COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years 2020-21 through 2022-23

Behavioral Health Services

October 27, 2020

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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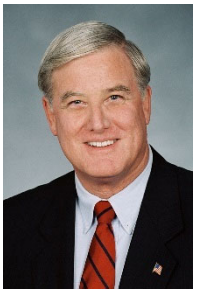
San Diego County Board of Supervisors



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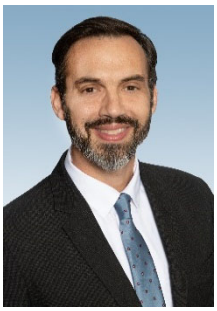

Luke Bergmann, Ph.D.
Director, Behavioral Health Services
Health and Human Services Agency

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A LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR

The Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years (FY) 2020-21 through 2022-23 (Three-Year Plan) is an opportunity for the County of San Diego Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) department to inform stakeholders, partners, clients, community members, and the Board of Supervisors of MHSA programmatic and funding priorities for the next three years and highlight some accomplishments from FY 2018-19. For FY 2020-21, the County of San Diego Chief Administrative Officer's Adopted Operational Plan (budget) for BHS is $778.5 million, with MHSA programs comprising over one third of the total budget for HHSA.

Our continued objective for BHS is to move forward with a bold, cross-sectoral approach to dramatically shift how residents of San Diego county access care and support for their behavioral health needs by transforming into a regionally distributed system characterized by upstream prevention and continuous care, rather than perpetual crisis. While we move toward this goal, the COVID-19 pandemic has been both a public health and behavioral health crisis, leading to dramatic changes in the behavioral health care and service landscape and calling for adjustments to our strategic and tactical approaches. In all this work we aim to make programmatic and investment decisions with health equity across race, class, gender and geography, in mind. The continued provision of MHSA services remains critical in achieving an integrated, seamless, and outcome-oriented behavioral health continuum.

I want to highlight some of the key priorities and achievements of BHS within this current climate, which include:

- Continuing support to our providers in the midst of a truly impressive transition from face-to-face contact to telehealth care as part of the COVID-19 response; the instantaneous adoption of telehealth services has been an incredible feat and a testament to the commitments of our community's treatment providers.
- Continuing the transformation of the Behavioral Health Continuum and meeting the increasingly urgent behavioral health needs of our communities; we have made significant progress on this work over the past year, including the expansion of crisis care as part of network services, and advancing the children's and Central Region behavioral health hubs and associated care coordination services.
- Focusing investments on continuum services that yield immediate impacts, including diversionary services, that keep people out of acute care but connect them to ongoing continuous care, long-term care and support, and care coordination services to maintain hospital availability for the COVID response, while keeping people connected to behavioral healthcare and extending our reach to those not currently receiving needed care.

Moving forward, we plan to continue key collaborations with partners, stakeholders, consumers, and other community members to maintain the health of our region while building a system that achieves the most collective impact so all residents are able to live well and thrive.

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 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 mental health programs and monitors progress toward statewide goals for children, transition-age youth (TAY), adults, older adults, and families. It supports programs to help with prevention and early intervention needs, and the necessary infrastructure, technology, and training to effectively support the public mental health system. Counties also 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 of San Diego must turn its emphasis to improving processes and focus on the most effective approaches demonstrated by successful outcomes.

In San Diego County, a majority of MHSA services are provided by community-based service providers through competitively procured contracts. To ensure quality services are provided, teams of subject-matter experts within the County of San Diego (County) Health and Human Services Agency, Behavioral Health Services (BHS) oversee programs through regular contract monitoring and communication with service providers. MHSA programs are client-centered, culturally aware, and employ detailed outcome measures that include clinical and functional improvement or stabilization, progress toward client goals, and achievement of client satisfaction.

As required by the Welfare and Institutions Code, counties must complete a three-year plan and subsequent annual updates for MHSA-funded programs. The most recent MHSA Three-Year Plan for Fiscal Years (FYs) 2017-18 through 2019-20, provided program and expenditure information for 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). This Three-Year Plan provides an overview of the recent Community Planning Process (CPP), and outlines programs for FY 2020-2023.

INVESTMENT OF RESOURCES

The proposed MHSA Three-Year Plan budget for Fiscal Years (FY) 2020-21 through 2022-23 is outlined in the chart below. The budget for FY 2020-21 is $192.8 million, reflecting a decrease of $21.7 million from the MHSA budget for the previous fiscal year due to anticipated increased Medi-Cal revenue drawdown related to COVID-19. By the end of FY 2022-23, the County will have invested an estimated $2.2 billion in MHSA programs since inception.

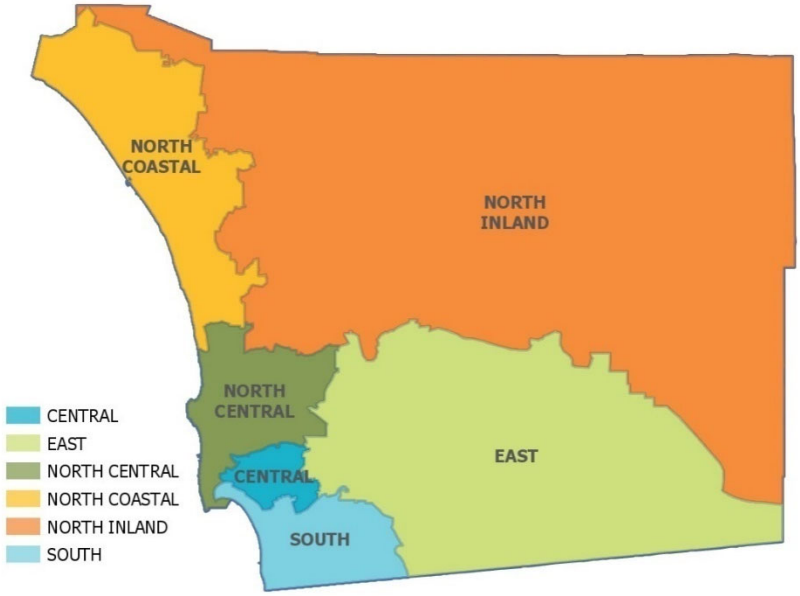
MHSA Component	*FY 2020-21 Budget*	*Percent of MHSA Budget*	*FY 2021-22 Budget*	*Percent of MHSA Budget*	*FY 2022-23 Budget*	*Percent of MHSA Budget*
Community Services and Supports (CSS)	$154,585,027	80%	$157,474,156	81%	$155,531,356	80%
Prevention and Early Intervention (PEI)	$26,723,724	14%	$26,323,724	13%	$26,323,724	14%
Innovation (INN)	$7,931,484	4%	$7,931,484	4%	$7,931,484	4%
Workforce Education and Training (WET)	$3,605,648	2%	$3,605,648	2%	$3,605,648	2%
Capital Facilities and Technological Needs (CFTN)	$0	0%	$0	0%	$0	0%
Total	**$192,845,883**	**100%**	**$195,335,011**	**100%**	**$193,392,212**	**100%**

The MHSA Three-Year Plan budget is based on priorities identified during the CPP in conjunction with staff recommendations.

A summary of the proposed expenditures by MHSA component for FYs 2020-21, 2021-22 and 2022-23 is available in Appendix A. Summaries of all programs funded with MHSA dollars are available in Appendix C.

LIVE WELL SAN DIEGO

Implementation of the MHSA demonstrates 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 customer-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 2018-19, MHSA-funded programs provided services to more than 78,000 children, youth and families, transition-age youth, adults, and older adults in the San Diego County, with an emphasis on individuals who were unserved or underserved.

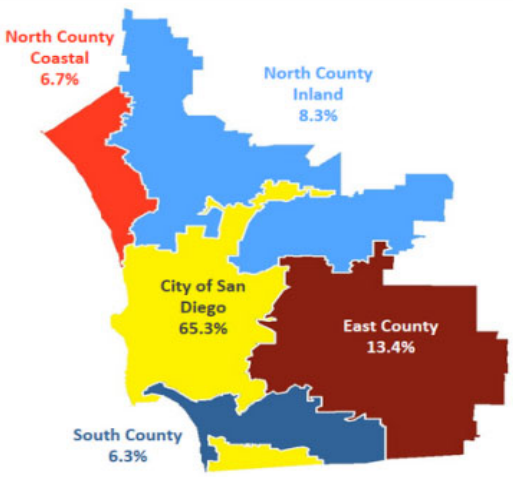


HOMELESSNESS AND HOUSING

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). In January 2020, more than 1,500 volunteers and outreach workers across San Diego County participated in the 2020 Point-in-Time Count, an annual effort to identify the number of persons experiencing homelessness in San Diego County. According to the 2020 WeAllCount Annual Report[1], an estimated 7,619 (3,648 sheltered and 3,971 unsheltered) men, women, and children identified as experiencing homeless in San Diego County. Of those, 8

[1] 2020 WeAllCount Annual Report: https://www.rtfhsd.org/wp-content/uploads/WeAllCount.pdf [as of July 9, 2020]

percent were veterans, 17 percent were chronically homeless, 8 percent were unsheltered youth, and 52 families were unsheltered. This count included changes in methodology to meet new Housing and Urban Development (HUD) requirements to count individuals experiencing homelessness in conditions that are considered unsheltered, including living on park benches, on sidewalks, in tents, and in vehicles. MHSA programs continue to provide extensive outreach, engagement, treatment services, and permanent supportive housing to individuals with SMI who are experiencing homelessness. The map to the right outlines the homeless population, by region, identified in the 2020 WeAllCount report.



PROJECT ONE FOR ALL (POFA)

In February 2016, the San Diego County Board of Supervisors implemented Project One for All (POFA) to connect 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, primary health care, social services, and housing to ensure they are able to become more stable and live lives that are more productive. As of February 29, 2020, 1,402 individuals experiencing homelessness were housed and received BHS 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), which, upon completion, will result in approximately 378 permanent supportive housing units. Of the 378 units, 304 have been operationalized, 25 units are scheduled to begin leasing by fall 2020, and 49 units are planned for development.

Status	*# of Housing Units*
Operationalized	304
Scheduled to be Leased	25
Planned for Development	49
Total Housing Units	**378**

NO PLACE LIKE HOME (NPLH)

On July 1, 2016, Governor Brown signed NPLH 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 assisted units in rental housing developments, including costs associated with the 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 (State HCD) 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 provide mental health services and help coordinate

access to other community-based supportive services. On November 6, 2018, Proposition 2, the ballot initiative to implement the No Place Like Home Act of 2018 was approved by voters through a statewide general election. Beginning in FY 2019-20, funding for debt service is excluded from MHSA revenue received by the counties. In FY 2018-19, MHSA funds were allocated to fund County staff dedicated to support the implementation and administration of the NPLH program, as outlined in Appendix A. In FY 2020-21 there are a total of four developments, totaling 133 NPLH units with conditional NPLH funding and services commitments.

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION

Many MHSA programs provide access and support for individuals either 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 2020-21, the total estimated investment in justice-related MHSA programs will be over $37 million.

See Appendix D for a list of MHSA programs that serve justice-involved clients.

PRUDENT RESERVE

Per Welfare and Institutions Code (WIC) 5847(b)(7), counties are required to establish and maintain a prudent reserve to ensure children, adults, families, and seniors can continue receiving services at current levels in the event of an economic downturn. In compliance with this guidance, the County's prudent reserve totals $33,478,186 equivalent to 33 percent of the County's average distribution for the previous five years. The current prudent reserve is comprised of MHSA Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) component funding totaling $26,712,351 and $6,765,835, respectively.

Due to the COVID-19 pandemic, estimated MHSA revenues may potentially fall below the originally budgeted levels in Fiscal Year 2020-21 and in future years. If expected revenues cannot meet the current programmatic needs, the County will elect to use prudent reserve funds to ensure the continuity of essential MHSA services. BHS may transfer up to $26,712,351 of prudent reserve funds to the CSS component as shown in Appendix A; however, the exact amount is unknown and will be dependent on the Medi-Cal drawdown associated with CSS programs. In compliance with WIC section 5847(i), the County is required to report the exact transfer amount in the MHSA Three Year Plan or Annual Update and reflect the transfer in the MHSA Annual Revenue and Expenditure Report (ARER). Should the need to access prudent reserve funds occur, the County will notify MHSA@dhcs.ca.gov of the intent to access the Prudent Reserve, the amount of Prudent Reserve funds expected to be transferred, and the component to which the funds will be transferred, within 10 business days of the decision to transfer funds under this section. The exact dollar amount will be reflected in a subsequent MHSA Annual Update and MHSA ARER.

THE ROAD AHEAD

BHS continues to move forward with the goal of dramatically shifting how residents of San Diego County access care and support for behavioral health needs by continuing to develop a regionally distributed model of care focused on prevention and continuous care, rather than perpetual crisis. Adding further complexity, the COVID-19 pandemic has greatly impacted our vulnerable populations and our system's financial, staffing, infrastructure, and other resources, creating new challenges to address; however, the delivery of essential behavioral health services within the community continues to be more critical than ever.

To ensure the continuity of essential services going forward, BHS continues to work diligently to identify short-, mid- and long-term mitigation strategies to address the anticipated decrease of MHSA revenues resulting from the pandemic, as follows:

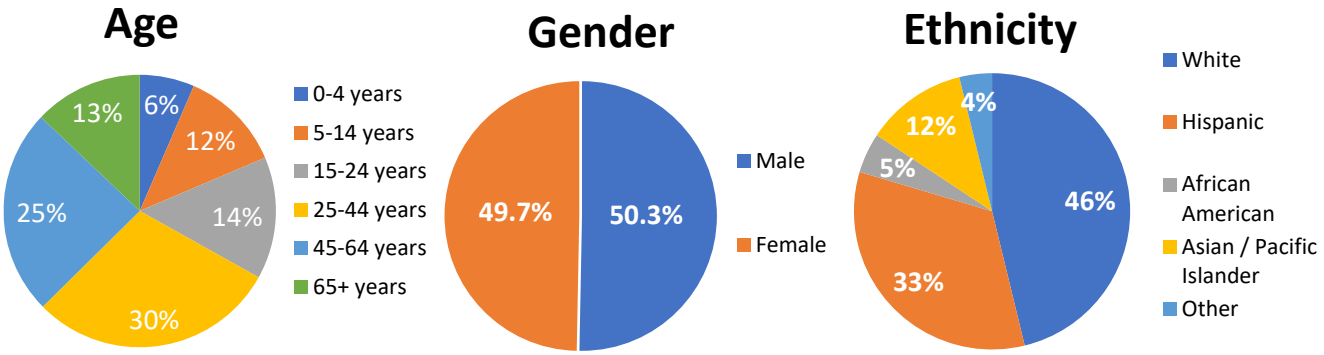
- Utilize MHSA Prudent Reserve funds, as needed, resulting from decreased MHSA revenues resulting from COVID-19 to ensure continuity of critical services. *AB 81 (Chapter 13, Statutes of 2020)*
- Continue support for the flexible use of funds between MHSA components, primarily Community Services and Supports (CSS) and Prevention and Early Intervention (PEI), outside of the prescribed percentage allocations to ensure service continuity. *CSAC Memo, AB 81 (Chapter 13, Statutes of 2020)*
- Reflect enhanced Medi-Cal drawdown in FY 2020-21 (FMAP) associated with COVID-19 in the MHSA Three-Year Program and Expenditure Plan and continue to optimize Medi-Cal (Federal Financial Participation) drawdown across all programs to ensure maximum availability of MHSA funding.
- Continue intensive evaluations of BHS programs to ensure optimal service delivery, maximum efficiency, effective outcomes, and alignment with the BH Continuum of Care.
- Continue pursuing the flexibility to use unspent Innovation (INN) funds for CSS and PEI components, to ensure the continuity of essential MHSA services.

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 estimated population for 2019 was 3,338,330[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 225,000 veterans are estimated to reside in the region along with additional uniformed military personnel and their families.

The estimated demographics for San Diego County based on 2013-2017 U.S. Census data from the American Community Survey 5-year estimates.



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 22 percent of county residents being bilingual. The county's threshold languages continue to be Spanish, Vietnamese, Arabic, Tagalog, and Farsi.

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

[2] Based on US Census Bureau estimated population estimate as of July 1, 2019

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

The Community Program Planning (CPP) process provides a structured way for the County of San Diego (County), in partnership with stakeholders, to collaborate and determine where to focus resources and effectively utilize MHSA funds in order to meet the needs of County residents. The CPP process includes participation from the County's Behavioral Health Advisory Board and System of Care Councils, and other stakeholders, organizations, and individuals. Throughout the year, the County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) stakeholder-led councils also provide a forum for council representatives and the community to stay informed and provide input. The CPP process is ongoing and the County encourages open dialogue to provide all community members with the opportunity to provide input on future planning.

CPP PROCESS

BHS contracted with the Institute for Public Health (IPH) at San Diego State University to coordinate and facilitate the 2019 community engagement process. The objective was to gather the community's perspective on the value of BHS programs and the impact to people receiving services. Beginning in December 2019, BHS conducted its annual Community Engagement Forums as part of its CPP Process. Stakeholders expressed the need to connect with individuals early, and to connect them to the right systems and services before a crisis occurs, and they identified a need for greater regional coordination to ensure effective care coordination across all levels of care. Building upon feedback from previous years, BHS hosted seven forums and convened four discussion groups. Forums were held primarily on weekends and evenings in neighborhood locations (including schools) to encourage community participation.

This year's engagement focused on prevention, innovation, and engagement. Community members identified behavioral health issues related to both substance use and mental health that are of growing concern in the community. They also discussed three proposed innovative program ideas, including enhancing treatment with outdoor activities, providing additional training to school staff to help them build student resiliency, and educating parents about bullying. Finally, the community gave input about how to best engage San Diego residents in the future. Forum participants also completed a satisfaction survey to evaluate the efficacy of the engagement. Forum attendance totaled 224 people. An additional 21 individuals participated in discussion groups, for a total of 251 individuals who participated in this year's process. Participants were actively involved in the events and expressed a high degree of satisfaction with the engagement process.

BHS also collaborated with public safety and justice system stakeholders to strengthen partnerships, develop strategies, and leverage funding for programs. These programs strive to divert clients with serious mental illness (SMI) or serious emotional disturbance (SED) and who are experiencing homelessness from justice system involvement, and provide discharge planning and short-term case management to justice system-involved persons who have SMI or SED as they transition back into the community.

The FY 2019-20 Community Engagement Report can be found in Appendix F.

MHSA THREE-YEAR PLAN REVIEW AND PUBLIC COMMENT PERIOD

A draft of the MHSA Three-Year Plan for Fiscal Years (FY) 2020-21 through 2022-23 was posted on the BHS website and the Clerk of the Board of Supervisors website on September 30, 2020. The plan was sent to BHS stakeholders, including the San Diego Mental Health Coalition, Mental Health Contractors Association, and hospital partners.

The County's Behavioral Health Advisory Board (BHAB), 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, held a public hearing at the conclusion of the 30-day public review and comment period.

Stakeholder comments on the MHSA Three-Year Plan are available in Appendix Q. The MHSA Issue Resolution Process for filing and resolving stakeholder concerns related to the MHSA CPP, and consistency between program implementation and approved plans, is available in Appendix G.

MHSA-FUNDED PROGRAMS

The section below summarizes all MHSA-funded programs for Fiscal Years 2020-21 through 2022-23, including a brief summary of each along with accomplishments from FY 2018-19. The programs are outlined for four of the five MHSA components, including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN) and Workforce Education and Training (WET). MHSA Capital Facilities and Technological Needs (CFTN) funds were one-time funding allocations that have been fully expended.

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 serious mental illness (SMI) or serious emotional disturbance (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 2020-21, the estimated total MHSA budget for CSS programs is $154,585,027.

Up to $3.6 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 or 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 2020-21.

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

System Development (SD) programs improve existing services and supports for individuals who currently receive services. This includes peer support (e.g. wellness centers), education, advocacy, and mobile crisis teams. 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 FY 2018-19 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 serious emotional disturbance (SED) and their families, including transition-age youth (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 full service partnership (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 2018-19 outcome report for children and adolescents is available in Appendix I.

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

In FY 2020-21, the estimated total MHSA budget for CY-FSP programs is $15,697,810. In FY 2020-21, the estimated annual cost per unduplicated client served in CY-FSP programs is $5,017, inclusive of all funding, and the estimated number of unduplicated clients to be served is 9,564.

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. In FY 2018-19, the program served 178 unique clients.

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 wellbeing. Partnership with the family, primary care, and education is a primary focus of successful treatment. In FY 2018-19, 25 school based FSP programs served 9,082 unique clients.

FAMILY THERAPY (CY-FSP)

The family therapy participation engagement program is a component of selected outpatient mental health clinics which uses parent partners with lived experience to provide education and support to caregivers of children and youth with SED. The program educates caregivers on the benefits of being actively engaged in

the treatment process and works collaboratively with the family to address and resolve barriers to participation. In FY 2018-19, 6 family therapy programs served 1,049 unique 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. In FY 2018-19, TBS served 833 unique clients.

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

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth who are 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 87% of youth participating in the WRAP programs avoided psychiatric hospitalization or re-hospitalization during treatment, and 97% of youth enrolled in the program avoided placement in a higher level of care. In FY 2018-19, 2 WRAP programs served 346 unique clients.

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

In FY 2020-21, the estimated total MHSA budget for CY-OE programs is $1,599,163; the estimated cost per unduplicated client served in CY-OE programs is $677, inclusive of all funding; and the estimated number of unduplicated clients to be served is 2,363.

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 those 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 2018-19, 6 programs with 12 HOWs served 2,699 unique clients.

FAMILY & YOUTH PARTNERSHIP (CY-OE)

Family & Youth Partnership 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. In FY 2018-19, 90 families were provided outreach and engagement, and of those, 85 youth received case management services.

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

In FY 2020-21, the estimated total MHSA budget for CY-SD programs is $11,528,861; the estimated cost per unduplicated client served in CY-SD programs is $3,454, inclusive of all funding; and the estimated number of unduplicated clients to be served is 5,864.

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.

ADOLESCENT DAY REHABILITATION (CY-SD)

Adolescent day rehabilitation provides a specialized curriculum within a congregate-care setting for foster youth that offers independent living skills. These services support the youths' transition into adulthood by increasing their knowledge of community resources, providing employment development services, teaching life skills, and encouraging self-sufficiency. In FY 2018-19, the program provided life skills training to 12 unique clients.

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 information collected to the CYF administration about the communities' behavioral health needs. The contract was amended in January 2019 to include the additional cloud-based trainings. In the second half of FY 2018-19 from January to June, a total of 110 individuals participated in 11 collaborations.

BRIDGEWAYS (CY-SD)

Bridgeways provides individual, group, and family therapy with medication management to youth that are at risk or currently involved in the juvenile justice system and have mental health and or substance use needs. Services are provided in the community or home to offer better access to services. Bridgeways also provides psychoeducational groups and coordinates with the youth's probation officer to assist with linkage to services upon release from detention facilities. In FY 2018-19, Bridgeways served 65 unique clients.

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 2018-19, the program provided treatment services to 36 youth and supported 66 youth through the drop-in center.

COUNTY OF SAN DIEGO - JUVENILE FORENSIC SERVICES (CY-SD)

The Juvenile Forensic Services STAT (Stabilization, Treatment and Transition) Team provides a full range of mental health services to SED youth currently on probation. The STAT Team services are designed to meet the individual need of the youth's family and cultural dynamics. The goals of the team, in addition to providing crisis mental health services, are to maximize successful transitions into the community, to reduce recidivism, and improve mental health outcomes. In FY 2018-19, the STAT Team provided transitional services to 393 unique clients.

CRISIS ACTION AND CONNECTION (CAC) (CY-SD)

The Crisis Action and Connection program provides children and youth who have had a recent acute psychiatric episode with intensive support and linkage to services and community resources. This program improves access to, and benefits of, mental health services to children, youth, and their families, which helps to divert or prevent use of acute services. The overall program was strengthened through two MHSA components known as Rapid Response and Intensive Respite. Rapid Response partners with PERT to expedite deployment of clinicians to support the youth and avoid escalation. Intensive Respite supports the mental health needs of youth who are in a short-term respite setting. In FY 2018-19, the program served 622 unduplicated clients. 42% of program referrals have been received as a step down from the emergency services unit. 34% of CAC referrals have been received as a step down from inpatient services.

EMERGENCY SCREENING UNIT (ESU) (CY-SD)

The Emergency Screening Unit provides emergency screening and crisis intervention services as a diversion from inpatient psychiatric hospitalizations, to children and adolescents experiencing a psychiatric crisis. The state-of-the-art facility is centrally located in Hillcrest and has 12 beds available. In FY 2018-19, the program provided 1,997 assessments, and had a 23% increase in utilization since the program expanded their bed capacity from 4 to 12 beds. The program successfully diverted 72% individuals who received ESU services from entering into a higher level of care such as emergency departments.

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

The Incredible Families – Child Welfare Services program, which provides parenting support groups and outpatient mental health treatment services for children and families involved with CWS, promotes children to be reunited with their families in the home. The program enhances parenting skills and strengthens the bond between parent and child. In FY 2018-19, Incredible Families supported approximately 200 parents who completed the parenting group and were successfully reunited with their children.

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 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. Families can also utilize case management and family partner support services through the program. 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. In FY2018-19, the program served 139 children and their families.

MEDICATION SUPPORT FOR WARDS AND DEPENDENTS (CY-SD)

The medication support program provides short-term individual and family treatment, medication management and linkage to community-based treatments for children and youth who are involved in the juvenile justice or child welfare systems. Connection to treatment is provided for up to 90 days and includes stabilization, support, linkage, and coordination to community providers. In FY 2018-19, the program served 88 unduplicated clients and completed 639 medication support evaluations.

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 2018-19, the program served a total of 78 unique clients.

PEER MENTORING (CY-SD)

The San Pasqual Academy (SPA) program provides individual, group, and family services to the County of San Diego Health and Human Services Agency, Child Welfare Services (CWS) youth in placement, and foster youth in residential settings. Services include: individual, group and family treatment; care coordination; case management; rehabilitative services; medication services; and peer mentorship to promote growth towards independence and self-sufficiency as youth transition to adulthood. Through the peer mentoring program, alumni who have successfully transitioned from SPA provide support to current students by modeling job skills, strong work ethic, and relationship skills. Peer mentors also provide awareness of independent living options, and information on how to facilitate growth toward independence and strengthen self-confidence. In FY 2018-19, 45 unique mentees participated in the program.

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. In FY 2018-19, services were provided to approximately 200 children and youth to provide a stable environment both at home and school.

RURAL INTEGRATED BEHAVIORAL HEALTH AND PRIMARY CARE SERVICES (CY-SD)

Rural Integrated Behavioral Health and Primary Care specialists provide behavioral health education and support to prevent the development of serious mental illness or addiction within rural community. The program helps patients manage their whole-person wellness, including emotional and behavioral concerns. Prevention and early intervention materials and education support is provided to prevent the development of SMI, SED or addiction in individuals of all ages.

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

Supplemental Security Income (SSI) Advocacy services submits SSI applications for eligible individuals to the Social Security Administration and provides follow-up, if needed. The program is able to expedite SSI awards

to individuals, and provide training, consultations, outreach, and education. In FY 2018-19, SSI Advocacy Services completed 207 child-specific applications, of which 89 resulted in an award.

TELEMEDICINE (CY-SD)

Telemedicine provides video, secure email, and phone consultation to improve accessibility of care in underserved and rural areas. It helps maintain technological infrastructure for the mental health system to ensure high-quality, cost-effective services, and support for clients and their families. Telepsychiatry services are made available for those clients that are unable to meet face-to-face with a psychiatrist. In FY 2018-19, the telemedicine program served 31 unique clients and provided 64 telepsychiatry sessions.

WALK-IN ASSESSMENT CLINIC AND MOBILE ASSESSMENT TEAM (CY-SD)

The Walk-In Assessment Clinic and Mobile Assessment Team provides mobile mental health crisis response and intervention services as well as walk-in assessment clinics for the North County. The program reduces the use of emergency and inpatient services, prevents escalation, and promotes the management of mental illness. In FY 2018-19, the program served 329 unique clients. 100% of clients served did not require hospital emergency room admittance or inpatient services.

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

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

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

The FSP ACT outcome report for TAY, adults and older adults is available in Appendix J. The Fiscal Year (FY) 2018-19 Update to the Five-Year BHS Housing Plan is available in Appendix K. Details of the housing projects funded through MHSA CSS funds can be found here: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa_housing.html

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

In FY 2020-21, the estimated total MHSA budget for TAOA-FSP programs is $49,091,740, with estimated cost per unduplicated client served in TAOA-FSP programs at $8,713 for TAY and adults, and $18,791 for older adults, inclusive of all funding. The estimated number of unduplicated clients to be served is 7,086 and 456, respectively.

ADULT RESIDENTIAL TREATMENT (TAOA-FSP)

The adult residential treatment program provides a broad range of services in a residential environment to assist individuals improve their quality of life and work towards independent living. These services include physical health screening and referrals to primary care professionals, wellness groups, peer support services, mentoring, and employment and education assistance.

ASSISTED OUTPATIENT TREATMENT (AOT) (TAOA-FSP)

Assisted Outpatient Treatment is an intensive, community-based service for persons who establish an AOT court settlement agreement, persons who are court-ordered to receive AOT, and persons who otherwise meet the AOT eligibility criteria. This program integrates behavioral health and rehabilitation treatment and recovery services for adults with a serious mental illness who have been identified as potential AOT candidates by the County of San Diego. In FY 2018-19, the program served 70 unique clients and the program had 39 admissions.

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 2018-19, the program served 121 unique 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.

COUNTY OF SAN DIEGO - PROBATION (TAOA-FSP)

The Probation Department provides a Probation Officer for FSP/ACT programs through behavioral health court. The staff provides 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.

CRISIS RESIDENTIAL SERVICES - NORTH INLAND (TAOA-FSP)

The North Inland Crisis Residential program is a short-term crisis residential facility with 15 beds that serves adults with SMI and co-occurring disorders. It is open twenty-four hours a day, seven days a week and provides mental health outpatient services as an alternative to hospitalization or step down from acute care within a hospital. In FY 2018-19, the program served 434 unique clients.

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 to achieve success and independence. These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as crisis stabilization, crisis outpatient, crisis residential, and services provided at the psychiatric hospital. ACT teams provide medication management, mental health services, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community.

In FY 2018-19, 2,886 unique clients were served through the 20 ACT programs resulting in a 44% overall reduction in emergency services from pre- to post-assessment. Additionally, there was a 63 percent reduction in the mean number of days spent and a 58 percent reduction in the number of FSP/ACT clients residing in: restrictive settings, including jail or prison, a state psychiatric hospital, and long-term care from pre- to post-assessment.

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 homelessness 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.

FULL SERVICE PARTNERSHIP (FSP) / ASSERTIVE COMMUNITY TREATMENT (ACT) - STEP DOWN FROM ACUTE (TAOA-FSP)

The FSP/ACT step down from acute program provides ACT services to clients with SMI who are homeless or at risk of homelessness and who are stepping down from acute care. These clients are not connected to outpatient services and are being discharged from an acute-care facility back into the community. The step-down program increases clinical and functional stability through a variety of mental health services, housing opportunities and educational and employment supports. The ACT program also provides strength-based case management (SBCM) services to clients who are not able to transition to a stand-alone SBCM program.

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

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

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 within a transitional residential program to increase independent living and reduce hospitalizations through educational and employment opportunities. Clients are not connected to outpatient services. The program increases clinical and functional stability through a variety of mental health services, housing opportunities, and educational and employment support. The program also provides SBCM services to clients who are not able to transition to a stand-alone SBCM program.

PAYEE CASE MANAGEMENT SERVICES (TAOA-FSP)

Payee case management services with a rehabilitation and recovery focus provide educational services to increase clients' money management skills, which includes the bio-psychosocial rehabilitation (BPSR) component. The program's goal is to assist in the development of skills and resources for clients to become their own payee or obtain a payee from outside the formal mental health system. In FY 2018-19, the program served 90 unique clients.

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

The program provides short-term, intensive case management services utilizing the ACT treatment model. Teams work toward preventing unnecessary hospitalization, improving quality of life, and improving client function. The program uses evidence-based models of intervention, such as ACT and SBCM. Participation in the program results in reduced hospitalizations, reduced recidivism, and improved quality of life. In FY 2018-19, the program served 428 unique clients.

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 2018-19, the program served 221 unique clients.

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

In FY 2020-21, the estimated total MHSA budget for TAOA-OE programs is $772,702; the estimated cost per unduplicated client served in TAOA-OE programs is $288, inclusive of all funding; and the estimated number of unduplicated clients to be served is 4,334.

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 2018-19, the program served 3,821 unique clients.

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

In FY 2020-21, the estimated total MHSA budget for TAOA-SD programs is $46,516,212; the estimated cost per unduplicated client served in TAOA-SD programs is $2,150, inclusive of all funding; and the estimated number of unduplicated clients to be served is 40,823.

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 2018-19, 73 clients out of 167 (51%) showed improvement in psychosocial skills, and 14 clients were discharged to a lower level of care.

BEHAVIORAL HEALTH ASSESSORS (TAOA-SD)

Behavioral health assessors screen, assess, and provide linkage for individuals being discharged from jail into behavioral health treatment and services in the community. This program provides comprehensive, integrated and culturally competent mental health services for individuals with SMI who have been found guilty of a non-violent crime and are awaiting sentencing. The program goal is to reduce incarceration, reduce homelessness, and provide timely access to services.

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 2018-19 the program served 3,287 unique 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 2018-19, the program served 3,821 unique clients.

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 2018-19, the program served 2,039 unique clients.

CLUBHOUSE (TAOA-SD)

Clubhouses provide rehabilitative, recovery, vocational services, and support to adults throughout the county. The program assists members with improving social skills, reducing isolation, and achieving independent functioning. Clubhouses aim to increase client self-sufficiency through the development of life skills, creating and maintaining relationships, sustaining housing, and supporting employment and education. In FY 2018-19, the program served 4,340 unique clients.

CRISIS STABILIZATION UNIT (CSU) - NORTH INLAND (TAOA-SD)

The North Inland CSU at Palomar Health provides critical treatment services in a hospital-based setting adjacent to the emergency or urgent care unit at Palomar Hospital in Escondido 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 FY 2018-19, the program served 978 unique clients.

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

The South Region CSU will provide 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 will provide 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 will have access to emergency department services if medical crises arise. The South Region CSU is a new program planned to be operational in FY 2020-21.

FAITH-BASED SERVICES (TAOA-SD)

The Faith-Based Services program provides community education, and faith-based behavioral health training and education in the North, Central, and North Central Regions, along with faith-based wellness and a mental health ministry that provides services countywide. The program focuses on client-driven services to improve functioning, quality of life by decreasing isolation, and increasing values and self-sufficiency. Faith-Based In-Reach service is a collaboration with the Sheriff and jails that pairs a mental health clinician with a member of the clergy to provide a "bridging service" between custody and community. In FY 2018-19, the program trained 360 unique clients.

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 improves supportive relationships. In FY 2018-19, the program served 371 unique clients.

HOME FINDER (TAOA-SD)

The Home Finder program provides outreach and engagement, housing navigation and location, and tenant-support services to individuals with SMI who are experiencing homelessness to identify and secure safe and

affordable housing. Staff are co-located at two Behavioral Health Services outpatient clinics to engage clients and help them find housing. In FY 2018-19, the program served 235 unique clients.

IN-HOME OUTREACH TEAMS (IHOT) (TAOA-SD)

IHOT teams are mobile clinicians who visit individuals with SMI who are difficult to engage and typically will not seek treatment on their own. IHOT teams visit individuals in their homes to assess and engage them, with the goal of linking them to the appropriate treatment services. In FY 2018-19, the program served 293 unique clients and 229 unique family members.

INPATIENT AND RESIDENTIAL ADVOCACY SERVICES (TAOA-SD)

Inpatient and Residential Advocacy Services offers on-going support, advocacy services, and training to staff and residents who are currently in County-identified skilled nursing facilities and County-identified board and care facilities. The program provides patient representation at legal proceedings when denial of rights is concerned, and handles patient complaints and grievances in these facilities.

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

The ICM program serves older adults with SMI who are in a locked setting with case management services to help support their reintegration into the community. In FY 2018-19, the program served 744 unique clients.

JUSTICE SYSTEM DISCHARGE PLANNING (TAOA-SD)

The Justice System Discharge Planning program provides comprehensive mental health services for individuals with SMI who have been found guilty of a non-violent crime and are awaiting sentencing. The goal is to reduce incarceration, institutionalization, and homelessness, while providing timely access to services. This program primarily serves the African-American and Latino populations and provides linkage to services which helps participants successfully navigate from custody to community in an effort to increase independence and reduce recidivism. In FY 2018-19, the program served 241 unique clients.

MENTAL HEALTH ADVOCACY SERVICES (TAOA-SD)

The Mental Health Advocacy program provides outpatient education and advocacy services including client outreach and engagement to clients receiving outpatient and non-residential services. In FY 2018-19, the program served 96 unique clients.

NORTH COASTAL MENTAL HEALTH CENTER AND VISTA CLINIC (TAOA-SD, TAOA-FSP)

North Coastal Mental Health Center and Vista Clinic provide outpatient mental health rehabilitation and recovery, crisis services, peer support, homeless outreach, case management, and long-term vocational support. The goal is to increase mental health services for TAY while decreasing homelessness and increasing self-sufficiency through development of life skills. In FY 2018-19, the program served 1,161 unique clients.

NORTH INLAND MENTAL HEALTH CENTER (TAOA-SD)

The North Inland Mental Health Centers provide outpatient mental health rehabilitation and recovery services, urgent walk-in appointments, peer support services, homeless outreach, case management, and long-term vocational support services to adults with SMI, including individuals with co-occurring SUD. The program is designed to increase access to mental health services and overcome barriers such as language, wait times, and lack of knowledge or awareness of available services. In FY 2018-19, the program served 1,086 unique clients.

NO PLACE LIKE HOME (NPLH) BHS (TAOA-SD)

The NPLH housing team within BHS supports the implementation of NPLH, which will provide approximately $125 million to the San Diego region to build permanent supportive housing for individuals with SMI and/or SED who are homeless, chronically homeless, or at-risk of chronic homelessness. The support team allows BHS to implement NPLH care coordination and related services for these funded developments. The program will reduce homelessness among clients, and it provides access to permanent supportive housing.

NO PLACE LIKE HOME, DEPARTMENT OF PUBLIC WORKS (DPW), ENVIRONMENTAL SERVICES UNIT (TAOA-SD)

To facilitate planning and support of the implementation of the No Place Like Home initiative, funding for required environmental reviews are conducted by DPW.

NO PLACE LIKE HOME, HOUSING & COMMUNITY DEVELOPMENT SERVICES (TAOA-SD)

To facilitate planning and support of the implementation of the No Place Like Home initiative, funding was added for new County of San Diego positions under the County of San Diego Health and Human Services Agency, Housing and Community Development Services (HCDS). Funding will allow HCDS to issue and monitor NPLH loans to housing developers. NPLH will reduce homelessness among BHS clients and provides access to permanent supportive housing.

PEER ASSISTED SUPPORT SERVICES (TAOA-SD)

The Peer-Assisted Support Services program provides coaching and social support services. The program focuses on improving mental health, reducing substance use, and increasing social support to individuals with SMI who are not connected to services. The program engages with individuals in inpatient or crisis residential programs and continues engagement until after discharge to ensure they are connected to the appropriate services. In FY 2018-19, the program served 300 unique clients.

PUBLIC DEFENDER - BEHAVIORAL HEALTH ASSESSOR (TAOA-SD)

The Public Defender Behavioral Health Assessors are licensed mental health clinicians who provide discharge planning, care coordination, referral and linkage, and short-term case management to persons with SMI who have been referred by the Court. The BHS clinicians are part of the Public Defender's office and provide assessment and linkage to community programs for individuals in-custody with SMI. In FY 2018-19, the program served an estimated 1,000 unique clients.

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.

SAN DIEGO HOUSING COMMISSION (TAOA-SD)

The San Diego Housing Commission, in partnership with the Home Finder program, provides housing subsidies and supports up to 100 homeless clients with SMI and co-occurring disorders to link them to housing and sustain their recovery. The 100 housing subsidies are part of SDHC's commitment of 733 subsidies to support Project One for All (POFA).

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 2018-19 the six START programs served 2,346 unique clients.

SHORT-TERM BRIDGE HOUSING (TAOA-SD)

Short-Term Bridge Housing program provides emergency and transitional housing in a residential setting throughout the county. Safe, sanitary housing is available on a nightly basis, and services are coordinated with designated homeless outreach workers (HOWs) and peer support services. The goal is to decrease homelessness for persons with SMI by connecting clients to housing supports and mental health services. Nine sites are located countywide and served 182 homeless individuals in FY 2018-19.

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

Supplemental Security Income (SSI) Advocacy services submits SSI applications for eligible individuals to the Social Security Administration and provides follow-up, if needed. The program is able to expedite SSI awards to individuals, and provides training, consultations, outreach, and education. In FY 2018-19, the program served 364 unique clients.

TELEMEDICINE (TAOA-SD)

Telemedicine provides video, secure email, and phone consultation to improve accessibility of care in underserved and rural areas. It helps maintain technological infrastructure for the mental health system to ensure high-quality, cost-effective services, and supports for clients and their families. Systems are provided to community-based providers in clinical outpatient, residential, and school-based settings in dozens of different locations. In FY 2018-19 the program served 10,607 unique clients.

TENANT PEER SUPPORT SERVICES (TAOA-SD)

The Tenant Peer Support Services program provides housing support for homeless clients to link them to the appropriate resources and assist them with the tools to sustain housing. The program is dedicated to serving the homeless population. In FY 2018-19, the program served 339 unique clients.

WALK-IN ASSESSMENT CENTER (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 2018-19, the program served 1,871 unique clients.

CSS PROGRAMS FOR ALL AGES (ALL)

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 2020-21, the estimated total MHSA budget for ALL-OE programs is $3,036,400; the estimated cost per unduplicated client served in ALL-OE programs is $2,448, inclusive of all funding; and the estimated number of unduplicated clients to be served is 1,273.

BEHAVIORAL HEALTH SERVICES - VICTIMS OF TRAUMA AND TORTURE (ALL-OE)

This program improves access to mental health services for victims of trauma and torture who are experiencing or at risk of SMI 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 2018-19, the program served 100 unique clients.

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 18-19, they served 871 unique adult clients and 92 unique older adult clients.

BEHAVIORAL HEALTH SERVICES FOR DEAF & HARD OF HEARING (ALL-OE)

This program provides outpatient mental health services, case management, and integrated SUD treatment and rehabilitation services tailored to individuals with SMI who are deaf and/or hard of hearing, to achieve a more adaptive level of functioning. The program includes group or individual sessions, crisis intervention, and referrals to other community-based organizations. In FY 2018-19, the program served 67 unique clients.

CLUBHOUSE - DEAF OR HARD OF HEARING (ALL-OE)

This member-operated clubhouse provides social skill development and rehabilitative, recovery, vocational, and peer support services for individuals who are experiencing SMI and are deaf or hard of hearing. In FY 2018-19, the program served 1,086 unique clients.

PSYCHIATRIC AND ADDICTION CONSULTATION AND FAMILY SUPPORT SERVICES (ALL-OE)

The Psychiatric and Addiction Consultation and Family Support Services program provides psychiatric and addiction consultation and family support services for primary care, pediatric and obstetric providers. The program improves the confidence, competence, and capacity of primary care pediatrics, and obstetricians in treating behavioral health conditions, and increases the identification of behavioral health issues by providing education, referrals, and linkages to support families. In FY 2018-19, the program provided 643 consultation services to primary care providers

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2020-21, the estimated total MHSA budget for ALL-SD programs is $6,178,876; the estimated cost per unduplicated client served in ALL-SD programs is $916, inclusive of all funding; and the estimated number of unduplicated clients to be served is 11,202.

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 2018-19, the program served 224 unique clients.

EMERGENCY MEDICAL TECHNICIAN (EMT) - MENTAL HEALTH CLINICIAN TEAM (ALL-SD)

This program pairs two licensed mental health clinicians with EMTs when responding to calls involving a person in psychiatric distress, to determine the best treatment options for these individuals. This program started in March of 2019 and in the last quarter of FY 2018-19, the EMT team provided a total of 239 contacts, including 30 crisis intervention contacts and 209 community engagement contacts.

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 come in contact with local law enforcement agencies and/or who need immediate mental health crisis intervention. In FY 2018-19, PERT provided a total of 25,002 contacts, including 10,962 crisis intervention contacts and 14,040 community contacts.

CSS PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2020-21, 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	*Population Served*	*FY 2020-21 Proposed Budget (All Funding)*	*FY 2020-21 Estimated Number of Unduplicated Clients*	*FY 2020-21 Estimated Cost Per Client*
CY-FSP	Children, Youth	$47,980,261	9,564	$5,017
CY-OE	Children, Youth	$1,599,163	2,363	$677
CY-SD	Children, Youth	$20,256,887	5,864	$3,454
TAOA-FSP	Adults, TAY	$61,740,142	7,086	$8,713
TAOA-FSP	OA	$8,568,550	456	$18,791
TAOA-OE	TAY, Adults, OA	$1,246,272	4,334	$288
TAOA-SD	TAY, Adults, OA	$87,749,521	40,823	$2,150
ALL-OE	ALL	$3,116,434	1,273	$2,448
ALL-SD	ALL	$10,260,118	11,202	$916
Total CSS		**$242,517,347**	**82,965**	

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, including MHSA, Realignment, Federal Financial Participation (FFP) and other funding.
- Administrative costs are not included.
- The FY 2020-21, estimated cost per client figures are based on the total proposed FY 2019-20 budget divided by the actual clients served in FY 2018-19, plus the estimated new unduplicated clients to be served in FY 2019-20 and FY 2020-21. FY 2018-19 data is the most recent full year of data available.
- The estimated average cost per client is a summary by work plan. The figure will vary by level of care and contract due to the varying contracted rates, services provided, and number of duplicate clients.
- The annual projected unique clients for FY 2020-21 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 2020-21. Additionally, clients may receive one or more different services, so there may be duplication of clients across work plans.

PREVENTION AND EARLY INTERVENTION (PEI)

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

In FY 2020-21, the estimated total MHSA budget for PEI programs is $26,723,724. 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 2020-21, this requirement will be met with nearly 59 percent of the budget for PEI programs budgeted for programs serving persons under 25.

A detailed budget for PEI may be found in Appendix A. The FY 2018-19 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.

CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY (CALMHSA)

The California Mental Health Service Authority (CalMHSA) is a Joint Powers Authority (JPA) created by counties to administer statewide PEI projects. CalMHSA supports efforts such as: maintaining and expanding social marketing campaigns; creating new outreach materials for diverse audiences; providing technical assistance and outreach to counties, schools, and local community-based organizations; providing trainings to diverse audiences; and, building the capacity of higher education institutions to reduce stigma and prevent suicide. Programs include: Each Mind Matters, Walk in Our Shoes, Directing Change, and Know the Signs. In FY 2020-21, BHS will contribute up to $400,000 of MHSA or other funds to CalMHSA for statewide PEI programs.

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

Check Your Mood is an annual event (held on October 10, 2019) in conjunction with National Depression Screening Day which engages and encourages San Diegans to monitor and assess their emotional well-being. Organizations across the San Diego region come together to provide free mental health resources, information, and Check Your Mood screenings to the community which helps to raise awareness and reduces the stigma related to mental health. BHS and other County of San Diego staff partnered with local businesses, healthcare agencies, community partners, and volunteers to provide these services at 90 sites throughout the county.

INTEGRATED PEER & FAMILY ENGAGEMENT (CO-03)

The Integrated Peer and Family Engagement program provides comprehensive, peer-based care coordination, mental health screening, brief treatment, and system navigation to adults with SMI and SUD. The peer and family support program focuses on whole-person health, self-management, self-care skills, and linkage to treatment and community resources. In FY 18-19, the program served 4,471 unique clients.

ALLIANCE FOR COMMUNITY EMPOWERMENT (DV-03)

Alliance for Community Empowerment (ACE) is a community response-team program that engages siblings of identified gang members to teach and encourage resiliency. The ACE team members engage children and youth in schools, recreational centers, and their homes. Parents are also engaged and supported with various activities which increase resilience, coping skills, and improve overall quality of life. In FY 2018-19, the program served 269 unique families through the Community Violence Response Teams.

COMMUNITY SERVICES FOR FAMILIES - CHILD WELFARE SERVICES (CWS) (DV-04)

Through this program, parents receive in-home training through a partnership with CWS about risk factors for child neglect and physical abuse. The curriculum teaches parenting skills and how to interact in a positive manner with their child, responding appropriately to challenging behaviors, recognizing hazards in the home, and responding to symptoms of illness and injury. The training program, which is known nationally as SafeCare, is conducted by CWS in cooperation with several community-based agencies. Through weekly in-home sessions, the goal is for children to remain safely in their home with the appropriate resources and linkage to services.

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 2018-19, the program served 4,540 unique clients.

EARLY INTERVENTION FOR PREVENTION OF PSYCHOSIS (KICK START) (FB-01)

The Kickstart program identifies and trains community leaders to identify the indicators of early psychosis. These leaders refer teens and young adults with potential behavioral health issues to clinicians who provide crisis intervention, treatment, individual and group therapy, and in-home services. Additionally, these youth can be transitioned to outpatient programs if needed. Early treatment of behavioral health issues results in increased well-being, school success, family involvement, improved functioning, and the reduction of hospitalizations. When the program began in FY 2019-20, Kickstart provided training to 800 community leaders. A total of 340 clients and their families were provided services demonstrated to increase well-being, school success, family involvement and improved functioning.

NATIVE AMERICAN PREVENTION AND EARLY INTERVENTION (DREAM WEAVER) (NA-01)

The Dream Weaver program is a partnership with three Native American health clinics that joins cultural practices with evidence-based practices. It operates on reservations and in urban areas and provides education and outreach at community events, cultural and social gatherings, and health clinics. The program provides information on available mental health services and behavioral health issues to prevent mental

illness and promote wellness activities in American Indian/Alaska Native communities and increases involvement in child abuse prevention activities. In FY 2018-19, the program served 7,238 unique clients.

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. These 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 2018-19, the program served 1,334 unique clients.

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

Positive Solutions provides home-based outreach, prevention and intervention services to older adults who are homebound and socially isolated. The program reaches out to these adults and engages them with Program to Encourage Active and Rewarding Lives (PEARLS) which provides mental health screening, assessment, and referral and linkage to care. In FY 2018-19, the program served 331 unique clients.

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 2018-19, the program served 516 unique clients.

BREAKING DOWN BARRIERS (BDB) INITIATIVE (PS-01)

Breaking Down Barriers is an outreach campaign that engages underserved communities including Latino, African American, Native American, African immigrants/refugees, and LGBTQ individuals to increase access to mental health services. The program reduces stigma and discrimination through increased awareness and acceptance of mental illness and treatment choices, and increases access and use of available services. In FY 2018-19, the program served 116 unique clients in the first half of the fiscal year, due to a contract expiration.

COUNTY OF SAN DIEGO - COMMUNITY HEALTH PROMOTION SPECIALISTS (PS-01)

Community Health Promotion Specialists (CHPS) staff within the HHSA Regions and Aging & Independence Services (AIS), in partnership with BHS staff, serve as community ambassadors for behavioral health prevention and early intervention initiatives. The CHPS staff develop and provide prevention activities such as providing materials at community events, and conducting activities for May is Mental Health Awareness Month, Suicide Prevention Month, Recovery Happens, and Check Your Mood.

FAMILY PEER SUPPORT PROGRAM (PS-01)

The Family and Adult Peer Support programs, Friends in the Lobby and In Our Own Voice, provide outreach and awareness through training and the dissemination of education materials in primary care, senior centers, faith-based forums, and other venues. Individuals with lived experience promote social and emotional wellness for adults, older-adults, and their families who are visiting individuals that have been hospitalized in psychiatric units. The programs reduce stigma and discrimination, increase acceptance of mental illness and awareness of treatment choices, and increase access and use of available services, especially in unserved and

underserved communities. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the County. In FY 2018-19, the program served 3,025 unique clients.

MENTAL HEALTH FIRST AID (PS-01)

The Mental Health First Aid program provides individuals the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The program provides county-wide, community-based education and training services. In FY 2018-19, the program trained 4,903 unique community members.

SUICIDE PREVENTION & STIGMA REDUCTION MEDIA CAMPAIGN - IT'S UP TO US (PS-01)

The countywide media campaign, It's Up to Us, is focused on suicide prevention, stigma reduction, and increased public awareness around behavioral health. The campaign provides awareness of the stigma of mental illness, promotes individual acceptance of mental illness, and provides materials and information on options for intervention, treatment, and recovery. In FY 2018-19 the campaign resulted in over 16,000 cable television spots and 475 social media posts reaching most of San Diego County's 3.2 million residents.

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. A copy of the plan can be found here: https://www.sdchip.org/wp-content/uploads/2018/06/6-5-18-FINAL_BIGSPCSPAPUpdate2018FINAL_rev1.pdf. In FY 2018-19, the program trained 3,468 individuals.

SUPPORTED EMPLOYMENT TECHNICAL CONSULTANT SERVICES (PS-01)

The Supported Employment Technical Consultant services program provides technical expertise and consultation on countywide employment development, partnership, engagement, and funding opportunities for adults with SMI. Services are coordinated and integrated through BHS to develop new employment resources.

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.

INDEPENDENT LIVING ASSOCIATION (ILA) (RE-01)

Independent living facilities are privately-owned homes or complexes that provide housing for adults with mental illness and other disabling health conditions. They serve residents who do not need medication oversight, are able to function without supervision, and live independently. Members of the Independent Living Association (ILA) include owners, operators and community-based organizations who advocate for quality housing. As of June 30, 2020, the ILA had 100 member homes that total 945 beds.

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 2018-19, 6 school-based PEI programs served 12,146 children in classroom lessons, 3,999 children in small groups, and 1,126 parents in parent group.

SCHOOL-BASED SUICIDE PREVENTION & EARLY INTERVENTION (HERE NOW) (SA-02)

The Helping, Engaging, Reconnecting and Educating (HERE) Now program provides school-based suicide prevention education and intervention services to middle-school students, high-school students, and TAY. Presentations on bullying, depression, and warning signs of suicide are provided to students, teachers, staff, and parents to increase awareness, promote conversations, and inspire connections. In FY 2018-19, the program served 42,504 unique clients.

VETERANS & FAMILY OUTREACH EDUCATION (COURAGE TO CALL) (VF-01)

The Courage to Call program provides confidential outreach, education, peer counseling, referrals, and support services to veterans and their families to increase awareness of mental illness and reduce mental-health risk factors. The program increases awareness of mental illness in the veteran community through these efforts to reduce mental-health risk factors. Services are provided to veterans and their family members. In FY 2018-19, the program served 2,988 unique clients.

PEI Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2020-21, 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 2020-21 Proposed Budget (All Funding)*	*FY 2020-21 Estimated Number of Unduplicated Clients*	*FY 2020-21 Estimated Cost Per Client*
CO-03 Integrated Peer & Family Engagement	ALL	$2,555,000	997	$2,563
DV-03 Alliance for Community Empowerment	Children, Youth	$403,520	260	$1,552
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$504,408		
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$1,109,680	7,099	$156
FB-01 Early Intervention for Prevention of Psychosis (Kick Start)	Children, TAY	$1,790,620	250	$7,162
NA-01 Native American Prevention and Early Intervention (Dream Weaver)	ALL	$1,760,356	7,109	$248
OA-01 Elder Multicultural Access & Support Services (EMASS)	OA	$574,162	1,145	$501
OA-02 Home Based Services - For Older Adults (Positive Solutions)	OA	$583,652	4,473	$130
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$1,090,271	7,618	$143
PS-01 Education and Support Lines	ALL	$4,781,900	12,390	$386
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$1,407,276	1,021	$1,378
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$302,640		
SA-01 School Based Prevention and Early Intervention	Children, Youth	$6,355,440	14,517	$438
SA-02 School Based Suicide Prevention & Early Intervention (Here Now)	Children, Youth, TAY	$1,815,840	34,668	$52
VF-01 Veterans & Family Outreach Education (Courage to Call)	ALL	$1,291,264	1,787	$723
Total PEI		$26,326,028		

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 following programs do not have data:
  - DV-04: Point of Engagement Programs - Embedded within Child Welfare Services (CWS).
  - PS-01: Community Health Promotion Specialist and Supportive Employment Technical Consultant Services.
  - RE-01: Independent Living Association
- The FY 2020-21 estimated cost per client figures are based on the total proposed FY 2020-21budget divided by the actual number of clients served in FY 2018-19, plus the estimated new clients to be served in FYs 2019-20 and 2020-21. FY 2018-19 is the most recent full year of data available.
- The estimated average cost per client is a summary by work plan. The figure will vary by service and contract based on the contracted rate, level of care, and number of duplicate clients.
- The annual projected unique clients for FY 2020-21 will vary from the number of unique clients served in Appendix L.

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 budget allocated to evaluation services provided by the University of California at San Diego (UCSD).

In FY 2020-21, the estimated INN expenditures will be $7,931,484.

A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix N. A detailed annual INN report with evaluation results is available at: https://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/mental_health_services_act/mhsa_innovation.html.

A summary of the estimated cost per client is available at the end of the INN section.

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. FY 2018-19 data is not available as program started in FY 2019-20.

TELEMENTAL HEALTH (INN-19)

Telemental Health provides 24/7 mental health treatment via electronic devices for tele-therapy to children, youth and adults who frequently use psychiatric emergency services and are not connected to a mental health provider. The goal is to reduce re-hospitalization and psychiatric emergency services for individuals by connecting them to mental health services via tele-therapy. In FY 2018-19, these services were provided to approximately 250 individuals, reducing the use of psychiatric emergency services.

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. This program is in its first operational year so data is not yet available.

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. The program is in its first operational year so data is not yet available.

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 2018-19, the clinic provided on-going stabilization for approximately 250 children and youth with complex psychiatric medication needs.

EARLY PSYCHOSIS EVALUATION AND LEARNING HEALTH CARE NETWORK (INN-24)

The Early Psychosis Evaluation and Learning Health Care Network program was a new INN program approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) for implementation in FY 2018-19. The program is a statewide collaborative led by the University of California, Davis, Behavioral Health Center of Excellence in partnership with other universities and multiple California counties. The program gives clinicians the opportunity to share and discuss outcomes with clients immediately upon completion, allows programs to learn from each other through a training and technical assistance collaborative, and allows the State to participate in the development of a national network to inform and improve care for individuals with early psychosis across the country. FY 2018-19 outcomes data is not available as program started in FY 2019-20.

INN ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2020-21, 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 2020-21 Proposed Budget (All Funding)*	*FY 2020-21 Estimated Number of Unduplicated Clients*	*FY 2020-21 Estimated Cost Per Client*
INN-18 Peripartum Program	TAY, Adults	$1,072,858	300	$3,576
INN-19 Telemental Health	ALL	$1,132,972	250	$4,532
INN-20 ROAM Mobile Services	ALL	$1,896,840	200	$9,484
INN-21 ReST Recuperative Housing	TAY (ages 18-25)	$1,074,028	48	$22,376
INN-22 Medication Clinic	Children, Youth	$1,990,820	510	$3,904
INN-24 Early Psychosis Evaluation and Learning Health Care Network	Youth, TAY	$201,626	245	$823
Total		$7,369,144	1,553	

Assumptions:

- Figures are rounded up 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 2020-21, estimated cost per client figures are based on the total proposed FY 2020-21 budget divided by the estimated proposed number of clients to be served in FY 2020-21, based on estimates from the programs.
- The estimated average cost per client is a summary by work plan.

WORKFORCE EDUCATION AND TRAINING (WET)

WET programs provide support, education, and training to the public mental health workforce to assist with the shortage of qualified individuals who provide services to persons with SMI or SED in the county. The WET component 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 2020-21, the estimated WET expenditures will be $3,605,648.

Annually, up to $3.6 million in CSS funds will be transferred to the WET component to continue funding programs. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually.

A detailed budget for WET may be found in Appendix A.

BEHAVIORAL HEALTH TRAINING CURRICULUM (BHTC) (WET-02)

The Behavioral Health Training Curriculum provides training and technical assistance to behavioral health and contracted behavioral health staff on trauma informed care, cultural competency, and mental health/substance use co-occurring disorders and primary care/behavioral health integration. Training is provided in-person and virtually via eLearning and webinar. In FY 2018-19, this program provided in-person training to approximately 4,100 county and contracted staff. Annually, approximately 10,000 eLearnings or webinars are completed by County and contracted staff.

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. During FY 2018-19, curriculum development and committees were formed to provide content for the 5-day training series and booster trainings with the academies to be held the following fiscal year.

TRAINING AND TECHNICAL ASSISTANCE (WET-02)

The Regional Training Center provides administrative and fiscal support to Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) for training, conferences, and consultants. In FY 2018-19, the program served 1,048 unique clients.

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 2018-19, the program had 91

participants graduate from the program through five peer specialist training series. By the end of the training series, 31 of the graduates were employed within the public behavioral health system.

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. During the 2018-19 academic year, 97 students were enrolled in the program and 40 students completed the program which brings the total to 310 total graduates since the program's inception. Over 355 academic counseling appointments were held to provide individual on-going support and guidance.

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 with-in public behavioral health. In June of 2019, two psychiatry residents graduated from the program and continue their work in public behavioral health.

SOUTHERN COUNTIES REGIONAL PARTNERSHIP (SCRP)

The Southern Counties Regional Partnership (SCRP) is comprised of ten counties in California and is an important workforce strategy to assist the public mental health system outreach to multicultural communities, increase diversity of the workforce, reduce stigma associated with mental illness and promote the use of web-based technologies and distance learning techniques. In FY19-20, SCRP provided a series of Trauma Informed Care trainings to the County and in FY20-21, SCRP will receive a grant on behalf of the Office of Statewide Health Planning and Development (OSHPD) to address the shortage of mental health practitioners in the public mental health system and supports individuals through workforce development, undergraduate scholarships, education stipends and educational loan repayment. As a participating county of the Regional Partnership, the County would contribute a share of the 33 percent match, totaling $919,431, allowing the County access to $3,281,356 of the total partnership WET grant funding of $15,340,829. The County has no plans of transferring funds in FY20-21 and has though December 31, 2024 to contribute the match.

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 Facility 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

County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) collects, analyzes, and reports MHSA data in monthly, quarterly, and annual reports by the BHS Quality Improvement (QI) team to determine if services are meeting expected outcome measures. The BHS Performance Improvement Team (PIT) also monitors targeted aspects of care 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 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

Optum San Diego serves as the Administrative Services Organization (ASO) 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 Child Welfare Services (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 and substance use disorders (SUD), access to emergency mental health services, and other services.

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 (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 Serious Emotional Disturbance (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. This research team specializes in the measurement, collection, and analysis of health outcomes data to help improve health care delivery systems and, ultimately, improve client quality of life.

The Research Centers work in collaboration with the BHS QI 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.

APPENDICES

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix A
MHSA Three-Year Expenditure Plan

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

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FY 2020-21 Through FY 2022-23 Three-Year 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 2020/21 Funding								
1 Estimated Unspent Funds from Prior Fiscal Years	$ 17,397,407	$ 2,106,186	$ 20,324,962	$ 1,280,862	$ -	$ 33,478,186	$ 74,587,602	
2. Estimated New FY2020/21 Funding*	$ 137,234,139	$ 34,428,173	$ 9,068,985				$ 180,731,297	Estimated revenue + interest
3. Transfer in FY2020/21[a/]	$ (2,900,000)	$ -	$ -	$ 2,900,000	$ -	$ -	$ -	
4. Discretionary One-Time Revenue							$ -	
5. Access Local Prudent Reserve in FY2020/21	$ 2,853,481					$ (2,853,481)	$ -	AB 81 (Chapter 13, Statutes of 2020)
6. Estimated Available Funding for FY2020/21	$ 154,585,027	$ 36,534,359	$ 29,393,947	$ 4,180,862	$ -	$ 30,624,705	$ 255,318,899	
B. Estimated FY2020/21 MHSA Expenditures	**$ 154,585,027**	**$ 26,723,724**	**$ 7,931,484**	**$ 3,605,648**	**$ -**		**$ 192,845,883**	
C. Estimated FY2021/22 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	$ 0	$ 9,810,635	$ 21,462,463	$ 575,214	$ -	$ 30,624,705	$ 62,473,017	
2. Estimated New FY2021/22 Funding*	$ 123,706,139	$ 31,046,173	$ 8,178,895				$ 162,931,207	Estimated revenue + interest
3. Transfer in FY2021/22[a/]	$ (3,500,000)			$ 3,500,000			$ -	
4. Discretionary One-Time Revenue	$ 13,409,147						$ 13,409,147	One-time funds
5. Access Local Prudent Reserve in FY2021/22	$ 23,858,870					$ (23,858,870)	$ -	
6. Estimated Available Funding for FY2021/22	$ 157,474,156	$ 40,856,808	$ 29,641,358	$ 4,075,214	$ -	$ 6,765,835	$ 238,813,370	
D. Estimated FY2021/22 Expenditures	**$ 157,474,156**	**$ 26,323,724**	**$ 7,931,484**	**$ 3,605,648**	**$ -**		**$ 195,335,011**	
E. Estimated FY2022/23 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	$ (0)	$ 14,533,084	$ 21,709,874	$ 469,566	$ -	$ 6,765,835	$ 43,478,359	
2. Estimated New FY2022/23 Funding*	$ 123,706,139	$ 31,046,173	$ 8,178,895				$ 162,931,207	Estimated revenue + interest
3. Transfer in FY2022/23[a/]	$ (3,600,000)			$ 3,600,000			$ -	
4. Discretionary One-Time Revenue	$ 15,000,000						$ 15,000,000	One-time funds
5. Access Local Prudent Reserve in FY2022/23	$ -						$ -	
6. Estimated Available Funding for FY2022/23	$ 135,106,139	$ 45,579,257	$ 29,888,769	$ 4,069,566	$ -	$ 6,765,835	$ 221,409,566	
F. Estimated FY2022/23 Expenditures	**$ 155,531,357**	**$ 26,323,724**	**$ 7,931,484**	**$ 3,605,648**	**$ -**		**$ 193,392,212**	
G. Estimated FY2022/23 Unspent Fund Balance	**$ (20,425,218)**	**$ 19,255,533**	**$ 21,957,286**	**$ 463,918**	**$ -**	**$ 6,765,835**	**$ 28,017,354**	

* Estimated new funding from State consultant estimates in June 2020

		Prudent Reserve Detail	
H. Estimated Local Prudent Reserve Balance	**Total**	*CSS*	*PEI*
1. Estimated Local Prudent Reserve Balance on June 30, 2020	$ 33,478,186	26,712,351	$ 6,765,835
2. Contributions to the Local Prudent Reserve in FY 2020/21	0	0	0
3. Distributions from the Local Prudent Reserve in FY 2020/21	(2,853,481)	(2,853,481)	0
4. Estimated Local Prudent Reserve Balance on June 30, 2021	$ 30,624,705	23,858,870	$ 6,765,835
5. Contributions to the Local Prudent Reserve in FY 2021/22	0	0	0
6. Distributions from the Local Prudent Reserve in FY 2021/22	(23,858,870)	(23,858,870)	0
7. Estimated Local Prudent Reserve Balance on June 30, 2022	$ 6,765,835	0	$ 6,765,835
8. Contributions to the Local Prudent Reserve in FY 2022/23	0	0	0
9. Distributions from the Local Prudent Reserve in FY 2022/23	0	0	0
10. Estimated Local Prudent Reserve Balance on June 30, 2023	$ 6,765,835	0	$ 6,765,835

Assumptions

- Assumes enhanced Federal Financial Participation (FFP) Medi-Cal drawdown in FY2020-21 due to COVID-19.
- Assumes optimization of FFP drawdown in FYs 2021-22 and FY22-23.
- Assumes use of Prudent Reserve funds due to estimated MHSA revenue reduction resulting from COVID-19.
- BHS will continue to support reallocation of unspent INN funds to CSS treatment programs due to COVID-19.
- BHS will be conducting an departmental-wide analysis of programs to mitigate the MHSA revenue shortfall in FY 2022-23 by identifying efficiencies, optimizing Medi-Cal drawdown and analyzing program impacts and effectiveness in alignment with the Behavioral Continuum vision.

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.

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2020/21					
	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 Partnerships	$ 1,008,800	763,635	245,165			
Children's School-Based Full-Service Partnership	$ 34,126,053	8,993,369	20,537,431		4,595,252	
Family Therapy	$ 1,086,895	1,055,731	31,164			
Therapeutic Behavioral Services	$ 4,907,812	2,258,893	2,648,919			
Wraparound Services (WRAP) - Child Welfare Services	$ 6,850,700	2,626,181	2,332,073		1,892,446	
TAOA-FSP Full Service Partnerships for Ages 18-60+						
Adult Residential Treatment	$ 705,787	705,787				
Assisted Outpatient Treatment	$ 1,441,696	925,709	515,988			
Behavioral Health Court	$ 1,892,509	1,252,389	640,120			
County of San Diego - Institutional Case Management (ICM)	$ 490,000	291,726	2,274		196,000	
County of San Diego - Probation	$ 901,690	541,014			360,676	
Crisis Residential Services - North Inland	$ 1,768,800	1,151,504			617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 42,410,548	24,294,706	15,894,598		2,221,244	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) – Housing	$ 11,696,197	11,696,197				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,030,706	2,030,706				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Institutions of Mental Disease (IMD)	$ 2,127,623	2,127,623				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 2,774,200	2,664,200			110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	338,152				
Payee Case Management Services	$ 126,100	126,100				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	500,491	250,514			
Strengths Based Case Management (SBCM)	$ 853,680	445,437	408,243			
				-		
TOTAL Full Service Partnership (FSP) Programs	**$ 118,288,953**	**64,789,551**	**43,506,488**		**9,992,914**	**-**
Non-FSP Programs						
ALL-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	469,447				
Behavioral Health Services and Primary Care Integration Services	$ 1,025,167	1,025,167				
Behavioral Health Services for Deaf & Hard of Hearing	$ 368,212	288,178	80,034			
Clubhouse - Deaf or Hard of Hearing	$ 291,041	291,041				
Psychiatric and Addiction Consultation and Family Support Services	$ 962,568	962,568				
ALL-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 540,717	207,209	333,508			
Emergency Medical Technician (EMT) - Mental Health Clinician Team	$ 259,262	259,262				
Psychiatric Emergency Response Team (PERT)	$ 9,460,140	5,712,405			3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services	$ 1,246,272	1,246,272				
Family & Youth Partnership	$ 352,890	352,890				
CY-SD System Development for Children & Youth						
Administrative Services Organization (ASO) - TERM	$ 356,776	356,776				
Adolescent Day Rehabilitation	$ 100,880	60,880			40,000	
BHS Children, Youth and Families (CYF) Liaison	$ 554,840	554,840				
Bridgeways	$ 564,928	242,471	98,457		224,000	
Commercially Sexually Exploited Children	$ 1,008,800	460,406	48,394		500,000	
County of San Diego - Juvenile Forensic Services	$ 1,100,000	1,100,000				
Crisis Action and Connection	$ 2,169,335	1,652,620	2,851		513,864	
Emergency Screening Unit	$ 5,897,179	3,780,732			2,116,448	
Incredible Families - Child Welfare Services	$ 1,961,329	1,126,649	56,992		777,688	
Incredible Years	$ 472,714	227,228	245,485			
Medication Support for Wards and Dependents	$ 854,454	399,721	115,932		338,800	
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning	$ 1,513,200	811,093	102,107		600,000	
Peer Mentoring	$ 80,704	48,704			32,000	
Placement Stabilization Services	$ 2,257,737	81,240	1,481,280		695,217	
Rural Integrated Behavioral Health and Primary Care Services	$ 126,100	76,100			50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	182,640			120,000	
Telemedicine	$ 21,300	21,300				
Walk-In Assessment Clinic and Mobile Assessment Team	$ 913,973	345,460	206,113		362,400	

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

TAOA-OE Outreach & Engagement for Ages 18-60+						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services – Adult	$ 1,246,272	772,702			473,570	
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 2,588,706	2,588,706				
Behavioral Health Assessors	$ 691,028	392,428			298,600	
Bio-Psychosocial Rehabilitation (BPSR)	$ 22,964,310	2,974,848	12,626,195		7,363,267	
Client Liaison Services	$ 367,474	367,474				
Client Operated Peer Support Services	$ 754,986	754,986				
Clubhouse	$ 5,023,852	5,023,852				
Crisis Stabilization Unit (CSU - North Coastal	$ 1,536,359	1,536,359				
Crisis Stabilization Unit (CSU) - North Inland	$ 10,245,258	3,580,736	5,230,380		1,434,142	
Crisis Stabilization Unit (CSU) - South	$ 5,951,920	3,283,762	1,230,486		1,437,672	
Faith-Based Services	$ 1,487,446	1,487,446				
Family Mental Health Education and Support	$ 97,248	97,248				
Home Finder	$ 761,227	761,227				
In-Home Outreach Teams (IHOT)	$ 4,288,276	4,288,276				
Inpatient and Residential Advocacy Services	$ 572,221	572,221				
Institutional Case Management (ICM) - Older Adults	$ 507,448	304,903	1,336		201,208	
Justice System Discharge Planning	$ 933,140	625,140			308,000	
Mental Health Advocacy Services	$ 442,748	442,748				
North Coastal Mental Health Center and Vista Clinic	$ 3,383,007	29,432	2,943,114		410,460	
North Inland Mental Health Center	$ 3,388,778	201,001	2,398,189		789,588	
No Place Like Home (NPLH) BHS	$ 520,936	520,936				
No Place Like Home, Department of Public Works (DPW), Environmental Services Unit	$ 27,500	27,500				
No Place Like Home, Housing & Community Development Services	$ 1,199,155	1,199,155				
Peer Assisted Support Services	$ 904,955	904,955				
Public Defender - Behavioral Health Assessor	$ 240,000	156,822			83,178	
San Diego Employment Solutions	$ 1,127,637	680,517			447,120	
San Diego Housing Commission	$ 121,056	109,056			12,000	
Short-Term Acute Residential Treatment (START)	$ 9,998,759	7,221,508			2,777,251	
Short-Term Bridge Housing	$ 1,203,332	1,203,332				
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	504,400				
Telemedicine	$ 372,015	328,697	43,318			
Tenant Peer Support Services	$ 1,529,363	1,377,761	-		151,602	
Walk-In Assessment Center	$ 4,014,983	2,968,780	1,046,203			

Total Non-Full Service Partnership (FSP) Programs	**$ 124,228,395**	**$ 69,632,212**	**$ 28,290,373**	**$ -**	**$ 26,305,810**	**$ -**

CSS Administration	$ 20,163,264	$ 20,163,264				
CSS MHSA Housing Program Assigned Funds	$ -	$ -	$ -	$ -	$ -	$ -
Total CSS Program Estimated Expenditures	**$ 262,680,612**	**$ 154,585,027**	**$ 71,796,861**	**$ -**	**$ 36,298,724**	**$ -**
FSP Programs as Percent of Total	76.5%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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 Partnerships	$ 1,008,800	772,214	236,586			
Children's School-Based Full-Service Partnership	$ 34,126,053	9,712,007	19,818,794		4,595,252	
Family Therapy	$ 1,086,895	1,056,822	30,073			
Therapeutic Behavioral Services	$ 4,907,812	2,351,583	2,556,229			
Wraparound Services (WRAP) - Child Welfare Services	$ 6,850,700	2,707,784	2,250,470		1,892,446	
TAOA-FSP Full Service Partnerships for Ages 18-60+						
Adult Residential Treatment	$ 705,787	705,787				
Assisted Outpatient Treatment	$ 1,441,696	943,764	497,932			
Behavioral Health Court	$ 1,892,509	1,274,788	617,721			
County of San Diego - Institutional Case Management (ICM)	$ 490,000	291,805	2,195		196,000	
County of San Diego - Probation	$ 901,690	541,014			360,676	
Crisis Residential Services - North Inland	$ 1,768,800	1,151,504			617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 42,410,548	24,850,883	15,338,421		2,221,244	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) – Housing	$ 11,696,197	11,696,197				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,030,706	2,030,706				
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Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 2,774,200	2,664,200			110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	338,152				
Payee Case Management Services	$ 126,100	126,100				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	509,257	241,748			
Strengths Based Case Management (SBCM)	$ 853,680	459,722	393,958			
TOTAL Full Service Partnership (FSP) Programs	**$ 118,288,953**	**66,311,911**	**41,984,127**	**-**	**9,992,914**	**-**
Non-FSP Programs						
ALL-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	469,447	-			
Behavioral Health Services and Primary Care Integration Services	$ 1,025,167	1,025,167	-			
Behavioral Health Services for Deaf & Hard of Hearing	$ 368,212	290,978	77,234			
Clubhouse - Deaf or Hard of Hearing	$ 291,041	291,041	-			
Psychiatric and Addiction Consultation and Family Support Services	$ 962,568	962,568	-			
ALL-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 540,717	218,879	321,838			
Emergency Medical Technician (EMT) - Mental Health Clinician Team	$ 259,262	259,262	-			
Psychiatric Emergency Response Team (PERT)	$ 9,460,140	5,712,405	-		3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services	$ 1,246,272	1,246,272				
Family & Youth Partnership	$ 352,890	352,890				
CY-SD System Development for Children & Youth						
Administrative Services Organization (ASO) - TERM	$ 356,776	356,776				
Adolescent Day Rehabilitation	$ 100,880	60,880			40,000	
BHS Children, Youth and Families (CYF) Liaison	$ 554,840	554,840				
Bridgeways	$ 564,928	245,917	95,011		224,000	
Commercially Sexually Exploited Children	$ 1,008,800	462,099	46,701		500,000	
County of San Diego - Juvenile Forensic Services	$ 1,100,000	1,100,000				
Crisis Action and Connection	$ 2,169,335	1,652,720	2,751		513,864	
Emergency Screening Unit	$ 5,897,179	3,780,732			2,116,448	
Incredible Families - Child Welfare Services	$ 1,961,329	1,128,643	54,998		777,688	
Incredible Years	$ 472,714	235,818	236,896			
Medication Support for Wards and Dependents	$ 854,454	403,778	111,876		338,800	
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning	$ 1,513,200	814,666	98,534		600,000	
Peer Mentoring	$ 80,704	48,704			32,000	
Placement Stabilization Services	$ 2,257,737	133,073	1,429,447		695,217	
Rural Integrated Behavioral Health and Primary Care Services	$ 126,100	76,100			50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	182,640			120,000	
Telemedicine	$ 21,300	21,300				
Walk-In Assessment Clinic and Mobile Assessment Team	$ 913,973	352,672	198,901		362,400	

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

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TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 2,588,706	2,588,706				
Behavioral Health Assessors	$ 691,028	392,428			298,600	
Bio-Psychosocial Rehabilitation (BPSR)	$ 22,964,310	3,416,658	12,184,384		7,363,267	
Client Liaison Services	$ 367,474	367,474				
Client Operated Peer Support Services	$ 754,986	754,986				
Clubhouse	$ 5,023,852	5,023,852				
Crisis Stabilization Unit (CSU - North Coastal	$ 1,536,359	1,536,359				
Crisis Stabilization Unit (CSU) - North Inland	$ 10,245,258	3,763,756	5,047,360		1,434,142	
Crisis Stabilization Unit (CSU) - South	$ 5,951,920	3,326,819	1,187,429		1,437,672	
Faith-Based Services	$ 1,487,446	1,487,446				
Family Mental Health Education and Support	$ 97,248	97,248				
Home Finder	$ 761,227	761,227				
In-Home Outreach Teams (IHOT)	$ 4,288,276	4,288,276				
Inpatient and Residential Advocacy Services	$ 572,221	572,221				
Institutional Case Management (ICM) - Older Adults	$ 507,448	304,950	1,290		201,208	
Justice System Discharge Planning	$ 933,140	625,140			308,000	
Mental Health Advocacy Services	$ 442,748	442,748				
North Coastal Mental Health Center and Vista Clinic	$ 3,383,007	132,416	2,840,130		410,460	
North Inland Mental Health Center	$ 3,388,778	284,918	2,314,272		789,588	
No Place Like Home (NPLH) BHS	$ 520,936	520,936				
No Place Like Home, Department of Public Works (DPW), Environmental Services Unit	$ 27,500	27,500				
No Place Like Home, Housing & Community Development Services	$ 1,199,155	1,199,155				
Peer Assisted Support Services	$ 904,955	904,955				
Public Defender - Behavioral Health Assessor	$ 240,000	156,822			83,178	
San Diego Employment Solutions	$ 1,127,637	680,517			447,120	
San Diego Housing Commission	$ 121,056	109,056			12,000	
Short-Term Acute Residential Treatment (START)	$ 9,998,759	7,221,508			2,777,251	
Short-Term Bridge Housing	$ 1,203,332	1,203,332				
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	504,400				
Telemedicine	$ 372,015	330,213	41,802			
Tenant Peer Support Services	$ 1,529,363	1,377,761			151,602	
Walk-In Assessment Center	$ 4,014,983	3,005,388	1,009,594			

Total Non-Full Service Partnership (FSP) Programs	**$ 124,228,395**	**$ 70,622,137**	**$ 27,300,448**	**$ -**	**$ 26,305,810**	**$ -**

CSS Administration	$ 20,540,107	$ 20,540,107				
CSS MHSA Housing Program Assigned Funds	$ -	$ -				
Total CSS Program Estimated Expenditures	**$ 263,057,455**	**$ 157,474,156**	**$ 69,284,575**	**$ -**	**$ 36,298,724**	**$ -**
FSP Programs as Percent of Total	75.1%					

