%
Race/Ethnicity	**N**	**%**
African American	11	24.4%
Hispanic or Latino	15	33.3%
Caucasian	11	24.4%
Other	6	13.3%
Missing	6	13.3%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	16	35.6%
Schizophrenia and Other Psychotic Disorders	12	26.7%
Bipolar Disorders	10	22.2%
Anxiety/PTSD/Acute Stress Reaction	2	4.4%
Other/Missing	5	11.1%
Total	45	100%

Characteristic	Total Participants (N=45)	
Sexual Orientation	N	%
Heterosexual or straight	29	64.4%
Bisexual/Pansexual/Sexually fluid	5	11.1%
Another orientation/Missing	6	13.4%
Prefer not to answer	5	11.1%
Total	45	100%
Military Status	N	%
Never served in the military	41	91.1%
Other/Missing	4	8.9%
Total		
Disability	N	%
Yes, Has a disability	9	20.0%
No, Does not have a disability	33	73.3%
Declined/Preferred not to answer	3	6.7%
Total	45	100%
Type of Disability	N	%
Learning/Developmental	7	77.7%
Physical/Chronic/Other	8	88.9%
Total[3]	-	-

[1] Total may exceed 100% since youth could select more than one response.
[2] Mental health diagnosis information is obtain form BHS Cerner data system.
[3] Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.

JBU Program Model





THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (CCYP) INNOVATIONS-22

Annual Report
Year 3 (7/01/2020-6/30/2021)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES (v.12.29.2021)

Table of Contents

Executive Summary 1
Program Description 3
Service Changes Due to COVID-19 4
Participant Characteristics 4
Utilization of Program Services 6
Behavioral Health Service (BHS) Utilization Patterns 9
Primary Program Outcomes 10
Other Program Activities 15
Primary Implementation Findings 15
Changes from Initial Program Design 17
Status Update on Prior Year Program Recommendations 18
Program Recommendations 19
Conclusion 19
Appendix 21

Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Center for Child and Youth Psychiatry (CCYP) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The CCYP program was designed to provide psychiatric evaluation and treatment to children and youth who have completed behavioral health treatment yet require ongoing and complex medication monitoring that is not viable with their primary care physician (PCP). An additional unanticipated role has emerged, however, in which CCYP provides psychiatric care when other County-funded programs experience temporary gaps in their ability to offer timely psychiatric care (e.g., due to psychiatrist departures or leaves of absence). This role of providing services to "ancillary" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere) ensured continuity of care and has become part of standard CCYP operations.

CCYP staff include assessment coordinators, a health care coordinator, a nurse, and contracted psychiatrists who provide services both at centrally located clinics and remotely via telepsychiatry. CCYP is also expected to provide psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. The initial design of CCYP, which already included a reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services.

Primary Findings for Fiscal Year (FY) 2020-21

1. During FY 2020-21, a total of 499 children and youth were served by the CCYP program, including 258 new intake clients and 241 who had enrolled in a prior year (program goal = 500 unique clients served per year). This represented more than 100 additional youth served than the 397 youth served during FY 2019-20.

2. CCYP served a racially and ethnically diverse population with the majority of youth identifying as Hispanic or Latino (55.8%).
3. CCYP continued to support other BHS programs that experienced disruptions in their ability to provide psychiatric care services. During FY 2020-21 CCYP enrolled 68 youth from eight different agencies as ancillary referrals. The ancillary population represented a growing proportion of new CCYP enrollees (26.4% during FY 2020-21 compared to 15.2% in FY 2019-20).
4. Per each 30 days of CCYP enrollment, ancillary clients were estimated to receive approximately twice as many psychosocial assessment and collateral service contacts as maintenance clients, which increased workload requirements for the Assessment Coordinators.
5. CCYP youth typically received services for an extended period of time as evidenced by a median duration of 319.5 days for the 296 persons who were receiving CCYP services as of 6/30/2021.
6. Less than 10% of the youth served by CCYP during FY 2020-21 had behavioral health concerns emerge that required a transition to a higher level of care (e.g., a return to ongoing therapy).
7. In quantitative and qualitative feedback, high percentages of both caregivers and youth indicated that they were satisfied with CCYP services.
8. BHS crisis/acute care services were rarely accessed during the 180 days prior to enrolling in CCYP or while enrolled in CCYP. This pattern, combined with the lengthy average enrollment, indicates that CCYP was achieving the primary objective of maintaining stability for clients with complex medication management needs.
9. With the ongoing COVID-19-related adjustments to service provision, CCYP psychiatrists and other staff indicated that they did not perceive a substantial difference between in-person and telehealth visits with regard to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information.
10. Feedback from CCYP caregivers indicated that many expected to continue to utilize CCYP services via telehealth with video even if in-person services become more readily available.

Conclusion

During FY 2020-21, the third year of program operations, CCYP served more youth than during the prior year (i.e., 499 in FY 2020-21 compared to 397 in FY 2019-20) and enrolled substantially more persons than discharged (258 to 135, respectively). This growth rate may challenge program capacity and potentially limit future availability for new enrollment without changes to staffing levels or discharge patterns.

Growth can be partially attributed to CCYP enrolling an increased number of ancillary youth (i.e., over 25% of new CCYP enrollees during FY 2020-21), who continued to receive therapy services at another organization while CCYP provided needed medication management and psychiatric care. Based on staff feedback and service utilization data, the ancillary youth appear to have higher acuity needs and/or require additional attention by CCYP to support coordination and communication with the external organization providing their ongoing therapy.

Overall, the patterns of lengthy CCYP program participation, the few program discharges, and the similar frequency of BHS crisis and acute care services utilized while in CCYP as compared to immediately prior to enrolling, indicated that CCYP achieved the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy. In addition, CCYP fulfilled a second objective by providing continuity of psychiatric medication management for youth who otherwise faced disruptions in their access to such services at the location

where they participated in ongoing therapy. The CCYP services provided to these ancillary youth helped to strengthen the local BHS system of care and minimize potential service delivery gaps.

Primary Recommendations for FY 2021-22

1. Continue to develop an educational and outreach oriented CCYP website (e.g., basic materials about disorders, resource library for caregivers, resource library for providers, past newsletters, commonly used handouts or worksheets).
2. Assess staffing requirements and/or staffing supports needed to best serve the unique service needs of the "maintenance" and "ancillary" CCYP populations.
3. Explore providing families with the equipment needed to obtain essential vital signs at home such as blood pressure monitoring tools.

Program Description

CCYP was developed to provide medication support to select children and youth who have completed behavioral health treatment services yet require ongoing monitoring of complex psychotropic medications that are essential for the child or youth's wellness and stability, but not easily managed by their PCP. Services are provided through a variety of means, including a centrally located psychiatric clinic and telepsychiatry at satellite clinics and clients' homes. CCYP provides linkages and facilitates access to psychotropic medication, including the administration of long-acting injectable psychotropic medication, when indicated and necessary for the child or youth's stability. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full-service clinics, schools, PCPs), and the communities they serve. CCYP is also expected to provide psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. A San Diego-based community organization, New Alternatives Incorporated (NAI), was contracted to provide CCYP services, which included: 1) establishing a team of psychiatrists, assessment coordinators, a nurse, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families.