FY 2020-21 Through FY 2022-23 Three-Year 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 Partnerships	$ 1,008,800	766,445	242,355			
Children's School-Based Full-Service Partnership	$ 34,126,053	9,228,758	20,302,043		4,595,252	
Family Therapy	$ 1,086,895	1,056,089	30,807			
Therapeutic Behavioral Services	$ 4,907,812	2,289,254	2,618,558			
Wraparound Services (WRAP) - Child Welfare Services	$ 6,850,700	2,652,910	2,305,344		1,892,446	
TAOA-FSP Full Service Partnerships for Ages 18-60+						
Adult Residential Treatment	$ 705,787	705,787				
Assisted Outpatient Treatment	$ 1,441,696	931,623	510,074			
Behavioral Health Court	$ 1,892,509	1,259,726	632,783			
County of San Diego - Institutional Case Management (ICM)	$ 490,000	291,752	2,248		196,000	
County of San Diego - Probation	$ 901,690	541,014			360,676	
Crisis Residential Services - North Inland	$ 1,768,800	1,151,504			617,296	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 42,410,548	24,476,881	15,712,423		2,221,244	
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) – Housing	$ 11,696,197	11,696,197				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,030,706	2,030,706				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Institutions of Mental Disease (IMD)	$ 2,127,623	2,127,623				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 2,774,200	2,664,200			110,000	
North Coastal Mental Health Center and Vista Clinic	$ 338,152	338,152				
Payee Case Management Services	$ 126,100	126,100				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	503,363	247,643			
Strengths Based Case Management (SBCM)	$ 853,680	450,116	403,564			
TOTAL Full Service Partnership (FSP) Programs	**$ 118,288,953**	**65,288,198**	**43,007,841**	**-**	**9,992,914**	**-**
Non-FSP Programs						
ALL-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 469,447	469,447				
Behavioral Health Services and Primary Care Integration Services	$ 1,025,167	1,025,167				
Behavioral Health Services for Deaf & Hard of Hearing	$ 368,212	289,095	79,117			
Clubhouse - Deaf or Hard of Hearing	$ 291,041	291,041				
Psychiatric and Addiction Consultation and Family Support Services	$ 962,568	962,568				
ALL-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 540,717	211,032	329,685			
Emergency Medical Technician (EMT) - Mental Health Clinician Team	$ 259,262	259,262				
Psychiatric Emergency Response Team (PERT)	$ 9,460,140	5,712,405			3,747,735	
CY-OE Outreach & Engagement for Children & Youth						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services	$ 1,246,272	1,246,272				
Family & Youth Partnership	$ 352,890	352,890				
CY-SD System Development for Children & Youth						
Administrative Services Organization (ASO) - TERM	$ 356,776	356,776				
Adolescent Day Rehabilitation	$ 100,880	60,880			40,000	
BHS Children, Youth and Families (CYF) Liaison	$ 554,840	554,840				
Bridgeways	$ 564,928	243,600	97,328		224,000	
Commercially Sexually Exploited Children	$ 1,008,800	460,960	47,840		500,000	
County of San Diego - Juvenile Forensic Services	$ 1,100,000	1,100,000				
Crisis Action and Connection	$ 2,169,335	1,652,653	2,818		513,864	
Emergency Screening Unit	$ 5,897,179	3,780,732			2,116,448	
Incredible Families - Child Welfare Services	$ 1,961,329	1,127,302	56,339		777,688	
Incredible Years	$ 472,714	230,042	242,672			
Medication Support for Wards and Dependents	$ 854,454	401,050	114,603		338,800	
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning	$ 1,513,200	812,264	100,936		600,000	
Peer Mentoring	$ 80,704	48,704			32,000	
Placement Stabilization Services	$ 2,257,737	98,218	1,464,302		695,217	
Rural Integrated Behavioral Health and Primary Care Services	$ 126,100	76,100			50,000	
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	182,640			120,000	
Telemedicine	$ 21,300	21,300				
Walk-In Assessment Clinic and Mobile Assessment Team	$ 913,973	347,822	203,751		362,400	

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

TAOA-OE Outreach & Engagement for Ages 18-60+						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services – Adult	$ 1,246,272	772,702			473,570	
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 2,588,706	2,588,706				
Behavioral Health Assessors	$ 691,028	392,428			298,600	
Bio-Psychosocial Rehabilitation (BPSR)	$ 22,964,310	3,119,562	12,481,481		7,363,267	
Client Liaison Services	$ 367,474	367,474				
Client Operated Peer Support Services	$ 754,986	754,986				
Clubhouse	$ 5,023,852	5,023,852				
Crisis Stabilization Unit (CSU - North Coastal	$ 1,536,359	1,536,359				
Crisis Stabilization Unit (CSU) - North Inland	$ 10,245,258	3,640,684	5,170,432		1,434,142	
Crisis Stabilization Unit (CSU) - South	$ 5,951,920	3,297,865	1,216,383		1,437,672	
Faith-Based Services	$ 1,487,446	1,487,446				
Family Mental Health Education and Support	$ 97,248	97,248				
Home Finder	$ 761,227	761,227				
In-Home Outreach Teams (IHOT)	$ 4,288,276	4,288,276				
Inpatient and Residential Advocacy Services	$ 572,221	572,221				
Institutional Case Management (ICM) - Older Adults	$ 507,448	304,919	1,321		201,208	
Justice System Discharge Planning	$ 933,140	625,140			308,000	
Mental Health Advocacy Services	$ 442,748	442,748				
North Coastal Mental Health Center and Vista Clinic	$ 3,383,007	63,165	2,909,382		410,460	
North Inland Mental Health Center	$ 3,388,778	228,488	2,370,702		789,588	
No Place Like Home (NPLH) BHS	$ 520,936	520,936				
No Place Like Home, Department of Public Works (DPW), Environmental Services Unit	$ 27,500	27,500				
No Place Like Home, Housing & Community Development Services	$ 1,199,155	1,199,155				
Peer Assisted Support Services	$ 904,955	904,955				
Public Defender - Behavioral Health Assessor	$ 240,000	156,822			83,178	
San Diego Employment Solutions	$ 1,127,637	680,517			447,120	
San Diego Housing Commission	$ 121,056	109,056			12,000	
Short-Term Acute Residential Treatment (START)	$ 9,998,759	7,221,508			2,777,251	
Short-Term Bridge Housing	$ 1,203,332	1,203,332				
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	504,400				
Telemedicine	$ 372,015	329,194	42,822			
Tenant Peer Support Services	$ 1,529,363	1,377,761			151,602	
Walk-In Assessment Center	$ 4,014,983	2,980,771	1,034,212			

Total Non-Full Service Partnership (FSP) Programs	**$ 124,228,395**	**$ 69,956,461**	**$ 27,966,124**	**$ -**	**$ 26,305,810**	**$ -**

CSS Administration	$ 20,286,699	$ 20,286,699				
CSS MHSA Housing Program Assigned Funds	$ -	$ -				
Total CSS Program Estimated Expenditures	**$ 262,804,046**	**$ 155,531,357**	**$ 70,973,965**	**$ -**	**$ 36,298,724**	**$ -**
FSP Programs as Percent of Total	76.1%					

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2020/21						
	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	$ 2,555,000	2,305,000			250,000		P
2. DV-03 Alliance for Community Empowerment	$ 403,520	403,520					P
3. DV-04 Point of Engagement	$ 504,408	504,408					P
4. EC-01 Positive Parenting Program	$ 1,109,680	669,680			440,000		P
5. FB-01 Kick Start	$ 1,790,620	446,132	634,488		710,000		EI
6. NA-01 Dream Weaver	$ 1,760,356	1,062,356			698,000		P
7. OA-01 Elder Multicultural Access & Support Services (EMASS)	$ 574,162	346,500			227,661		P
8. OA-02 Positive Solutions	$ 583,652	583,652					P
9. OA-06 Caregiver Support	$ 1,090,271	1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / SP
Breaking Down Barriers (BDB) Initiative	$ 441,653	441,653					
County of San Diego - Community Health Promotion Specialists	$ 620,703	372,422			248,281		
Family Peer Support Program	$ 200,307	200,307					
Mental Health First Aid	$ 504,400	504,400					
Suicide Prevention & Stigma Reduction Media Campaign - It's Up	$ 2,294,044	2,066,641			227,403		
Suicide Prevention Action Plan	$ 504,400	504,400					
Supported Employment Technical Consultant Services	$ 216,393	216,393					
11. RC-01 SmartCare	$ 1,407,276	1,407,276					P / EI
12. RE-01 Independent Living Association	$ 302,640	302,640					O
13. SA-01 School Based Program	$ 6,355,440	6,355,440					P
14. SA-02 Here Now	$ 1,815,840	1,815,840					SP
15. VF-01 Courage to Call	$ 1,291,264	1,291,264					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	$ 3,433,529	$ 3,433,529					
PEI Assigned Funds	$ 400,000	$ 400,000					
Total PEI Program Estimated Expenditures	$ 30,159,557	$ 26,723,724	$ 634,488	$ -	$ 2,801,346	$ -	

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2021/22						
	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	$ 2,555,000	2,305,000			250,000		P
2. DV-03 Alliance for Community Empowerment	$ 403,520	403,520					P
3. DV-04 Point of Engagement	$ 504,408	504,408					P
4. EC-01 Positive Parenting Program	$ 1,109,680	669,680			440,000		P
5. FB-01 Kick Start	$ 1,790,620	446,132	634,488		710,000		EI
6. NA-01 Dream Weaver	$ 1,760,356	1,062,356			698,000		P
7. OA-01 Elder Multicultural Access & Support Services (EMASS)	$ 574,162	346,500			227,661		P
8. OA-02 Positive Solutions	$ 583,652	583,652					P
9. OA-06 Caregiver Support	$ 1,090,271	1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / SP
Breaking Down Barriers (BDB) Initiative	$ 441,653	441,653					
County of San Diego - Community Health Promotion Specialists	$ 372,422	372,422					
Family Peer Support Program	$ 200,307	200,307					
Mental Health First Aid	$ 504,400	504,400					
Suicide Prevention & Stigma Reduction Media Campaign - It's Up	$ 2,066,641	2,066,641					
Suicide Prevention Action Plan	$ 504,400	504,400					
Supported Employment Technical Consultant Services	$ 216,393	216,393					
11. RC-01 SmartCare	$ 1,407,276	1,407,276					P / EI
12. RE-01 Independent Living Association	$ 302,640	302,640					O
13. SA-01 School Based Program	$ 6,355,440	6,355,440					P
14. SA-02 Here Now	$ 1,815,840	1,815,840					PS
15. VF-01 Courage to Call	$ 1,291,264	1,291,264					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	$ 3,433,529	$ 3,433,529					
PEI Assigned Funds	$ -						
Total PEI Program Estimated Expenditures	$ 29,283,873	$ 26,323,724	$ 634,488	$ -	$ 2,325,661	$ -	

FY 2020-21 Through FY 2022-23 Three-Year 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	$ 2,555,000	2,305,000			250,000		P
2. DV-03 Alliance for Community Empowerment	$ 403,520	403,520					P
3. DV-04 Point of Engagement	$ 504,408	504,408					P
4. EC-01 Positive Parenting Program	$ 1,109,680	669,680			440,000		P
5. FB-01 Kick Start	$ 1,790,620	446,132	634,488		710,000		EI
6. NA-01 Dream Weaver	$ 1,760,356	1,062,356			698,000		P
7. OA-01 Elder Multicultural Access & Support Services (EMASS)	$ 574,162	346,500			227,661		P
8. OA-02 Positive Solutions	$ 583,652	583,652					P
9. OA-06 Caregiver Support	$ 1,090,271	1,090,271					P
10. PS-01 Education and Support Lines							P / S&D / SP
Breaking Down Barriers (BDB) Initiative	$ 441,653	441,653					
County of San Diego - Community Health Promotion Specialists	$ 372,422	372,422					
Family Peer Support Program	$ 200,307	200,307					
Mental Health First Aid	$ 504,400	504,400					
Suicide Prevention & Stigma Reduction Media Campaign - It's Up	$ 2,066,641	2,066,641					
Suicide Prevention Action Plan	$ 504,400	504,400					
Supported Employment Technical Consultant Services	$ 216,393	216,393					
11. RC-01 SmartCare	$ 1,407,276	1,407,276					P / EI
12. RE-01 Independent Living Association	$ 302,640	302,640					O
13. SA-01 School Based Program	$ 6,355,440	6,355,440					P
14. SA-02 Here Now	$ 1,815,840	1,815,840					PS
15. VF-01 Courage to Call	$ 1,291,264	1,291,264					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	$ 3,433,529	$ 3,433,529					
PEI Assigned Funds	$ -						
Total PEI Program Estimated Expenditures	$ 29,283,873	$ 26,323,724	$ 634,488	$ -	$ 2,325,661	$ -	

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2020/21					
	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 (Cycle 4)						
1. INN-18 Peripartum Services	$ 1,072,858	1,072,858				
2. INN-19 Telemental Health	$ 1,132,972	1,132,972				
3. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,896,840	1,896,840				
4. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,074,028	1,074,028				
5. INN-22 Medication Clinic	$ 1,990,820	1,518,618	472,202			
6. INN-24 Early Psychosis and Learning Health Care Network	$ 201,626	201,626				
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 1,034,541	$ 1,034,541				
Total INN Program Estimated Expenditures	$ 8,403,686	$ 7,931,484	$ 472,202	$ -	$ -	$ -

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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 (Cycle 4)						
1. INN-18 Peripartum Services	$ 1,072,858	1,072,858				
2. INN-19 Telemental Health	$ 1,132,972	1,132,972				
3. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,896,840	1,896,840				
4. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,074,028	1,074,028				
5. INN-22 Medication Clinic	$ 1,990,820	1,518,618	472,202			
6. INN-24 Early Psychosis and Learning Health Care Network	$ 201,626	201,626				
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 1,034,541	$ 1,034,541				
Total INN Program Estimated Expenditures	$ 8,403,686	$ 7,931,484	$ 472,202	$ -	$ -	$ -

FY 2020-21 Through FY 2022-23 Three-Year 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 (Cycle 4)						
1. INN-18 Peripartum Services	$ 1,072,858	1,072,858				
2. INN-19 Telemental Health	$ 1,132,972	1,132,972				
3. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ 1,896,840	1,896,840				
4. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ 1,074,028	1,074,028				
5. INN-22 Medication Clinic	$ 1,990,820	1,518,618	472,202			
6. INN-24 Early Psychosis and Learning Health Care Network	$ 201,626	201,626				
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 1,034,541	$ 1,034,541				
Total INN Program Estimated Expenditures	$ 8,403,686	$ 7,931,484	$ 472,202	$ -	$ -	$ -

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2020/21					
	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	$ 1,819,980	1,819,980				
2. WET-03 Mental Health Career Pathway Programs	$ 322,908	322,908				
3. WET-04 Residency and Internship Program	$ 1,462,760	1,462,760				
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 3,605,648	$ 3,605,648	$ -	$ -	$ -	$ -

FY 2020-21 Through FY 2022-23 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2021/22					
	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	$ 1,819,980	1,819,980				
2. WET-03 Mental Health Career Pathway Programs	$ 322,908	322,908				
3. WET-04 Residency and Internship Program	$ 1,462,760	1,462,760				
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 3,605,648	$ 3,605,648	$ -	$ -	$ -	$ -

FY 2020-21 Through FY 2022-23 Three-Year 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	$ 1,819,980	1,819,980				
2. WET-03 Mental Health Career Pathway Programs	$ 322,908	322,908				
3. WET-04 Residency and Internship Program	$ 1,462,760	1,462,760				
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	$ 3,605,648	$ 3,605,648	$ -	$ -	$ -	$ -

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix B

Certifications and Minute Order

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

LIVEWELLSD.ORG

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, OCTOBER 27, 2020

MINUTE ORDER NO. 7

SUBJECT: APPROVE THE MENTAL HEALTH SERVICES ACT THREE-YEAR PROGRAM AND EXPENDITURE PLAN FOR FISCAL YEARS 2020-21 THROUGH 2022-23 (DISTRICTS: ALL)

OVERVIEW

The Mental Health Services Act (MHSA) provides funding to counties to address a broad continuum of mental health service needs, including prevention, early intervention, system development, and to address the necessary infrastructure, technology, and training to effectively support the public mental health system. MHSA programs provide services to children, youth, and families, transition age youth, adults, and older adults, with an emphasis on individuals who are unserved or underserved. In Fiscal Year 2018-19 MHSA programs served over 78,000 unique individuals. MHSA is comprised of five components:

- Community Services and Supports (CSS);
- Prevention and Early Intervention (PEI);
- Innovation (INN);
- Workforce Education and Training (WET); and
- Capital Facilities and Technological Needs (CF/TN).

The County of San Diego (County), Health and Human Services (HHSA) Behavioral Health Services (BHS) is presenting the recommended MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2020-21 through 2022-23 (Three-Year Plan). As mandated by the MHSA, the Three-Year Plan, inclusive of all programs and expenditures funded by the MHSA, requires approval by the Board of Supervisors prior to submission to the California Mental Health Services Oversight and Accountability Commission (MHSOAC).

Today's recommended action requests that the Board receive and approve the Three-Year Plan, which includes estimated MHSA funds of $192.8 million in Fiscal Year (FY) 2020-21, $195.3 million in FY 2021-22, and $193.4 million in FY 2022-23. The Three-Year Plan also includes $400,000 assigned to the California Mental Health Services Authority (CalMHSA) to continue statewide PEI campaigns and local PEI initiatives as part of the FY 2020-21 amount. Since the establishment of the MHSA, the County has invested over $1.5 billion of MHSA funding to expand and enhance critical mental health programs. Continued investments in MHSA services through the implementation of the Three-Year Plan supports the goal of dramatically shifting how residents of San Diego County access care and support for behavioral health needs through the continued development of a regionally distributed model of care focused on prevention and continuous care, rather than perpetual crisis. Over the last several years, at the Board's direction, BHS has continued to aggressively invest MHSA funding into critical prevention, treatment and support services.

Today's action supports the countywide *Live Well San Diego* vision by enhancing access to behavioral health services, promoting well-being in children, adults and families, and encouraging self-sufficiency, which promotes a region that is building better health, living safely, and thriving.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER
Receive and approve the MHSA Three-Year Program and Expenditure Plan for Fiscal Years 2020-21 through 2022-23 (Three-Year Plan) and authorize the Director, Health and Human Services Agency, to submit the Three-Year Plan to the California Mental Health Services Oversight and Accountability Commission.

FISCAL IMPACT
Funds for this request are included in the Fiscal Year (FY) 2020-22 Operational Plan for the Health and Human Services Agency. If approved, this request will result in estimated Mental Health Services Act (MHSA) costs and revenues of $192.8 million in FY 2020-21, inclusive of $400,000 dedicated to the California Mental Health Services Authority (CalMHSA), to continue participation in statewide prevention and early intervention campaigns and local initiatives. The funding source is MHSA. The proposed MHSA budget reflects enhanced Medi-Cal drawdown in FY 2020-21 tied to a Federal Medi-Cal Assistance Percentage (FMAP) associated with COVID-19. There will be no change in net General Fund cost and no additional staff

BUSINESS IMPACT STATEMENT
N/A

ACTION:
ON MOTION of Supervisor Desmond, second by Supervisor Fletcher, the Board of Supervisors took action as recommended.

AYES: Cox, Jacob, Gaspar, Fletcher, Desmond

State of California)
County of San Diego) §

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

ANDREW POTTER
Clerk of the Board of Supervisors

Signed
by Marvice Mazyck, Chief Deputy

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix C
MHSA Program Summary

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

LIVEWELLSD.ORG

MHSA Program Summaries Fiscal Year 2020-2023
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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	Transition Age Youth, Adults/Older Adults with serious mental illness 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
ALL-OE	Behavioral Health Services and Primary Care Integration Services	Mental Health and Primary Care Services Integration Services	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 to 59 years	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network 7535 Metropolitan Dr. San Diego, CA 92108 (619) 542-4300	All
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	Children, Transition Age Youth, Adults/Older Adults who are deaf or hard of hearing and who have a serious mental illness or substance use disorder	• 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
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
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 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	All
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 436 S. Magnolia Ave., Suite 201 El Cajon, CA 92020 (619) 401-7410	All
ALL-SD	Psychiatric Emergency Response Team (PERT)	Psychiatric Emergency Response Team	Connects law enforcement officers with psychiatric emergency clinicians to serve children and adults 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 and the Native American community	• Case coordination • Linkage and limited 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

MHSA Program Summaries Fiscal Year 2020-2023
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's FSP Housing	TBD	Homeless/Runaway Youth Behavioral Health FSP Shelter Beds for Transition Age Youth (TAY)	Provide shelter and support services to homeless youth with the purpose of providing immediate shelter and support transition to stable housing	Homeless children and youth up to age 21	• Short term housing • Case management	TBD	TBD
CY-FSP	Children's Full Service Partnership (FSP)	TBD	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	TBD	1, 4
CY-FSP	Children's School Based Full Service Partnership (FSP)	Child/Youth Case Management	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	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle	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	Family Health Centers - Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2382 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-7520	1, 2,3, 4
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	Homeless children and youth up to age 21 attending a Juvenile Court and Community School (JCCS) who meet medical necessity and serious emotional disturbance (SED) criteria and who may be involved with the juvenile justice system	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 1679 E. Main St., Suite 102 El Cajon, CA 92021 (619) 441-1907	2
CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Research Foundation - Mobile Adolescent Services Team (MAST)	Mental Health assessment and treatment services for students and their families at the Juvenile Court and Community School (JCCS) sites, home, 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 attending a Juvenile Court and Community School (JCCS) who meet medical necessity and serious emotional disturbance (SED) criteria and who may be involved with the juvenile justice system	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-3261	All

MHSA Program Summaries Fiscal Year 2020-2023
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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 attending a Juvenile Court and Community School (JCCS) who meet medical necessity and serious emotional disturbance (SED) criterial and who may be involved with the juvenile justice system	• 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
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	1, 4, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	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 7907 Ostrow St., Suite F San Diego, CA 92111 (858) 300-8282	3, 4
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
CY-FSP	Children's School Based Full Service Partnership (FSP)	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 7339 El Cajon Blvd., Suite K La Mesa, CA 91942 (619) 668-6200	2

MHSA Program Summaries Fiscal Year 2019-2020
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's School Based Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	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, 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
CY-FSP	Children's School Based Full Service Partnership (FSP)	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
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
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) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	All

MHSA Program Summaries Fiscal Year 2020-2023
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's School Based Full Service Partnership (FSP)	North County Lifeline	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
CY-FSP	Children's School Based Full Service Partnership (FSP)	Palomar Family Counseling 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	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthrone St. Fallbrook, CA 92028 (760) 731-3235	2, 3, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familia	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 5 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 Families 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650	1
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
CY-FSP	Children's School Based Full Service Partnership (FSP)	Rady OutPatient Psychiatry North Coastal	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 3142 Vista Way, Suite 205 Oceanside, CA 92056 (760) 758-1480	3, 5
CY-FSP	Children's School Based Full Service Partnership (FSP)	Rady Outpatient Psychiatry North Inland	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 625 W. Citacado Pkwy., Suite 102 Escondido, CA 92025 (760) 294-9270	2,3,5

MHSA Program Summaries Fiscal Year 2020-2023
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Children's School Based Full Service Partnership (FSP)	School Based Program	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	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	4
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
CY-FSP	Children's School Based Full Service Partnership (FSP)	School-Based Outpatient Behavioral Health Services	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	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	Social Advocates for Youth 4275 El Cajon Blvd., Suite 101 San Diego, CA 92105 (619) 283-9624	4
CY-FSP	Children's School Based Full Service Partnership (FSP)	South Bay Community Services (Mi Escuelita)	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
CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	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	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
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

MHSA Program Summaries Fiscal Year 2020-2023
Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services	Intensive, individualized, one- to-one behavioral coaching program available to children/youth up to 21 years old 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	• One on one behavioral coaching	New Alternatives - TBS 8755 Aero Drive, Suite 230 San Diego, CA 92123 (858) 256-2180	All
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	All
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (North Coastal)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery services	North County Serenity Outpatient 3355 Mission Ave. #239 Oceanside, CA 92058 760-685-4840	5
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (Central)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery Services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	4
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (East)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery Services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	2
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (North Central)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery Services	McAlister Institute for Treatment and Education 1400 North Johnson Ave., Suite 101 El Cajon, CA 92020 (562) 513-6917	4
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (North Inland)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery Services	McAlister Institute for Treatment and Education 1400 North Johnson Ave., Suite 101 El Cajon, CA 92020 (562) 513-6917	5
CY-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	Perinatal Outpatient - Homeless Outreach (South)	Women and perinatal substance use disorder treatment	Perinatal outpatient substance use disorder and co-occurring treatment and recovery services	Women, pregnant and parenting women, and adolescent females ages 15 and older	• Recovery Services	McAlister Institute for Treatment and Education 1400 North Johnson Ave., Suite 101 El Cajon, CA 92020 (562) 513-6917	1

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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 3003 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CY-SD	BHS Children, Youth and Families (CYF) Liaison	Family Youth Liaison (YL)	The Family Youth Liaison collaborates with Children, Youth and Families (CYF) administrative staff to ensure family and youth voice and values are incorporated into service development, implementation plans, and service delivery	Advance, train, and coordinate family/youth partnership in CYF programs	Children and youth up to age 21 served by CYF providers and their families	• Coordinates administrative functions in which family/youth participate • Trains CYF programs management staff to work with support Family/Youth Partners • Develops and provides CYF system trainings and coaching sessions • MHSA Issue Resolution point of contact	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6580	All
CY-SD	BridgeWays Program Services	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. San Diego, CA 92115 (619) 221-8600 x2503	All
CY-SD	Commercially Sexually Exploited Children (CSEC)	San Diego Youth Services - I CARE	Individual/group/family services provided at schools, 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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	County of San Diego - Probation	Probation After Hours (STAT Team)	Multi-disciplinary team provides transitional services as youth rejoin the community following incarceration	Ensure probation children and youth with mental illness have access to mental health services, with successful reintegration into the community and potential reduction in recidivism	Probation children and youth up to age 21 currently in detention or in the community who require mental health services to enhance functioning and reduce symptomology	• Individual/group/family treatment • Crisis intervention • Care coordination • Case management • Medication management • Community based mental health services	Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
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	1
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
CY-SD	Incredible Families	Incredible Families	Outpatient mental health treatment and support services for children and families involved in Child Welfare Services	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	TBD	All
CY-SD	Incredible Years	Children Seriously Emotionally Disturbed	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. The Incredible Years program includes parent training, teacher training and treatment services for children within a school-based program setting	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	2, 3, 5
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 2851 Meadow Lark Dr. San Diego, CA 92123 (858) 571-1964	All

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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 schools, 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. San Diego, CA 92103 (619) 525-9903	All
CY-SD	Peer Mentoring	San Pasqual Academy Children's Mental Health Services	Individual/group/family services to children and youth in an academy setting to support self-sufficiency. Provides peer mentorship services to Child Welfare Services youth in placement to foster adolescent growth towards independence and self sufficiency	Support adolescent growth towards independence and self sufficiency for youth preparing to exit the foster care system	Children and youth at San Pasqual Academy ages 12-21 years old who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	New Alternatives Inc. San Pasqual Academy 17701 San Pasquel Valley Rd. Escondido, CA 92025 (760) 233-6005	All
CY-SD	Placement Stabilization Services	Comprehensive Assessment and Stabilization Services (CASS)	Provides mental health services to children and youth who are placed through Child Welfare Services in various foster home placements. Services available by referral from Child Welfare Services	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 meet medical necessity and serious emotional disturbance criteria who are at risk of changing placement to a higher level of care	• 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
CY-SD	Placement Stabilization Services	Polinsky Children's Center Outpatient Services (PCC)	Provides mental health assessment and treatment services to children and youth for a short term assessment period while at Polinsky Children's Center. Collaboration with Child Welfare Services for transition plan to enhance permanency and stability	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) 357-6879	All
CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	Paraprofessionals within rural community clinics provide behavioral health education to prevent development of serious mental illness or addiction. Help patients manage health, emotional, and behavioral concerns	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	• Rural integrated behavioral health and primary care services	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5400	2, 5

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CY-SD	Walk-In Assessment Clinic and Mobile Assessment Team	Behavioral Crisis Center and Mobile Assessment Team Services	Provides mobile crisis mental health services in conjunction with walk-in assessment clinics for the North County region	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness	Children and youth up to age 21 who are experiencing a mental health crisis or urgent need for mental health services	• Crisis response & intervention • Assessment • Medication management • Linkage to hospital • Short term follow-up visits to facilitate warm hand-off as applicable and/or outpatient services, as indicated • Case management	New Alternatives, Inc. North County Crisis Intervention and Response Team 225 West Valley Pkwy., Suite 100 Escondido, CA 92025 (760) 233-0133 1020 S. Santa Fe Ave., Suite B-1 Vista, CA 92084 (760) 233-0133	5
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) Institutional Case Management (ICM)	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	Telecare Corporation Telecare Agewise 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Start 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) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3, 5
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	TBD	Full Service Partnership/Assertive Community Treatment - Justice Integrated Services	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 an acute setting (Behavioral Health unit)	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	TBD	All
TAOA-FSP	Adult Residential Treatment/ Full Service Partnership (FSP)	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	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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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
TAOA-FSP	County of San Diego - Institutional Case Management	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
TAOA-FSP	County of San Diego - Probation	Probation Officer for BH 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
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
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 337 West Mission Ave. Escondido, CA 92025 (760) 975-9939	All

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Full Service Partnership (FSP) / and Assertive Community Treatment (ACT)	IMPACT Downtown IMPACT	Fully integrated 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 at-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
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
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACTION East	Services for homeless persons with serious mental illness or substance use disorder	Planned hybrid model will integrate Assertive Community Treatment intensive case management services with substance use disorder treatment and recovery services	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
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Center Star ACT	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
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	Ensure clients are provided access to good quality housing in the Central and North Central Regions of San Diego County	Transition Age Youth, and adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnosis of substance abuse	• Supportive Housing	Mental Health Systems Inc. (MHS) 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	4
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, and adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnoses of substance abuse	• Supportive Housing	Community Research Foundation (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 398-0355	1

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	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	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
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	North Star - Strengths Based Case Management (SBCM)	Full Service Partnership Strengths-Based Case Management	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
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	Services are designed using the Assertive Community Treatment model and 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
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
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	TBD	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	TBD	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	TBD	Full Service Partnership/Assertive Community Treatment - Justice Involved	TBD	TBD	TBD	TBD	TBD

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TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	TBD	Full Service Partnership/Assertive Community Treatment - Transition Age Youth (TAY) Housing	TBD	TBD	TBD	TBD	TBD
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step down from IMD	City Star Act	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	Mental Health Services (MHS), Inc., 8775 Aero Dr., Suite 132 San Diego, CA 92123 (858) 609-8742	All
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
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Crestwood Behavioral Health, Inc.	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility	Provide transitional residential beds and bio-psychosocial rehabilitative services to seriously mentally ill adults with co-occurring disorders	TBD	TBD	Crestwood Behavioral Health, Inc. 5550 University Ave, Suite A San Diego, Ca 92105 (619) 481-5447	All
TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	TBD	Full Service Partnership/Assertive Community Treatment - Transitional Residential and Adult Residential Facility	TBD	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder	TBD	TBD	TBD
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 homeless and have a serious mental illness	Provide residential support, crisis intervention, and transitional housing services	Adults/Older Adults who are homeless with a serious mental illness	• Temporary housing for eligible individuals • Provide food • Linkage to transitional housing • Case management	Uptown Safe Haven 2822 5th Ave. San Diego, CA 92103 (619) 294-7013	All
TAOA-FSP	Full Service Partnership (FSP) and 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

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TAOA-FSP	North Coastal Mental Health Center and Vista Clinic	North Coastal Mental Health Clinic and Vista BPSR Clinic	Outpatient mental health and rehabilitation and recovery, crisis walk in, peer support, homeless outreach, case management and long term vocational support	Increase mental health services for Transition Age Youth. Decrease incidence of homelessness. Increase client's self-sufficiency through development of life skills	Adults 18 years and older who have serious mental illness, including those who may have a co-occurring substance use disorder. Transition Age Youth emphasis	• Outpatient mental health clinic • Treatment, rehabilitation, and recovery services	Mental Health Systems, Inc. (MHS) North Coastal Mental Health Center 3209 Ocean Ranch (TEMP SITE) Oceanside, CA 92058 (760) 967-4483 Vista 550 West Vista Way, Suite 407 Vista, CA 92083 (760) 758-1092	5
TAOA-FSP	Payee Case Management Services	Rep Payee	Payee case management services	Key component of the program is increasing clients' money management skills	Adults 18 years and older	• Payee Case Management with a rehabilitation and recovery focus to adults who meet eligibility criteria • Increasing clients' money management skill • Bio-Psycho-Social Rehabilitation (BPSR)	National Alliance on Mental Illness (NAMI) San Diego Adult Outpatient 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	All
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

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TAOA-FSP/SD	Strengths Based Case Management (SBCM) Bio-Psychosocial Rehabilitation (BPRS)	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
TAOA-FSP/SD	Strengths Based Case Management (SBCM) Bio-Psychosocial Rehabilitation (BPRS)	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 835 3rd Ave., Suite C Chula Vista, CA 91911 (619) 429-1937	1
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	Mid-Coast Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both the 12-step models (e.g., AA, NA) and non-12-step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgement) drug diversion services to adults	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	4
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

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TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	South Regional Recovery Center	Non-residential substance use disorder treatment and recovery service center. Incorporating evidence-based treatment and recovery services	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12 step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety). Also, PC 1000 (Deferred Entry of Judgment) drug diversion services to adults	McAlister Institute for Treatment and Education South Regional Recovery Center 1180 Third Ave., Suite C-3 Chula Vista, CA 91911 (619) 691-8164	1
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	East 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 problems addressing both disorders for adults experiencing co-occurring substance use disorder and mental health problems	Adults 18 years and older with substance use disorder problems, including those who may have co-occurring mental health disorder	• Non-residential substance use disorder treatment rehabilitation services	McAlister Institute for Treatment and Education East Regional Recovery 1365 North Johnson Ave. El Cajon, CA 92020 (619) 440-4801	2
TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	North Inland 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	Ensure that adults experiencing co-occurring substance use disorder and mental health problems receive services that comprehensively address both disorders, so the individual may achieve a substance use disorder free lifestyle	Adults 18 years and older with substance use disorder, including those who may have co-occurring mental health	• Non-residential substance use disorder treatment and recovery services to Transition Age Youth, adults and older adults with substance use disorder-induced problems, including co-occurring mental health disorders • Services incorporate evidence-based treatment and recovery service approaches that incorporate both 12-step models (e.g., AA, NA) and non-12 step models (e.g., SMART Recovery, Rational Recovery, and Secular Organizations for Sobriety.) Also, PC 1000 (Deferred Entry of Judgement) drug diversion services to adults	McAlister Institute for Treatment and Education North Inland Recovery Center 200 East Washington Ave., Suite 100 Escondido, CA 92025 (760) 741-7708	5

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TAOA-OE	Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	Substance Use Disorder Recovery Center	Non-residential substance use disorder treatment and recovery for adults and Transition Age Youth	Support integrated treatment of co-occurring disorder issues for those enrolled in substance use disorder treatment. Reduce stigma associated with mental health concerns and provide additional support or referrals according to needed	Adults 18 years and older who are Asian and Pacific Islander	• Non-residential substance use disorder treatment • Family education	Union of Pan-Asian Communities (UPAC) 3288 El Cajon Blvd., Suites 3, 6, 10, 11, 12 & 13 San Diego, CA 92104 (619) 521-5720	4
TAOA-SD	Augmented Services Program (ASP)	TBD	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 shall receive additional services from these B&C facilities beyond the basic B&C level of care	TBD	All
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	1, 4
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Community Wellness Center	Certified Bio-Psychosocial Rehabilitation Wellness Recovery Center that 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	Adult 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 Medi-Cal certified treatment, rehabilitation, and recovery services • This clinic offers walk in service during their normal hours of operation	New Leaf Recovery Center 3539 College Ave. San Diego, CA 92115 (619) 818-1013	4
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 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	1, 4
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

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TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Jane Westin Wellness & Recovery Center	Urgent Walk-In Services for Mental Health Evaluation	Provide one time, short-term 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 1568 6th Ave. San Diego, CA 92101 (619) 235-2600 ext. 201	1, 4
TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Logan Heights Family Counseling	Provides outpatient, case management, brokerage and vocational support 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	Family Health Centers Logan Heights 2204 National Ave. San Diego, CA 92113 (619) 515-2355	1, 4
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	1, 4
TAOA-SD	Client Liaison Services	Client Liaison Services	Client liaison services aims to increase client participation and involvement in Behavioral Health Services Adult and Older Adult System of Care through peer advocacy	Develop and coordinate increasing client involvement and partnership in the development of policies, practices and programs to ensure client needs are accommodated	Adults 18 years and older who have a serious mental illness and receive services through Behavioral Health Services	• Peer advocacy • Engagement and education	Recovery Innovations, Inc. 2701 North 16th St Phoenix, AZ 85006 (602) 650-1212	All
TAOA-SD	Client Operated Peer Support Services	Client Operated Peer Support Services	Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to support agencies	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Adults 18 years and older who have a serious mental illness living in San Diego County	• Client-operated peer support services program that includes countywide peer education, peer advocacy, peer counseling, peer support of client-identified goals with referrals to relevant support agencies • Skill development classes to adults with serious mental illness	Recovery Innovations, Inc. 2701 North 16th St. Phoenix, AZ 85006 (602) 636-4400	All
TAOA-SD	Clubhouse	Casa Del Sol Clubhouse (South Region)	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 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 living in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Community Research Foundation (CRF) - South Bay Casa Del Sol Clubhouse 1157 30th St. San Diego, CA 92154 (619) 429-1937	1
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	TBD	2

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TAOA-SD	Clubhouse	Episcopal Community Services Friend to Friend (F2F) 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 Road, Suite 320 San Diego CA 92123 (619) 543-1434	4
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
TAOA-SD	Clubhouse	Mariposa Clubhouse (North Coastal 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 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
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
TAOA-SD	Clubhouse	TBD	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	TBD	All
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
TAOA-SD	Clubhouse	The Meeting Place & Warm Line	The program 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., Suite 101 San Diego, CA 92103 (619) 294-9582	4

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TAOA-SD	Clubhouse	Visions Clubhouse (South Region)	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 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 and reside in San Diego County	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Association Visions Clubhouse 226 Church Ave. Chula Vista, CA 91911 (619) 420-8603	1
TAOA-SD	Clubhouse - BPSR	BPSR Center (Mid City) BPSR Center (Serra Mesa) EAST WIND	Provides outpatient, case management brokerage, clubhouse and vocational support services	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	• Case management • Mobile outreach • Long-term vocational services, outpatient mental health rehabilitation; recovery services	Union of Pan Asian Communities (UPAC) - Mid City 5348 University Ave., Suites 101 & 120 San Diego, CA 92105 (619) 229-2999 UPAC Serra Mesa 8745 Aero Dr., Suite 330 San Diego, CA 92123 (858) 268-4933	1, 4
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 555 E. Valley Pkwy. Escondido, CA 92025 (760) 739-3000	3, 5
TAOA-SD	Faith Based	TBD	Faith Based Behavioral Health Training and Education Academy to train faith-based members to support existing crisis response teams (Formerly INN 13 Faith Based Initiative)	TBD	TBD	TBD	TBD	4
TAOA-SD	Faith Based	TBD	Faith Based Wellness and Mental Health In-Reach Ministry to provide support to existing crisis response teams (Formerly INN 13 Faith Based Initiative)	TBD	TBD	TBD	TBD	All
TAOA-SD	Home Finder	Home Finder	Housing support for BHS adult clinics	Identify and secure safe and affordable housing	Adults 18 years and older who are enrolled in BHS programs with serious mental illness who are homeless or at risk for homelessness	• Support identifying and securing safe and affordable housing (both single and shared occupancy). • Create and update a centralized hub for housing resources and roommate matching services • 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 for the Homeless 3860 Calle Fortunada San Diego, CA 92113 (619) 542-1877	1, 4

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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
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
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
TAOA-SD	In-reach Services	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 5660 Copley Dr. San Diego, CA 92114 (619) 244-8241	All
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 102 San Diego, CA 92114 (619) 266-9400	All
TAOA-SD	Mental Health Advocacy Services	TBD	Mental Health Advocacy Services program will provide advocacy support type services to individuals with mental health disorders and their family members	Increase and improved access to services for the individuals to be served	TDB	• Advocacy support services • Client outreach and engagement • Education services	TBD	All

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Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
TAOA-SD	Peer Assisted Support Services	TBD	Provide services for persons diagnosed with Severe Mental Illness (SMI) who use acute crisis-oriented mental health services but are not effectively connected with community resources and/or lack active support networks through the provision of peer specialists. (Formerly INN 15 Peer Assisted Transitions)	TBD	TBD	TBD	TBD	All
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
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	4

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Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	San Diego Housing Commission	Housing Voucher program	New Housing Coordinators for San Diego Housing Commission (Access to 100 Vouchers)	Provide support for housing	Adults 18 years and older who have a serious mental illness	• Housing Vouchers	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400	4
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) 232-7048 CRF ISIS Crisis Center (619) 575-4687	All

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Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	United Homes	Provide short-term residential services to individuals with serious mental illness and may have co-occurring substance use disorder	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• Provides additional services to people with serious and prolonged mental illness in licensed residential care facilities (also known as B&C facilities) Identified eligible persons shall receive additional services from these B&C facilities beyond the basic level of care	United Homes-Emergency Shelter Beds 336 South Horne St. Oceanside, CA 92054 (760) 612-5980	3, 5
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	East Region	Provide short-term residential services for individuals with serious mental illness or may have a co-occurring substance use disorder	TBD	TBD	TBD	TBD	2
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	Interfaith Community Services	Provide short-term residential services to individuals with serious mental illness and may have co-occurring substance use disorder	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• 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
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	Ruby's House Independent Living	Provide short-term residential services to individuals with serious mental illness and may have co-occurring substance use disorder	Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency	Transitional Age Youth, 16 to 25 years of age females, who have a serious emotional disturbance or a serious mental illness who may have co-occurring substance use disorder	• Provide shelter and food in a residential setting that has staff available during all operating hours • Provide safe and sanitary quarters on a nightly basis and in a location acceptable to the County • Coordinate services with designated County-contracted Peer Support Services program to promote delivery of peer support services	Ruby's House Independent Living Facility 1702 Republic St. San Diego, CA 92114 (619) 756-7211	4
TAOA-SD	Short-Term Bridge Housing (formerly Emergency Shelter Beds - ESB)	Urban Street Angels (Transitional Shelter Beds for Transition Age Youth)	Supplemental housing for Transitional Age Youth in an independent living environment	The provision of housing and support services to homeless mentally ill Transition Age Youth by providing accessible short-term and transitional beds for identified clients	Transitional Age Youth, 16 to 25 years of age, who have a serious emotional disturbance or a serious mental illness who may have a co-occurring substance use disorder	• Emergency shelter and transitional beds • Case Management	Urban Street Angels, Inc. 3090 Polk Ave. San Diego, CA 92104 (619) 415-6616 Shelter Sites: 5308 Churchward St. San Diego, CA 92114 (male house) 4634 Bancroft St. San Diego, CA 92116 (female house)	4
TAOA-SD	Telemedicine	Exodus Recovery, Inc.	Provide Telepsych Hub Telemedicine services on an on-demand basis	Outpatient psychiatric prescriber services for children, and adult mental health consumers utilizing Telehealth practices and technology	Exodus Program Clients	• Telehealth prescriber services	Exodus Recovery, Inc. 2950 El Cajon Blvd. San Diego, CA 92104 (619) 528-1752	All

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Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD	Tenant Support Services	Alpha Project for the Homeless	Provide services to implement the Project One for All (POFA) Outpatient Hub for 357 Clients (Tenant Peer Support Services)	On-going support for homeless clients enrolled in BHS designated outpatient MH clinics. Services will include housing navigation and tenant support services for clients with Tenant Based Subsidies	TBD	TBD	Alpha Project for the Homeless 3737 Fifth Avenue #203 San Diego CA 92103 (619) 542-1877	4
TAOA-SD	Walk-In Assessment Center	Exodus Recovery, Inc.	Provide walk-in services assessment and referral services to individuals experiencing a mental health episode	Increase access to mental health services and overcome barriers such as language, wait times, lack of knowledge or awareness of available services	Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder	• Walk-in treatment center • Rehabilitation and recovery services	North County Walk in Assessment Center 1520 South Escondido Blvd. Escondido, CA 92025 (760) 871-2020 Vista Walk In Assessment Center 524 & 500 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5

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Community Services and Supports (CSS)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
TAOA-SD/CY-SD	Family Mental Health Education and Support	Family Mental Health Education and Support	Provides a series of educational classes presented by family members using and established family education curriculum to provide education and support to persons who have relatives (or close friends) with mental illness	Promote integration of family education services. Increase family involvement coping skills and improve supportive relationships	Family members and friends of persons who have a serious mental illness	• Provides a series of educational classes presented primarily by family members or persons with serious mental illness using and established family education curriculum to provide education and support to persons who have relatives or close friends with mental illness • Increase family members coping skills and support increased involvement and partnership with the mental health system	National Alliance on Mental Illness (NAMI) San Diego Adult Outpatient 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	All
TAOA-SD/CY-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

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Prevention and Early Intervention (PEI)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
CO-02	Adult Drug Court Treatment and Testing	Adult Drug Court - Central Case Management	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services • Outpatient drug-free treatment and intensive day care rehabilitative services • Mental health screening	Mental Health Systems Inc. (MHS) San Diego Center For Change 3340 Kemper St., Suite 103 San Diego, CA 92110 (619) 758-1433	4
CO-02	Adult Drug Court Treatment and Testing	Adult Drug Court - East Case Management	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential treatment, recovery, and ancillary services. • Outpatient drug-free treatment and intensive day care rehabilitative service in an environment free of substance use disorder • Mental health screening	Mental Health Systems Inc. (MHS) East County Center For Change 545 N. Magnolia Ave. El Cajon, CA 92020 (619) 579-0947	2
CO-02	Adult Drug Court Treatment and Testing	Adult Drug Court - North	Provides intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	•Non-residential treatment, recovery, and ancillary services •Outpatient drug-free treatment and intensive day care rehabilitative services. •Mental health screening	Mental Health Systems Inc. (MHS) North County Center For Change 504 W. Vista Way Vista, CA 92083 (760) 940-1836	2, 3, 5
CO-02	Adult Drug Court Treatment and Testing	Collaborative Drug Court - South	Provides Intensive treatment services to offenders with long histories of drug use and criminal justice contacts, previous treatment failures, and high rates of health and social problems	Support the target population in their efforts to become and remain free from substance use disorder, provide mental health screening and referrals, screen for mental health concerns, and reduce stigma associated with mental health issues	Non-violent male and female offenders, with a history of substance use disorder and co-occurring disorders, who have been referred to treatment by the Adult Drug Court team and accepted for intake in an environment free of substance use disorder	• Non-residential Substance Use Disorder (SUD) treatment, recovery, and ancillary services • Outpatient drug-free treatment and intensive day care rehabilitative services • Mental health screening	Mental Health Systems Inc. (MHS) San Diego Center For Change 3340 Kemper St., Suite 103 San Diego, CA 92110 (619) 758-1434	1, 4
CO-03	Integrated Peer & Family Engagement Program - Next Steps	Next Steps	Provides comprehensive, peer-based care coordination, brief treatment and system navigation to adults with mental health and substance use disorder	Provide mental health screening and services to adults 18 years and older, including transition age youth and older adults with substance use disorder	Adults 18 years and older	• On call either in person or via mobile devices • Screening tool for mental health and substance use disorder	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
DV-03	Community Violence Services (South - Alliance for Community Empowerment)	Alliance for Community Empowerment	Provides trauma informed, community centered, family driven and evidence based Community Violence Response services in Central Region, but may serve clients outside the region	Increase in resilience; improvement in parenting knowledge; increases problem-solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho-social impact of trauma	Middle-school age youth boys and girls affected by violence	• Direct 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	4

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Prevention and Early Intervention (PEI)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
DV-04	Community Services for Families - CWS	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
DV-04	Community Services for Families - CWS	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
DV-04	Community Services for Families - CWS	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
DV-04	Community Services for Families - CWS	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
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
FB-01	Early Intervention for Prevention of Psychosis (TAY & Children)	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
NA-01	Native American Prevention and Early Intervention	Indian Health Council, Inc.	PEI and substance use disorder treatment services to 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 Region 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
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
NA-01	Native American Prevention and Early Intervention	Southern Indian Health Council, Inc.	Provides PEI and substance use disorder 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

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Prevention and Early Intervention (PEI)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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) 9360 Activity Rd., Suite B San Diego, CA 92126 (619) 238-1783 ext. 30	All
OA-02	Home Based Services (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) 9360 Activity Rd., Suite B San Diego, CA 92126 (619) 238-1783 ext. 30	1, 4, 5
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
PS-01	ACEs Prevention and Family Functioning	TBD	Reduce Adverse Childhood Experiences (ACEs) by strengthening family functioning that builds emotional intelligence, interpersonal communication skills	Program goals are increased emotional intelligence skill development, improved interpersonal communication, reduction in individual and family dysfunction, improved employment and job/career development	Underserved and Unserved custodial, non-custodial married and /or unmarried parents of children under the age of 18	• Outreach and Engagement • Prevention Education • Education and Training to support emotional intelligence development, interpersonal communication • Employment and career development support	TBD	All
PS-01	Father 2 Child	Father 2 Chid	Provide outreach and parenting education, improve father, dad, caregiver and child emotional support, communication and parenting interaction	Improve interpersonal communication, reduction in individual and father and child dysfunction, improved employment and career for father and dad.	Fathers, dads, caregivers of childen under 17 years of age	• Outeach • Prevention Education	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	4
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) 637-3006	All
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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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	Civilian Inc. 2468 Historic Decatur Rd., Suite 250 San Diego, CA 92106 (619) 243-2290	All
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	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	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
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	Employment is an essential element of comprehensive mental health services for adults with serious mental illness. Supported Employment is a key strategy for meeting both the employment and service needs of adults with serious mental illness and the MHSA target populations. These services improves access to employment opportunities	Service providers, employers, agencies, government organizations, and other stakeholders	• Promote employment opportunities for adults with serious mental illness	San Diego Workforce Partnership, Inc. 3910 University Ave., Suite 400 San Diego, CA 92105 (619) 228-2952	All
RC-01	Rural Integrated Behavioral Health & Primary Care Services	Integrated Behavioral Health and Primary Care Services in Rural Communities	Provides Rural Integrated Behavioral Health and Primary Care Services for prevention and early intervention services	Increase access to and usage of services	Children, Transition Age Youth, Adults/Older Adults	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5122	All
RE-01	Independent Living Association (ILA)	CHIP Independent Living Association (ILA)	Creates an Independent Living Facility Association with voluntary membership	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
SA-01	School Based PEI - North Inland	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

MHSA Program Summaries Fiscal Year 2020-2023
Prevention and Early Intervention (PEI)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
SA-01	School Based PEI- South	South Bay Community Services - 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
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
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) 362-4300	3, 4
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) 362-4301	4
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
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	Reduce suicides and the negative impact of suicide in schools. Increases education of education 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
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 service providers	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors or stressors. Improves access to mental health and PEI services, information and support	Veterans, active duty military, Reservists, National Guard, and family members	• Education and Navigation • Peer counseling • Linkage to mental health services • Mental health information • Support hotline	Mental Health Systems, Inc. (MHS) 9445 Farnham St., Suite 100 San Diego, CA 92123 (858) 636-3604	All

MHSA Program Summaries Fiscal Year 2020-2023
Innovations (INN)

Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
INN-16	Urban Beats	Urban Beats	Provides an artistic expression that includes the use of multiple models of artistic expression including visual arts, spoken word, music, videos, and performances and social media created and developed by Transition Age Youth	Increase the engagement and retention rates in mental health treatment of serious emotional disturbance and serious mental illness and at risk Transition Age Youth by incorporating a Transition Age Youth focused recovery message into an artistic expression and social marketing	Transition Age Youth who are clients of the mental health system with serious emotional disturbance/serious mental illness or at-risk of mental health challenges	• Develop youth leaders within Transition Age Youth community • Increase access to services • Whole health and prevention services	Pathways Community Services 3330 Market St. San Diego, CA 92102 (858) 227-9051	1, 2, 4
INN-17	Mobile Hoarding Intervention Program	Cognitive Rehabilitation and Exposure Sorting Therapy (CREST) mobile hoarding units (formerly IMHIP)	Provide education and intervention services to diminishes long term hoarding behaviors in Older Adults	Improve the health, safety, quality of life, and housing stability of individuals through provision of comprehensive hoarding behavioral intervention and treatment services	Older Adults 60 years and older with hoarding disorder and a serious mental illness in the Central, South, and North Regions	• Community outreach and engagement • In-home therapy • Family support	Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All
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	Peripartum women and partners, especially in communities at risk of trauma	• Outreach and engagement through public health nurses • Interventions to prevent and treat postpartum depression	Vista Hill Foundation 6070 Mission Gorge Road San Diego, CA 92120 (858) 514-5100	All
INN-19	Telemental Health	BH Connect	Provides post psychiatric emergency services follow-up treatment and stabilization via electronic devices for tele-therapy	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	• Follow-up mental health treatment and stabilization via tele-therapy • Case Management • Access to tele-therapy platform for treatment and resources • Outreach and engagement	Vista Hill Foundation 8825 Aero Dr., Suite 315 San Diego, CA 92123 858-956-5900	All
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 • 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-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 • 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
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 1404 Fifth Ave. San Diego, CA 92101 (619) 415-6616	1, 2, 4
INN-22	Med Clinics	Center for Child and Youth Psychiatry (CCYP)	Provides ongoing medication management for children and youth with complex psychiatric pharmacological needs	Promote stabilization by providing accessible follow up for complex psychiatric pharmacological needs	Children and youth up to age 21	• Medication management • Psychiatric consultation • Outreach and engagement • Psycho-educational seminars and groups for families	New Alternatives 8755 Aero Dr., Suite 306 San Diego, CA 92123 858) 634-1100	All
INN-24	Early Psychosis Evaluation and Learning Health Care Network	Early Intervention for Prevention of Psychosis; Kickstart	TBD	TBD	TBD	TBD	TBD	All

MHSA Program Summaries Fiscal Year 2020-2023
Workforce Education and Training (WET)

Work Plan	RER Program Name	Program Name	Program Name and Contract Agency	Program Description	Contact Information	Districts
WET-02	Behavioral Health Training Curriculum	Behavioral Health Training Academy	RIHS (formerly BHETA)	MHSA, Workforce Education and Training: Training and Technical Assistance. Includes Justice Involved Training Academy; CYF Outcomes coordination of the Child and Adolescent Needs and Strengths outcomes measure; and Drug Medi-Cal, Organized Delivery System	San Diego State University Research Foundation 5250 Campanile Dr. San Diego CA 92182	All
WET-04	Community Psychiatry Fellowship	The Residency and Internship Program (Community Psychiatry Fellowship)	Regents of the University of California, University of California San Diego, Community Psychiatry Fellowships	Programs are for physicians and public mental health nurse practioners- one for adult psychiatry residents and fellows, the second 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, 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
WET-03	Consumer and Family Academy	RI International	Consumer/Family Academy, TAY/Adult/Older Adult Peer Specialist Training	Provide recovery-oriented, peer specialist training to adults 18 years and older to prepare them to work in the County of San Diego's public behavioral health system. Using the training participants' personal recovery experiences as a foundation to prepare participants to work as partners at the practice, program and policy levels. Additional training will be provided to behavioral health providers to facilitate the best use of the unique skills peer specialist staff	Recovery Innovations, Inc. 2701 North 16th St., Suite 316 Phoenix, AZ 85006 (602) 650-1212	All
WET-02	Cultural Competency Academy	Cultural Competency Academy	San Diego State University Research Foundation	The Cultural Competency Academy will provide awareness, knowledge, and skill based trainings that focus on clinical and recovery interventions for multi-cultural populations while ensuring in that all trainings focus on being trauma informed from environmental to clinical applications	San Diego State University Research Foundation 5250 Campanile Dr. San Diego CA 92182	All
WET-03	Public Mental Health Academy	Public Mental Health Academy - Academic Counselor	San Diego Community College District	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-02	Training and Technical Assistance	Training and Technical Assistance (Big Why Conference, We Can't Wait Conference)	Regional Training Center (RTC)	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

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix D
MHSA Justice Involved Programs

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

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Population Served	*Program Name and Description*	*FY 2020-21 MHSA Three Year Plan Funding**	*MHSA Component*
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.	$ 10,263,052	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	**The Stabilization Treatment and Transition (STAT) Probation After-Hours** program funds Probation Officer positions, offering individual, group and family treatment for youth in juvenile detention facilities.	$ 278,554	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.	$ 1,692,421	CSS
Youth	**Outpatient Perinatal Recovery Centers** are adding more mental health clinicians who identify and provide interventions for co-occurring disorders. The women served by this program, who are generally involved in Drug Dependency Court, often come to treatment with their young children, who also receive supportive mental health services through a mental health clinician that works with the caregiver and child.	$ 1,235,401	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.	$ 6,420,167	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.	$ 1,876,000	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.	$ 901,690	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		**$ 37,559,151**	

*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.

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix E
County of San Diego Demographics

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

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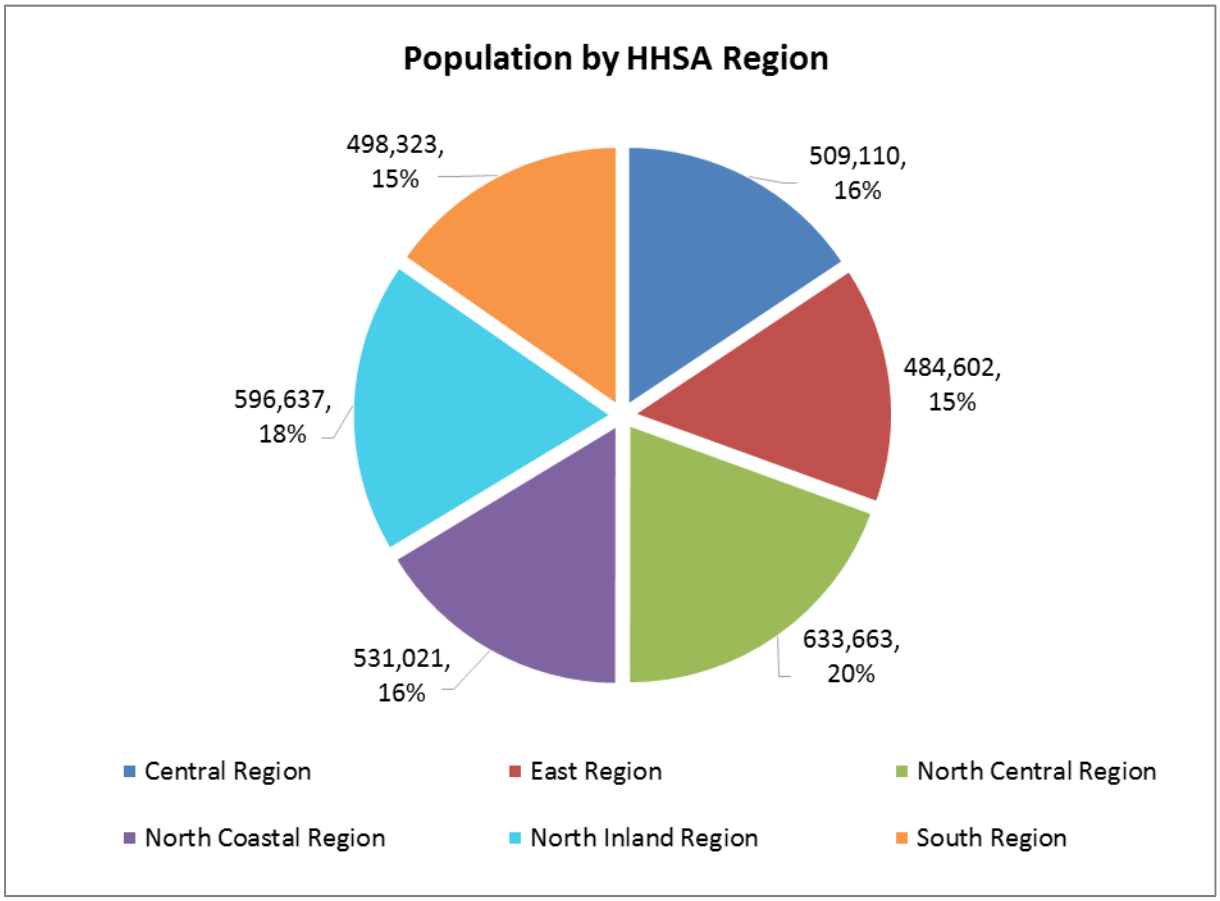
Demographics are for San Diego County in Fiscal Year 2016-17, the most recent full set of data available.

POPULATION

HHSA Region	*Population*	*%*
Central Region	509,110	16%
East Region	484,602	15%
North Central Region	633,663	20%
North Coastal Region	531,021	16%
North Inland Region	596,637	18%
South Region	498,323	15%
San Diego County	**3,253,356**	**100.0%**



Source: HHSA Office of Business Intelligence, FY2016-17 Population Dashboard

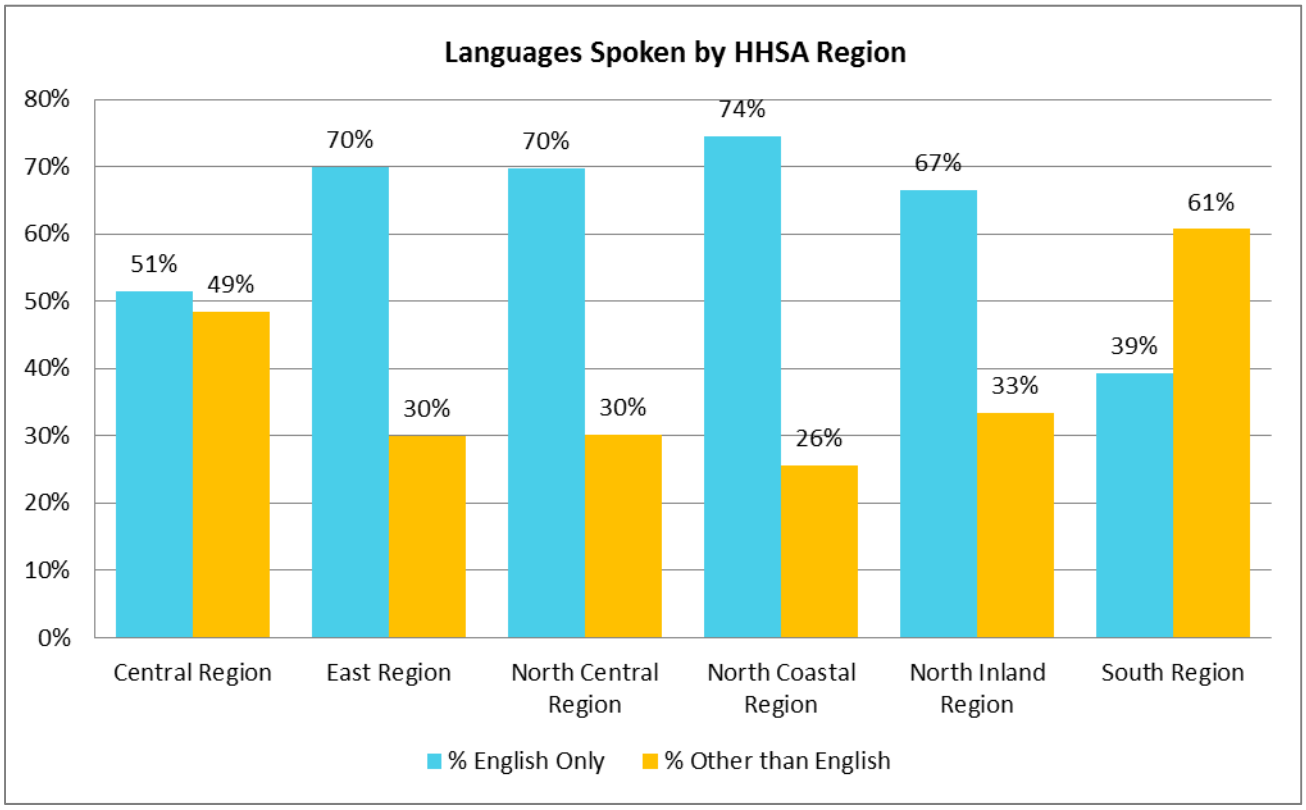
RACE/ETHNICITY

HHSA Region	*Not Hispanic or Latino*	*White*	*Black or African American Alone*	*American Indian and Alaska Native Alone*	*Asian Alone*	*Native Hawaiian and Other Pacific Islander Alone*	*Some Other Race Alone*	*Two or More Races*	*Hispanic or Latino*
Central Region	290,499	150,434	56,193	1,297	65,600	2,429	605	13,941	218,611
East Region	352,152	277,696	27,723	2,646	20,641	3,649	1,136	18,661	132,450
North Central Region	532,962	361,985	21,687	1,684	120,097	2,216	1,310	23,983	100,701
North Coastal Region	381,557	314,572	17,019	1,777	30,765	2,103	922	14,399	149,464
North Inland Region	422,823	318,043	11,827	3,687	67,728	1,416	820	19,302	173,814
South Region	197,044	96,974	19,802	742	64,221	2,230	750	12,325	301,279
San Diego County	**2,177,037**	**1,519,704**	**154,251**	**11,833**	**369,052**	**14,043**	**5,543**	**102,611**	**1,076,319**

Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

LANGUAGE SPOKEN (5 YEARS OLD AND GREATER)

HHSA Region	*Total Population 5 Years Old and Greater*	*English Only (5 Years Old and Greater)*	*% English Only*	*Primary Language Other than English (5 Years Old and Greater)*	*% Other than English*
Central Region	476,601	245,347	51%	231,254	49%
East Region	453,681	317,477	70%	136,204	30%
North Central Region	596,959	416,679	70%	180,280	30%
North Coastal Region	494,691	368,394	74%	126,297	26%
North Inland Region	555,151	369,338	67%	185,813	33%
South Region	464,479	182,469	39%	282,010	61%
San Diego County	**3,041,562**	**1,899,704**		**1,141,858**	

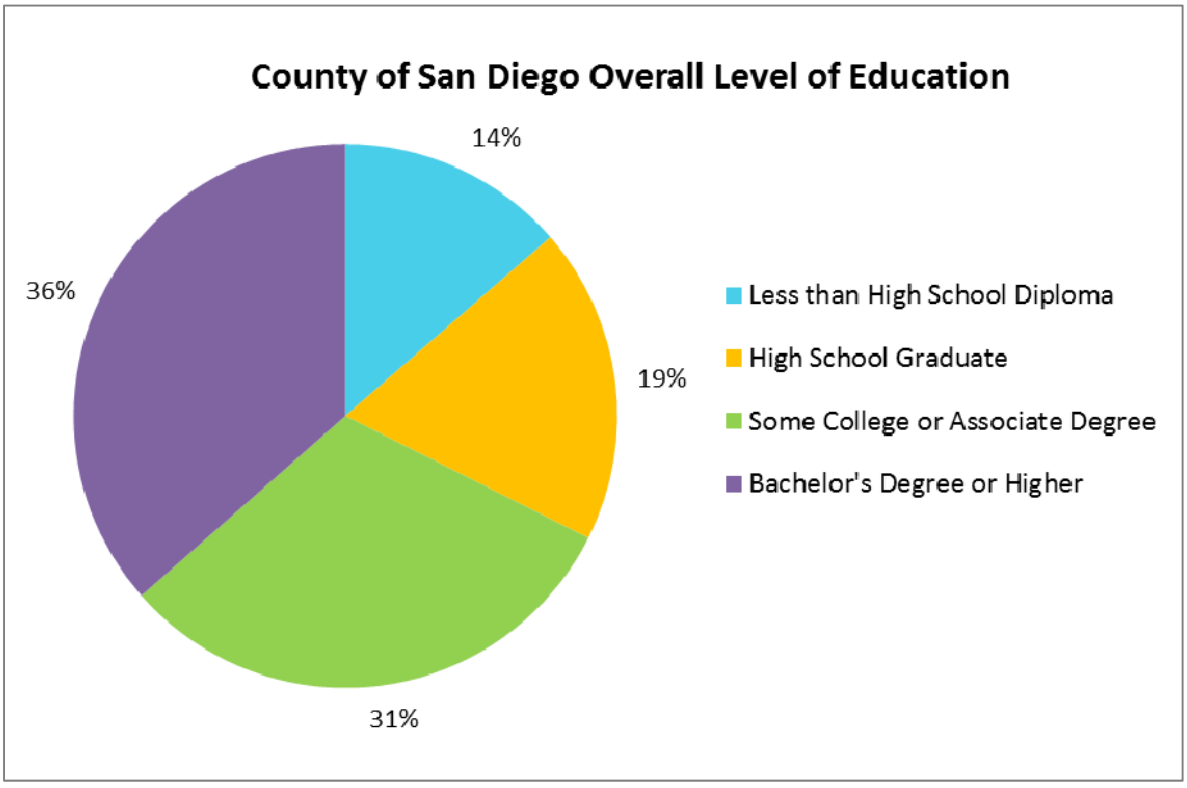


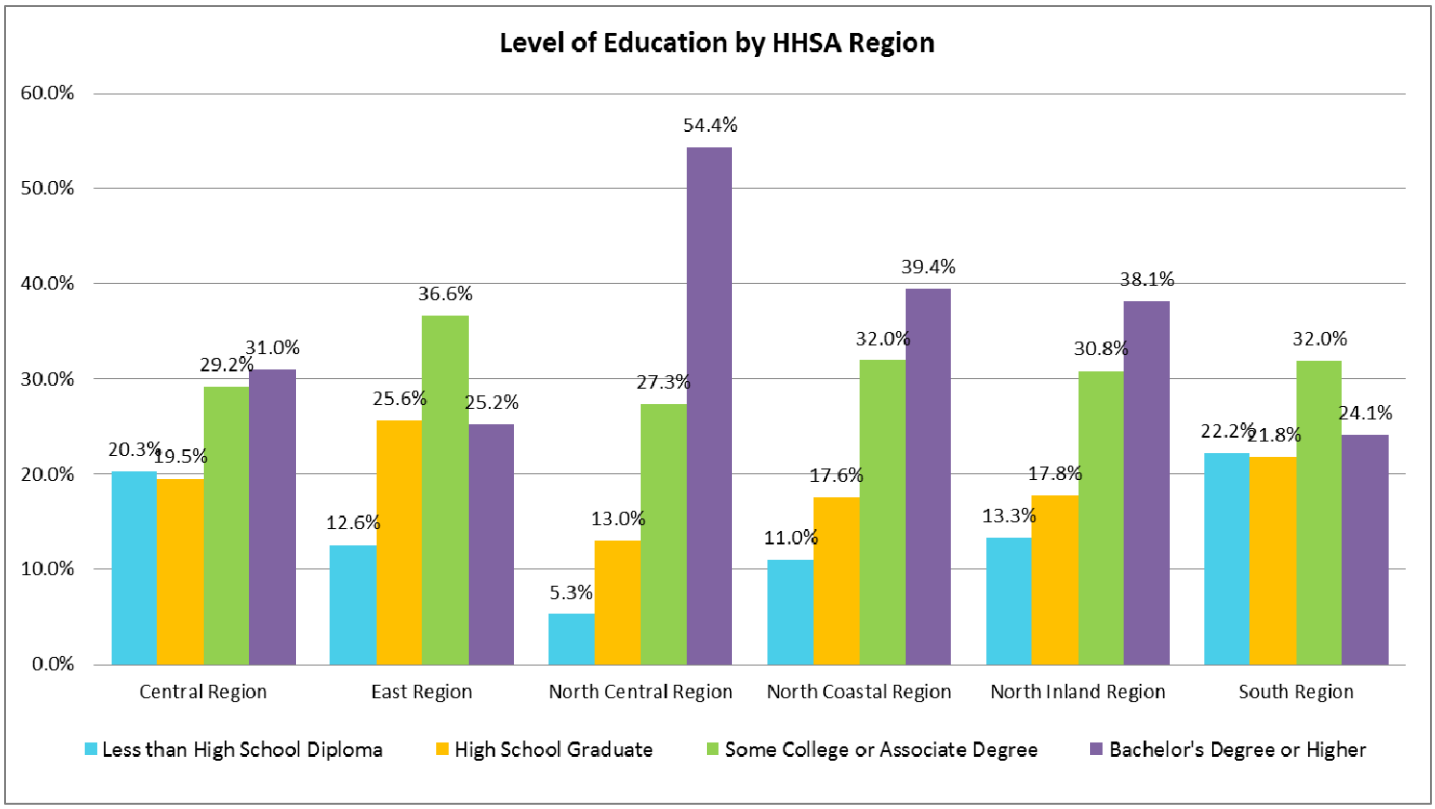
Source: Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

LEVEL OF EDUCATION

HHSA Region	*Population 25 and Older*	*Less than High School Diploma*	*High School Graduate*	*Some College or Associate Degree*	*Bachelor's Degree or Higher*
Central Region	337,185	68,477	65,713	98,608	104,387
East Region	326,362	40,962	83,508	119,532	82,360
North Central Region	436,714	23,155	56,818	119,313	237,428
North Coastal Region	348,520	38,505	61,220	111,469	137,326
North Inland Region	397,764	52,863	70,764	122,578	151,559
South Region	315,215	69,997	68,607	100,749	75,862
San Diego County	**2,161,760**	**293,959**	**406,630**	**672,249**	**788,922**
% of Total	**100%**	**14%**	**19%**	**31%**	**36%**

HHSA Region	*Population 25 and Older*	*Less than High School Diploma*	*High School Graduate*	*Some College or Associate Degree*	*Bachelor's Degree or Higher*
Central Region	100%	20.3%	19.5%	29.2%	31.0%
East Region	100%	12.6%	25.6%	36.6%	25.2%
North Central Region	100%	5.3%	13.0%	27.3%	54.4%
North Coastal Region	100%	11.0%	17.6%	32.0%	39.4%
North Inland Region	100%	13.3%	17.8%	30.8%	38.1%
South Region	100%	22.2%	21.8%	32.0%	24.1%

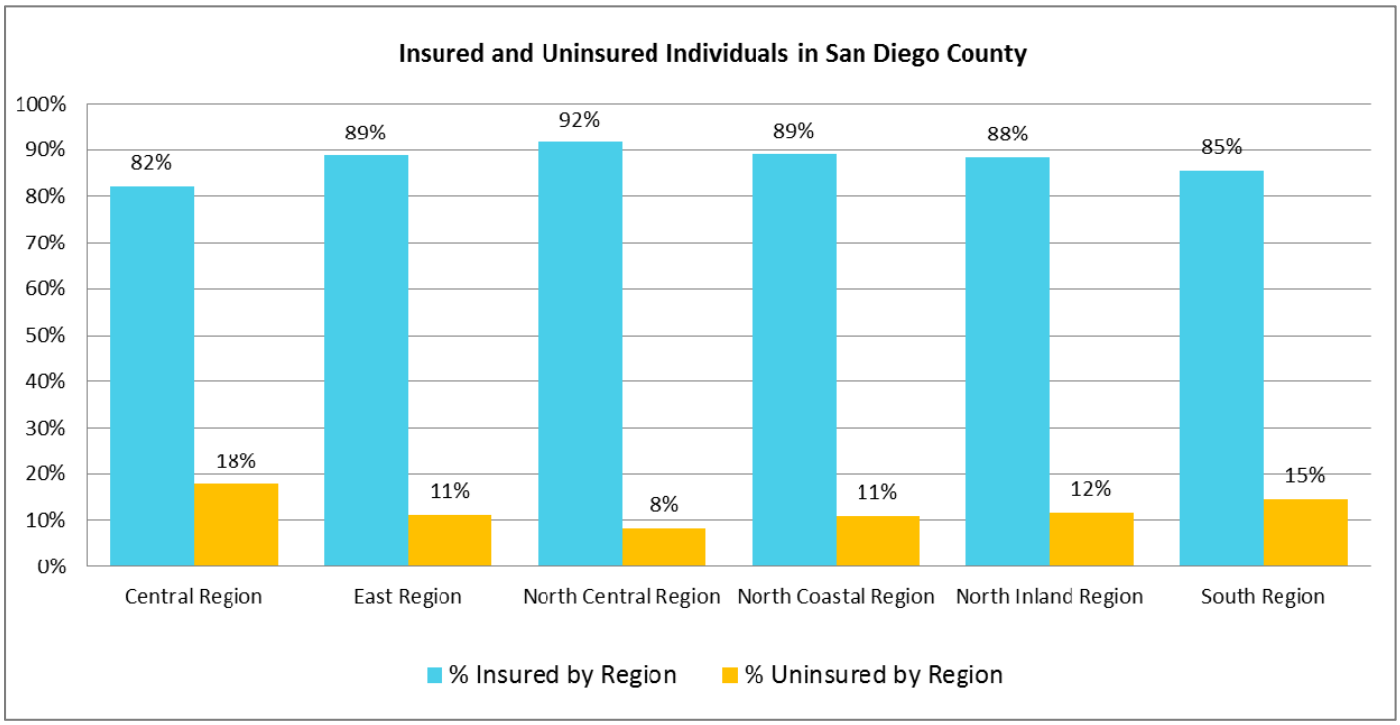




Source: Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

INSURED AND UNINSURED

HHSA Region	*Health Insurance Population*	*Insured Individuals*	*% Insured by Region*	*Uninsured Individuals*	*% Uninsured by Region*
Central Region	493,795	405,929	82%	87,866	18%
East Region	472,806	419,654	89%	53,152	11%
North Central Region	615,121	563,775	92%	51,346	8%
North Coastal Region	502,538	447,464	89%	55,074	11%
North Inland Region	590,787	521,866	88%	68,921	12%
South Region	479,204	409,624	85%	69,580	15%
Total San Diego County	**3,154,251**	**2,768,312**		**385,939**	



Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix F
Community Engagement Report 2020

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

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County of San Diego
Health and Human Services Agency
Behavioral Health Services
Community Engagement Report
Fiscal Year 2019-20

Reported by

The Institute for Public Health
School of Public Health
San Diego State University

March 2020

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

Table of Contents

Executive Summary

The County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS), provides behavioral health services, including mental health and substance use disorder services, to more than 80,000 San Diego County residents of all ages. These services are implemented through programs operated by the County and through organizations and providers that contract with the County.

As required by the Mental Health Services Act (MHSA) and in alignment with *Live Well San Diego* goals, BHS solicits annual feedback from the community about behavioral health needs. Community members identify existing and emerging behavioral health issues, suggest ideas for programs and services, and discuss ways to better engage and serve the community. Community input then informs the development of new programs and the expansion or modification of existing programs. The engagement process prioritizes identifying and understanding the needs of unserved and underserved populations.

For the Fiscal Year 2019-20 community engagement process, BHS contracted with the Institute for Public Health (IPH) at San Diego State University (SDSU) to coordinate and facilitate community engagement events. Seven community forums, three focus groups, four follow-up interviews, and two key informant interviews were held between December 17, 2019 and February 10, 2020.

This year's engagement focused on prevention, innovation, and engagement. Community members identified behavioral health issues related to both substance use and mental health that are of growing concern in the community and brainstormed preventive strategies. They also discussed three innovative program ideas, including enhancing treatment with outdoor activities, providing additional training to school staff to help them build student resilience, and educating parents about bullying. Finally, the community gave input about how to best engage San Diego residents in the future. Forum participants also completed a satisfaction survey to evaluate the efficacy of the engagement.

Forum attendance totaled 224 people. An additional 21 individuals participated in focus groups, four individuals participated in follow-up interviews, and two service providers participated in key informant interviews, for a total of 251 individuals who participated in this year's process. Participants shared their thoughts at all the events and expressed a high degree of satisfaction with the engagement process.

Findings related to growing concerns about substance use included:

- The community, especially youth, have increased access to and are more frequently using a variety of substances, particularly vape products, marijuana, alcohol, prescription drugs, opioids (with emphasis on fentanyl), crystal methamphetamine, acid, and homemade drugs.

- Certain populations of people seem to be the most vulnerable to substance use issues, including youth, young adults, veterans, pregnant women, mothers, homeless individuals, immigrants, refugees, and older adults.
- Complex issues are at the heart of substance use problems, including co-occurring mental health struggles, the desire to self-medicate, stress and pressure (especially among students), economic insecurity, social isolation, and untreated trauma. The population's lack of knowledge about substances and their potential effects also contribute to growing rates of use.
- The response to substance use is often inappropriate and the options for treatment are far too limited.

Findings related to growing concerns about mental health included:

- People are suffering from higher rates of anxiety, depression, and suicide attempts. Trauma causes and worsens mental health issues. Mental health problems can lead to substance use and to violence within the home and in the community.
- Social isolation is becoming a crisis; the increased use of social media and technology have contributed to this issue. Social isolation underlies many mental health challenges.
- Most people do not have adequate knowledge about mental health and wellness and so are unable to recognize signs and symptoms, seek treatment, or offer appropriate help to those around them.
- Certain populations of people suffer disproportionately and do not have equal access to or receive equitable treatment for mental health problems. This includes youth, immigrants, refugees, California Indians, military personnel and veterans, LGBTQIA individuals, homeless individuals, and foster youth.
- It is difficult to access timely, effective mental health treatment, and this treatment is segregated from substance use treatment and from physical health care.

Suggestions to address these issues included:

- Raise awareness about substance use and mental health issues through a variety of means. Use these efforts to decrease stigma and teach coping skills.
- Decrease access to substances through new policies and laws.
- React with appropriate consequences and effective interventions to youth who are caught using substances.
- Enhance wellness by increasing connections and support in the community.
- Expand, diversify, and integrate treatment services and make them accessible to more people.

Across all engagement activities, four main themes emerged as priorities for the community. First, they emphasized the importance of prioritizing ***education***. Educational efforts should include teaching about substance and about mental health and wellness, should be tailored to whatever groups are targeted so that they are effective and meaningful, and should be culturally competent. These efforts must be extensive and undertaken at all levels at schools, in the

community, with professionals, and through the media. Youth, families, school personnel, service providers, and other community members would all benefit.

Second, participants felt strongly that to truly address behavioral health issues, a focus must be placed on building ***community*** support. This support must include efforts to decrease isolation, build supportive relationships, and enhance wellness. Community programming should include recreational activities for all ages, mentoring programs, home visiting programs, and a wide variety of social services. Participants stressed the importance that community programs and services be staffed by members of the community.

Third, as in past years, a key priority identified was the ***integration*** of programs and services. A holistic approach that addresses physical and mental health, substance use issues, and social determinants of health simultaneously is far more likely to be effective than the current approach of addressing each of these issues on their own. For youth, these services should be primarily based in schools.

Finally, the community was emphatic that ensuring ***equity*** should be a priority in behavioral health services. Many populations experience disproportionate barriers to receiving the care they need, and when they do receive care it is often of poorer quality than the care received by others. Barriers to care are exacerbated by the lack of culturally competent services available.

IPH staff were grateful for the community's willingness to contribute their ideas and to discuss sensitive issues. The depth of feedback was impressive. The community's valuable insights inform BHS on directions to prioritize, expand, and modify its programming.

Introduction

BHS is dedicated to improving the lives of San Diego's 3.3 million residents by addressing mental health concerns, treating mental illness, and preventing and treating substance use disorders. BHS provides substance use and mental health services through County-operated facilities and through contracted providers. These services are funded, in part, by the Mental Health Services Act (MHSA). The goal of MHSA is to increase access to behavioral health services and reduce disparities in the delivery of services for unserved and underserved Californians.

In order to receive MHSA funding, all California counties implement a Community Program Planning process in which the community actively participates. For BHS, one important part of this process is to facilitate annual community engagement events, such as public forums and focus groups, during which community members can discuss concerns related to behavioral health in San Diego. For this year's events, conversations focused on the prevention of behavioral health crises, innovative programming ideas, and ways to better engage with the community. In addition to meeting MHSA requirements, this community engagement process also aligns with San Diego County's *Live Well San Diego* vision of "building better health, living safely, and thriving." Community input gathered from this process is used to inform the development of new programs and services and to make modifications to existing programs and services.

For this year's process, the IPH was tasked with developing, promoting, and facilitating community-wide forums, focus groups, and interviews, and with distributing and collecting satisfaction surveys at each forum. The IPH was also responsible for all data collection and analysis and for drafting this report.

The FY 2019-20 community engagement process included seven community forums, three focus groups, four follow-up interviews, and two key informant interviews. The methods used by the IPH and the results gathered are presented in the first and second sections of this report. Common themes across events are identified and discussed in the third section of the report. A comparison of this year's results with previous years' results is presented in section four. Community members were asked to evaluate the forums in short satisfaction surveys; these results are presented in the fifth section of this report, along with IPH recommendations for future engagement efforts.