Since the first year of the CCYP program (i.e., FY 2018-19), an unanticipated role for CCYP emerged and has been subsequently incorporated into CCYP operations. In addition to the intended focal population discussed above, CCYP was identified as an important county-wide resource that could fulfill the need for temporary access to psychiatric services when other county-funded programs experienced a gap in capability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). Providing continuity of psychiatric care in these situations was determined to be an important ongoing benefit that CCYP could contribute to support the overall Children, Youth, and Families (CYF) BHS system of care. Youth who were admitted via this additional service strategy (i.e., ancillary referrals), differed from the traditional maintenance CCYP enrollees in that they continued to receive psychotherapeutic care services from the referring agency while CCYP provided needed medication management support. This required additional communication and coordination between CCYP and the organization providing the therapy services.

The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to administrative and institutional barriers, the anticipated partnerships have not been viable so an emphasis on the medically fragile has not been implemented as part of CCYP operations.

Service Changes Due to COVID-19

The COVID-19 pandemic first affected the San Diego area in a substantial manner during March 2020 and continued to impact the San Diego community and BHS programs throughout FY 2020-21. Various State of California and County of San Diego public health orders were issued throughout FY 2020-21 that affected 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 remote interactions with service recipients via telehealth sessions with a video component (where feasible) or telephone during FY 2020-21. Most COVID-19-related County of San Diego official public health orders were ended as of June 15, 2021, however, service provider agency protocols to promote the safety of staff and the community members they served continued. For many BHS programs, responding to and navigating changes brought about by COVID-19 substantially impacted how services were provided throughout most of FY 2020-21, particularly the switch to, or greater utilization of, telehealth service delivery approaches.

The initial design of CCYP, which included a substantial reliance upon telehealth services to provide psychiatric care throughout the entire county, allowed CCYP to adjust to the new practice realities without substantial disruption to ongoing services. Due to the ongoing COVID-19 pandemic, CCYP clients continued to be seen remotely throughout FY 2020-21. As discussed in more detail below, caregivers have become increasingly comfortable utilizing Zoom and other secure platforms to attend telepsychiatry or telehealth sessions with the psychiatrists and assessment coordinators, allowing CCYP to further streamline services and increase availability of services. CCYP administrative staff have been available to provide technical support as needed. Additionally, the CCYP program has worked to ensure that updated policies regarding receiving and providing documentation securely have been updated and all staff have been trained on the new procedures.

Participant Characteristics

As shown in Table 1, a total of 258 persons enrolled into the CCYP program during FY 2020-21 (as compared to 211 in FY 2019-20). Of the 258 enrollees, 190 (73.6%) were considered maintenance enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), and 68 (26.4%) were considered ancillary enrollees, which represents an increase in the number of ancillary referrals and percentage of the CCYP population as compared to FY 2019-20 (32 and 15.2%, respectively). These ancillary enrollees were approved to receive CCYP services due to their inability to obtain needed psychiatric care at their primary (non-CCYP) service provider. A total of eight different organizations referred ancillary enrollees to CCYP during FY 2020-21.

Table 1. CCYP Program Enrollment for FY 2019-20 (N=258)

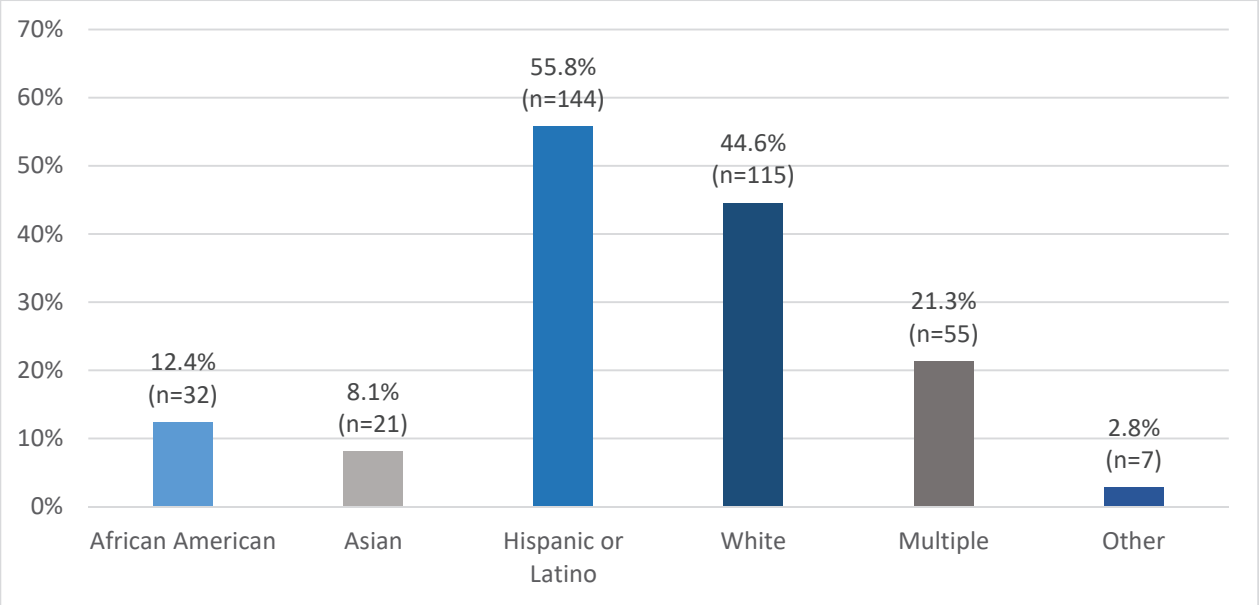
Type of CCYP Enrollee	N	% of Total
Maintenance enrollees (i.e., not receiving therapy elsewhere)	190	73.6%
Ancillary enrollees (i.e., receiving therapy elsewhere)	68	26.4%
Total CCYP enrollees	**258**	**100%**

Key characteristics of the 258 persons who enrolled in CCYP during FY 2020-21 (i.e., includes both maintenance and ancillary referrals) are discussed below. A more complete listing of participant characteristics and response options can be found in the appendix. Additional analyses not reported here found similar demographic characteristics between maintenance and ancillary clients.

During FY 2020-21, the majority (69.4%; n=179) of clients enrolled in CCYP were at least 12 years old or older, with approximately one-third of clients age 5 to 11 (30.6%; n=79). Similar numbers of males and females enrolled (46.9%; n=121 and 52.3%; n=135, respectively). Almost two-thirds of clients identified as heterosexual (60.5%; n=156), with 12.4% (n=32) indicating being bisexual, pansexual, or sexually fluid and 19.0% (n=49) declining to select an orientation.

While most clients reported English as their primary language (88.8%; n=229), nearly 10% indicated Spanish (8.1%; n=21) and 3.1% (n=8) another primary language. As shown in Figure 1, CCYP served a racially and ethnically diverse population. Over half of participants identified as Hispanic or Latino (55.8%; n=144), followed by White (44.6%; n=115), multiple racial/ethnic backgrounds (21.3%; n=55), African American (12.4%; n=32), and Asian (8.1%; n=21).