BHS and the IPH began planning for the community engagement process in October 2019. The first focus group was held on December 19, 2019, and the first community forum was held on

January 8, 2020. The engagement process officially concluded on February 10, 2020. Details about the planning process, the facilitation of the events, and the methods of data analysis are provided below.

Collaborative Planning

The IPH worked in collaboration with BHS to select dates and locations for events and to determine best approaches for the promotion of the community engagement, recruitment of community members, facilitation of forums and focus groups, and data collection and analysis.

Initial weekly meetings with BHS focused on securing dates, finalizing topics, and ensuring that events were scheduled at venues that would be amenable to high rates of community participation. Subsequent meetings focused on details of the process including recruitment, promotion, data collection, logistics, and facilitation. Ad hoc phone and in-person meetings were also held as necessary.

As part of the planning process, IPH and BHS worked with members of the Cultural Competency Resource Team and the Behavioral Health Advisory Board to ensure the community and cultural sensitivity and relevancy of materials were utilized in the engagement process. The Cultural Competency Resource Team is made up of community stakeholders, county contractors, and BHS staff. Their goal is to ensure that all county services are delivered in a culturally competent manner. The participant satisfaction survey tool was presented to members of the team for their review, and a conference call was held to solicit the group's feedback. The Behavioral Health Advisory Board (BHAB) is made up of community members and service providers. BHAB met with IPH to discuss identify additional focus group audiences.

Staffing

IPH recruited and hired 17 master's and doctoral level students in the fields of public health, psychology, and social work to facilitate discussions during the Community Forums. More than half of the student facilitators were bilingual, speaking Spanish, Farsi/Dari, Vietnamese, Bengali, and Mandarin. After undergoing screening and hiring, the students received extensive training about conducting community-based qualitative research. This included training on data collection methods, effective forum, focus group, and interview facilitation, and how to handle difficult situations. The students then practiced what they learned in mock forums before the engagement process began.

Six to 12 student facilitators were assigned to work at each Community Forum hosting tables of two to ten community members. The role of the student facilitators was to lead their individual table through the discussion topics, record their feedback, solicit feedback as needed, document any questions or concerns, capture additional feedback unrelated to the forum topic, and ensure community members felt welcomed, appreciated, and heard. After each forum, facilitators wrote up their notes, identified common themes from their small groups, and submitted these notes to the IPH administrative team for analysis.

Community Forums Planning

Topics

For the past several years, the community has identified prevention as a priority area of focus during engagement events. In addition, BHS is committed to growing prevention in the coming years and is especially interested in community ideas about how to place more emphasis on prevention. As such, it was determined that the primary focus of the community engagement this year would be on identifying emerging behavioral health issues and effective prevention strategies. The two key questions for the engagement included: (1) What issues related to mental health and substance use are of growing concern in the community? and (2) What methods could be used to prevent these issues from worsening? In addition, community members were also queried for feedback about three innovative program ideas from BHS and about how BHS could better engage the community in these types of conversations.

Scheduling

Once topic selection was finalized, IPH staff worked to schedule dates, times, and locations for the community forums. The forums were planned at varying times of the day and different days of the week to accommodate different schedules of community members. To ensure regional/geographic diversity, at least one forum was scheduled in each of the six HHSA designated regions. Other factors considered in venue selection included cost, capacity, equipment (e.g. tables, chairs, AV, etc.), accessibility by public transportation, ADA compliance, and availability of free parking. Once forum locations were selected, IPH staff worked with venue staff to complete the reservation process. The schedules for the forums are found in Table 1.

Table 1. Community Forum Schedule

Date: Wednesday, January 8, 2020 Time: 6:30pm to 8:00pm	Lemon Grove Academy Elementary School 7885 Golden Ave, Lemon Grove, 91945
Date: Thursday, January 9, 2020 Time: 6:30pm to 8:00pm	Kearny Senior High School 1954 Komet Way, San Diego, 92111
Date: Saturday, January 11, 2020 Time: 10:00am to 11:30am	Country Club Senior Center 455 Country Club Lane, Oceanside, 92054
Date: Saturday, January 25, 2020 Time: 10:00am to 11:30am	Woodland Park Middle School 1270 Rock Springs Rd, San Marcos, 92069
Date: Tuesday, January 28, 2020 Time: 6:30pm to 8:00pm	Normal Heights Community Center 4649 Hawley Blvd, San Diego, 92116
Date: Wednesday, January 29, 2020	North Inland Live Well Center

Time: 3:00pm to 4:30pm	649 W Mission Ave, Escondido, 92025
Date: Saturday, February 1, 2020 Time: 10:00am to 11:30am	Bonita Vista High School 751 Otay Lakes Rd, Chula Vista, 91913

Registration

To track the number of participants attending each forum and to estimate supply and catering needs, forum participants were asked to pre-register online at ListenToSanDiego.org, an ADA compliant website developed by IPH staff. The participant data received through ListenToSanDiego.org were stored in a registration form on Qualtrics, an online survey software. Participants were also able to pre-register by phone or through a QR code that was printed on promotional flyers. Registration phone numbers and the website address were provided on all printed promotional materials. Registration was available and equally accessible in English, Spanish, Arabic, Farsi, Vietnamese and Tagalog. Upon registration, participants were asked to identify any special assistance or translation services they may need during the event.

Participants who attended a forum without pre-registering were considered "walk-in" participants. All walk-in attendees were asked to complete a paper registration form at check-in. The information from the paper forms was entered into the database and merged with the data collected online. Walk-in registration forms were available in the six previously mentioned languages, as well. A sample of the registration forms can be found in the Appendix 1.

Registrants were asked to provide basic information, including ZIP code, and identification with listed community groups and special populations. The data recorded through registration are summarized in the Results section.

Marketing and Outreach

A basic marketing and outreach plan outlined goals and strategies to reach identified marketing targets (see Appendix 2). The community forums were promoted through a variety of communication and media channels including an IPH-developed website, flyer distribution, in-person and cold-call canvassing, digital and print media buys, social media campaigns, online public calendars, and email marketing.

Listen to San Diego website

First, the IPH revised and updated the www.ListentoSanDiego.com website, deployed for the 2018 BHS Community Engagement process, that allowed for online registration and gave detailed information about the community engagement process. The website was available in the County's five designated threshold languages: Spanish, Arabic, Tagalog, Vietnamese, and Farsi (screenshots can be viewed in Appendix 3).

Promotional flyers

IPH staff created promotional flyers utilizing the County of San Diego Live Well Marketing guidelines (see Appendix 4). Individual flyers for each forum were created along with an "all forums" flyer listing all scheduled events. Each flyer was translated (through a subcontract with Native Interpreting) into the County's five designated threshold languages.

The flyers included forum date, time, and location and included the topics that would be discussed. Registration instructions, including the website address and registration phone number and email were provided. Lastly, the flyer informed the intended audience that either breakfast or dinner would be provided during the events and eligible participants would receive a gift card for their participation.

Flyers were posted in public places (e.g. libraries, senior and recreation centers) within the neighborhood and region of each forum. Prior to posting flyers, IPH staff researched the most common languages spoken in targeted neighborhoods to ensure promotional materials were posted in the appropriate languages. More than 950 flyers, in multiple languages, were distributed through this method.

Canvassing

IPH staff compiled lists by region of marketing targets including organizations that provide prevention or treatment services for individuals with behavioral health issues or support services for their loved ones, religious organizations including churches, synagogues, and mosques, large employers, libraries, YMCAs, community and recreation centers, and senior living and retirement communities. These organizations and businesses were then canvassed in person, through cold-calling, and/or through email. The engagement process was discussed with the person contacted, and flyers were provided. When possible, the targets received both hard-copy and electronic versions of the flyers to enable easier distribution to their constituents. Additionally, City Managers of Lemon Grove, Oceanside, San Marcos, and Chula Vista were contacted in this manner to promote the events within their regions.

Media Buys

The forums were also promoted through print and digital media buys. Advertising space was purchased in The Union Tribune to advertise for all of the forums. Additionally, advertisements were run in The Coast News and The Inland Edition to promote the Oceanside and San Marcos Forums, and Uptown News to promote the City Heights Forum. In The Star News, both an English and Spanish version of the advertisement was printed to promote the Chula Vista Forum.

Social Media

In addition, posts were made on social media and networking sites including Facebook, LinkedIn, and the Nextdoor App.

Public Calendars

Online public calendars were utilized as a community wide advertising method. If possible, digital versions of flyers were attached to a calendar item. If that option was not available, then each event was posted individually with all event details. Forum events were posted to the following online calendars:

- Fox 5 San Diego online calendar
- Patch
- 10 News San Diego online Community Calendar
- KPBS Community Calendar
- City of Chula Vista Online Calendar
- OnSanDiego
- SanDiego.com
- SpinGo San Diego
- eLiveLife San Diego Event Guide
- The Pulse

A listing of print, social and online media advertisements and examples of media buys can be found in the Appendix 5.

Email Blasts

Email blasts were conducted within BHS; all BHS staff were invited to attend the forums. In addition, BHS staff were encouraged to share forum information with their professional and personal networks. Additionally, two email blasts were sent to the list of last year's forum registrants with topic and event details (see Appendix 6).

Facilitation

The community forums were facilitated using a modified world café method. The world café model is an effective strategy for facilitating large group dialogues (http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/). This model incorporates both small group and large group discussions within the same event. During the community forums, attendees participated in small group discussions within their tables as well as a whole group dialogue and prioritization of issues.

The IPH provided facilitators who had been trained to lead small-group discussions. Each table consisted of two to ten community members and one or more trained facilitators as well as translators, when needed. Forums were hosted by and large group discussions were led by IPH Research Associate, Martha Crowe, who has extensive experience in community-based research and group facilitation.

Preparation

Prior to each event, IPH staff coordinated with venue staff to ensure adequate numbers of tables and chairs, proper banquet style layout (see example in the Appendix 7), and access to requested audiovisual (AV) equipment. Staff also arranged catering and hosting supplies for each event. Dinners and continental breakfasts were provided as well as coffee, tea, and water at each event. Snacks including fruit, granola bars, and cookies were provided at the afternoon forum at Escondido Live Well Center.

Tables were organized into groups of two to ten participants. Participants were randomly assigned to a table, except where translation services were requested. In those instances, attendees were preassigned a table that included bilingual facilitators and translators.

IPH staff also assembled and transported the materials, supplies, and AV equipment listed below to each venue.

Figure 1. Forum Materials, Supplies, and Equipment

Registration Table	Facilitator Supplies and Materials	AV Equipment
● Registration List ● Blank, Walk-in registration forms (for those unable to pre-register) in all core languages. ● Pens ● Extra Participant Packets and Facilitator Supplies ● Community/Satisfaction Survey in all core languages. ● County “swag” materials and giveaways.	● Easel and flip chart ● Table numbers and stanchions ● Markers ● Index cards ● Name tags ● Pens ● Gift cards and gift card tracking forms ● iClickers ● Participant Packets (including Community/Satisfaction Survey, All Forum Flyer, County Council Meeting Calendar, and Definitions Document)	● Portable PA system ● iClicker base and software ● Laptop ● Projector ● Extra Batteries

The forums were scheduled for an hour and a half block of time. IPH staff arrived early to set up the room, equipment, food and tables. A detailed forum schedule was created to help staff and facilitators manage time appropriately.

Forum Process

Registration

The first fifteen minutes of the event were devoted to registration. IPH staff greeted participants and directed them to the check-in/registration table. Those who pre-registered were asked to sign in and then given their table assignment. Guests who had not pre-registered were asked to complete a paper registration form and then received a table assignment. After checking-in, participants were encouraged to enjoy refreshments before sitting at their table.

Once at their table, the guests were greeted by a trained table facilitator. The facilitators introduced themselves and continued to engage in friendly conversation with participants for the duration of the registration period.

Each participant was provided with an *iClicker* remote device to be used during the whole group voting sessions. *iClicker* is an audience response system that allows presenters to quickly poll a large audience and view the results of the polling in real-time. The voting process is explained in the *Process* section below.

The forum moderator assured participants that their feedback, regardless of the modality in which they provided it, would be incorporated into a comprehensive report for the BHS. The moderator also offered assurance that their feedback would remain anonymous, and that they were not required to remain for the entire duration of the forum or answer any questions, should they feel uncomfortable doing so.

After the registration process was complete, BHS Director Luke Bergmann, PhD welcomed participants to the forum and discussed the County's increased funding for behavioral health services and emphasized the importance of community feedback. Following Dr. Bergmann's message, the event moderator thanked all attendees for their participation and informed them about the purpose and structure of the forum, as well as the topics that would be discussed. The moderator then explained the purpose of the following materials in the participants' packets, placed at each seat.

- *Participant Satisfaction Survey.* This short questionnaire was intended to gather participant feedback about the structure and organization of the community event.
- *Index cards.* These blank cards were intended as another method to provide feedback to the County. If a participant was unable or unwilling to share his/her thoughts during the group discussions, she/he was encouraged to use the index cards.
- *Helpful Definitions.* This page of definitions was intended to ensure the participant's comprehension of specific terminology that would be used throughout the forum, such as "resiliency," "innovation," and "prevention." A copy of the document, including the defined terminology, can be found in Appendix 8.

After the welcome message, the event moderator explained the format and process of the event to the group. The process was modified slightly depending on the composition of the group at the forum. At smaller forums, for example, iClickers were used sparingly, allowing the participants to share their ideas with the whole group and to have more in-depth conversations at their tables. At times, it was important for some of the smaller groups to be able to continue to speak and brainstorm about the ideas they chose as important, rather than the ideas the whole voted on as priorities. In general, the process was as follows:

Identifying emerging issues

First, the table facilitator would ask their group to identify their concerns and thoughts about emerging issues related to substance use. The group would share their ideas while the facilitator took notes on a large flip chart. If necessary, the facilitator would follow scripted prompts to elicit further discussions.

After a full discussion, the facilitator would ask the group to prioritize the issues they had identified – "which of these," the facilitator would ask, "most urgently needs to be addressed?" A vote, with a show of hands at the table, would ensue. The facilitator would tally the votes and then record the top issue with the highest number of votes on a pre-printed form. This form was delivered to the forum moderator. The moderator would then type the issue submitted by each table into a pre-formatted PowerPoint presentation.

This process was repeated a second time with the groups identifying emerging issues in their communities related to mental health.

The emerging issues from all tables were presented on a large projector screen to the entire group. At most forums, participants then used the iClicker remotes to vote on the issues they felt were the most important. After the voting session, each group began to discuss solutions for the top issue identified for the topic being discussed at their table. At two forums, voting resulted in a tie. Groups were then instructed to discuss solutions to the issue they voted on as a table as most critical.

Identifying prevention strategies

The process for identifying top prevention strategies was similar to the process for identifying emerging issues. First, the facilitators would present questions to their group to initiate a discussion about ideas to prevent the substance use or mental health issue from becoming more serious in the community. After some dialogue, the facilitators would ask the table members to prioritize the proposed solutions by asking "of all of these, which would you most like to see implemented now?" Table members would choose one or two solutions as the highest priority, their decision would be recorded, and this information would be delivered to the forum moderator. The moderator would again compose and present the PowerPoint slides in preparation for a whole-group vote. Finally, the moderator would ask all forum participants to vote, using the iClickers, for what they considered to be the highest priority solution for the issue presented. The solution with the highest number of votes was considered the "top solution."

Additional feedback and forum conclusion

Near the end of each forum, participants were asked to provide quick feedback in a "speed round" about three innovative program ideas the County is considering. The program ideas discussed were: 1) Outdoor activity to be conducted along with behavioral health treatments; 2) Special training for school staff to build resilience in children; and 3) Education for parents about bullying, especially cyberbullying and the use of social media. Finally, participants were asked to share their ideas for how the County can best engage with the community about behavioral health. At the conclusion of each forum, participants (except County employees or contracted staff) completed a participant satisfaction survey to receive a $10 gift card for attending.

Forum interpreters and special assistance

Interpretive services were available by request for all forums; Spanish language translation was provided at four forums (Oceanside, San Marcos, Escondido, and Bonita Vista). American Sign Language interpreters were available at three forums (Normal Heights, Escondido and Bonita Vista). Additionally, more than half of the table facilitators were bilingual in the following languages: Spanish, Bengali, Vietnamese, Farsi/Dari, and Mandarin.

Debriefing and forum modifications

At the conclusion of each forum, IPH staff held two brief meetings. The first meeting was with the BHS leadership staff present to gather their feedback about the forum. IPH staff noted all input. The second debriefing was a short check-in with table facilitators to discuss what worked well and what needed to be modified. The IPH staff also reviewed satisfaction survey results for each forum and met before each subsequent forum to make improvements to the process. A team huddle was held prior to each forum with all IPH staff and table facilitators to explain any modifications made. In this way, forums were continuously improved throughout the engagement process.

Data Analysis

Basic information about all forum participants was recorded in the registration form on Qualtrics. Statistical analyses of these data were conducted using SPSS (v25). A summary of participant demographics is presented in the Results section.

All ideas generated at the forums were documented on flip charts. This information, along with the ideas suggested on the index cards provided at each table, were then documented by the facilitator. IPH staff reviewed this data, and coding categories were created so that the data could be organized.

Voting results were recorded on iClicker software. These results were reviewed for common themes and were clustered using an inductive qualitative analysis process.

Participant Satisfaction and Demographic Survey

As required by the Mental Health Services Act, the IPH created a satisfaction and demographic survey (see Appendix 9) completed by participants before leaving the forum. Participants were

asked about their overall satisfaction with the event, the convenience of the location and the day and time chosen, the relevance of the topics discussed, and how they learned about the event. They were also provided a space in which to provide suggestions for improvement. Participants were also asked to provide personal demographic information, including age, race, language, sexual orientation, veteran status, gender identity and identification with groups, such as immigrant, refugee, homeless, or LGBTQI populations, among others. Satisfaction and demographic survey results were entered into the satisfaction and demographic survey form in Qualtrics and analyzed with SPSS (v25) software. Demographic results are reported in the Community Forums and Follow-Up Interviews section. Satisfaction results are presented in the Satisfaction Survey section of this report.

Focus Groups

Three focus groups were conducted to allow for in-depth conversations and to gather input about behavioral health services in San Diego. In consultation with BHS and its stakeholders, it was determined that the focus groups would target three specific populations: 1) current and aging-out foster youth; 2) LGBTQIA individuals; and 3) high school students. An additional population, childcare providers, was also identified, and individual phone interviews were conducted with those participants.

The first focus-group was conducted at Voices for Children and engaged seven current and aged-out foster youth. The second focus-group was held at The San Diego LGBT Community Center with four individuals. The third focus-group was held with ten students involved with the Friday Night Live leadership program through the San Diego County Office of Education.

Focus groups were conducted in a semi-structured manner. Trained IPH facilitators used predetermined questions to generate conversation, and discussions were then allowed to flow in a conversational manner. Emerging issues related to substance use and mental health and solutions were discussed. Focus group participants were also asked to provide feedback on how the County can better engage and communicate with their population. An IPH notetaker was present at each focus group to record the participants' ideas.

Focus groups commenced with a discussion about the purpose and process of BHS community engagement. Participants were asked to give verbal consent for their participation, were reassured that participation was voluntary, and were told that all feedback would remain anonymous. Each participant received a $20 Target gift card for participating.

For each focus group, IPH staff reviewed notes and clustered similar responses. The feedback shared in the focus groups is comprehensively documented in the results section of this report.

Interviews

In addition to forums and focus groups, community feedback about behavioral health needs in San Diego was gathered via follow-up interviews with the general public and targeted key

informant interviews with childcare providers. These interviews were conducted on the phone and offered via two separate Zoom meetings. Following the format of the community forums and focus groups, questions about emerging issues and the corresponding solutions relating to substance use and mental health were discussed. Participants were also asked for their ideas about how the county can best engage in conversations with the community around these topics in the future. Interview questions can be viewed in Appendix 10.

Results

Community Forums and Follow-Up Interviews

Forum and Follow-up Interview Participants

A total of 224 people attended seven community forums. Details about attendees at each forum are provided in Table 2 below. Additional individuals pre-registered for the forums using the listentosandiego.org website but did not attend. These individuals are not represented in the data summarized in this report.

Table 2. Participants by Forum

Date	Time	Region	Location	Pre-registered	Walk-In	Attended
1/08	Evening	East	Lemon Grove Academy Elementary School	28	8	21
1/09	Evening	Central	Kearny Senior High School	28	4	17
1/11	Saturday morning	North Coastal	Country Club Senior Center	23	46	58
1/25	Saturday morning	North Inland	Woodland Park Middle School	44	14	43
1/28	Evening	Central	Normal Heights Community Center*	38	11	25
1/29	Evening	North Inland	North Inland Live Well Center	31	16	33
2/01	Saturday morning	South	Bonita Vista High School	46	6	27
			Total	**238**	**101**	**224**

* This forum was informal in nature, as the facility contact failed to arrive to open the facility. Feedback was gathered in small groups on the patio of the facility. All attendees were offered one-on-one follow-up interviews

All promotional materials encouraged pre-registration for forums at ListenToSanDiego.org. Those who pre-registered ***and*** attended are represented in Table 2 above along with those who attended but did not pre-register (walk-in). As part of the participant satisfaction survey, forum

participants were asked to provide demographic information. Some participants did not respond to all questions, resulting in varied sample sizes in the data summarized below.

Demographic information collected included: age group; race; ethnicity; primary language used; sexual orientation; domain of disabilities; veteran status; assigned sex at birth; current gender identity; identification with selected community groups; and ZIP code.

Most forum participants were between the ages of 25-59 years old (51%), identified as White (53%), spoke English as their primary language (68%), identified their sexual orientation as straight (85%), did not have a disability (84%), were not veterans (93%), were assigned female gender at birth (64%), and currently identified as female (65%).

Table 3. Survey Respondent Age Groups (n= 185)

Age Group	n	%[1]
age 0-15 years old	17	9%
age 16-25 years old	41	22%
age 25-59 years old	94	51%
age 60 years old or over	33	18%

[1]Totals may not sum to 100% due to rounding.

Table 4. Survey Respondent Race (n= 176)

Race	n	%[1]
American Indian or Alaska Native	7	4%
Asian	7	4%
Black or African American	7	4%
Native Hawaiian or other Pacific Islander	2	1%
White	93	53%
Other[2]	40	23%
More than one race	8	5%
Declined to answer	12	7%

[1]Totals may not sum to 100% due to rounding.
[2]Other responses included: Hispanic (Hispana/o)/Latino (n=30); Mexican (Mexicana) (n=7); Human (n=2)

Table 5. Survey Respondent Ethnicity (n= 132)

Ethnicity	n	%[1]
Hispanic or Latino	**91**	**69%**
Caribbean	0	0%
Central American	8	6%
Mexican/Mexican American/Chicano	58	44%
Puerto Rican	1	1%
South American	2	2%
Other[2]	2	2%
Non-Hispanic or Non-Latino	**38**	**29%**

African	3	2%
Asian Indian/South Asian	1	1%
Cambodian	0	0%
Chinese	0	0%
Eastern European	3	2%
European	13	10%
Filipino	3	2%
Japanese	2	2%
Korean	0	0%
Middle Eastern	0	0%
Vietnamese	0	0%
Other[3]	5	4%
More than one ethnicity	10	8%
Declined to answer	**3**	**2%**

Totals may not sum to 100% due to rounding.
[2]Other responses included: Ados; and American (n=1 each)
[3]Other responses included: Native American - Lakota/Ogalala; Persian; and Samran (n=1 each)

Table 6. Survey Respondent Primary Language Used (n= 185)

Primary Language	n	%[1]
English	126	68%
Farsi	1	1%
Spanish	47	25%
Tagalog	4	2%
Other[2]	7	4%

[1]Totals may not sum to 100% due to rounding.
[2]Other responses included: Chammarro; English and German; English and Spanish; Portuguese; Romanian; Russian; and Spanish, Swahili and Kikuyu (n=1 each)

Table 7. Survey Respondent Sexual Orientation (n= 182)

Sexual Orientation	n	%[1]
Gay or Lesbian	6	3%
Straight or Heterosexual	154	85%
Bisexual	5	3%
Questioning or unsure of sexual orientation	2	1%
Another sexual orientation[2]	1	1%
Declined to answer	14	8%

[1]Totals may not sum to 100% due to rounding.
[2]Another sexual orientation response included: Pansexual (n=1)

Table 8. Disability of Survey Respondent (n= 185)

Do you have a disability?	n	%[1]
Yes	25	14%
If yes[2]		
Communication domain: Difficulty seeing	5	

Communication domain: Difficulty hearing, or having speech understood	4	
Communication domain: Other	0	
Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)	5	
Physical/mobility domain	8	
Chronic health condition (including, but not limited to, chronic pain)	3	
Other[3]	1	
No	155	84%
Declined to answer	5	3%

[1]Totals may not sum to 100% due to rounding.
[2]Multiple responses to specify disabilities
[3]Other response included: Hemi (n=1)

Table 9. Survey Respondent Veteran Status (n= 187)

Are you a veteran?	n	%[1]
Yes	12	6%
No	174	93%
Declined to answer	1	1%

[1]Totals may not sum to 100% due to rounding.

Table 10. Survey Respondent Sex at Birth (n= 188)

Sex at Birth	n	%[1]
Male	64	34%
Female	121	64%
Other	0	0%
Declined to answer	3	2%

[1]Totals may not sum to 100% due to rounding.

Table 11. Survey Respondent Current Gender Identity (n= 185)

Current Gender Identity	n	%[1]
Male	62	34%
Female	120	65%
Transgender	1	1%
Genderqueer	0	0%
Questioning or unsure of gender identity	0	0%
Another gender identity[2]	1	1%
Declined to answer	1	1%

[1]Totals may not sum to 100% due to rounding.
[2]Another gender identity response included: Non-binary (n=1)

Participants were asked whether they identified with any listed special populations; each registrant could choose as many categories as were applicable. The number and total percentage of people who identified with each group is listed in Table 12 below.

Table 12. Survey Respondent Special Population Groups Multiple Responses Question (Respondents=139)

Special Population Groups	n	%[1]
Hispanic or Latino	91	66%
Asian/Pacific Islander	11	8%
Black or African American	12	9%
American Indian or Alaskan Native	10	7%
Immigrant	25	18%
Refugee/Newcomer	1	1%
Veterans/Military	16	12%
Experiencing Homelessness	2	1%
African	2	1%
Chaldean	1	1%
LGBTQI	11	8%
Declined to answer	30	22%

[1]Percentages and totals are based on respondents.

Participants were also asked if they represented listed community groups; each registrant could again choose as many categories as applied. The number and total percentage of people who identified with each community group is listed in Table 13. Of note 62% of attendees identified as community members, while 48% identified as school personnel, law enforcement, or service providers.

Table 13. Forum Participant Community Groups Multiple Responses Question (Respondents=172)

Community Group	n	%[1]
Community Member	107	62%
Consumer	13	8%
Family Member of Consumer	17	10%
Law Enforcement	2	1%
School Personnel	13	8%
Provider	67	39%
None of the Above	20	12%
Total	**239**	

[1]Percentages and totals are based on respondents.

Forum attendees were asked to provide their ZIP codes, which were then grouped into six San Diego County HHSA-defined regions. The number and proportion of forum attendees from each region is provided in Table 14. The North Coastal and South regions had the most representation, and the Central and North Central regions had the least.

Table 14. Forum Participant Region (n=182)

Region	n	%
Central	15	8%
North Central	15	8%

East	23	13%
North Coastal	53	29%
North Inland	24	13%
South	52	29%
	182	

[1]Percentages and totals are based on respondents.

At the Normal Heights Community Center in the Central Region, there were unavoidable site issues which did not allow enough time to reschedule the forum. IPH held informal conversations on the patio of the center as most individuals decided to stay. Four follow-up interviews were conducted after the forums. An additional attendee at the Bonita Vista High School forum also requested a one on one interview. Interviewees were asked the same questions as forum attendees; the combined results are presented below.

Forum and Follow-up Interview Findings

Forum participants discussed five main topics: (1) substance use issues of growing concern in the community; (2) mental health issues of growing concern in the community; (3) strategies for the prevention of substance use and mental health crises; (4) three BHS innovative programming ideas; and (5) ways to better engage community members. Please see Appendix 11 for a list of ideas that were briefly mentioned during a single forum but not discussed at length.

Substance Use: Issues of Growing Concern

Five primary findings emerged from forum discussions about growing problems with substance use. First, participants identified the increased use of several substances as particularly concerning. Second, participants indicated that some sub-populations in San Diego are particularly vulnerable to issues with substance use. Third, participants emphasized that complex issues often underlie substance use problems and that substance use must be understood within the context of these complicated issues. Fourth, participants noted repeatedly that there are too few educational efforts being made regarding substance use. Finally, participants feel that effective, culturally relevant, immediately available, and integrated treatment options are limited for people with substance use disorders and that treatment is not equally accessible or equitably delivered to people in some populations.

Increased use of specific substances

Community members at each forum named several specific substances that they believe are being used with greater frequency – and causing more problems in the community- than in the past. These substances include tobacco/vaping products, marijuana, alcohol, prescription drugs, opioids, crystal methamphetamine, acid, homemade concoctions, and other substances.

Vaping/tobacco products

> "Even teens who know drugs are bad think vaping is ok."
>
> Forum Participant

During nearly every conversation about substance use, vaping arose as a topic of intense concern for the community, particularly use among high school students and young adults. The original marketing of vape products was to stop smoking cigarettes, the community said, which led people to assume they were safe. Community members believe that this is a false perception and that now many vape products are created for and marketed to youth. This includes flavored products that smell appealing (e.g. like French toast) and cannot be easily detected by adults and products designed to look like other things – like vape pens that look like flash drives. Vape products are promoted and sold through social media to youth. "Influencers" on social media create "hype" around vaping. In schools, youth frequently vape in the bathrooms and are even able to vape during class. Attendees commented that vape products, like Juul, are easily available at vape shops, and older kids sell the products to younger kids. Parents, teachers, and other school staff often do not know what vaping is, which contributes to its use among youth. Community members emphasized that vaping is common at young ages – particularly in middle schools.

Marijuana

Community members frequently discussed how the legalization of marijuana has led to increased access to marijuana in a greater number of forms, including edibles and very potent "cannabis wax." Youth can easily buy marijuana products. Older individuals buy marijuana products from dispensaries and then sell the products at a highly increased price to underage youth; some dispensaries, according to participants, are selling directly to underage youth. This is particularly problematic with cannabis delivery services where people can order products online and have them delivered to their homes. Youth are particularly attracted to edible products, like gummy bears, and to "wax," which is a highly concentrated form of THC that can be smoked in "wax pens." The potency of these products, participants said, is not regulated, and stronger products are being created and sold than in the past. In addition to buying products that are resold from dispensaries, youth are also accessing marijuana from social media sites, from booths at swap meets, and from other unsafe sources. The legalization of marijuana, the community believes, has led the public to believe that it is a safe substance, and there are few or no educational or public awareness campaigns being implemented to educate the community about the potential dangers. Marijuana is also being smoked far more frequently in public spaces, and it is not uncommon to smell marijuana out in public.

Alcohol

Participants noted that alcohol is the most easily accessible of all drugs and often causes the greatest impacts – physical, emotional, social – for individuals and within families. Alcohol, it was noted, is especially dangerous when mixed with other substances. The social acceptability of

drinking alcohol contributes to its abuse, and many people do not understand how dangerous alcohol use can be. In youth, several issues were discussed. First, many stores are willing to sell alcohol to underage youth, forum participants noted. Second, youth are drinking more frequently during school hours, sneaking alcohol into school in water bottles. Third, youth are binge drinking and "black out," rendering themselves vulnerable to sexual assault and other crimes. Fourth, parents are sometimes giving alcohol to their children and their friends because they believe it is safer for them to drink at home than at parties. Finally, companies are marketing alcohol to young people - drinks like "hard lemonade" that are fruity and appealing to youth.

In families, it was noted that alcohol use contributes to domestic violence and to accidents within the home. Many adults, the community discussed, are unaware of what constitutes overuse of alcohol – they believe the amount they drink is normal even when it is excessive.

> "Alcohol interacts with medications and the aging body. It increases falls and causes cognitive decline and dementia."
>
> Follow-up Interview Participant

In seniors, alcohol use was reported by participants as especially prevalent. This is problematic because it interacts with medications and creates difficulties in determining causes of dementia and cognitive decline. Alcohol use in seniors exacerbates mobility issues, contributes to falls, and intensifies depression and other mental health issues.

Prescription drugs

Although some of the table conversations about the abuse of prescription drugs related to opioids (see below), community members also shared that psychotropic drugs, such as Adderall and Xanax, are frequently misused, particularly among youth. Youth who attended the forums indicated that these drugs are often brought from home and sold for recreational use. Participants also shared the belief that drugs like painkillers are overprescribed (often, they believe, at the behest of pharmaceutical companies). A primary issue with prescription drug use among youth is the easy access they have through their parents' and grandparents' medicine cabinets. Relatives may be unaware of the importance of locking up these medications.

Opioids/fentanyl

Community members expressed belief that the opioid crisis is being addressed in San Diego County but that the increased use of opioids continues to be an alarming issue. People become addicted to drugs like Vicodin or Percocet and then, when they no longer have access to or can no longer afford these, they move on to using "street" drugs like heroin. At most of the forums, participants mentioned the dangers of fentanyl, which can be cut into other drugs without the knowledge of the user. Several participants suggested that fentanyl is cheap and is now being used by itself as a recreational drug, rather than as an additive to other drugs. Fentanyl,

participants stated, is one of the most dangerous opioids and often leads to fatal overdoses. For "harder" drugs like opioids, addiction happens quickly. This addiction, in turn, can lead to serious mental health issues and suicide attempts.

Crystal methamphetamine

Crystal methamphetamine or "meth" was identified as a substance of growing concern among youth and adults. Participants believe that meth is frequently produced in rural areas in San Diego and that it is also frequently brought across the Mexico/San Diego border. It was noted that meth is especially easy to get in North County, East County, and in San Ysidro. Meth can, some asserted, be smoked in vape pens, which makes it look more socially acceptable.

Acid

Although few details were provided, youth who attended three of the forums indicated that the use of acid is becoming more popular among high school students.

Homemade drugs

During several of the forums, forum attendees mentioned that youth are concocting drugs at home, often from recipes found on the internet. This includes drugs crafted from cough syrup, toothpaste, and cold medicines, and inhalants made from cleaning products, paint, and markers. One drug discussed was "lean" which is created by combining prescription-grade cough syrup with soda and candies.

Other substance use issues mentioned

Other substance use issues that were mentioned but not extensively discussed included: (1) addiction to video games; (2) chewing tobacco; (3) cigarettes; (4) non-FDA approved herbal products; (5) mushrooms; (6) cocaine; and (7) crack cocaine.

Vulnerable populations

Certain populations of people within San Diego County were identified as being particularly vulnerable to problems with substance use. Community members expressed concern about youth and young adults, veterans, pregnant women, mothers, homeless individuals, immigrants, refugees, and seniors. They also discussed unique issues facing Latino populations, such as fears regarding deportation and the unique and poorly understood needs of tribal populations – both urban and those who live on reservations. Certain populations are believed to be targeted by people selling drugs, such as gang members, people in rehabilitation programs, and students with lower rates of academic achievement.

Youth were the population discussed with the greatest frequency and in greatest depth in relation to substance use. The community expressed great concern about how easily youth can access vape products, marijuana, and prescription drugs, about how normalized drug use has become among youth, and about parents' lack of knowledge about these drugs. They worry that youth start with "small" drugs like marijuana in edible forms and that this use leads to the use of "harder" drugs that quickly become addictive. The community expressed a strong feeling that

substance use is being initiated at much younger ages than in the past and that youth are unaware of, or do not care about, the serious potential consequences. The community believes that substance use – particularly related to vaping and marijuana but also including other drugs as well – has grown among the youth population and that substance use represents a crisis among youth in San Diego. They also discussed the lack of effective deterrents and consequences for youth who are caught using substances. Suspension and expulsion lead to more drug use, they said, rather than to rehabilitation, and these seem to be the primary consequences for students.

Underlying issues

Community members felt strongly that it is important to recognize, acknowledge, and discuss the complicated issues that often underlie substance use. One common topic of conversation, for example, was that marijuana (as well as other drugs) is often used to "self-medicate" issues such as anxiety, ADHD, and depression. Participants emphasized that substance use and mental health issues are usually inextricably linked and that addressing one issue without acknowledging and addressing the other leads to failure in many interventions.

Community members also discussed the high levels of stress faced by students. The community, including youth themselves, believes, for example, that students are under far greater pressure than in the past to achieve in school and that the bar for achievement has been raised almost impossibly high for many. Students end up with little downtime and turn to using substances to relax and escape from the stress and pressure. Students emphasized that asking for help related to substance use is highly stigmatized and that their families often lack empathy for an addiction. Addiction is treated as a problem that was created by the youth and must be solved on their own.

> "Increased isolation and stress, paired with decreased social support, are causing people to be more distressed…which leads to the abuse of substances."
>
> Forum Participant

Families are under greater stress caused in large part by the exceptionally high cost of living in San Diego County. Parents are working more hours and, simultaneously, lack the support that they need to successfully raise their children. Community members are more socially isolated than in the past; this is particularly true, according to participants, for seniors. Youth are left at home alone more often. At home, they may have access to alcohol and other drugs and have the time and space to use them. In some families, drug and alcohol use is intergenerational: the kids see the parents using substances, which increases their risk for using substances themselves. The struggle for individuals to obtain stable employment contributes to substance use. Living in poverty or with insecure income and/or housing is often, at the heart of why people turn to drugs and alcohol.

In addition, at the root of many substance use disorders, many participants emphasized, is untreated trauma. People who experience adverse childhood events, like abuse, witnessing domestic violence, entry into foster care, homelessness, parental drug use, and interaction with the criminal justice system, are more vulnerable to substance use disorders. Despite this, mental health and substance use treatment are generally not integrated.

Lack of knowledge

The rise in substance use in the community, forum participants frequently stated, has occurred in part because few educational efforts are being implemented in schools, in communities, and in the public domain. Individuals, particularly young people, are often unaware of the potential impact of substance use. Parents are often uneducated about youth substance use, particularly newer products and new means of access. Products are being marketed as safe that may be dangerous, and this contributes to the normalization and social acceptability of substance use.

Limited effective, timely, culturally relevant, integrated treatment options

In addition, forum participants often discussed the difficulties of receiving immediate and effective treatment for those with substance use disorders who are seeking help. They felt that navigating the treatment system is a complex and challenging process. More detoxification programs, outpatient rehabilitation programs, and in-patient beds are needed, as are counselors and therapists who have special expertise in drug treatment. They also asserted that, for substance use prevention and treatment to be effective, it must be conducted in conjunction with education about and attention to mental health issues. The lack of coordination between providers of substance use and mental health treatment underlies the failure of many interventions. Finally, participants emphasized that the lack of culturally relevant prevention and treatment creates barriers for many people, including Native Americans, Latinos, refugees, LGBTQ individuals, and people from other minority groups. They have unequal access to care because of these barriers, and because much of the treatment is not designed for people from their communities, it is less effective for them. This creates an environment in which both access to and the provision of services is inequitable.

Mental Health Issues of Growing Concern

Focus group participants discussed several topics related to growing concerns about mental health issues. First, several mental health issues were identified as becoming more prevalent in the community. Second, social isolation has grown, in part, because of the increased use of technology. Third, populations, including youth, refugees and other immigrants, Native Americans, military personnel, members of the LGBTQIA community, and homeless individuals are especially vulnerable and experience barriers to care. Fourth, people lack knowledge about mental health and wellness and there is a stigma attached to discussing mental health. Finally, mental health treatment is often inaccessible, unaffordable, not culturally relevant, inequitable, and not integrated with physical health care.

Mental health issues identified

Forum participants identified anxiety, depression, and suicide attempts as growing concerns in the community. They also discussed the prevalence of ADHD, bipolar disorder, and schizophrenia, and the frequency with which people who have these illnesses try to self-medicate with substances such as alcohol, marijuana, methamphetamine, and opioids.

Another primary focus of forum conversation was the impact of trauma on mental health and the need for more people in helping professions – from teaching to medical care – to understand and adopt a trauma-informed approach to service. Community members spoke frequently of the impact of adverse experiences, including those that happen in childhood and others, such as the experiences of many refugees, on mental health and about the community's inability to effectively address the impact of these experiences. This means that the very people who need care the most are the least likely to receive care that is relevant and effective. As during conversations about substance use, community members pointed out, that when trauma goes unaddressed, substance use can result, as people try to ease their suffering by whatever means they can.

Participants also talked about their belief that one of the most serious consequences of growing rates of untreated mental health issues is increased violence in homes (child abuse and domestic violence), in workplaces, and in the community. This violence, according to feedback, is a result of untreated mental health problems. Exposure to this violence then, in turn, creates further trauma to individuals within the community.

Social isolation and technology

Forum participants believe that the community's mental health has deteriorated largely due to increased social isolation caused by the increased use of technology, particularly the internet. Community members interact in person far less than in the past. And while they may not feel "alone" because they are interacting online, the reality is that people have become more isolated. The reliance on online relationships and services has also, they believe, contributed to a breakdown in communication and coping skills, and to a lack of sense of belonging. The "false narratives" presented on social media can also heighten a sense of inadequacy and failure as people believe others' lives are picture-perfect. In addition, many participants discussed the increasing evidence that "screen time" negatively impacts mental health. For youth, cyberbullying is a constant reality, and many feel that their social connections are dependent upon maintaining an active social media presence, which creates stress and limits down time. In addition, video games were occasionally mentioned by participants, some of whom believe violent video games are contributing to poor mental health and increased levels of violence.

In addition, some community members related concerns about the increasing social isolation of older adults. Seniors are less likely now than in the past, they said, to have family living nearby. Limited mobility and limited access to affordable transportation contribute to this isolation. This isolation, then, leads to depression which may go untreated because of barriers to accessing care.

Vulnerable populations

Youth

Across all forums, participants were clear in the belief that rates of anxiety and depression, which often lead to suicide attempts, are rising among youth. Community members attributed this rise to increased pressure to succeed, social media and the internet, bullying, inadequate resources in school, and lack of knowledge about mental health and wellness among youth and their families.

Similar to the conversations about underlying causes of substance use, a common theme regarding mental health issues in youth was the increased pressure on youth to succeed in school. The amount of homework commonly given to middle and high schoolers was identified as a key source of stress.

Social media and large amounts of time online have created increased social pressure. Youth compare themselves to others on social media, whose profiles and lives seem "perfect," and this causes them to worry obsessively about their imperfections and to question their self-worth. For girls, especially, participants said, body-shaming is common online, and their self-image becomes quite negative. It is important to most youth to be popular online – they may obsessively check for followers, "likes," and views. The time spent online has also caused youth to lose much of the downtime that allows for them to truly relax and decompress. At the same time, while they are seldom truly "alone," this lack of face to face socialization also leads to underdeveloped social and communication skills and fewer opportunities to learn how to regulate their emotions in healthy ways. Screen time is also interfering with sleep, and a lack of sleep is a pressing issue among high schoolers. Adults at the forums discussed the growing evidence about the impact of too much screen time on youth mental health.

> "These kids have hopes and dreams and don't feel like they will get the opportunity to achieve them because they are Latino."
>
> Forum Participant

Another issue commonly discussed was the impact of bullying – both in person and cyberbullying - on youth mental health. While everyone seems to recognize how detrimental bullying can be (both to the victim and the perpetrator), few know how to address it or even whose responsibility it is to intervene. Cyberbullying has also created complications. The use of apps like SnapChat, on which texts disappear, make it far more difficult to identify and prove when bullying is occurring.

Community members are concerned about how few resources are available in schools to address student mental health. Most schools, they said, for example, have only one or two guidance counselors available. Participants also referenced vast disparities in school resources and

facilities. Students who attend schools in low-income areas and students of color, participants felt, have fewer supports available to them, creating inequities.

Another common topic at the forums was the difficulty parents have accessing and helping manage the care of their young adult children. Once they have turned 18, the parents no longer have access to their records and have no rights to help manage their care. This is true even for those parents who allow their children to stay on their health insurance until they are 26 years old.

> "Three refugee families I know have had sons commit suicide in the last few months."
>
> Forum Participant

> "The issue with immigration and citizen status can trigger depression, stress, and anxiety. High school students that are undocumented have limited opportunities… it leads to shame and allows students to not reach their full potential in the classroom."
>
> Forum Participant

Refugees and immigrants

Many refugees experience trauma in their countries of origin and then the further stress of immigration, culture shock, language barriers, seeking employment, and trying to resettle in a new country, according to participants. They often have post-traumatic stress disorder and frequently suffer from anxiety and depression. They face enormous challenges in obtaining mental health care: they often do not know how to access resources and cannot find providers who speak their language or understand their culture; they may be hesitant to use resources fearing that their immigration status could be affected; and they may have cultural beliefs that discourage the discussion of mental health concerns. The lack of representation of refugees in provider populations contributes to mistrust and discomfort for people who need services.

All immigrants, forum participants said, experience a great deal of stress. For those without proper documentation, fears have increased about detention and deportation. This has led to high rates of anxiety. Fears about immigration status also create a significant barrier to care; those who are concerned about being "reported" are highly unlikely to seek out any kind of mental health care.

Native Americans/California Indians

Native Americans (some participants used the term California Indian, while others preferred Native American), according to forum participants, have high rates of suicide attempts. They also suffer from disparities in rates of other mental illnesses, such as anxiety and depression.

However, they often cannot afford care, and there are few programs available that serve tribal populations. The clinics that are available often require long drives and have wait times, both of which are highly problematic for acute conditions like psychosis.

Military personnel and veterans

Forum participants named military personnel and veterans as being particularly vulnerable to mental health issues, especially Post Traumatic Stress Disorder (PTSD). Participants believe that suicide rates among the military are increasing.

LGBTQIA

Forum participants also shared that they believe members of the LGBTQIA community are under great stress, and as a result, are at greater risk of mental health issues. LGBTQIA individuals are often bullied in the workplace and in the community and are misunderstood. They are more likely, the community said, to experience trauma, and therefore, to have anxiety, depression, and suicide attempts. Confusion about one's gender identity can also contribute to stress, anxiety and depression.

Homeless individuals

Forum participants noted that mental health (and substance use) issues are common among the homeless. These conditions may have resulted in an individual becoming homeless or may have been the result of becoming homeless. Untreated mental illness was viewed by forum attendees as the most significant contributor to homelessness in San Diego – an issue identified at most of the forums as a crisis in the community.

> "Housing is a desperate need for people suffering from severe mental illness."
>
> Forum Participant

Lack of knowledge

Community members emphasized that most individuals are not knowledgeable enough about mental health issues or mental wellness. The stigma surrounding mental illness exacerbates this problem; people are afraid to ask questions or to seek help because of fears about being negatively labeled. Parents may not recognize that their children (or they, themselves) are experiencing depression or anxiety and, even if they do, have no idea how to help them. Some community members reported that school personnel do not take mental health issues seriously or do not know how to recognize the signs of an emerging mental health crisis. Concern was expressed that law enforcement personnel are ill-equipped to respond to incidents involving people with mental health issues and that incarcerating these people does not help them.

Insufficient, segregated treatment

Although the focus of the forums was prevention, conversations often turned to mental health treatment. The insufficient availability of affordable facilities, counselors, and therapists, participants said, creates a barrier for people who need care. Even for those who have insurance, the out-of-pocket expenses are often prohibitive, and the wait times can be long. Receiving necessary care for acute mental health issues in a timely manner is especially challenging. The system is also difficult to navigate, and for people living in rural areas, services are often far away, participants explained. In addition, many people are hesitant to seek and receive care from people who are culturally different from them, and the body of service providers who are available is not diverse. These factors, in turn, contribute to mental health issues going unaddressed when they are less severe so that the first point of care for many people is when they are in crisis. When individuals receive treatment, they are quickly released from the treatment and do not receive adequate follow-up care. This discourages them from seeking help in the future. When people are incarcerated for crimes that may have arisen from their mental health issues, they no longer receive mental health care, and their treatment is hampered. And as with the conversations around substance abuse, community members frequently discussed the failure of the healthcare system to address physical health, mental health, and substance use issues in a coordinated manner. Health care providers, for example, they said, cannot access mental health records and vice versa. Care is not individualized, and there is no continuity of care from one provider to another.

Strategies for the Prevention of Behavioral Health Crises

Forum and follow-up interview contributors shared many ideas for how to better address behavioral health issues in order to prevent crises. Their ideas focused on: (1) raising awareness, decreasing stigma, and teaching alternative coping skills; (2) decreasing access to substances; (3) enhancing wellness by increasing connection and building support; and (4) diversifying, expanding, and integrating services and treatment options.

Raise awareness, decrease stigma, teach alternative coping skills

Raising awareness about substance use and mental health was the most frequently cited prevention strategy. The entire community needs education about these issues, and emphasis needs to be placed on educating students, families, and community leaders. By speaking more openly and frequently about these issues, the stigma attached to substance use disorders and mental illness is decreased, and through educational efforts, healthy coping skills can be taught, and resiliency can be improved, according to participants.

Among students, there was a consensus that education about the potential dangers of substance use, particularly vaping as it becomes more popular, needs to begin in schools at a very young age. These messages are best delivered by peers or by people with lived experiences who can relate well to youth. Videos can also be used from famous people, like sports stars, who are starting to discuss these issues. Ensuring that messages are delivered by people of similar cultural backgrounds can also be important. Students who participated in forums emphasized that the

way conversations about drugs are currently occurring – primarily in traditional school assemblies - doesn't work. They want and need motivational guest speakers with lived experience to come and speak to them in small groups. Students also suggested field trips that provide interactive experiences would also be helpful – touching the lungs of someone who died from vaping, for example, or meeting people who went to jail for dealing drugs. Participants also discussed the importance of using schools to educate students about mental health. Children and youth need to be taught to identify their emotions, to understand the signs and symptoms of problems like anxiety and depression in themselves and their friends, and to seek help from appropriate sources when they need it. They also need, participants said, to be taught about the relationship between excessive screen time and the use of social media and levels of depression and anxiety, and they need to learn healthy coping skills to deal with the pressures and stress of growing up. More clinical staff, as well as counselors, "hope navigators," and coaches should be provided for schools to provide this type of education and support. Students emphasized that the more students could design and run these programs, both about mental health and substance use, themselves - giving them some ownership over them – the more effective they will be. They also stressed the need to raise awareness about and improve understanding of the LGBTQIA community as part of these efforts, since this community is disproportionately affected by mental health issues resulting from trauma.

Some participants also expressed that teachers and other school staff need education about mental wellness and mental illness. These participants felt that school staff need to be taught to recognize signs of distress and to respond to it appropriately and empathetically. On the other hand, some participants felt that school staff are already too overburdened to take this on and that class sizes are too large to realistically allow teachers to recognize problems in individual students.

> "Increasing representation in these efforts is the most pressing need to address sensitive issues like these."
>
> Forum Participant

Parents need to be continuously educated, participants stated, starting when their children are infants or preschoolers, about substances. Raising parental awareness about substances – what they are, what they look like, and what the potential impacts are– can occur regularly in schools, in churches, and in other community venues. Signs of substance use should be explained.

Most parents, participants expressed, need a better understanding of what anxiety and depression are, what the signs of these problems are, and that having depression or anxiety does not reflect negatively on their children or on them. They need to be given the right tools to figure out if their children are suffering and how to respond if they are. They also need assistance in finding and navigating resources. Education about mental health for parents should occur in

school meetings, but it also needs to occur through peer education and mentorship. Because of the sensitive nature of the issues and the stigma attached to discussing mental health, this education will be most effective when families teach families or when lay people from the community provide the education. Utilizing programs like promotora programs could be immensely helpful. Messages about mental health need to be tailored to the group that is being targeted and need to be given by members of that community. One group of participants, for example, explained that among many Spanish speaking communities, information shared through word of mouth is more effective in getting the message across than written communication. Trust needs to be established for this education to be effective with parents. Students were clear that they feel their parents need to have a better understanding of the stress they are under and the impact that extreme pressure can have on their mental health.

In the broader community, awareness should be raised about substance use and mental health both through more local, community efforts and through comprehensive public awareness campaigns, according to participants. People need to be taught that vaping may be just as, or more, dangerous as smoking cigarettes and that the legalization of marijuana does not mean that it is safe to use. Media coverage about the potential dangers of vaping and marijuana should be increased. Promotional materials about the dangers of vaping should be created and disseminated using models that were successfully implemented in the past about tobacco and cigarette smoking.

> "Jessica Simpson coming out and talking about her addictions – those are good stories to latch onto"
>
> Follow-up Interview Participant

Community and religious leaders should be utilized to educate community members about the importance of understanding mental health. The community needs to be taught not only about signs and symptoms of mental illness, but also about healthy ways to cope with stress, anxiety, and depression. Stigma will be reduced if respected leaders speak openly about mental health and begin to normalize these conversations. Resources need to be explained, and people will need assistance navigating mental health services.

Public awareness campaigns about mental health are also important, forum participants said. One suggestion was to increase the number of suicide prevention hotline posters that are placed in public places like bridges and trolley stops. Public awareness campaigns need to be culturally relevant. Among immigrant communities, for example, fears about being deported as the result of accessing mental health services need to be addressed. For young people, public awareness campaigns should utilize social media platforms. Consideration should be given to fun and creative ways to raise awareness. One suggestion, for example, was to create a program to encourage comedians to make skits about mental health. Another was to create games and apps

that teach kids and adults how to identify, address, and communicate their mental health issues appropriately. Utilizing celebrities to help normalize mental health issues and substance use disorders is another approach the community believes is helpful.

Finally, two professional groups were cited as needing better awareness of behavioral health issues: law enforcement personnel and health care providers. Police officers, and people in positions of authority, need to be educated about behavioral health and how to interact with people with substance use disorders and mental health challenges in an empathetic and sensitive manner, participants said. They also need to be aware of available resources and provide "warm hand-offs" to these services. Health care providers need better training about the impact of Adverse Childhood Experiences (ACEs), how to screen for behavioral health issues, and how to provide trauma-informed care.

Participants noted that some programs already offer this type of education. Mental Health First Aid is one such program which is County-funded. This program gives everyone a basic level of mental health knowledge so that people will respond appropriately to a mental health crisis or to someone in distress

Decrease access to and appeal of vape products and other drugs

Another strategy to prevent substance use, particularly vaping and marijuana use among youth is, participants suggested, to make access to these substances far more challenging. This could be accomplished in several ways, including:

- Implement different reporting systems in schools that allow for students to safely and anonymously report substance use
- Install smoke detectors in school bathrooms
- Increase taxes on vape products and marijuana
- Prohibit the sale of flavored vaping products, edible marijuana products, and products made to look like other things (e.g. Juul that look like flash drives)
- Have much stronger consequences for stores and individuals who sell to underage youth and increase surveillance
- Restrict the advertising of marijuana and vape products
- Prohibit marketing to youth
- Restrict vape and marijuana shops from being near schools
- Require warning labels on all marijuana products about possible health effects
- Ban advertisements on television for all drugs

Enhance wellness by increasing connection and building support

Participants recognized social isolation as a primary underlying cause of both substance use issues and mental health issues and expressed the belief that social isolation is an emerging crisis. They had many ideas about how to address this. First, for youth, it is important, they said, to offer free and low-cost activities that are appealing to young people: athletic activities, animal therapy programs, the arts and theater, and community service, for example. Youth need to have exposure to a wide variety of free activities to figure out what they enjoy. These activities may

also activate "pleasure" centers in the brain – similar to what substances can do. All these benefits then help maintain wellness and prevent substance use. Another frequent suggestion was to ensure that schools are offering classes that focus on life skills, like driving, cooking, auto shop, home economics, resume building and interviewing. These kinds of classes are an opportunity to decrease stress about the upcoming transition to independence. Finally, all schools, it was suggested, should have a designated "safe space" for students in which they can congregate, discuss their feelings, and deal with their emotions.

Community and neighborhood- based programs are critical, participants said. They suggested holding health fairs in the community, hosting community wellness groups, creating community wellness centers, and offering fun adult activities in neighborhoods. Another option they suggested is to hold classes in schools, churches, and other places for people of all ages that focus on wellness. These programs should be facilitated by people of similar cultural backgrounds. Having community-represented programs increases cohesion and a sense of inclusion. The United Women of South Africa, one participant shared, conducts this type of program -- a peer-based program that incorporates the concept of "brotherhood" to increase accountability about being a community member who does not use drugs.

> "We were told to put our son on the street if we really wanted him to get immediate help for his mental illness."
>
> Forum Participant

Forum and interview contributors also emphasized the importance of family-based programs to build networks of support to strengthen families. Family-to-family parenting classes and mentoring programs staffed by people of similar cultural backgrounds (e.g. refugees teaching refugees) would be especially helpful to families who are stressed. Coping skills could be taught and practiced and resources could be introduced.

For older adults, participants suggested expanded home visiting programs, phone services, and peer mentoring programs. They emphasized that older adults are more comfortable discussing their concerns with other older adults. Programs like the Retired Senior Volunteer Patrol (RSVP) were discussed as examples of effective programs.

Expand, diversify, and integrate services and treatment options

Although the emphasis of the forums was on prevention, community members showed concern about substance use and mental health treatment options available and accessible in the community. They also cited segregation of services and inequitable access to and provision of services as concerns. They stressed that more inpatient and outpatient facilities and programs are needed, particularly in North County and in rural areas. This care needs to be integrated. It is difficult to find care for co-occurring mental health and substance use issues, for example, and medical and behavioral health occurs separately. Communication needs to occur between all

treatment and follow-up providers. Social services also need to be interconnected. Funding needs to occur across systems, and management care plans, like Medi-Cal, should be able contract with community-based organizations to allow for flexibility in funding.

Assessment needs to occur early and referrals for services should be seamless. In addition, they said, behavioral health treatment needs to take a more holistic approach and incorporate nutrition, supplements, mindfulness, and other wellness methods. Social determinants of health must be addressed for any treatment to be successful. The limited duration of drug rehabilitation programs was also a topic of conversation; thirty-day programs, people felt, are not long enough for success in addressing drug addiction. The process of recovery is lifelong. Mental health and substance use issues should be treated like other chronic diseases with follow-up throughout the lifespan. Each person who goes through recovery should have an effective recovery team that includes a family member, a peer, and a clinician.

Another key issue that the community discussed is the shortage of behavioral health service providers, particularly who are culturally matched to the people who need services and in rural areas. The community suggested creating incentive programs to increase the number of service providers. This could include incentives around housing and student loan forgiveness. The County and other officials should also be advocating to increase reimbursement rates from Medi-Cal and Medicaid so that a greater number of providers would take people with this kind of insurance.

Mobile health units that provide behavioral health services were discussed as one important strategy to increase access to care. These units should offer care in a non-stigmatizing manner and could utilize trained lay people from the communities they are in to assist in the provision of services. These services should be user-friendly and attractive. A mental health unit (perhaps a social worker crisis team) like PERT but that does not include law enforcement would be helpful. This unit could be sent out on calls to assess crisis situations and could call for a 5150 if needed and follow victims to the hospital. They could also provide navigation services and follow up care on release to ensure a continuum of care.

> "Recovery cannot and should not be rushed."
>
> Forum Participant

During these discussions, participants unanimously agreed that funding for behavioral health services should be increased. They pointed out that many effective prevention and treatment services already exist. They felt strongly that funding for these programs should be maximized to make them sustainable because, they said, too often programs that are working close due to a lack of funding. They pointed to drug diversion programs as an example of success, as well as the PERT program.

Forum participants also discussed the need for "urgent care" services related to behavioral health needs. People need easy access to places, like walk-in clinics, where their needs can be addressed immediately before they become a crisis. This is especially challenging for anyone who is uninsured or underinsured (e.g. their co-pays are prohibitive). School-based services for students and their families were discussed as one "urgent care" option.

Supportive housing for those with behavioral health needs was also frequently discussed. The community wants supportive behavioral health housing that is available as soon as individuals are released from behavioral health facilities. This housing should include individual units, 24/7 support and supervision, group classes, and individual therapy. They also stressed that housing is a desperate need for persons suffering from severe mental illness. Board and care homes, they said, are "dismal and minimal."

One specific suggestion offered at several forums was to tax marijuana and vape products at a high rate and to use these revenues to fund the expansion of behavioral health programs.

> "Shed light on and give more support and funding to resources that are already available."
>
> Forum Participant

Feedback about BHS Innovative Program Ideas

Forum and interview contributors were asked to provide feedback about three ideas that BHS is considering as Innovative programs. MHSA Innovation projects must meet criteria in state law and be submitted to the Mental Health Services Act Oversight and Accountability Commission for approval. Ideas are developed locally with input from community stakeholders. BHS provided the following outlines for innovative ideas:

1. Outdoor activities to support behavioral health treatment: Outdoor activity therapy as an additional support for treatment that would enhance recovery. This might be considered for all age groups in treatment.
2. Training for school staff: This focuses on providing training to school staff (including teachers and non-academic staff) and before/after school care staff about ways to support development and strengthening of emotional resilience in students they interact with daily. Ages would range from elementary school to middle and high school students.

It is hypothesized that this could support positive development and reduce risk of mental illness and suicide.

3. Cyberbullying prevention and parent awareness: This innovation idea focuses on developing ways to address online bullying as well as direct person-to-person bullying. It would increase awareness of parents about platforms/apps to be mindful of and what to look out for. This might involve development of some type of communication app to keep parents informed.

> "Excellent! Exercise increases endorphins and helps people focus and engage in talk therapy. This is an old idea, dating back to ancient Greeks. It definitely works and patients love it."
>
> Follow-up Interview Participant

Feedback about these programming ideas was mixed and is presented below.

Outdoor activities

> "This will not be effective for couch potatoes and may not appeal to people of color."
>
> Forum Participant

Community members had mixed reactions to this programming idea. Some thought it was a good idea that would allow people to "connect with nature," get fresh air, improve their physical and mental health, and teach them a positive coping mechanism. Specific activities suggested included hiking, biking, ropes courses, small animal care, trips to national parks, camping, survival training, school gardens and gardening, rafting, canoeing, beach clean-ups, and volunteering outdoors. Other benefits discussed about this kind of programming would be reduced stigma and teaching people self-care and mindfulness.

Others thought that emphasis should be placed, instead, on making sports less expensive, making gyms more affordable, creating community gardens at school, or planting more trees. In addition, some people felt that this would exclude or alienate people who do not like outdoor activities. Several people also suggested that this would not appeal to people of color. Others thought that families are too busy to be involved in this type of treatment, and some expressed concern about the cost of such a program.

Training for school staff

Some participants felt that school staff would benefit greatly from learning about how to promote student resiliency. A variety of approaches was suggested, including having school personnel screen the movie "resiliency," making the training for the whole school community so that parents and students are included, and ensuring that the training is held on a consistent basis. Participants emphasized that to truly be effective the entire staff would need to be trained, from cafeteria workers to members of the administration. They also suggested that concrete guidelines for school personnel about how to incorporate strategies into lesson plans and into their workdays would be necessary and that the cultural competency of the program would need to be ensured.

On the other hand, several groups who were queried about the program emphasized that they "do not like this idea," explaining that money should be directed, instead, directly to children or to community programs. One group, for instance, said "this is not an innovative idea. There are already systems and programs to do this. What should be done is to educate the community and families. Promotoras and community liaisons should help teach the community how to support students, rather than the schools." Many participants emphasized that teachers and other school staff are already overburdened. In addition, some participants expressed doubt about whether this kind of program would work: "this will not be enough to reduce depression and suicide attempts." Still others stressed that large class sizes do not allow for teachers to form personal connections with students, so that it is not feasible for teachers to attend to the mental health of or establish trust with their students.

> "Teachers are already overburdened."
>
> Forum Participant

Cyberbullying prevention and parent awareness

> "This type of training would help school staff identify and help students who are distressed."
>
> Forum Participant

In general, forum attendees and interviewees were supportive of the idea of providing parents with education not just about cyberbullying but also, more generally, about social media. Parents, they said, need ongoing education about the social media platforms and apps. They need to understand the language of social media (e.g. abbreviations and emojis) and to be taught how to set up security measures on phones and computers. Parents, they said, need to learn how to identify if their child is being bullied and/or is the perpetrator of bullying. They also should be

informed about the potentially devastating consequences of being bullied, and, participants shared, suicide prevention should be addressed. Finally, parents should be educated about proper use of technology and proper amounts of screen time and should be encouraged to set up "non-tech" family activities like game nights.

Specific programming ideas offered were: (1) include teachers in engagement forums; (2) show simulated cyber bullying; (3) have kids design the program, calling it something like "what I wish my parents knew". These educational seminars could be offered at places of employment, schools, churches, or community centers.

Potential obstacles to success with this type of program include the ability and willingness of parents to be involved; the difficulty of providing cultural and linguistic support for non-native English speakers; fears of being deported as a result of attending; and the time it will take to teach parents about technology.

Increasing Community Engagement

The final question forum attendees and interviewees were asked was about how to improve community engagement around the issues of substance use and mental health. It should be noted that many of these ideas (indicated by an *) were implemented for this year's engagement process. Community ideas are listed below.

Locations, dates, and times

- Host events at schools*, churches, and community centers*
- Stop holding these on Saturday mornings; people want to sleep in
- Do not hold events at schools at night. The lighting is bad, and the rooms are hard to find
- Host smaller, community-based events
- Go to events in communities that are already occurring and collect feedback there, instead of inviting them to an outside event when they don't feel comfortable and lack trust
- Events should be hosted throughout the year
- Do not schedule forums after the holidays
- Have these at back-to-school nights
- Provide people with dinner and a seminar

Promotion

- Advertise forums on television and social media*, including nextdoor.com*
- Market to large companies*; use employers to advertise these events to employees
- Forums need to look interesting in promotional materials
- Have an online bulletin board from the county with a list of forums and different resources such as where to find help if suffering from a mental health issue
- Market to people in the field*
- Send mass emails to parents at schools where forums are held; advertise through schools
- Start promoting much earlier
- Disburse information through NAMI website and other parent and other support groups
- Utilize the SELPA consortium to advertise the forums

- Advertise at sporting events
- Post flyers in health care centers
- Have *Live Well San Diego* employees share and spread the word*
- Advertise on college campuses
- Do text message alerts – like Amber Alerts but the kind you can opt into or sign up for
- Use community leaders to spread information about the forums
- Send information about events with utility bills
- Create a county-wide campaign (like "Love Your Heart") to get the word out
- Use bus ads
- Post flyers at recreation centers*
- Be clearer on the flyers about what the forums are about
- Use Community PATCH
- Robocalls from school database
- Advertise on the radio

Other ideas

- Get sponsorships for the events
- Better explain the importance of these events
- Increase incentives
- Draw more attention to incentives
- Partner with schools to offer extra credit to students who attend
- Host more events like these forums
- Send out follow-up communications about the forums, then report and what is being done with the results, ask for suggestions for future forums
- Provide questions in advance
- Allow people to give feedback online rather than coming in person
- Events do not appeal to people who are living here for a transitional period
- Community members are hesitant and intimidated when service providers come to these forums. Make the events for community members only
- Do tables at sports practices and other events that parents attend for their children. Make them quick conversations

Focus Groups

Three focus groups were held. Participants were asked the same questions as the forum participants, except that they were not asked to comment on innovative programming ideas. The first focus group was held with aging-out and former foster youth who are members of the Voices for Children Real Word panel, the second with members of the LGBTQIA community at the San Diego LGBTQ Community Center, and the third with high school students who were members of the San Diego County Office of Education Friday Night Live leadership program.

The Real Word Panel: Aging-out and Former Foster Youth

Seven people attended this focus group on December 19, 2019, consisting of aging-out and former foster youth from the ages of 18-28. These young adults are members of the Voices for Children Real Word Panel, a group devoted to speaking in the community about their experiences in the foster care system. Three of the participants are in college, two are high school seniors, and two are now working and living independently.

Substance Use Issues of Concern

The members of the Real Word panel identified two substance use issues that are extremely common among all youth: vaping and marijuana.

> "Vaping is an epidemic. Even middle schoolers are doing it. The bathrooms at school are dangerous."
>
> Focus Group Contributor

Vaping

Vaping, the focus group said, is easy to hide. There's no smell, so the vape can be held in and then blown down their shirts when adults aren't looking. Even young kids vape, they said, and they are being sold dangerous, counterfeit cartridges.

Marijuana

The focus group also discussed the prevalence of marijuana use. They reported that "weed" is especially easy to get. They can buy it themselves at dispensaries, or if they are too young, from older kids who sell it to them at a higher price. In fact, they shared, many young people consider this a small business endeavor and are making good money from the re-sale of marijuana. Foster youth, they explained, often use marijuana to address issues with anxiety and depression. They self-medicate and this becomes an unhealthy coping mechanism. They also use marijuana for fun because it feels good.

> "Drug treatment makes you worse. My sister got sent to treatment for smoking weed and came out a cocaine addict."
>
> Focus Group Contributor

The focus group spoke extensively about what they feel is the inappropriate and ineffective approach taken with foster youth who are caught using marijuana. They are often sent to drug rehabilitation that is designed for people who use "harder" drugs than marijuana. While in these programs, foster youth are exposed to other, more addictive drugs. In addition, the failure to address underlying trauma and mental health issues as part of treatment undermines the efficacy of the program.

Mental Health Issues of Concern

The group brought up several areas of concern related to mental health: the rising rates of anxiety, depression, and suicide attempts among foster youth; the root causes of these problems; the differential expression of these mental health issues; and perceived inadequacy of treatment for these issues.

> "My best friend seemed fine. She was 23. I thought she was doing great. Three weeks ago, she threw herself off the Coronado bridge."
>
> Focus Group Contributor

Rising rates of anxiety, depression and suicide

First, the focus group said, depression, anxiety, and suicide attempts are rising among youth, and this is particularly true for foster youth. They described depression as an illness that all foster youth experience and suicide as a "part of daily life" for foster youth. Several participants shared recent experiences losing loved ones to suicide. They described becoming nearly numb to this experience of loss.

Root causes

Underlying these mental health issues, they said, is the trauma they have experienced – both within their families and in the foster care system. In addition, the youth described intense pressure to succeed and to not "become a statistic" or "like their parents." They also talked about how foster youth use the internet to fill a relational void. Their relationships are often fractured and temporary, so they turn to social media and online relationships. This approach, however, does not provide human connection and creates a situation in which they are constantly comparing their lives to other people's lives. The focus group was unanimous in their belief that screen time has a direct, negative impact on mental health.

> "We wear a mask. Success and depression can be best friends."
>
> Focus Group Contributor

Differential expression of mental health problems

Depression and anxiety can exhibit in a variety of ways for all youth, but this is especially true in foster youth. This group (the Real Word Panel) is among the most successful of its kind, members said. At this point in their lives, they have become adept at appearing stable and happy. There is a stigma to talking about mental health and a desire to appear tough, so even though most people in foster care understand how common these issues are, they don't discuss them.

For other foster youth, the outlets for depression and anxiety include anger, violence, unsafe behaviors like cutting, bad attitudes, isolating, and academic failure, among others. Because depression and anxiety are either not outwardly expressed or expressed in ways that are not obvious to the adults around them, the signals of distress are often missed or misinterpreted. Rather than identifying and treating underlying issues, acting-out behaviors are too often punished. This punishment then makes the mental health problems worse. In addition, the group said, too few consistent, caring adults are present in their lives. Group home staff and foster parents are paid to care for them and often do not take a personal interest, so there are too few people invested in ensuring that they are ok.

Inadequacy and inequity of therapeutic services

These young adults also made clear their beliefs that the therapeutic services available to foster youth are of poor quality and are inconsistently delivered. They feel strongly that they are often provided with inexperienced therapists, many of whom are not yet licensed. Many of these therapists, they said, do not have training in dealing with trauma or in the unique needs of foster youth. Often, they said, they did not receive any type of therapy.

Strategies for the Prevention of Behavioral Health Crises

Participants in this focus group had three primary ideas for how to prevent substance use and mental health crises among foster youth: mental health and substance use education; treatment specifically designed to address marijuana use; and adult mentors and role models.

Education

First, the focus group participants outlined an education program that begins in early childhood and extends through adolescence. This program could be for all children but would be especially important for foster youth. The goal of the education would be to teach children how to identify and express their feelings so that they understand what they are experiencing. They would be taught, in ways appropriate to their age, about mental health and wellness and would be given the tools they need to speak up for themselves. They would learn to identify symptoms of anxiety and depression and would be taught about different types of therapy and how to identify a qualified therapist who is a good match for their needs. They would also be taught about the potential impacts, short and long term, of substance use. Substance use education would, ideally, be presented by a person or a panel of people who had lived in foster care and used substances. Youth, they said, will respect that kind of honesty and will not question the motivation for the education. In this way, youth would be educated and empowered.

Treatment for marijuana use

Another solution the group advanced was to design drug treatment that is specific for marijuana use. Marijuana is not addictive, they asserted, and most youth use it to cope with pressure and stress. The strategies used, therefore, to stop youth from its continued use need to be vastly different from those used for other drug problems.

> "I wish I had someone to come just once a week to help me get things done -- like learning to use a bank or grocery shop. Kids with supportive parents have this. We don't. Having someone to help you learn all this is a big part of having good mental health."
>
> Focus Group Contributor

Mentoring

This group of young people made evident that they did not have enough people in their lives to care about them and teach them life skills. The need for a caring adult presence in their lives was strongly expressed. One explained that what their life was missing was a safe person to talk to who would listen without judgment and pressure. Foster youth, they said, need advocates to stand up for them, listen to them, and believe in them. Several of the participants mentioned that their Court Appointed Special Advocates (CASAs) served in this role for them.

Engaging Youth

When asked how foster youth could be better engaged in these kinds of conversations, the focus group participants suggested that hosting more groups like these would be beneficial. Although having conversations at the youths' placements is convenient, it also inhibits honest feedback, so hosting events in neutral places is important. They also suggested ensuring that foster youth feel truly heard and following up with them about improvements that are being made to services for foster youth.

The San Diego LGBTQ Community

Four people participated in this focus group at the San Diego LGBTQ Community Center on January 14, 2020.

Substance Use Issues of Concern

Focus group attendees noted that two drugs are prevalent in their community: crystal methamphetamine and marijuana. They also discussed concerns related to drug dealers and predators who target people near the Center and to treatment approaches that are ineffective.

Methamphetamine

"Meth" is commonly used in the LGBTQ community as a party drug, participants shared. Meth is snorted, eaten, and smoked. It is easily accessible, low-cost, and popular, particularly among people who go to clubs. This is a growing problem in the community, focus group members noted, and it affects people's ability to function in daily life. Concerns were also expressed that meth is being cut with fentanyl.

> "Everyone needs someone to make proud."
>
> Focus Group Contributor

Marijuana

Focus group participants said that marijuana is frequently used in their community, but they did identify this as causing individual or community-wide problems. The availability of edibles decreases respiratory problems that can result from smoking marijuana, one participant said.

Drug dealers/predators

A primary concern shared by focus group attendees is the presence of drug dealing "predators" who hang around the Center. These people, the group explained, convince members of the LGBTQIA community to exchange sex for drugs. They prey on people who are particularly vulnerable.

Ineffective, segregated treatment approaches

Focus group members characterized current approaches to drug treatment as "bungled." Mental health and substance use treatment need to occur simultaneously, for example. Twelve-step programs are not the right approach for everyone, they said. People need to be treated holistically – treating an addiction without treating social and mental health issues does not work.

Mental Health Issues of Concern

Focus group attendees discussed the intense trauma faced by most members of the LGBTQIA community and the mistreatment the community sometimes experiences by service providers.

Trauma

The primary mental health concern discussed at this focus group was the traumatic experiences faced by members of the LGBTQIA community. Focus group members talked about being rejected by family, friends, and religious communities, being kicked out of their homes, struggling with issues related to their bodies and gender, being invalidated by mental health professionals, facing job discrimination, and being sexually assaulted (and not believed when they reported it). These experiences have severe, negative consequences on their mental health and lead to PTSD as well as issues with substance use, joblessness, and homelessness.

Mistreatment

The focus group expressed gratitude for living in a community that includes many allies and advocates. They also described situations, however, in which they have faced discrimination and mistreatment by professional service providers. They discussed the reaction of medical and law enforcement personnel when they have reported sexual assault; they stated that often these professionals imply that they "asked for it" or deserved it. This is especially true for people who are transgender. They also discussed facing discrimination at homeless shelters. Many homeless LGBTQIA individuals would rather live on the streets than go to a "straight" shelter. The discrimination this community has experienced, they explained, has led to a great deal of mistrust of service providers, and as a result, members of this community often will not seek care when they need it.

Strategies for the Prevention of Behavioral Health Crises

The focus group attendees suggested three preventive strategies: (1) educate and empower members of the LGBTQIA community; (2) strive to increase acceptance and understanding in the community, by professionals, and by religious institutions; and (3) implement programs in the community designed specifically for this community.

Education and empowerment

The main strategy advocated for by members of this focus group was to educate and empower LGBTQIA individuals. First, the community needs education about substance use, its impact, and the resources available for people who want and are seeking help. Explaining how substances may be used to self-medicate mental health issues would be especially helpful. Second, starting at a young age, individuals need to be taught to understand and accept themselves. They need to learn to articulate and explain their feelings, to identify signs of mental illness, and to be given tools to cope with adversity.

Increase understanding and acceptance

Education and advocacy also need to occur with members of the broader community, according to participants. More efforts must be made to increase understanding and acceptance among health care professionals, law enforcement, and other service providers as well as religious and community leaders. Government and corporate leaders need to take a more active role in encouraging understanding.

> "We need to help people figure out: what is keeping you from being fully you?"
>
> Focus Group Contributor

Community-based programs

Focus group participants agreed the behavioral health programs for the LGBTQIA community need to be based in Hillcrest and need to be specifically designed for members of the community. This includes drug rehabilitation programs, inpatient and outpatient mental health treatment, homeless shelters, and sexual assault response programs. If this is not possible, mobile teams, as are currently utilized in downtown neighborhoods, should be implemented to help LGBTQIA who are experiencing acute mental health or substance use issues or homelessness.

> "We have been wounded in many ways…often by well-meaning people."
>
> Focus Group Contributor

Engaging the LBTQIA Community

The focus group members emphasized that to better engage their community in these types of conversations, a message needs to get out to the community that

they are not alone and that there are people who care about them. Community leaders, respected professionals, and famous people need to speak out more often to encourage involvement.

Friday Night Live Leadership Group: High School Students

Ten students from local high schools participated in this focus group. These students were sophomores, juniors, and seniors from three different high schools who are members of the Friday Night Live leadership group through the San Diego County Office of Education.

Substance Use Issues of Concern

The youth in this focus group listed several substances that youth are using with greater frequency than in the past, discussed underlying causes of substance use in youth, and debated appropriate actions by schools in response to substance use.

Vaping, marijuana, alcohol, and other substances

These high school students focused primarily on the use of vape products, marijuana, and alcohol but mentioned a few other substances as well.

Vaping

Vaping, the youth said, is extremely common. Juul, which is a brand of e-cigarettes, is especially popular. They are expensive, the youth said, so they tend to be more common among youth coming from higher-income families. The youth also said that vaping is more common among white youth than youth of color. The youth in this group indicated that teens know which smoke shops they can purchase from because some stores do not check identification. They also said that it is easy to get someone older to purchase vape products for them.

> "Over these past few years, e-cigarettes have evolved into cool things that are super appealing. I think there are 250 flavors! And using these just looks cool, much cooler than smoking cigarettes."
>
> Focus Group Contributor

Marijuana

The youth indicated that marijuana use, particularly in the form of "wax," a form of marijuana that is highly concentrated, is rampant among their peers. They indicated that "weed" is more frequently used by youth of color. Youth, they said, often see the adults in their families and communities using marijuana. They rarely purchase the marijuana directly from dispensaries because, the youth said, it is more expensive to do that. One youth said that weed might be $60-70 at a dispensary, but from a "friend" or a dealer would be in the range of $40-45. Dealers, they detailed, include gang members in their neighborhoods, or even more commonly, people online. Many dealers, they explained, contact youth through Snapchat or Instagram and then they deliver it to the youth. A friend may tell the youth to add that person to their social media app or

the dealers may ask the youth directly to add them. The biggest concern with marijuana, the teens said, is that youth are often purchasing the weed from unknown sources, and they are unaware of its potency or potential impact.

> "We went to pick my sister up one night from a party. The parents had supplied hard alcohol like tequila. We thought she would die. We had to take her to the emergency room."
>
> Friday Night Live Focus Group Contributor

Alcohol

The focus group also discussed frequent use of alcohol by teens. They described this use as mostly occurring at parties. Sometimes, they said, the parents are present at the parties and provide the alcohol themselves. Two participants described experiences with friends or family members who were taken to the hospital for alcohol poisoning after binge drinking.

Other substances

The youth also mentioned, but did not discuss extensively, the use of acid and Xanax by their peers.

Underlying causes

Focus group contributors discussed four root causes of substance use in youth: (1) trauma and the feeling that no one cares; (2) the lack of caring adults in their lives; (3) the stress associated with being a teen; and (4) social media.

> "You can have as many presentations as you want, but unless you have principals and teachers who care, who will do anything about it, nothing will change."
>
> Friday Night Live Focus Group Contributor

Trauma

Many youths who use substances, the teens explained, are doing so in reaction to trauma they have experienced. They use the substances to self-medicate and to feel good, they said.

Lack of caring adults

The youth talked extensively about how many of them feel as if no one cares about them, and this, then, makes it hard to be motivated to "stay clean." They pointed to underfunded schools, large class sizes, and unqualified teachers and other school personnel as problems that contribute to youth substance use issues.

> "A friend of mine, she felt like nobody around her cared. The only way she could feel a little happier was by smoking and vaping."
>
> Friday Night Live Focus Group Contributor

Stress

Many youths, like those who attended this focus group, who are motivated to achieve, the teens purported, are experiencing high levels of stress and pressure. They take multiple AP courses, feel they need to receive straight As, and constantly check their class rankings. They believe that it is much harder to get into college than it used to be and that if they falter at all academically, they will not be admitted to a college. Vaping, using marijuana, and drinking, they explained, are all ways to relieve this pressure and are used as a means of escape: "it makes me feel good," one youth said.

Social media

The final underlying cause the youth discussed was the constant presence of social media. They explained that most teens are on social media for many hours every day. People who are considered "influencers" on social media present substance use as "cool" and as safe.

School Response

The focus group attendees felt strongly that schools have not yet developed the appropriate response to student substance use. Sometimes, they reported, policies are too strict and invasive. One policy they cited was the rule some schools have that students must sign and in and out of the bathrooms. This does nothing to stop vaping and drug use in bathrooms and, furthermore, feels like an invasion of privacy. On the other hand, the students also shared that most teachers ignore it when students are obviously high. This, they said, makes students feel that the teachers do not care about their well-being.

> "This perpetuates a fear of fear and distress. When people who are supposed to be helping question your every move, it's not healthy."
>
> Focus Group Contributor

Mental Health Issues of Concern

The focus group identified anxiety and depression as issues that affect many children and youth. They also discussed who these issues impact the most and the reasons underlying an increase in rates of these issues.

Youth Affected by Anxiety and Depression

Focus group members expressed that they feel rates of anxiety and depression are growing. Although they emphasized that everyone could suffer from these issues, they felt two groups are especially vulnerable to anxiety and depression. The first is youth, like them, who are "over-achievers" who tend to feel that they need to meet and exceed extremely high expectations in all areas of their lives. Their definition of failure includes getting anything less than an A or not being one of the top ranked youth at school, and this self-expectation leads to devastation in the

face of anything less than perfection. The other group who suffer disproportionately is youth who have experienced trauma and/or who do not have stable home lives. Traumatic experiences often go unaddressed, they said, and the school does not have the resources to help children whose lives at home are complex and challenging. It is important to note that children start experiencing these issues at incredibly young ages, as young as elementary school.

> "Depression and anxiety are not only a problem in high school. Really young kids get it, and it gets worse as it remains untreated."
>
> Focus Group Contributor

Underlying Causes

The group identified four reasons for the rise in anxiety in depression among youth: (1) stress and the normalization of pressure and adversity; (2) bullying; (3) social media; and (4) lack of knowledge and skills related to emotions and mental health.

Stress, pressure and adversity

As with substance use, these students discussed increased pressure and stress as a key factor underlying mental health issues in youth. They pointed out that it has become normal to "cry for an hour after school" with worry about homework. They asserted that adversity has become normalized and, to some extent, celebrated. This is illustrated by college application questions that ask them to discuss the adversity they experienced and how they overcame it. Parents, they said, are often intolerant when students discuss feeling overwhelmed. They expect them to be tough and to do whatever is necessary to succeed.

Bullying

Bullying, in person and online, focus group participants asserted, is a root cause of mental health issues. Often the bullying is subtle: it is about exclusion, rather than physical aggression. The subtlety of the bullying makes it more challenging to address and causes youth to feel "different and depressed." Youth of color, from low income or single parent families and those with different abilities are the most frequently targeted by bullies. Furthermore, they said, teachers do not often put a stop to the bullying.

> "Teachers don't put a stop to bullying and those who are bullied internalize it and think 'I am dumb, I give up'."
>
> Friday Night Live Focus Group Contributor

Social media

Another factor that contributes to anxiety and depression, focus group attendees said, is the amount of time youth spend on social media. The "screen time" not only isolates youth, it also

contributes to a feeling of inadequacy. Youth compare their lives with "influencers" and have low self-esteem because of the constant comparisons.

Lack of mental health knowledge

One key aspect of emotional and mental wellness, the group emphasized, is the ability to identify feelings: to name them, to communicate them appropriately, and to know when feelings are overwhelming to the point of needing help. When children lack this knowledge and these skills, they said, they may not understand what they are feeling, when they need help, or how to get the help they need. Adults – including parents and school personnel – also frequently lack this knowledge, and as a result, do not notice, or ignore, when youth are distressed.

> "It's also a home thing. Parents should be more educated. They sometimes think being bullied is character development and that we should ignore it and deal with it."
>
> Focus Group Contributor

Strategies for the Prevention of Behavioral Health Crises

The students put forth three ideas to prevent behavioral health crises in youth. First, more mental health education needs to occur with youth, parents, and school personnel. Second, more support, care, and concern need to be available in school. Third, create and enforce logical, appropriate, and effective laws and policies regarding substance use.

Mental health education

The first strategy the focus group discussed was providing students, parents, and school personnel with more information about mental health and wellness. This includes teaching students to get to know themselves, understand their feelings, and recognize when they need help. This should start in elementary school, should be incorporated into the curriculum, and should continue throughout high school. Youth should also be given the tools, they said, to respond in appropriate ways, that are both comforting and helpful, to peers who are experiencing mental health problems. Parents need to be taught about the impact of things like social media and bullying. They need to understand that sometimes sadness is serious and given resources to respond. Teachers, administrators, and other school personnel need similar training. They need to learn to recognize the signs of mental health issues and be given the resources to respond in helpful ways. Giving teachers creative tools to do this would be helpful. One suggestion, for example, was for teachers to ask students to list their four or five best qualities and see who struggles with this kind of exercise. Another idea was to have "circles" one day a week where students discuss how they are feeling. This is helpful with bonding and stress relief and would allow teachers, or coaches, to get to know students better.

More support, care, and concern

One of the feelings expressed most frequently during this focus group was the perception that adults simply do not care enough about youth. Suggestions to address this perception included increasing the number of trained mental health professionals available in school, implementing regular sessions with teachers to discuss mental health, and decreasing class sizes. Schools, the students said, need to address the issues at the heart of substance use and mental health crises, and to do this, they need to build systems of support for students.

> "Students and teachers both tend to minimize mental health and think that academic achievement is more important than mental health…teachers minimize tears…so students think this is how they are supposed to feel."
>
> Focus Group Contributor

Engaging Youth

The focus group had few specific ideas for how to better engage youth. Rather, their conversation about engagement focused on the idea that youth need to believe that adults will truly listen to them, will take their ideas seriously, and will then act on those ideas to make changes. Trust must be built, the youth said, before more engagement is possible.

Key Informant Interviews

One group targeted for a focus group as part of this engagement was people who provide services for children 0-5 years old. IPH requested key informant interviews with service providers in this field. Two interviews were scheduled. Both interviewees had spent many years working in early childhood education.

> "I lost my son a year ago. He took Xanax that was laced with fentanyl. He was suffering from depression. He wasn't trying to take his life, but he was self-medicating. Other people at his school have also passed away in similar situations."
>
> Key Informant Interview Participant

Substance Use Issues of Concern

One interviewee noted that the use of crystal methamphetamine, particularly in the Imperial Beach area, has decreased and that, in this early childhood environment, drug use is not a significant problem. The other interviewee, however, noted that teens and young adults are using drugs to self-medicate and to deal with stress. Substance use generally starts, the interviewee said,

> "We only have three counselors at our school. Every time I am having a hard time at school, they say 'go see your counselor.' Then the counselors are always busy doing educational stuff. It doesn't feel like they care. We need people who will take the time to listen to us."
>
> Focus Group Contributor

with marijuana but quickly moves to stronger substances. Teens are going to extremes, and it is becoming an epidemic. They are buying drugs from unknown sources, and these are sometimes cut with dangerous substances like fentanyl, leading to fatal overdoses.

Mental Health Issues of Concern

Like the discussions during community forums, the key informant interview participants have observed increased rates of anxiety and depression, particularly among youth. They pointed to social media as one key factor contributing to this increase, noting that everyone finds out immediately when a young person does something embarrassing. They also discussed how difficult it is for many people to access mental health care. Even with insurance, it is hard to find good counseling quickly. For youth who need medication, getting appointments with psychiatrists is challenging, and the medications are often unaffordable.

Strategies for the Prevention of Behavioral Health Crises

These interviewees outlined two primary interventions to prevent mental health crises. First education is vitally important. This education needs to begin early. They pointed out that the 0-5 age range is critical to children developing into healthy teens and adults. This is when programs should begin teaching children to recognize, name, and address their feelings. Parents of children this age should be given the tools they need to help their children identify and regulate their emotions. Teachers and other service providers working in early childhood education should be taught how to recognize signs and symptoms of trauma and mental health issues. Teachers need to be given tools and resources to help kids when they, themselves, are overwhelmed. Partnerships between schools and families need to be emphasized, they said.

With older youth, education should include information about substances. People who have seen the effects of substance use need to provide real-life examples of what can happen. In addition, these efforts must recognize and discuss the interaction between mental health challenges and substance use. They should also include discussions about the use and impact of social media.

In addition to education, these interviewees emphasized the need for more role models for young people. This is especially true, they said, for children coming from homes in which they witness drug use and violence. School staff can show them, they said, “a different way to be,” but they also need other supportive adults in their lives.

Engaging the Community

Interviewees stressed that in order to truly engage the community, efforts must "meet people where they already are." This includes going into communities to gather feedback, rather than asking them to come to events. It also includes communicating with people in ways that are meaningful to them. Young people, for example, prefer to receive communication via text messages or over social media. Older people, on the other hand, like to get hard copies of flyers and information about events and resources.

Conclusions

The FY 2019-20 engagement process successfully brought together diverse community members from all areas of the County to discuss their concerns and ideas about prevention, innovation, and engagement. Hundreds of individuals offered valuable feedback, giving an expansive view of issues affecting San Diegans and generating novel ideas for how to address those issues. Focus groups and key informant interviews with targeted audiences allowed for in-depth feedback from both vulnerable groups and people with special expertise. From the satisfaction surveys, the people who came to the forums were pleased with the process and welcomed the opportunity to share their thoughts.

This year's engagement shed light on behavioral health issues that are of serious concern to the community in San Diego County and that have the potential to become crises in the coming years. New issues emerged as areas of concern, including the use of vape products, the increased accessibility of marijuana, the presence of fentanyl in the community, the online sale of substances, the impact of social media and technology, increasing social isolation, and increased rates of anxiety, depression, and suicide attempts. Many prevention strategies were suggested, such as:

> "We are not as real as we could be about this. There is so much that kids don't realize."
>
> Key Informant Interview Participant

- Educating many segments of the population, including youth, young adults, parents, families, community leaders, school personnel, law enforcement, and health care providers as well as the general community, utilizing many modalities, to raise awareness of, decrease stigma about, and teach coping skills for substance use and mental health issues
- Educating and empowering vulnerable populations such as LGBTQIA individuals and foster youth

- Increasing understanding and acceptance of groups such as LGBTQIA people, people with mental illness, foster youth, and people of color in the community, by professionals, and by religious institutions
- Decreasing access to substances through the enactment of laws and policies and through appropriate school responses to youth substance use
- Increasing the number of caring adults available as role models and mentors for youth
- Increasing the number of mental health professionals and mental health services available in schools
- Enhancing wellness by implementing community-based programs and services that increase connection, decrease social isolation, and build support systems
- Offering treatment designed specifically for marijuana use
- Fully funding and expanding existing, effective mental health and substance use programs
- Diversifying, expanding, and integrating services and treatment options so that people are treated holistically

From the forums, focus groups, and interviews, several overarching themes and community priorities emerged: (1) education; (2) community; (3) integration; and (4) equity.

Education

Education was highlighted at each community engagement event as the most important prevention strategy to implement – about both substance use and mental health. This education should begin early, with preschool children and their parents, and should extend through adulthood. All educational efforts should be tailored to the groups targeted. It should be culturally competent and relevant and delivered by fellow members of the target group. Ideally, the people to whom the education is presented should be involved in its design. The education should be delivered in schools, in community hubs like recreation centers and churches, to professional groups at their meetings, over social media, and over mass media, like television and radio. Children, youth, young adults, parents, families, school personnel, law enforcement personnel, health care and other service providers, and the general community would all benefit from further education about these topics.

Substance Use Education

Youth

Substance use education for youth, the community felt, should emphasize the potential negative physical and mental health effects of different substances, particularly those that may seem safe like vaping and marijuana. Youth should be made aware of the possibility of fentanyl being cut into substances and the extreme danger it poses. The education needs to be “real and not conducted in the traditional manner through all-school assemblies with messages delivered by adults in authority. Effective education about substance use for youth might include offering

small group sessions by people with lived experiences, delivering messages over social media and online, particularly by online "influencers," and offering hands-on experiences like field trips. Youth need to be involved in making decisions about this education for them to feel invested in it.

Parents and Families

Substance use education for parents and other relatives needs to focus on teaching them about what substances are available to youth, how they access the substances, and what the potential impacts are. Parents need to understand, for example, what vape products look and smell like, what forms marijuana now comes in, and how social media is used to sell these products. They also need to be educated about homemade substances. Parents also need to be given tools to help prevent substance use, like advice about locking up medications, not using substances themselves, the dangers of allowing youth to drink in their homes, and how to recognize the signs of substance use. They need access to expertise to help guide them if they suspect substance use and to programs and resources that can help their children if they are using drugs. This education needs to be offered regularly, as issues related to substance use evolve over time.

School Personnel and Other Service Providers

As with parents, school personnel and other service providers need education about substances – what they look and smell like, the signs and symptoms of use, and the potential effects. According to participants, the education needs to include tools to appropriately and effectively respond to people who are using substances: how should they interact, what language should they use to discuss the issue, what programs should they refer them to, and what consequences are appropriate. It was clear from the engagement process that teachers, especially, are unsure of how to respond in a way that is helpful to students when they suspect substance use.

The Broader Community

The community needs to better understand that legality does not equal safety regarding e-cigarettes, marijuana, and alcohol, participants said. Community leaders should help educate people about these substances, and media efforts, online and on tv and radio, should be designed to decrease the social acceptability of using these products and educate about the potential health impacts. Past successful public awareness campaigns related to smoking could be used as models for these efforts.

Mental Health Education

Mental health education should destigmatize mental illness, to teach people to identify and recognize their feelings and to get to know themselves, to educate people about the symptoms of a serious health problem, to teach about how to maintain mental wellness, to empower people to speak up when they need help. It should teach coping skills, raise awareness about what resources are available and how to access them successfully, and give people the tools they need to respond helpfully and appropriately when someone they care about is distressed. It should also be utilized to discuss the interaction of substance use and mental health.

Youth

Education about feelings, the community said, should start with young children. Even preschool children can be taught to recognize what they are feeling as well as strategies to regulate their emotions. Providing their teachers and caregivers with tools to help them learn is important. With older children and young adults, education should focus on distinguishing temporary negative feelings from more serious mental health problems. Youth need to understand what the symptoms are of anxiety disorders and depression. They need to know where to turn if they are feeling overwhelmed and how to respond when their friends express suicidal ideation. They need and want safe spaces to discuss these issues with trusted adults. Youth also need to be taught about how screen time can negatively impact them, about the necessity of getting enough sleep, about how to cope with stress and pressures, and about how to balance their desire for academic achievement with having enough time to do other things that interest them and to relax and decompress. Importantly, youth from groups that are often marginalized, such as members of the LGBTQIA community, foster youth, and youth of color, need specialized education to teach them to accept themselves for who they are, to stand up to bullying, and to empower them to speak up when they've been hurt or when they are hurting, according to participants.

Parents and Families

Youth who participated in the community engagement frequently commented that their parents, in wanting what is best for them, often emphasize academic achievement over mental wellness. In addition, in many families, no one talks about feelings and/or mental health, and so, when they are feeling overwhelmed, youth do not tell their parents. Parents, too, expressed that they are unsure of how to approach mental health issues with their children in a way that will not feel intrusive and are unsure about how to find resources when their children seem to need help. Education to help parents recognize signs of mental illness and to help them navigate services would be helpful, as would partnerships between schools and families about mental health and wellness. Parents also need to be taught about the impact of screen time on youth and how to put limits on this time, according to youth.

School Personnel and Other Service Providers

Educating school personnel about mental health and wellness is important, the community said, but they also recognized that many schools are already overburdened, that class sizes may be too big for meaningful connection between teachers and each of their students, and that funding for these types of educational efforts is extremely limited. Ideally, the community said, all school personnel would be educated to understand the impact of trauma on children, how to implement trauma-informed practices, and how recognize and appropriately respond to the signs and symptoms of mental illness. The community said they understood that placing the responsibility for children's mental health on schools is a burden, and they advocated for more funding not just for providing this type of continuing education to school personnel but also for the placement of

more mental health professionals in schools and for strategies such as smaller class sizes to facilitate close teacher-student relationships.

Law enforcement personnel and healthcare providers also need education, the community asserted, about mental illness and about trauma-informed approaches to care.

The Broader Community

Public awareness campaigns that draw attention to the prevalence of mental illness are important, the community asserted, to destigmatize mental illness. These campaigns should make use of celebrity spokespeople as well as community leaders. Campaigns to increase understanding and acceptance of groups, like LGBTQIA individuals, are also critical to the well-being of the community.

Community

Social isolation was named by the community as a problem reaching crisis proportions in San Diego. The community was emphatic that many people feel, and are, alone, that social media and online relationships have decreased human interaction and connection, and that too many people lack the supportive relationships they need to function well and thrive. Building a sense of belonging and community is of the utmost importance.

Youth

Youth need to be surrounded by supportive, caring adults and need to believe that what happens to them matters to the people around them, according to participants. Mentoring programs and strong relationships with school personnel and coaches, so that this responsibility does not fall on parents alone, should be developed. Youth also need to have the time and resources to explore non-academic areas of interest, like sports, the arts, and community service and need to be encouraged to participate in these. This would reduce the time they spend alone at home and the time they spend online and on social media. These types of programs would also reduce their risk of substance use and mental health problems.

Parents and Families

Parents need more support to raise their families. Family to family mentoring programs, free childcare, home visiting programs, and community-based parenting classes and family recreational programming were suggested as possible ways to provide this support. It is important for this support to come from people who are culturally similar, to enhance trust and increase enthusiasm for participating.

Marginalized Populations

People from populations that experience discrimination and mistreatment, like LGBTQIA communities, foster youth, refugees, immigrants, and people of color, need services offered in their neighborhoods by people who are nonjudgmental and culturally competent, according to participants. They also need to receive more frequent messages that they are not alone and that

efforts are being made to increase understanding and acceptance and decrease mistreatment of and discrimination against them. For immigrants and refugees, fears about deportation need to be addressed directly. Community leaders should take a lead role in communicating these kinds of messages.

Integration

As in previous years, the integration and coordination of services was named by the community as a priority to enhance behavioral health in San Diego County. Social determinants of health, like poverty, job insecurity, exposure to violence, lack of childcare, too few recreational and open spaces, and geographical isolation, the community said, are at the heart of substance use and mental health issues. Failing to integrate social services that address these issues into behavioral health treatment seriously undermines the effectiveness of that treatment.

Furthermore, substance use programs that do not address underlying mental health issues are doomed to fail, the community asserted. Mental health and substance use care need to be integrated and service providers need to communicate and coordinate with each other.

Mental health and substance use providers need to understand, assess, and address adverse childhood experiences and trauma. Their care should be trauma informed. It should also be culturally competent and, whenever possible, provided by a person from a similar background as the service recipient.

Physical and mental health are also too often treated separately, the community said. Physical problems can cause mental health issues, and vice versa. They are intertwined. Health care providers need to understand and communicate about their patients' mental health, and behavioral health. Care providers need to know their clients' health history and communicate with their health care providers.

Finally, for youth, it is important for social programs, mental health care, and substance use treatment to be integrated into their school experiences. School-based services are more likely to be accessed by youth. These services need to be offered in a non-stigmatizing way, need to be designed by and for youth, and need to be more fully funded. Utilizing schools as venues for parent and family services should also be considered.

Equity

At focus groups and the forums this year, the community was clear that addressing inequities in access to and the delivery of behavioral health services is of critical importance, according to community participants. Greater barriers to care created by language and cultural differences, fear of deportation, more hours spent at work, geographic locations, mistrust, hesitancy to engage in services for cultural reasons, lack of knowledge, and lack of adequate insurance exist for many populations. Engaging these communities in conversations about what these barriers

are and how to overcome them is an important first step in addressing this inequity in access. Placing services within communities and ensuring that community leaders communicate about their availability would also help address this inequity.

Service provision is also inequitable, they said, for three reasons. First, the services were often designed for other populations (often white, middle class populations) so they lack relevance for other populations. This is especially true, for example, for tribal populations as well as immigrants and refugees. Second, the population of service providers from diverse backgrounds is extremely limited. This means, therefore, that services are often delivered by people who do not fully understand the background and experiences of the people they are serving – which, ultimately, not only erodes trust, but can also cause harm. Finally, for groups like foster youth, services like therapy, are often delivered by inexperienced clinicians who lack the expertise to treat people who have experienced chronic, complex trauma. Acknowledging these inequities would help, the community said, build trust that efforts are being made to eradicate them. Involving these populations in the design and delivery of services is another imperative strategy to address and eliminate these inequities.

Annual Results Comparison

Each year, BHS selects a relevant theme to guide the Community Engagement Process. Although all feedback is accepted and cataloged, the theme helps assure that all aspects of the system of care receive attention over time. This year, the Engagement Process focused on Prevention and Early Intervention (PEI), which differs from earlier years that were centered around effective treatments and interventions. PEI looks at the San Diego County region as a whole and asks how to create thriving communities that minimize unhealthy outcomes. We expected new themes to emerge from questions around prevention, while other similar patterns to remain, for example, issues dealing with access and system integration. Indeed, new themes were frequently raised, by Community Engagement participants, as discussed in the section below.

An examination of the results from this year compared to the past three years reveals several relatively new areas of intense community concern about both substance use and mental health issues. Despite these differences, two similar overarching themes and priorities emerged as well as two new priorities that were mentioned, but not highlighted, during the past three engagements.

New Areas of Concern about Substance Use

Vaping

At each event, vaping was discussed at length. Although this was mentioned as a concern during the 2018 process, it was not a major topic of conversation. This year, however, many participants

identified vaping as the substance use issue of greatest concern to them, particularly the use of vape products among youth. The community shared that vaping has become incredibly common and is easier for youth to hide than other substances. They also discussed worries about the targeted marketing of vape products to youth and about the lack of research on the short-term and long-term potential impacts of vaping. The community was emphatic that more public education is needed about the potential harmful effects of vaping and that the marketing and sale of vape products to youth needs to be addressed.

Marijuana

Although marijuana use was listed as a concern during last year's engagement, the community believes that in recent months, because of the legalization of this product in California, the use of marijuana has grown exponentially. Two specific topics arose related to marijuana. First, participants in the engagement believe that marijuana is being used to self-medicate mental health issues. It is easier and perhaps more appealing, they said, for individuals to access marijuana than mental health services. Second, new types of marijuana products are being used, including "wax," which has high potency levels of THC in it. These products are not regulated, and the potential health effects are unknown.

Fentanyl

Far more concern was relayed about fentanyl this year than in past engagements. Community members shared that fentanyl is being added to other substances, sometimes leading to fatal overdoses. They also talked about the increased use of fentanyl by itself as a recreational drug. The participants were keenly aware of the dangers of this substance and are worried about its increased presence in the community.

The Online Sale of Substances

This was the first engagement during which participants discussed the sale of substances over the internet. Youth, it was reported, can order marijuana from online dispensaries and have it delivered to them. In addition, youth are often targeted for sales of all types of substances over social media apps like Instagram and Snapchat. Parents are generally unaware that this is occurring, and even when they are aware, cannot view their children's activities on applications like Snapchat, from which conversations are automatically erased.

New Areas of Concern about Mental Health

Increased Rates of Anxiety, Depression, and Suicide Attempts

Unlike in past years, community engagement contributors this year specifically identified anxiety, depression, and resulting suicide attempts as of greater concern now than in the past. They believe that rates of these mental health issues have risen and that access to effective care has not been improved. The community identified several populations they feel are most vulnerable

to these issues: youth, immigrants, refugees, California Indians, people of color, veterans, members of the LGBTQIA community, and seniors.

The Impact of Social Media and Technology on Mental Health

Social media and technology were named and discussed as primary contributors to mental health problems. For youth, the community discussed the constant comparisons to other people and the pressure to be popular online. They also talked about the emerging research that shows a direct link between screen time and mental health problems, including depression and anxiety. For everyone, the impact of the false narrative of easy, perfect lives that is presented on social media was a point of discussion. The community also pointed out that technology has made many activities, like shopping, much more convenient, but this convenience can also lead to decreased interpersonal interactions.

Growing Social Isolation

Community members who attended events this year pointed to growing social isolation as an emerging crisis in the community. Community recreational activities were identified as important strategies to address mental health issues in last year's forums, but this year, the community was adamant that social isolation is worsening and is exacerbating mental health problems. Too many people, they said, feel alone and lack the support and trusting relationships they need to lead happy, healthy, and productive lives.

Themes: Similarities with Past Three Years

Care Coordination/Integration

In 2016, 2017, and 2018, the community identified the coordination of care across services – health care, mental health care, and social services -- as a priority. This year, the community again discussed the detrimental impact of the separation of services on people who have behavioral health issues. The emphasis this year, however, was on the necessity of integrating substance use and mental health care. The community expressed strong belief that mental health issues are often the root causes of substance use problems and that these two issues must be addressed simultaneously for any intervention to be effective. They also discussed the necessity, as in past years, of addressing social determinants of health, such as poverty, unemployment, and homelessness as part of any efforts to improve behavioral health.

Cultural Competency/Equity

Over the past three years, the community identified the provision of culturally competent services as a priority to improve the behavioral health of the community. This issue was again a primary theme that arose from the engagement process this year. The community's emphasis this year, however, was on equitable access to and delivery of high-quality services across different populations. Discussions centered on barriers to care created by differences in income, English speaking abilities, the impact of severe trauma on the ability to utilize resources, and the

mistrust that must sometimes be overcome when service providers are from very different backgrounds than the service recipients. As in previous years, community members repeatedly emphasized that they want and need services to be offered in their neighborhoods by members of the group with whom they identify.

Emerging Priorities

Engagement participants in past years touched upon but did not prioritize on the other two themes stressed this year, education and community.

Education

In 2016, education and public awareness were listed as subthemes of "Children's Behavioral Health," while in 2018 education was subsumed under the theme of "Prevention." This year, education was the most frequently discussed strategy to prevent behavioral health crises, including education for children, young adults, families, school personnel, and community members. As in 2016 and 2018, the community also discussed the importance and potential effectiveness of public health campaigns related to behavioral health issues.

Community

For the last three years, the delivery of services within communities was cited as a specific strategy to increase the cultural competency of behavioral health services. This year, however, enhancing community – not just by offering services within the community, but also by increasing community support – was a vital component of reducing social isolation. Reducing isolation, in turn, was one of the most important components to improving the community's behavioral health. Participants emphasized the need for people to understand that "they are not alone" and to develop relationships that offer support for stressful times.

Participant Evaluation & IPH Recommendations

Community Forum Participant Evaluations

Forum participants were asked to complete evaluations assessing their satisfaction with the event. Results are summarized herein. The survey was not distributed at the January 28, 2020 forum, due to the logistical complications.

Overall Satisfaction

Overall satisfaction was high (Table 16). Satisfaction slightly improved over time as improvements were made based on preceding forums. Results show satisfaction increased from 89% of

participants reporting being *satisfied* or *very satisfied* at the first (Lemon Grove) forum to 100% of participants at the Bonita Vista High School forum.

Table 16. Overall Satisfaction With The Event

Forum Location		Percent within each category[1]			
	n	*Not at all Satisfied*	*Somewhat Satisfied*	*Satisfied*	*Very Satisfied*
Lemon Grove (1/08)	19	5%	5%	42%	47%
Kearny Mesa (1/09)	13	0%	15%	15%	69%
Oceanside (1/29)	50	0%	4%	40%	56%
Woodland Park (1/25)	41	0%	2%	46%	51%
Escondido (1/29)	33	3%	9%	30%	58%
Bonita Vista (2/01)	27	0%	0%	26%	74%
Totals	**183**	**1%**	**5%**	**36%**	**58%**

[1]Totals may not sum to 100% due to rounding.

Event Location

Forum participants were asked about the convenience of the event location. The Oceanside forum at Country Club Senior Center received the lowest marks, with 73% of participants rating it as *convenient* or *very convenient*.

Table 17. Convenience of Location

Forum Location		Percent within each category[1]			
	n	*Not at all Convenient*	*Somewhat Convenient*	*Convenient*	*Very Convenient*
Lemon Grove (1/08)	21	0%	14%	38%	48%
Kearny Mesa (1/09)	14	0%	14%	43%	43%
Oceanside (1/29)	54	6%	22%	43%	30%
Woodland Park (1/25)	43	2%	5%	37%	56%
Escondido (1/29)	33	0%	0%	42%	58%
Bonita Vista (2/01)	27	0%	15%	37%	48%
Totals	**192**	**2%**	**12%**	**40%**	**46%**

[1]Totals may not sum to 100% due to rounding.

Day and Time of the Event

Forum participants overall found that the selected days of the week suited their schedules: overall 98% *somewhat agreed* or *agreed* that the day of the week of the forum was a good fit for their schedules.

Table 18. Day of the week was a good fit for schedule

Forum Location		Percent within each category[1]			
	n	*Disagree*	*Somewhat disagree*	*Somewhat agree*	*Agree*
Lemon Grove (Wednesday, 1/08)	21	0%	5%	14%	81%
Kearny Mesa (Thursday, 1/09)	14	0%	0%	36%	64%
Oceanside (Saturday, 1/15)	54	2%	2%	19%	78%

Woodland Park (Saturday, 1/25)	43	0%	0%	9%	91%
Escondido (Wednesday, 1/29)	33	0%	0%	33%	67%
Bonita Vista (Saturday, 2/01)	27	0%	0%	15%	85%
Totals	**192**	**1%**	**1%**	**19%**	**79%**

[1]Totals may not sum to 100% due to rounding.

Participants were also asked about whether the time of the event was a good fit for their schedules. In general, all times of day were rated as convenient.

Table 19. Time of event was a good fit for schedule

Forum Location		Percent within each category[1]			
	n	*Disagree*	*Somewhat disagree*	*Somewhat agree*	*Agree*
Lemon Grove (1/08, 6:30pm)	21	0%	0%	33%	67%
Kearny Mesa (1/9, 6:30pm)	14	0%	7%	29%	64%
Oceanside (1/11, 10am)	54	0%	4%	15%	82%
Woodland Park (1/25, 10am)	43	0%	0%	14%	86%
Escondido (1/29, 3pm)	33	0%	3%	15%	82%
Bonita Vista (2/1, 10am)	27	0%	0%	15%	85%
Totals	**192**	**0%**	**2%**	**18%**	**80%**

[1]Totals may not sum to 100% due to rounding.

Topics

Forum participants were asked whether the topics covered at the event were useful. The topics were well-rated with all attendees.

Table 20. Topics covered at event were useful

Forum Location		Percent within each category[1]			
	n	*Disagree*	*Somewhat disagree*	*Somewhat agree*	*Agree*
Lemon Grove (1/08)	21	0%	10%	19%	71%
Kearny Mesa (1/9)	13	0%	0%	8%	92%
Oceanside (1/11)	51	0%	4%	6%	90%
Woodland Park (1/25)	43	2%	0%	12%	86%
Escondido (1/29)	33	0%	6%	12%	82%
Bonita Vista (2/1)	27	0%	0%	11%	89%
Totals	**188**	**1%**	**3%**	**11%**	**86%**

[1]Totals may not sum to 100% due to rounding.

How Participants Heard About Forums

Lastly, attendees were asked how they learned of the forums. Although paper flyers were somewhat effective, email communication appeared to be the most effective mode of promotion.

Table 21. How attendee learned of event

Forum Location	n	Percent of Respondents[1]					
		Flyer	*Friend/Colleague /Family Member*	*Email*	*Newspaper*	*Social Media*	*Other*
Lemon Grove (1/08)	21	38%	14%	48%	0%	5%	10%
Kearny Mesa (1/09)	13	15%	23%	8%	0%	15%	39%
Oceanside (1/11)	54	7%	28%	20%	0%	4%	48%
Woodland Park (1/25)	43	0%	28%	58%	0%	0%	16%
Escondido (1/29)	33	24%	30%	42%	0%	3%	18%
Bonita Vista (2/1)	27	22%	26%	37%	11%	0%	11%
TOTALS[2]	**191**	**15%**	**26%**	**37%**	**2%**	**3%**	**26%**

[1]Percentages and totals are based on respondents.

[2]Total percentages add up to more than 100 because respondents could choose more than one answer

Suggestions, Praise, and Other Comments

Participants were also asked to provide suggestions for how the events could be improved. These responses were qualitatively coded into themes found in Figure 2. The most common responses focused on logistics. Many participants took the opportunity to recognize the organization and thank the facilitators. Positive feedback received is listed in Figure 3, and other comments are listed in Figure 4.

Figure 2. Suggestions for improving community forums

- Logistics
  - Fix the lighting to see the screen better
  - Better signage [n=3]
  - Have more supplies to make the public feel more welcome
  - Have more coffee
  - Serve healthier food
  - Set-up and size of room made it hard to hear
- Outreach and attendance
  - More advertising [n=13]
  - Forums would benefit to hear from youth and students [n=3]
  - Offer locations that target specific communities
  - Invite friends
  - Continue language services
  - Better wording for advertisement and signage
  - Clarify objective of the forums on flyers
  - Send questions earlier to get general feedback from agencies

- Location and timing
    - Do not schedule during a high traffic time
    - Start earlier
    - Have cleaner, accessible locations
    - Day of week: M-F time
- Format/Facilitation
    - Be considerate when asking language preference
    - Don't make some topics off limits
    - Make sure the voting reflects the discussion
    - Don't "rewrite" comments to meet other agenda
    - Voting for both questions should be together
    - Define questions [n=2]
    - Offer more education during and after the forum [n=2]
    - Allow more time for voting
    - Make more connections [n=2]
    - Cut down mic time
    - Allow more discussion time [n=5]
    - Talk more about drug prevention, severe mental illness, and homelessness
    - Perhaps questions around how to connect services/lack of services
    - Try to prevent disruptive people in forum
- Miscellaneous suggestions
    - Give away free Moringa tree to participants

Figure 3. Positive feedback

- Thank you!
- Great conversation
- Very useful
- Inclusionary effort
- The event was organized and very professional
- Fantastic facilitator
- Enjoyed coming
- People were attentive
- Interactive exercises increased engagement
- Group breakouts are great addition
- Great timing

Figure 4. Other Comments

- County should have issued a statement that integrated health hubs including mental health services is the established best practice in the county and new stand-alone and remote facilities are NOT.
- Alerta “vape” (mostrarla y estrenar que significa).
- Didn't like having to pick one substance issue (if we address preventing youth substance use it would address ALL substances, not just 1) (and youth typically start w/ alcohol, marijuana, vaping) Addressing nicotine without marijuana to prevent youth sends a mixed message - kids believe marijuana is less harmful than nicotine, yet often vape both. Need to continue to focus on a comprehensive approach from effective policies (i.e. taxes, enforcing age restrictions, advertising, confronting commercial mg) to assessments and reference to resources for all levels (mild and severe), broad media campaigns.
- Single payer/Medicare for all provides better comprehensive universal care for less cost and divorces healthcare for employment.
- Need meetings on homeless mental health and mentally ill incarceration problems.
- Most ideas were mid-stream, not upstream. If we want to make real change, we need more focus on system change and equity-focused policy change.
- Phoenix house founder said it takes 5 years to cure drug abuse, with still no guarantee.
- Increase grants for support activities.

County of San Diego
Health and Human Services Agency
Behavioral Health Services
Community Engagement Report
Fiscal Year 2019-20

SAN DIEGO STATE UNIVERSITY

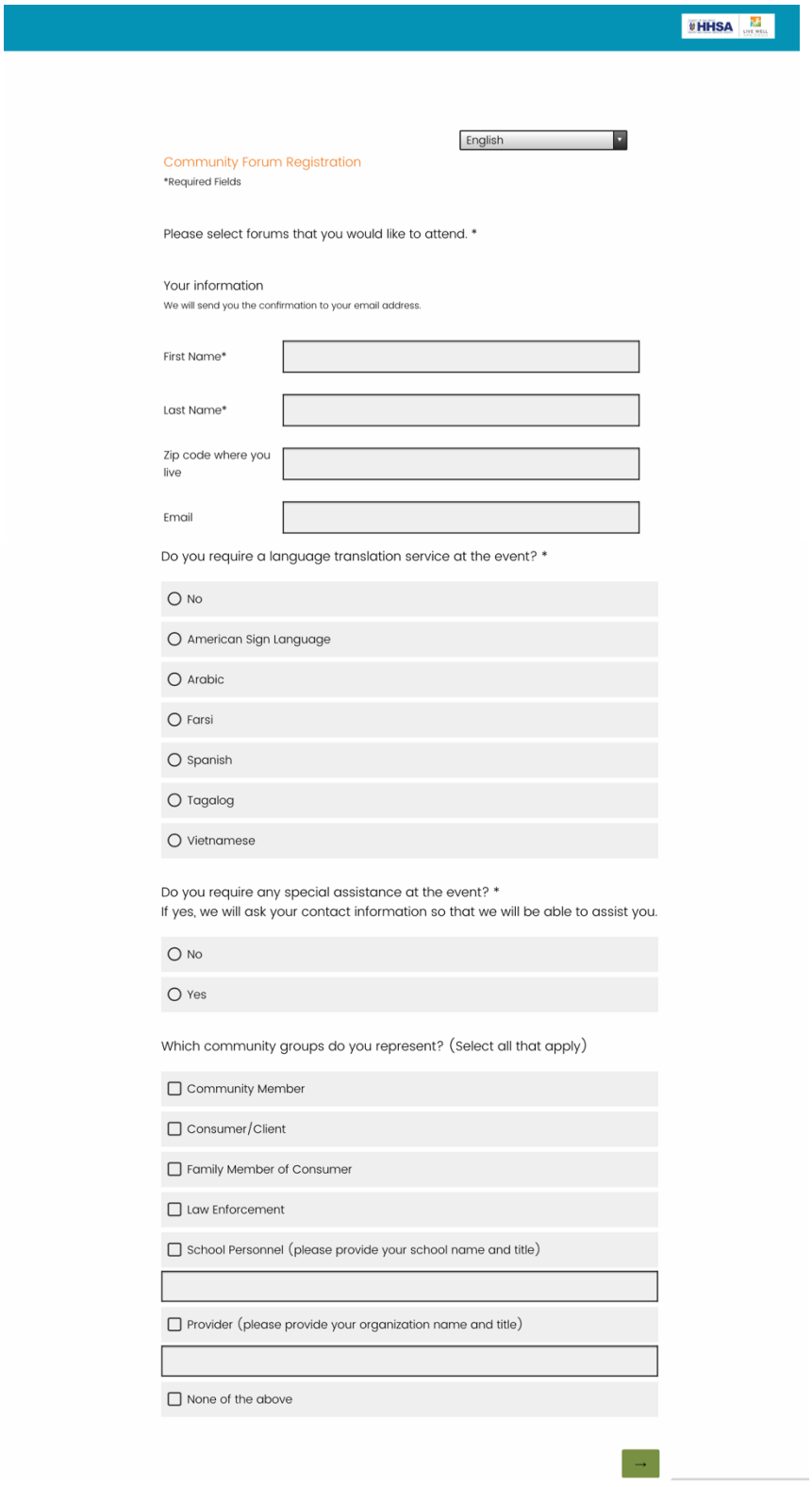
Institute for Public Health

Contents

1. Forum Documents

a. Forum Registration Document, English

Online



English

Community Forum Registration

*Required Fields

Please select forums that you would like to attend. *

Your information

We will send you the confirmation to your email address.

First Name*

Last Name*

Zip code where you live

Email

Do you require a language translation service at the event? *

- ○ No
- ○ American Sign Language
- ○ Arabic
- ○ Farsi
- ○ Spanish
- ○ Tagalog
- ○ Vietnamese

Do you require any special assistance at the event? *
If yes, we will ask your contact information so that we will be able to assist you.

- ○ No
- ○ Yes

Which community groups do you represent? (Select all that apply)

- ☐ Community Member
- ☐ Consumer/Client
- ☐ Family Member of Consumer
- ☐ Law Enforcement
- ☐ School Personnel (please provide your school name and title)
- ☐ Provider (please provide your organization name and title)
- ☐ None of the above

→

Walk-In

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

Date: / /2020 ☐ AM ☐ PM

Community Forum Registration

* Required Fields

Would you like to receive an email from the County of San Diego about the results of these events? *
NOTE: We will not share your email address with the County of San Diego BHS without your permission.

- ☐ Yes Email: _____
- ☐ No

First Name (e.g., Jane) Last Name (e.g., Smith)

Name *

ZIP Code where you live *

Which community groups do you represent? Select all that apply *

- ☐ Community member
- ☐ Consumer/Client
- ☐ Family Member of Consumer
- ☐ Law Enforcement
- ☐ School Personnel (please provide your school name and title)
  - School and Tile: _____
- ☐ Provider (please provide your organization name and title)
  - Organization and Title: _____

  Are you an employee or contractor with the County of San Diego Behavioral Health Services (BHS)?

  Please note BHS contractors and employees are not eligible to receive gift cards.

  ☐ Yes
  ☐ No
- ☐ None of the above

Registration for 2019-20 Behavioral Health Community Engagement Forums (ENG) Location: _____

b. Forum Registration Document, Arabic

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

Date: ____ / ____ /2020 ☐ AM ☐ PM

التسجيل للمنتدى المجتمعي

* حقول مطلوبة

هل ترغب في تلقي رسائل بريد إلكتروني من مقاطعة سان دييغو حول نتائج هذه الفعاليات؟ *
ملاحظة: لن نشارك عنوان بريدك الإلكتروني مع خدمات الصحة السلوكية لمقاطعة سان دييغو دون موافقتك.

☐ نعم بريد إلكتروني: ____
☐ لا

الاسم الأول (مثال: Aaliyah)　　　　اسم العائلة (مثال: Abadi)

الاسم *

الرمز البريدي لمكان إقامتك *

أي من مجموعات المجتمع تمثّل؟ اختر كل ما ينطبق *
☐ عضو مجتمع
☐ مدافع/ عميل
☐ فرد من أسرة المدافع
☐ الشرطة
☐ موظف مدرسة (يرجى ذكر اسم مدرستك ومسماك الوظيفي)
  ○ المدرسة والمسمى الوظيفي: ____
☐ مزوّد (يرجى ذكر اسم منظمتك ومسماك الوظيفي)
  ○ المنظمة والمسمى الوظيفي: ____
  هل أنت موظف أو متعاقد مع خدمات الصحة السلوكية (BHS) لمقاطعة سان دييغو؟
  يرجى العلم بأن موظفي ومتعاقدي BHS غير مؤهلين للحصول على بطاقات هدايا.
  ☐ نعم
  ☐ لا
☐ لا شيء مما سبق

c. Forum Registration Document, Farsi

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

Date: ____/____/2020 ☐ AM ☐ PM

ثبت نام برای همایش اجتماعی

*فیلدهای الزامی

آیا مایلید درباره نتایج این رویدادها ایمیلی از انجمن همگو دریافت کنید؟ *
توجه: ما آدرس ایمیل شما را بدون اجازه خودتان در اختیار BHS انجمن همگو قرار نخواهیم داد.

☐ بله، ایمیل: ____
☐ خیر

نام کوچک (مثلاً Anahita)   نام خانوادگی (مثلاً Orsi)

نام *

کد پستی محل زندگی شما *

نشان دهید کدام گروه های اجتماعی هستید؟ تمام موارد مربوط را انتخاب کنید *

☐ عضو جامعه
☐ مشتری/مراجع
☐ عضو خانواده مشتری
☐ مجری قانون
☐ پرسنل مدرسه (لطفاً نام مدرسه و سمت خود را ذکر کنید)
 ○ مدرسه و سمت: ____
☐ ارائه دهنده (لطفاً نام سازمان و سمت خود را ذکر کنید)
 ○ سازمان و سمت: ____

آیا کارفرمای پیمانکار خدمات بهداشت رفتاری انجمن همگو (BHS) هستید؟
لطفاً توجه داشته باشید که کارکنان پیمانکاران BHS واجد شرایط دریافت کارت هدیه نیستند.
☐ بله
☐ خیر

☐ هیچکدام از موارد فوق

d. Forum Registration Document, Spanish

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

Date: / /2020 ☐ AM ☐ PM

Inscripción para el Foro de la Comunidad

* Respuesta requerida

¿Le gustaría recibir un correo electrónico del Condado de San Diego sobre los resultados de estos eventos? *
TENGA EN CUENTA: No compartiremos su dirección de correo electrónico con el BHS del Condado de San Diego sin su permiso.

☐ Sí Correo electrónico: _____
☐ No

Nombre (p.ej., Julia) Apellido (p.ej., García)

Nombre *

Código postal donde vives *

¿Qué grupos comunitarios representas? Seleccione todos los que correspondan *

- ☐ Miembro de la comunidad
- ☐ Consumidor / cliente
- ☐ Miembro de la familia del consumidor
- ☐ Oficial de la ley / las fuerzas del orden
- ☐ Personal de la escuela (proporcione el nombre y el título de su escuela)
  - o Escuela y título: _____
- ☐ Proveedor (proporcione el nombre y el título de su organización)
  - o Organización y título: _____

¿Es usted un empleado o contratista de los Servicios de Salud Mental (BHS) del Condado de San Diego?
Tenga en cuenta que los contratistas y empleados de BHS no son elegibles para recibir tarjetas de regalo.

- ☐ Sí
- ☐ No
- ☐ Ninguna de los anteriores

Registration for 2019-20 Behavioral Health Community Engagement Forums (Spanish) Location: _____

e. Forum Registration Document, Tagalog

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

Date: / /2020 ☐ AM ☐ PM

Pagpaparehistro para sa Forum ng Komunidad

* Mga Puwang na Kinakailangang Sagutan

Nais mo bang makatanggap ng email mula sa County ng San Diego tungkol sa mga resulta ng mga event na ito? *
TANDAAN: Hindi namin ibabahagi ang iyong email address sa BHS ng County ng San Diego nang wala ang iyong pahintulot.

- ☐ Oo Email: _____
- ☐ Hindi

Pangalan (hal., Jane) Apelyido (hal., Smith)

Pangalan *

ZIP Code kung saan ka nakatira *

Sa aling mga grupo ng komunidad ka kumakatawan? Piliin ang lahat ng naaangkop *

- ☐ Miyembro ng Komunidad
- ☐ Konsyumer/Kliyente
- ☐ Miyembro ng Pamilya ng Konsyumer
- ☐ Tagapagpatupad ng Batas
- ☐ Tauhan ng Paaralan (mangyaring ibigay ang pangalan ng paaralan at titulo)
  - Paaralan at Titulo: _____
- ☐ Provider o Tagapagkaloob ng Pangangalagang Pangkalusugan (mangyaring ibigay ang pangalan ng organisasyon at titulo)
  - Organisasyon at Titulo: _____

  Ikaw ba ay isang empleyado o kontratista sa Mga Serbisyo sa Kalusugan sa Pag-uugali (Behavioral Health Services, BHS) ng County ng San Diego?

  Mangyaring tandaan na ang mga kontratista at empleyado ng BHS ay hindi karapat-dapat na tumanggap ng mga gift card.

  - ☐ Oo
  - ☐ Hindi
- ☐ Wala Sa Itaas

f. Forum Registration Document, Vietnamese

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

Date: ____/____/2020 ☐ AM ☐ PM

Đơn ghi danh cho Diễn đàn Cộng đồng

* Cần phải điền

Quý vị có muốn Quận hạt San Diego gửi email cho quý vị về các kết quả của những diễn đàn này không? *
LƯU Ý: Chúng tôi sẽ không chia sẻ email với Cơ quan Dịch vụ Sức khoẻ Tâm thần BHS của Quận hạt San Diego nếu không được phép của quý vị.

- ☐ Có Email: _____ _____
- ☐ Không

Tên (thí dụ Lan) Họ (thí dụ Nguyen)

Tên *

ZIP Code nơi cư ngụ *

Quý vị đại diện cho nhóm nào trong cộng đồng? Đánh dấu vào tất cả những gì thích hợp *

- ☐ Thành viên cộng đồng
- ☐ Người tiêu thụ/Khách hàng
- ☐ Thành viên gia đình của người tiêu thụ
- ☐ Nhân viên Thực thi pháp luật
- ☐ Nhân viên Trường (xin cho biết tên trường và chức vị)
  - Trường và Chức vị: _____ _____
- ☐ Người cung cấp (xin cho biết tên cơ quan và chức vị)
  - Tên cơ quan và Chức vị: _____ _____

  Quý vị có phải là nhân viên hay nhà thầu với Cơ quan Dịch vụ Sức khoẻ Tâm thần BHS của Quận hạt San Diego không?

  Xin lưu ý các nhà thầu hay nhân viên của BHS không được nhận thẻ tặng.

  - ☐ Có
  - ☐ Không
- ☐ Không là gì trên đây cả

g. Walk-In Registration Sign-In Sheet

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

of Walk-In Participants:_____

of BHS/County Staff:_____

of Translators:_____

Date, Location

First Name	Last name	Email	BHS?

2. Initial Marketing Goals and Strategy

BHS Community Forum
Marketing and Outreach Efforts

GOAL

Secure a minimum of 100 attendees per forum with a majority of attendees identifying as "community member."

STRATEGY

Marketing and outreach to the general public with focused efforts on where community members work and live:

- Larger Employers
- Religious Institutions
- Community Centers
- YMCAs
- Libraries

COUNTY WIDE

All Forums Flyer Distribution

- Via Phone Call and Email to Large SD employers, Large Religious Organizations, County Contacts
- Via Phone Call and Email to University Schools of Public Health, Social Work, Psychology (SDSU, UCSD, USD, PLNU, National University)

Social Media

- All Forums event scheduled on FaceBook with link to registration site (ListenToSanDiego.com). Event shared by IPH and County staff via personal pages.
- LinkedIn posting to network contacts by IPH and County staff.

All Forums Advertising

- San Diego Union Tribune Advertisement (print and online)
- County-wide Online Event Sites
- La Prensa Spanish Newspaper Advertisement
- El Latino Spanish Newspaper Advertisement
- San Diego Reader Advertisement

REGIONAL/LOCAL

Flyer Distribution

- Via Phone Call and Email to employers, religious organizations, neighborhood and business associations, public health organizations, service/social clubs (Rotary/Kiwanis/Soroptimist/Lion's Clubs)

- Via Phone Call and Email to City of Chula Vista, City of Lemon Grove, City of Oceanside, City of San Marcos
- In Person to recreation, community and senior centers, libraries, YMCAs

Social Media

- Events scheduled on FaceBook with link to registration site (ListenToSanDiego.com)
- Events shared by IPH and County staff via personal pages

Individual Forum Advertising

- San Diego Community Newspaper Group Advertisements (Beacon, Beach & Bay Press, Uptown News, Downtown News, Mission Times Courier, La Mesa Courier, Village News)
- San Marcos Record Advertisement
- Oside News (Oceanside) Advertisement
- Patch (Lemon Grove) Advertisement
- Star News (Chula Vista) Advertisement

3. ListenToSanDiego.com Screenshots

Behavioral Health Services
Community Engagement Forums

Supporting healthy, safe, and thriving communities.

Please join us at any of the forums below to share your ideas about mental health and substance use disorder prevention, innovation and engagement!

Register »

East Region
Wednesday, January 8, 2020

6:30pm - 8pm
(6:15pm Check-in)

Lemon Grove Academy Elementary Auditorium

7885 Golden Avenue
Lemon Grove, CA 91945

Dinner will be provided.

North Central Region
Thursday, January 9, 2020

6:30pm - 8pm
(6:15pm Check-in)

Kearny Senior High School Room 301

1954 Komet Way
San Diego, CA 92111

Dinner will be provided.

North Coastal Region
Saturday, January 11, 2020

10am - 11:30am
(9:45am Check-in)

Country Club Senior Center

455 Country Club Lane
Oceanside, 92054

Continental breakfast will be provided.

North Inland Region
Saturday, January 25, 2020

10am - 11:30am
(9:45am Check-in)

Woodland Park Middle School Performing Arts Center

1270 Rock Springs Road
San Marcos, CA 92069

Continental breakfast will be provided.

Central Region
updated Tuesday, January 28, 2020

6:30pm - 8pm
(6:15pm Check-in)

Normal Heights Community Center

4649 Hawley Blvd
San Diego, CA 92116
(corner of School St)

Dinner will be provided.

North Inland Region
Wednesday, January 29, 2020

3:30pm - 5:00pm
(3:15pm Check-in)

North Inland Live Well Center Room C & D

649 W. Mission Avenue
Escondido, 92025

Light snack will be provided.

South Region
Saturday, February 1, 2020

10am - 11:30am
(9:45am Check-in)

Bonita Vista High School Library

751 Otay Lakes Road
Chula Vista, CA 91913

Continental breakfast will be provided.

Community members will receive a $10 gift card for participating.
For questions, please call: 619-594-6812 or email: sbondshepard@sdsu.edu

خدمات الصحة السلوكية
منتديات المشاركة المجتمعية

لدعم مجتمعات صحية وآمنة ومزدهرة

يرجى الانضمام إلينا في أي من المنتديات أدناه لمشاركة أفكارك حول الصحة النفسية والوقاية من استخدام المواد المخدرة والابتكار والتعاون

سجل

الأربعاء، 8 يناير 2020

6:30pm - 8pm
(موعد التسجيل 6:15pm)

Lemon Grove Academy Elementary Auditorium

7885 Golden Avenue
Lemon Grove, CA 91945

يتم تقديم وجبة عشاء

الخميس، 9 يناير 2020

6:30pm - 8pm
(موعد التسجيل 6:15pm)

Kearny Senior High School Room 301

1954 Komet Way
San Diego, CA 92111

يتم تقديم وجبة عشاء

السبت، 11 يناير 2020

10am - 11:30am
(موعد التسجيل 9:45am)

Country Club Senior Center

455 Country Club Lane
Oceanside, 92054

يتم تقديم وجبة إفطار

السبت، 25 يناير 2020

10am - 11:30am
(موعد التسجيل 9:45am)

Woodland Park Middle School Performing Arts Center

1270 Rock Springs Road
San Marcos, CA 92069

يتم تقديم وجبة إفطار

الثلاثاء 28 يناير 2020

6:30pm - 8pm
(موعد التسجيل 6:15pm)

Normal Heights Community Center

4649 Hawley Blvd
San Diego, CA 92116
(زاوية شارع سكول)

يتم تقديم وجبة عشاء

الأربعاء، 29 يناير 2020

3:30pm - 5pm
(موعد التسجيل 3:15pm)

North Inland Live Well Center Rooms C & D

649 W. Mission Avenue
Escondido, 92025

السبت، 1 فبراير 2020

10am - 11:30am
(موعد التسجيل 9:45am)

Bonita Vista High School Library

751 Otay Lakes Road
Chula Vista, CA 91913

يتم تقديم وجبة إفطار

أعضاء المجتمع مؤهلون للحصول على بطاقة هدايا بقيمة 10 دولارات للمشاركة

للاستفسار، يرجى الاتصال على الرقم: 619-594-6812 أو على البريد الإلكتروني: sbondshepard@sdsu.edu

HHSA | LIVE WELL SAN DIEGO

خدمات بهداشت رفتاری
هم‌اندیشی‌های تعامل اجتماعی

حمایت از جوامع سالم، ایمن و در حال رشد

لطفاً در هر یک از هم‌اندیشی‌های زیر به ما ملحق شوید تا نظرات خود را در مورد سلامت روان، پیشگیری از مصرف مواد، نوآوری و تعامل در اجتماع بگذارید

ثبت

دوشنبه 8 اکتبر 2020

6:30pm - 8pm
(ورود 6:15pm)

Lemon Grove Academy Elementary
Auditorium

7885 Golden Avenue
Lemon Grove, CA 91945

شام سرو می‌شود

پنج شنبه، 9 ژانویه 2020

6:30pm - 8pm
(ورود 6:15pm)

Kearny Senior High School
Room 301

1954 Komet Way
San Diego, CA 92111

شام سرو می‌شود

شنبه، 11 ژانویه 2020

10am - 11:30am
(ورود 9:45am)

Country Club Senior Center

455 Country Club Lane
Oceanside, 92054

صبحانه سرو می‌شود

شنبه، 25 ژانویه 2020

10am - 11:30am
(ورود 9:45am)

Woodland Park Middle School
Performing Arts Center

1270 Rock Springs Road
San Marcos, CA 92069

صبحانه سرو می‌شود

چهارشنبه 28 سپشنبه 2020

6:30pm - 8pm
(ورود 6:15pm)

Normal Heights Community Center

4649 Hawley Blvd
San Diego, CA 92116
(corner of School St)

شام سرو می‌شود

چهارشنبه 29 ژانوي 2020

3:30pm - 5pm
(ورود 3:15pm)

North Inland Live Well Center
Rooms C & D

649 W. Mission Avenue
Escondido, 92025

شنبه، 1 فوریه 2020

10am - 11:30am
(ورود 9:45am)

Bonita Vista High School
Library

751 Otay Lakes Road
Chula Vista, CA 91913

صبحانه سرو می‌شود

اعضای جامعه واجد شرایط دریافت یک کارت هدیه 10 دلاری به ازای شرکت کردن هستند.
در خصوص سؤالاتتان، لطفاً با این شماره تماس بگیرید: 619-594-6812 یا به این ادرس ایمیل بزنید: sbondshepard@sdsu.edu

HHSA | LIVE WELL SAN DIEGO

Servicios de Salud del Comportamiento
Foros de Participación Comunitaria

Apoyando comunidades saludables, seguras y prósperas.

¡Encuéntrenos en cualquiera de los foros a continuación para compartir sus ideas sobre salud mental, prevención del uso de sustancias, innovación y participación!

Regístrese »

miércoles 8 de enero, 2020

6:30pm - 8pm
(Llegue a las: 6:15pm)

Lemon Grove Academy Elementary
Auditorium

7885 Golden Avenue
Lemon Grove, CA 91945

Cena incluida

jueves 9 de enero, 2020

6:30pm - 8pm
(Llegue a las: 6:15pm)

Kearny Senior High School
Room 301

1954 Komet Way
San Diego, CA 92111

Cena incluida

sábado 11 de enero, 2020

10am - 11:30am
(Llegue a las: 9:45am)

Country Club Senior Center

455 Country Club Lane
Oceanside, 92054

Desayuno incluido

sábado 25 de enero, 2020

10am - 11:30am
(Llegue a las: 9:45am)

Woodland Park Middle School
Performing Arts Center

1270 Rock Springs Road
San Marcos, CA 92069

Desayuno incluido

martes 28 de enero, 2020

6:30pm - 8pm
(Llegue a las: 6:15pm)

Normal Heights Community Center

4649 Hawley Blvd
San Diego, CA 92116
(en la esquina de la calle de la escuela)

Cena incluida

miércoles 29 de enero, 2020

3:30pm - 5pm
(Llegue a las: 3:15pm)

North Inland Live Well Center
Rooms C & D

649 W. Mission Avenue
Escondido, 92025

sábado 1 de febrero, 2020

10am - 11:30am
(Llegue a las: 9:45am)

Bonita Vista High School
Library

751 Otay Lakes Road
Chula Vista, CA 91913

Desayuno incluido

Los miembros de la comunidad serán elegibles para recibir una tarjeta de regalo de $10 por participar.
Para preguntas, llame al: 619-594-6812 o envíe un correo electrónico a: sbondshepard@sdsu.edu

Mga Serbisyo sa Kalusugan ng Pag-uugali
Mga Forum sa Pakikibahagi ng Komunidad

Sinusuportahan ang mga komunidad na malusog, ligtas at umuunlad.

Mangyaring samahan kami sa alinman sa mga forum sa ibaba upang ibahagi ang iyong mga ideya tungkol sa kalusugan ng pag-iisip, pag-iwas sa paggamit ng alkohol at droga, inobasyon at pakikibahagi!

Magparehistro »

Miyerkules
Enero 8, 2020

6:30pm - 8pm
(6:15pm Tsek in)

Lemon Grove Academy Elementary Auditorium

7885 Golden Avenue
Lemon Grove, CA 91945

Libre ang Hapunan

Huwebes
Enero 9, 2020

6:30pm - 8pm
(6:15pm Tsek in)

Kearny Senior High School Room 301

1954 Komet Way
San Diego, CA 92111

Libre ang Hapunan

Sabado
Enero 11, 2020

10am - 11:30am
(9:45am Tsek in)

Country Club Senior Center

455 Country Club Lane
Oceanside, 92054

Libre ang Agahan

Sabado
Enero 25, 2020

10am - 11:30am
(9:45am Tsek in)

Woodland Park Middle School Performing Arts Center

1270 Rock Springs Road
San Marcos, CA 92069

Libre ang Agahan

Martes
Enero 28, 2020

6:30pm - 8pm
(6:15pm Tsek in)

Normal Heights Community Center

4649 Hawley Blvd
San Diego, CA 92116
(sa kanto ng School St)

Libre ang Hapunan

Miyerkules
Enero 29, 2020

3:30pm - 5pm
(3:15pm Tsek in)

North Inland Live Well Center Rooms C & D

649 W. Mission Avenue
Escondido, 92025

Sabado
Pebrero 1, 2020

10am - 11:30am
(9:45am Tsek in)

Bonita Vista High School Library

751 Otay Lakes Road
Chula Vista, CA 91913

Libre ang Agahan

Ang mga miyembro ng komunidad ay makakatanggap ng $10 na gift card para sa pakikibahagi.
Para sa mga katanungan, mangyaring tumawag sa: 619-594-6812 o email: sbondshepard@sdsu.edu

Dịch vụ Sức khỏe Tâm thần
Diễn đàn Cổ võ Cộng đồng Tham gia

Hỗ trợ để phát triển các cộng đồng an toàn và lành mạnh.

Xin mời quý vị tham dự trong bất cứ diễn đàn nào dưới đây để chia sẻ ý kiến của quý vị về sức khỏe tâm thần, phòng ngừa sử dụng chất quốc cấm, sáng tạo và tham gia!

Đăng ký »

Thứ tư
8 tháng Giêng, 2020

6:30pm - 8pm
(6:15pm tối Ký tên có mặt)

Lemon Grove Academy Elementary Auditorium

7885 Golden Avenue
Lemon Grove, CA 91945

Cung cấp Cơm tối

Thứ năm
9 tháng Giêng, 2020

6:30pm - 8pm
(6:15pm tối Ký tên có mặt)

Kearny Senior High School Room 301

1954 Komet Way
San Diego, CA 92111

Cung cấp Cơm tối

Thứ bảy
11 tháng Giêng, 2020

10am - 11:30am
(9:45am tối Ký tên có mặt)

Country Club Senior Center

455 Country Club Lane
Oceanside, 92054

Cung cấp Điểm tâm

Thứ bảy
25 tháng Giêng, 2020

10am - 11:30am
(9:45am tối Ký tên có mặt)

Woodland Park Middle School Performing Arts Center

1270 Rock Springs Road
San Marcos, CA 92069

Cung cấp Điểm tâm

Thứ ba
28 tháng Giêng, 2020

6:30pm - 8pm
(6:15pm tối Ký tên có mặt)

Normal Heights Community Center

4649 Hawley Blvd
San Diego, CA 92116
(Góc đường của trường)

Cung cấp Cơm tối

Thứ tư
29 tháng Giêng, 2020

3:30pm - 5pm
(3:15pm tối Ký tên có mặt)

North Inland Live Well Center Rooms C & D

649 W. Mission Avenue
Escondido, 92025

Thứ bảy
1 tháng Hai, 2020

10am - 11:30am
(9:45am tối Ký tên có mặt)

Bonita Vista High School Library

751 Otay Lakes Road
Chula Vista, CA 91913

Cung cấp Điểm tâm

Các thành viên cộng đồng sẽ được tặng thẻ $10 nếu tham dự.
Nếu có câu hỏi, xin vui lòng gọi: 619-594-6812 hay email: sbondshepard@sdsu.edu

4. Event Flyers

a. Individual Flyer Sample

Behavioral Health Services
North Central Region
Community Engagement Forum

Share Your Ideas!

Supporting healthy, safe, and thriving communities.

Everyone Welcome!

Forum Discussion Topics

Mental Health and Substance Use Prevention, Innovation and Engagement

Kearny Senior High School, Room 301

1954 Komet Way, San Diego, 92111

Thursday, January 9, 2020

6:30pm to 8:00pm

(6:15pm Check-In)

Dinner will be provided.
Community members will be eligible to receive a $10 gift card for participating.

Register at: ListenToSanDiego.org

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO | SAN DIEGO STATE UNIVERSITY Institute for Public Health

b. All Forums Flyer

Behavioral Health Services Community Engagement Forums

Supporting healthy, safe, and thriving communities.

Share Your Ideas!

Everyone Welcome!

Forum Discussion Topics: Mental Health and Substance Use Prevention, Innovation, and Engagement

Date: Wednesday, January 8 Time: 6:30pm to 8:00pm	Lemon Grove Academy Elementary School 7885 Golden Ave, Lemon Grove, 91945	Check In: 6:15pm Dinner Provided
Date: Thursday, January 9 Time: 6:30pm to 8:00pm	Kearny Senior High School, Room 301 1954 Komet Way, San Diego, 92111	Check In: 6:15pm Dinner Provided
Date: Saturday, January 11 Time: 10am to 11:30am	Country Club Senior Center 455 Country Club Lane, Oceanside, 92054	Check In: 9:45am Breakfast Provided
Date: Saturday, January 25 Time: 10am to 11:30am	Woodland Park Middle School, PAC 1270 Rock Springs Rd, San Marcos, 92069	Check In: 9:45am Breakfast Provided
Date: Tuesday, January 28 Time: 6:30pm to 8:00pm	Normal Heights Community Center 4649 Hawley Blvd, San Diego, 92116	Check In: 6:15pm Dinner Provided
Date: Wednesday, January 29 Time: 3pm to 4:30pm	North Inland Live Well Center 649 W Mission Ave, Escondido, 92025	Check In: 2:45pm Snacks Provided
Date: Saturday, February 1 Time: 10am to 11:30am	Bonita Vista High School, Library 751 Otay Lakes Rd, Chula Vista, 91913	Check In: 9:45am Breakfast Provided

Community members will be eligible to receive a $10 gift card for participating.

Register at: ListenToSanDiego.org

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

SAN DIEGO STATE UNIVERSITY Institute for Public Health

5. Print, Social, Online Marketing and Advertising

a. Coast News 1/10/20 Ad

Tiger Woods joins field for Torrey Pines

REGION — Tiger Woods has committed to the 2020 Farmers Insurance Open at Torrey Pines, during which he'll pursue an eighth tournament victory and the chance to become the PGA Tour's all-time winningest golfer, event organizers announced Jan. 9.

Woods, at 82 wins, needs only one more victory to move ahead of World Golf Hall of Famer Sam Snead. Woods, the tournament's all-time leading money winner with nearly $7 million earned, will look to add to his tournament legacy with an eighth win at the event across 19 overall appearances.

"The fact that Tiger will have his first opportunity to set the all-time record for PGA Tour wins at the Farmers Insurance Open is truly fitting," Century Club of San Diego CEO Marty Gorsich said. "Tiger has had such remarkable success here, dating back to his eighth career victory, when he won this tournament for the first time in 1999. What he has done since returning from his back injuries has been great for the game of golf, and we are excited to welcome him back for a fourth consecutive year."

The Farmers Insurance Open now includes 16 of the world's top 50 golfers according to the Official World Gold Rankings, and nine past Farmers Insurance Open winners have committed, including the last 10 winners, including defending champion and No. 8-ranked Justin Rose.

The field for the Jan. 23-26 tournament does not finalize until Jan. 17.

— City News Service

Pickleball for all: San Marcos hosts first tournament

By Stephanie Stang

SAN MARCOS — It's been said that pickleball is the fastest growing sport you've never heard of, but don't tell folks that who have been playing it for years.

Martin Vazquez, from Corona, California, said his wife talked him into it three years ago after he lost interest in racquetball. "She said hey, 'I found this new game called pickleball.' And I said, 'Pickle what? You hit a wiffleball with a paddle and I said is that a real sport?' She said, 'Yeah you have to play with me' and I said I wasn't interested ... and so finally ... love at first sight."

The sport continues to grow in popularity around the country and now also has a place in San Marcos. After some research, the San Marcos Parks and Rec Department decided to host its first tournament Jan. 4 and Jan. 5 at the Corky Smith Gymnasium with about 30 teams signed up.

"It's been a great thing." said Dorcy Norton, pickleball tournament director. "Hopefully, we'll get more going here. They only have limited time because basketball is such a priority in this space."

Norton is independent and runs tournaments on the weekends all around the West Coast. "San Marcos is very innovative," she said. "They always have been. My kids played sports in San Marcos."

She said San Marcos desires to bring new recreational programs that are current and interesting. "I have to say the city of San Marcos is really good about catching onto what is latest and greatest," she said. "The community service program here is phenomenal."

Tournaments attract folks like Vazquez and his wife, who love the sport but enjoy meeting new people while travelling the country, more. "We have travelled to play in Hawaii, Texas, Oregon, Florida and Arizona," he said. "We have met so many people. At the national tournament at Palm Desert, we met people from Canada, Australia, Mexico and all over. It's social game and we've met a lot of friends. The majority of our circle of friends right now are pickleball players."

There are many similarities to any "paddle" sport yet many different rules to pickleball. "It's kind of like ping pong," Vasquez said. "It's kind of like tennis. It's kind of racquetball but different. It's a similar thing that you are trying to get your ball past your opponent but trying to get your opponent to get the ball out or into the net."

PICKLEBALLERS Amy and Joe Barrion played in the San Marcos pickleball tournament Jan. 4-5. The two-day event started with a round-robin competition leading to playoffs in nine indoor courts at the Corky Smith Gymnasium. *Photo by Stephanie Stang*

Norton managed racquetball tournaments when the sport was popular as well. "Thirty something years ago racquetball was getting ready to boom and take off," she said. "That's exactly where pickleball is. When we started playing pickleball four or five years ago, it was mostly an older person sport. Nowadays the median age, I'm not 100% sure but I'm gonna say it's probably down in the 40s. There are lots of 20-year-olds playing. They are teaching it in the schools."

What was once considered a sport only for baby boomers has become popular for all ages according to co-director Vicente Rodriguez. "It's a quick game to learn and it's also a lot of fun to play right away," he said. "You don't have to be an expert to enjoy it. Although, there's plenty of room to become a nuanced player or an expert player. So, there are high-caliber players that play pickleball as well."

Depending on the part of the country people are playing in, it's typically outdoors but can be indoors as well. There are televised professional matches as well now with prize money totaling $25,000 to $50,000. Once a player steps on the floor, he or she is considered a 2.0 or 2.5 level out of 5.

The players can sometimes take the sport very seriously. That's why tournament Rodriguez always reminds them, "part of pickleball is sportsmanship." At the San Marcos event, signs were posted all over the gymnasium encouraging players to "have fun."

Along those lines, he said the sport can quickly become addictive and uses a good game of golf as an analogy to describe the fun behind pickleball.

"When you are playing golf and you hit the ball just right and the right distance and you get the satisfaction, your brain rewards you for that," Rodriguez said. "You are forever chasing that feeling again in golf. In pickleball, you get that feeling every third shot."

Players looking for other tournaments and players in the area can search www.usapa.org or pickleballtournaments.com.

Who's NEWS?

Business news and special achievements for North San Diego County. Send information via email to community@coastnewsgroup.com.

NEW ADDITIONS AT LIBRARY

The Escondido Library Foundation has donated six new AWE Early Learning Stations and six new AWE Early Learning Tablets to the Escondido Public Library, at 239 S. Kalmia St., Escondido. The stand-alone stations have the latest educational software, a touch-screen interface and are bilingual in English and Spanish. The tablets are for use inside the library with a valid library card. The six tabletop stations are available for use in the Youth Services Department and the six tablets are expected to be available at the Youth Services desk by the new year.

VID ELECTS LEADERS

Vista Irrigation District (VID) board of directors elected Richard Vásquez as its president and Patrick Sanchez as its vice-president for 2020. Vásquez, a retired civil engineering designer, has served as the chair of the district's public affairs, fiscal policy, and water sustainability committees. Sanchez has served on the board since March 2017 and represents Division 4, which encompasses the Shadowridge area of Vista. Sanchez, a retired director of parks, recreation and community services, worked in public service for 34 years and recently served as chair of the public affairs committee and on the water sustainability committee. Vásquez and Sanchez are joined by directors Marty Miller (division 1), Paul Dorey (division 3) and Jo MacKenzie (division 5) to form the VID board of directors.

TOP ATHLETES

Redshirt junior Marcus Brown of men's basketball and junior Emma Forel of women's basketball were named the Cal State San Marcos Student-Athletes of the Month for December.

TYPE O BLOOD NEEDED

San Diego Blood Bank is asking those who have type O blood, to donate blood immediately. Supplies of O positive and O negative blood are at critically low levels. Type O positive is the most common blood type, and therefore needed by many hospital patients, while type O negative is the universal blood type and can be given to any patient, and is often used in emergency rooms when there is no time to determine the blood type of the patient. To be eligible to donate blood you must be at least 17 years old, weigh at least 114 pounds and be in general good health. Make an appointment at SanDiegoBloodBank.org or by calling (800) 469-7322. Walk-ins are also welcome.

BRIGHTEST AND BEST

Kendal Cliburn of Carlsbad and Mary Holmberg of San Marcos achieved the Dean's List at Belmont University for the Fall 2019 semester.

b. Coast News 1/24/20 Ad

Vista woman launches campaign to save ill aunt

By Hoa Quach

VISTA — Vista resident Amanda Hernandez said there hasn't been a Friday that has gone by where she didn't spend time with her aunt, Lupe Sutherland. Their close bond built over outings to the movie theaters, Legoland and the nail salon took a turn in recent months when Sutherland, a longtime hairstylist was diagnosed with a rare cancer.

Today, Hernandez is asking for the public to support Sutherland as she battles small cell carcinoma of the ovaries, a type of ovarian cancer with only about 300 known cases, according to the U.S. National Library of Medicine National Institutes of Health.

"Lupe is not working right now while she's in chemotherapy, as it's taking too much of a toll on her," said Hernandez, who works in marketing. "The main goal is to cover her bills, necessities, and any other expenses that may pop up. Rather than worry and stress about how she will cover the bills, Lupe can focus on treatment and recovery."

Hernandez said Sutherland has played a pivotal role in her life since she was born in the city of Vista years ago.

"Lupe has played such an important role in my life," Hernandez said. "She has always been there for me to offer advice, tell funny stories, and encourage me to grow my faith."

AMANDA HERNANDEZ embraces her aunt, Lupe Sutherland, who is battling a rare cancer. *Courtesy photo*

It's because of that strong relationship that Hernandez was compelled to create a GoFundMe campaign for Sutherland when they learned of her diagnosis. The fundraiser has raised more than $11,000 from nearly 100 donors, but Hernandez hopes to raise $20,000 to cover all medical bills.

The majority of the donors have been colleagues and customers from throughout San Diego County who have known Sutherland through her work as a hairstylist.

"The response to Lupe's fundraiser has blown me away. The generosity of her colleagues, clients, and friends is incredibly heartwarming," Hernandez said. "I've received so many kind messages from people telling me how much they love Lupe. Some of them have been clients of hers for over 30 years. However, when you really know Lupe — her kind heart and gracious spirit — it makes sense that so many people want to rally behind her."

One of those longtime customers, and now, donor, is Barbara Keegan. Keegan said she's known Sutherland for more than 30 years.

"Lupe is one of a kind," Keegan said. "(She) always has a smile on her face and ready to chit chat."

In fact, Keegan also had ovarian cancer and found comfort in Sutherland.

"When I was diagnosed with ovarian cancer in 2018 my hair started coming out in clumps, of course, I made an appointment with Lupe to shave my head," Keegan said. "She did not charge me. When I left the shop, we all hugged and tears were flowing from everyone in the shop."

Other donors are customers who have known Sutherland for at least 35 years.

Aside from fundraising, Hernandez sees the campaign as a way to increase awareness about small cell carcinoma. It's also made Hernandez even more grateful for her aunt, she said.

"The fundraiser has brought some awareness to the type of ovarian cancer that she has, and necessity to find it early," Hernandez said. "I don't think the diagnosis has changed our relationship, but it has changed me. It's easy to take loved ones for granted when life is normal and easy.

As the campaign spreads awareness about ovarian cancer, Hernandez said Sutherland is thankful for the support she's received over the last few months.

"She has told me multiple times that she's thankful I started it," Hernandez said. "It's the least I can do."

For more information about the fundraiser or to donate, go to gofundme.com/f/qz5pg-help-lupe-fight-cancer.

PARKING

CONTINUED FROM A1

of the stigma surrounding the homeless population, namely that people fear them and don't look at them like they're human beings.

"I wasn't suffering from addiction or mental illness just the consequences of failed planning, but I was criminalized for being homeless," White said. "If we stay overwhelmed because it looks scary or hard, we won't solve this problem."

Opponent Donna Fazio DiBenedetto said the project is built on too many assumptions including that the city will be able to find housing for the participants and it will not lead to an increase in homeless coming to the area, and uncertainties like where the people are going to go during the day.

"You're obviously not quite ready for this project and there's no reason to rush into it, none whatsoever," she said.

Jeff Morris said the city has lied to them to the point where there is "no trust level" and they're ready for a change on the dais.

"Our motivation is to get rid of you," he said. "If you're not going to work with us what good are you? ... You guys are not doing your job properly and we're just done. We're over it."

Prior to the meeting, thousands of people signed a petition to stop the lot from going forward and the City Council has been threatened with litigation by a community-lead group called NC3 that alleges that the council falsely claimed a Shelter Crisis, and that they violated a number of different measures by moving forward with this without public comment.

Councilman Tony Kranz, who was the sole vote against the program, said it's been a very difficult process and the division in the community "breaks my heart." He said that because of a HEAP grant and an urgency to get a program in place the council jumped through "very critical, very important steps that involve bringing the community along."

Mayor Catherine Blakespear said she didn't think the council cut corners and she supports the lot because she believes it is the moral thing to do.

"And fundamentally it comes down to compassion is as compassion does," she said. "I have frequently had the thought about the 16th Century proverb ... 'There but for the grace of God go I' ... It's a recognition that the misfortune that has befallen someone else could come to you and it can come to any of us."

The lot could be operational as soon as Jan. 30.

There will be an evaluation of the lot in May at which point the council can vote to extend the contract for three additional four-month periods, ending in May of next year.

CITY MANAGER

CONTINUED FROM A8

ment.

"I'm very excited," City Councilman Dwight Warden said. "I think people are really going to like her. She is very capable and very personable."

Johnson grew up in a military family and said she feels very comfortable in new environments. She said is excited to get to know San Diego County and Del Mar in the coming weeks.

"I want to know all things Del Mar," Johnson said. "I have a collaborative style and I am very interested in hearing what their (Del Mar community) ideas are and their interests are in maintaining the quality of life there."

Mayor Ellie Haviland weighed in acknowledging that Johnson's experience working in an ocean community could not come at a better time for Del Mar.

"It in many ways is a perfect storm that Christa was available (and) had reached the right experience in her career at a time when Del Mar can benefit from her experiences and her skill set," Haviland said.

Druker motioned for a vote on the proposed contract and hiring Johnson as the new city manager, which was then seconded by Haviland.

The council unanimously agreed 6-0 to hire Johnson, who will begin as city manager on Feb. 12.

c. Uptown News 1/10/20 Ad

As you zip south on Pershing Drive past the golf course toward Downtown, imagine this road as it was before January 1923: narrower than 25 feet and unpaved. (Photos by Katherine Hon)

Pershing Drive

Named to honor those who served

PastMatters
KATHERINE HON

Do you know the name of the major road in North Park that honors a World War I general and all San Diegans who fought in that war? Hint: It is a freeway exit from Interstate 5 to North Park.

It is Pershing Drive, named for General John Joseph Pershing. It isn't surprising that few know the answer — the naming and the war itself happened more than 100 years ago.

North Park started growing in the early 1900s when the streetcar — called the "University Avenue Electric road" in a 1907 San Diego Union article — connected the area to Downtown San Diego along University Avenue that year and along 30th Street soon afterward. These streetcar routes extended the public transportation network initiated in 1906 by extension of the San Diego Electric Railway line from Mission Cliff Pavilion in University Heights to the eastern boundary of Normal Heights along Adams Avenue.

After World War I ended in 1918, housing in North Park began to boom. Although the streetcar continued to serve faithfully until 1949, there was an increasing demand for better roadways to satisfy the desire for transport by personal automobile. In "North Park: A San Diego Urban Village, 1896-1946," Donald Covington wrote, "The ideal became the sanitized, all-electric, stucco hacienda, a romantic amalgamation of Edison, Bell, Ford and Zorro with telephone jacks and radio aerial intact. The patio succeeded the verandah; the tiled breakfast room challenged the paneled dining room; the screened sleeping porch gave way to the two-tiny laundry porch; and the motor car became the new house pet with its own attached garage."

Many North Park businessmen could see that everyone's new "house pet" required a better connection to Downtown for North Park to thrive. A possible connection was the existing road through Balboa Park — still known only as the "Big Grade" — that snaked from 18th Street to the northeast corner of the park at 28th Street. But that road was steep, narrow, and unpaved. The cost to change the hazardous roadway into a 25-foot wide paved boulevard was initially proposed to come from public donations.

Richard Allen Chapman — president of a real estate and insurance company at the time — presented the proposal to improve the Big Grade and name it Pershing Memorial Drive to city officials in November 1918. The San Diego Union's Nov. 15, 1918 issue reported that he intended the project to include "suitable monuments or slabs at both ends of the drive giving the names of the general staff in command of the American forces in France, together with the names of all men from the city of San Diego who died on the field of battle in the cause of liberty."

The Board of Park Commissioners unanimously supported the concept. Soon afterward, the City Council approved the project and promised matching funds.

Throughout 1919, prominent San Diegans including North Park residents Jack Hartley, Will Stevens and Charles Small contributed. The world-renowned opera singer Mrs. Ernestine Schumann-Heink — a beloved figure in San Diego — gave a concert in the Spreckels Organ Pavilion which was advertised in the San Diego Union's May 24, 1919 issue as "the biggest musical event of the year." The newspaper article noted that the entire proceeds would be "donated to a fund to Build Pershing Paved Road and Monument to the San Diego Boys who died in the service."

John Joseph Pershing (1860-1948), the road's namesake and the representative for all San Diegans who had been killed in the war, was born on a farm in Missouri. He attended the United States Military Academy (West Point) from 1882 to 1886 and served in the U.S. Army through multiple military campaigns prior to World War I.

He served as the commander of the American Expeditionary Forces (AEF) on the Western Front in World War I from 1917 to 1918. As AEF commander, Pershing was responsible for a fighting force that started as 27,000 inexperienced men and grew to more than 2 million soldiers.

Sufficient funds for the project finally were raised by mid-1922 with the help of G. Aubrey Davidson, president of the Southern Trust and Commerce Bank; George Marston, president of The Marston Company department store; and Charles Small, manager of the Bishop Cracker and Candy Company. In January 1923, paving was completed, and Pershing Drive was opened to travel. It does not appear that the proposed monuments were ever constructed.

In April 1923, the name of the road continuing north to University Avenue was changed from Oregon Street to Pershing Avenue in response to a petition supported by residents, although residents along 28th Street also petitioned for their street to have that honor. At this time, spurs of newly improved Pershing Drive lined up with both streets. In 1992, nearly 70 years later, the Pershing Spur was closed to accommodate plans for Bird Park, which opened officially in September 1997.

—Katherine Hon is the secretary of the North Park History Society. Reach her at info@northparkhistory.org or 619-294-8990.

This sidewalk stamp from about 1914 is on what is now Pershing Avenue at Utah Street. The name for this residential

d. Union Tribune Metro 1/12/20 Ad

Ad Number: 7663548-1
Insertion Number:
Size: 3 x 5.25
Color Type: 4 Colors
Client Name: San Diego State University
Advertiser: Local News/B005/ME
Section/Page/Zone: Behavioral Health Services Communit
Description:

The San Diego Union-Tribune
Publication Date: 01/12/2020

EDD BYRNES • 1933-2020

ACTOR WAS TEEN IDOL AS 'KOOKIE' IN '77 SUNSET STRIP'

BY ROBERT JABLON

Edd Byrnes, who played cool kid Kookie on the hit TV show "77 Sunset Strip," scored a gold record with a song about his character's hair-combing obsession and later appeared in the movie "Grease," has died. He was 87.

Byrnes died Wednesday at his home in Santa Monica, his son, Logan Byrnes, said in a statement.

Byrnes, born Edward Byrne Breitenberger on July 30, 1933, in New York City, came from a poor family. His alcoholic father died when he was 13.

Byrnes worked a variety of jobs, but he yearned for an acting career.