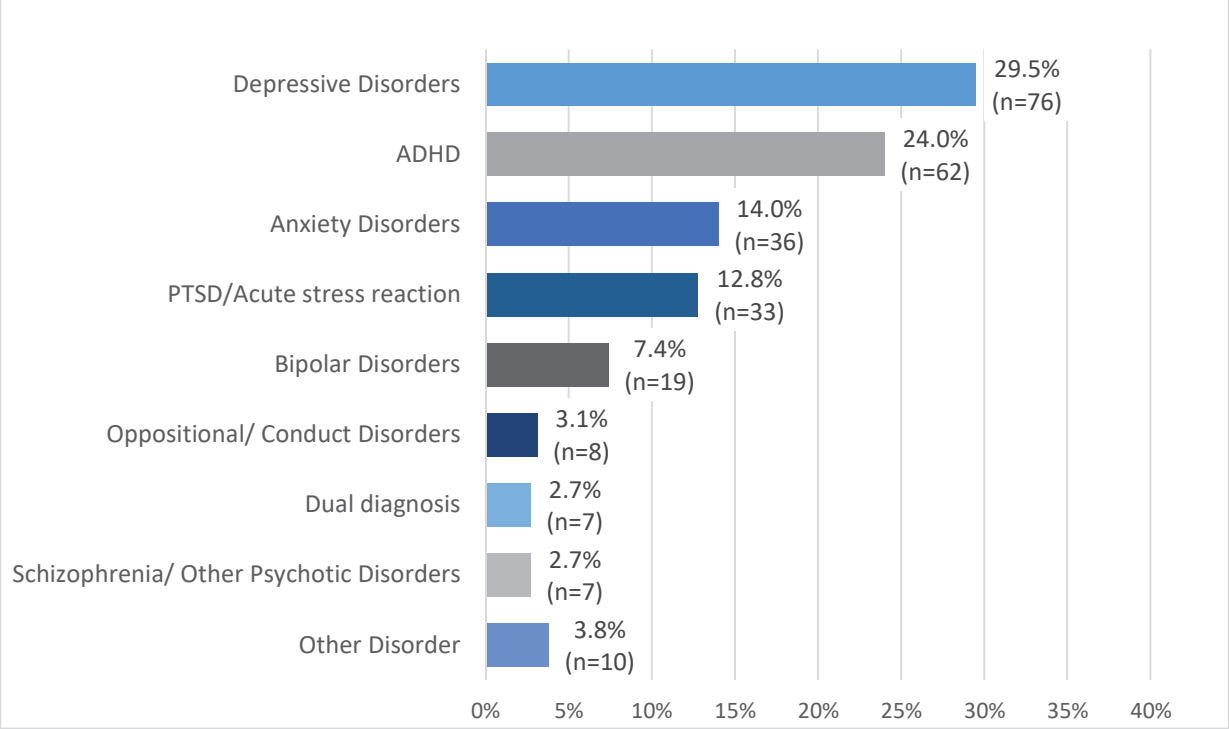
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP during FY 2020-21 (N=258)



Note: Total may exceed 100% since more than one race/ethnicity could be selected.

As shown in Figure 2, the youth served by CCYP had a wide range of mental health diagnoses. The most common diagnoses included depression (29.5%; n=76), ADHD (24.0%; n=62), and anxiety disorder (14.0%; n=36).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP during FY 2020-21 (N=258)



In addition, 12.0% (n=31) of the FY 2020-21 enrollees reported having a non-mental-health-related disability. The most common disability reported among CCYP participants was a learning disability (5.4%; n=14).

Utilization of Program Services

Program Service Contacts/Service Utilization

During FY 2020-21, the CCYP program served a total of 499 youth (419 maintenance and 80 ancillary youth). This total was comprised of the 258 FY 2020-21 enrollees, plus 241 prior year enrollees who were still active during FY 2020-21. The 499 youth served during FY 2020-21 represented approximately 100% of the original service targets established prior to CCYP implementation (n=500) and an increase of more than 100 youth served compared to the previous year (i.e., 397 youth were served during FY 2019-20).

As reported in Table 2a, maintenance clients received an average of 12.2 services during FY 2020-21 with approximately 70% (n=302) receiving at least one psychosocial assessment (mean of 2.0) and 81.6% receiving at least one medication management-oriented service (n=342; mean of 7.0). Interactions with the nurse were also common, with 64.4% having at least one session and a mean of 5.2 sessions. Overall, the CCYP program provided a substantial amount of psychiatric care to persons needing these specialized services. To generate a population-based, service contact estimate of workload for CCYP team members, the average number of services provided during each 30 days that a participant was enrolled in CCYP was

calculated. For each 30 days that a maintenance client was enrolled, an estimated 1.46 CCYP services were provided, with half of those being medication management visits (0.73) with the psychiatrists.

Table 2a. Services Provided by CCYP to Maintenance Clients during FY 2020-21* (N=419)

Type of CCYP Service	Persons with at Least One Service		Mean Number of Services (of Persons with Service)	Mean Number of Services per 30 Days	Total Number of Services
	N	%			
Any CCYP service	391	93.3%	12.2	1.46	4,760
Psychosocial assessment	302	72.1%	2.0	0.19	602
Medication management	342	81.6%	7.0	0.73	2,387
Nurse consult	270	64.4%	5.2	0.43	1,409
Other services (e.g., collateral)	193	46.1%	1.9	0.11	362

**Note: Analyses include all maintenance clients enrolled in CCYP at any point during FY 2020-21, which means that for some, certain services may have occurred in the previous year or if they enrolled at the end of FY 2020-21 they may not have received all relevant services as of 6/30/2021.*

Table 2b presents the same CCYP service contact information for the 80 ancillary clients. Ancillary clients received an average of 8.1 services during FY 2020-21. Almost all (86.3%; n=69) received at least one psychosocial assessment (mean of 2.0) and 75.0% received at least one medication management-oriented service (n=60), with a mean of 4.5, which was substantially lower than the mean for maintenance clients (i.e., 7.0). Interactions with the nurse were also less common for ancillary clients with 46.3% having at least one session and a mean of 4.3 sessions (as compared to 64.4% for maintenance clients). The generally lower mean levels of services received by ancillary clients likely reflects their shorter durations of CCYP enrollment. However, when examined per 30 days of CCYP enrollment, ancillary clients received more overall services than maintenance clients (1.74 to 1.46 services, respectively). Of note, the per 30-day estimates for medication management and nurse consultation services were nearly identical between ancillary and maintenance clients, but ancillary clients had essentially twice as many psychosocial assessment and other/collateral service contacts per 30 days as did maintenance clients. From a CCYP workload perspective, this means that the increased enrollment of ancillary clients that occurred during FY 2020-21 disproportionately affected the Assessment Coordinators who provide these additional supportive services.

Table 2b. Services Provided by CCYP to Ancillary Clients during FY 2020-21 (N=80)

Type of CCYP Service	Persons with at Least One Service		Mean Number of Services (of Persons with Service)	Mean Number of Services per 30 Days	Total Number of Services
	N	%			
Any CCYP service	78	97.5%	8.1	1.74	635
Psychosocial assessment	69	86.3%	2.0	0.38	137
Medication management	60	75.0%	4.5	0.74	270
Nurse consult	37	46.3%	4.3	0.44	159
Other services (e.g., collateral)	29	36.3%	2.4	0.19	69

**Note: Analyses include all maintenance clients enrolled in CCYP at any point during FY 2020-21, which means that for some, certain services may have occurred in the previous year or if they enrolled at the end of FY 2020-21 they may not have received all relevant services as of 6/30/2021.*

Program Duration

To generate a better understanding of typical CCYP participation patterns, the following analyses examine CCYP program duration and discharge status for all FY 2020-21 maintenance and ancillary CCYP clients. Table 3 shows that the average duration for all maintenance clients still participating in CCYP services as of 6/30/2021 was more than a year at 407.8 days. The median duration, which represents the midpoint value (i.e., 50% are shorter and 50% are longer), indicates that half of all CCYP maintenance enrollees had been enrolled in CCYP for more than 319 days. In contrast, ancillary clients still participating in CCYP services as of 6/30/2021 had much shorter mean and median duration values of 156.5 and 74.0 days, respectively.