At 17, he began to work as a photographer's model and was drawn into male hustling with wealthy older men that introduced him to a "strange world" of "art, wealth, sadism, limousines, sex for money, theater and fine restaurants," Byrnes wrote in his 1996 autobiography, "Kookie' No More."

Still pursuing acting, in 1955 he drove to L.A. "with a few hundred dollars and a dream of making it big in the entertainment business," his son wrote.

Byrnes was best known as Kookie on the private-detective series "77 Sunset Strip," which ran from ran from 1958 to 1964. Byrnes played a hip parking attendant at a Hollywood nightclub who helped out with cases. He was known for his hipster lingo, including the catch phrase "Baby, you're the ginchiest!"

When he wasn't making wisecracks, Gerald Lloyd "Kookie" Kookson III was lovingly combing his well-greased hair.do.

The show made Byrnes a teen idol who at the height of his popularity received 15,000 fan letters a week.

"Kookie, Kookie (Lend Me Your Comb)," a novelty record he recorded with Connie Stevens, sold more than 1 million copies and

rose to No. 4 on the Billboard Hot 100 chart in May 1959.

However, Byrnes chafed under a contract that cost him the chance of several roles in movies such as "Ocean's Eleven." He walked off the show in the second season, demanding a bigger part and better pay, and he didn't return until 1960, when Kookie had become a partner in the detective agency.

Still yearning for larger parts, he bought out his Warner Bros. contract in 1963. He worked steadily but never again achieved the fame of his Kookie years.

He appeared in dozens of movies and on episodes of several TV shows, including "Fantasy Island" and "Murder, She Wrote." In 1975, Byrnes was hired to host a new game show called "Wheel of Fortune" and filmed two pilots, but the job eventually went to Chuck Woolery.

In the 1978 John Travolta movie "Grease," he played Vince Fontaine, the suave host of the "National Bandstand" TV dance show.

In his personal life, Byrnes struggled with alcohol and drug addictions for years before managing to kick them.

He was married to actress Asa Maynor from 1962 to 1971. The marriage ended in divorce.

In addition to his son, he is survived by his partner, Catherine Gross; a sister, Jo-Ann Breitenberger; and a brother, Vincent Breitenberger.

Jablon writes for The Associated Press.

BUTTERFLY
Status change stalls in 2011

FROM B1

burned areas and blossoming sites.

"It can maintain that, but with urban development in San Diego and the presence of more wide-ranging fires, its habitat is more degraded," with isolated patches of chaparral that are harder for the butterfly to access, Cornelisse said. "That's what has caused it to become endangered."

When the first petition under the Endangered Species Act failed to gain traction, the conservation groups followed with a second petition in 2004. The U.S. Fish and Wildlife Service analyzed and rejected it, concluding that it didn't warrant listing, Hendron said.

The San Diego region had already survived the 2003 Cedar fire, and in 2007, it endured another series of firestorms that torched 368,316 acres, an area larger than the city of Los Angeles. That included swaths of old growth chaparral the butterfly relied on. Urban development spurred by a growing population claimed many more acres of that habitat.

By 2011, the Fish and Wildlife Service determined that it did indeed deserve protection. By that time, however, the service was complying with court-ordered deadlines for other environmental reviews, and ranked the butterfly listing as "precluded by other workload priorities," said Listing and Recovery Division Chief Bradd Baskerville-Bridges.

It remained on hold until this year, when the service issued its listing proposal, starting the process to protect it under the federal Endangered Species Act. Safeguards will include designation of 35,000 acres of critical habitat in San Diego County.

There are 45 sites where it is known to exist, out of 95 historical occurrences, Baskerville-Bridges said. Many of those are in southeast San Diego County, he said.

INSIGNIA ENVIRONMENTAL AND ROCKS BIOLOGICAL

The Hermes copper butterfly, found in San Diego County, is proposed for threatened species status.

About 65 percent of the critical habitat area is already within conservation areas or federal lands, Hendron said, while the remaining 35 percent are on private land. The critical habitat restrictions don't apply to those, unless there's a federal nexus such as federal funding or permits. Large development projects that require federal permits for land use or stream bed alterations could fall into that category.

"We're continuing to work with project proponents in consultation," Baskerville-Bridges said. "We don't think it will be a hindrance, but we will continue to protect the species."

San Diego County Building Industry Association Vice President Matthew Adams said the organization is still analyzing the proposed listing, but expects to comment on any provisions that affect home developments.

"We have to evaluate the maps and see where that is," he said. "If it's all in (multiple species conservation plan) land, that's one thing. But if it could affect areas identified for housing, we'll have to address that. Whatever the impacts, it's another layer of bureaucracy we will have to address, as we're trying to provide housing for our citizenry."

Hogan, for his part, is also concerned about the intersection of habitat and housing. He worries that master-planned communities proposed in the South County could sprawl over some of the butterfly's remaining chaparral habitat, and said brush reduction measures laid out in fire prevention programs could claim more of it. Conservation groups will continue to press for the butterfly's protection on multiple fronts, he said.

"Environmental groups will support this proposal and request that it be strengthened," he said. "Whether it's listed or not, environmentalists will ask that local agencies like the county and city of San Diego expand conservation measures under their respective multiple species conservation plans to provide protections for this species. And we'll be asking the U.S. Forest Service and Cal Fire to revisit plans to destroy so much important habitat."

Cornelisse said the Center for Biological Diversity will analyze the listing plan and critical habitat maps, paying close attention to exempt areas that should be included for the species' protection, but said the measure is a step in the right direction for the Hermes copper butterfly.

"Generally, we're very pleased with the fact that they're responding to our petitions and our efforts, and now it can get the help it deserves to hopefully survive," she said.

deborah.brennan@sduniontribune.com

WINDFALL
Distribution formula challenged

FROM B1

file suit in 2014 challenging that decision.

They contend in the lawsuit that the county misinterpreted and misapplied the state legislation that dissolved redevelopment agencies. Lawyers for the county say the formula the county uses is correct.

While only those seven cities filed the lawsuit, a ruling in their favor would be expected to also affect most other cities and counties in California.

Counties using the formula more favorable to cities would be vindicated and would be allowed to continue with that practice. Counties using the formula less favorable to cities would have to shift to the other approach.

They also would be required to make lump-sum payouts to each affected city. Those payouts would be equal to the difference between the amount each city has been receiving and the amount the city is entitled to under the formula that's more favorable to cities.

In addition, those cities would get more property tax revenue in all subsequent years because counties would be required to start using the formula that's more favorable to cities.

A Superior Court judge in Sacramento ruled in favor of the seven local cities in 2015, ordering San Diego County to give them large payouts to make up for years of using the wrong formula and to use the formula favorable to cities moving forward.

Later in 2015, the county appealed the ruling to the Third District Court of Appeal in Sacramento.

The city of San Diego's Independent Budget Analyst and city finance officials say the appeals court is expected to schedule oral arguments in the case sometime this year and then make a ruling. They said it's not clear exactly when this year the appeals court will move forward with the case.

If the appeals court upholds the lower court ruling, the independent budget analyst estimates the city's lump-sum payment would be $35 million to $40 million.

But, the budget analyst notes, even a favorable ruling this year won't guarantee the payout comes immediately. The case could be appealed to the state Supreme Court.

In addition, the two sides could settle the case and agree to a slower method of compensating the cities than a lump-sum payout.

Cities are allowed to use excess revenue from their former redevelopment agencies as unrestricted "general fund" money, meaning they have wide discretion in how they spend it.

The other six cities involved in the case would receive smaller payouts than San Diego because their redevelopment agencies generated smaller amounts of property tax increment.

The difference between the two formulas — the one more favorable to cities and the one less favorable — centers on whether the county can "cap" the amount of property tax received by any particular agency.

San Diego County chose to use a formula that limits what a city can receive to the maximum amount they would have received if their redevelopment agency had not been dissolved.

In contrast, the formula more favorable to cities calculates the property tax owed to each city by first providing them money they owe for debts and obligations and then dividing whatever is left over among cities, school districts and other local agencies entitled to a share of the money.

In some cases, that allows cities with significant debts and obligations to receive more property tax revenue than they would have received if their redevelopment agency hadn't been dissolved.

Superior Court Judge Michael Kenny ruled in 2015 that the formula used by San Diego County "unfairly reduces" the shares received by such cities. He said the state Legislature would have clearly stated if they wanted counties to use the formula less favorable to cities.

The seven local cities that filed the lawsuit are being represented in the case by Colantuono, Highsmith & Whatley, a Los Angeles firm specializing in redevelopment revenue cases. Holly Whatley, the lead lawyer in the case, didn't respond to multiple phone calls last week seeking comment.

Whatley sent a letter last month urging the appellate court to take up the case as soon as possible. She said many cities need to know the outcome of the case for long-term budgeting purposes.

Lawyers for the county declined to comment last week.

david.garrick@sduniontribune.com

e. Union Tribune North Co 1/12/20 Ad

Ad Number: 7663548-1
Insertion Number:
Size: 3 x 5.25
Color Type: 4 Colors

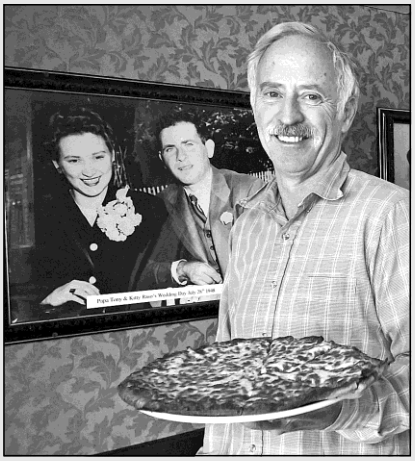
Client Name:
Advertiser: San Diego State University
Section/Page/Zone: Local News/B006/NO
Description: Behavioral Health Services Communit

The San Diego Union-Tribune

Publication Date: 01/12/2020

f. Star News (Spanish) 1/31/20 Ad

SILVER SERVING



La Bella Pizza Garden was a Silver Star winner in the Best Pizza category of the 2019 Best of South County Reader's Poll. The annual survey asks readers to share their thoughts on who the best people, places and services are in South County. The winners were named Jan. 29 at a party in Seven Mile Casino. Pictured is owner Tony Rasso.

ARTS

CONTINUED FROM PAGE 3

temporary exhibition component of the airport's arts program, which consists of public art and performing arts components as well. The exhibit featuring ARTS youth designers' seating prototypes will be up at the airport through March.

"We're really trying to encourage these aspiring artists and designers to try out the design process and help them think about the power of design in public spaces," Lockhart said. She added that the DesignAHEAD program gives students the opportunity to work like a professional designer with a client.

Before diving into the prototype creation process, Lockhart explained that students had an orientation where they met with design and construction staff, arts program staff and the operations team at the airport and had the opportunity to explore the airport.

"We use the art vehicle to welcome folks to the region and so I think this does that really nicely by showcasing the work of local students and talent we have right here, home grown talent," Lockhart said.

Through DesignAHEAD, the San Diego International Airport has also partnered with San Diego City College, High Tech High School Chula Vista, Southwestern College and the University of San Diego over the past couple of years.

Lockhart said in the future, the airport's arts program plans to formalize DesignAHEAD beyond it being a pilot program and extend its reach to other local schools in San Diego across a variety of grade levels.

"Our long-term lofty goal for this program is that were helping to cultivate the next generation of designers and especially that might lend their talent to the aviation field," Lockhart said.

Participating schools included: Sweetwater High School, Hilltop High School, Chula Vista High School, Olympian High School, Mar Vista High School, Castle Park High School, Otay Ranch High School

HUB

CONTINUED FROM PAGE I

ways for high school students, programs to increase access to higher education to students from low-income underrepresented groups and support for post-military career transitions.

In the next six months, UCSD Extension Dean Ed Abeyta said UCSD and National City aim to start pilot programming for the hub.

"This was a conversation with the community about what the community needs," Abeyta said.

He added that trust and sustainability is "paramount" in building relationships with the National City community, and building a hub in National City speaks to UCSD's core values and ongoing effort to expand their reach in the South Bay.

When it comes to a target audience for the resources being offered, Abeyta said it's really people from every stage in life ranging from kids in preschool to people that are post-retirement.

"You can think of it almost like a buffet where you can get what you need but you can also change it as you need," Abeyta said.

AroundTown

Chili Cook-Off!
Feb 1, 12-3 p.m.
Coronado Beach Harley-Davidson, 3201 Hoover Ave. in Coronado

Coronado Beach Harley-Davidson is hosting a Chili Cook-Off on Feb. 1 from noon to 3 p.m. Come show what you've got! Winner takes home swag and $100 gift card. Can't cook? Don't worry, come out and cast your vote for your favorite!

Sign Up Now! Limited Spots Available! Email marketing@cbharley.com to reserve your spot.

Hello Kitty Cafe Truck West
Feb. 1 10 a.m. - 7 p.m.
Otay Ranch Town Center, 2015 Birch Road in Chula Vista

Hello Chula Vista! The Hello Kitty Cafe Truck is coming to Otay Ranch Town Center from 10 a.m to 7 p.m. Come say hello to us at the covered food pavilion area and pick up some super cute treats and merchandise, while supplies last.

Valentine's Day Potluck & Dance
Feb. 6, 12-3 p.m.
Chula Vista Senior Citizens Club, 270 F. St. in Chula Vista

The Chula Vista Senior Citizens Club is hosting a Valentine's Day Potluck & Dance on Feb. 6. Bring a dish to share, refreshments will be served. Music by Piña! Tickets available at the door for $5!

2020 Southwest Regional Wave Regatta
Feb. 7, 8 a.m.
Feb. 9, 1 p.m.
Chula Vista Marina, 550 Marina Parkway in Chula Vista

Formula Wave Class is hosting the first annual Southwest Regional Wave Regatta. Join them at Chula Vista Marina for their first FWC Regatta of the 2020 season.

SD Fixit Clinic in Chula Vista
Feb. 15 1- 3 p.m.
Norman Park Senior Center, 270 F St. in Chula Vista

San Diego FixIt Clinic, Zero Waste San Diego, Fixit Clinic and San Diego Reuse & Repair Newtork is hosting a fixit clinic at Norman Park Senior Center. Bring your broken, non-functioning things: electronics, appliances, computers, toys, bicycles, clothes, etc. for assessment, disassembly, and possible repair.

g. Star News (English) 1/31/20 Ad

THE STAR-NEWS

COURTS

Jury convict arsonist for slaying of OB man

By Neal Putnam
THE STAR-NEWS CORRESPONDENT

After 2 1/2 days of deliberations, a jury convicted a National City man Monday of first-degree murder of an Ocean Beach man whose body has never been found.

Deputy District Attorney Jeffrey Dort said Brian Eleron Hancock, 49, will have to serve a minimum of 25 years in prison before he could become eligible for parole in the death of Peter Bentz, 68.

Dort said Hancock faces a sentence of 85 years to life in part because of his prior convictions for arson in 1999 and residential burglary in 2003.

"I'm totally satisfied," said the victim's brother, Kirk Bentz, after the verdict. "This is the correct and just verdict for Peter."

Bentz was last seen leaving a gym on security cameras on Nov. 21, 2017. No credit card or Internet activity has surfaced from Bentz since then. His blood was found in 17 locations in his apartment after investigators looked underneath the carpeting.

Kirk Bentz testified as the trial's first witness and said his brother failed to show up at his home for Thanksgiving after dropping out of sight.

San Diego Superior Court Judge Joan Weber set sentencing for Feb. 26. Hancock remains in jail without bail.

"Brian Hancock brutally killed Peter Bentz," said Dort afterwards. "The verdict is appropriate, based on the evidence."

The seven woman, five man jury didn't linger after their decision and attorneys did not talk to them. They began deliberations Jan. 22 in a trial that started Jan. 7.

"The San Diego Police Department did an incredible job, piecing together a case no one knew about, based on cell phone records and credit card receipts," said Dort, who described it as "an airtight, circumstantial evidence case."

Dort told Bentz's family the defense "went down the slope of 'Let's make Peter as bad as he can be." Dort told jurors Hancock lied on the witness stand.

Jimmy Rodriguez, Hancock's attorney, had argued for acquittal, saying Bentz may be in Mexico and the prosecution had not proved its case. He did not comment afterwards.

Hancock, an electrician, denied killing Bentz, whom he described as a sexual partner after meeting him to do electrical work in his apartment.

Dort argued to jurors that Hancock wanted revenge for Bentz secretly videotaping him and another woman having sex in Bentz's apartment. A woman testified she had sex with Hancock and thought Bentz might have videotaped it.

The woman testified someone sent her a video that she could not open and she feared it showed her and Hancock. She said Hancock told her he would talk to Bentz about it.

Another woman said Hancock told her he stabbed Bentz seven times. And his ex-wife testified he threw a bag of Bentz's identification and other items off a freeway.

A napkin containing Bentz's blood and Hancock's DNA was found in the bag that was strewn along Interstate 5 near Logan Heights. Hancock was seen on video using Bentz's credit cards and driving his car after he disappeared.

Hancock testified that Bentz told him he was going to Mexico for a vacation and claimed he was in contact with Bentz for five days after he disappeared. He said he had Bentz's permission to use his credit cards and his Toyota Highlander.

Bentz is believed to have buried in Campo because Hancock's phone pinged in a stationary location for 4 1/2 hours in Campo on Nov. 24, 2017. A tag for a tool was found in Campo that Hancock had purchased with Bentz's credit cards, according to testimony.

Angelina Hancock, his ex-wife, testified her husband wanted "to transport Peter's body" in new boxes she had purchased. She testified under a grant of immunity after signing an agreement with the DA's office.

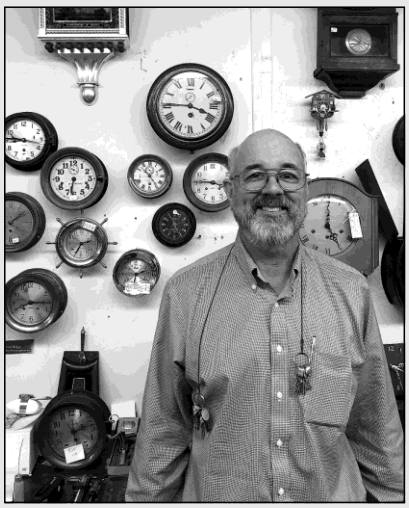
In a conversation Angelina Hancock had with her husband in jail, she said "he discussed burying Peter." She said she didn't know where he buried the body.

Angelina Hancock testified she first learned of the sexual relationship between her husband and Bentz after reading a sexually oriented text from Bentz on Hancock's phone while he was in the shower.

"As he recently shared with me about his relationship with Peter, it's something I can't provide for him," said his ex-wife, who divorced Hancock after 20 years of marriage.

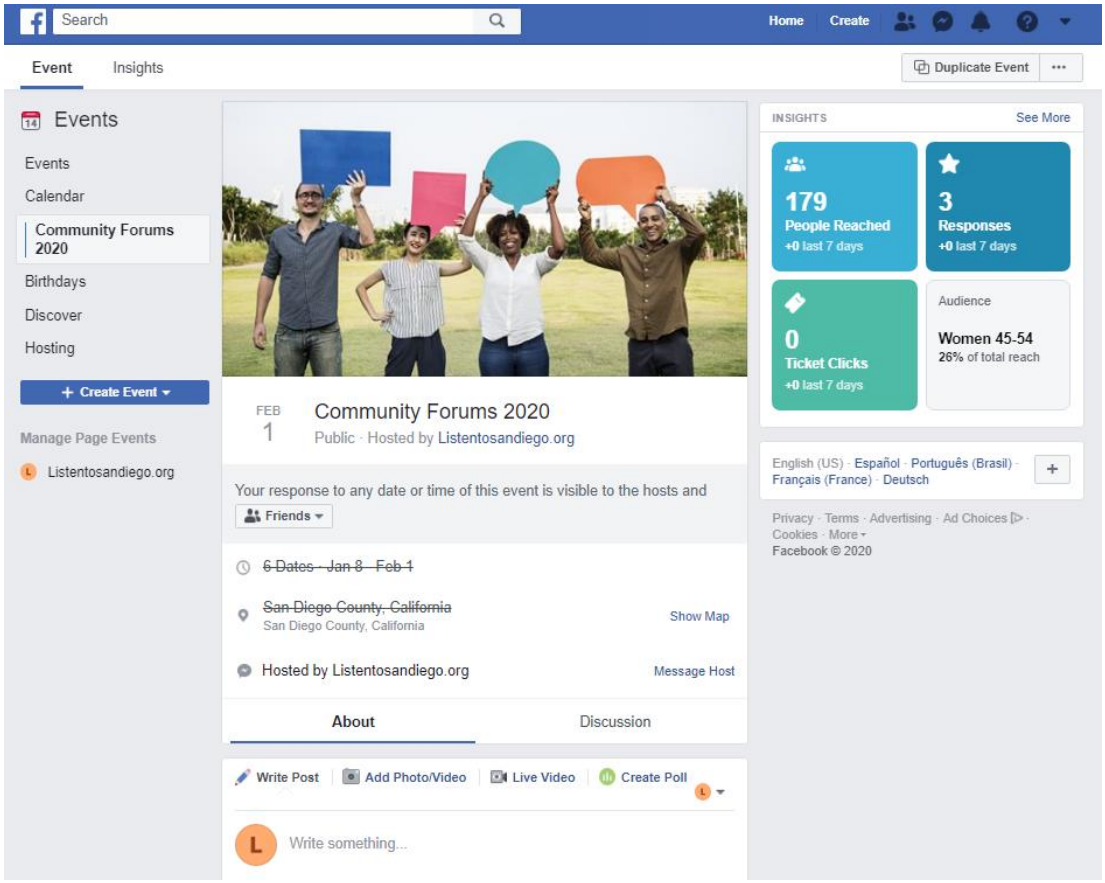
Hancock's sentence for murder is 25 years, and the judge could add 50 years for the two previous convictions plus 10 years.

GOLDEN HOUR

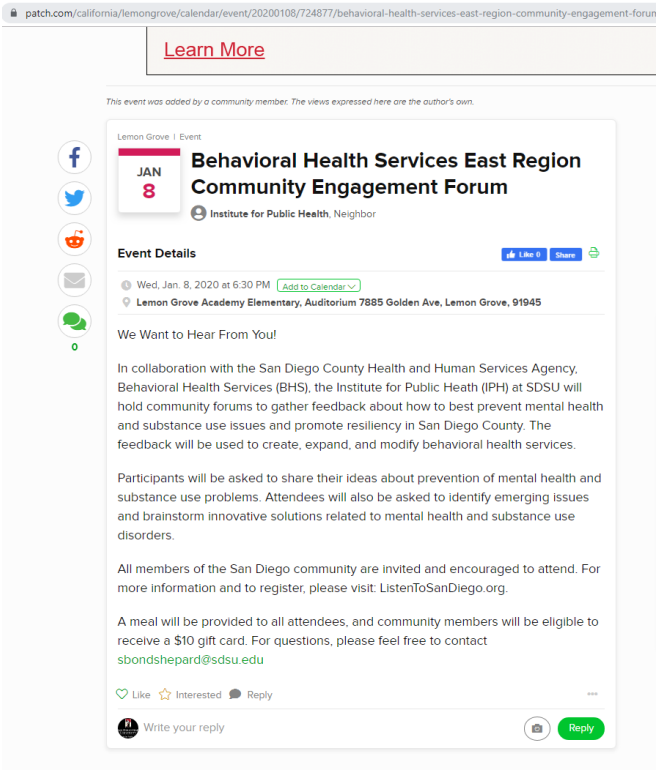


Dave Rossie was a Gold Star winner in the Best Jeweler category of the 2019 Best of South County Reader's Poll. The annual survey asks readers to share their thoughts on who the best people, places and services are in South County. The winners were named Jan. 29 at a party in Seven Mile Casino.

h. Facebook Event Screenshot



i. Patch Lemon Grove, Sample Online Ad



6. Email Marketing Sample, Past Participants

San Diego State University Mail - We'd like to hear from you again this ...

SAN DIEGO STATE UNIVERSITY

We'd like to hear from you again this year!

Institute for Public Health <noreply@qemailserver.com> Mon, Dec 23, 2019 at 8:55 AM
Reply-To: Institute for Public Health <instituteforpublichealth@sdsu.edu>
To:

Dear Elsa,

Last year you registered to attend one or more Community Forums conducted by the Institute for Public Health on behalf of San Diego County's Behavioral Health Services. We'd like to invite you to attend again this year.

Details
In collaboration with the San Diego County Health and Human Services Agency, Behavioral Health Services, the Institute for Public Health at SDSU will hold six community forums across San Diego County to gather feedback about how to best prevent mental health and substance use issues and promote resiliency in San Diego County. The feedback will be used to create, expand, and modify behavioral health services.
Participants will be asked to share their ideas about prevention of mental health and substance use problems. Attendees will also be asked to identify emerging issues and brainstorm innovative solutions related to mental health and substance use disorders.

All members of the San Diego community are invited and encouraged to attend any one of the scheduled forums. For more information, please visit: ListenToSanDiego.org
To Registor, please visit:

A meal will be provided to all attendees, and community members will be eligible to receive a $10 gift card. For questions, please feel free to contact Sarah Shepard at sbondshepard@sdsu.edu or 619-594-6812.

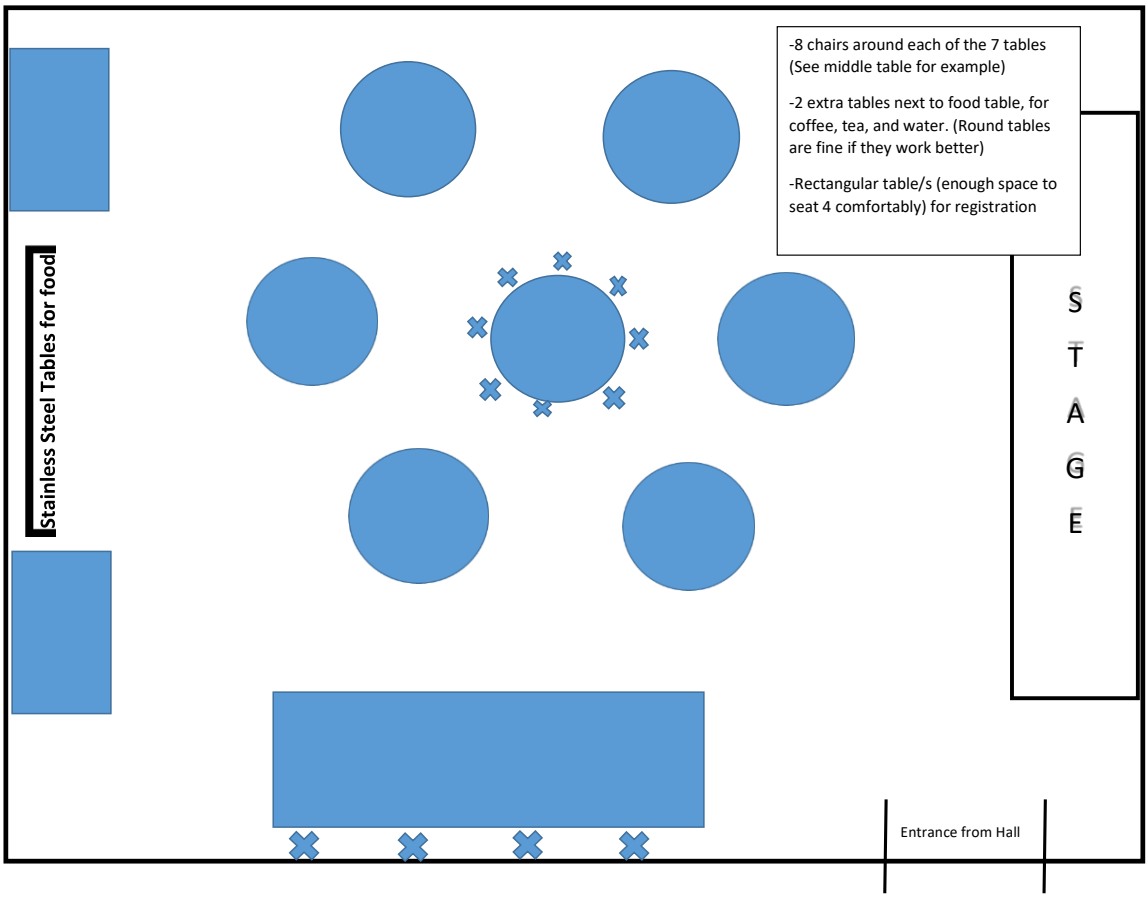
We hope to see you at an upcoming Community Forum!

Sarah Shepard
Special Consultant, Events
Institute for Public Health
San Diego State University
619-594-6812 (O)

sbondshepard@sdsu.edu (E)
https://iph.sdsu.edu

All Forums Flyer 2020.pdf

7. Event Layout



8. Helpful Definitions

Behavioral Health

Behavioral health refers to a person's overall mental and emotional health. Behavioral health problems include mental health issues, like anxiety and depression. It also includes substance use issues, like problems with alcohol or drugs.

Substance Use Disorder

Substance use disorders occur when someone repeatedly uses alcohol or drugs and develops serious problems because of this. These can be health problems, disabilities, or the person being unable to work or care for themselves, their loved ones, or their homes.

Prevention

Prevention tries to stop a problem before it occurs. For substance use prevention, this means making sure that people don't abuse drugs or alcohol or become addicted to them. For mental health, this means making sure people are mentally and emotionally healthy and that, if they have a mental illness, they get connected to treatment at the earliest point of need.

Innovation

Innovation means new ideas and creative thoughts – ways of solving problems that we haven't tried before.

Resiliency

Resiliency is being able to quickly recover from difficulties, like physical or mental health problems or from hard events, like a death or the loss of a job. To be resilient is to be able to become strong, healthy, or successful again after something bad happens.

9. Satisfaction Survey Tool

County of San Diego Health and Human Services Agency, Behavioral Health Services
The County of San Diego Wants to Hear from You!

Event Feedback Survey

Date: ____/____/2020 ☐ AM ☐ PM

1. **Overall, how satisfied were you with this event?**
   - ☐ Very Satisfied
   - ☐ Satisfied
   - ☐ Somewhat Satisfied
   - ☐ Not at all Satisfied
2. **How convenient was this location for you?**
   - ☐ Very Convenient
   - ☐ Convenient
   - ☐ Somewhat Convenient
   - ☐ Not at all Convenient
3. **The day of week of this event was a good fit for your schedule**
   - ☐ Agree
   - ☐ Somewhat Agree
   - ☐ Somewhat Disagree
   - ☐ Disagree
4. **The time of day of this event was a good fit for your schedule**
   - ☐ Agree
   - ☐ Somewhat Agree
   - ☐ Somewhat Disagree
   - ☐ Disagree
5. **The topics covered at today's event were useful**
   - ☐ Agree
   - ☐ Somewhat Agree
   - ☐ Somewhat Disagree
   - ☐ Disagree
6. **How did you learn of this event?**
   - ☐ Flyer
   - ☐ Friend/Colleague/Family Member
   - ☐ Email from: _____
   - ☐ Newspaper Ad
   - ☐ Social Media
   - ☐ Other: _____

Do you have suggestions for how these events could be improved? [open ended]

Do you have any other comments to share with us? [open ended]

County of San Diego Health and Human Services Agency, Behavioral Health Services
The County of San Diego Wants to Hear from You!

The following demographic data collected on this form will be used strictly to generate summary reports about community engagement forums held by County of San Diego HHSA Behavioral Health services.

1. What is your age group? (Please select one)
   - ☐ age 0-15 years old
   - ☐ age 16-25 years old
   - ☐ age 25-59 years old
   - ☐ age 60 years old or over
   - ☐ Prefer not to answer

2. What is your race? (Check all that apply)
   - ☐ American Indian or Alaskan Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or other Pacific Islander
   - ☐ White
   - ☐ Other (please specify) _____
   - ☐ Prefer not to answer

3. Are you of any following origin? (Select all that apply)
   - ☐ Hispanic or Latino:
     - ☐ Caribbean
     - ☐ Central American
     - ☐ Mexican/Mexican-American/Chicano
     - ☐ Puerto Rican
     - ☐ South American
     - ☐ Other (please specify) _____
   - ☐ Non-Hispanic or Non-Latino:
     - ☐ African
     - ☐ Asian Indian/South Asian
     - ☐ Cambodian
     - ☐ Chinese
     - ☐ Eastern European
     - ☐ European
     - ☐ Filipino
     - ☐ Japanese
     - ☐ Korean
     - ☐ Middle Eastern
     - ☐ Vietnamese
     - ☐ Other (please specify) _____
   - ☐ Prefer not to answer

County of San Diego Health and Human Services Agency, Behavioral Health Services
The County of San Diego Wants to Hear from You!

4. What is the **primary** language you speak or use at home other than English? (Please select one)
   - ☐ English
   - ☐ Arabic
   - ☐ Farsi
   - ☐ Spanish
   - ☐ Tagalog
   - ☐ Vietnamese
   - ☐ Other (please specify) _____

5. What best describes your sexual orientation? (Please select one)
   - ☐ Gay or Lesbian
   - ☐ Heterosexual or Straight
   - ☐ Bisexual
   - ☐ Questioning or unsure of sexual orientation
   - ☐ Queer
   - ☐ Another sexual orientation (please specify) _____
   - ☐ Prefer not to answer

6. Do you have a disability, 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 severe mental illness?
   - ☐ Yes
     - Communication domain:
       - ☐ Difficulty seeing,
       - ☐ Difficulty hearing, or having speech understood
       - ☐ Other (please specify) _____
     - ☐ Mental domain not including a mental illness (including but not limited to a learning disability, developmental disability, dementia)
     - ☐ Physical/mobility domain
     - ☐ Chronic health condition (including, but not limited to, chronic pain)
     - ☐ Other (please specify) _____
   - ☐ No
   - ☐ Prefer not to answer

7. Are you a veteran? (Please select one)
   - ☐ Yes
   - ☐ No
   - ☐ Prefer not to answer

8. What was your assigned sex at birth? (Please select one)
   - ☐ Male
   - ☐ Female
   - ☐ Other (please specify) _____
   - ☐ Prefer not to answer

County of San Diego Health and Human Services Agency, Behavioral Health Services
The County of San Diego Wants to Hear from You!

9. Please mark the gender identity that best describes you currently. (Please select one)
   - ☐ Male
   - ☐ Female
   - ☐ Transgender
   - ☐ Genderqueer
   - ☐ Questioning or unsure of gender identity
   - ☐ Another gender identity (please specify) _____
   - ☐ Prefer not to answer

10. Do you identify with any of these *additional* groups? (Select all that apply)
    - ☐ Immigrant
    - ☐ Refugee/Newcomer
    - ☐ Asylee
    - ☐ Veterans/Military
    - ☐ Homeless
    - ☐ African
    - ☐ Chaldean
    - ☐ LGBTQI
    - ☐ Prefer not to answer

10. Interview Questions

a. Small Discussion Group Questions

HHSA BHS Community Engagement Small Discussion Questions

1. **What issues related to mental health and well-being are emerging as new problems for <<insert target population>>?**
2. **What types of efforts should be made to prevent those issues?**
3. **What issues related to substance abuse (alcohol, tobacco, drugs - prescription or illegal) are becoming more problematic among <<target population>>? Are there certain issues that seem to be getting worse?**
4. **What types of efforts should be made to prevent those issues?**
5. **What's the best way for the County to reach out to <<target population>> with messages about the prevention of substance use and mental health issues?**
6. **How can we engage <<target population>> in finding solutions?**

b. Key Informant Interview Questions

HHSA BHS Community Engagement Key Informant Interview Questions

Start by explaining that the interview will be anonymous and that they should feel free to offer as much or as little input as they'd like. They do not have to answer any questions they don't want to answer. Explain purpose: to get a sense of what behavioral health issues are growing in our community, to come up with ways to prevent behavioral health crises, to explore some innovative programming ideas, and to come up with ways to better engage the community.

1. **Tell me about your interest in behavioral health? (Are you a service provider? If so, for whom do you work? What is your job title? What services do you provide?)**

2. **What substance use issues/problems do you see as getting worse recently? What are you most concerned about?**

3. **How could we prevent those issues from getting worse? How do we stop them from becoming a crisis? What are our best preventive strategies?**

4. **What mental health issues do you see growing in the community? What are you concerned about in terms of future potential crises?**

5. **How do we prevent these issues from getting worse? How do we stop them from becoming a crisis? What are our best preventive strategies?**

6. **The County is considering three ideas for some innovative programming. Could you give me your quick feedback about each of these ideas?**

- Outdoor activity to go along with behavioral health treatment
- Special training for school staff to build resiliency in children.
- Education for parents about bullying, especially cyberbullying and the use of social media?

7. **What are some ways the County could engage the community in discussing these issues?**

11. Additional Community Member Feedback

Forum Participant Feedback: Substance Use

- Doctors are ignoring the benefits of non-Western medicine which leads to the overprescribing of drugs
- The community needs to be more aware of the CURES program – it might change drug seeking
- Consider giving away Moringa (the Miracle Tree)
- People do not properly dispose of prescription drugs
- Although drunk-driving is decreasing, “drug-driving” is increasing
- Need more research on addiction
- Need more crisis houses
- ERs are overcrowded due to overdoses
- Youth use “lean” promethazine codeine
- Burglaries are more common from people trying to steal to be able to buy drugs
- Batteries in vape products may explode
- Make vaping illegal for all ages
- All County contracted organizations should have Narcan on hand. It should be in a first aid kit

Forum Participant Feedback: Mental Health

- Alzheimer’s and dementia
- Residents and visitors using health care system
- Privacy and protection rights
- Violence and active shooters
- Depression and suicide is growing among men 40 an older
- Overuse of psychiatric medications among children
- Psychiatric medications can cause schizophrenia and death
- County website is not user-friendly for community members. The phone numbers are not updated and the descriptions do not identify characteristics like “walk-in” or “free clinic”
- Lack of empathy for people with disabilities
- Prevention does not work
- Need to increase the number of PERT officers
- Real vs fake depression
- Youth lack responsibility and motivation, which results in depression and failure in life
- We need to enforce assisted outpatient treatment for people with severe schizophrenia, bipolar disorder, and severe major depression – their free will needs to be stopped
- HIPPAA prevents family members from being involved in the care of people with SMI
- Keep School Resource Officers (SRO’s) in Vista Unified School District
- Have more funding for security in schools like SRO’s. They are trained to help kids with mental illnesses and illegal situations
- Universal healthcare would solve many of these problems
- Need more research about how to effectively treat PTSD
- Need more research about brain injuries – need to educate parents about injuries from football and boxing
- Victims of and witnesses to school and community shootings need more help

- Educate the community and providers about the Controlled Substance Utilization Review and Evaluation program (CURES)
- Students should have warm greetings to start their day off and have food and snacks available if they are hungry
- Dog therapy should be provided at every school
- Tiny home communities for families involved in child welfare system
- Teachers should be allowed to use calming tools like fuzzy socks, essential oils, and physical activity
- More fathers need to be involved in school activities
- Consequences to the people who cause mental health problems, like bullies, should be more severe
- We need programs that focus on nutrition. Food is our medication and there's so much we can do with what we ingest

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix G
MHSA Issue Resolution Process

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

LIVEWELLSD.ORG

Mental Health Services Act (MHSA) Issue Resolution Process
Updated May 26, 2020

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 provider.
- The MHSA issue shall be forwarded to the Consumer and Family Liaisons, RI International and NAMI San Diego, for review within one (1) business day 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.
- 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.

Consumer and Family Liaisons:

Judi Holder
RI International
3838 Camino Del Rio North, Suite 380
San Diego, CA 92108
(858) 274-4650
Judi.Holder@recoveryinnovations.org

Valerie Hebert
NAMI San Diego
5095 Murphy Canyon Road, Suite 320
San Diego, CA 92123
(858) 634-6580
Email: CYFliaison@namisd.org or
https://namisandiego.org/cyf-liaison

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix H
Community Supports and Services (CSS) Annual Report FY 2018-19

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

LIVEWELLSD.ORG

FY 2018-19 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

ATTACHMENT A

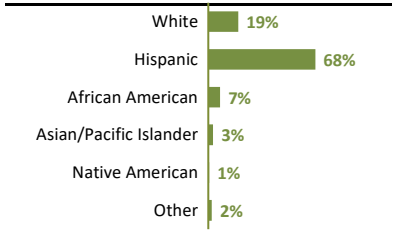
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Children & Youth - Full Service Partnership (CY-FSP; n=8,757)

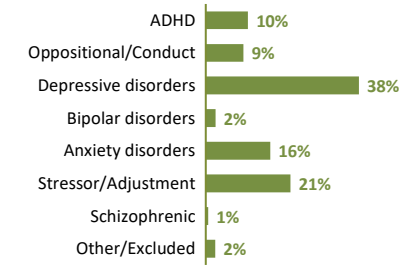
Living Situation	%
House or Apartment	93%
Correctional Facility	1%
Foster Home	3%
Group Home	1%
Children's Shelter	<1%
Homeless	2%
Other/Unknown	1%

Language	%
English	87%
Spanish	13%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	<1%

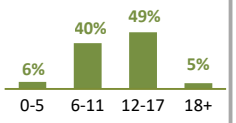
Race/Ethnicity (*excludes missing/unknown*)



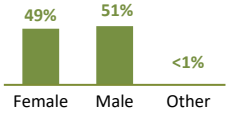
Diagnosis (*excludes missing/invalid*)



Age



Gender



CY-FSP **25%** (8,757)

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

CY-OE programs were not active in FY 2018-19

Total CSS Clients *(unduplicated)* N = 34,514

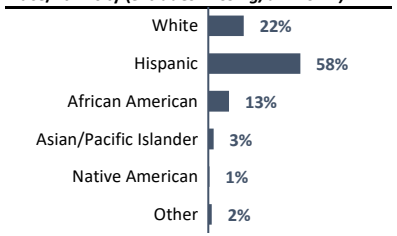
Children & Youth - System Development (CY-SD; n=2,886)

CY-SD **8%** (2,886)

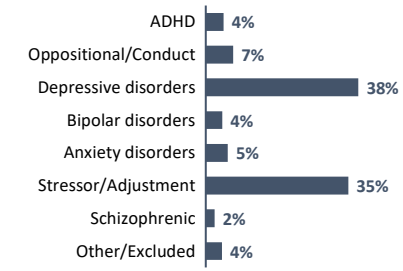
Living Situation	%
House or Apartment	64%
Correctional Facility	11%
Foster Home	10%
Group Home	4%
Children's Shelter	8%
Homeless	1%
Other/Unknown	3%

Language	%
English	91%
Spanish	9%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	<1%

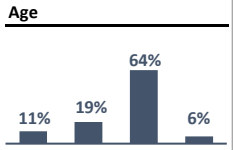
Race/Ethnicity (*excludes missing/unknown*)



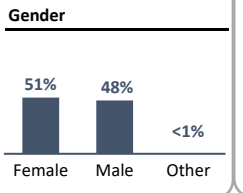
Diagnosis (*excludes missing/invalid*)



Age



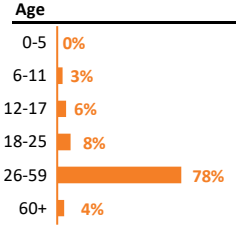
Gender



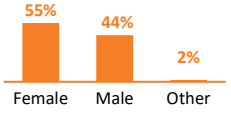
All CSS - Outreach and Engagement* (ALL-OE; n=179)

ALL-OE **1%** (179)

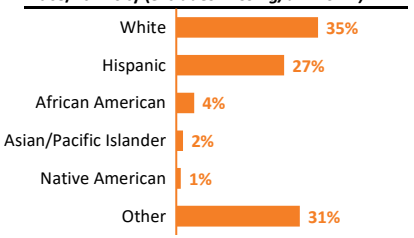
Age



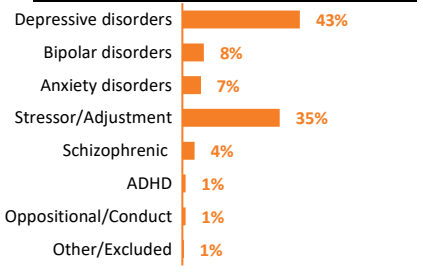
Gender



Race/Ethnicity (*excludes missing/unknown*)



Diagnosis (*excludes missing/invalid diagnoses*)



Living Situation	%
Lives Independently	92%
Justice Related	0%
Board & Care	2%
Institutional	0%
Foster Home	1%
Group Home	0%
Children's Shelter	0%
Homeless	4%
Other/Unknown	1%

Language	%
English	20%
Spanish	10%
Arabic	11%
Vietnamese	0%
Tagalog	0%
Farsi	3%
Other/Unknown	56%

**Clients may be duplicated*

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: 3/23/2020
FOR INTERNAL USE ONLY

FY 2018-19 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

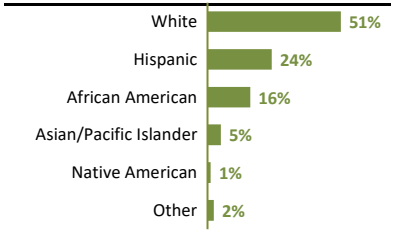
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

TAY, Adult, Older Adult - Full Service Partnership (TAOA-FSP; n=5,626)

Living Situation	%
Lives Independently	52%
Board & Care	14%
Justice Related	1%
Homeless	13%
Institutional	16%
Other/Unknown	4%

Language	%
English	93%
Spanish	5%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	2%

Race/Ethnicity (*excludes missing/unknown*)



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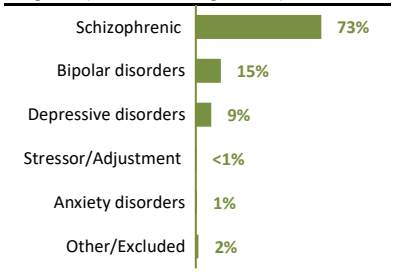

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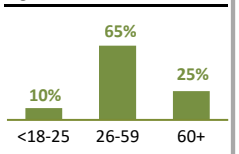
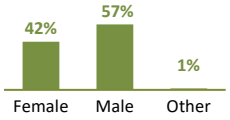


Gender



TAOA-FSP **16%** (5,626)

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

TAOA-OE programs were not active in FY 2018-19

Total CSS Clients *(unduplicated)* N = 34,514

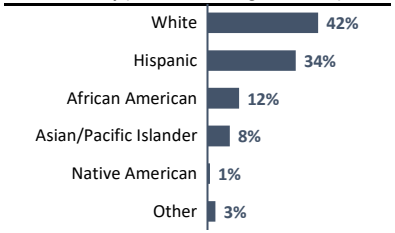
TAY, Adult, Older Adult - System Development (TAOA-SD; n=13,464)

TAOA-SD **39%** (13,464)

Living Situation	%
Lives Independently	64%
Board & Care	7%
Justice Related	1%
Homeless	17%
Institutional	1%
Other/Unknown	10%

Language	%
English	81%
Spanish	7%
Arabic	1%
Vietnamese	2%
Tagalog	<1%
Farsi	<1%
Other/Unknown	8%

Race/Ethnicity (*excludes missing/unknown*)



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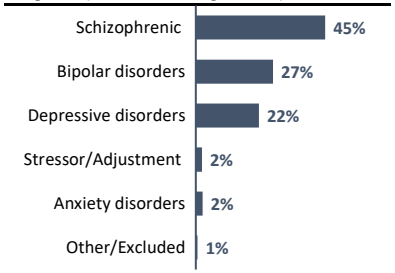
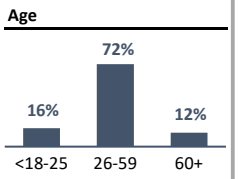
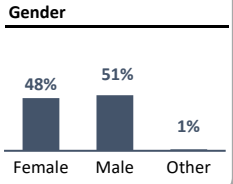


Age

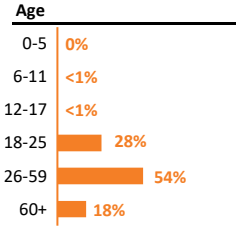


Gender

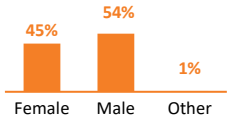


ALL-SD **26%** (8,886)

Age

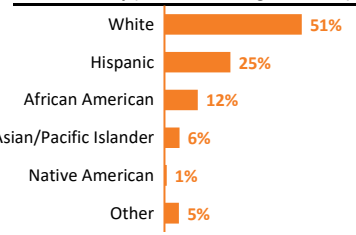


Gender

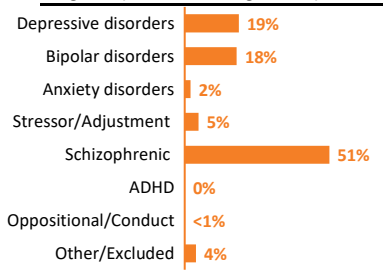


All CSS - System Development† (ALL-SD; n=8,886)

Race/Ethnicity (*excludes missing/unknown*)



Diagnosis (*excludes missing/invalid*)



Living Situation	%
Lives Independently	69%
Justice Related	1%
Board & Care	4%
Institutional	2%
Foster Home	0%
Group Home	0%
Children's Shelter	0%
Homeless	21%
Other/Unknown	3%

Language	%
English	91%
Spanish	4%
Arabic	3%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	2%

†Clients may be duplicated

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: 3/23/2020
FOR INTERNAL USE ONLY

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix I
FSP Outcomes Report FY 2018-19
Children, Youth and Families

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

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Full Service Partnerships OUTCOMES REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Children, Youth & Families (CYF) FSP Summary *FY 2018-19*

What Is This?

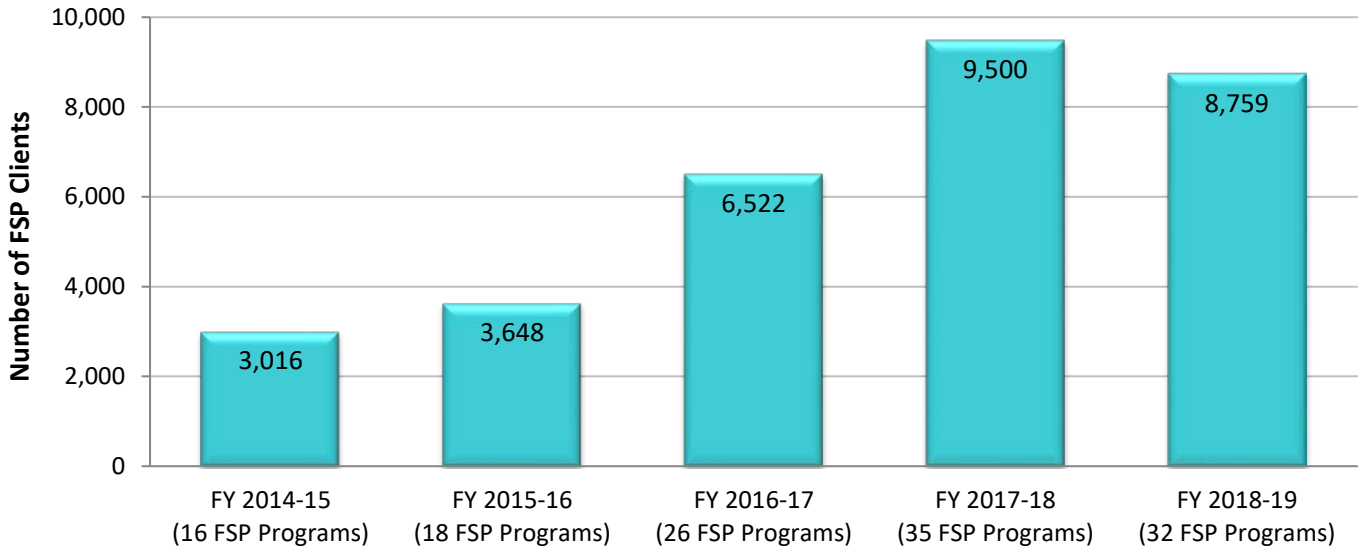
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals and treatment plan, and clients can access designated staff 24 hours a day/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?

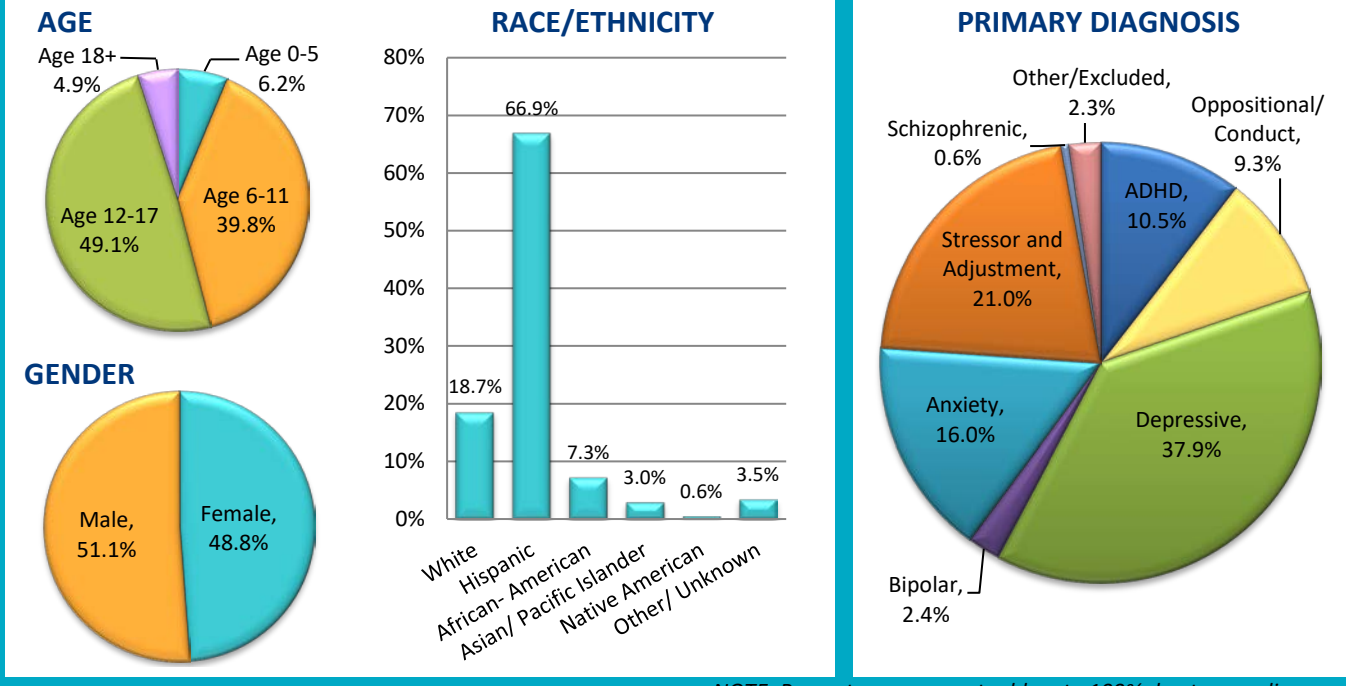
In Fiscal Year (FY) 2018-19, a total of 8,759 unduplicated clients received services through 32 CYF FSP programs, an 8% decrease from 9,500 FSP clients served in 35 CYF FSP programs in FY 2017-18.



Who Are We Serving? (continued)

In FY 2018-19, FSP clients were more likely to be male and Hispanic. The most common diagnosis among FSP clients was depressive disorder.

FSP Client Demographics and Diagnoses (N = 8,759)



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 2018-19.

Referral Sources (N = 4,964)

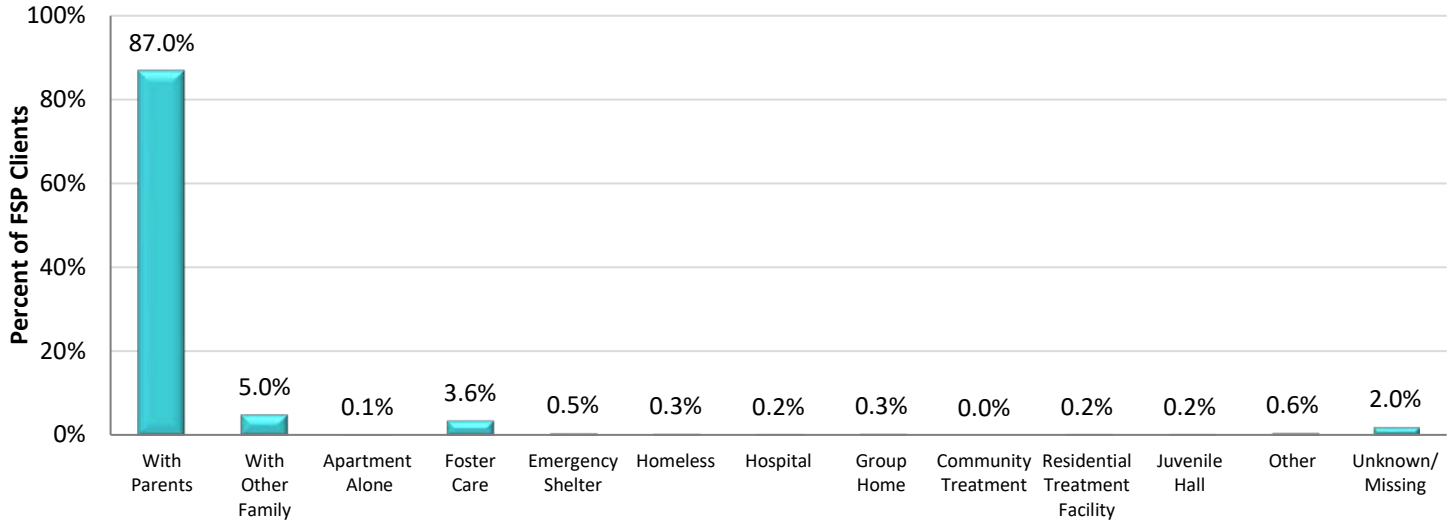
FSP referrals for clients with an intake assessment in FY 2018-19 were as follows (in order of frequency): school system (42%), family member (21%), primary care physician (10%), self-referral (9%), mental health facility (6%), social service agency (5%), other county agency (3%), Juvenile Hall (2%), acute psychiatric facility (1%), friend (1%), emergency room (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 2018-19.

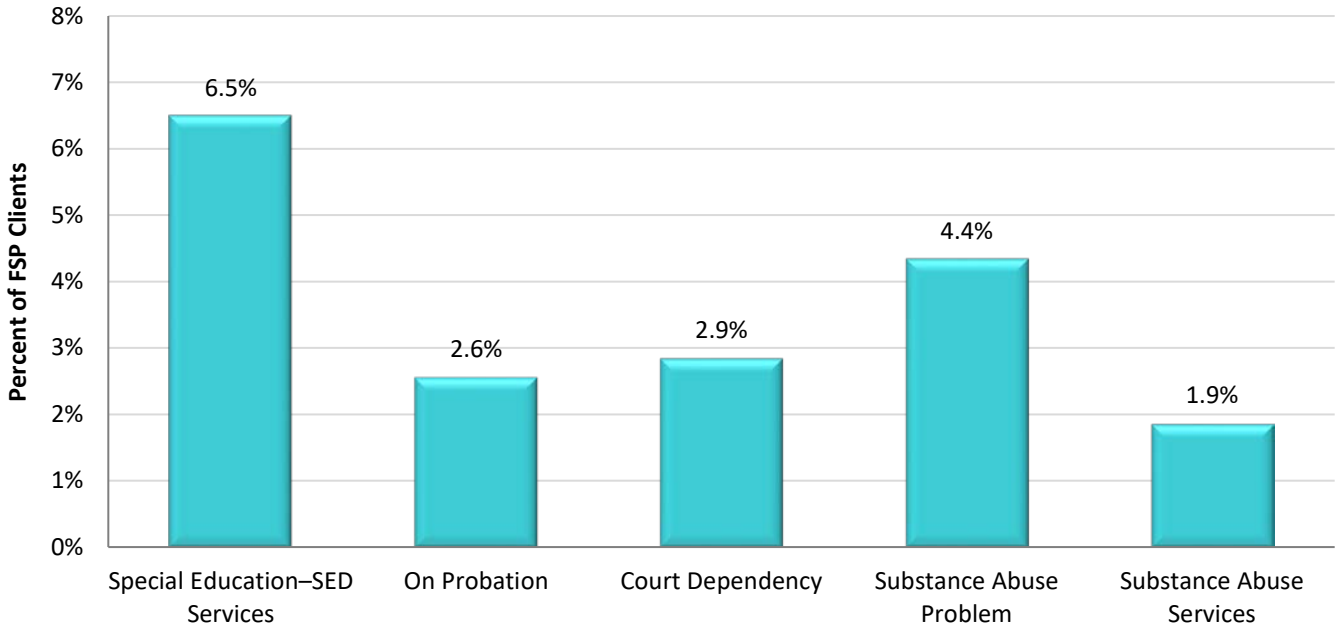
Living Arrangement at Intake (N = 4,964)*

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



Risk Factors at Intake (N = 4,964)*

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 4,243 (86%) 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 2018-19.*
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 2018-19, a total of 11 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of 8,759 unduplicated clients who received services from an FSP program in FY 2018-19, 174 (2.0%) had at least one inpatient episode and 320 (3.7%) had at least one Emergency Screening Unit visit during the treatment episode. The method of calculating episode overlap has been enhanced in the current fiscal year and may not be comparable to previous fiscal years.

Are Children Getting Better?

FSP providers collected outcomes data with the Pediatric Symptom Checklist (PSC and PSC-Y) and California Child and Adolescent Needs and Strengths (CANS). Scores were analyzed for youth discharged from FSP services in FY 2018-19 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 an SUD component in FY 2018-19, 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), or 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.

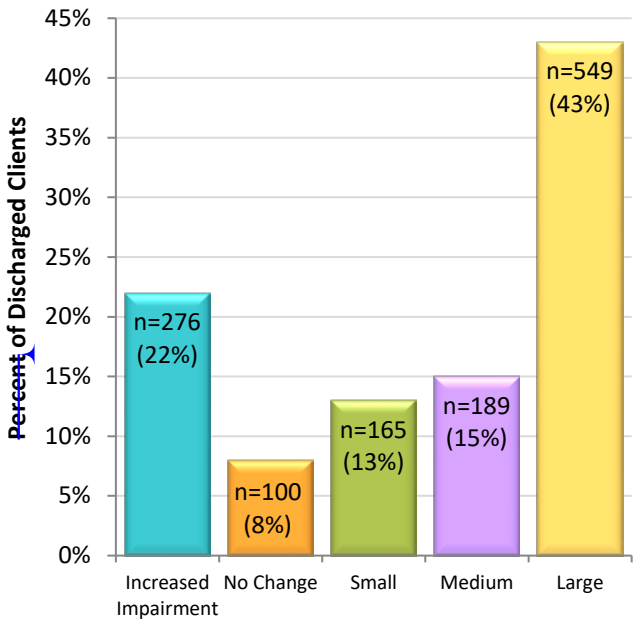
- ***Clinically Significant Improvement***

  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.

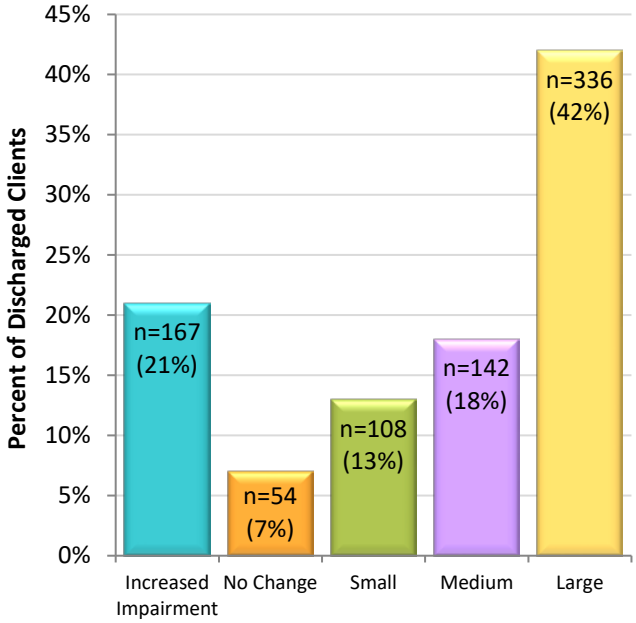
Are Children Getting Better? (continued)

PSC Amount of Improvement from Intake to Discharge

FSP Parent/Caregiver (N = 1,279)

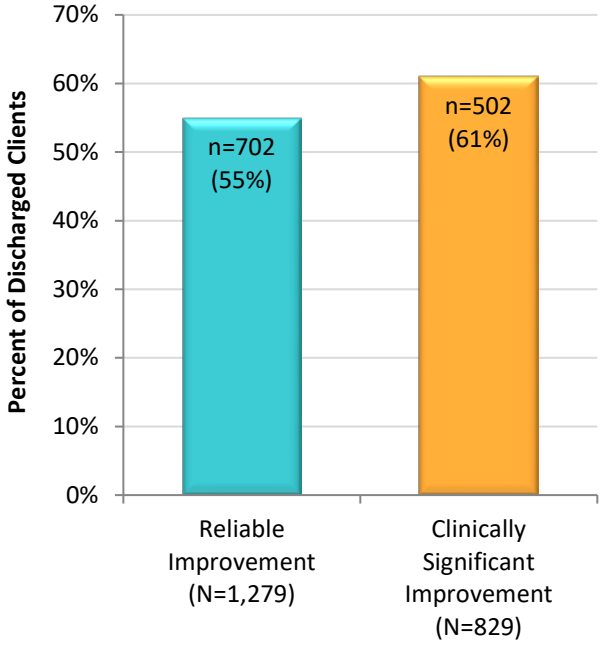


FSP Youth (N = 807)

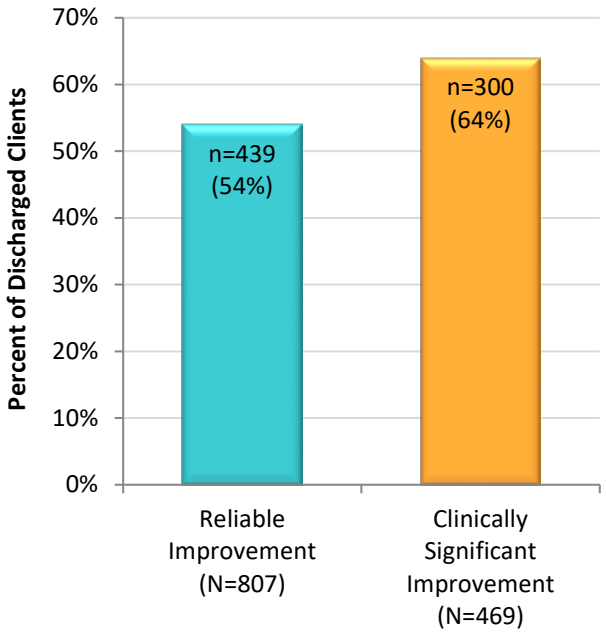


PSC Reliable and Clinically Significant Improvement from Intake to Discharge

FSP Parent/Caregiver



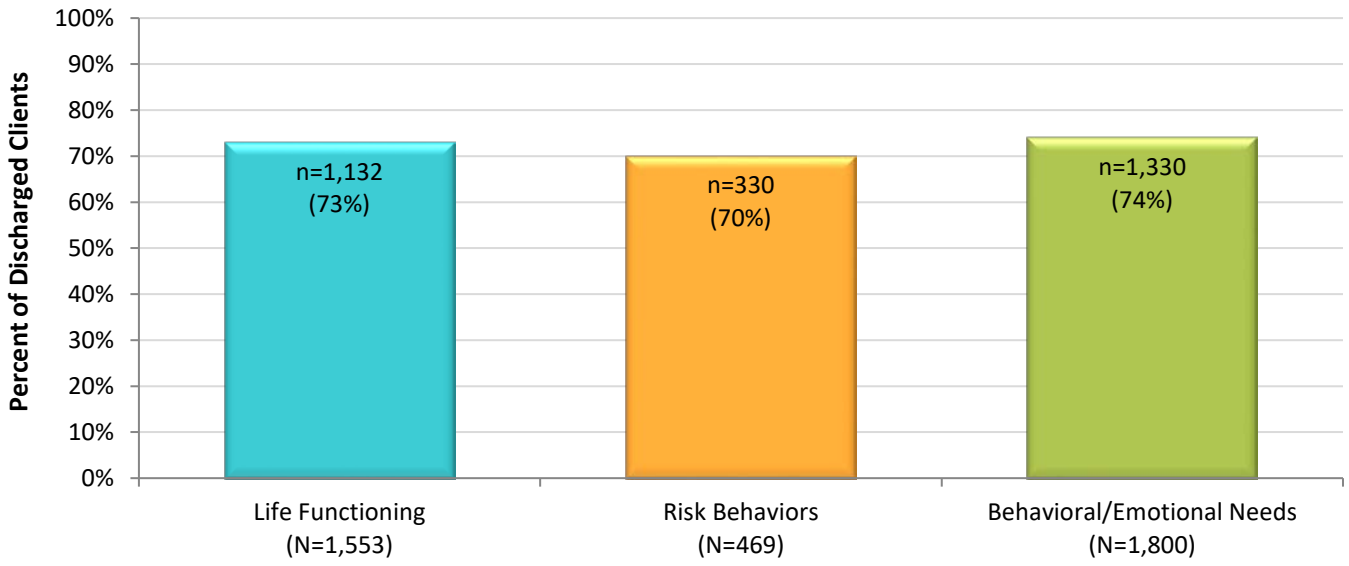
FSP Youth



Are Children Getting Better? (continued)

FSP CANS Scores

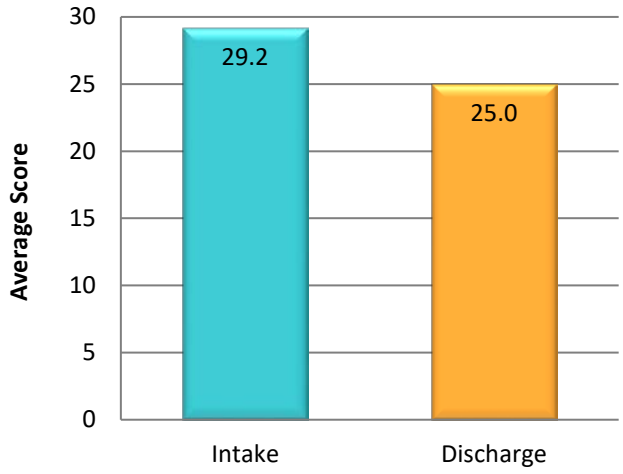
The CANS is a structured assessment, completed by clinicians for clients ages 6 through 21, to identify youth and family strengths and needs. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge in one of the three CANS domains: Life Functioning, Risk 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 PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their SUD counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 27 discharged clients in FY 2018-19.

PESQ Severity Scale (N = 27)



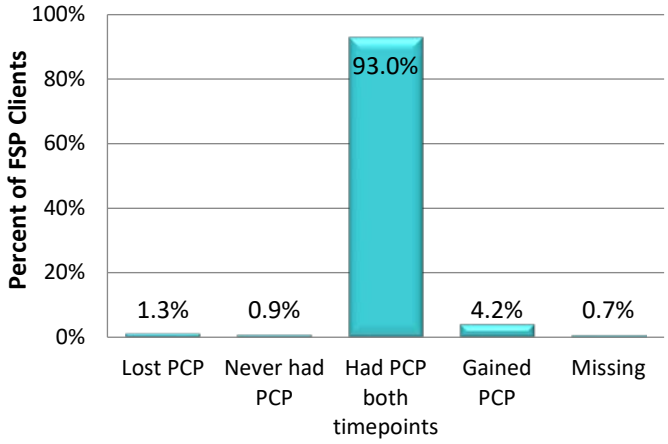
PESQ Clinical Cutpoint

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.

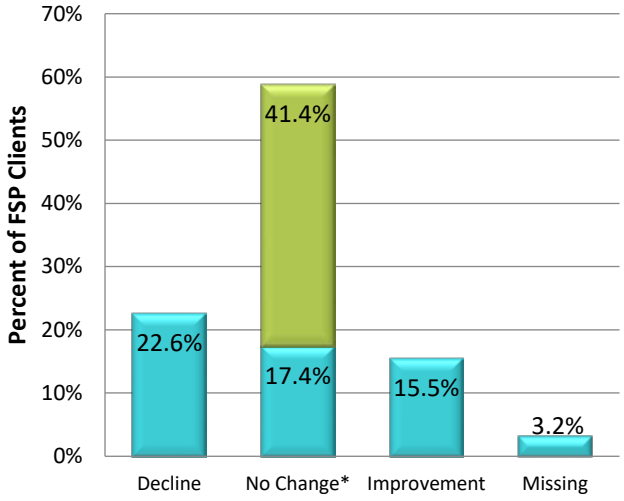
Primary Care Physician (PCP) Status (N = 4,679)

93% of FSP clients had and maintained a PCP.



School Attendance (N = 4,679)

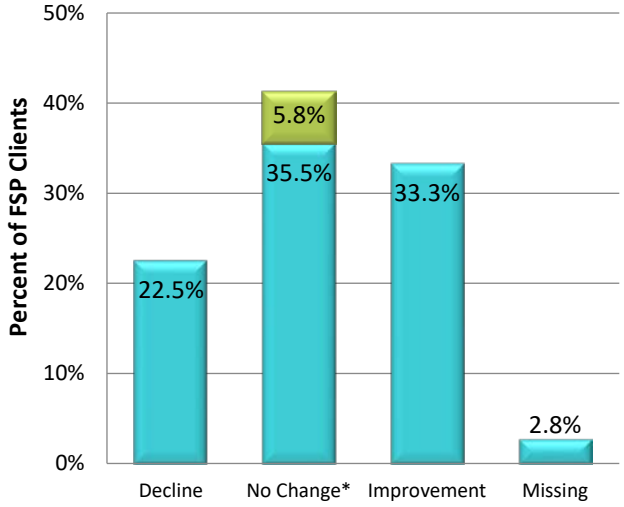
57% of FSP clients either improved (16%) or maintained excellent (41%) school attendance at follow-up assessment as compared to intake.



**Of the 59% of clients for whom no change was noted, 41% (green portion of bar) had consistently excellent attendance (intake and discharge assessments indicated the most positive category for school attendance).*

Academic Performance (N = 4,679)

39% of FSP clients either improved (33%) or maintained excellent (6%) grades at follow-up assessment as compared to intake.



**Of the 41% 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?

- 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. 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.
- More than half of youth FSP clients either improved or maintained excellent school attendance during their participation in FSP programs.

Next Steps

- FSP programs should continue to work with schools so that youth FSP clients can improve academic performance.

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.

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

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix J
Annual System-wide Assertive Community Treatment (ACT) Report FY 2018-19 - Adult

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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 20 ACT programs* in San Diego County during fiscal year (FY) 2018-19.

- 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

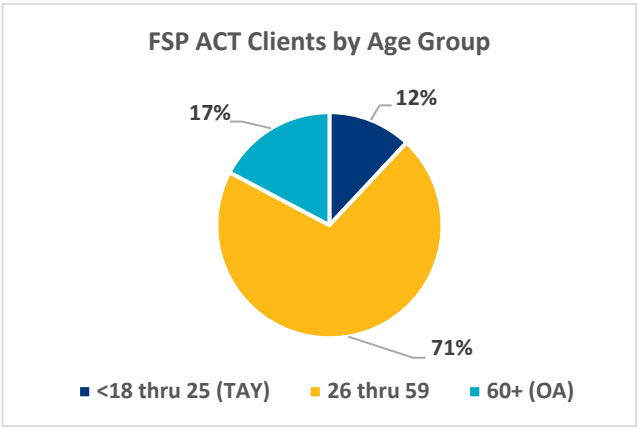
  were retrieved from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) system used by FSP programs across the State of California.
- Recovery outcomes and progress toward recovery were obtained from the County of San Diego's Mental Health Outcomes Management System (mHOMS).

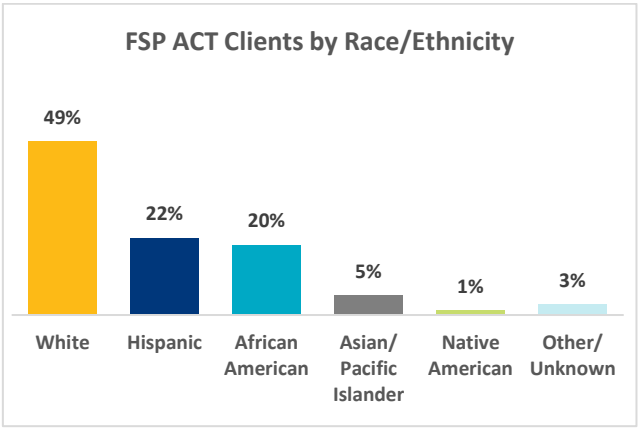
*Data from the following programs are included in this report (program name and sub-unit): CRF Downtown IMPACT (3241, 3244, 3245), Telecare Gateway to Recovery (3312), Telecare Project 25 (3315), Telecare LTC (3331), MHS North Star (3361, 3364), CRF IMPACT (3401, 3404), MHS Center Star (3411, 3413, 3414), 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).

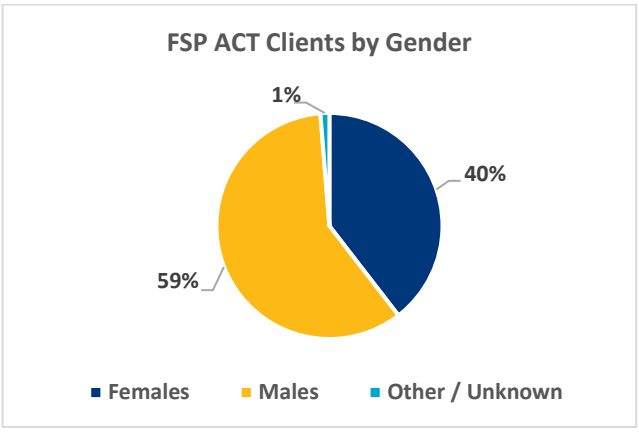
Note: Due to rounding, percentages in this report may not sum to 100%.

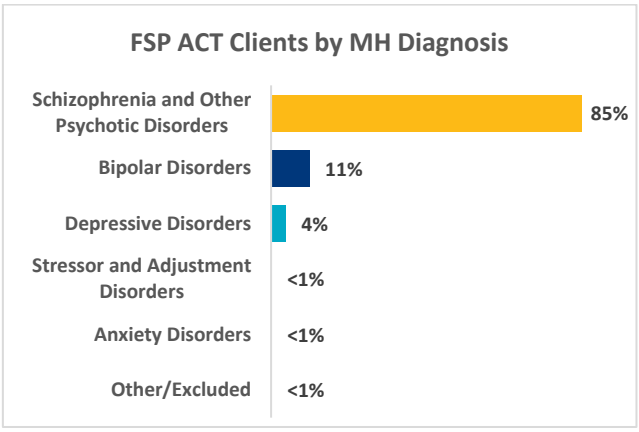
Demographics and Diagnoses

During FY 2018-19, 2,886 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (71%), a majority were male (59%), and the vast majority had a primary mental health diagnosis of schizophrenia or a psychotic disorder (85%). The next most common primary mental health diagnosis among FSP ACT clients served during the fiscal year was bipolar disorders (11%). In addition to their primary mental health diagnosis, 82% of FSP ACT clients served during FY 2018-19 had a history of substance use disorder. Almost half of FSP clients who received services from ACT programs during this period were White (49%), and approximately one-fifth each were Hispanic (22%) or African American (20%).

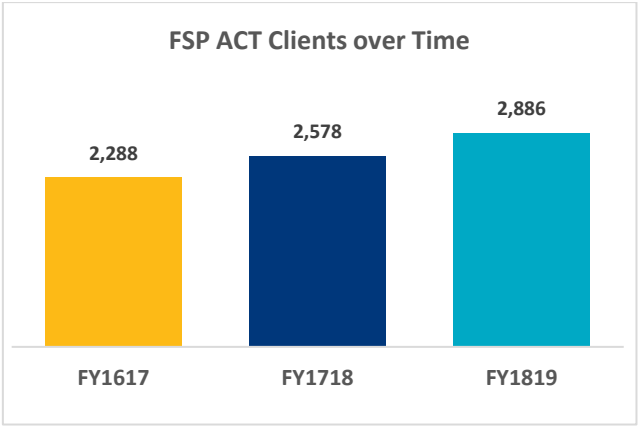








Since FY 2016-17, there have been approximately 300 additional FSP clients served by ACT teams each year. These additional clients reflect a 26% increase in the number of FSP clients served by ACT programs since FY 2016-17. The distribution of the key demographics highlighted above among FSP ACT clients served during FY 2018-19 is similar to the demographics of the clients served by these programs during the previous two fiscal years.



Meeting FSP ACT Clients' Basic Needs*

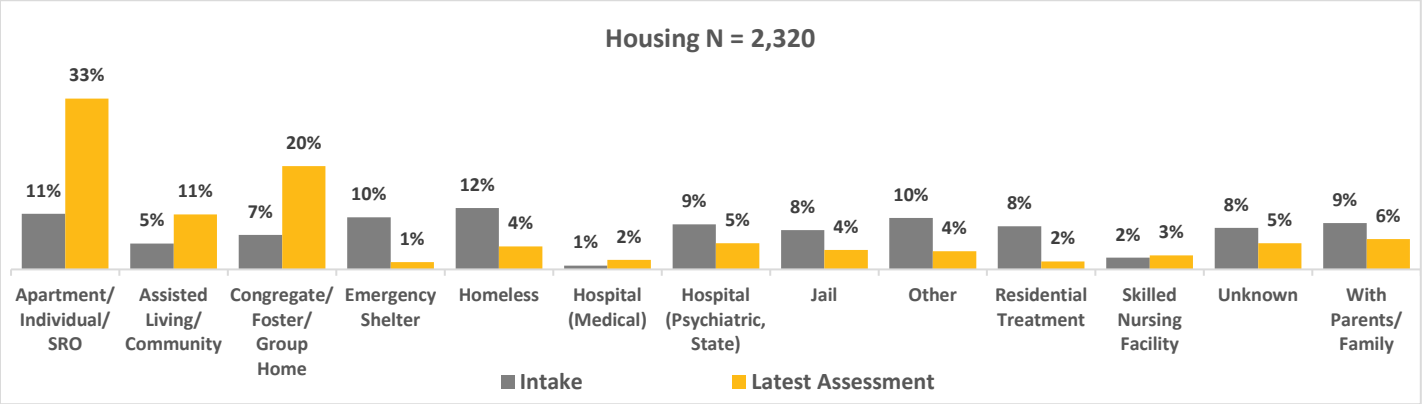
Housing

During FY 2018-19, FSP clients served by ACT programs showed progress in several areas of basic needs. Compared to intake, three times as many clients were living in an apartment/individual/single room occupancy (SRO) setting at the time of their latest assessment (11% at intake versus 33% 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 (20%) and the proportion of clients living in an assisted living or community setting more than doubled from intake (5%) to the latest assessment (11%).

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 only 1%, the proportion of clients reporting a psychiatric hospital as their residence decreased from 9% to 5%, and the proportion of homeless clients decreased by two-thirds from intake (12%) to latest assessment (4%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment/individual/single room occupancy** (SRO) setting **tripled** from intake (11%) to latest assessment (33%).
- The proportion of **clients** housed in an **emergency shelter decreased** from 10% at intake to only 1% at the latest assessment.
- The proportion of **homeless clients decreased** by **two-thirds** from intake (12%) to latest assessment (4%).