Table 3. CCYP Duration for Youth Receiving Services During FY 2020-21

	Maintenance (N=419)			Ancillary (N=80)		
	N	Mean Number of Days	Median Number of Days	N	Mean Number of Days	Median Number of Days
Open in CCYP as of 6/30/2021	296	407.8	319.5	68	156.5	74.0
Discharged during FY 2020-21	123	436.3	433.0	12	277.7	229.0

Maintenance clients who had discharged during FY 2020-21 had mean and median CCYP program participation durations of 436.3 and 433.0 days, respectively. In contrast, the mean and median CCYP program participation duration values for discharged ancillary clients were substantially shorter (277.7 and 229.0 days, respectively). These findings indicate that both maintenance and ancillary CCYP clients stay enrolled in CCYP for an extended period of time, with maintenance clients typically participating in CCYP services for more than a year. The duration differences between maintenance and ancillary CCYP clients highlight the comparatively shorter-term orientation of ancillary clients who are receiving CCYP services due to a temporary disruption in their ability to access psychiatric care in their primary service program where they are receiving ongoing therapy. These shorter CCYP durations result in a greater amount of "churn" among ancillary CCYP clients (i.e., onboarding into CCYP and then transitioning back to home programs and all associated coordination and communication required with clients, their families, and their primary service program).

As discussed in more detail below, efforts to increase program capacity contributed to the reorganization of some staffing responsibilities as well as provided additional motivation for developing partnerships to increase the number of youths who can be successfully discharged to PCPs or Federally Qualified Health Centers (FQHCs) for ongoing medication management. During FY 2020-21, a total of 13 maintenance youth CCYP discharges (approximately 10% of all 123 CCYP discharges) were coordinated specifically to transfer medication management responsibilities back to their PCP. Approximately 30% of all CCYP discharges for maintenance youth (n=37) were due to the emergence of behavioral health needs that required higher levels of care beyond the medication management services provided by CCYP. Given that over 400 maintenance youth received CCYP services during FY 2020-21, this indicates that less than 10% of youth were discharged for reasons of needing more intensive services such as a return to ongoing therapy.

BHS Utilization Patterns

BHS Services Utilization Before and During CCYP

To assess the extent to which CCYP was able to support stable mental health among their clients without need for crisis or acute care services, BHS service utilization patterns before and during CCYP enrollment were compared. This was accomplished by using the Cerner administrative database that documents the provision of BHS-funded services throughout San Diego County to identify mental health services received by CCYP clients from other BHS providers. Since the time enrolled in CCYP varies considerably between maintenance and ancillary clients and can be quite lengthy (i.e., frequently more than a year for maintenance clients), a standardized metric was created to enable equivalent comparisons for BHS service utilization before and during CCYP. The standardized metric for the "during CCYP" period reflects the average amount of services youth would be expected to receive during a 180-day period with CCYP. This metric facilitates comparisons to the 180-day period immediately prior to entering CCYP and between maintenance and ancillary clients.

The standardized or average utilization of other BHS services during a 180-day period while enrolled in CCYP was calculated by adding all FY 2020-21 BHS services (by service type) that occurred while clients were enrolled in CCYP and dividing that by the total number of days that all clients were enrolled in CCYP during FY 2020-21. The resulting value represents the average number of BHS services that CCYP clients received per day, which is then multiplied by 180 to generate the estimate of BHS services that CCYP clients would receive during any 180-day period in CCYP. This allows for an equivalent comparison to the average amount of BHS services utilized by youth during the 180 days prior to CCYP.

Table 4. Comparison of BHS Service Utilization Prior to and During CCYP

	Maintenance Clients (N=419)		Ancillary Clients (N=80)	
	Average number of BHS services per person during 180 days pre-CCYP	Average number of BHS services per person during standardized 180 days in CCYP	Average number of BHS services per person during 180 days pre-CCYP	Average number of BHS services per person during standardized 180 days in CCYP
Inpatient hospitalization	0.07	0.02	0.13	0.08
Crisis stabilization visits	0.16	0.09	0.35	0.67
PERT[1]	0.03	0.04	0.05	0.18
Therapeutic behavioral services	2.88	0.14	2.09	1.63
Outpatient sessions (not CCYP)	17.53	2.96	21.34	14.02

[1] *PERT = Psychiatric Emergency Response Team*

For the 419 maintenance youth served by CCYP during FY 2020-21 (see Table 4), crisis/acute care services such as inpatient hospitalizations, crisis stabilization visits, and PERT contacts were relatively rare events (i.e., much less than 1 instance per person) during the 180 days prior to CCYP enrollment. This is consistent with CCYP program design in that persons referred to CCYP have been determined to be relatively stable and not in need of ongoing therapy. In comparison, during an equivalent 180 days while enrolled in CCYP services, the average number of instances for each of these crisis/acute care services was essentially the same as during the 180 days prior to entering CCYP. Given that CCYP was designed to provide psychiatric care without requiring participation in outpatient therapy, the average number of non-CCYP outpatient sessions understandably reduced substantially from 17.53 in the 180 days immediately before CCYP to 2.96 for the 180 days enrolled in CCYP. Feedback from CCYP staff indicated that non-CCYP outpatient visits that occurred while enrolled in CCYP were frequently related to situations where emergent circumstances resulted in the need for a youth to reconnect with a program that offered ongoing therapy. To facilitate the transition, a "warm-handoff" occurred during which a person was simultaneously enrolled in both CCYP and another outpatient treatment program.

A comparison of the behavioral health service utilization patterns of ancillary and maintenance clients prior to CCYP and while enrolled in CCYP reveals some key differences. While still relatively rare events, inpatient hospitalizations, crisis stabilization visits, and PERT encounters are approximately twice as common in ancillary clients prior to CCYP enrollment and remains higher during CCYP enrollment when compared to maintenance clients. These findings are consistent with the expectation that maintenance clients are determined to be more stable and not in need of ongoing therapeutic services, whereas the ancillary clients are still in active treatment elsewhere and rely on CCYP to provide medication management services to address a temporary disruption in access to psychiatric care. For the same reason, it is not surprising that ancillary clients exhibited a much higher utilization of outpatient treatment services while enrolled in CCYP compared to maintenance clients (14.02 and 2.96, respectively) given that ancillary clients are expected to be receiving treatment services elsewhere.

Overall, these findings highlight the difference in service needs between the maintenance and ancillary CCYP clients and provide evidence that CCYP was typically able to successfully maintain stable mental health among their participants, particularly among the maintenance client population.

Of note, the findings regarding BHS service utilization before and during CCYP were similar to those reported for FY 2019-20. Identifying this pattern of findings across multiple years, combined with the lengthy CCYP program participation (i.e., typically more than a year) indicates that CCYP is consistently able to maintain the stability and well-being of youth by providing regular psychiatric consultation services.

Primary Program Outcomes

Three assessment-based outcome tools are reported in this section of the report. The Child and Adolescent Needs and Strengths (CANS) and the Pediatric Symptoms Checklist (PSC) are BHS-required tools to evaluate services provided across all levels and types of care. It is important to note that the primary goal of CCYP is maintaining stability through medication management only; thus, it is not necessarily expected that significant improvements would be seen between initial enrollment into CCYP and later follow-up assessments. Note that only clients that are part of the primary target population of

"maintenance" enrollees are included in these analyses (i.e., those who are only receiving CCYP medication management services and not receiving therapy services in other programs).

Child and Adolescent Needs and Strengths (CANS)

The CANS is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In CCYP, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 222 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2020-21 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a "2" or "3" indicating a specific area that could be potentially addressed in the service or treatment plan (many of these areas are not specifically addressable by the medication management services provided by CCYP). Table 5 shows the mean number of needs at initial assessment and last available assessment for the domains of Child Behavioral and Emotional Needs, Life Functioning, and Risk Behaviors. These findings show reductions at the last available follow-up for the three CANS domains, with Child Behavioral and Emotional Needs, and Life Functioning showing statistically significant reductions (i.e., change unlikely due to chance). These ratings suggest that although only medication management services were provided by CCYP, there were still some areas of need identified at intake that improved while participating in CCYP.

Table 5. CANS Average Change from Initial Assessment (N=222)

	FY 2020-21 (N=222)	
Key CANS Domains	**Initial Mean Number of Needs**	**Follow-up Mean Number of Needs**
Child Behavioral	1.74	1.00**
Life Functioning	1.06	0.79**
Risk Behaviors	0.13	0.09

***statistical significance at p < 0.01*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). As shown in Table 6, for each CANS domain approximately 70-80% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment. The percent of persons with an improvement across these three domains was similar to what was reported in the FY 2019-20 Systemwide Annual Report for the overall County of San Diego CYF BHS for discharged clients (i.e., approximately 70-75% had at least one improvement for each domain). The fact that most of the CCYP population with needs at baseline exhibited at least some progress on the CANS suggests that CCYP services provided by the psychiatrists and care team continue to help children, youth, and families make improvements in their overall well-being.

Table 6. Persons with CANS Improvement at FY 2020-21 Follow-up (N=222)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Child Behavioral	169	122	72.2%
Life Functioning	122	89	73.0%
Risk Behaviors	20	16	80.0%

Pediatric Symptoms Checklist (PSC)

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 7.

In FY 2020-21, the PSC-35 was administered at entry into CCYP, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 135 caregivers and 82 youth completed both an initial and follow-up/discharge PSC assessment. At program entry, 48.9% of parents and 39.0% of youth reported PSC scores that indicated clinical concern (see Table 7). At follow-up, 45.2% of parents still reported scores of clinical significance, however this lack of change is to be expected, as there are no therapy services offered as part of the CCYP program. Interestingly, youth self-reported scores improved with only 26.8% scoring beyond the clinical cutoff at follow-up. Likewise, an examination of mean score changes in youth self-report show a small, but statistically significant reduction (i.e., improvement) for both the Internalizing subscale and the total PSC score. With the reduced sample sizes for completed self-report PSC assessments (as compared to the clinician completed CANS), the findings should be interpreted cautiously as they may not reflect the broader experiences of the full CCYP population.

Table 7. PSC Average Change from Baseline

	Parent/Caregiver Report (N=135)					Child/Youth Report (N=82)				
		% Above clinical cutoff[1]		Mean			% Above clinical cutoff[1]		Mean	
Composites:	N	Baseline %	Post %	Baseline	Post	N	Baseline %	Post %	Baseline	Post
PSC Score	135	48.9%	45.2%	26.8	26.5	82	39.0%	26.8%	23	20.2*
Attention Subscale	135	37.0%	38.5%	5.4	5.5	82	25.6%	22.0%	4.5	4.5
Internalizing Subscale	135	37.0%	36.3%	3.7	3.6	82	41.5%	24.4%	3.7	3.1*
Externalizing Subscale	135	34.8%	35.6%	4.9	4.9	82	11.0%	14.6%	3.1	2.6

**statistical significance at $p < 0.05$; [1] PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7. Note: Higher scores indicate worse condition.*

To better understand the distribution of PSC change scores within the CCYP client population and to facilitate comparisons with the overall CYF BHS system, analyses were conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2019-20 Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 8. Distribution of FY 2020-21 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=135)		Child/Youth Report (N=82)	
Amount of Change	**N**	**%**	**N**	**%**
Increased impairment (i.e., 1+ point increase)	62	45.9%	28	34.1%
No improvement (i.e., 0-1 point reduction)	13	9.6%	8	9.8%
Small improvement (i.e., 2-4 point reduction)	13	9.6%	13	15.9%
Medium improvement (i.e., 5-8 point reduction)	16	11.9%	12	14.6%
Large improvement (i.e., 9+ point reduction)	30	22.2%	21	25.6%

As shown in Table 8, approximately one-third of parents/caregivers (34.1%) and children/youth (40.2%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 45.9% of caregivers and 34.1% of children reported a higher PSC score at follow-up, indicating perceptions of increased impairment. Given that the CCYP population was determined to be relatively stable and not needing ongoing therapy upon entrance into CCYP, this finding of increased impairment likely reflects, at least in part, a "ceiling effect" in that there was not much room for improvement for many youths so it is not surprising that a portion of parents and youth might identify a few additional concerns at a later time point. Overall, these findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes.

Substantial variability and similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2019-20 Systemwide Annual Report. Approximately 40% of caregivers and children/youth reported large improvements while about 20-25% reported increased impairment from initial PSC assessment. While caution is warranted when making any direct comparisons between CYF and CCYP PSC change score analyses, it is not surprising that the CCYP population appears to exhibit lower levels of PSC improvement, given the specific nature of the CCYP population (i.e., demonstrating mental health stability without a perceived need for ongoing therapy), and the fact that the CYF analyses only include persons with completed discharge assessments (i.e., have concluded treatment goals). However, the variability of PSC change scores among CCYP clients is a reminder that there are CCYP clients who may benefit from additional therapeutic support and may require linkage to ongoing behavioral health care outside of CCYP.

Caregiver and Client Perspectives on CCYP Services

A total of 56 caregiver feedback surveys and 41 youth feedback surveys were completed at either the 6-month time point or discharge during FY 2020-21. As shown in Table 9, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (89.3% and 82.9%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on client functioning and help-seeking. More caregivers reported that their child was able to

function better in life (83.6%), compared to 75.6% of children/youth. Likewise, 94.4% of caregivers reported knowing where to get help and 83.7% felt comfortable seeking help, compared to 67.5% and 61.0%, respectively, among youth. Most caregivers reported feeling the needs of their family were met by the program (85.5%), while 68.3% of youth reported the same. The above findings should be interpreted with some caution as the number of caregivers and youth who completed a feedback survey is relatively low (i.e., less than 20% of all CCYP participants); however, the response patterns are similar to prior years.

Table 9. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=56)**	**Youth (N=41)**
As a result of this program, my child is/I am able to function better.	83.6%	75.6%
As a result of this program, my child/I know where to get help.	94.4%	67.5%
As a result of this program, my child is/I am more comfortable seeking help for myself.	83.7%	61.0%
My child's/my needs were met by this program.	85.5%	68.3%
Overall, I am satisfied with the services I received here.	89.3%	82.9%

For the open-ended caregiver and youth feedback survey questions (n=55 caregivers; n=41 youth with codable responses), at least two evaluators reviewed and coded the individual question responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. In addition, at the end of this fiscal year, three caregivers were interviewed via telephone, 24 caregivers and two youth completed a brief survey as part of interview recruitment, and 69 caregivers and youth completed telepsychiatry-specific surveys.

Across both caregivers and youth, respondents reported that CCYP is succeeding at providing needed medication management, providing supportive, responsive, helpful, attentive services, as well as flexible and convenient appointments. Families reported that if CCYP was not available they would not know where else to go for psychiatric medication management services given many PCPs are not comfortable prescribing the types and/or combinations of medications needed by their children.

Families were asked specifically about telepsychiatry, and about half indicated they would prefer telepsychiatry all the time while the other half would prefer a hybrid model. Many families cited convenience, safety due to the pandemic, and the visits being more comfortable than in-person as benefits to telepsychiatry, whereas some families were interested in some in-person interaction for rapport building as well as to allow the psychiatrist to view the client's symptoms more directly.