Employment

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

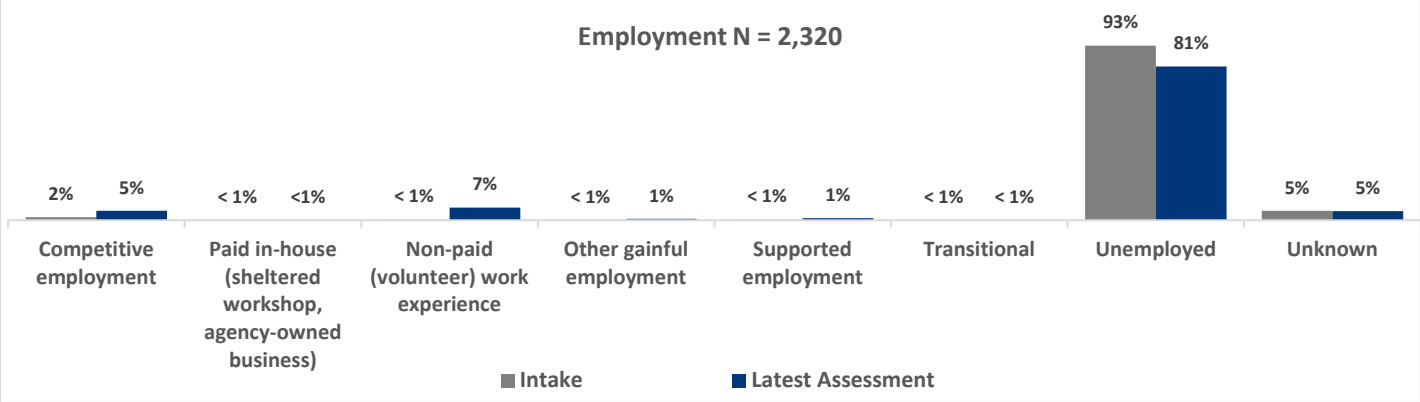
While most clients remained unemployed at the time of the latest assessment (81%), there was a 12% reduction in the number of clients that were unemployed at the latest assessment (1,889 clients) compared to intake

Key Findings: Employment

- There was a 12% **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.

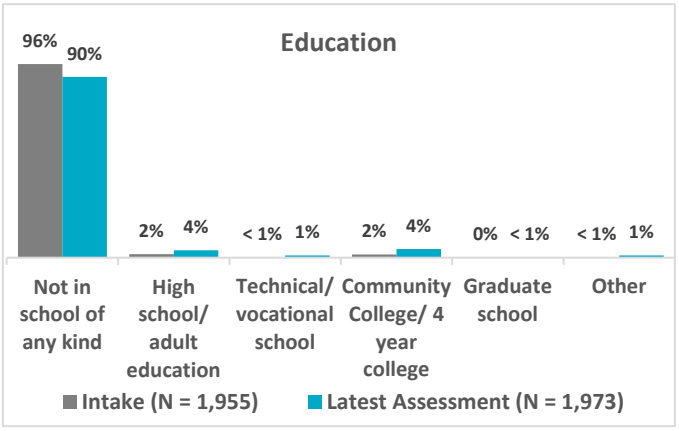
*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2018-19, as of the 12/2019 DHCS DCR download.

(2,148 clients). The most notable increase in employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (7 clients at intake compared to 155 clients at the latest assessment). Additionally, there were roughly three times as many FSP ACT clients employed in competitive settings at the time of the latest assessment (116 clients) compared to the number employed at intake (38 clients). Similarly, there were about three times as many FSP ACT clients working in supported employment settings at the time of the latest assessment (25 clients) compared to intake (8 clients). Lastly, while only one client was employed in another gainful employment setting at intake, 19 clients were employed in this setting at the time of the latest assessment.



Education

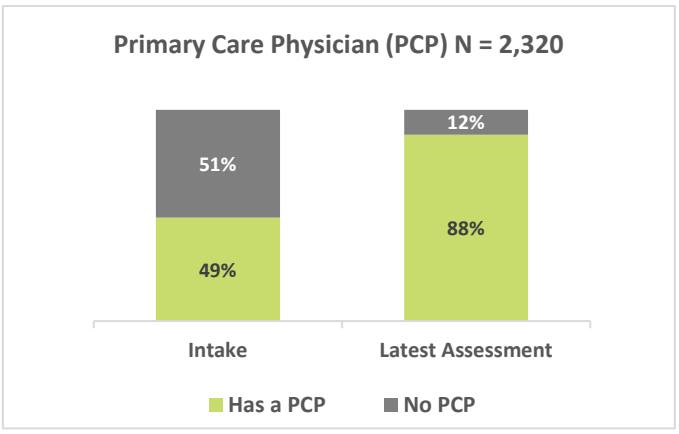
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 1,955 FSP ACT clients with education information available at intake[†], 77 (4%) were enrolled in an educational setting. At the time of the latest assessment, 203 of the 1,973 FSP ACT clients with educational information available (10%) 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 and those enrolled in high school or adult education (2% at intake versus 4% at the latest assessment for both settings) compared to other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2018-19, there was a large increase in the number and proportion of clients who had a primary care physician at the time of the latest assessment compared to intake. Slightly less than half (49%; 1,136 clients) had a primary care physician at intake, while a majority (88%; 2,048 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 2018-19 were similar to those observed during previous fiscal years.



[†]Education information was missing for 365 clients at intake, and 347 clients at the time of the latest assessment.

Changes in Service Use and Setting

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

FSP 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), Crisis Residential (CR), and services provided at the psychiatric hospital. Overall, utilization of these types of services decreased by more than half (53%) from pre- to post-assessment during FY 2018-19. 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 (77% and 65%, respectively, compared to reductions of 17% to 31%).

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 **CR** services per client **remained relatively stable** among FSP ACT clients from pre to post assessment.

Similar to the reduction in overall emergency service utilization, there was a 44% 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 (77%) and services at the psychiatric hospital (56%). The number of clients who received a PERT service decreased by 32% from pre- to post-assessment and the number of clients who received a CS or a UO service decreased by 16% and 15%, respectively, from pre- to post-assessment. A reduction in the mean number of emergency services per client was also observed from pre- to post-assessment (16%) with the most notable reductions observed among those receiving services from the CS (16%) and psychiatric hospital levels of care (20%).

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2018-19 were similar to reductions in utilization observed among this population during FY 2016-17 and FY 2017-18. CS and CO services were new levels of care that were introduced in FY 2015-16, and there was an expected initial increase in utilization of these services during FY 2016-17 and FY 2017-18. CO was renamed to UO in FY 2018-19 to more accurately reflect the types of services provided at that level of care.

	# OF SERVICES			# OF CLIENTS*			MEAN # OF SERVICES PER CLIENT		
Type of Emergency Service	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
CS	298	209	-30%	147	123	-16%	2.03	1.70	-16%
UO†	334	277	-17%	158	134	-15%	2.11	2.07	-2%
PERT	506	351	-31%	311	213	-32%	1.63	1.65	1%
Crisis Residential	567	131	-77%	316	73	-77%	1.79	1.79	0%
Psychiatric Hospital	1,348	468	-65%	491	214	-56%	2.75	2.19	-20%
Overall	**3,053**	**1,436**	**-53%**	**668**	**372**	**-44%**	**4.57**	**3.86**	**-16%**

**The overall number of clients at Pre (n=668) and Post (n=372) 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=1,118) had an enrollment date ≤ 7/1/2018 and discontinued date (if inactive) > 7/1/2018. 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 10/2018 CCBH download. The 12/2019 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 (63% 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 (92% reduction) and the number of clients who resided in a state hospital (94% reduction). Notable reductions were also observed in the number of days (71% reduction) and the number of clients (65% 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 over a one and half times increase (155%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 42% 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, the rates of change between pre- and post-assessment for each type of restrictive setting during FY 2018-19 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 decreased by 65% from pre to post during FY 2017-18, but increased by 32% during FY 2018-19. This phenomenon can be explained by the fact that during FY 2018-19 the number of FSP ACT clients residing in a state hospital decreased by a greater proportion from pre to post than the total number of days clients spent in a state hospital. During FY2017-18, the opposite was true. This scenario is also noted in 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 2017-18.

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**, **state hospital**, and **jail/prison** settings **increased** from pre- to post-assessment while the mean number of days per client in **long-term care** 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	30,720	18,636	-39%	315	154	-51%	97.52	121.01	24%
State Hospital	7,313	579	-92%	50	< 5	-94%	146.26	193.00	32%
Long-Term Care	65,387	19,209	-71%	235	82	-65%	278.24	234.26	-16%
Overall	**103,420**	**38,424**	**-63%**	**559**	**233**	**-58%**	**185.01**	**164.91**	**-11%**
Acute Medical Hospital	3,610	9,193	155%	171	242	42%	21.11	37.99	80%

**The overall number of clients at Pre (n=559) and Post (n=233) 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.*

Note: Clients in this analysis (n=1,640) had an enrollment date ≤ 7/1/2018 and discontinued date (if inactive) > 7/1/2018. Clients had to be active throughout the fiscal year to be included.

[§]Data source: DHCS DCR 12/2019 download; 12-month pre-enrollment DCR data rely on client self-report.

Measuring Progress Towards Recovery**

Overall Assessment Means for Assessments 1 and 2

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

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

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

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

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

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

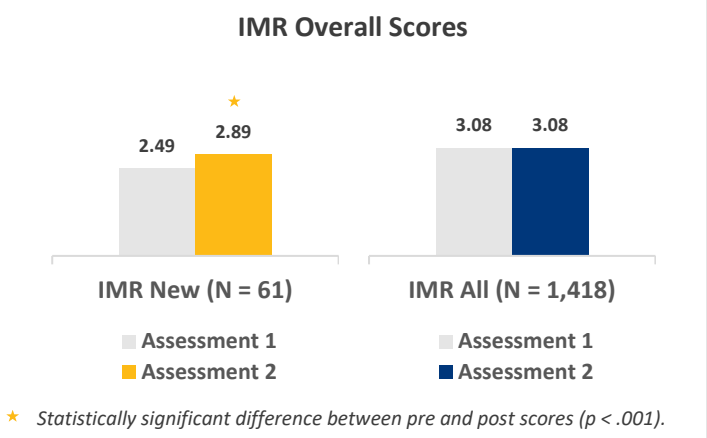
- **New** clients are defined as those who:
  1. began receiving ACT services in 2018 or later,
  2. had two IMR or RMQ assessments during FY 2018-19 (assessments 1 and 2),
  3. had a first service date within 30 days of their first IMR assessment.
- **All** clients include every FSP ACT client with at least two IMR or RMQ assessments during FY 2018-19 (assessments 1 and 2), regardless of the length of FSP services from ACT programs.

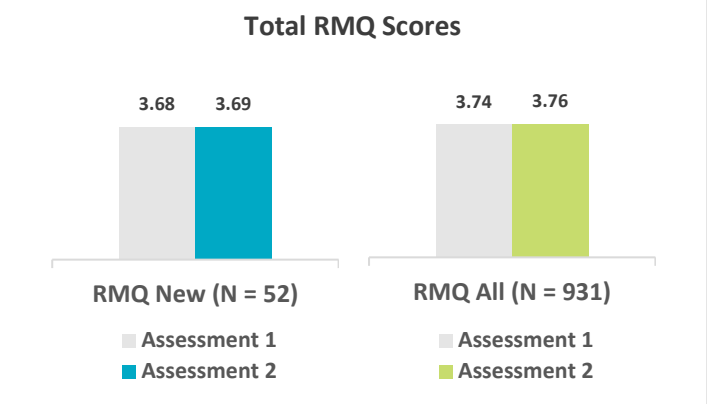
Clients receiving FSP services from ACT programs are generally reassessed on these IMR and RMQ measures every six months to measure progress towards recovery. In general, assessment scores for New clients tend to more directly demonstrate the effect of FSP ACT services on client outcomes because All 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. Overall IMR assessment 2 mean scores were significantly higher than overall IMR assessment 1 mean scores for New clients ($p < .001$).

There was not a significant difference between overall IMR assessment scores for All clients. A lack of observed change in scores for All clients may be due to the inclusion of clients receiving services from FSP ACT programs for several years in the analysis. 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 did not reach statistical significance for either group of 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.





** Outcomes data are sourced from mHOMS FY 2018-19; Data include all mHOMS entries as of 3/10/2020 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2018-19, 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, New FSP ACT clients had significantly higher mean Recovery and Management subscale scores ($p < .001$) at assessment 2 than they did at assessment 1. These data suggest that New clients made significant progress towards recovery and were better able to manage their symptoms from assessment 1 to assessment 2. Changes between assessment scores on the Recovery and Management subscales among All FSP clients were not statistically significant, suggesting that on average, these clients maintained their recovery and symptom management between assessments.

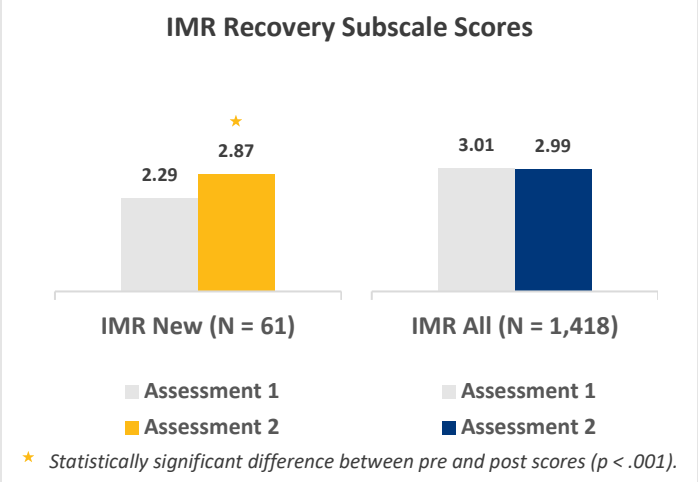
Key Findings: Assessment Outcomes

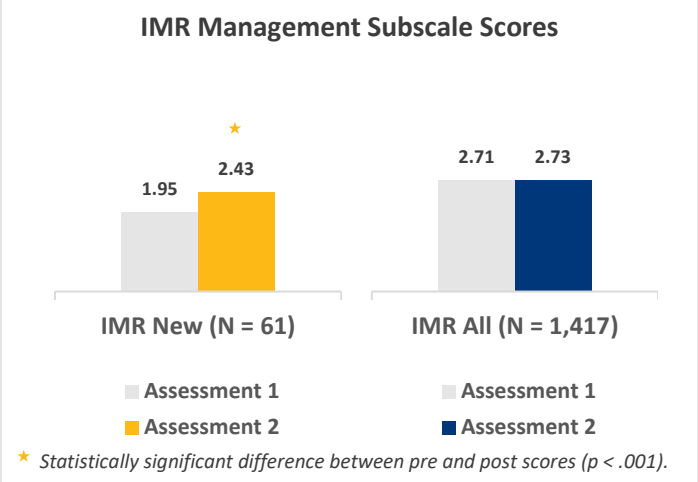
- Mean **Overall IMR** scores were **significantly higher** at the latest assessment compared to the first assessment for **New** clients.
- Mean **Recovery** and **Management** subscale scores were **significantly higher** at the latest assessment compared to the first assessment for both **New** clients.
- Mean **Substance Use** subscale scores were **significantly lower** at assessment 2 compared to the assessment 1 for **New** clients.
- Differences in mean **Overall IMR** scores and **IMR subscale** scores were **not statistically significant** between assessments for **All** clients.
- RMQ ratings suggest that both **New** and **All** clients rated their progress higher than clinicians did.

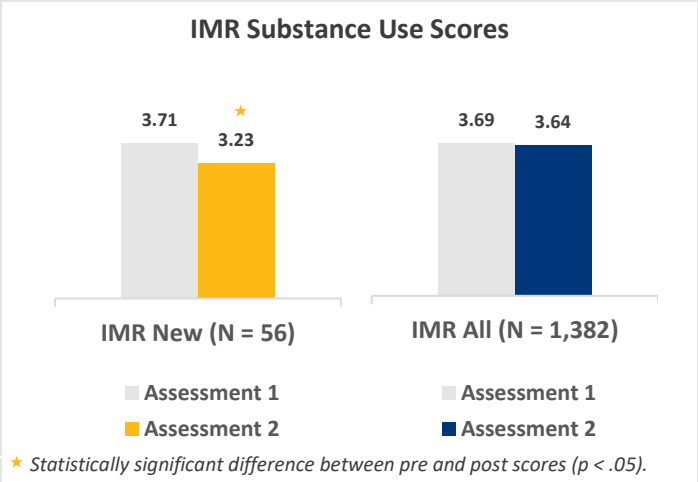
Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or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

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

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.

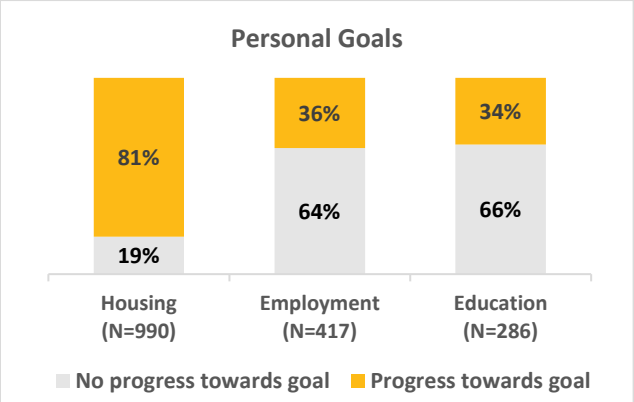






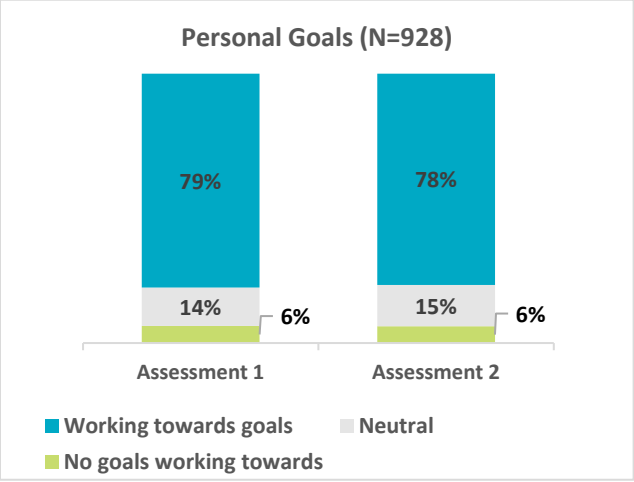
Progress Towards Key Treatment Goals

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 2017-18, most FSP ACT Clients served during FY 2018-19 with a completed Goal assessment (990 clients; 90%) had a goal related to housing on their treatment plan. Of these clients, clinicians reported that 81% made progress towards their individual housing goal at the time of the latest assessment. Fewer FSP ACT clients had goals related to employment (417 clients; 38%) or education (286 clients; 26%) on their treatment plan, compared to the number with housing related goals. Additionally, about one-third of clients with goals related to employment or education made progress towards their goals at the time of the most recent assessment (36% and 34%, respectively). 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 (78%) agreed or strongly agreed that they had a goal (or goals) they were working towards. At assessment 1, 14% of clients reported they were "neutral" about working towards goals, compared to 15% at assessment 2. Only 58 FSP ACT clients (6%) disagreed or strongly disagreed with the statement that they were working towards achieving goals at the time of the latest assessment. Responses to this RMQ item were unavailable for three clients at both assessments. Figures reported in 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.

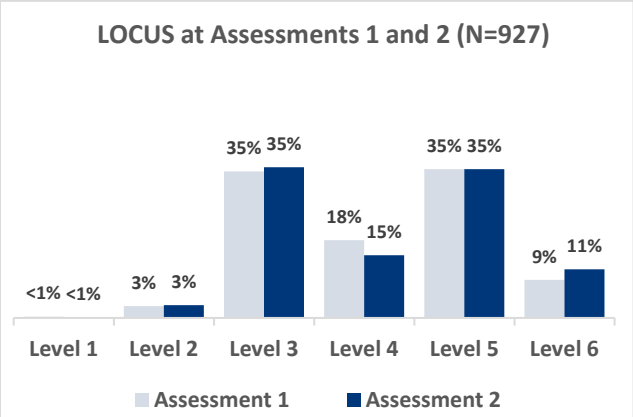
In the LOCUS, levels of care are viewed as levels of resource intensity. Lower numbered levels correspond with lower intensity resources and services.

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

Key Findings: Goals and LOCUS

- **Most** 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** (81%) **made progress** towards that goal by assessment 2.
- **Most** clients (78%) 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 3** or **Level 5** treatment setting at both times points.



Similar to LOCUS results from previous fiscal years, the greatest proportion of FSP ACT clients were recommended for high-intensity community-based services (Level 3) and medically monitored residential services (Level 5) by clinicians at both assessment time points (35% for both Levels at both time points).

A slight 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 slight increase in the proportion of clients recommended for medically managed residential services (Level 6) was observed between assessments.

Conclusion

With the addition of several new FSP ACT programs within the San Diego County Behavioral Health System of Care during the past few years, there has been increased interest in learning more about the impact of these programs on clients' service use and outcomes. The FSP ACT model aims to serve homeless clients with severe mental illness, as evidenced by the vast majority of clients served during FY 2018-19 with 1) a housing-related goal (90%), 2) a diagnosis of schizophrenia or psychotic disorder (85%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 62% at intake).

Similar to trends reported from previous fiscal years, FSP ACT clients served during FY 2018-19 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 (11%) to latest assessment (33%); the proportion housed in an emergency shelter decreased from 10% at intake to 1% at the latest assessment; and the proportion of homeless clients decreased from 12% at intake to 4% at the latest assessment. There was also a 12% reduction in the number of clients unemployed at the latest assessment compared to intake, and an 80% 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 53% 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 (63% 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 2018-19, 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.

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix K
Housing Update Executive Summary

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

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Executive Summary

Housing is a critical resource for achieving health and wellness, particularly for people with limited means who struggle with behavioral health issues. This Behavioral Health Strategic Housing Plan, as updated, provides a framework for current housing needs and outlines the planning process for the implementation of the Plan's Goals that maximize housing options for people with behavioral health issues in San Diego County.

The initial Plan was finalized in 2014 and included a robust stakeholder process that included input from consumers, service providers, housing developers and operators, and funders of housing and services. Annual updates to the Plan include policy, legislative and financial resource updates, as well as updated feedback from consumers in the form of Housing Council discussions, focus groups with clients, stakeholder check-ins and surveys. Throughout the Plan, we analyze the importance of housing in achieving recovery, while mapping out local housing needs as well as the resources and tools available to meet those needs. The Plan also specifically recognizes the importance of the Mental Health Services Act (MHSA) in transforming the range of housing and services options to those who were previously unserved or under-served in our communities, as well as recognizing the significant accomplishments in meeting present goals. The specific Plan Goals, as identified in the original Behavioral Health Strategic Housing Plan are to:

1. Expand Inventory of Affordable and Supportive Housing
2. Increase Access to Independent Living Options
3. Provide Opportunities to "Move On" To More Independent Housing Options
4. Expand Opportunities to Increase Income (Employment and Benefits)
5. Lessen Isolation and Keep People Connected to Their Communities
6. Develop Improved Data Collection and Analysis Capacity

The Plan then defines the key strategies and activities that have been implemented to achieve these goals as well as the process to be used to evaluate and update the Plan on an annual basis, creating a living document that reflects and responds to the changing housing and services environment in San Diego from year to year.

This update includes current information regarding a variety of housing and services options for people with behavioral health issues in San Diego County. In particular, this Plan update outlines progress on the opportunity to create significant new supportive housing options under the No Place Like Home initiative.[1] This document also provides narrative related to COVID-19 and its unprecedented potential detrimental impacts on the behavioral health system, as well as the development and/or operation of affordable and supportive housing. The COVID-19 pandemic creates an opportunity for discussion and consideration of housing policy changes that may be needed to keep vulnerable populations healthy and safe in the future by mitigating the harm caused by intense economic disruption resulting from the urgent public health crisis. Housing policy directly impacts health and well-being, and this Plan update outlines the importance of enhancing our current ability to serve our most vulnerable populations in more effective and efficient ways as we respond to the COVID-19 crisis.

[1] http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix L
Prevention and Early Intervention (PEI) System-wide Summary

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

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CHILD & ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2018—2019 ANNUAL REPORT

The Mental Health Services Act 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, and youth and transition age youth (TAY) and their families. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by the program via outreach efforts, including but not limited to: presentations, community events, and fairs.

DATA: Child and Adult PEI Programs

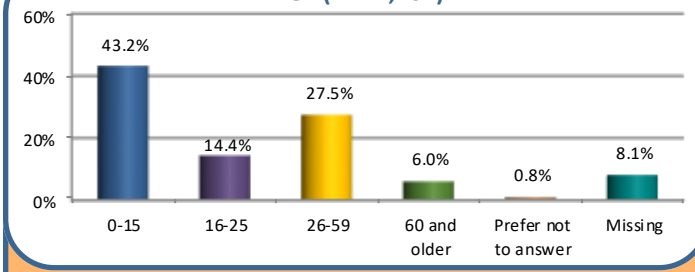
REPORT PERIOD: 7/1/2018-6/30/2019

NUMBER OF PARTICIPANTS WITH DATA IN FY 2018-19: 41,164 (Unduplicated)*†‡

**Data for all students participating in the HERE Now Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.*
†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 presented in this report: (N=41,164 vs. N=21,064).
‡All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.

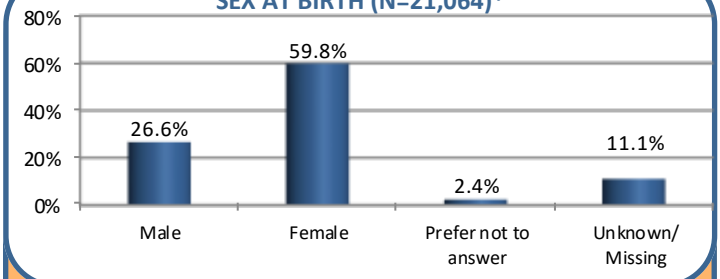
PARTICIPANT SYSTEMWIDE DEMOGRAPHICS

AGE (N=41,164)



Forty-three percent of participants were under the age of 16, and twenty-eight percent were between the ages of 26-59.

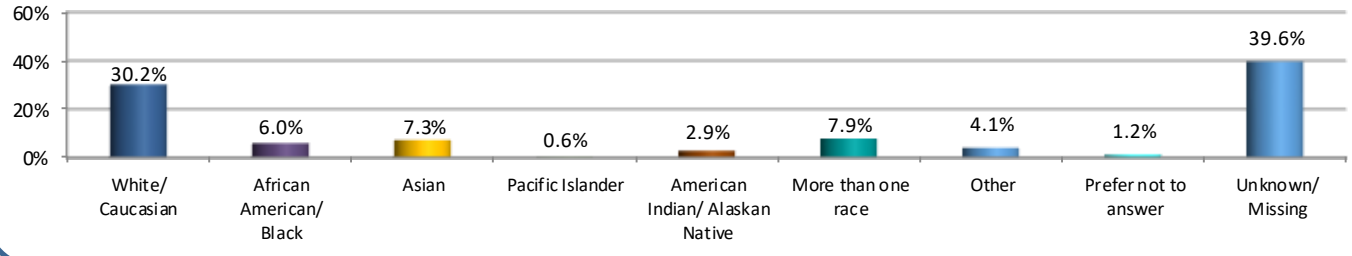
SEX AT BIRTH (N=21,064)*



Sixty percent of participants identified their sex at birth as female.

** Not all programs are required to collect data for every indicator, which accounts for the lower denominator (N=21,064 vs N=41,164).*

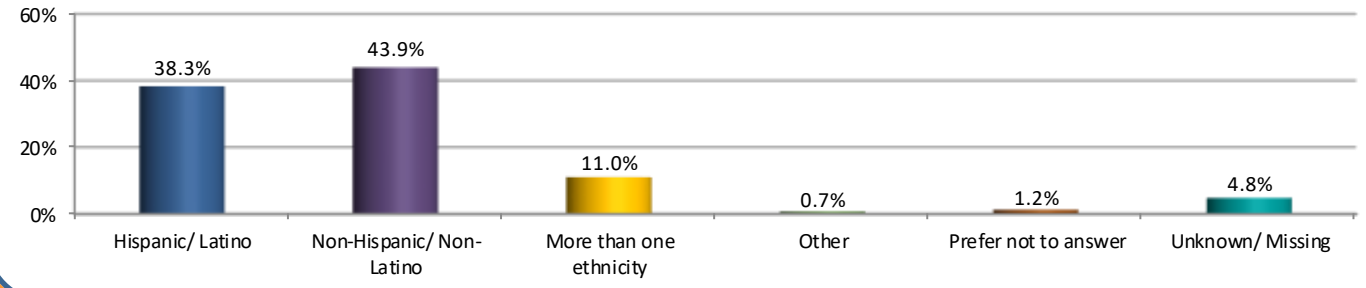
RACE (N=41,164)



Thirty percent of participants identified their racial background as White/Caucasian. Eight percent of participants identified as having more than one racial background and seven percent of participants identified as Asian. The percentage of un-known/missing includes clients who only endorsed being Hispanic/Latino and did not indicate a racial category.

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

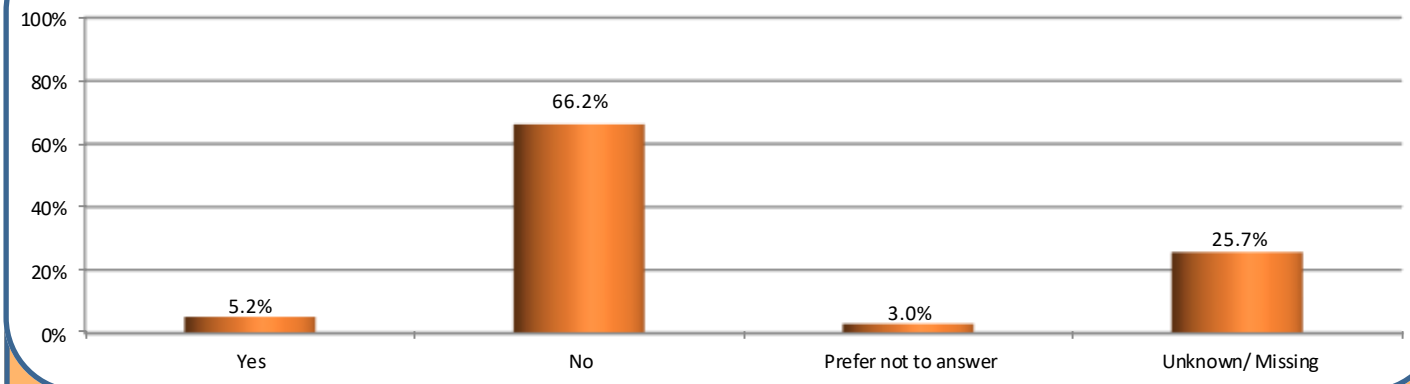
ETHNICITY (N=41,164)



Nearly forty-four percent of participants identified their ethnic background as non-Hispanic/ non-Latino. Thirty-eight percent of participants identified their ethnic background as Hispanic/Latino.

MILITARY SERVICE

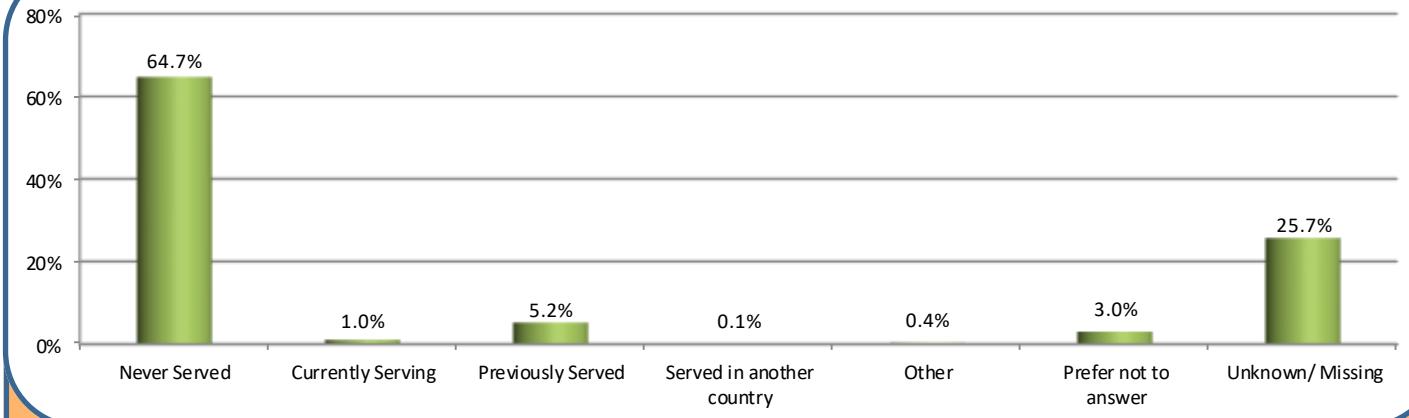
VETERAN STATUS (N=21,064)*



Information on veteran status indicated more than five percent of participants had 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=21,064 vs N=41,164).*

MILITARY STATUS (N=21,064)*

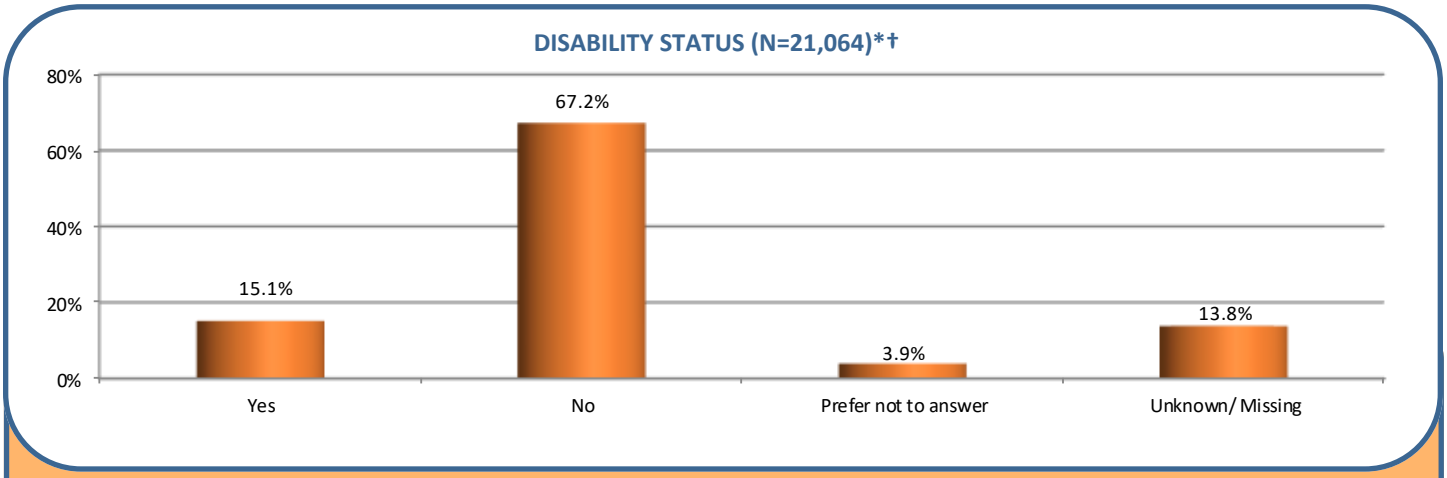


Nearly sixty-five percent of participants had never served in the military. One percent of participants indicated they are currently serving in the military and over five percent indicated they had previously served in the military.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=21,064 vs N=41,164).*

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

DISABILITY STATUS



Fifteen percent of participants reported having a disability. Four percent of participants preferred to not answer this question.

**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.*

†Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=21,064 vs N=41,164).

DISABILITY (N=21,064)*†‡	Count	%
Difficulty seeing	755	3.6
Difficulty hearing or having speech understood	381	1.8
Mental disability not including mental illness	830	3.9
Learning disability	404	1.9
Developmental disability	92	0.4
Physical/ Mobility disability	822	3.9
Chronic health condition/ Chronic pain	1,234	5.9
Dementia	79	0.4
Other communication disability	106	0.5
Other mental disability not related to mental illness	255	1.2
Other disability	434	2.1
No disability	14,160	67.2
Prefer not to answer	832	3.9
Unknown/ Missing	2,899	13.8

Over sixty-seven percent of the participants indicated no disability. Nearly six percent of participants indicated having a chronic health/chronic pain condition. Approximately four percent of participants each indicated having a physical/ mobility disability, a mental disability not including mental illness, or difficulty seeing.

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

†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.

‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=21,064 vs N=41,164).

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

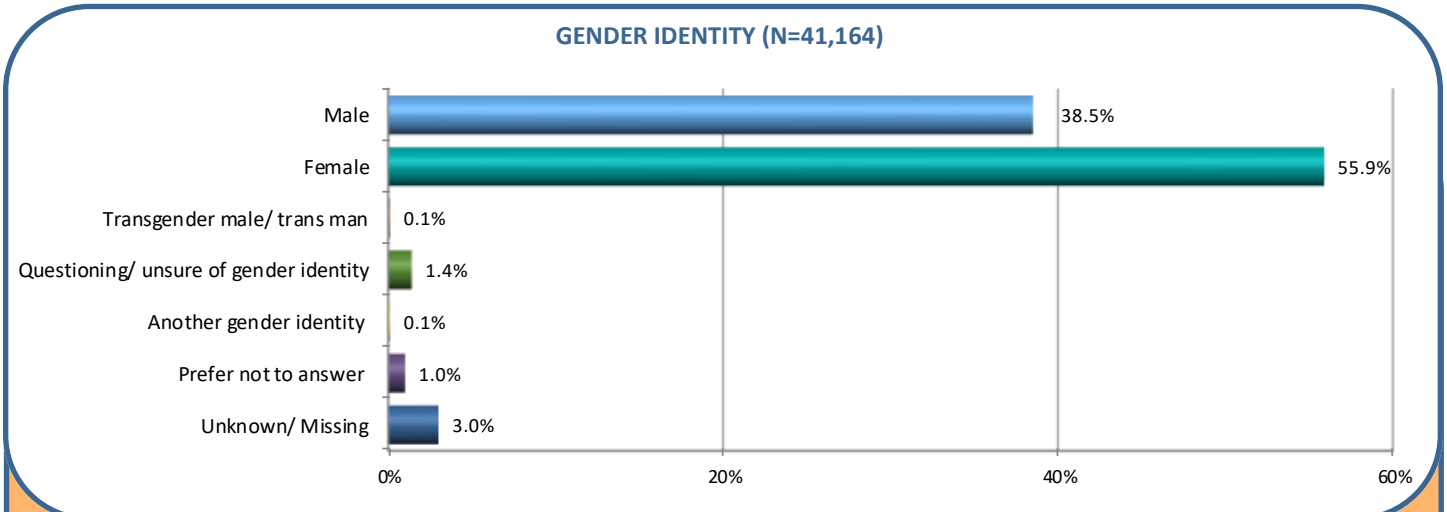
PARTICIPANT LANGUAGE

PRIMARY LANGUAGE (N=21,064)*	N	%
English	9,238	43.9%
Spanish	7,418	35.2%
American Sign Language	66	0.3%
Arabic	666	3.2%
Armenian	27	0.1%
Cantonese	11	0.1%
Farsi	47	0.2%
French	20	0.1%
Hebrew	18	0.1%
Mandarin	14	0.1%
Tagalog	137	0.7%
Vietnamese	75	0.4%
Other	757	3.6%
Prefer not to answer	254	1.2%
Unknown/ Missing	2,316	11.0%

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

** Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 21,064 vs N=41,164).*

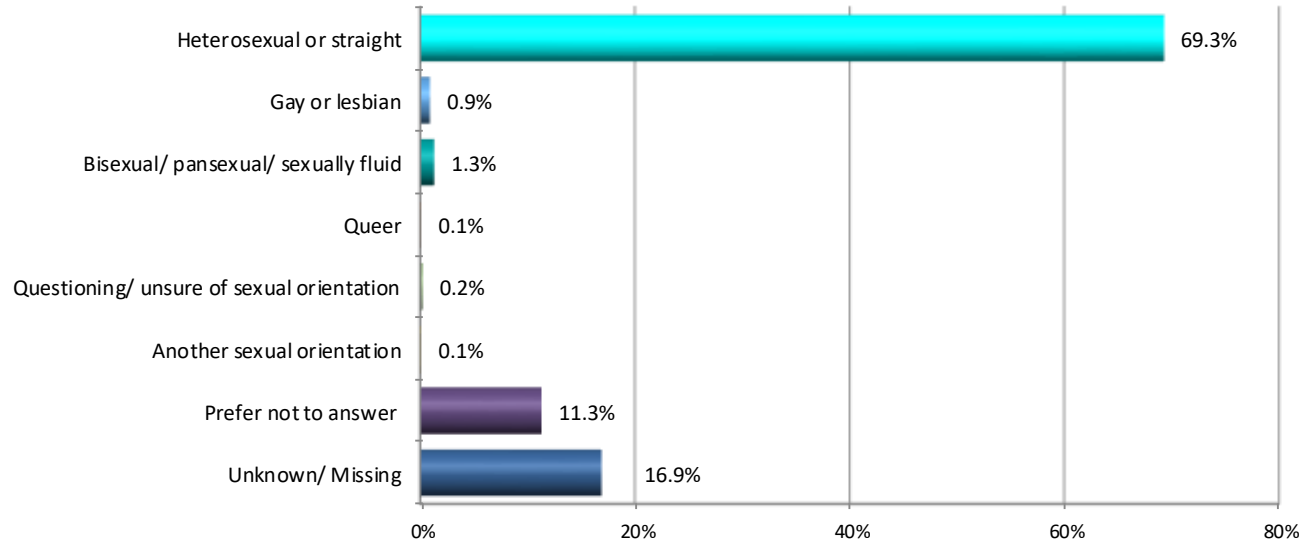
GENDER IDENTITY



Fifty-six percent of the participants identified as female. Thirty-nine percent of participants identified as male.

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

SEXUAL ORIENTATION (N=21,064)*

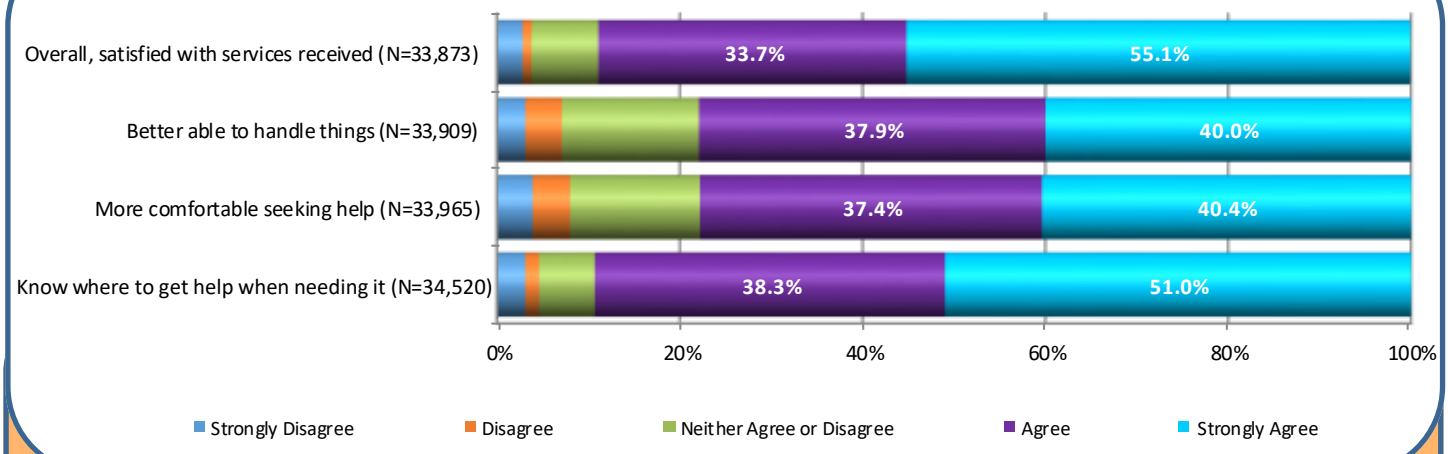


Sixty-nine percent of the participants identified their sexual orientation as heterosexual/straight. Approximately one percent of participants identified their sexual orientation as bisexual/pansexual/sexually fluid, or gay or lesbian. Eleven percent of participants preferred not to answer this question.

** Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=21,064 vs N=41,164).*

PARTICIPANT SYSTEMWIDE PROGRAM SATISFACTION

PROGRAM SATISFACTION*†



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

**Satisfaction data not available for all participants.*

†Satisfaction data may include duplicate participants.

CHILD AND ADULT PARTICIPANT SYSTEMWIDE REFERRAL TRACKING SUMMARY

In FY 2016-17, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals made by PEI programs and successful linkage to services.

In FY 2018-19, A total of 1,025 participants received a mental health referral, and 374 of these participants successfully received a mental health service as a result of the referral* (Linkage Rate = 36.5%).

A total of 324 participants received a substance use referral, and 157 of these participants successfully received a substance use service as a result of the referral* (Linkage Rate = 48.5%).

The average time between referral and linkage to services was twenty-four days.

**Referral data were not available for all programs.*

The Health Services Research Center (HSRC) at University of California, San Diego is a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the 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.

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

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix M
PEI Components and Priorities

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

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Prevention and Early Intervention Priority Areas Fiscal Year 2020-23

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-02	Mental Health Systems, Inc	Adult Drug Court Treatment and Testing - North						x
CO-02	Mental Health Systems, Inc	Adult Drug Court Treatment and Testing - South						x
CO-02	Mental Health Systems, Inc	Adult Drug Court Treatment and Testing - East						x
CO-02	Mental Health Systems, Inc	Adult Drug Court Treatment and Testing - Central						x
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	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-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

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix N
Innovation Report

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

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FAITH BASED INITIATIVE (INNOVATIONS-13): #1 FAITH BASED ACADEMY

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (1/1/16 - 12/31/18)

The Faith Based Academy was one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) that comprised the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative included improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts were intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the Faith Based Academy included the mutual education of behavioral health providers and faith leaders in order to promote greater understanding of each other as well as the range of resources available to effectively address behavioral health needs.

Two community organizations were selected to provide Faith Based Academy services (Interfaith Community Services and Neighborhood House Association). Each agency was responsible for: 1) developing and refining a structured training curriculum that addressed a range of relevant behavioral health topics (e.g., recognizing mental health conditions, suicide prevention, stigma reduction, the role of faith in recovery, etc.), and 2) hosting multiple Faith Based Academies for faith leaders and behavioral health providers. In addition to representing a unique outreach, engagement, and training mechanism, a primary innovation of the Faith Based Academy was the explicit emphasis on "cross education" of both faith leaders and behavioral health providers such that each group of participants was expected to develop a better understanding of the strengths and resources of the other. This two-way education was intended to improve relationships and reduce uncertainty and stigma between faith communities and behavioral health providers. Participants interested in sharing the information they learned were connected with another Faith Based Initiative organization that utilized these Faith Champions to provide behavioral health-related community education presentations.

EXECUTIVE SUMMARY

The Faith Based Academy was designed to educate faith leaders about behavioral health issues and make behavioral health providers more aware of faith community needs and resources while highlighting the role of faith within treatment and recovery. These objectives were accomplished through the development of a structured, multi-session curriculum that covered a range of behavioral health topics. Faith leaders and behavioral health providers were then recruited to attend and complete the academy.

- A total of 488 persons participated in 25 Faith Based Academies.
- Most (73.2%) participants were between the ages of 26-59 and the majority were female (76.8%). Slightly over half (53.9%) identified as Hispanic/Latino, with 38.1% indicating Spanish as their primary preferred language.
- Faith leaders and behavioral health providers indicated they learned important information and gained confidence by participating in the academy. While enthusiastic overall, behavioral health providers tended to rate aspects of the training slightly less positive than the faith leaders.
- Primary Academy outcomes as reported by participants included: 1) increased knowledge, 2) stronger relationships, and 3) inspiration for initiating actions that reflected and/or furthered faith and behavioral health integration.
- Key factors identified by staff that helped the program achieve its goals included: 1) interactive nature of Academy sessions, 2) well written curriculum, 3) content contributors and presenters with diverse expertise, 4) passionate and organized staff, 5) high quality presentations, and 6) faith leader/behavioral health provider networking opportunities.

FUTURE DIRECTIONS

As a result of the positive pilot study findings for the INN-13 Faith Based Academy, BHS decided to continue financial support for these trainings using ongoing behavioral health funding sources. Future Academies will utilize the curriculum developed during this pilot study and build upon the lessons learned regarding successful delivery of Academy training sessions to foster increased behavioral health provider and faith leader knowledge, awareness, and integration. The Faith Based Academy program will be merged with the INN-13 Community Education program (another INN pilot program) to better coordinate the identification of champions and incorporate them into community education and outreach opportunities.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. *To develop a Faith Based Academy that integrates faith based leaders and clergy with behavioral health providers to support the development of collaborations and partnerships and to support capacity building.*

This objective comprises two distinct program activities: 1) development of the Faith Based Academy (i.e., content and structure), and 2) conducting Faith Based Academies in the community. For the first objective, the selected organizations started with a core set of topics to be covered (as specified by BHS) and then successfully worked with behavioral health professionals and faith leaders to design a detailed curriculum for use in the Academies. The process of developing the curriculum required a significant investment of time on the part of program staff to pull together relevant expertise, create the presentation content, and then refine and synthesize into a cohesive multi-session Academy. A significant challenge was consolidating all required and desired information into a 12-15 hour training Academy. In addition to the curriculum, the programs developed a comprehensive resource list of relevant community organizations.

For the second activity, a total of 488 persons participated in 25 Academies throughout the duration of the MHSA funded INN-13 pilot project phase. Based on available survey responses (n=443), this included 257 persons who primarily identified as faith leaders (FLs) and 186 who primarily identified as behavioral health providers (BHPs). Several different Academy formats were attempted (e.g., separate Academies for faith leaders and behavioral health professionals, 1-2 hours per week for a series of weeks versus full-day sessions over several days, etc.). While modifications and refinement were ongoing, the model that appeared to be most successful was to host Academies with both the target groups attending together over two full day sessions (sometimes with a shorter "kick-off" session the night before the first all-day session). Programs acknowledged challenges with trying to cover the substantial course content while also allowing sufficient time for discussion and engagement to promote shared learning and initial relationship building between faith leaders and behavioral health providers.

Overall, survey results indicated that Academy participants, particularly the faith leaders, learned new substantive information and how to better engage with each other (e.g., make referrals). Based on interviews with faith leaders and behavioral health providers, the primary impacts of Academy participation were: 1) increased knowledge, 2) stronger relationships between faith leaders and behavioral health providers, and 3) the confidence/tools to take further actions after the Academy related to integrating faith and behavioral health. There was much interest in the "alumni" events that brought people together after the initial Academies as well as requests for next steps for ongoing educational and training opportunities.

2. To identify faith based and behavioral health champions to provide ongoing community facilitator trainings.

Champions were identified and some transitioned on to the related MHSA funded INN-13 Community Education program. However, this aspect of the program was more challenging than initially expected due to logistical coordination and communication difficulties between the two separate programs. Additionally, while many persons were eager to share what they learned, they did not have the time or desire to become official champions and work as part of this other organization. Feedback from participants and program staff suggested the development of another version of the champions who would essentially become ambassadors to bring back the information they learned to their own places of worship, work, or other community agencies they interacted with. Based on the experiences of the pilot phase, it was determined to combine the functions of the Faith Based Academy and the Community Education programs into one organization for better coordination.

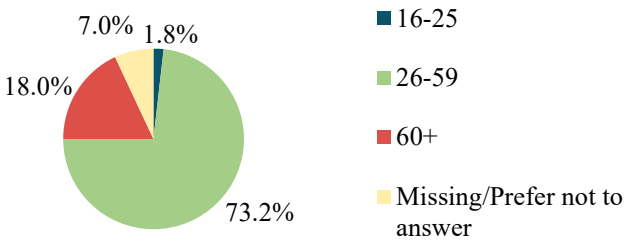
3. To introduce small community based organizations, particularly faith based organizations, to County contracting.

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS

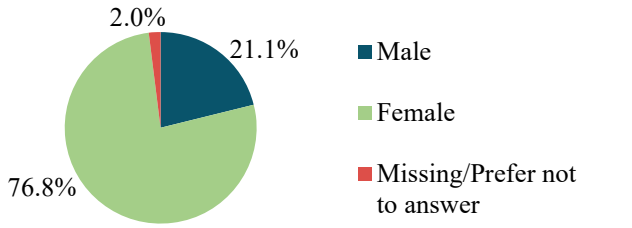
The following self-reported characteristic data were collected from Faith Based Academy participants.[1]

AGE (N=488)



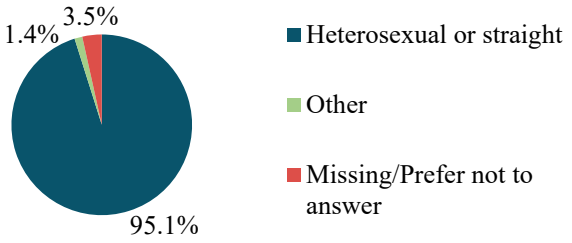
The majority of participants (73.2%) were between the ages of 26 and 59.

GENDER IDENTITY (N=488)



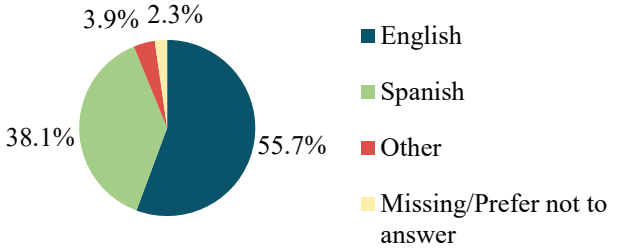
About three-quarters of participants were female (76.8%) and 21.1% of participants were male.

SEXUAL ORIENTATION (N=488)



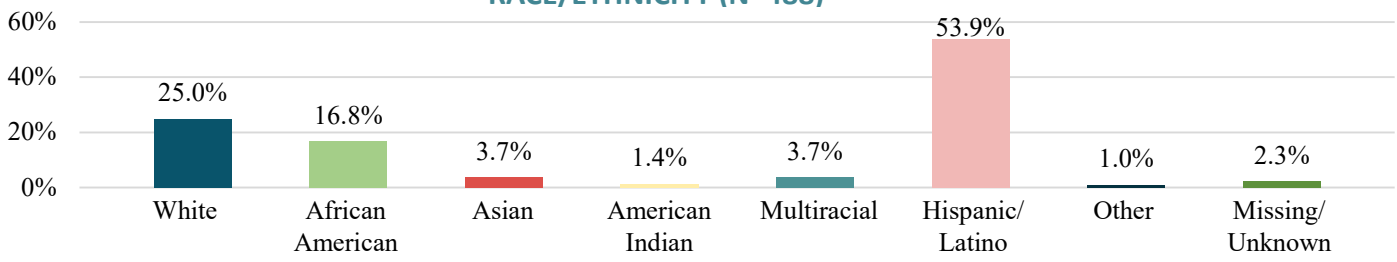
Most (95.1%) participants were heterosexual or straight and 3.5% of participants did not provide a response.

PRIMARY LANGUAGE (N=488)



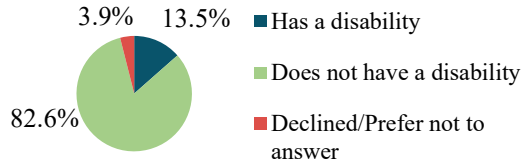
English was the primary language of most participants (55.7%) followed by Spanish (38.1%).

RACE/ETHNICITY (N=488)



Over half of the participants identified themselves as Hispanic (53.9%) with 25% identifying as White. Totals may exceed 100% as participants were able to indicate more than one race/ethnicity.

DISABILITY STATUS[2] (N=488)



13.5% of participants reported having some form of non-SMI related disability.

A little over 5% (6.2%) indicated they had served in the military.

TYPE OF DISABILITY (N=488)

Type	n	%
Communication	23	4.7
Mental (e.g., learning)	15	3.1
Physical	16	3.3
Chronic Health	17	3.5
Other	11	2.3

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

[1] Percentages may not total to 100% due to rounding. [2] A disability was 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 (SMI).

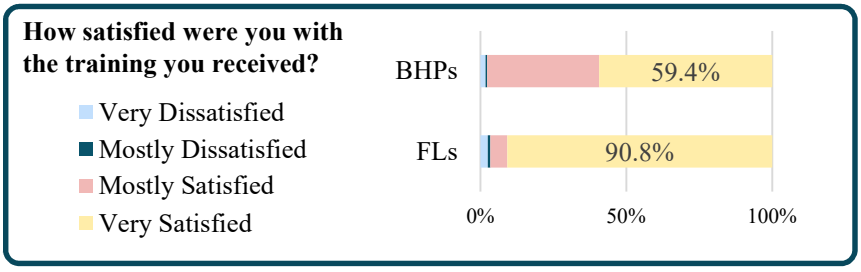
POST-TRAINING SURVEY RESULTS

A total of 443 persons completed a Faith Based Academy training and a post-training survey (257 faith leaders and 186 behavioral health providers). As shown in Table 1, while the ratings regarding the content and impact of the trainings were generally favorable, the mean score differences between the two groups indicated that behavioral health providers may not have felt as informed about how to access or work with faith community resources as faith leaders felt informed about behavioral health issues and resources.

TABLE 1. POST-TRAINING SURVEY

Faith Leaders (FL) (n=257): "As a result of this training…"	*FL* *Means*	*BHPs* *Means*	Behavioral Health Providers (BHPs) (n=186): "As a result of this training…"
I know where to get help regarding mental health conditions and wellness for children/adolescents	4.6	4.2	I know where to access faith community resources for mental health conditions and wellness for chld./adols.
I know where to get help regarding substance abuse conditions and resources for chld./adols.	4.6	4.1	I know where to access faith community resources for substance abuse conditions for chld./adols.
I know where to get help regarding mental health conditions and wellness for adults/older adults	4.6	4.3	I know where to access faith community resources for mental health conditions and wellness for adults/older adults
I know where to get help regarding substance abuse conditions and resources for adults/older adults	4.6	4.1	I know where to access faith community resources regarding substance abuse conditions for adults/older adults
I know better when to refer/recommend someone to receive formal behavioral health services	4.7	4.3	I know better when to refer/recommend someone to faith based behavioral health resources
I am more comfortable discussing mental health and substance abuse issues	4.7	4.3	I am more comfortable talking with faith representatives about integrating spiritual needs and behavioral health care
I know better how to educate members of my faith community about behavioral health services	4.7	4.3	I know better how to educate other behavioral health providers about faith based behavioral health resources
I know better how to reduce the stigma of behavioral health within my faith community	4.7	4.3	I know better how to reduce the stigma of behavioral health within faith communities
I am more confident that rehabilitation and recovery are possible	4.7	4.4	I am more confident that faith communities can help support rehabilitation and recovery
I am more likely to refer/recommend someone to receive formal behavioral health services	4.8	4.5	I am more likely to refer/recommend someone to participate in faith community behavioral health resources
Scale responses: Strongly disagree (1), Disagree (2), Neither agree/disagree (3), Agree (4), Strongly agree (5)			

FIGURE 1. OVERALL TRAINING SATISFACTION



In Figure 1, the majority (90.8%) of Faith Leaders reported being "very satisfied" with the training they received compared to about 60% (59.4%) of Behavioral Health Providers. This is consistent with the slight differences in mean score ratings presented in Table 1.

FAITH LEADER AND BEHAVIORAL HEALTH PROVIDER INTERVIEWS

The following findings were generated from a series of interviews and focus groups conducted with Faith Leaders (n=13) and Behavioral Health Providers (n=11) who previously completed one of the BHS-funded Academies. Where relevant, we indicate if a specific idea or impact was primarily associated with either BHPs or FLs.

In addition to widespread acknowledgement of the importance of bringing together FLs and BHPs, three primary areas emerged regarding how the Academy impacted participants:

1. **Increased Knowledge**
   a. New information about topics of faith, behavioral health, and their integration.
      i. BHPs reported increased understanding of:
         1. The terminology used by the faith community.
         2. The need for integration of faith and behavioral health.
         3. Their own personal beliefs about faith.
         4. How to handle faith oriented discussions with clients.

         "When I first started I didn't have a clue how to discuss [faith] … But as I went on, I saw how important it was to talk about those things when they brought those up, and how it was very healing for them to talk about those things."

      ii. FLs reported learning:
         1. New concepts related to psychology and mental illness.
         2. Increased knowledge of "warning signs" or when someone may need professional help.

         "God can use modern medicine to heal this person. You're limiting God by just praying."

   b. Awareness of community resources.
      i. All individuals reported increased awareness of the resources available in their communities.
      ii. The resource binders were considered particularly useful in identifying community resources.

2. **Stronger Relationships (i.e., "Bridging the Gap")**
   a. Addressing misconceptions.

      "I didn't realize how many mental health providers have a very active faith."

      "*We're at a point now where trust is starting, and so we are able to stand together to work for the common good of our communities that we both want to serve."*

   b. Increased comfort interacting with each other.
      i. Discussions may have been initially uncomfortable, however each person interviewed felt that the resulting understanding of the other group was worth their time.

         "In the grand scheme of things, I believe that it's a good process for the two groups to be together in the same room, be trained together and hear each other's language. There's a lot of differences in the words that we use and how we refer to certain concepts."

         "[The faith leaders] were asking a lot of questions. They were fully engaged and especially when you start talking about the different diagnoses they were very interested in it. I think, who better to be trained than these people who are actually in the church and can spot maybe if somebody is going through a mental health problem?"

FAITH LEADER AND BEHAVIORAL HEALTH PROVIDER INTERVIEWS (CONTINUED)

c. Creating opportunities to make connections.

i. Interviewees reported exchanging information with each other so they had a specific, trusted person to reach out to for future referrals and questions.

ii. Maintaining and promoting connections after the training was challenging, but crucial.

1. Events such as BHP and FL breakfasts and luncheons were helpful.

2. Significant interest in exploring other mechanisms such as regular "alumni" events, communication and dissemination of information via email, blog, etc.

3. **Engaging in Actions that Reflect and Encourage Faith and Behavioral Health Integration**

a. Behavior changes.

i. Overall, greater empowerment and movement toward action among both FLs and BHPs.

"I think it has informed my approach with faith based and other behavioral health-based individuals… helped me have these conversations and partner with other faith based and behavioral health colleagues."

ii. FLs reported increased confidence and likelihood of referring a help seeker to a BHP.

"*I recommended a few families to see [a psychologist] and get the help they need. And they are really happy."*

"Now I can, with confidence, refer parents to take their kids to a professional."

iii. BHPs indicated changes in practice related to:

1. Assessment procedures (i.e., more attention to faith factors).

2. More dialogue and actions with clients about faith matters when clients express interest in these areas.

3. Organizational climate (e.g. more discussion of faith in clinical settings and between clinicians).

4. Organizational structure (e.g. training graduates, becoming a "go-to" person about faith issues with clients).

b. Dissemination of information (i.e., "The Ripple Effect").

i. BHPs and FLs are working together to bring mental health education into the churches.

"It helped me to understand more and with my knowledge now I'm trying to help other people understand by offering a new class."

ii. FLs reported including behavioral health information from the training in their church newsletters, social media, and even bringing it to their (non-church) place of employment.

iii. BHPs indicated sharing information with colleagues and developing written materials that examine the integration of faith and behavioral health.

iv. Interviewees reported that they frequently encourage others to take the Academy training.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year the administrative and provider staff were asked to participate in a brief online survey regarding their experiences with, perceptions about, and recommendations for the Faith Academy. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the two annual surveys.

1. The major program goals identified by staff:

a. Facilitate connections between mental health service providers and community clergy.
b. Educate faith leaders and faith communities about mental illness.
c. Reduce stigma surrounding mental illness and seeking mental health services.
d. Provide resources.
e. De-stigmatize religion in clinical practice.
f. Educate mental health professionals about faith based communities.
g. Increase the ability of faith leaders to support their community.

2. Factors that helped the program achieve goals:

a. Interactive nature of the Academy encouraging participant engagement.
b. Well written curriculum with plenty of mental health information.
c. Contributors bringing diverse expertise and experiences to the program and presentations.
d. Staff being passionate, committed, and organized.
e. Quality of the presentations and the information provided.
f. Networking opportunities that the trainings provide.
g. Bilingual workshops, presenters, and staff.

3. Factors that inhibited the program from achieving goals:

a. Time challenges/difficulties in fitting necessary material into available time for presentations.
b. Focusing only on Christianity.
c. Lack of buy-in about spirituality and mental health services.
d. Ineffective outreach efforts.
e. Complexity of merging different content styles.
f. Challenges in recruiting participants who would benefit the most.

4. Recommendations to help the program better achieve goals:

a. More preparation time for locating personnel and developing the curriculum.
b. Increase outreach efforts made to non-Christian places of worship/agencies.
c. Offer workshops to the public for wider access and broader distribution of the information.
d. Increase outreach efforts made to engage faith based leaders and mental health providers.
e. Add additional years to the program.
f. Provide more time for each training.
g. Survey participants about their availability to increase attendance.
h. Offer continuing education opportunities.
i. Get more information from faith based providers on perceived community needs.

5. Desired supports, tools, and/or trainings for the program:

a. More funding for resources and more equipment for producing curriculum materials.
b. Increased communication between related faith based “Innovation” programs for continuity and relationship building.
c. County provided trainings.
d. Volunteer assistance.
e. Training faith leaders to encourage referrals to the behavioral health system.
f. Yearly meetings to make improvements and revise goals.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY (CONT.)

6. Key "innovations" making this program unique:

a. The goal is education and not clinical or case management.
b. The need the program helped fill in the community.
c. The facilitators and panelists who can share their personal experiences.
d. The resource guide.
e. Participant engagement in exercises (i.e., the interactive nature of the training).
f. The quality of the presentations.
g. Different types of individuals are welcomed and community team building is encouraged.

7. Successful strategies to identify and recruit faith community members:

a. Using a wide variety of workshop times during the week and workshop venues.
b. Using people who took the training to "advertise" their experience.
c. Visiting churches in the local area.
d. Advertising in church bulletins.
e. Having groups meet at the end of the year to share challenges/successes.
f. Personal referrals.
g. Stipends.

8. Successful strategies to identify and recruit behavioral health providers:

a. Providing information about the value and purpose of the Academy training.
b. Most behavioral health providers are easy to recruit because they are interested in this type of training.
c. Stipend.
d. Certifications from the County to validate the training of the agencies involved.
e. Flexible scheduling.
f. Offering free Continuing Education Units (CEUs).
g. Promoting through local colleges.

9. Recommendations for another agency starting a faith academy:

a. Find people who have the same passion and commitment.
b. Have group activities that engage participants.
c. Sustain/maintain the training process.
d. Simplify the curriculum.
e. Have lots of resources.
f. Use presenters with lived experience.
g. Train presenters to be able to effectively link congregations to community resources.

10. Strategies used to increase interactions between faith leaders and behavioral health providers:

a. Providing social events or opportunities for the cohort to network with each other.
b. Interactive activities.
c. Giving participants the opportunity to share their stories/testimonials.
d. Incentives.
e. Meals (e.g., breakfasts, luncheons).
f. Conferences with mental health professionals.
g. Community panels.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Faith Based Academy program outcomes and operations throughout the three year MHSA Innovations-funded pilot study. These findings were derived from multiple sources, including participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar integrated faith based behavioral health training programs. The key learnings are organized into general thematic categories.

1. ***Impact on Academy Participants***
   a. Based on feedback from Academy attendees, the effects of Academy participation were evident across three primary domains: 1) increased knowledge, 2) stronger relationships, 3) continued actions to promote faith and behavioral health integration.
   b. Important to help Academy participants think through and identify a wide range of potential post-Academy actions that they could do to help further promote faith and behavioral health integration (e.g., within their place of employment, where they worship, among their family and friends).
   c. Post-Academy opportunities to continue engagement and interaction (e.g., luncheons and other "alumni" events), were viewed as very important to continuing the faith and behavioral health integration started during the Academies.
2. ***Curriculum Development***
   a. Developing the curriculum and associated resource guide required substantial time commitments to acquire, consolidate, and polish the information for use in the Faith Based Academy.
   b. Existing community partners/networks helped facilitate and provide credibility to the curriculum development process.
3. ***Academy Preparation/Logistics***
   a. Faith leaders and behavioral health providers should be included in the same Academy training sessions to promote interaction, integration, and co-learning (in contrast to offering separate academies for each type of participant).
   b. Academies appear to work best when provided training via several in-depth sessions (e.g., 2-4) over two weekends rather than as a weekly session over many weeks.
   c. Important to keep class size small enough to allow for active discussion/participation (target = 20 participants).
   d. Scheduling is often limited by availability of targeted faith leaders (typically Saturdays) and behavioral health providers (typically weekdays).
   e. Finding available and qualified presenters can be challenging, but particularly useful during full-day trainings to have multiple presenters so they can focus on their specific areas of expertise and provide variation in presentation styles for attendees.
4. ***Academy Presentations***
   a. It is challenging to fit the required and desired content into a reasonable length for Academy (e.g., 12-15 hours of training).
   b. Need to balance presentation with enough content to educate attendees on each topic while also allowing sufficient time for attendees to engage with each other and discuss the material.
   c. Presenters acting as facilitators rather than lecturers/teachers allowed participants to demonstrate their own expertise.
   d. Team building exercises helped in getting faith leaders and behavioral health providers to work together and get to know one another.
   e. While post-Academy ratings of satisfaction and learnings were generally high, behavioral health providers typically reported slightly lower ratings than faith leaders. This suggests a need to ensure that the material presented is sufficiently engaging and educational for behavioral health providers.
   f. Although the Faith Based Academies were open to persons from all faiths, content language was more oriented towards the Christian perspective given the initial target populations (i.e., Latinos and African Americans). Explicit acknowledgement of this orientation and expressed openness to other faiths may facilitate comfort with core material by non-Christians.
5. ***Participant Outreach***
   a. Important to identify and recruit key faith leaders (e.g., clergy), to personally participate in the Faith Based Academy since "once the pulpit embraces an idea, it will disseminate more broadly" throughout congregation/faith community.
6. ***Relationship to Community Education Program***
   a. Good coordination and communication is needed with the programs providing Community Education component of the Faith Based Initiative to facilitate identification and recruitment of appropriate Faith Champions.

PROGRAM CHANGES FROM INITIAL DESIGN

There were no changes to the INN-13 Faith Based Initiative #1, Faith Based Academy that fundamentally differed from the initial program design. However after trying multiple formats, it was found that it generally worked best to offer Academies that included both faith leaders and behavioral health providers simultaneously over the course of two weekends via several in-depth sessions (e.g., 2-4). Total Academy length was approximately 12-15 hours.

FUTURE DIRECTIONS

Based on the positive pilot study findings for the INN-13 Faith Based Academy, BHS decided to continue financial support for these trainings using ongoing behavioral health funding sources. Future Academies will utilize the curriculum developed in this pilot study as well as the lessons learned regarding successful delivery of Academy training sessions to foster increased behavioral health provider and faith leader knowledge, awareness, and integration. The Faith Based Academy program will be merged with the INN-13 Community Education program (another INN pilot program) to better coordinate the identification of champions and incorporate them into community education and outreach opportunities.

For additional information about the INN–13 Faith Based Initiative #1, Faith Based Academy, and/or this report, send your inquiry to: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #2 COMMUNITY EDUCATION

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (7/1/16 - 6/30/19)

Community Education was one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) that comprised the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative included improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts were intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the Community Education program included extending behavioral health related education (e.g., recognizing mental health conditions, suicide prevention, stigma reduction, etc.) into congregations and communities that may not otherwise have access to this information.

Two community organizations, Stepping Higher and NAMI San Diego (National Alliance on Mental Illness), provided Community Education services. Within their target region in the county, each agency was responsible for: 1) using Faith Champions to train behavioral health facilitators for community outreach and educational presentations, and 2) identifying agencies to partner with to host behavioral health related presentations. An important feature of this program was utilization of graduates from the Faith Based Academy as trained community facilitators to present the behavioral health related information. One of the other Faith Based Initiatives, the Faith Based Academy, supported the work of the Community Education program by identifying potential Faith Champions from Academy participants and then linking such persons to the Community Education program. The Community Education programs were expected to reduce stigma frequently associated with behavioral health needs and improve knowledge about available treatment and support resources.

EXECUTIVE SUMMARY

The Community Education program was designed to utilize Faith Champions identified in the Faith Based Academy to conduct behavioral health related workshops in the community and/or train additional facilitators to do so. The Community Education program also helped develop relationships with community faith leaders to expand opportunities and locations for delivering the educational workshops. These activities were intended to reduce behavioral health stigma in faith communities and increase knowledge about available resources.

- A total of 1,823 persons (1,175 from Central; 648 from North Inland region) provided personal characteristic information at 104 different Community Education presentations (program targets = 1,320 attendees and 120 presentations).
- Central Region presentation attendees were primarily female (53.5%) and included youth (8.9%), adults (54.1%), and older adults (28.2%). Most identified as African-American (55.5%).
- In the North Inland region, the majority (59.4%) of attendees indicated Spanish as their primary language (as compared to 10.0% in the Central Region).
- Based on post-training survey responses, most attendees (90.8%) agreed or strongly agreed that the training increased their knowledge about relevant behavioral health issues and available resources. Of particular interest, the majority (87.6%) agreed or strongly agreed that they were committed to increasing awareness in their community.
- Attendees highlighted the importance of seeking help for behavioral health issues and learning how to obtain such assistance as key lessons of the presentations.
- The programs trained 80 champions (program target = 91).
- Key factors identified by staff that helped the program achieve its goals included: 1) skilled and passionate workshop facilitators and program staff, 2) maintaining accurate knowledge of available community resources to facilitate referrals, 3) ability to provide informative presentations on a wide range of topics, and 4) good community relationships/credibility.

FUTURE DIRECTIONS

Based on the experiences and findings from the INN-13 Faith Based Community Education Program pilot study, BHS continued the provision of these services using behavioral health funding sources. To better coordinate faith based education and training initiatives within San Diego County, the Community Education services were combined with the INN-13 Faith Based Academy services (another INN pilot program) to create one integrated program. The ongoing funding allowed the structure and operations of the Community Education services to continue as initially designed while building upon the partnerships and experiences developed during the pilot project phase.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To facilitate community education presentations to faith and behavioral health communities focusing on faith and spiritual values, mental health conditions, substance abuse, wellness and community health.

The INN-13 Faith Based Community Education programs were able to host 104 presentations in the community that covered a wide range of behavioral health related topics (e.g., managing stress and anxiety, identifying risk factors for suicide, substance abuse treatment approaches, caring for persons with serious mental illness, etc.). A total of 1,823 persons attended these presentations and provided personal characteristic information. Attendees indicated learning more about the specific topics, how to access help, and being encouraged to help promote positive changes in their community (e.g., reducing stigma). Overall, the Community Education program had initially projected to host 120 presentations for 1,320 attendees, so although the total number of presentations was slightly less than anticipated, the total number of attendees exceeded expectations.

The presentation topics were discussed by presenters who integrated behavioral health and faith perspectives. The presentations were typically held at religious (e.g., churches or synagogues) or other community organizations. Identifying locations to host presentations, particularly during the initial implementation of the program required a significant investment of time into outreach activities and into developing relationships with faith and community leaders. This was necessary in order to develop sufficient trust that the potentially sensitive material would be presented in a manner that reflected both the faith and behavioral health understandings generally consistent with the beliefs of the host organizations. The use of financial incentives to provide compensation to presenters and, where appropriate, provide presentation locations (i.e., paying facility rental fees or providing donations), was determined to be an important factor for increasing the availability of suitable presenters and locations to host the presentations.

2. To utilize champions from the MHSA funded INN-13 Faith Based Academy to train additional presenters and/or provide community education presentations.

The INN-13 Faith Based Community Education program was able to obtain champions who had previously completed the INN-13 Faith Based Academy training program. These persons were utilized within the Community Education program as presenters for the community presentations and as trainers to help support training of other presenters. A lesson learned through the implementation of these programs was that effective identification and utilization of potential champions was made more challenging and complicated due to the fact that the Faith Based Academy and Community Education programs were separate organizational entities. More clarity and guidance were needed regarding how the two programs were to work together in order to sequentially identify and then train champions, particularly during initial program implementation. Based on the experiences of the pilot study, it was determined to combine these two different programs into one program as a way of better coordinating the relevant training activities.

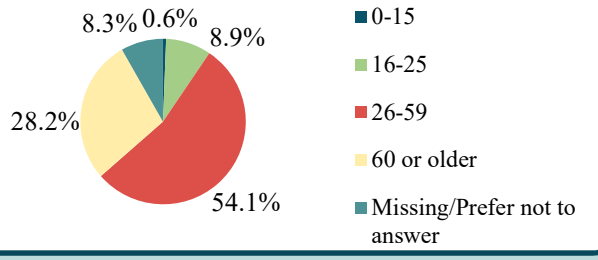
3. To introduce small community based organizations, particularly faith based organizations, to the process of contracting with the County.

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS – CENTRAL REGION PRESENTATIONS

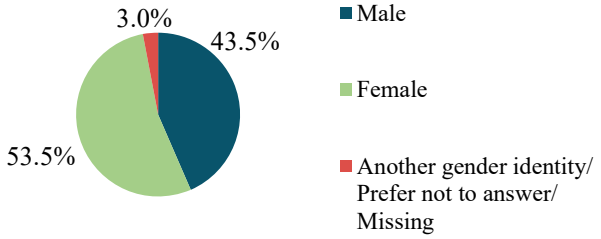
The following characteristic data were collected from an audience self-report survey administered at the community presentations.[1]

AGE (N=1,175)



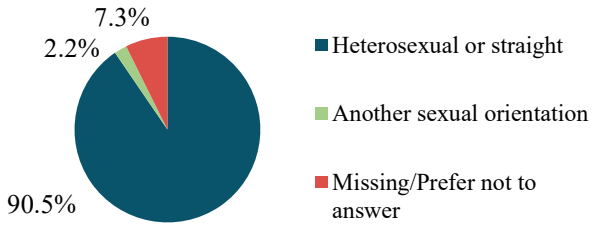
The majority (54.1%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=1,175)



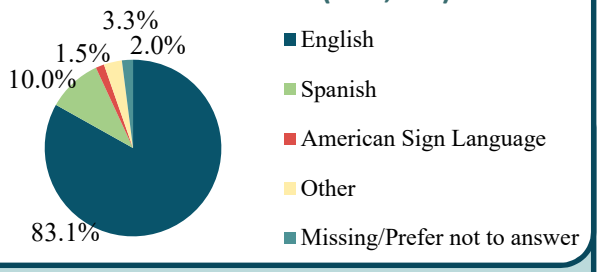
Over half of participants were female (53.5%) and 43.5% were male.

SEXUAL ORIENTATION (N=1,175)



Most (90.5%) participants identified as heterosexual or straight*.

PRIMARY LANGUAGE (N=1,175)



English was the primary language of most participants (83.1%) followed by Spanish (10.0%).

RACE/ETHNICITY (N=1,175)

	n	%
African-American	652	55.5
American Indian	28	2.4
Asian	30	2.6
Hispanic/Latino	241	20.5
Pacific Islander	5	0.4
White	161	13.7
Multi-Racial/Ethnic	39	3.3
Other	14	1.2
Missing/ Prefer not to answer	84	7.1

Totals may exceed 100% since attendees were able to indicate more than one race/ethnicity.

TYPE OF DISABILITY[2] (N=1,175)

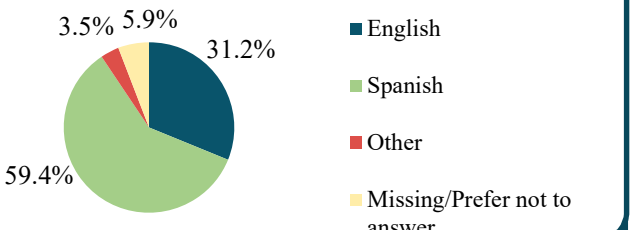
	n	%
Communication (e.g., seeing, hearing)	76	6.5
Mental (e.g., learning, developmental)	52	4.4
Physical	75	6.4
Chronic health condition	72	6.1
Other	46	3.9

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

PARTICIPANT CHARACTERISTICS – NORTH INLAND REGION PRESENTATIONS

Primary language was the only demographic information collected from attendees of North Inland region presentations. Implementation delays contributed to the lower number of attendees in North Inland.

PRIMARY LANGUAGE (N=648)



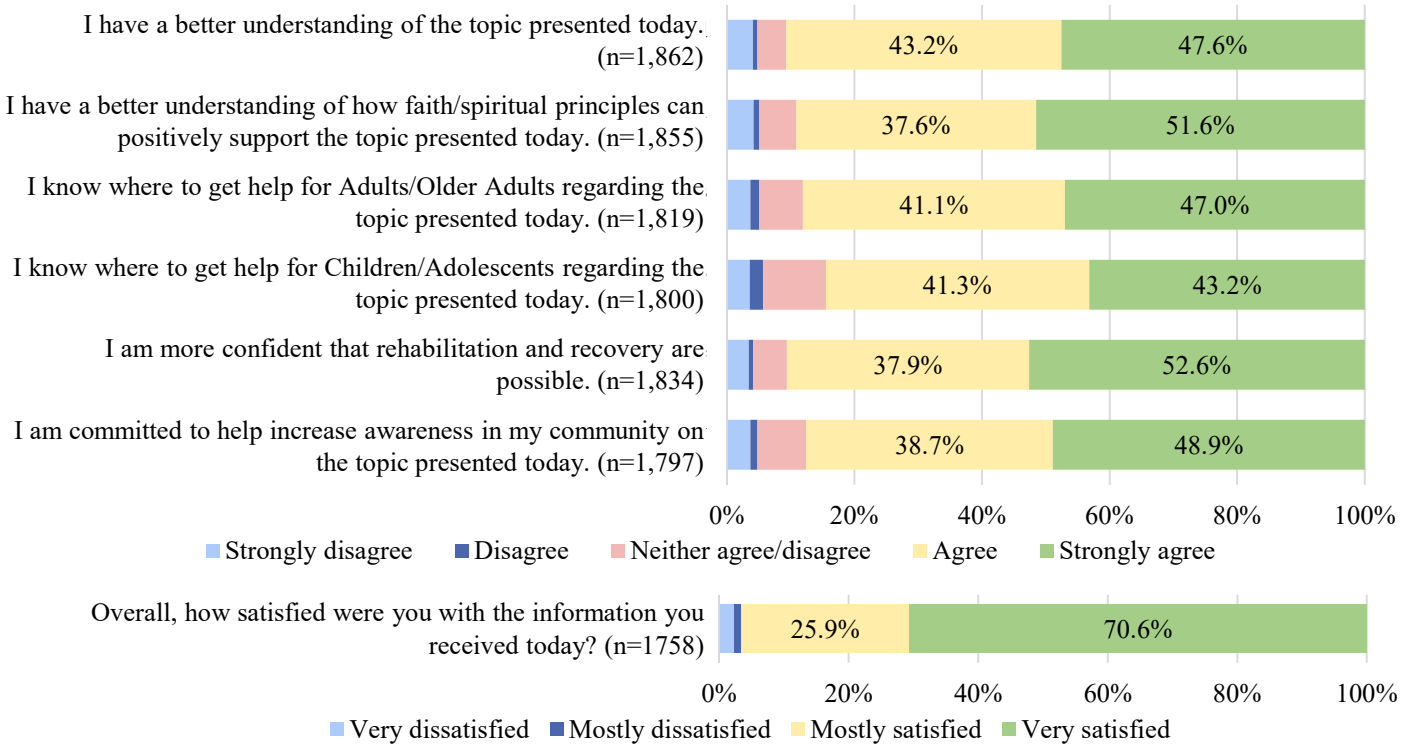
The majority of participants (59.4%) spoke Spanish as their primary language.

[1] Percentages may not total to 100% due to rounding. [2] A disability was 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 (SMI).
**Another sexual orientation includes Queer, Questioning/unsure of sexual orientation, and Another sexual orientation.*

POST-PRESENTATION SURVEY RESULTS

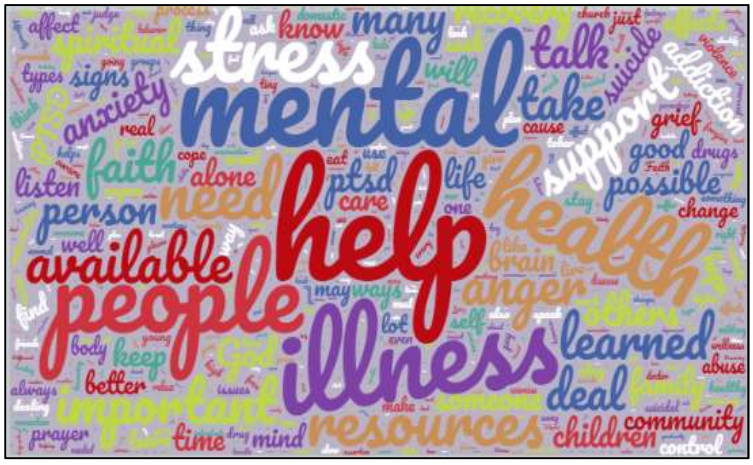
The programs provided a total of 104 different behavioral health related Community Education presentations. As shown in Figure 1, the vast majority of community attendees (approximately 85% or more) at educational presentations agreed or strongly agreed that as a result of the training they were more knowledgeable, knew where to obtain appropriate assistance, and were more capable and committed advocates to help others in their community. Of particular interest for achieving the goals and objectives of the overall Faith Based Initiative and this specific Community Education strategy, the majority (87.6%) agreed or strongly agreed that they were committed to increasing awareness within their community. This suggests that the desired "ripple effect" of education and ultimately community transformation is potentially underway in that persons trained through the Faith Based Academy (Faith Based Initiative #1) are now providing community educational workshops and/or training facilitators to do so as part of the Community Education program (Faith Based Initiative #2). This is then leading attendees of those presentations to indicate that they are motivated to further expand the reach of this material by helping to increase awareness of these behavioral health topics among the people they know. Additionally, almost all presentation attendees indicated they were satisfied with the information they received (25.9% were mostly satisfied and 70.6% were very satisfied). The patterns were similar between North Inland and Central regions.

FIGURE 1. COMMUNITY EDUCATION POST-PRESENTATION OUTCOMES AND SATISFACTION



POST-PRESENTATION QUALITATIVE SURVEY RESULTS

FIGURE 2. COMMUNITY EDUCATION POST-PRESENTATION LEARNINGS



At the end of each community presentation, attendees were asked an open-ended question on what they thought were the most important things they had learned. Figure 2 is a visual representation of the approximately 1,200 responses of what attendees indicated learning, with more frequently utilized words appearing with greater prominence.

One of the most frequently indicated word was "help." In addition to learning where to get help for mental illnesses, people also indicated learning there was nothing wrong with asking for and receiving help. Another frequently cited word was "stress." Specifically, attendees said they learned about the variety of ways stress impacts mental and physical health as well as effective ways in which to deal with stress to maximize mental wellness.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year the administrative and provider staff were asked to participate in a brief online survey regarding their experiences with, perceptions about, and recommendations for the Community Education program. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the two annual surveys.

1. The major program goals identified by staff:

a. Provide the community with resources.
b. Raise awareness of mental health matters in Latino and African American communities.
c. Educate the community about mental health issues and the role of faith in mental health recovery.
d. Decrease stigma surrounding the topic of mental health.
e. Bridge the gap between faith and mental health issues.
f. Encourage people to use resources without fear.
g. Identify community resources.
h. Increase rapport between faith leaders and behavioral health providers.
i. Increase understanding of professional help.
j. Provide free mental health education.
k. Train facilitators on giving community presentations.

2. Factors that helped the program achieve goals:

a. Quality facilitators (e.g., interactive, knowledgeable about topics and accessing resources).
b. Resources (e.g., list of counseling services, an app that has resource recommendations).
c. Varied presentation topics providing good information.
d. Good staff characteristics (e.g., preparedness, flexibility, adaptability, patience).
e. Relationships within the community.
f. Meeting the community in their local area.
g. San Diego County helping to extend educational resources.
h. Open communication and collaboration of all involved.
i. The marketing and promotion.

3. Factors that inhibited the program from achieving goals:

a. Stigma about mental health illness and accessing mental health services.
b. Not collaborating with the other related faith based "Innovation" funded programs.
c. Not having enough presenters for the Spanish-speaking community.
d. Lack of communication with the faith community.
e. Slow/inefficient marketing that was not highly visible.
f. Limited church hours made coordinating presentations difficult.
g. Not enough time to build relationships in the community.

4. Recommendations to help the program better achieve goals:

a. Increase marketing and outreach efforts.
b. Increase interagency communication.
c. Have more Spanish-speaking staff & facilitators.
d. Target the information more directly at the immediate needs of recipients.
e. Do not limit facilitators to only Faith Based Academy graduates.
f. Target younger audiences.
g. Make mental health appointments and doctor referrals on site.
h. Bring in licensed clinicians to further discussions and dialogue.

5. Key strengths of the program:

a. Strong facilitators and staff.
b. Involvement of the faith community.
c. The support it provides to the community.
d. The community relationships it produces.
e. The ability to work with an underserved minority population.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY (CONT.)

6. Desired supports, tools, and/or trainings for the program:

a. Resource information for emergency assistance.
b. Increased marketing support.
c. Expansion to more areas in the community.
d. Increased participation in the faith breakfast.
e. Public speaking training.
f. Certificates from the County to validate teaching credentials.
g. More communication and planning at the beginning of the program.

7. Key "innovations" making the program unique:

a. The faith based component of the mental health training.
b. Connecting with the community "at ground zero."
c. Creating a bridge between behavioral health and faith professionals.
d. Staff availability to assist those in need.
e. Presenters having a combination of expertise & lived experience.
f. Targeting Latino populations through their faith community.

8. Strategies utilized to identify potential organizations or locations for community outreach:

a. Personal networking (e.g., word of mouth, talking to friends).
b. Reaching out to organizations in the area.
c. Using graduates from the target communities.
d. Talking to the faith community.
e. Speaking directly with faith Leaders (e.g., pastor, priest, etc.).
f. Networking through similar events.
g. Encouraging referrals.
h. Using social media.
i. Sending community newsletters.

9. Factors needed for successful community education presentations:

a. Marketing to ensure the community knows about the presentation.
b. Knowledgeable presenters.
c. The location of the presentation.
d. Networking.
e. Faith communities being open to mental health topics.
f. Connecting with the head of a faith community.
g. Business cards.
h. An adequate number of presenters.
i. Likeable presenters.
j. Timeliness of presentations.

10. Primary impacts/outcomes of your activities within the community:

a. Faith entities have more knowledge about mental illness.
b. Mental illness stigma reduction.
c. Increased community openness to address mental health.
d. More awareness of the importance to connect faith and mental health.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Community Education program outcomes and operations throughout the three year MHSA Innovations-funded pilot study. These findings were derived from multiple sources including participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar faith based Community Education programs. The key learnings are organized into general thematic categories.

1. ***Outreach and Relationships Crucial for Creating Presentations Opportunities***
    a. Need to develop trusting relationships with faith leaders in order to gain access to congregations.
    b. Existing credibility and relationships in the community are crucial for program success.
    c. Establishing, maintaining, and nurturing relationships with church leaders are crucial but time consuming activities which are needed to create opportunities for presentations in faith communities.
    d. Working with local community centers increased the number of presentation opportunities.
    e. Community centers can facilitate access to priority populations such as males and Latinos.
    f. As program became more established, additional opportunities for presentations facilitated by persons who attended previous workshops.
    g. Ongoing relationships with certain faith leaders and community centers allowed for "repeat" presentation opportunities with either the same subject matter with different populations or different content areas over time.
2. ***Program Logistics/Structure to Support Successful Presentations***
    a. Program relies on dedicated and passionate staff committed to achieve program objectives.
    b. Use of financial incentives to support presenters and where appropriate, presentation venues, was very important to ensure availability of persons to present the material and locations to host the presentations.
    c. Managing program logistics requires substantial time (e.g., finding venues, facilitating marketing/outreach, facility preparation).
    d. Presenters need to be knowledgeable and good communicators.
    e. When possible, beneficial to match experienced and new presenters together to support ongoing presenter training.
    f. Important to ensure a sufficient number of people are working at each presentation to facilitate a smooth process from set-up through clean-up, and promote a positive experience for both attendees and presentation staff.
    g. Role plays are effective tools for teaching about commonly diagnosed mental illnesses.
    h. Importance of meeting community members in the community (e.g., go to where they already are).
    i. Potentially sensitive or uncomfortable topics requires respectful and supportive communication.
    j. Need to be aware of, and ensure security of presenters and audience in varied community settings (e.g., include security guard as part of presentation team as needed).
3. ***Challenges and Strategies for Facilitating Connections to Community Resources***
    a. Often difficult to find appropriate, local resources for community member referrals, especially for primarily Spanish speaking attendees.
    b. For presentations at community centers, can often refer and/or link attendees back to their own community center to meet needs for further education and other resources prompted by the presentation.
    c. After presentations, it is common that a certain amount of 'case management' occurs during which staff answer attendee questions and seek to direct attendees to relevant community resources for further information and assistance.
4. ***Key Audience Group to Try to Reach***
    a. Persons who are not seeking out this information represent an important target audience (e.g., need to have opportunities to present to congregations, schools, and other locations where audience didn't purposefully choose to attend an educational presentation in order to reach persons who may not otherwise recognize the need for such information/services).

ADDITIONAL PROGRAM ACTIVITIES

Overall, the programs trained a total of 80 champions (35 from the North Inland region and 45 from the Central region) to assist with community presentations, whereas the projected number of champions anticipated to be trained throughout this study was 91. There were difficulties in the coordination and communication between the INN-13 Faith Based Academy programs that were expected to identify potential champions and the INN-13 Community Education programs that were expected to provide training to those persons. These difficulties contributed to the decision to combine the Faith Based Academy and the Community Education into one program for ongoing services in the future.

PROGRAM CHANGES FROM INITIAL DESIGN

While there were learning and operational adaptations throughout the implementation of the INN-13 Faith Based Community Education pilot study, there were no changes that differed substantially from the initial program design.

FUTURE DIRECTIONS

Based on the experiences and findings from the INN-13 Faith Based Community Education Program pilot study, BHS continued the provision of these services using ongoing behavioral health funding sources. To better coordinate faith based education and training initiatives within San Diego County, the Community Education services were combined with the INN-13 Faith Based Academy services (another INN pilot program) to create one integrated program. The ongoing funding allowed the structure and operations of the Community Education services to continue as initially designed while building upon the partnerships and experiences developed during the pilot project phase.

For additional information about the INN–13 Faith Based Initiative #2, Community Education and/or this annual report, please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #3 CRISIS RESPONSE TEAM

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (7/1/16 - 6/30/19)

The Crisis Response Team (CRT) was one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) that comprised the County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The goals of the Faith Based Initiative included improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts were intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objectives of the CRT included the provision of faith based support services to individuals and families experiencing crisis situations (e.g., attempted or completed suicides, homicides, domestic violence), to improve their behavioral health and wellbeing. CRT services were ancillary to, and not replacement of, first responders.

Two community organizations, Stepping Higher and Interfaith Community Services, provided CRT services during this time period. Within two target areas, Central Region and Escondido, these programs were responsible for: 1) providing trained staff who could respond 24 hours a day to crisis situations as they occurred, and 2) offering short-term follow-up visits (up to 90 days), to support the individuals and families who experienced the crisis event and attempt to link them to appropriate behavioral health and non-behavioral health services. An innovative feature of this program was the provision of additional supports in the midst of and following a crisis event that incorporate shared understandings of faith and community to de-escalate situations and promote peace and healing within challenging circumstances. The emotional supports and additional linkages to community resources were expected to improve the behavioral health and wellbeing of those receiving CRT services.

EXECUTIVE SUMMARY

The CRT was designed to support individuals and families during and after experiencing crisis events (up to 90 days). The team had faith leaders and behavioral health professionals who responded quickly to crisis situations whenever needed (24 hours a day). The initial contacts were expected to help de-escalate challenging situations, and the follow-up services were designed to promote longer-term recovery and wellbeing.

- CRT served a total of 432 persons from 165 crisis events.
- Reflecting the family centric approach, almost one-quarter (22.9%) of persons served were under age 16.
- More than half (56.3%) of the persons served were female. The majority (50.7%) indicated Spanish as their primary language and most participants identified as Hispanic/Latino (60.2%) or African American (33.8%).
- Almost everyone (98.9%) with follow-up data (n=284) reported being satisfied with their overall CRT program experience. More specifically, the majority indicated satisfaction with the initial crisis services provided, the professionalism of the staff, the resources provided by team, and the quality of follow-up services.
- Primary services/resources participants reported receiving included: counseling (80.4%), food assistance (54.7%), religious support (52.4%), suicide prevention info (44.9%); domestic violence resources (32.9%) and connections to mental health services (32.9%).
- Participants identified the integration of faith and behavioral services as an important CRT program benefit.
- Key program challenges included: 1) difficulty initiating direct referrals from first responders (e.g., police and fire), such that this strategy was eventually dropped, 2) difficulty maintaining CRT availability 24 hours/7 days a week, 3) unable to identify a provider for CRT services throughout North Inland region, eventually reduced area to only Escondido to make it more manageable, and 4) substantial time required to build trust and appropriate community connections for CRT awareness and utilization.

FUTURE DIRECTIONS

While CRT services were generally perceived to be beneficial to those who received them, given the operational challenges and the resources required to effectively provide such services, it was decided that the faith based CRT program would not be extended beyond the conclusion of the MHSA INN funded pilot study. The programs were able to provide integrated behavioral health and faith based support to persons in crisis during the pilot program and there were many lessons learned regarding how to implement and operate this type of an innovative program. However, given the overall demands and priorities of the County of San Diego BHS service system and the availability of other related services, it was decided to not continue the CRT program as part of ongoing BHS services.

2020-07-23

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To establish a community based, faith based team that pairs licensed/master's level behavioral health clinicians and faith based clergy to respond to individual/family crisis situations (e.g., incidents of suicide, homicide, domestic violence), as needed 24 hours/seven days a week and provide crisis intervention, counseling, and support services.

The CRTs were staffed with faith leaders and behavioral health professionals who could respond to crisis events 24 hours/day seven days a week. The teams responded to 165 crisis events and provided services to 432 persons (total target number of persons served = 560). Delays in identifying an organizational partner and then implementing a CRT program in North County (eventually had to reduce scope of service from the initially intended North Inland Region to only Escondido) resulted in fewer persons served given the much shorter duration of the program.

The CRTs responded to many different crisis events, including homicides, the primary crisis events included domestic violence calls and suicide (attempts and completed). While initial expectations were that crisis calls might come directly from first responders (i.e., police and fire personnel), calls primarily originated from clergy who were made aware of a crisis situation and who had prior knowledge of the crisis team and initiated contact. Developing appropriate referral connections into the CRT program was a challenge that required substantial investments of time.

Based on the survey results, recipients of the crises service noted high levels of satisfaction with the CRT and many indicated that having in-home services available at all hours was very helpful. The integrated faith and behavioral health approach was also viewed favorably by service recipients. Staff indicated that this approach appeared to help with de-escalating tensions and stress in the midst of difficult situations.

2. To provide follow-up support and services to individuals and families for up to 90 days after the crisis event.

The CRTs followed-up with persons after the crisis event to see if additional support and services were needed (for a period of time up to 90 days). Survey responses indicated that participants with follow-up services who were willing to complete a follow-up survey (n=284) rated the follow-up services very highly and frequently reported receiving both additional emotional support as well as material supports from the CRTs. Primary services/resources participants reported receiving included: counseling (80.4%), food assistance (54.7%), religious support (52.4%), suicide prevention info (44.9%); domestic violence resources (32.9%) and connections to mental health services (32.9%).

3. To link individuals and families to behavioral health services and other community supports as needed.

As reported in the participant survey, recipients of CRT services were connected to mental health services (32.9%) and a wide variety of other community resources (e.g., legal assistance, housing, domestic violence care, employment).

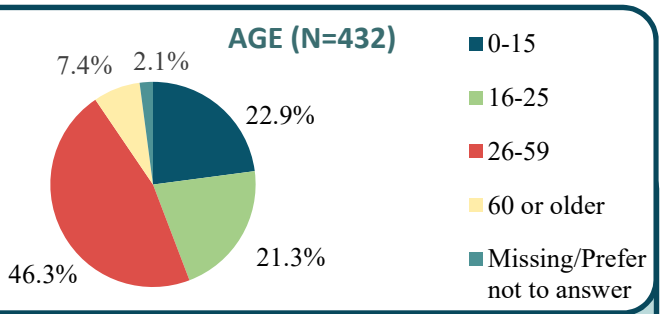
4. To introduce small community based organizations, particularly faith based organizations, to the process of contracting with the County.

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS

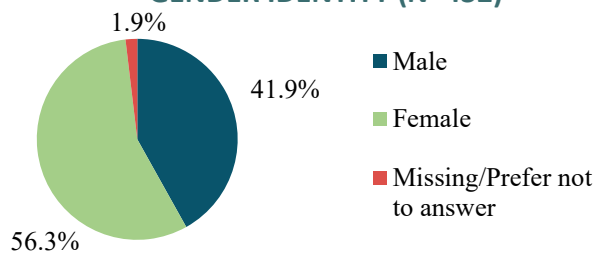
The following self-reported characteristic data were collected from the 402 Central Region and 30 Escondido CRT participants.[1]

AGE (N=432)



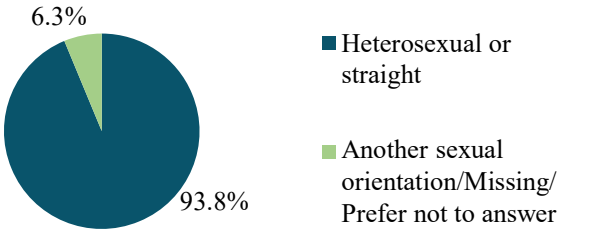
Indicative of the family-centered approach, almost half of participants (46.3%) were age 25 or younger.

GENDER IDENTITY (N=432)



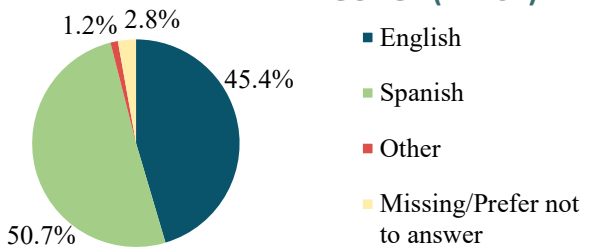
A slight majority of participants were female (56.3%).

SEXUAL ORIENTATION (N=432)



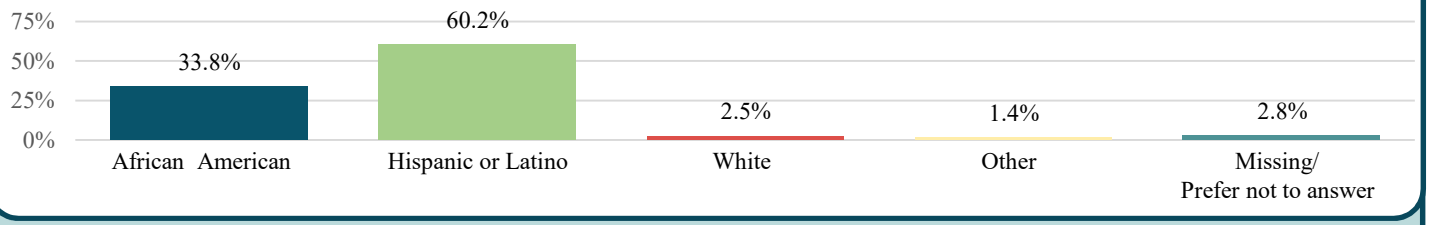
The majority of participants (93.8%) identified as heterosexual or straight.

PRIMARY LANGUAGE (N=432)



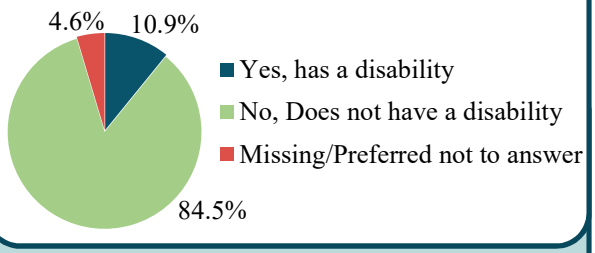
Spanish was the primary language of most participants (50.7%), followed by English (45.4%).

RACE/ETHNICITY (N=432)



The majority of participants (60.2%) identified as Hispanic or Latino, followed by 33.8% who identified as African-American.

DISABILITY STATUS[2] (N=432)



Nearly 11% of participants reported having some form of non-SMI related disability.

Prior military service was reported by 5.8% of participants.

TYPE OF DISABILITY (N=432)

Type	n	%
Visual	8	1.9
Hearing	< 5	< 1.2%
Learning	13	3.0
Dementia	< 5	< 1.2%
Chronic Health	14	3.2
Other	6	1.4

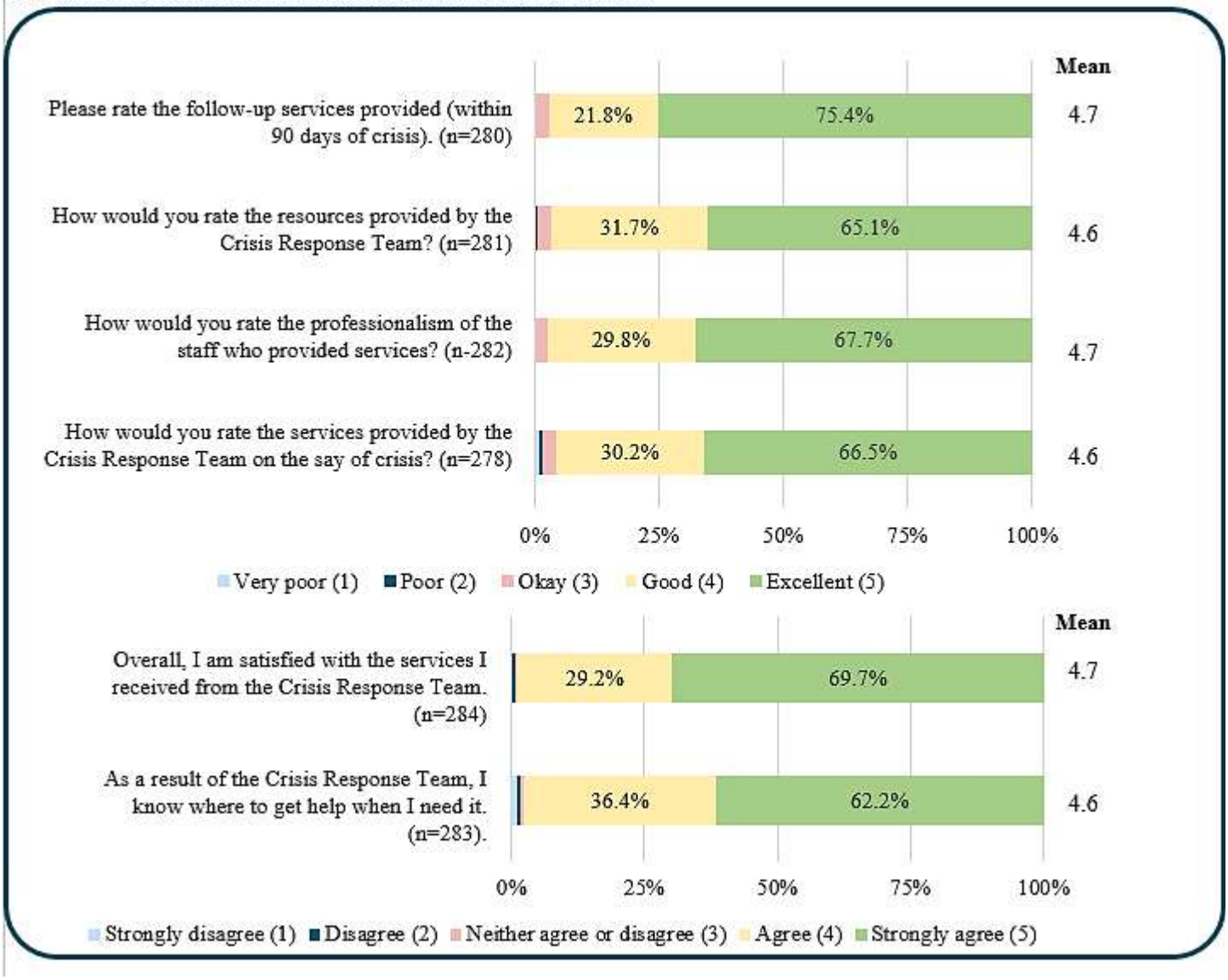
This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

[1] Percentages may not total to 100% due to rounding. [2] A disability was 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 (SMI).

CRISIS RESPONSE TEAM SERVICES FEEDBACK SURVEY

Persons from the 165 crisis events who had received services from the Crisis Response Team were asked to provide feedback about their interactions with the team at the end of the follow-up service period (within 90 days of the initial crisis event). The results from the completed surveys are presented in Figure 1 (note: more than one person may have completed a survey for each crisis event). In general, participants indicated high assessments of their experiences with the team and the services they provided (e.g., approximately 65-75% provided the highest rating of "excellent" for each question domain). Nearly all respondents agreed (29.2%) or strongly agreed (69.7%) with the statement indicating satisfaction with services received. The general response patterns were similar between those receiving CRT services in the Central Region and those receiving services in Escondido.

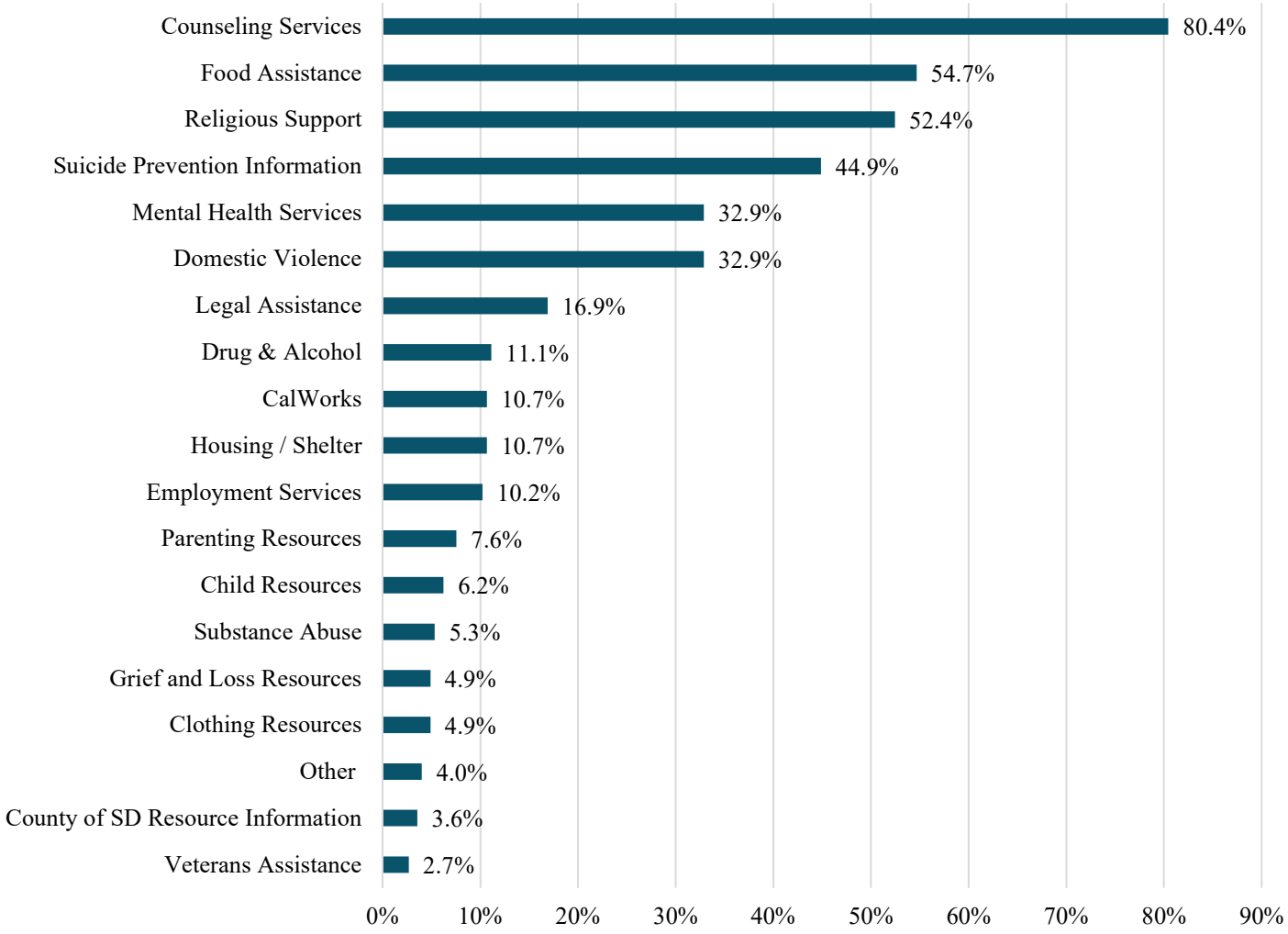
FIGURE 1. CRISIS RESPONSE TEAM SERVICE FEEDBACK SURVEY



RESOURCE UTILIZATION

The following figure indicates the types of services provided by the CRT as indicated by persons from the 165 crisis events who completed a follow-up survey. Consistent with the qualitative responses regarding resource benefits (see page 6), tangible resources such as food services were utilized by a majority of participants. Counseling and Mental Health services were also frequently provided for participants. Religious information was specifically indicated in more than half (52.4%) of the participants' responses. (Note: Participants could indicate more than one resource utilized so cumulative percentages will exceed 100%).

FIGURE 2. RESOURCES UTILIZED BY CRISIS RESPONSE TEAM (N=225)



QUALITIATIVE SURVEY RESPONSES REGARDING MOST BENEFICIAL ASPECTS OF CRT

Persons who had received services from the CRT were asked to provide feedback about their interactions with the team. The results of the open-ended, qualitative portion of the survey are summarized below. In general, participants reflected an appreciation for the resources offered by the CRT, as well as the presence of mental health professionals working in collaboration with faith leaders. Additionally, participants reported the team's service approach (i.e., fast responding time, family centered services, and in-home visits) as a beneficial aspect of the CRT.

1. **Participants reported resources as a beneficial aspect of the CRT.**

   A. *Tangible resources such as housing, food, and clothing helped participants:*

   - "I was able to find a place to stay for me and my boys."
   - "They helped me with food and clothes."
   - "Helping my dad find a job."

   B. *Participants reported that the knowledge and education offered by the CRT was beneficial:*

   - "They gave us a lot of information and where to go if we need something."
   - "The resources and information I received was very helpful."
   - "They were so helpful with the information they gave us."
   - "Information on suicide, developmental disabilities, and the food pantry."

2. **Participants reported emotional and spiritual support provided by counselors and clergy as helpful.**

   - "Counseling was extremely helpful."
   - "I felt peace and my counselor gave me information I didn't know."
   - "They didn't judge me."
   - "I can call when I need you! The Police can't do prayer & counseling like this."
   - "La concejeria y las oraciones por mi y mi familia." [The concern and prayers for me and my family.]
   - "They listen to me and prayed for me."

3. **Participants reported the service approach as a valuable facet of the CRT.**

   A. *The CRT's ability to respond quickly to situations, and remain available throughout the program, was appreciated by participants:*

   - "That they came fast to talk to me."
   - "Availability of staff, both clergy and mental health professionals."
   - "Has the time to come and talk to us."
   - "Personal attention and availability."

   B. *In-home services were reported as helpful to participants:*

   - "I like that you guys came to my house!"
   - "I got to be with my family, in my own home."
   - "Just having the team here in my home for support."

   C. *Family centered care was noted by participants as an important component of the program.*

   - "That they were able to include the whole family for a resolution."
   - "They gave me resources that helped me and my baby."
   - "Thank you for helping my son. He needs this extra support."

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year the administrative and provider staff were asked to participate in a brief online survey regarding their experiences with, perceptions about, and recommendations for the CRT. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the two annual surveys.

1. The major program goals identified by staff:

a. To provide services that de-escalate crisis situations (e.g., attempted suicides, domestic violence).
b. To provide resources and support to minority communities.
c. To restore peace back into peoples' homes.
d. To provide care and support from a faith based perspective.
e. To encourage counseling services.
f. To provide follow-up services after crisis.
g. To provide hope and emotional support.

2. Factors that helped the program achieve goals:

a. Resource information (e.g., a resource binder).
b. Availability of behavioral health staff and clergy as needed.
c. Experienced/knowledgeable clergy and behavioral health professionals.
d. Team member skills (e.g., active listening skills, ability to normalize feelings).
e. Existing relationships within the community.
f. Responding quickly to hotline calls.
g. Team commitment to support others and make a difference in the community.
h. Timely follow-up (e.g., within days) after crisis contact.
i. Having a team comprised of similar racial/cultural backgrounds as clients.
j. Marketing.
k. Multidisciplinary team.
l. Communication with law enforcement.
m. In-home visits or meeting the clients where they are.

3. Factors that inhibited the program from achieving goals:

a. Limited interagency coordination and communication (e.g., police, fire).
b. Individuals declining assistance.
c. Not enough resources to meet service needs.
d. Lack of promotion to the community.
e. Families not having good experiences with services in the past.

4. Recommendations to help the program better achieve goals:

a. Better interagency coordination (e.g., police, fire).
b. Increased funding.
c. Expand service areas to other regions.
d. Police and fire departments agreeing to send referrals.
e. Capacity to provide long-term follow-up care with clients.
f. Consolidation of resource information and ongoing updates of resource availability.
g. Ability to receive calls from multiple sources (e.g., pastors, community leaders).

5. Key program strengths:

a. Strength of the team and support provided to each other.
b. Needed resources and help being provided to the community.
c. Quality of the crisis intervention program.
d. Offering integrated faith based mental health services.
e. Using a team approach to provide services.
f. Community relationships.
g. Empowering clients and promoting self-representation.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY (CONT.)

6. Key program 'innovations" making the program unique:

a. Faith based aspect of services.
b. Service is available 24/7.
c. Collaboration with law enforcement.
d. Minority groups being served by professionals.
e. High-risk populations being helped.
f. Bilingual staff.
g. Staff training/background is multidisciplinary.
h. Connections within the community.
i. Recipients of the service feel that staff really care.

7. Desired supports, tools, and/or trainings for the program:

a. Additional mental health and crisis training.
b. Facilitate communication and training between law enforcement and crisis team.
c. Additional faith training (e.g., incorporating faith material into crisis situations).
d. County updates on available resources within the community.

8. Impact of the faith based aspect of the program on services provided:

a. Allows those who receive the service to incorporate their faith into the process.
b. Facilitates cultural connections within African-American and Latino communities.
c. Supplies hope and provides relief.
d. Promotes trust and openness to suggestions and information.
e. Encourages de-escalation by relying on one's faith/beliefs.

9. Recommendations on how to educate other service personnel (e.g., police, fire) about Crisis Response Team services:

a. Have presentations or meetings to educate police and fire departments about the program.
b. Create a memorandum of understanding with police and fire departments.
c. Distribute materials periodically to remind police and fire departments about the program.
d. Encourage service personnel to work in collaboration with the Crisis Response Team.

10. Ideas on how to educate the general community about Crisis Response Team services:

a. Social media marketing.
b. Share information with other service providers/agencies.
c. Present information at community events/presentations (e.g., Task Order 2 presentations, schools).
d. Share information in churches and other faith based organizations.
e. Distribute newsletters within behavioral health service organizations.
f. Develop marketing materials (e.g., a brochure, a community flier).
g. Conduct prevention trainings (e.g., substance use, domestic violence).
h. Advertise in the newspaper.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Crisis Response Team (CRT) outcomes and operations throughout the three-year CRT MHSA Innovations-funded study. These findings were derived from multiple sources including, participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar faith based CRT programs. The key learnings are organized into general thematic categories.

1. ***Value of the Integrated Behavioral Health and Faith Based CRT Approach***
    a. Faith based approach promotes participant trust and openness.
    b. Faith based approach facilitates crisis de-escalation by utilizing existing beliefs and support mechanisms.
    c. Faith based counseling and emotional support identified by participants as a primary CRT benefit.
2. ***CRT Community Awareness and Outreach***
    a. Establishing direct referrals from police did not materialize as anticipated due to a variety of complications (e.g., liability concerns, jurisdiction/geographic boundaries).
    b. Educating and engaging with pastors is essential as they can be a "first line of defense" and recommend that persons call the Crisis Response Team.
    c. Encouraging people to spread information via "word of mouth" is an effective way to establish trust in the community.
    d. Due to need to balance high demand for services with program capacity to provide services, CRT program had to be strategic regarding outreach and awareness activities so that they were not overwhelmed with calls.
3. ***CRT Program Structure***
    a. Must be able to provide quick response time at all hours to meet participants' needs in time of crisis.
    b. Ability to provide in-home services (as opposed to requiring participants to go elsewhere) was important.
    c. Follow-up support services after the crisis event were utilized by many participants.
    d. Team-based approach relies on collaborative, passionate, and skilled team members.
    e. Team-based approach required good coordination, communication and overall leadership.
4. ***Linkages to Community Resources***
    a. CRT programs learned to provide full information resource packet to all participants since they may not articulate all needs during initial contact.
    b. Referrals or "warm hand-offs" to other resources such as counselors or psychiatrists can be challenging since the person has already established trust and shared sensitive information with the Crisis Response Team member.
    c. There often are more community resources available for women with children than there are for men with children.
5. ***CRT as "Preventative Care" for Future Crisis Avoidance***
    a. After initial interaction, some participants contact program directly if same/similar crisis emerges as a form of "pre-911" call.
    b. After trust has been established in the community, some participants may prefer to contact the Crisis Response Team instead of the police.
6. ***Community Relationships***
    a. High quality faith based and behavioral health reputation in community promotes credibility.
    b. Interagency coordination and communication is essential for effective program operations (e.g., crisis teams, BHS, Police Department, Fire Department).
7. ***CRT Implementation and Operational Challenges***
    a. Difficult to establish referrals from official first responders (i.e., police and fire), so eventually drop efforts to establish such referrals and focus instead on relationships with clergy and others who could initiate CRT referrals.
    b. Maintaining CRT availability and readiness to respond 24 hours a day difficult within available resources.
    c. Difficult to identify a program willing to implement CRT in North Inland region, resulted in substantial delays.
    d. Substantial time required to identify and establish relationships with appropriate community partners for referrals.

PROGRAM CHANGES FROM INITIAL DESIGN

While there were certainly program learnings and adaptations throughout the course of the three-year CRT MHSA program, there were no fundamental shifts or changes from the initial design of using integrated clergy and behavioral health clinician teams to provide faith based emotional and tangible supports to persons in crisis situations and within the 90-day period following the event. However, one change from initial expectations was that instead of getting referrals directly from first responders (i.e., police and fire personnel), most referrals ended up coming through other clergy who had prior knowledge of the CRT or "word-of-mouth" as the program became more widely known. Additionally, the intention was to have two CRT programs (one in the Central Region and one in the North Inland Region), throughout the entire three-year MHSA INN-funded initiative, but it was difficult to identify a partner program interested in providing North Inland Region CRT services. BHS had to conduct multiple rounds of solicitation seeking such a provider before eventually reducing the target area to only Escondido. This change allowed for a program to agree to provide CRT services, but the delays associated with identifying the program and then working through initial implementation challenges resulted in the CRT program in Escondido only being operational for approximately one year. These experiences contributed to the large difference in persons served between the Central Region (n=402) and in Escondido (n=30).

FUTURE DIRECTIONS

While CRT services were generally perceived to be beneficial to those who received them, given the operational challenges and the resources required to effectively provide such services, it was decided that the faith based CRT program would not be extended beyond the conclusion of the MHSA INN funded pilot study. The programs were able to provide integrated behavioral health and faith based support to persons in crisis during the pilot program and there were many lessons learned regarding how to implement and operate this type of an innovative program. However, given the overall demands and priorities of the County of San Diego BHS service system and the availability of other related services, it was decided to not continue the CRT program as part of ongoing BHS services.

For additional information about the INN–13 Faith Based Initiative #3, Crisis Response Team and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #4 WELLNESS & MENTAL HEALTH IN-REACH MINISTRY

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (7/1/16 - 6/30/19)

The Wellness and Mental Health In-Reach Ministry (WMHIM) was one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) that comprised the County of San Diego Heath and Human Services Agency's Behavioral Health Services (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative included improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts were intended to increase knowledge of and access to appropriate behavioral health services for traditionally underserved persons, particularly within African-American and Latino communities. The specific objective of the WMHIM was to engage with inmates who have a Serious Mental Illness (SMI), such as schizophrenia, while they are still in jail and develop a trusting relationship to support the transition back into the community and facilitate linkages to needed behavioral health and non-behavioral health services.

One community organization, Training Center, was selected to provide the WMHIM program. Within target regions in the county, the program was responsible for: 1) attempting to meet regularly with inmates who have a SMI while they are still in jail but are nearing their release date, and 2) offering short-term, post-release follow-up services (up to 90 days) to help individuals successfully transition back into the community by providing emotional support, empowerment, and linkages to appropriate services. An innovative feature of this program was the provision of behavioral health supports and linkages to community resources combined with a faith/spirituality perspective to help promote trusting relationships and personal growth. The emotional support and connections to community resources provided through WMHIM were expected to improve the behavioral health and well-being of those receiving services and contribute to lower rates of recidivism.

EXECUTIVE SUMMARY

The Wellness and Mental Health In-Reach Ministry (WMHIM) was designed to engage inmates with SMI while they are still in jail in order to build supportive relationships with them and help them access needed services upon release that will allow them to successfully transition back into the community and reduce future recidivism.

- A total of 442 persons participated in WMHIM.
- Of those who reported any personal characteristics (n=320), approximately 20% (19.7%) of the participants were female and 15.0% were Transitional Age Youth (i.e., age 18-25).
- The program served a diverse population, with 38.8% identifying as White, 24.4% as African-American, and 19.4% as Hispanic or Latino.
- Analysis of San Diego County jail data indicated a substantial reduction in re-bookings (i.e., interactions with police that resulted in transportation to jail and the assignment of a booking number) into jail after participants became involved with the WMHIM program. This decrease was evident across both short-term (i.e., 30-day) and intermediate term (i.e., 90-day and 180-day) recidivism analyses. For example, 30-day recidivism dropped from 34.3% before WMHIM to 13.3% and 180-day recidivism dropped from 76.9% to 46.2% before and after enrolling in WMHIM, respectively.
- Similarly, total bookings decreased sharply after involvement with the WMHIM program. Total bookings dropped from 160 before to 59 after WMHIM in the 30-day analyses, and from 617 before to 311 after WMHIM in the 180-day analyses. In both analyses, total bookings dropped by approximately 50% or more.
- Key factors identified by staff that helped the program achieve its goals included: 1) repeated interactions with inmates pre-release, 2) the ability to identify and offer linkages to needed services post-release, 3) prayer and a respectful faith based team, 4) teamwork between religious and non-religious groups, and 5) coordination within the team and with external partners to maintain contact with participants post-release.

FUTURE DIRECTIONS

The BHS system decided to consolidate multiple programs that focused on transitioning persons with SMI from jail settings back into the community. As such, this specific WMHIM pilot study program was not continued following the conclusion of the MHSA Innovations funding stage. However, the lessons learned about effective faith based engagement and support of persons returning to the community from jail were integrated into the ongoing faith based program with the expectation of continued reductions in recidivism.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. *To develop a Wellness and Health Ministry that focuses on supporting community re-entry for adults diagnosed with an SMI while in jail by providing spiritual and behavioral health support.*

The WMHIM program assembled a team of faith leaders and behavioral health providers, many with relevant lived experience related to the criminal justice system and/or mental health treatment system. Jail personnel identified potentially eligible persons and notified the WMHIM team of the person's estimated release date. The WMHIM team then attempted to make multiple visits to the individual while they were in jail to provide spiritual support and develop a trusting relationship. Building on these personal connections, WMHIM team members would also work with the individual to develop their post-release plans, particularly related to housing and establishing linkages to ongoing behavioral health treatment. When the actual release date was known in advance (release dates were subject to frequent changes due to many different circumstances), the WMHIM team member would meet the person at the jail to provide transportation wherever they wanted to go. The WMHIM team members identified this ride from jail as crucial for maintaining contact during the pre-release to post-release transition. Once released, the WMHIM team worked to connect them to any available services for which the person qualified. Lack of available/affordable housing, program wait lists, and/or complicated enrollment/eligibility determination criteria created challenges for getting persons directly into needed care.

Overall, the WMHIM team was passionate and committed to the task of trying to facilitate community re-entry from jail and create connections to community treatment and supports. While not able to prove causality, an indicator that suggests the WMHIM team was successful at their overall objective for many persons they worked with was the decline in bookings into jail and total booking after participation in the WMHIM program (as compared to their prior experiences). This was evident for both short-term (i.e., 30- and 90-day) and longer-term (i.e., 180-days) recidivism rates as well as total bookings during these time periods. Reductions of 30-50% or more were evident across these metrics.

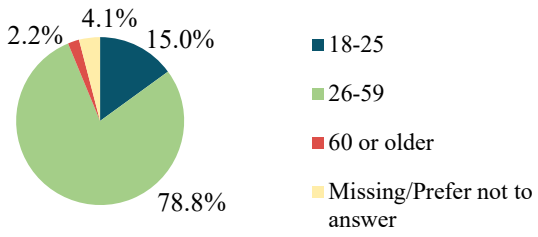
2. *To introduce small community based organizations, particularly faith based organizations, to the process of contracting with the County.*

An overall goal of the INN-13 Faith Based Initiative was to expand the network of small community based organizations, particularly faith based organizations, who had the capacity to partner with the County of San Diego via service contracts to provide desired behavioral health related services within faith communities. To help accomplish this goal BHS utilized a Task Order process instead of the standard "Request for Proposal" process to lessen the burden associated with developing an extensive proposal and encourage a larger number of organizations who may not have had prior experience with County contracting to express interest in the INN-13 Faith Based Initiative. BHS decided to divide the INN-13 Faith Based Initiative into four smaller Task Order components (i.e., #1 Faith Based Academy, #2 Community Education, #3 Crisis Response Teams, and #4 Wellness and Mental Health In-Reach Ministry) and then have different providers selected for each targeted region in an attempt to make the scope of work more manageable for smaller organizations and to maximize the number of participating organizations. This Task Order approach was successful at creating many new partnerships between BHS and community based organizations, however, having multiple smaller dollar contracts presented coordination and communication challenges for BHS and some organizations had difficulty achieving the level of monitoring, tracking, and reporting typically required with County contracts.

PARTICIPANT CHARACTERISTICS

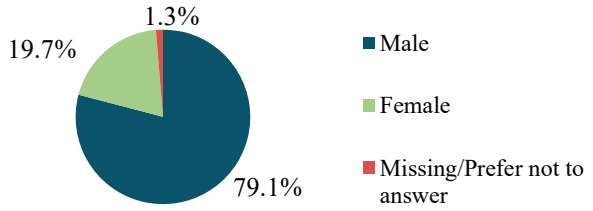
Of the 442 persons who participated in WMHIM, 320 persons completed a self-report characteristic form during their enrollment.[1]

AGE (N=320)



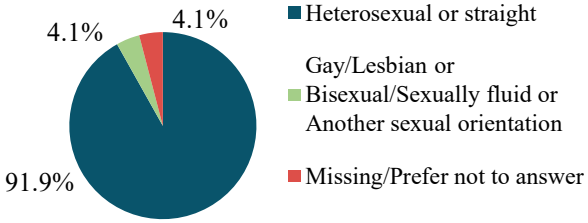
The majority of participants (78.8%) were between the ages of 26 and 59.

GENDER IDENTITY (N=320)



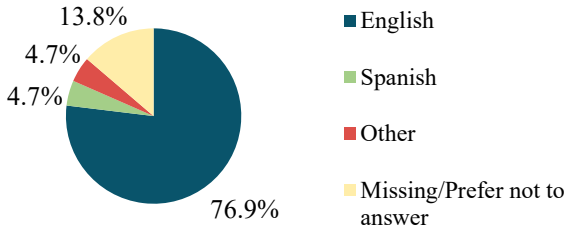
A little over three-quarters of participants were male (79.1%) and 19.7% of participants were female.

SEXUAL ORIENTATION (N=320)



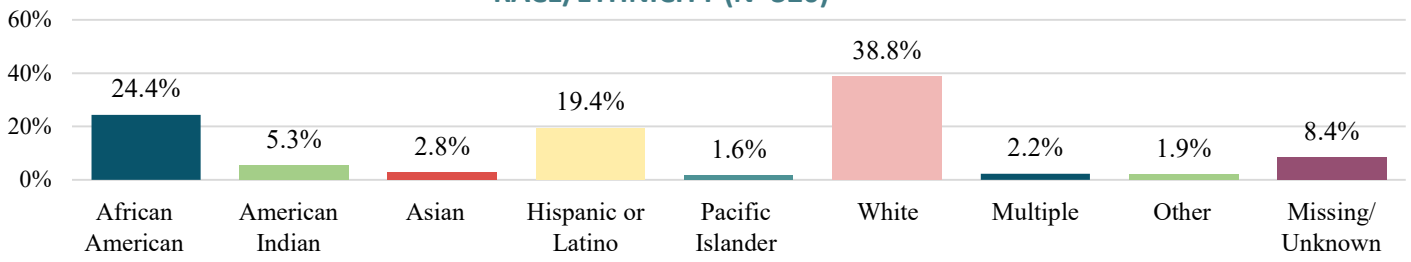
Most (91.9%) participants identified as heterosexual or straight.

PRIMARY LANGUAGE (N=320)



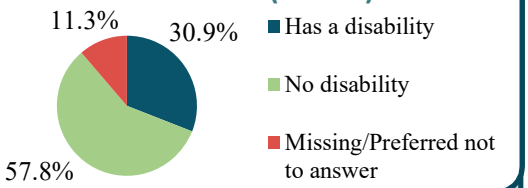
English was the primary language of most participants (76.9%).

RACE/ETHNICITY (N=320)



Close to forty percent (38.8%) of participants identified themselves as White, followed by 24.4% who identified as African American. Totals may exceed 100% as participants were able to indicate more than one race/ethnicity.

DISABILITY STATUS[2] (N=320)



Nearly thirty-one percent of participants reported having some form of non-SMI related disability.

9.0% of participants indicated they had served or were currently serving in the military.

TYPE OF DISABILITY (N=320)

Type	n	%
Communication	16	5.0
Mental (e.g., learning)	14	4.4
Physical	12	3.8
Chronic Health	5	1.6
Other	67	20.9

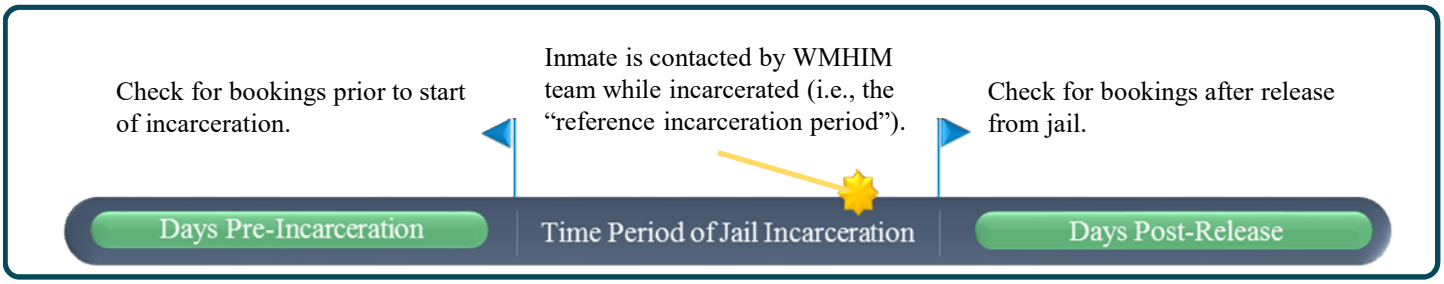
This table indicates the types of non-SMI disabilities reported as a percentage of all participants. Totals may exceed 100% as attendees could indicate more than one type of disability.

[1] Percentages may not total to 100% due to rounding. [2] A disability was 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 (SMI).

COUNTY OF SAN DIEGO CRIMINAL JUSTICE SYSTEM RECIDIVISM

A primary objective of WMHIM is to reduce future interactions with the County of San Diego criminal justice system after participants are released from jail. To assess the extent to which program participation may be associated with such a decline, the pattern of County jail bookings was examined before and after involvement with the WMHIM team. The instance of incarceration when first enrolled into the WMHIM program acts as the "reference" incarceration period from which to look forward and backward in time to determine the relevant recidivism information. As illustrated in Figure 1, jail data were reviewed to identify the number of times, if any, inmates had been booked during a 30-, 90-, and 180-day interval before the start of the reference incarceration period (i.e., when first enrolled in WMHIM). We then conducted a similar assessment of the data to identify any bookings that occurred during the 30-, 90-, and 180-day period after being released from jail. To ensure equal observation periods both before and after the reference incarceration period for all analyses, only inmates released at least 180 days before the end of FY 2018-19 (6/30/2019), were included in the recidivism analyses (n=338).

FIGURE 1. ILLUSTRATION OF PROCESS TO COMPRE PRE- AND POST-INCARCERATION BOOKING RATES



As shown in Table 1, at each time interval examined (30-, 90-, and 180-day), the recidivism rate and total number of bookings immediately prior to the reference incarceration (i.e., when the inmate first connected with the WMHIM program) was substantially higher than after initiating involvement with the WMHIM program. For example, of the 338 WMHIM participants included in these analyses, 34.3% (n=116) had at least one booking within the 30 days ***before*** their reference incarceration, but only 13.3% (n=45) had at least one booking within the 30 days ***after*** release from their reference incarceration. When examining a 180-day period before and after the reference incarceration, the corresponding recidivism rates were 76.9% (n=260) to 46.2% (n=156), respectively, and total bookings declined from 617 to 311 (a reduction of almost 50% in total bookings). The very high recidivism rates and total bookings prior to WMHIM program involvement indicate that the population served by this program was a high need, complex population with frequent justice system contacts. While these analyses do not allow for a specific test of causation, the findings suggest that participation in WMHIM contributed to a reduction in overall and repeat bookings into the County of San Diego jail. While substantial recidivism rate and total booking reductions were evident over both short- and intermediate-term time frames, the level of bookings occurring after WMHIM involvement indicate that opportunities for further improvements in supporting the transition from jail to back into the community remain.

TABLE 1. COUNTY OF SAN DIEGO BOOKINGS INTO JAIL BEFORE AND AFTER REFERENCE INCARCERATION PERIOD

	Before Start of Reference Incarceration (Total persons = 338)	After Release from Reference Incarceration (Total persons = 338)
At least one booking within: 30 days	34.3% (n=116)	13.3% (n=45)
Total bookings within: 30 days	160	59
At least one booking within: 90 days	62.1% (n=210)	32.8% (n=111)
Total bookings within: 90 days	370	162
At least one booking within: 180 days	76.9% (n=260)	46.2% (n=156)
Total bookings within: 180 days	617	311

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year the administrative and provider staff were asked to participate in a brief online survey regarding their experiences with, perceptions about, and recommendations for the In-Reach Ministry. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the two annual surveys.

1. The major program goals identified by staff:

a. To build positive relationships with inmates pre-release (e.g., encouragement, counseling, pastoral ministering).
b. To incorporate a faith based perspective into program services.
c. To encourage and empower releasing inmates.
d. To provide resources and facilitate referrals.
e. To maintain connections with participants post-release.
f. To prevent re-incarceration of releasing inmates with serious mental illness.
g. To help releasing inmates find housing.
h. To help releasing inmates get into mental health and rehabilitation programs.

2. Factors that helped the program achieve goals:

a. Having repeated positive interactions with inmates.
b. Identifying appropriate service providers and programs.
c. Having complete/accurate information to provide to participants regarding services in the community.
d. Lots of prayer/reliance upon one's faith.
e. Using teamwork between non-religious and religious groups to help releasing participants.
f. Facilitating access to needed post-release services.
g. Having coordinated release efforts to maintain participant contact.
h. Having clearance to enter jails and prisons.
i. Staff skills.

3. Factors that inhibited the program from achieving goals:

a. Not enough contact with inmates.
b. Lack of available/appropriate housing for participants.
c. Lack of coordinated release efforts (e.g., with the participant, the parole officer, the program where the participant is going).
d. Lack of participant buy-in (e.g., won't meet or show up at scheduled times, drops out of the program).
e. Strict eligibility requirements in post-release programs.
f. Lack of funding.
g. Mental health treatment programs with required wait times (e.g., 30 days) before qualification.

4. Recommendations to help the program better achieve goals:

a. Identify ways to increase funding.
b. Increase the amount of housing available for participants being released.
c. Increase the ability to work with inmates prior to their release date (e.g., increase the number of visits).
d. Test for drugs and alcohol.
e. Expand program referrals and enrollments.
f. Improve internal communication and coordination.
g. Increase the amount of information received from the jail (e.g., mental health and incarceration histories).
h. Create a position for a program coordinator.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY (CONT.)

5. Key strengths of the program:

a. The combination of spirituality and mental health.
b. The quality of contact with inmates (e.g., one-on-one, personalized, empowering).
c. Having a unified passionate team.
d. The training employees receive.
e. The ability to achieve positive changes (e.g., lessening recidivism).
f. Resource knowledge (e.g., community programs, eligibility requirements).

6. Desired supports, tools, and/or trainings for the program:

a. Accurate resource information (e.g., community programs, eligibility requirements).
b. More information on current programs and services for inmates with a mental illness.
c. A "dispatch" like position to track/communicate current and accurate program participant information.
d. Increased ability to work with inmates over multiple visits prior to their release date.
e. Yearly trainings to keep knowledge and skills up to date.
f. A shortened version of reporting/documentation requirements.

7. Primary strategies for connecting/developing relationships with inmates prior to release from jail:

a. Visiting with inmates frequently.
b. Having staff/volunteers with prior incarceration experiences.
c. Listening without judgment and empowering participants with support and encouragement.
d. Sharing faith (e.g., personal stories, journeys towards faith, prayer).
e. Offering the potential of safe housing post-release.
f. Combining behavioral health and faith based approaches.

8. Primary strategies for maintaining contact with participants after they were released from jail:

a. Providing or acquiring relevant phone numbers.
b. Developing relationships with family members.
c. Encouraging participants to maintain contact (e.g., regular “check-ins”).
d. Making in-person contacts (e.g., homes, treatment programs, shelters).
e. Keeping track of where the participant is currently living.
f. Sponsoring participants who are in recovery.

9. Factors that prevented/inhibited linking participants to services and supports:

a. Limited time to work with inmates and coordinate program referrals prior to release.
b. Not enough services for participants with serious mental illness.
c. Restrictions in program eligibility.
d. Lack of participant buy-in/motivation.
e. Not enough housing/treatment beds.
f. Lack of funding.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Faith Based Academy program outcomes and operations throughout the three year MHSA Innovations-funded pilot study. These findings were derived from multiple sources including, participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform future initiatives designed to implement and operate similar integrated, faith based behavioral health training programs. The key learnings are organized into general thematic categories.

1. ***Service approach/ethos***
    a. Integrating behavioral health knowledge and a faith/spirituality perspective facilitates development of supportive and empowering relationships with inmates with SMI.
    b. The personal "lived experience" of program staff and volunteers with the criminal justice and behavioral health system increases credibility with inmates.
    c. Supportive relationships combined with availability of community resources and services appear to be important factors contributing to positive life changes.
    d. Need a flexible team that can be available on short-notice and during non-traditional work hours to respond to unpredictable jail release timing and challenges that may arise at any time after release.
2. ***Pre-release relationship building and transition planning***
    a. Multiple pre-release contacts are important relationship building opportunities that facilitate maintaining post-release connections with participants.
    b. Important to know when persons are releasing so that the team can mobilize to meet them in-person and continue their work on connecting them to post-release services.
3. ***Post-release engagement strategies and resource needs***
    a. Providing post-release transport facilitates maintaining post-release connections with participants.
    b. Access to safe post-release housing is often limited, which then becomes a primary post-release focus for participants.
    c. Linking to relevant outpatient and residential treatment services can be challenging (e.g., limited availability within desired geographic areas, strict eligibility requirements, program waitlists, participant focusing on other needs).
    d. Establishing a post-release assistance/services plan (e.g., housing, treatment, employment, family reunification) prior to their actual release helps keep inmates engaged and motivated to work with WMHIM after they are released.
4. ***Participant characteristics***
    a. Participants often need a range of behavioral health and non-behavioral health related services after release.
    b. While most participants were males, about 20% were females who may experience other types of needs (e.g., child care) and challenges (e.g., domestic violence) that need to be addressed.
5. ***Administrative needs of small community organizations***
    a. Additional education, supports, and openness to simplifications where feasible can help small "grassroots" organizations navigate and respond to bureaucratic requirements associated with County of San Diego contracts.

PROGRAM CHANGES FROM INITIAL DESIGN

There were no changes to the INN-13 Faith Based Initiative #4, WMHIM that fundamentally differed from the initial program design. Throughout this initiative, WMHIM staff attempted to make contact with eligible inmates while they were still incarcerated in order to develop a relationship that could then be relied upon to help the person transition back into the community.

FUTURE DIRECTIONS

The County BHS system decided to consolidate multiple programs that focused on transitioning persons with SMI from jail settings back into the community. As such, this specific WMHIM pilot study program was not continued following the conclusion of the MHSA Innovations funding stage. However, the lessons learned about effective faith based engagement and support of persons returning to the community from jail were integrated into the ongoing faith based program with the expectation of continued reductions in recidivism.

NOBLE WORKS (INNOVATIONS-14)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT: (7/1/15 - 12/31/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Noble Works program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). Noble Works was designed to increase employment of persons with Serious Mental Illness (SMI) with a particular emphasis on expanding employment opportunities beyond traditional low-wage, low-skill positions. Through improvements in their employment situation, Noble Works was expected to also boost participants' sense of empowerment, social connectedness, and overall quality of life. The Union of Pan Asian Communities (UPAC) was the lead agency in the Noble Works collaboration, with Pathways Community Services providing employment services oriented towards transitional age youth (TAY), and the National Alliance on Mental Illness San Diego (NAMI SD) providing community presentations and other training supports.

Noble Works utilized a multi-faceted approach based on Supported Employment principles that targeted both prospective employers and persons with SMI. Core components of the program included utilization of Employment Specialists, who helped participants prepare for and find competitive employment positions of interest, and peer-support Job Coaches, who provided individualized support for maintaining employment. UPAC and NAMI SD conducted community presentations to help reduce stigma and educate potential employers about hiring persons with SMI. Other innovative Noble Works components included funding for apprenticeships to incentivize hiring persons with SMI, access to the NAMI SD Tech Café, technology-related training and certificate opportunities (e.g., CompTIA A+), entrepreneurial business development supports, and other employment resources.

EXECUTIVE SUMMARY

The Noble Works program (INN-14) was designed to increase competitive employment among persons with SMI by providing extensive pre- and post-employment training and support via Noble Works Employment Specialists and Job Coaches. Noble Works program activities also included outreach to and education of potential employers to decrease stigma and expand awareness of employment opportunities.

- A total of 295 persons enrolled into Noble Works.
- The majority of enrollees were male (58.7%) and one-third (33.9%) were TAY (i.e., age 18-25). More than half (54.5%) reported some college education or more.
- Overall, 26.8% participants (n=79) obtained at least one job (similar rates were evident for TAY and non-TAY).
- Of the 113 total jobs acquired, the median wage was $11.50/hour with an average of 26.2 work hours per week. Participants employed at the end of the program or at the time they exited Noble Works (n=53) had been continuously employed for an median of 186 days.
- Approximately 20% of the jobs acquired were classified as occupations that required at least a "medium" amount of preparation (i.e., skills, education, experiences) to obtain.
- Compared to participants who obtained jobs, participants who did not were rated as having greater functional impairment and lower coping capabilities at their follow-up assessment. This suggests one potential factor contributing to difficulties obtaining jobs was related to participants' deteriorating mental health and/or well-being.
- Primary factors inhibiting achievement of program goals appeared to include: 1) challenges maintaining participant engagement/interest in program, 2) difficulties with job development/outreach efforts, and 3) high staff turnover.

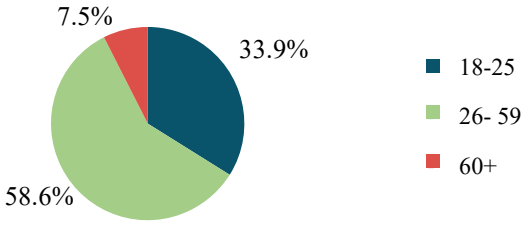
FUTURE DIRECTIONS

Based on the results of the MHSA funded INN pilot project and other BHS system priorities, it was determined to not continue the Noble Works program. While the overall program ended, two components, Apprenticeships and Consumer Owned Businesses were added to one existing BHS program that already provided Supported Employment/Individual Placement and support services to consumers with SMI. These unique approaches are expected to create additional opportunities to tailor employment and business start-up related services to the interests and skills of participants.

PARTICIPANT CHARACTERISTICS

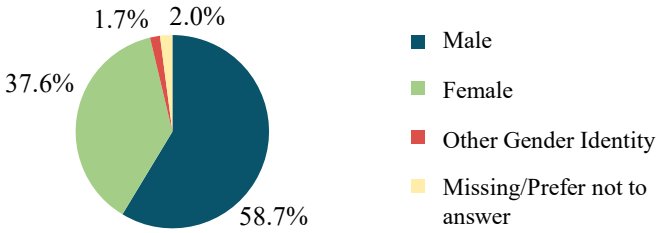
The following characteristic data were collected from a participant self-report survey at the start of Noble Works.[1]

AGE (N=295)



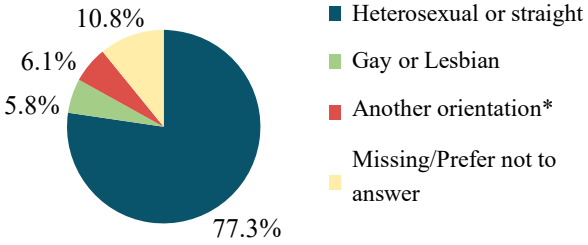
Over half (58.6%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=295)



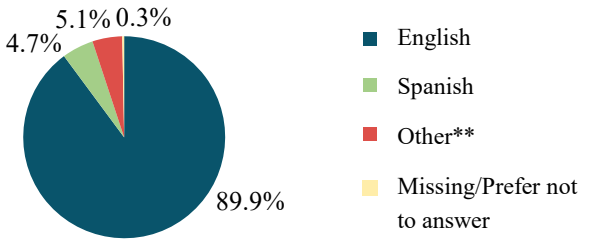
Nearly 60% (58.7%) of participants were male and 37.6% were female.

SEXUAL ORIENTATION (N=295)



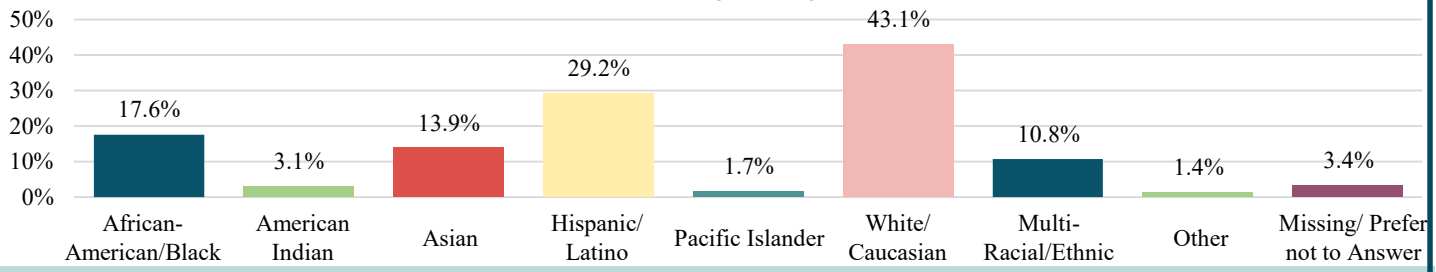
The majority (77.3%) of participants were heterosexual or straight, and 5.8% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=295)



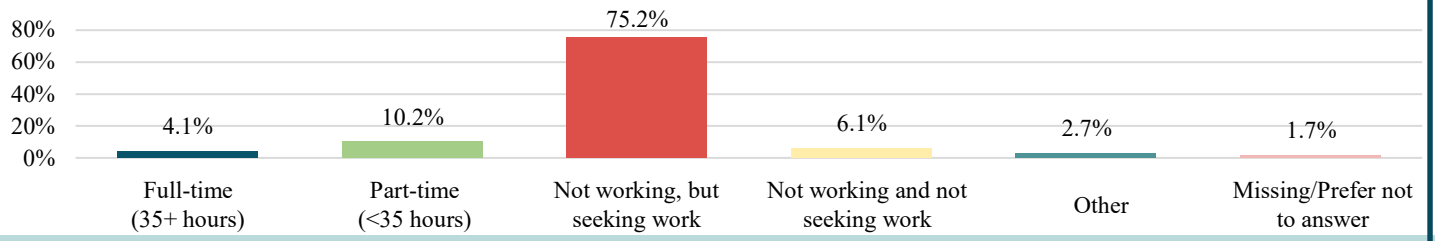
English was the primary preferred language for almost all of the participants (89.8%).

RACE/ETHNICITY (N=295)



Similar proportions of participants identified themselves as White (43.1%) and Hispanic/Latino (29.2%). Totals may exceed 100% as participants could indicate more than one race/ethnicity.

EMPLOYMENT STATUS (N=295)

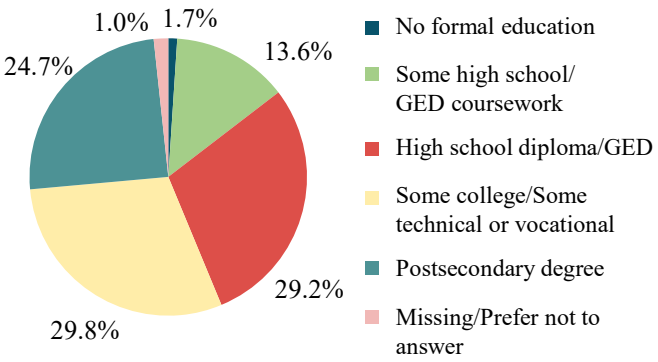


As expected for this type of program, most participants were either not working, but seeking work (75.2%), or in part-time positions (10.2%), when they started Noble Works.

*[1]Percentages may not total to 100% due to rounding. *Another orientation includes Bisexual/Pansexual/Sexually fluid.**Other includes Farsi, Lao, Mandarin, Russian, Tagalog, and Vietnamese.*

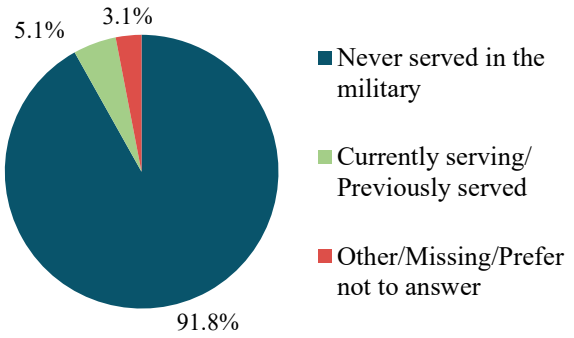
PARTICIPANT CHARACTERISTICS (CONTINUED)

EDUCATION LEVEL (N=295)



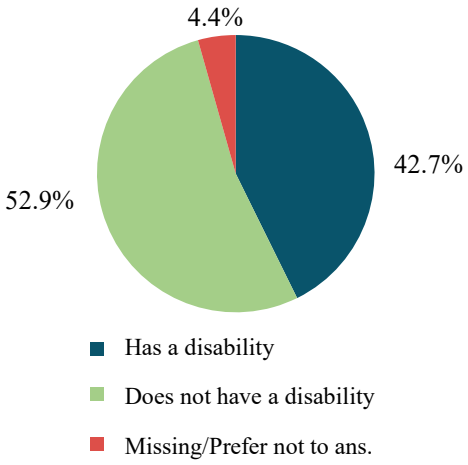
Approximately half of the participants (54.5%) had at least some postsecondary education.

MILITARY STATUS (N=295)



The majority (91.9%), of participants had never served in the military.

DISABILITY[2] STATUS (N=295)



A minority (42.7%) of the participants indicated having some form of non-SMI related disability.

TYPE OF DISABILITY (N=295)

Type	n	%
Communication	36	12.2
Mental (e.g., learning)	53	18.0
Physical	28	9.5
Chronic health condition	22	7.5
Other	26	8.8

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

[2] *A disability was 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 (SMI).*

JOBS ACQUIRED THROUGH NOBLE WORKS

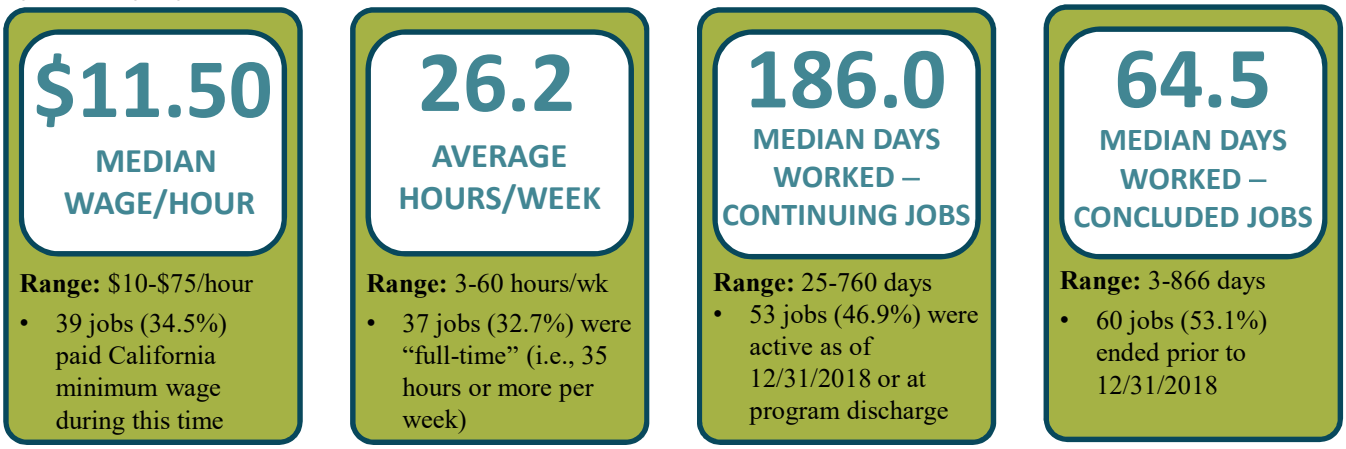
A total of 113 jobs were acquired by 79 people through the Noble Works program during its implementation from 07/1/2015-12/31/2018. As shown in Table 1, the jobs acquired covered a wide assortment of occupations, with the most common positions in the domains of office/administrative support (24.8%), food preparation and serving (20.4%), and sales (17.7%).

TABLE 1. JOB DOMAINS FOR JOBS ACQUIRED THROUGH NOBLE WORKS

	n	%
Building and Grounds Cleaning and Maintenance Occupations	8	7.1
Business and Financial Operations Occupations	2	1.8
Community and Social Services Occupations	6	5.3
Construction and Extraction Occupations	2	1.8
Food Preparation and Serving Related Occupations	23	20.4
Healthcare Support Occupations	6	5.3
Installation, Maintenance, and Repair Occupations	2	1.8
Office and Administrative Support Occupations	28	24.8
Personal Care and Service Occupations	3	2.7
Production Occupations	7	6.2
Protective Service Occupations	3	2.7
Sales and Related Occupations	20	17.7
Transportation and Material Moving Occupations	3	2.7

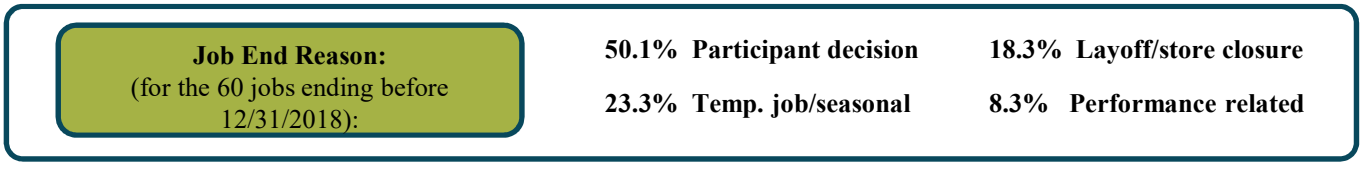
The median wage for these positions was $11.50 per hour. Of the 113 jobs obtained, 32.7% were full-time. The average number of hours worked per week was 26.2. Of the 53 jobs that were either still active as of 12/31/2018 or active at the time of program discharge, the median duration was 186.0 days. Meanwhile, the median duration of days worked for jobs that ended prior to 12/31/2018 was 64.5 days.

FIGURE 1. CHARACTERISTICS OF JOBS ACQUIRED THROUGH NOBLE WORKS DURING PROGRAM IMPLEMENTATION 07/1/2015-12/31/2018



As shown in Figure 2, for the majority of jobs that ending before 12/31/2018, the primary reason was due to the participant deciding to leave the position. There were less than 9% reported instances of jobs ending primarily due to performance-related issues.

FIGURE 2. PRIMARY REASONS WHY JOBS ENDED DURING PROGRAM IMPLEMENTATION 07/1/2015-12/31/2018



JOBS ACQUIRED THROUGH NOBLE WORKS (CONTINUED)

Based on the U.S. Department of Labor Occupational Information Network (O*NET) Standard Occupational Classifications (SOC), most of the jobs obtained through the Noble Works program required either little/no preparation (30.1%) or some preparation (48.7%), as shown in Table 2. This is generally consistent with the finding that 34.5% of the jobs started at minimum wage. During its final year of operations Noble Works was able to expand job placement opportunities to include a position in Category 5 (i.e., occupations that need extensive preparation). Approximately 20% of the jobs obtained were Category 3 or above.

TABLE 2. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	34	30.1
2 - Occupations that need some preparation	55	48.7
3 - Occupations that need medium preparation	14	12.4
4 - Occupations that need considerable preparation	9	8.0
5 - Occupations that need extensive preparation	1	0.9

As shown in Figure 3, 26.8% (n=79) of the participants who ever enrolled in Noble Works obtained a job by the end of program implementation (12/31/2018). Transitional age youth (TAY; age 18-25) were as likely and as timely as adults in finding jobs through the Noble Works program. However, TAY are more likely than adults to leave the program before getting a job. While many of the jobs were found within three months of entering Noble Works, some participants may take six or more months to find their first job.

FIGURE 3. NOBLE WORKS OVERALL JOB ACQUISITION DATA

LIFE OF PROGRAM
(07/1/2015 - 12/31/2018)

- 295 unduplicated participants
- 307 enrollments into the Noble Works program (some participants enrolled multiple times)
- 79 persons obtained a job through Noble Works
- 26.8% ever employed in job obtained via Noble Works
- Time to job acquisition took an average of 144.8 days
- No meaningful difference in number of days to acquire first job between TAY and adults
- Transitional age youth (TAY; age 18-25) job acquisition similar to adults (25.0% vs. 27.7%, respectively)

NOBLE WORKS BUSINESS START-UP ACTIVITIES

Noble Works provided financial support and technical assistance to help five participants start businesses that reflected their unique interests and skills (e.g., jewelry making, catering consultant, grant writing company).

NOBLE WORKS SOCIAL ENTERPRISE ACTIVITIES

Noble Works assisted in the development of the Neighborhood Enterprise Center and participants received culinary arts training/employment in "Kitchen Creation," a rentable commercial kitchen used by local entrepreneurs to prepare food (e.g., caterers) as well as space to provide culinary arts related trainings/certifications.

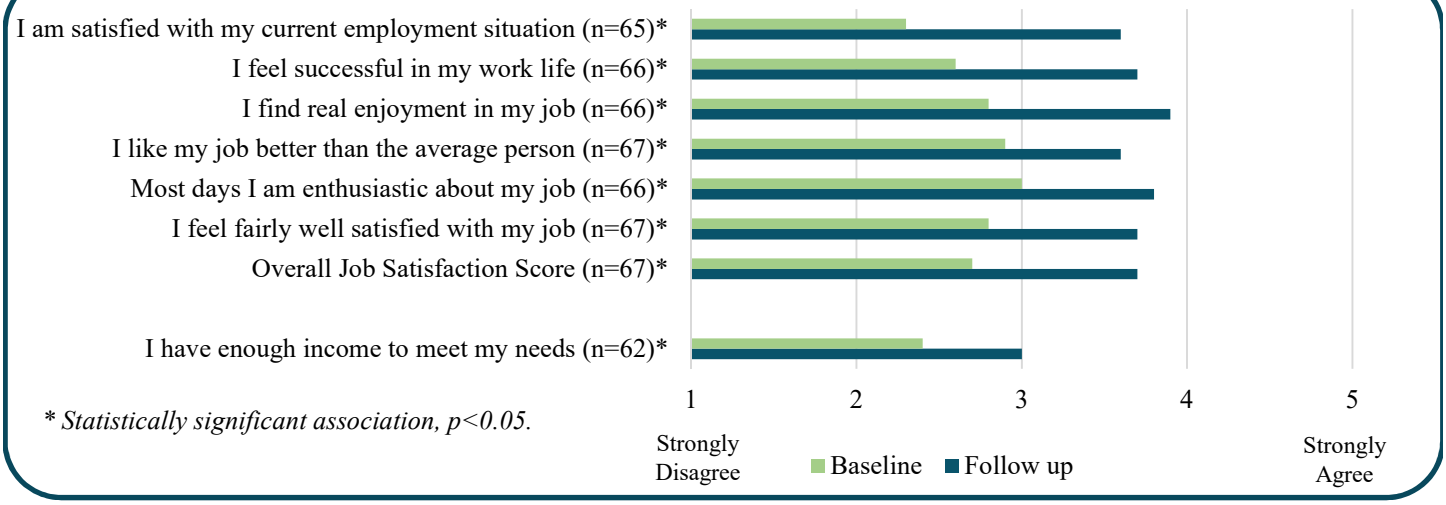
EXITS FROM NOBLE WORKS PRIOR TO JOB ACQUISITION

Of the 295 participants who entered the Noble Works program 59.3% (n=175) left the program prior to obtaining a job due to indicating they were no longer interested in receiving Noble Works services or dropping out due to loss of contact.