When asked about ideas for improving CCYP, most respondents said that overall services are helpful and did not have any specific recommendations. Some suggestions mentioned included increasing staff diversity to provide better racial/gender representation of clients/caregivers; improved communication between staff and clients, including more contact and attention and improved technical and interpersonal interactions with CCYP staff; and expanding services and referrals, in particular counseling services for those having difficulty transitioning away from counseling. Overall, both the qualitative and quantitative

feedback from caregivers and youth who completed a survey indicated high levels of satisfaction with CCYP services.

Other Program Activities

Establishing New Partnerships

CCYP has been pursuing a partnership with Children's Primary Care Medical Group (CPCMG) to develop a transition pipeline from CCYP service utilization to primary care services with providers able to continue medication management. This desired transition was motivated, in part, by a recognition that CCYP had many long-term stable clients who would likely be able to be cared for by either their current PCP with proper supports or another PCP with more experience managing psychotropic mediations. During FY 2020-21, a total of 13 youth were purposefully discharged from CCYP and transitioned back to medication management by their PCP. Increasing the number of youth who could successfully be cared for by PCPs would allow CCYP to admit additional new clients with more complex needs. In addition to the resources within CPCMG to assist PCPs with patients who have potentially complex medication management needs related to behavioral health, additional supports by psychiatrists from SmartCare (an independent organization designed to provide psychotropic medication consultations for PCPs) can be accessed. In this manner, coordination and communication between CCYP, CPCMG, and SmartCare is anticipated to allow for more successful discharges of CCYP clients to the care of PCPs. In FY 2020-21, contact was made with CPCMG leadership/representatives and plans were developed to identify youth who were candidates for transitioning medication management services to a CPCMG PCP. This partnership will be further developed during FY 2021-22 and opportunities to transition youth to local FQHCs for ongoing medication management needs will be explored.

Primary Implementation Findings

Findings in this section were derived from three primary data sources: 1) CCYP stakeholder meetings, 2) the Annual CCYP Staff/Psychiatrist Survey, and 3) semi-structured interviews with psychiatrists conducted during spring 2021. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of FY 2020-21. CCYP program staff and contracted psychiatrists were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 13 respondents (6 psychiatrists and 7 assessment coordinators/administrators/support staff) from the 13 CCYP staff or contractors invited to participate in the survey (i.e., a 100.0% response rate). For the primary open-ended staff survey questions, at least two evaluators reviewed and coded the individual responses and any discrepancies were discussed to arrive at a consensus on the key response themes. Secondary open-ended questions were summarized. For the psychiatrist interviews, the transcribed interviews were analyzed using elements of the Rapid Assessment Procedures framework (RAP; Beebe, 2001; Palinkas & Zatzick, 2019). The first step was to create a summary template from the main questions in the interview guide. Two independent coders reviewed each recording. Coders then independently completed summary templates for each interview. The templates were compared and any inconsistencies were discussed with a third member of the research team. Finalized summary templates were entered into a matrix and then distilled into themes.

Program Outreach and Recruitment

Similar to FY 2019-20, outreach and recruitment were not perceived as substantial challenges for the CCYP program. In its third year of operation, the CCYP program continues to be well known throughout San Diego County and accepted referrals from more than 20 different organizations/providers (both maintenance and ancillary referrals). In response to the continued substantial demands for youth psychiatric services, additional partnership opportunities were developed in which CCYP would be responsible for medication management while the partner organization continued to provide needed counseling/therapy services.

CCYP Participant Engagement and Retention

The CCYP program was successful at retaining clients in services as evidenced by lengthy program participation and few program dropouts. A goal for FY 2020-21 was to enhance client engagement strategies, and staff reported using several strategies such as a focus on listening during clinical interactions, providing psychoeducation, day-to-day tips, follow-up outreach, appointment reminders and separate appointments with the caregiver when necessary. Overall, these strategies seem to have been successful, as CCYP staff overall did not indicate client engagement as a concern this year.

When psychiatrists were asked to comment specifically on factors affecting client medication adherence, providers mentioned: a lack of available resources for clients who need additional supports, difficulties in obtaining labs, a lack of understanding among clients regarding why medication is needed, and a lack of understanding among clients of medication side effects. Resources needed include increased psychoeducation materials, assistance with completing lab draw appointments, assessment coordinators to provide increased reminders and check-ins, and supports such as telephone alarms and pill boxes.

Experience with Telehealth Services

Staff identified several strengths of the telepsychiatry platform: including that the mode of service delivery provides unique insight into life at home (e.g., family dynamics), that clients can be more open and comfortable at home, a decreased no-show rate, and increased flexibility of scheduling. The main challenges identified by staff included technology challenges, client preferences to not use video capabilities during sessions (i.e., audio only), and difficulties obtaining needed vitals. Proposed solutions include having technology support available and giving clients a choice between phone and video conferencing for appointments. Additionally, providing families with the equipment to obtain essential vital signs at home, such as blood pressure monitoring tools, might improve remote service provision efforts. Overall, psychiatrists reported that telepsychiatry in CCYP worked similarly to other programs they worked for, with comments that CCYP was more organized and flexible about digital platform use.

Approximately 11-25% of clients were estimated to prefer telephone-only sessions even when they had the ability to participate in a video session. This is likely due to both client preferences as well as the additional technology proficiency/comfort issues required to conduct a video session.

Communication and Administrative Processes

Staff indicated a need for increased community and collaboration among various provider types within CCYP (psychiatrists, assessment coordinators, nurse), as well as more streamlined internal communication

protocols. Staff also suggested additional training on the administrative elements of the program such as managing the intake process, billing codes, and documentation standards, as well as increased efforts to streamline and simplify such protocols when possible.

Staff also requested clear indicators for discharge from CCYP. Some psychiatrists indicated that those clients appropriate for transfer might be those on no more than two medications, those prescribed basic medications such as stimulants, simple anti-depressants, alpha antagonists, anti-anxiety medications, and ADHD medications. To increase the comfort and capacity of PCPs to manage psychotropic medications, staff suggested developing a consultation/collaboration model between CCYP psychiatrists and PCPs, and implementing specific training and psychoeducation for PCPs through consultation programs such as SmartCare. However, one staff member noted that there could be billing issues with these types of collaborative activities.

Impact of COVID-19 on CCYP Staff

In terms of COVID-19 impact, CCYP psychiatrists and other staff members indicated there were aspects of their lives, both related and unrelated to work, that continued to be sources of stress and anxiety because of the pandemic. Additionally, they noted continued increased stress and potential for destabilization among CCYP youth and their caregivers. Some staff did indicate that the remote work setting allows for greater flexibility and reduced no-shows. Other staff indicated they felt that their productivity was lower because of the remote work setting as compared to prior office-based workflow.

Workload Challenges

Similar to the previous fiscal year, staff continued to indicate high caseload levels for the Assessment Coordinators, which may in part contribute to turnover for this position. Although the role was shifted from a Care Coordinator to an Assessment Coordinator over the last two years to primarily focus on client intake assessments and the facilitation of more psychiatry sessions, both psychiatrists and assessment coordinators reported that some families (particularly the ancillary families where the client is still receiving therapy) have more extensive needs that would benefit from additional Care Coordinator services. Further, ancillary referrals who are still receiving psychotherapeutic services elsewhere do not have the benefit of the natural within-agency lines of communication across psychiatry and psychotherapy, thus requiring additional support from CCYP that is not built into the current program structure. One solution moving forward might be to assign an Assessment Coordinator to maintenance CCYP clients, and a more traditional Care Coordinator to the ancillary clients.

Changes from Initial Program Design

1. In FY 2020-21, the Care Coordinator position at CCYP was rebranded to Assessment Coordinator to reflect the primary responsibilities of this position more accurately.

2. New partnerships were developed with new contractors (e.g., BHConnect), which have uniquely affected the types of services provided by CCYP. Some of these ancillary youth required an increased level of services from CCYP as they still need therapy, case management and linkages to community resources based on their mental health concerns, which are primarily provided by their treatment provider. To support this population, CCYP has developed new service strategies to expedite communication, collaboration, and coordination between the youth, their families, the CCYP

psychiatrists, and the providers at their ongoing treatment program in order to effectively meet the needs of these youth.

3. In addition, CCYP provide psychiatry services for eight County BHS contracted programs that experienced disruptions in their ability to provide psychiatric services. Deviating from the initial design of CCYP, these youth required continued therapy and have mental health needs not originally intended for CCYP. CCYP leadership continues to work closely with their COR to update policies related to the changing service population and challenges that occur as a result.

Status Update on Prior Year Program Recommendations

Recommendation 1: Conduct a detailed review of CCYP staff roles, responsibilities, and workload to refine program capacity estimates for focal service populations.

FY 2020-21 Update: CCYP program leadership has worked with existing CCYP staff to examine and review tasks, duties, and documentation requirements. Specific changes to the health care coordinator and assessment coordinator positions were reported.

During FY 2020-21, the health care coordinator position was given new responsibilities related to telehealth documentation, County QI timelines, and examining efficiencies and productivity of the psychiatrists and assessment coordinators. As a result, CCYP achieved an increase in the availability of psychiatry hours for clients.

In addition, the assessment coordinator position has been streamlined. Assessment coordinators are required not to see clients monthly, but every six months instead, unless otherwise determined by mental health needs. As a result, assessment coordinators can see more clients and increase efficiency in their day-to-day duties.

Recommendation 2: Continue to develop community partnerships to facilitate transitioning stable clients with less complex medication requirements back to PCPs or FQHCs for medication management.

FY 2020-21 Update: CCYP has made referrals to Children's Primary Care Medical Group (CPCMG) when necessary. Although the partnership with CPCMG has been slow to ramp up, collaboration efforts have increased to date. Additionally, coordinators are aware of the SmartCare referral process and all staff will continue to be trained on SmartCare. As an ongoing effort, leadership will continue to identify and connect with additional alternatives (PCPs and FQHCs) for families who are appropriate for discharge from CCYP.

Recommendation 3: Continue to develop partnerships with other organizations that provide youth-oriented behavioral health services but have insufficient or nonexistent access to psychiatric medication management services.

FY 2020-21 Update: Partnership development has shown expansion over the last year with more ancillary clients being served, a partnership with BHConnect, and increased numbers of County-contracted programs receiving CCYP services.

Recommendation 4: Examine strategies to enhance client active engagement in services.

FY 2020-21 Update: To enhance engagement, CCYP has developed a strategy to expand the information on their website. For example, CCYP developed and distributed a monthly newsletter starting in FY 2021-

22. The newsletter will highlight an article written by one of the psychiatrists and focus on a common diagnosis, its intervention strategies, and medication considerations. Additional information will include healthy recipes, no or low-cost community activities, and other community and educational resources. Special consideration will be given to the reader's attention span and capabilities so that the newsletter can effectively offer useful solutions, educate caregivers, and provide a knowledge base of community resources.

Recommendation 5: Revise evaluation approach to minimize staff and participant burden, while still generating information relevant to enhancing understanding of CCYP program outcomes and opportunities for improvement.

FY 2020-21 Update: The evaluation team and program leadership collaboratively decided to stop using an assessment tool that was determined to not generate useful information in order to reduce participant and staff burden. To generate information from which to better understand participant experiences and perceptions, particularly related to telehealth service provision, new brief survey tools were developed and distributed to CCYP participants.

New Program Recommendations

1. Continue to develop educational and outreach oriented CCYP website (e.g., basic materials about disorders, resource library for caregivers, resource library for providers, past newsletters, commonly used handouts or worksheets).
2. Assess staffing requirements and/or staffing supports needed to best serve the unique service needs of the “maintenance” and “ancillary” CCYP populations.
3. Explore opportunities to provide families with the equipment needed to obtain essential vital signs at home such as blood pressure monitoring tools.

Conclusion

During FY 2020-21, the third year of program operations, CCYP served a total of 499 children and youth (419 maintenance and 80 ancillary clients). Of these, 258 enrolled in CCYP during FY 2020-21 (190 maintenance referrals and 68 ancillary referrals). CCYP enrolled substantially more persons than discharged during FY 2020-21 (258 to 135). This rate of annual growth will contribute to program capacity challenges that will potentially limit future availability for new enrollment without changes to staffing levels or discharge patterns.

Growth can be partially attributed to CCYP enrolling an increased number of ancillary youth (i.e., over 25% of new CCYP enrollees during FY 2020-21), who continued to receive therapy services at another organization while CCYP provided needed medication management or psychiatric care. Based on staff feedback and CCYP service utilization data, the ancillary youth appear to have higher acuity needs and require additional attention by CCYP in order to support coordination and communication with the external organization providing ongoing therapy.

During FY 2020-21, CCYP maintenance youth typically received services for more than a year (i.e., median length of stay for those who discharged during FY 2020-21 was 433 days). Overall, CCYP maintenance enrollees utilized crisis or acute care BHS services at a rate similar to or lower than prior to CCYP enrollment.

Due to the inclusion of telehealth services in CCYP's initial design, the program continued to serve clients during the ongoing COVID-19 pandemic without substantial disruption to services. Staff and caregiver feedback provided in FY 2020-21 expressed favorable views of telehealth services. Telehealth services are expected to remain a primary modality for providing services even if in-person services become more available.

Although pragmatic needs remain, CCYP is developing the program's ability to address these issues. Community partnerships have expanded to meet the needs of the service population and opportunities for enhanced client engagement are being explored via digital spaces such as the CCYP website and mailing lists. Remaining challenges are specific to caregiver or client needs that could be supported by in-person solutions, specifically challenges related to technological barriers to telehealth and assistance obtaining lab draws and vitals.

For more information about this Innovation program and/or the report please contact:

David Sommerfeld, Ph.D. (dsommerfeld@health.ucsd.edu)

Appendix

Participant Characteristics of Persons Enrolled during FY 2020-21

Characteristic	Total Participants (N=258)	
Age Group	N	%
5 to 11	79	30.6%
12 to 15	95	36.8%
16 to 17	69	26.7%
18 to 20	15	5.8%
Total	258	100%
Gender	N	%
Male	121	46.9%
Female	135	52.3%
Prefer not to answer	2	0.8%
Total	258	100%
Sexual Orientation	N	%
Heterosexual or straight	156	60.5%
Gay or lesbian	5	1.9%
Bisexual/Pansexual/Sexually fluid	32	12.4%
Questioning/Unsure of sexual orientation	11	4.3%
Other sexual orientation	5	1.9%
Missing/Prefer Not to Answer	49	19.0%
Total	258	100%
Language	N	%
English	229	88.8%
Spanish	21	8.1%
Other	8	3.1%
Total	258	100%
Race/Ethnicity	N	%
African American	32	12.4%
Asian	21	8.1%
Hispanic or Latino	144	55.8%
White	115	44.6%
Multiple	55	21.3%

Characteristic	Total Participants (N=258)	
Other	7	2.8%
Total[1]	-	-
Mental Health Diagnosis[2]	N	%
Depressive Disorders	76	29.5%
ADHD	62	24.0%
Anxiety Disorders	36	14.0%
PTSD/Acute stress reaction	33	12.8%
Bipolar Disorders	19	7.4%
Oppositional/ Conduct Disorders	8	3.1%
Dual diagnosis	7	2.7%
Schizophrenia/ Other Psychotic Disorders	7	2.7%
Other Disorder	10	3.8%
Total	258	100%
Disability	N	%
Yes, has a disability	31	12.0%
No, does not have a disability	227	88.0%
Total	258	100%
Type of Disability	N	%
Seeing	7	2.7%
Other Communication	5	1.9%
Learning	14	5.4%
Developmental	6	2.3%
Physical/Chronic/Other	6	2.3%
Total[3]	-	-

[1] Total may exceed 100% since participants could select more than one response.
[2] Mental health diagnosis information is obtained from BHS Cerner data system.
[3] Since participants could select more than one specific non-mental health related disability, the percentages may total more than the percent who indicated having any disability.

APPENDIX P

GLOSSARY OF ACRONYMS

Glossary of Acronyms

ACE:	Alliance for Community Empowerment
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
BPSR:	Bio Psycho Social Rehabilitation
CalMHSA:	California Mental Health Services Authority
CalWORKs:	California Work Opportunity and Responsibility to Kids
CASRC:	Child and Adolescent Research Center
CCRT:	Cultural Competency Resource Team
CFTN:	Capital Facilities and Technological Needs
CHFFA:	California Health Facility Financing Authority
CHW:	Community Health Workers
CWS:	Child Welfare Services
CLAS:	Culturally and Linguistically Appropriate Services
CREST:	Cognitive Rehabilitative and Exposure Sorting Therapy
CSEC:	Commercially Sexually Exploited Children
CPP:	Community Planning Process
CSU:	Crisis Stabilization Unit
CSS:	Community Services and Supports
CYF:	Children, Youth, and Families
DMC/ODS:	Drug Medi-Cal Organized Delivery System
EMASS:	Elder Multicultural Access and Support Services
ESU:	Emergency Screening Unit
FSP:	Full Service Partnership
FY:	Fiscal Year
HHSA:	Health and Human Services Agency
HCDS:	Housing and Community Development Services
HOW:	Homeless Outreach Workers
HSRC:	Health Services Research Center
ICM:	Institutional Case Management
IHOT:	In-Home Outreach Team
ILA:	Independent Living Association
IMAR:	Illness Management Recovery
INN:	Innovation
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
NAMI:	National Alliance on Mental Illness
NPLH:	No Place Like Home
OE:	Outreach and Engagement
PERT:	Psychiatric Emergency Response Team
PEI:	Prevention and Early Intervention
PIT:	Performance Enhancement Team
PSC:	Peer Specialist Coaches
POFA:	Project One for All
QI:	Quality Improvement
REACH:	Resources for Enhancing Alzheimer's Caregiver Health
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
START:	Short-Term Acute Residential Treatment
SUD:	Substance Use Disorder
TAOA:	Transition Age Youth, Adults and Older Adults
TAY:	Transition Age Youth
TN:	Technological Needs
UCSD:	University of California, San Diego
WET:	Workforce Education and Training
WIC:	California Welfare and Institutions Code
WRAP:	Wellness Recovery Action Plan

APPENDIX Q

GLOSSARY OF TERMS

Glossary of Terms

Aftercare: a program of outpatient treatment and support services provided for individuals discharged from an institution, such as a hospital or mental health facility, to help maintain improvement, prevent relapse, and aid adjustment of the individual to the community. Aftercare may also refer to inpatient services provided for convalescent patients, such as those who are recovering from surgery.

Assertive Community Treatment (ACT): a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address every aspect of their life, whether it is medication, therapy, social support, employment, or housing.

CalAIM: (California Advancing and Innovating Medi-Cal) is a multi-year initiative by the California Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal members through broad delivery system, program and payment reform across the Medi-Cal program.

Case Management: a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

Cognitive Training: a term that reflects the theory that cognitive abilities can be maintained or improved by exercising the brain, in an analogy to the way physical fitness is improved by exercising the body.

Complex Behavioral Health Conditions: can include serious mental illness (e.g., schizophrenia, bipolar disorder, or major depressive disorder) or other mental health conditions, with or without co-occurring substance use disorders that, individually or in combination, have an impact on one or more functional abilities. Functional limitations can impede an individual's ability to live independently at home and engage in the community.

Crisis Intervention: is the brief 'first-aid' use of psychotherapy or counseling to persons who have undergone a highly disruptive experience, such as an unexpected bereavement or a disaster. Crisis intervention may prevent more serious consequences of the experience, such as posttraumatic stress disorder. It is also a psychological intervention provided on a short-term, emergency basis for individuals experiencing mental health crises, such as an acute psychotic episode or attempted

Culturally Appropriate: community interventions that are defined as meeting each of the following characteristics: (a) The intervention is based on the cultural values of the group, (b) the strategies that make up the intervention reflect the subjective culture (attitudes, expectancies, norms) of the group, and (c) the components that make up the strategies reflect the behavioral preferences and expectations of the group's member.

Exposure Therapy: a form of therapy in which clinicians create a safe environment in which to "expose" individuals to the things they fear and avoid. The exposure to the feared objects, activities or situations in a safe environment helps reduce fear and decrease avoidance.

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.

Motivational Interviewing: a client-centered yet directive approach for facilitating change by helping people to resolve ambivalence and find intrinsic reasons for making needed behavior change. Originally designed for people with substance use disorders, motivational interviewing is now broadly applied in health care, psychotherapy, correctional, and counseling settings. It is particularly applicable when low intrinsic motivation for change is an obstacle. Rather than advocating for and suggesting methods for change, this approach seeks to elicit the client's own goals, values, and motivation for change and to negotiate appropriate methods for achieving it.

Outreach: an activity of providing services to any populations who might not otherwise have access to those services. In addition to delivering services, outreach has an educational role, raising the awareness of existing services.

Peer Support: counseling or support by an individual who has experience and/or status equal to that of the client.

Personal Health Record (PHR): an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorized, in a private, secure, and confidential environment. A PHR includes health information managed by the individual. The clinician's record of patient encounter, a paper- chart or electronic medical record (EHR) is managed by the clinician and/or health care institution.

Primary Care: basic or general health care a patient receives when he or she first seeks assistance from a health care system provided by licensed general practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians.

Psychiatric Assessments: evaluations based on present problems and symptoms, of an individual's biological, mental, and social functioning, which may or may not result in a diagnosis of a mental illness.

Screening, Brief Intervention and Referral to Treatment (SBIRT): an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. The SBIRT model was incited by an Institute of Medicine recommendation that called for community-based screening for health risk behaviors, including substance use.

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 aged 18 or older 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, 422 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 communitybased organizations, health professionals and related professionals to reduce the incidence of suicide; reduce factors that increase the risk for suicidal thoughts and behaviors; and increase the factors that help strengthen, support, and protect individuals from suicide.

Supplemental Security Income benefits (SSI): pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. SSI is a federal income supplement program funded by general taxes. It is designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

Supportive Housing: an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities.

Trauma Informed Care: a style of care that accounts for the widespread impact of trauma and the understanding of potential paths for recovery. It includes the recognition of the signs and symptoms of trauma in clients, families, staff, and others. Organizations that are traumainformed 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 R

STAKEHOLDER COMMENTS