JOBS ACQUIRED THROUGH NOBLE WORKS (CONTINUED)

As shown in Figure 4, for persons who ever obtained a job through the Noble Works program, each measure of job satisfaction increased substantially from program entry (baseline) to post-job follow-up. Starred items had a statistically significant change in mean score from baseline to follow-up ($p<0.05$). The overall job satisfaction score (i.e., the average of all six satisfaction items), increased from 2.7 at baseline to 3.7 post-job (on a scale from 1-5 with higher values corresponding to greater job satisfaction). The statistically significant increases indicated that obtaining a job through Noble Works dramatically improved perceptions of their employment circumstances. While increasing post-job, the sense of having enough income only rose to about a 3 (on a scale of 1-5), suggesting opportunities for further improvements in this area.

FIGURE 4. EMPLOYMENT RELATED SATISFACTION - COMPARISION OF INITIAL AND FOLLOW-UP RATINGS



* *Statistically significant association, p<0.05.*

The Illness Management and Recovery (IMR) scale is an assessment utilized by the Noble Works staff to measure perceptions of a participant's recovery, with higher values indicating better outcomes. Overall, no improvements were seen in IMR scores between participants first and last IMR assessment, and looking at participants final IMR score, no significant differences were seen in IMR score changes between participants with lower job satisfaction and those with higher job satisfaction. However, significant differences were seen in IMR inventory scores between participants who acquired a job and those who did not (Table 3). Participants who acquired a job had significantly improved IMR score ratings in the areas of contact with people outside family, time in structured roles, impairment of functioning, and coping. Whereas, participants who did not acquire job had similar or worsened IMR ratings in those same areas.

TABLE 3. IMR MEAN SCORES FOR PERSONS WHO DID AND DID NOT ACQUIRE A JOB THROUGH NOBLE WORKS

	Without job acquisition (n=156)			With job acquisition (n=72)			
	Baseline	Follow-up	Paired t-test, p-value	Baseline	Follow-up	Paired t-test, p-value	Significant difference at last follow-up, between groups
IMR4 'Contact with people outside my family'	3.4	3.4	0.699	3.5	4.0	0.002	*
IMR5 'Time in structured roles'	2.5	2.4	0.186	2.4	3.3	< 0.001	*
IMR7 'Impairment of functioning'	3.3	2.8	< 0.001	3.0	3.6	0.001	*
IMR11 'Coping'	3.6	3.0	< 0.001	3.6	3.8	0.465	*

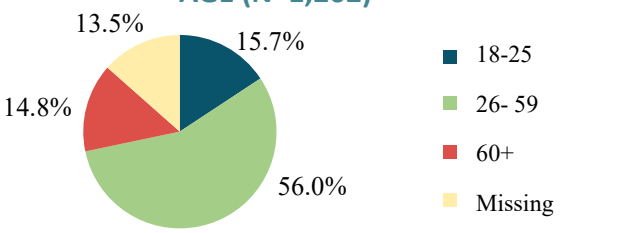
* *Statistically significant association, p<0.05.*

Another assessment used by Noble Works is the recovery markers questionnaire (RMQ), a self-report measure of a participant's own perception of their recovery. Improvements in participants' overall RMQ composite scores between their initial and final assessments were not seen, however, improvements were seen in individual RMQ domains such as having enough income, contributing to the community, being less bothered by symptoms, and dealing more effectively with daily problems. Exploratory analysis using regression modeling suggested that final RMQ composite scores were associated with baseline RMQ scores before a job was acquired and with a participant's level of job satisfaction. The magnitude of this effect was small, but it does lend support to the idea that people who liked their jobs showed greater self-reported improvements.

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

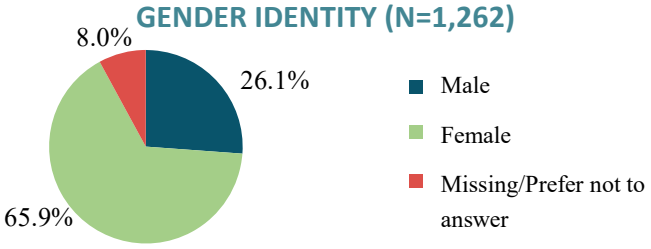
Throughout the life of the Noble Works program (7/1/15-12/31/18), NAMI SD, a program partner, conducted 97 "In Our Own Voice" (IOOV) community outreach and education presentations regarding mental illness and recovery. Either in conjunction with NAMI SD, or independently, Noble Works representatives also conducted 64 "Trainings to Businesses" presentations that provided mental health related education to potential employers. The charts below provide an overview of select presentation attendee demographics and outcomes, with 'respondent type' only pertaining to the "Trainings to Businesses" presentations.

AGE (N=1,262)



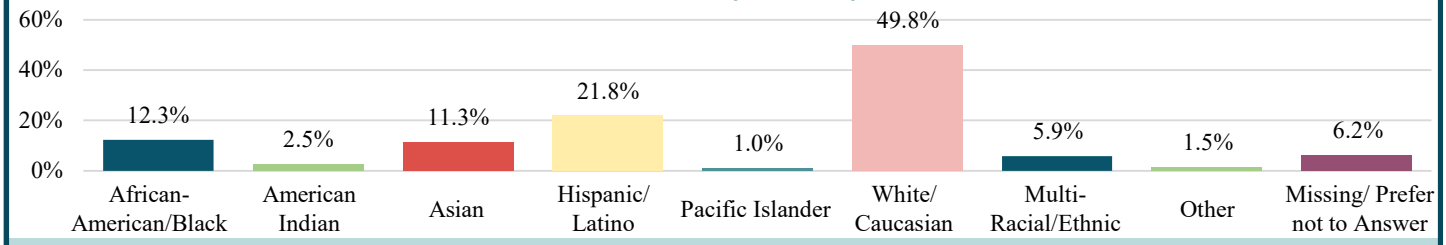
Over half (56.0%) of attendees were between the ages of 26 and 59.

GENDER IDENTITY (N=1,262)



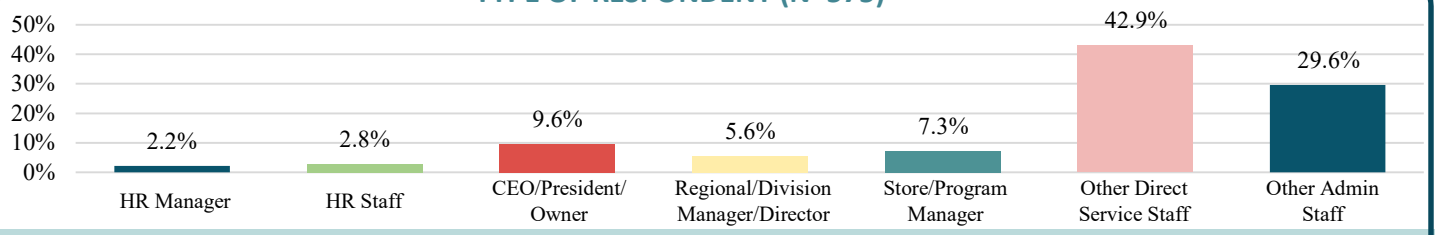
The majority of attendees were female (65.9%).

RACE/ETHNICITY (N=1,262)



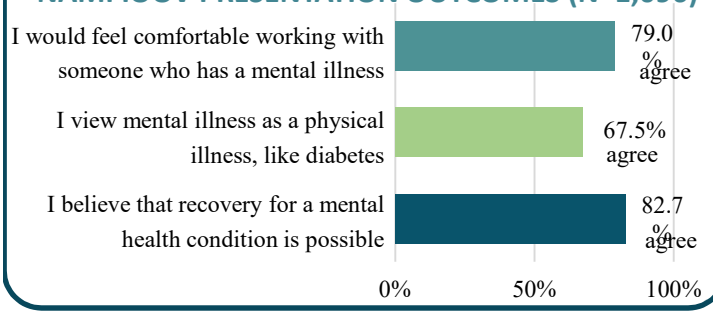
The majority of attendees identified as White/Caucasian (49.8%), with 21.8% indicating an Hispanic/Latino background. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

TYPE OF RESPONDENT (N=575)

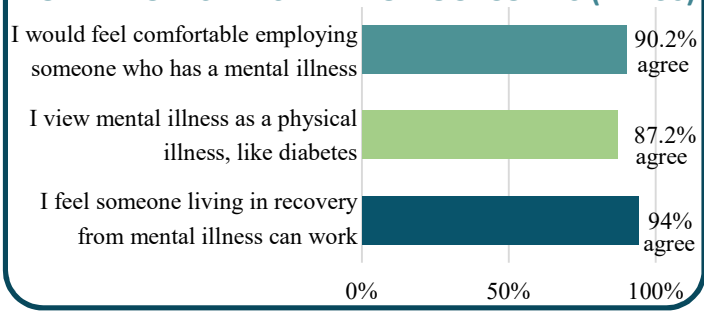


Almost half (43.0%) of the attendees identified themselves as direct service staff, with close to one-third (29.6%) identifying as administrative staff.

NAMI IOOV PRESENTATION OUTCOMES (N=1,096)



NOBLE WORKS PRESENTATION OUTCOMES (N=430)



The majority of respondents indicated positive attitudinal changes as a result of NAMI SD's IOOV and Noble Works "Training to Businesses" presentation. These findings reflect ongoing efforts to normalize attitudes about mental health in the workforce. However, more improvements are possible since only 67.5% from IOOV indicated viewing mental illness similar to a physical illness.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year of providing Noble Works program services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Noble Works program. The following represent key findings identified via qualitative analyses of the open-ended staff survey response from the three annual surveys.

1. *Primary factors that helped achieve Noble Works goals:*
    a. Skilled and passionate staff who worked to support participants and increase participant employment opportunities.
    b. Participants being provided one-on-one support through working with an employment specialist or job coach.
    c. Community presentations that worked to increase knowledge of mental health, reduce stigma, and emphasize the vital role that employment plays in mental health recovery.
    d. Tools and resources such as classes, employment leads, and connections within the community provided by the program that were available to help support and educate participants.
    e. Partnerships and collaborations within the Noble Works program as well as with programs and organizations in the community.
    f. Participants who were engaged in program activities and were motivated to learn and enhance their skills.

2. *Primary factors that inhibited achieving Noble Works goals:*
    a. High levels of staff turnover created challenges affecting program operations.
    b. Staff uncertainty about job roles/tasks (e.g., communication methods with participants and employers).
    c. Challenges maintaining participant effort and interest.
    d. Intake process inhibits quick engagement with participants and connections to potential employers.
    e. Outreach efforts not reaching the right types of businesses, employers, or the community.

3. *Primary challenges obtaining and maintaining employment for participants:*
    a. Employers with a lack of awareness about mental illness who are resistant to learning about the program or getting to know participants.
    b. Participants who want a 'dream job' but do not want to take classes, trainings, or certifications to qualify.
    c. Participants not properly managing their symptoms.
    d. Unrefined work skills (e.g., communication skills, professional behavior, social interactions, conflict resolution).
    e. Participants with low motivation.
    f. Lack of relevant and suitable job openings.

4. *Primary factors that facilitated ongoing participant engagement in Noble Works:*
    a. Staff efforts to build relationships with participants and maintain regular contact with supportive communication.
    b. Resources and incentives offered to participants for participating in program activities and classes.
    c. Unique opportunities that are available to participants through the Noble Works program, such as Kitchen Creations, and the Tech Café.
    d. Passionate staff that are committed to empowering participants.
    e. A welcoming and inclusive environment where participants can see the progress they are making within the program.
    f. Time spent with participants to build trust and rapport and to meet clients “where they are at” within their recovery and to work with them regarding their employment interests.

5. *Primary impacts of trainings and business development opportunities:*
    a. Increases the chances that a participant will be hired.
    b. Contributes to the quality/marketability of the program as a whole.
    c. Capitalizes on the strengths/interests of participants.
    d. Enhances learning opportunities.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to Noble Works outcomes and operations throughout the three and one half year MHSA Innovations-funded study. These findings were derived from multiple sources including participant feedback surveys, staff surveys, and discussions with program and BHS personnel. These learnings are intended to inform implementation and operational activities of any similar job placement and support programs. The key learnings are organized into general thematic categories.

1. ***Noble Works program implementation and operations***
   a. Program start-up issues (i.e., hiring, training, establishing facilities, collaborating with partners, developing trainings) required substantial time commitments.
   b. Noble Works staff were passionate and committed to achieving program objectives.
   c. Staff trainings, such as in Supported Employment evidence-based practices, supported the achievement of program objectives.
   d. High staff turnover was an ongoing substantial challenge to Noble Works' implementation and operations.
2. ***Creating/identifying training/mentorship opportunities***
   a. Training and certification programs need to be reviewed cautiously to promote greater likelihood that the time required of program staff and participants will lead to specific employment opportunities.
   b. The development of personal job mentors as part of the Noble Works program was difficult to establish, with few people interested in acting as a job mentor for Noble Works participants.
   c. The development of the multi-faceted Neighborhood Enterprise Center, near the end of the pilot study timeframe, created new job-specific training and certifications opportunities for the Noble Works SMI population.
3. ***Creating/identifying employment opportunities***
   a. Program was successful at identifying a diverse set of jobs for participants.
   b. In general, approximately 20% of jobs acquired through Noble Works were classified as needing at least a "medium" amount of preparation, skills, and/or experience (i.e., SOC Job Zone of Category 3 or higher).
   c. The Noble Works program demonstrated the capability for business "start-ups" among the SMI population, but findings suggest that such services were only relevant for a small portion of those served by Noble Works.
   d. Identifying and educating potential employers was difficult, but this objective was perceived as crucial for increasing the pool of known employment opportunities.
   e. Community presentations with employers appeared to have helped with overall mental health awareness and stigma reduction, but did not often contribute to the identification of new employers with employment opportunities for Noble Works participants.
4. ***Job placement rates and associated outcomes***
   a. Participant satisfaction with their employment situation increased after participating in the Noble Works program.
   b. Participant satisfaction with their employment situation was positively associated with a range of other self-reported indicators of their well-being (e.g., self-fulfillment, social connectedness).
   c. Job placement timing varied substantially (i.e., average of 145 days; range from less than 30 days to more than 200).
   d. It was challenging to identify jobs that were of interest to, as well as a good skills match for, Noble Works participants.
   e. Difficult to maintain participant motivation throughout process.
   f. Poor symptom management perceived as a barrier to job acquisition.
   g. Noble Works overall job placement rate (26.8%), was lower than typically achieved by structured Supported Employment/Individual Placement and Support programs (i.e., 50-65%).
   h. TAY (i.e., participants age 18-25) had similar rates of job acquisition as adults/older adults.

PROGRAM CHANGES FROM INITIAL DESIGN

Over the course of the INN-14 Noble Works pilot program, the staffing roles were adapted to more closely reflect the standard practices and procedures of the structured Supported Employment/Individual Placement and Support model of service delivery. This primarily entailed ending some of the job classes and combining the Job Coach and Employment Specialist roles into one position so that all staff work on all stages of the job identification, placement, and post-employment support process.

FUTURE DIRECTIONS

Based on the results of the MHSA funded INN pilot project and other BHS system priorities, it was determined to not continue the Noble Works program. While the overall program ended, two components, Apprenticeships and Consumer Owned Businesses were added to one existing BHS program that already provided Supported Employment/Individual Placement and support services to consumers with SMI. These unique approaches are expected to create additional opportunities within the existing program to further tailor employment and business start-up related services to the interests and skills of participants.

For additional information about the INN–14 Noble Works program and/or this report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

PEERLINKS (PEER ASSISTED TRANSITIONS) (INNOVATIONS-15)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT (7/1/16 - 6/30/19)

The Peer Assisted Transitions (INN-15 PAT) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). PAT was subsequently renamed to "PeerLINKS" to better reflect the services it provides and is henceforth referred to by this name. The primary innovation purpose of PeerLINKS was to increase the depth and breadth of services for persons diagnosed with Serious Mental Illness (SMI) who use acute crisis-oriented mental health services but are not effectively connected with community resources and/or lack active support networks through the provision of peer specialists. The program was delivered by National Alliance on Mental Illness (NAMI) San Diego and received referrals from Scripps Mercy's inpatient unit and emergency department, UC San Diego's inpatient unit and emergency department, Vista Balboa Crisis Center, and New Vistas Crisis Center.

EXECUTIVE SUMMARY

PeerLINKS was designed to provide a culturally-competent, recovery-focused program for adults with SMI who receive care at two psychiatric hospitals and crisis residential facilities. The program started operation on July 1, 2016 with participants enrolled in the program from November 2016 onwards.

- During Fiscal Years 2016-18 to 2018-2019 a total of 659 unique participants were newly enrolled in the program.

Participant Demographics

- The majority of participants were between the ages of 26 and 59 (80.4%), there were slightly more male (49.9%) than female participants (45.8%), 76.2% were heterosexual, English was the primary language for the large majority (95.1%), and 55.1% were White/Caucasian. A small minority were veterans (5.5%).
- All participants had SMI. Of those, a little more than half (51.7%) reported having an additional non-SMI related disability.

Participant Rated Outcomes and Program Satisfaction

- The large majority of participants were satisfied with the services they received (96.9%), and as a result of the program, 92.2% knew where to get help when needed, 89.4% were more comfortable seeking help, and 85.4% were better able to handle things.

Participant Outcomes: Participants improved on a range of assessments.

- **Milestones of Recovery Scale (MORS):** Overall, participants increased in their MORS score from an average of 2.2 (experiencing high risk/not engaged) to 4.8 (not coping successfully/engaged). This increase was statistically significant. A total of 86.0% improved on the MORS, 10.3% remained stable, and 3.7% of participants decreased.
- **Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS):** Pre-post data on the CHAMPSSS showed that participants had statistically significant increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and had more people actively support them in recovery. In addition, participants demonstrated statistically significant improvements on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, and Suicidality Scales.

EXECUTIVE SUMMARY (CONTINUED)

Health and Substance Use

- Pre-post data on the Patient-reported Outcomes Measurement Information System (PROMIS) Global Health demonstrated improvement in both Global Physical Health and Global Mental Health scores. The improvement on the Global Mental Health Scale suggested a meaningful change. Average scores were in the moderate to mild range of functioning/impairment, with participants' average level of physical health being higher (better) compared to their mental health.
- On average, participants showed statistically significant improvement in all substance use related questions (PROMIS-Derived Substance Use) at baseline and most recent follow-up assessment, indicating less substance use treatment need.

Housing and Employment

- A total of 41.9% of participants moved into less restrictive and more independent housing. The average housing level improved from 3.2 at baseline to 4.2 at the most recent assessment, which was statistically significant.
- Pre-post data on housing outcomes indicated that the total number of participants and the total number of days being homeless decreased.
- Pre-post data on employment outcomes showed that the percentage of participants who were competitively employed increased from 8.9% to 16.7%. The number of participants who identified as unemployed decreased from 83.7% to 68.0%. The majority were unemployed due to mental health symptoms or disability. The average increase in employment level was statistically significant.

Linkages to Services

- Overall, 3,490 successful connections to services or resources were made. Participants could be connected to multiple services. For mental health services, 592 successful connections were made for 237 participants. For substance abuse services, 225 successful connections were made for 94 participants.
- Across all ten dimensions of wellness, a total of 488 or 74.1% of participants received at least one linkage or successful connection.
- Mental Health service data based on Linkage and Referral Tracker entries for participants who had been in the program for *at least 30 days* showed that, of those 412 participants who had been in the program for at least 30 days, 336 had either a referral or linkage across the mental dimension and 213 were successfully connected.

Critical Events

- Overall, the number of participant reported emergency interventions related to physical health, mental health/substance use, and physical and mental health/substance use decreased from baseline to the most recent follow-up assessment. The number of participants and the number of encounters participants had with non-psychiatric hospitalization and jail/prison settings decreased from baseline to follow-up.

Service Utilization

- Participant service utilization based on Cerner Community Behavioral Health system data indicated a decrease in psychiatric hospitalization re-admission. Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=197), the 30-day recurrence rate decreased from 21.3% (42 participants) to 15.7% (31 participants); i.e., a decrease of 26.2% or 11 participants. Among the crisis residential cohort (participants with a crisis residential treatment index event; N=283), the 30-day recurrence rate increased from 11.7% (33 participants) to 12.7% (36 participants); i.e., an increase of 9.1% or 3 participants.

FUTURE DIRECTIONS

Based on the positive findings from the INN-15 PeerLINKS innovations program, County of San Diego Behavioral Health Services dedicated ongoing Community Services and Supports Program (CSS) funding to continue the PeerLINKS program. This funding allowed the structure and operations of the program to continue uninterrupted. Under the new contract, Peer Assisted Supportive Services began services on 8/1/2019. The new contract increased the number of unique participants served per year and expanded to a third crisis residential program. Participants are able to remain in the program up to 6 months.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. *To provide peer support services to adults with Serious Mental Illness (SMI) who present at Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as at the Community Research Foundation's (CRF) Vista Balboa and New Vistas Crisis Residential facilities.*

Using MHSA's Innovation (INN) funding, the PeerLINKS program was successfully developed, implemented, and refined to provide peer support services to adults with SMI. PeerLINKS enrolled a total of 659 individuals; 46.5% of participants were referred from psychiatric inpatient unit settings and 51.3% from crisis homes; a small percentage of participants (2.2%) were referred from emergency departments.

2. *To engage with persons in the inpatient or crisis residence setting; maintenance of engagement with person following discharge from inpatient/residential setting, and support with navigation of behavioral health system of care and other support resources.*

The team of nine Peer/Family Support Specialists typically met with participants while still in the inpatient crisis residence setting or ED and continued to work with them in the community. Whenever possible, the Peer/Family Support Specialist who was assigned to work with them continued to work with the same participant during their entire time in the program, thus reducing the need for multiple warm handoffs. Once in the community, their assigned Peer/Family Support Specialist met with them in areas convenient to the participant. Throughout the program, their assigned Peer/Family Support Specialist partnered with the same participants to identify each participant's needs, goals, and preferences and supported them in being connected with services and resources of their choosing. Participants were empowered and encouraged by their Peer/Family Support Specialist to have an active role in their recovery and in reaching their goals. Therefore, in addition to being connected to resources, they learned and practiced being connected to a variety of resources and services. As a result, many participants (92.2%) agreed or strongly agreed that they felt comfortable navigating resources and accessing services as a result of the program.

3. *To enroll a minimum of 200 unduplicated adult participants into the program annually.*

The PeerLINKS program started operation on July 1, 2016 with participants enrolled in the program from November 2016 onward. A total of 659 unduplicated adult participants were enrolled into PeerLINKS. In the first year of operation (FY 2016-17), 189 participants enrolled; during the second year of operation (FY 2017-18), 272 participants enrolled; and 201 participants were enrolled during the third year (FY 2018-19), of which a small number of individuals had previously been enrolled in PeerLINKS.

4. *To decrease psychiatric hospitalization re-admissions and crisis residential facility re-admissions.*

Participant service utilization based on Cerner Community Behavioral Health system data indicated a decrease in psychiatric hospitalization re-admission. Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=197), the 30-day recurrence rate decreased from 21.3% (42 participants) to 15.7% (31 participants); i.e., a decrease of 26.2% or 11 participants. Among the crisis residential cohort (participants with a crisis residential treatment index event; N=283), the 30-day recurrence rate increased from 11.7% (33 participants) to 12.7% (36 participants); i.e., an increase of 9.1% or 3 participants.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES (CONTINUED)

5. To increase linkages with formal support services and identify personal goals for recovery and wellness.

An important aspect of the program was linking participants with formal support services. The Linkage and Referral Tracker was used to track discussions, referrals, linkages, and successful connections that Peer/Family Support Specialists made to other services. It reports on ten Dimensions of Wellness which include physical health, social health, mental health, substance abuse, housing, occupation/education, financial assistance/benefits and legal, transportation, identification, and basic needs. A total of 3,490 successful connections with formal support services were made for 455 unique participants since program operation started. In addition, 4,444 referrals and 1,512 linkages were made (for 518 unique participants and 351 unique participants, respectively). For the mental health dimension, 592 successful connections were made for 237 unique participants. For participants enrolled in the program for at least 30 days (N=412), 336 unique participants were referred or linked to mental health related services, while 213 unique participants were successfully connected (63.4% successfully connected). For the substance abuse dimension, 225 successful connections for 94 unique participants were made. Across all ten dimensions of wellness, a total of 488 or 74.1% of participants received at least one linkage or successful connection. The Linkage and Referral Tracker was also used as a shared decision-making tool with participants and to help set their personal goals for recovery and wellness.

6. To increase participant's active social support recovery network.

Compared to baseline, participants reported increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and having more people actively support them in recovery at follow-up, as measured by the CHAMPSSS. These increases were statistically significant. The program reported that several participants reconnected with family and their children, others found new individuals that joined their lives and supported their well-being and recovery.

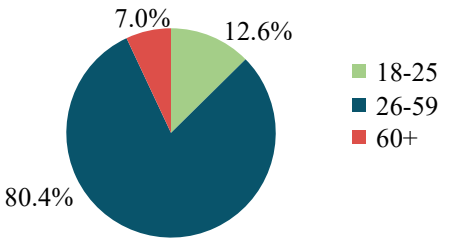
7. To demonstrate improved level of recovery.

On average, participants showed statistically significant improvement in all of the CHAMPSSS subscales (i.e., Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, Suicidality, and Impact of Symptoms Scales) with the exception of Substance Use Frequency Scale which stayed the same. In addition, MORS scores have been increasing from an average of 2.2 to 4.8, which was statistically significant. A total of 86.0% of participants improved on the MORS and 10.3% remained stable (no change in score). Only 3.7% decreased. In addition, the large majority of participants agreed or strongly agreed that as a result of the PeerLINKS program, they know where to get help when needed (92.2%), are more comfortable seeking help (89.4%), and are better able to handle things (85.4%).

PARTICIPANT CHARACTERISTICS

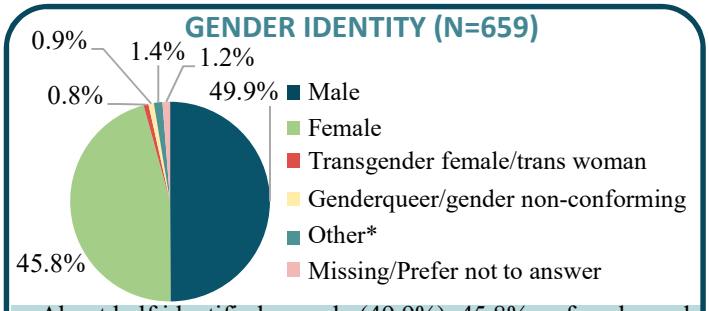
The following characteristic data were collected from the intake assessment administered at the start of the program.[1]

AGE (N=659)



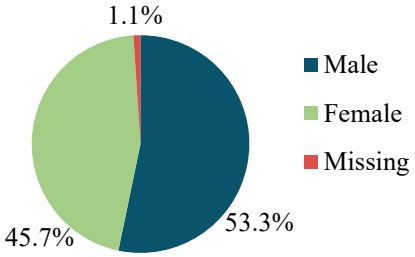
The majority of participants were 26-59 years old (80.4%), 12.6% were 18-25 years old and 7.0% were 60 years or older.

GENDER IDENTITY (N=659)



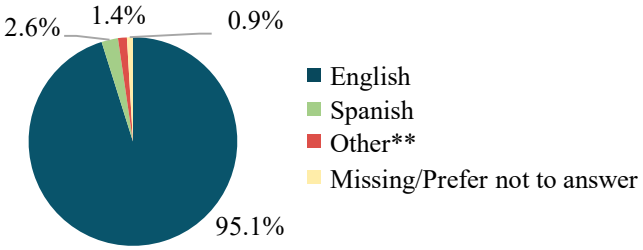
About half identified as male (49.9%), 45.8% as female, and 3.0% transgender female, genderqueer, or another gender identity.

SEX AT BIRTH (N=659)



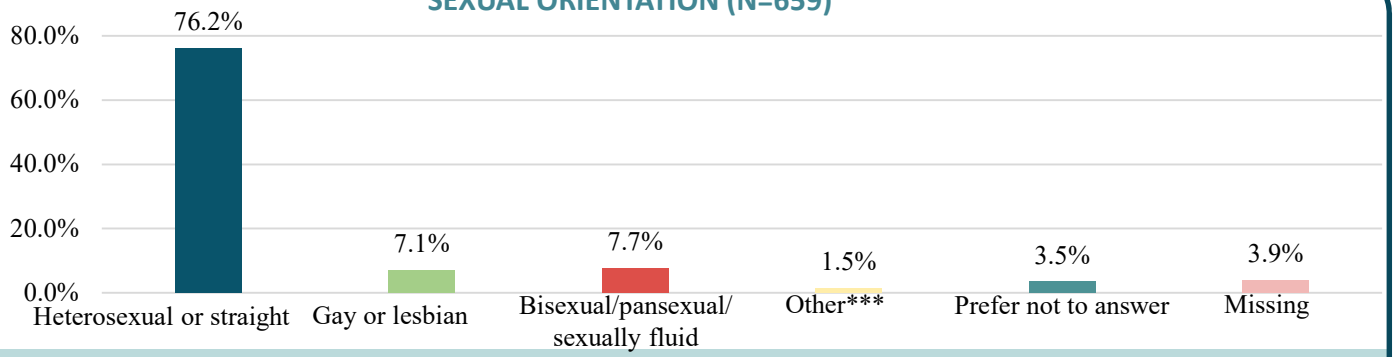
53.3% identified as male on their birth certificate, while 45.7% identified as female.

PRIMARY LANGUAGE (N=659)



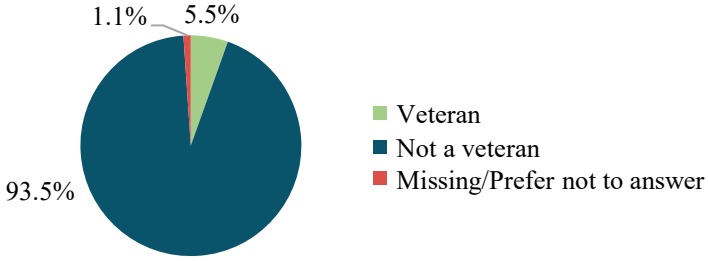
The large majority (95.1%) of participants spoke English as their primary language.

SEXUAL ORIENTATION (N=659)



76.2% of participants identified as heterosexual or straight, 7.1% as gay or lesbian, and 7.7% bisexual/pansexual/sexually fluid.

VETERAN STATUS (N=659)

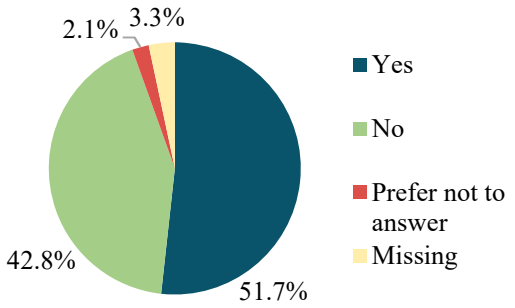


The majority of participants were not veterans (93.5%) and 5.5% were veterans.

[1] Percentages may not total to 100% due to rounding. *Other includes Transgender male/trans man, Questioning/unsure of gender identity, and Another gender identity. **Other includes American Sign Language, Arabic, Cambodian, Japanese, Vietnamese, and Other. ***Other includes Queer, Questioning/unsure of sexual orientation, and Another sexual orientation.

PEERLINKS PROGRAM PARTICIPANT DEMOGRAPHICS (CONTINUED)

DISABILITY STATUS (N=659)[2]



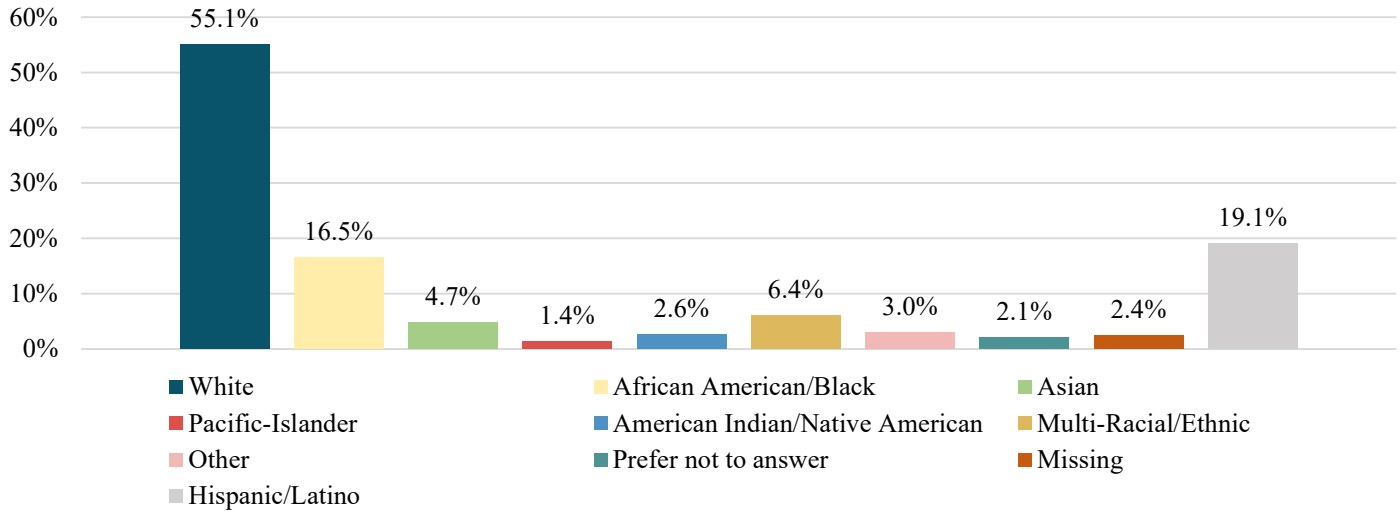
All participants had SMI. In addition, a total of 51.7% reported having some type of non-SMI related disability.

TYPE OF DISABILITY (N=659)

Type	N	%
Communication disability	92	14.0
Mental disability (e.g., learning)	85	12.9
Physical disability	76	11.5
Chronic health condition	114	17.3
Other	129	19.6

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

RACE/ETHNICITY (N=659)



The majority of participants were White/Caucasian (55.1%), 16.5% were African American/Black, and 19.1% identified as Hispanic/Latino ethnicity. Totals exceed 100% as participants were able to indicate more than one race/ethnicity.

[2] A disability was 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 (SMI). Data includes communication disability, mental disability, physical/mobility disability, and other. Communication disabilities include difficulty seeing, difficulty hearing or having speech understood, and other communication disability. Mental disabilities not related to mental illness include learning disability, developmental disability, dementia, and other mental disability not related to mental illness. Physical/mobility disabilities include chronic health condition/chronic pain.

KEY EVALUATION FINDINGS

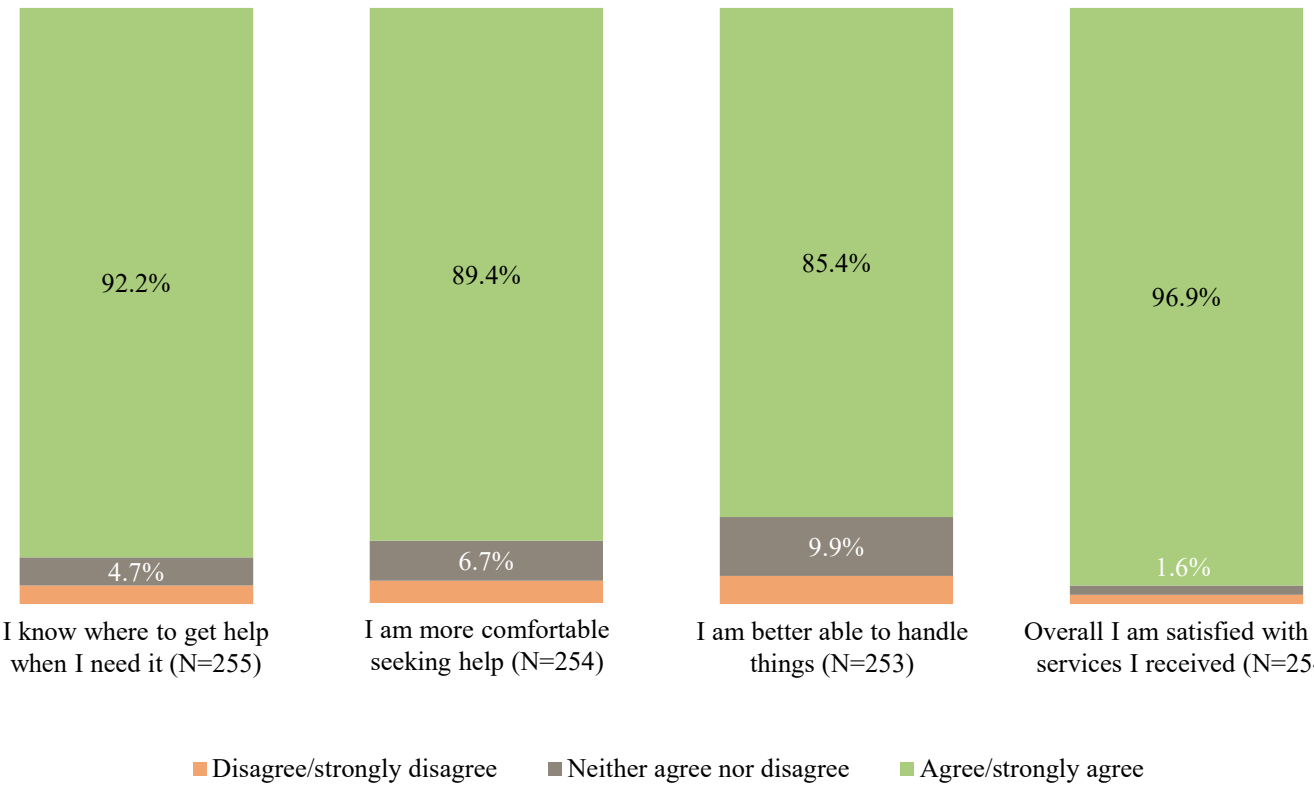
The key evaluation findings are based on a comprehensive set of assessment tools used by PeerLINKS. The assessments are administered by Peer/Family Support Specialists and other trained mental health professionals. They include participant demographics, key outcome domains (housing, employment, and critical events), the Milestones of Recovery Scale (MORS), the Linkage & Referral Tracker, and the Encounter Form. Participants complete an integrated self-assessment, the Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS), which includes the PROMIS Global Health scales (mental health and physical health) as well as items measuring substance use, suicidality, satisfaction, and impact of symptoms on daily activities. In addition, the CHAMPSSS form includes four items measuring satisfaction and participant outcomes, which have been used extensively across a wide range of programs in San Diego County. The data are entered into the Mental Health Outcome Management System (mHOMS), an electronic health record system.

PARTICIPANT SATISFACTION AND PARTICIPANT-RATED OUTCOMES

Program participants responded to the post outcome survey, which is completed at follow-up and discharge assessments. The survey captures items regarding knowledge about where to get help, comfort in seeking help, coping, and overall satisfaction with program services. Figure 1 provides data for participants' most recent assessment.

Overall, the large majority of participants agreed or strongly agreed that as a result of the PeerLINKS program, they know where to get help when needed (92.2%), are more comfortable seeking help (89.4%), and are better able to handle things (85.4%). The large majority of participants agreed or strongly agreed that they were satisfied with the services they received at PeerLINKS (96.9%).

Figure 1: Participant Satisfaction and Participant Rated Outcomes



PARTICIPANT RECOVERY

MILESTONES OF RECOVERY SCALE (MORS)

The Milestones of Recovery Scale (MORS) captures recovery as assessed by trained staff using a single-item recovery indicator. Participants are being 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 past month. Although MORS ratings do not comprise a linear scale, higher ratings are associated with greater recovery. The MORS is completed at baseline and at regular follow-up assessments (the most recent follow-up assessment can be at 1, 2, 3, 6, 9, 12 months, or discharge, whichever comes sooner).

Changes in MORS Ratings Over Time

A total of 271 participants had valid MORS assessments at two (or more) points in time. The data matching process selected the most recent complete MORS follow-up assessment during the reporting timeframe (i.e., FY 2016-17 to FY 2018-19) and matched this to the baseline assessment. The average duration between the baseline and most recent MORS assessment was approximately 4.4 months (134 days).[3]

Overall, MORS scores from these 271 participants have been increasing from an average of 2.2 to 4.8 (summarized in Figure 2). This increase was statistically significant. Specifically, as shown in Figure 3, 86.0% of participants improved on the MORS and 10.3% remained stable (no change in score). Only 3.7% decreased.

Figure 2: Change in Average MORS Scores (Pre-post, N=271)

Figure 3: Change in MORS Scores (Pre-post, N=271)

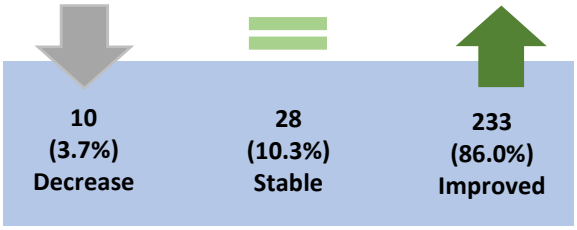


Table 1 compares the distribution of MORS scores at baseline and the most recent follow-up assessment.[4] At baseline, 90.0% of participants had MORS scores within the extreme risk and high risk categories (scores 1-3) and only 7.3% had scores at or above 5. In contrast, at follow-up 21.4% had scores in the extreme/high risk categories, and 72.3% scored 5 or above.

Table 1: MORS Ratings (Pre-post; N=271)

		Baseline		Most recent	
1	Extreme Risk	41.3%		2.2%	
2	High Risk/Not Engaged with mental health providers	17.7%	90.0%	3.7%	21.4%
3	High Risk/Engaged with mental health providers	31.0%		15.5%	
4	Poorly Coping/Not Engaged with mental health providers	2.6%	2.6%	6.3%	6.3%
5	Poorly Coping/Engaged with mental health providers	6.6%		46.1%	
6	Coping/Rehabilitating	0.7%	7.3%	21.4%	72.3%
7	Early Recovery	0.0%		3.3%	
8	Advanced Recovery	0.0%		1.5%	

[3] The average duration was calculated for participants with a valid baseline and most recent follow-up MORS who had only been enrolled in the program once (N=240). The average baseline and most recent follow-up MORS score (2.2 and 4.8) was the same for the N=240 participants and the slightly larger sample of N=271 participants. [4] Percentages may not total to 100% due to rounding.

PARTICIPANT RECOVERY (CONTINUED)

COMBINED HEALTH ASSESSMENT: MENTAL, PHYSICAL, SOCIAL, SUBSTANCE, STRENGTHS (CHAMPSSS)

The CHAMPSSS assesses participants' perceptions and experiences that indicate recovery, symptom reduction, and increased self-esteem. Scores range from 1 to 5 and items were coded such that higher scores indicate more positive perceptions and experiences.[5]

Changes in Participants' Active Social Support and Recovery Network

Changes in participants' active social support and recovery network were measured based on three items included in the CHAMPSSS. Mean CHAMPSSS items that reflect active social support and recovery networks are displayed in Table 2 below. Compared to baseline, participants reported increased satisfaction with social activities and relationships, more frequent contact with people that care about them, and having more people actively support them in recovery at follow-up. The improvement in responses to all three were statistically significant.

Table 2: Mean CHAMPSSS Active Social Support and Recovery Network Items at Baseline and Follow-up (Pre-post)

CHAMPSSS Item	N	Baseline		Follow-up	
		M	SD	M	SD
In general, how would you rate your satisfaction with your social activities and relationships? (Item 5)	266	2.0	1.1	2.5	1.1
I had contact with people that care about me. (Item 10)	261	3.2	1.2	3.7	1.0
Outside of health care professionals, how many individuals actively support you in your recovery? (Item 32)	239	3.2	4.6	4.9	8.0

[5] Item 30 "How would you rate your pain on average" ranges from 0-10 but was recoded to a 5-point scale. Participants can enter any value for Item 32 "Outside of health care professionals, how many people actively support you in your recovery?".

PARTICIPANT RECOVERY (CONTINUED)

COMBINED HEALTH ASSESSMENT: MENTAL, PHYSICAL, SOCIAL, SUBSTANCE, STRENGTHS (CHAMPSSS)

Changes in CHAMPSSS Subscales

Mean CHAMPSSS subscale scores are displayed in Table 3. On average, participants showed improvement in all of the CHAMPSSS subscales with the exception of Substance Use Frequency Scale which stayed the same. The increases on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, Suicidality Scales and Impact of Symptoms Scales were statistically significant.

Table 3: Mean CHAMPSSS Subscale Scores at Baseline and Follow-up (Pre-post)

CHAMPSSS Subscale	N	Baseline		Follow-up	
		M	SD	M	SD
Global Health Scale (average of items 1-7, 25, 29, and 30)[6]	269	2.6	0.6	2.9	0.8
Resilience Scale (average of items 8, 9, 10, 11, and 12)	268	3.2	0.8	3.5	0.8
Depression Scale (average of items 13, 14, and 15)	267	2.3	0.9	3.1	0.9
Anger Scale (item 16)	264	3.0	1.1	3.5	1.0
Anxiety Scale (average of items 17, 18, and 19)	266	2.4	0.9	3.1	1.0
Substance Use Scale (average of items 20 and 21)	265	3.7	1.3	4.3	1.0
Memory/Cognition Scale (average of items 22 and 23)	265	2.9	1.1	3.4	1.1
Suicidality Scale (item 24)	265	3.3	1.3	4.2	1.0
Impact of Symptoms Scale (item 26)	260	2.6	1.0	3.1	0.8
Substance Use Frequency Scale (average of items 27 and 28)[7]	264	4.6	0.7	4.6	0.8

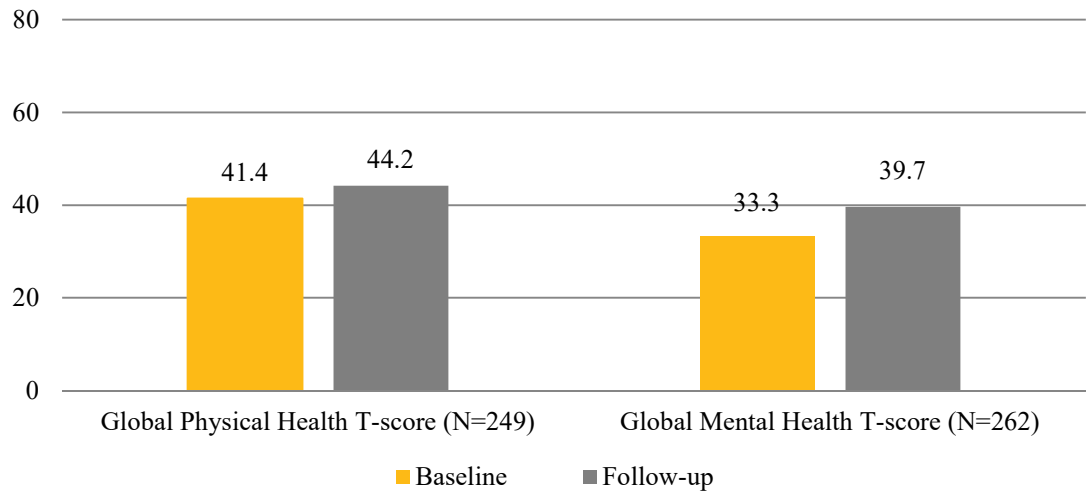
[6] Item 30 "How would you rate your pain on average" ranges from 0-10 but was recoded to a 5-point scale. Participants can enter any value for Item 32 "Outside of health care professionals, how many people actively support you in your recovery?". [7]The intake assessment is usually undertaken while participants are in Behavioral Health Units or Crisis Residential facilities. This might account for the low levels of substance use frequency (i.e., a high average score on the Substance Use Frequency Scale) reported by participants at baseline as access to substances would be prohibited in these facilities. The data indicates that levels were also low at follow-up.

PARTICIPANT RECOVERY (CONTINUED)

PROMIS GLOBAL HEALTH

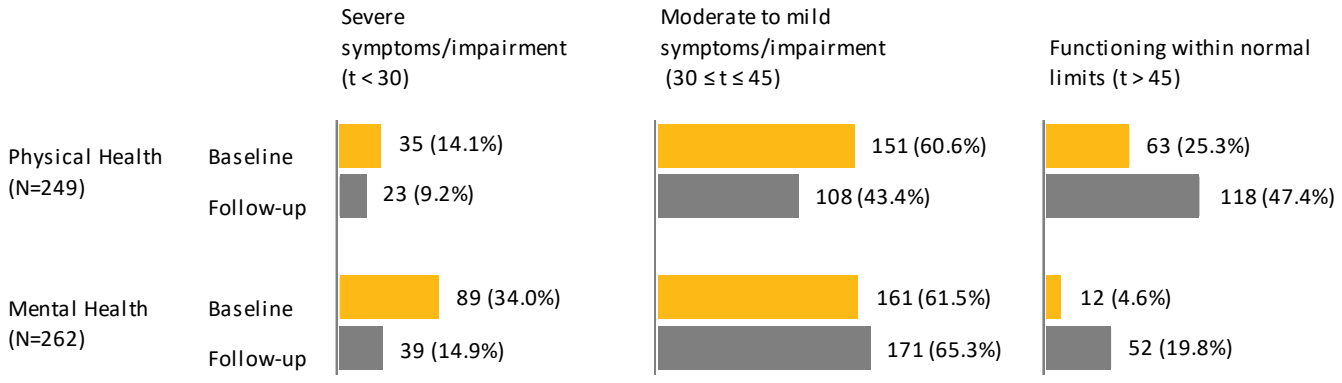
The PROMIS Global Health Scale is a 10-item patient-reported assessment of symptomatology, functioning, and health-related quality of life including physical health, mental health, and social health. PROMIS Global Health scores have been converted into T-score values. T-scores are standardized such that a score of 50 represents the average for the general population, and the standard deviation around the mean is 10 points. As a rule of thumb, half a standard deviation (5 points on the T-score metric) can be viewed as an estimate of a meaningful change.[8]

Figure 4: PROMIS Global Physical and Mental Health Mean T-scores at Baseline and Follow-up



On average, PeerLINKS participants demonstrated improvement in both Global Physical Health and Global Mental Health scores (Figure 4). The improvement on the Global Mental Health Scale suggested a meaningful change. Average T-scores were in the moderate to mild range of functioning/impairment, with participants' average level of physical health being higher (better) compared to their mental health. Figure 5 provides additional breakdowns of participant groups by levels of symptoms/functioning.

Figure 5: Percentage of Participants by Level of Symptoms/Functioning for PROMIS Global Physical Health and Mental Health at Baseline and Follow-up (Pre-post)



[8] http://www.healthmeasures.net/score-and-interpret/interpret-scores/meaningful-change

PARTICIPANT RECOVERY (CONTINUED)

PROMIS-DERIVED SUBSTANCE USE

Table 4 shows participants' answers to substance use related questions at baseline and most recent follow-up assessment. Items are scored on a scale from almost always=1 to never=5, with higher scores indicating less substance use treatment need. Participants were reporting on the past 7 days. On average, participants showed improvement across the 10 substance use items. The improvement in responses to all items with the exception of "I used alcohol or substances throughout the day" were statistically significant. The average scores across all items was 4.2 at baseline and 4.6 at the most recent assessment and the improvement was statistically significant.

Table 4: PROMIS-Derived Substance Use

PROMIS Derived Substance Use Items	N	Baseline		Follow-up	
		M	SD	M	SD
I used alcohol or substances throughout the day.	192	4.5	1.1	4.7	0.9
I had an urge to continue drinking or using substances once I started.	192	4.2	1.3	4.5	1.0
I felt I needed help for my alcohol or substance use.	191	3.9	1.5	4.5	1.1
I took risks when I used alcohol or substances.	191	4.3	1.3	4.6	0.9
I felt guilty when I used alcohol or substances.	186	4.2	1.4	4.5	1.1
Others complained about my alcohol or substance use.	190	4.2	1.3	4.7	0.9
Alcohol or substance use created problems between me and others.	190	4.2	1.4	4.6	1.0
Others had trouble counting on me when I used alcohol or substances.	193	4.2	1.3	4.6	1.0
I felt dizzy after I used alcohol or substances.	192	4.3	1.2	4.7	0.9
Alcohol or substance use made my physical or mental health symptoms worse.	193	4.1	1.5	4.7	0.9
Mean PROMIS-Derived Substance Use (average of items 1-10)	193	4.2	1.1	4.6	0.8

PARTICIPANT RECOVERY: KEY OUTCOMES

HOUSING

A total of 41.9% of participants moved into less restrictive and more independent housing level and for 41.9% of participants, the housing level remained unchanged. Only 16.3% of participants moved to more restrictive/less independent housing (Figure 6).

Figure 6: Housing Levels Summary (Pre-post, N=203, Excluding Other or Unknown Housing Levels)

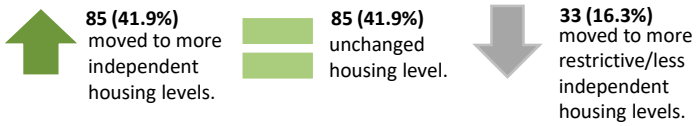


Figure 7 shows the percentage of participants in each housing level as reported for the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=203). The average housing level was 3.2 at baseline and 4.2 at the most recent assessment, indicating that, on average, the housing level improved. This increase was statistically significant.

Figure 7: Housing Levels (Pre-post, N=203, Excluding Other or Unknown Housing Levels)[9]

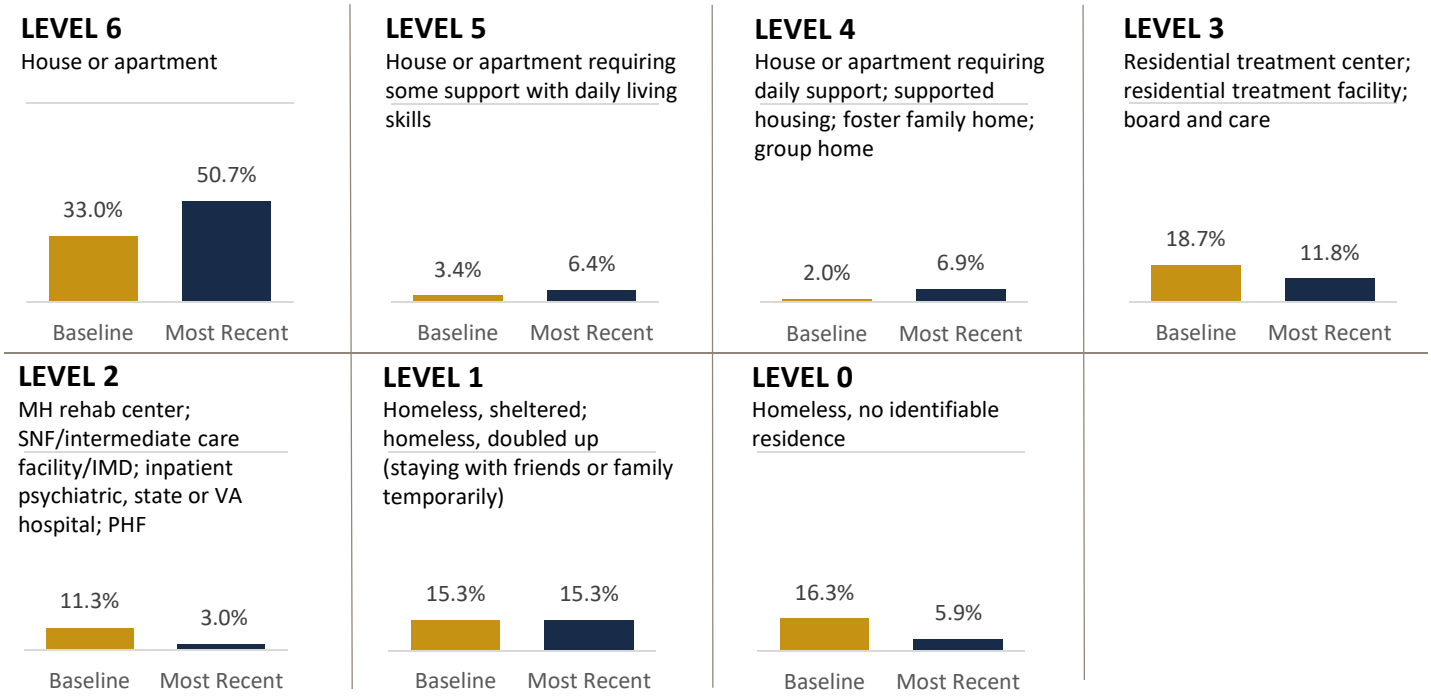


Table 5: Homeless Settings During Past 30 days (Pre-post, Excluding Other or Unknown Homeless Settings)

Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings)	Baseline	Most Recent
# of participants unsheltered at least 1 day	69	24
# of Days	1203	509
Total participant responses	184	184

Sheltered (staying in emergency shelters or transitional housing)	Baseline	Most Recent
# of participants sheltered at least 1 day	49	36
# of Days	833	807
Total participant responses	185	185

Doubled-up (temporarily staying with friends or family)	Baseline	Most Recent
# of participants doubled-up at least 1 day	39	26
# of Days	733	640
Total participant responses	172	172

Table 5 shows a decrease in the number of participants and number of days being homeless unsheltered, sheltered, and doubled-up.

Across all three homeless settings, the total number of participants living unsheltered, sheltered, or doubled-up, decreased from the baseline assessment to the most recent follow-up assessment, indicating that the program has been successful in decreasing the number of homeless participants. It should be noted that the intake assessment is usually undertaken while participants are in Behavioral Health Units or Crisis Residential facilities. Some participants would not necessarily consider themselves homeless while in these settings and the number of homeless participants or days homeless at baseline may be underreported.

[9] Values <5 for Level -1 Justice related (Juvenile Hall, CYA home, correctional facility, jail, etc.) are de-identified and not shown to protect the confidentiality of the individuals summarized in the data.

PARTICIPANT RECOVERY: KEY OUTCOMES

EMPLOYMENT

Table 6 shows the percentage of participants in each employment level as reported in the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=203). The average employment level (for participants with Levels 0-4 at baseline and most recent assessment) increased from 0.5 to 0.9. This increase was statistically significant. The percentage of participants who selected "not employed" decreased from 83.7% to 68.0%. The percentage of participants who were competitively employed increased from 8.9% to 16.7%.

Table 6: Employment Levels (Pre-post, N=203)

Employment Level	Baseline		Follow-up	
	N	Percent	N	Percent
Level 0: Not employed	170	83.7%	138	68.0%
Level 1: Volunteer/job training/other gainful/employment activity	5	2.5%	5	2.5%
Level 2: Paid in-house work	2	1.0%	1	0.5%
Level 3: Transitional employment/enclave/supported employment	1	0.5%	6	3.0%
Level 4: Competitive employment	18	8.9%	34	16.7%
No employment level: student, retired, homemaker	12	5.9%	24	11.8%
Total responses	208	102.5%	208	102.5%
Total number of participants	203	100.0%	203	100.0%

Note: Percentages exceed 100% due to multiple responses. Statistical significance was calculated on a matched sample of n=180 participants with a Level 0-4 at baseline and most recent follow-up.

Table 7 shows the reasons for unemployment for participants who had been unemployed at both time points where the reason was available (N=78). The majority were unemployed due to mental health symptoms or disability.

Table 7: Reasons for Unemployment (Pre-post, N=78)

Reasons for Unemployment	Baseline		Follow-up	
	N	Percent	N	Percent
Disabled	24	30.8%	18	23.1%
Mental Health Symptoms	58	74.4%	55	70.5%
Other	11	14.1%	10	12.8%
Total responses	93	119.2%	83	106.4%
Total number of participants	78	100.0%	78	100.0%

Note: Percentages exceed 100% due to multiple responses.

LINKAGES TO SERVICES

PeerLINKS uses the Linkage and Referral Tracker, which is a tool that helps Peer/Family Support Specialists and other healthcare professionals track the discussions, referrals, linkages, and successful connections they make to other services, and whether these linkages were successful.[10] The Linkage and Referral Tracker was specifically designed for programs that focus mainly on connecting people with needed services, rather than providing treatment themselves. It can also be used as a shared decision-making tool with participants and to help set their personal goals for recovery and wellness.

Table 8 quantifies the discussions, referrals, linkages, and the extent of the successful connections. A total of 3,490 successful connections were made during the reporting period. Specifically, for the mental health dimension, 592 successful connections were made for 237 unique participants. For the substance abuse dimension, 225 successful connections were made for 94 unique participants.

Across all ten dimensions of wellness, a total of 488 or 74.1% of participants received at least one linkage or successful connection (not shown in table).

Table 8: Linkage and Referral Tracker Summary (N=651)

Dimension of Wellness	Linkage and Referral Tracker Actions			
	Discussed (Unique Participants)	Referred (Unique Participants)	Linked (Unique Participants)	Successfully Connected (Unique Participants)
Physical Health	1776 (n=603)	260 (n=161)	102 (n=66)	282 (N=127)
Social Health	1697 (n=508)	352 (n=166)	91 (n=58)	324 (N=129)
Mental Health	4203 (n=616)	1037 (n=369)	307 (n=159)	592 (N=237)
Substance Abuse	2208 (n=558)	373 (n=172)	100 (n=62)	225 (N=94)
Housing	3287 (n=614)	859 (n=291)	282 (n=145)	360 (N=177)
Occupation/Education	1738 (n=524)	302 (n=140)	108 (n=63)	166 (N=80)
Financial Assistance/Benefits and Legal	2688 (n=595)	588 (n=240)	201 (n=111)	267 (N=136)
Transportation	1313 (n=588)	189 (n=138)	91 (n=66)	349 (N=188)
Identification	1296 (n=554)	125 (n=79)	64 (n=40)	110 (N=72)
Basic Needs	2283 (n=573)	359 (n=168)	166 (n=86)	815 (N=329)
Total	22489 (n=649)	4444 (n=518)	1512 (n=351)	3490 (N=455)

[10] Definition of actions: Discussed – talked about a specific tool and/or service with participant (e.g., discussed prospect of the participant renting an apartment); Referred – provided a participant with information (e.g., a phone number or address) about a specific tool and/or service to enable the participant to obtain that tool and/or service on his/her own; Linked – made an appointment for a participant to obtain a specific tool and/or service (e.g., made an appointment for the participant to meet with a leasing agent to complete a rental application); Successfully Connected – confirmed that the participant actually obtained a specific tool and/or service (e.g., if the participant submitted a rental application and obtained an apartment).

LINKAGES TO SERVICES

Tables 9 shows Mental Health service data based on Linkage and Referral Tracker entries for participants who had been in the program for at least 30 days. Of those 412 participants who had been in the program for at least 30 days (not shown in table), 336 had either a referral or linkage across the mental dimension and 213 were successfully connected, i.e., a successful connection rate of 63.4% (Table 9).

The following caveats need to be noted. Participants who had been successfully connected and left the program within less than 30 days will have been excluded from this analysis. The column "Unique Participants Referred or Linked" shows the count of the unique number of participants who have either been referred, linked, or had a successful connection without a preceding referral or linkage (i.e., a referral or linkage was implied). A successful connection may not necessarily mean that the program initiated a preceding referral/linkage; the program could have provided services to support the participant to attend ongoing services.

Table 9: Mental Health Service Successful Connection Rate for Participants in the Program for at Least 30 Days (N=336 participants referred or linked; N=412 participants had been in the program for at least 30 days)

Type of Mental Health Service	Unique Participants Referred or Linked	Unique Participants Successfully Connected	% Successfully Connected
Independent psychiatrist	41	23	56.1%
Private counselor/therapist	65	26	40.0%
Specialty mental health clinic	193	99	51.3%
Primary care provider	17	6	35.3%
Behavioral health within primary care clinic	50	23	46.0%
Intensive outpatient/day treatment	61	26	42.6%
Inpatient treatment	44	33	75.0%
Crisis house	55	26	47.3%
Self-help groups e.g., WRAP, Road to Recovery	94	34	36.2%
Clubhouse	129	44	34.1%
Other	127	58	45.7%
Total	336	213	63.4%

CRITICAL EVENTS (BASED ON mHOMS DATA)

Table 10 shows the number of different types of emergency interventions participants received during the past 30 days. The data is based on participant self-report during regular assessments by PeerLINKS staff. The data is entered into mHOMS. Overall, the number of emergency interventions related to physical health, mental health/substance use, and physical and mental health/substance use decreased from baseline to the most recent follow-up assessment.

The number of participants and the number of encounters participants had with non-psychiatric hospitalization and jail/prison settings decreased from baseline to follow-up (Table 11). It should be noted that some participants who are experiencing critical events at baseline and at follow-up may have a higher level of need and may require additional support.

Table 10: Number of Emergency Interventions Participants Received During Past 30 Days (Pre-post)

Physical health related	Baseline	Most Recent
# of participants with at least 1 service	38	10
# of services	52	14
Total participant responses	179	179

Mental health/substance use related	Baseline	Most Recent
# of participants with at least 1 service	137	21
# of services	217	42
Total participant responses	190	190

Physical AND mental health/substance use related	Baseline	Most Recent
# of participants with at least 1 service	29	DID*
# of services	51	6
Total participant responses	172	172

Table 11: Number of Critical Events During Past 30 days (Pre-post)

Non-psychiatric hospitalization	Baseline	Most Recent
# of participants with at least 1 encounter	18	DID*
# of encounters	28	8
Total participant responses	175	175

Jail/prison	Baseline	Most Recent
# of participants with at least 1 encounter	9	DID*
# of encounters	11	DID*
Total participant responses	186	186

Note. *Values <5 are de-identified (DID) and not shown to protect the confidentiality of the individuals summarized in the data.

SERVICE UTILIZATION (CONTINUED)

PEERLINKS PARTICIPANT SERVICE UTILIZATION ANALYSES USING CERNER COMMUNITY BEHAVIORAL HEALTH (CCBH)

The utilization of Behavioral Health Services by PeerLINKS participants was examined 30 days before and after starting the PeerLINKS program in order to assess recurrence rates (see Table 12). Participants who were enrolled in PeerLINKS prior to 07-01-2019 and had an index event (i.e. the psychiatric hospitalization or crisis residential treatment episode that occurred around the time of enrollment) identified in CCBH data were included in this analysis. The pre-30-day recurrence rate is determined by whether a prior admission ended within 30 days before the start of the index event. The post-30-day recurrence rate is determined by whether a subsequent admission started within 30 days after the end of the index event.

Participant service utilization based on Cerner Community Behavioral Health system data indicated a decrease in psychiatric hospitalization re-admission. Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=197), the 30-day recurrence rate decreased from 21.3% (42 participants) to 15.7% (31 participants); i.e., a decrease of 26.2% or 11 participants. Among the crisis residential cohort (participants with a crisis residential treatment index event; N=283), the 30-day recurrence rate increased from 11.7% (33 participants) to 12.7% (36 participants); i.e., an increase of 9.1% or 3 participants.

Table 12: 30-Day Recurrence Rates for PeerLINKS Participants (N=480)[11]

	Number of participants included in each cohort	Participants with at least one recurrence event within 30 days prior to PeerLINKS enrollment[12]	30-day recurrence rate prior to PeerLINKS enrollment[12]	Participants with at least one recurrence event within 30 days after PeerLINKS enrollment[13]	30-day recurrence rate after PeerLINKS enrollment[13]
Hospital Cohort	197	42	21.3%	31	15.7%
Crisis Residential Cohort	283	33	11.7%	36	12.7%

Note: [11] Includes participants enrolled in PeerLINKS from 07-01-2016 to 06-30-2019 with an index event (i.e., hospitalization or crisis residential treatment episode) identified in Cerner. [12] 30-day recurrence rate prior to PeerLINKS enrollment determined by whether a prior admission ended within 30 days before the start of the index event. [13] 30-day recurrence rate after PeerLINKS enrollment determined by whether a subsequent admission occurred within 30 days after the end of the index event.

SUMMARY OF STAFF PERSPECTIVES - ANNUAL STAFF FEEDBACK SURVEY

At the end of each year of providing the program services, administrative and Peer/Family Support Specialist staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. For the open-ended survey questions, at least two evaluators reviewed and coded the responses independently. Any discrepancies were discussed to arrive at a consensus on the key response themes. The following represent key findings identified via qualitative analyses of the open-ended staff survey response across three annual surveys.

1. *Key program "innovations" or factors that make this program unique:*
    - Program services rendered come from peers with lived experience.
    - Participant-centered support provided by peers.
    - Staff ability to link participants to community resources and external connections.

2. *Major program goals identified by respondents:*
    - Providing peer support to participants.
    - Linking participants to resources in the community.
    - Reducing participant readmissions to hospitals and crisis homes.
    - Enrolling participants in PeerLINKS.

3. *Factors that helped the program achieve these goals:*
    - Staff access to community services and resources for participants.
    - Knowledgeable team with a variety of skills for staff to rely on for support.
    - Compassion for participants, rapport with participants.
    - Collaboration between PeerLINKS staff, other service providers, behavioral health team, etc.
    - Peer support that staff provide to participants.

4. *Specific challenges to reaching the program goals described by respondents:*
    - Participant related factors (e.g., losing contact with participants, lack of participant engagement).
    - Lack of available housing in San Diego County.
    - Administrative and documentation processes (e.g., challenges to make referrals to services that participants would like to be connected to, long wait times for external services).
    - Lack of resources and/or staffing.

5. *Tools and supports needed to do job well as defined by respondents:*
    - Support from leadership.
    - A well-equipped work environment (e.g., adequate workspace, computer technology/electronic health record).
    - Continued staff training (e.g., peer support training, self-care training, mental health training).
    - Clear roles and expectations including program processes.
    - Team support/team building.
    - Staff development/reward.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to PeerLINKS outcomes and operations throughout the three year PeerLINKS MHSA Innovations-funded study. These findings can help inform any potential future initiatives to implement a program like PeerLINKS in other communities.

1. Participant referral and engagement

- **Engaging regularly with referral sites:** The program served adults living with a Severe Mental Illness, who had multiple acute care visits and were not effectively connected to resources/services or lacked a strong support network. Referrals were received from each referral site on a regular schedule. Visiting sites regularly, particularly during the early stages of the program, allowed PeerLINKS staff to build trust with the sites' staff and to provide and clarify information about the program or referral.
- **Connecting participants to case management and the "right level of care":** To increase the team's awareness and understanding of the various case management programs, the program co-organized a Case Management Panel where representatives from several case management teams and programs from San Diego County were represented. Discussing participants' need and eligibility for case management became an additional part of the individual weekly supervision of the Behavioral Health Clinician with each Peer/Family Support Specialist. All participants who were appropriate for case management services and were open to being connected to this service were referred to case management. While many of the participants were connected to the appropriate level of care based on the participants meeting eligibility and criteria, the program found that for some participants, "the right level of care" was the one in which the participant was willing and able to engage with.
- **Rebuilding participants' family ties:** The PeerLINKS team found that far less family members of participants were involved in the lives of participants than what had originally been anticipated by the program. The program supported participants with rebuilding ties to family, and supported family members as needed.
- **Providing flexibility in facilitating Program Advisory Groups:** Given that PeerLINKS meets participants in the community and there is no common place where participants visit the program regularly, quarterly program advisory groups tended to have low participant attendance. Despite the attendees providing valuable insights and ideas, the program felt that it would be beneficial to be allowed to hold several individual interviews instead. This would likely yield higher participation and would cause less of a burden for each participant (i.e., no need to travel to participate). This would also allow participants who are uncomfortable in groups to be able to participate.
- **Checking-in with participants post closure:** A post-closure follow-up phone call was implemented in early 2019 in order to check-in with participants approximately three months and six months after they had graduated or left the program. The program found that many participants had changed phone numbers and, thus, staff were unable to reach them; this was especially true when participants were called six months after their closure.

2. Connecting participants to external resources

- **Challenges connecting participants to housing resources:** A large proportion of participants lack housing and any form of income. PeerLINKS did not have dedicated funds for housing, or housing vouchers available. A key learning for future programs that wish to provide similar services to a high proportion of individuals who are experiencing homelessness or at risk for homelessness, is to have access to sufficient housing funds, dedicated beds and vouchers. During the second year of the program, PeerLINKS was able to access information and enter participants into the Homeless Management Information System/Coordinated Entry System (HMIS/CES) and refer participants to a Housing Navigator within CES. Additionally, the program continued to refer participants to housing programs and navigators if the participant was interested in receiving such services.
- **Flexibility in using additional funds:** During the second and third year of the program, NAMI San Diego obtained a donation to provide items important for participants' recovery and well-being which augmented the program's limited budget for these items. For example, the PeerLINKS program used donor funds to buy home/kitchen/cleaning items for participants who obtained their own apartment/home following lengthy periods of homeless or transitional housing. Additionally, PeerLINKS received generous donations from several locally based businesses and individuals, specifically: nearly 150 items (toiletries, towels and sleeping bags) from employees of a commercial real estate company, gift-certificates for free haircuts from the owner of a local hair salon, and free pet food from a small pet store/veterinary's office.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS" (CONTINUED)

3. Peer/Family Support Specialists

- **Recruiting diverse workforce of Peer/Family Support Specialists:** Peer/Family Support Specialists were recruited from a variety of sources including, posting on RI International's listserv for graduates of Peer Employment Training (PET), NAMI San Diego's listserv for graduates of Peer/Family Support Specialist training, and Peer/Family Support Specialist Job Clubs. Over the course of the program, PeerLINKS had a diverse team including individuals from various backgrounds (including varied ethnic backgrounds, ages, gender, and members of the LGBTQ community). Nonetheless, applicants to the Peer/Family Support Specialist position tended to be predominantly female, thus, it was a challenge for the program to maintain a representation of other genders on the team at all times.
- **Establishing career progression for Peer/Family Support Specialists:** The program included two Peer/Family Support Specialist leadership positions, specifically Team Leads. Over the course of the program, PeerLINKS realized that the team needed additional career progression opportunities. These opportunities are being implemented going forward.
- **Clarifying the role of the program and Peer/Family Support Specialist:** Peer/Family Support Specialists reported to experience certain barriers in accessing services for participants, which was partly attributed to a perceived lack of awareness of their role. PeerLINKS took various approaches to clearly communicate the role, purpose, and limits of the work of the Peer/Family Support Specialist as well as the program to participants, referring agencies, and external programs. PeerLINKS created a Partnership Agreement Form which was reviewed with all potential participants before they enrolled in the program. An abbreviated form was also created and shared with referral sites. A program brochure that provided an overview of the program was created for outreach purposes.
- **Multiple Peer/Family Support Specialists supporting a participant:** Whenever possible, the Peer/Family Support Specialist who was assigned to work with a participant provided support throughout the program participation. However, this was not always feasible. At times, it had been logistically necessary to have the initial or intake visit completed by one team member and for another to be assigned as the Peer/Family Support Specialist. This had an unforeseen benefit, especially when the participant's assigned Peer/Family Support Specialist was not available (e.g., on vacation), as there was another individual on the team that the participant had met and was comfortable to work with.

PROGRAM CHANGES FROM INITIAL DESIGN

There were no changes to the INN-15 PeerLINKS program that differed substantially from the initial design over the course of the service provision (7/1/2016 to 6/30/2019). Some basic practices and procedures were adjusted across the three year period, as described in a number of enhancements to the program under "Key Program Implementation and Operational Learnings." However, no fundamental or program-wide changes were made.

FUTURE DIRECTIONS

Based on the positive findings from the INN-15 PeerLINKS innovations program, County of San Diego Behavioral Health Services dedicated ongoing Community Services and Supports Program (CSS) funding to continue the PeerLINKS program. This funding allowed the structure and operations of the program to continue uninterrupted. Under the new contract, Peer Assisted Supportive Services, began services on 8/1/2019. The new contract increased the number of unique participants served per year and expanded to a third crisis residential program. Participants are able to remain in the program up to 6 months.

For additional information about the INN–15 PeerLINKS program and/or this report,

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URBAN BEATS (INNOVATIONS-16)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES ANNUAL REPORT: YEAR 4 (7/1/18 - 6/30/19)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Urban Beats program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) and was developed to provide Transition Age Youth (TAY; age 16-25) with increased access to and knowledge of behavioral health treatment and wellness services, as well as reduce mental illness stigma for TAY and the community. The primary innovation of this program is the utilization of artistic expression to communicate a recovery-focused message to TAY and develop artistic skills and self-esteem. The program now includes a therapist who provides counselling and emotional support directly to Urban Beats TAY as needed. This is expected to increase access to and utilization of behavioral health care by Urban Beats TAY since these services can be accessed within the network of trusted Urban Beats relationships rather than requiring a referral to an external provider agency for services. For TAY with significant needs the Urban Beats therapist works to identify and link the TAY to appropriate ongoing care. The Urban Beats program expanded and now operates in multiple communities throughout the Central and North Central Regions of San Diego County.

The Urban Beats program consists of a 20-hour curriculum that focuses on improving TAY wellness and developing each TAY's desired form of artistic expression. Following the structured multi-week classes, Urban Beats staff provide individualized attention to each TAY to help create a performance piece in their preferred form of artistic expression (such as drawing, poetry, song, videography, etc.). Throughout the program, the TAY present their creations in public performances designed to create greater self-esteem among Urban Beats participants, educate the community about mental health issues, and reduce stigma.

EXECUTIVE SUMMARY

The Urban Beats program was designed to provide wellness education and social support to TAY with mental health needs through individualized development of artistic expression skills and interests. Artistic expression is expected to reduce stigma in both TAY and the general community through public performances.

- During FY 2018-19, a total of 200 new, unduplicated TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial diversity in race/ethnicity, language, sexual orientation, and gender identity. However, females comprised a much smaller proportion than males (28.5% and 64.5%, respectively).
- Analyses indicate a reduction in the utilization of County of San Diego acute/crisis behavioral health services after starting Urban Beats (e.g., inpatient psychiatric hospitalizations, crisis residential treatment, emergency/crisis-oriented psychiatric visits).
- Urban Beats appears to improve attitudes regarding mental health services as participants indicated they felt more comfortable talking to mental health professionals and were more likely to think that professional mental health services were effective for improving mental health.
- Over 80% of participants reported being satisfied with Urban Beats, with the majority indicating that, as a result of the program, they knew better where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms.
- Of participants who had at least one session with the "in-house" clinician (n=40), the majority (75%) received trauma informed therapy services. Approximately 5% of all clinical sessions included a focus on crisis interventions.
- The Urban Beats program increased the number of community performances to 42 (from 28 in FY 2017-18), with attendees completing 958 outcomes surveys.
- Urban Beats staff identified the following key factors that helped achieve program goals: 1) collaborations and partnerships in the community, 2) intensive outreach and engagement, 3) offering art as a focus, and 4) program design (e.g., unique resources, individual mentoring).

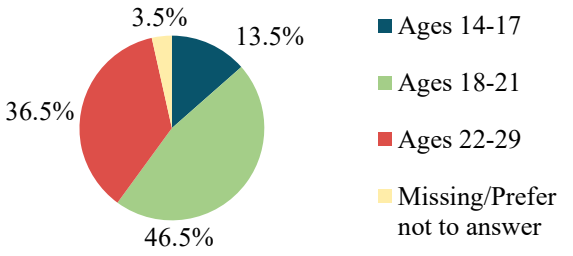
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) implement a process for following up with TAY after program completion, 2) explore mandatory clinical services, 3) attend/participate in quarterly health fairs, 4) incorporate specialized services for TAY not interested in the program or other "in-house" services, 5) create/implement curriculums for unique TAY populations, and 6) consider omitting Twitter and Sound Cloud from data tracking.

PARTICIPANT CHARACTERISTICS[1]

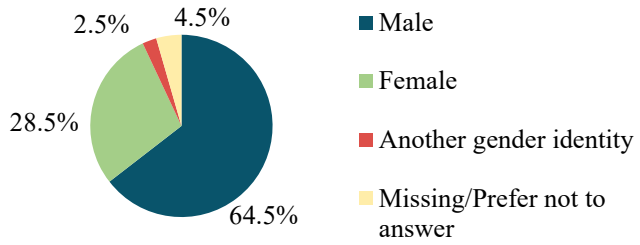
The following self-reported characteristic data were collected from participants during the initial or follow-up visit.[1]

AGE (N=200)



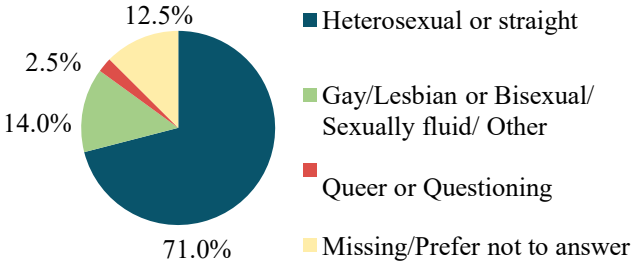
Most participants (46.5%) were between the ages of 18 and 21, with 36.5% between the ages of 22 and 29.

GENDER IDENTITY (N=200)



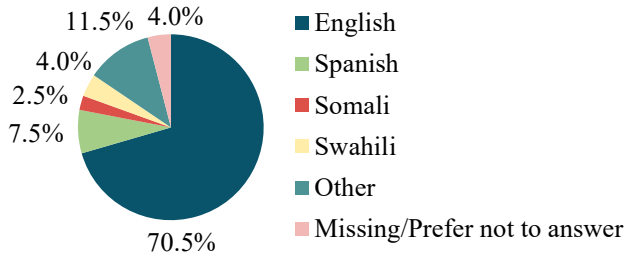
About two-thirds (64.5%) of participants were male and 28.5% of participants were female.

SEXUAL ORIENTATION (N=200)



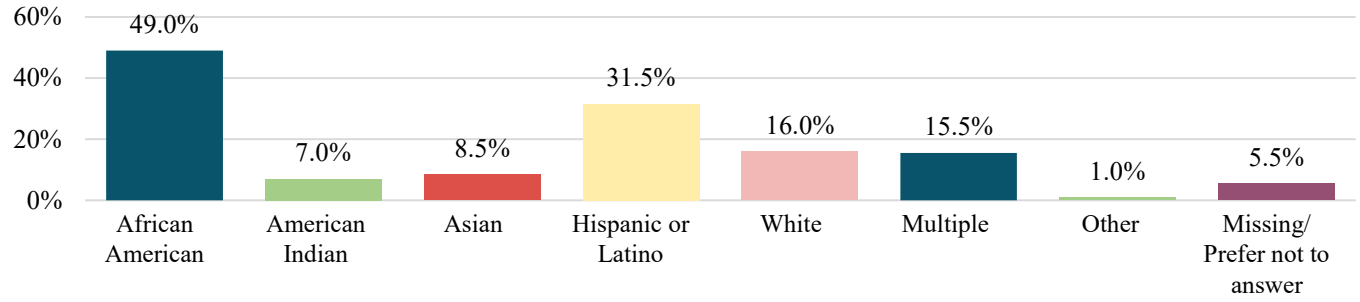
The majority (71.0%) of participants identified as heterosexual or straight.

PRIMARY LANGUAGE (N=200)



The majority (70.5%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=200)

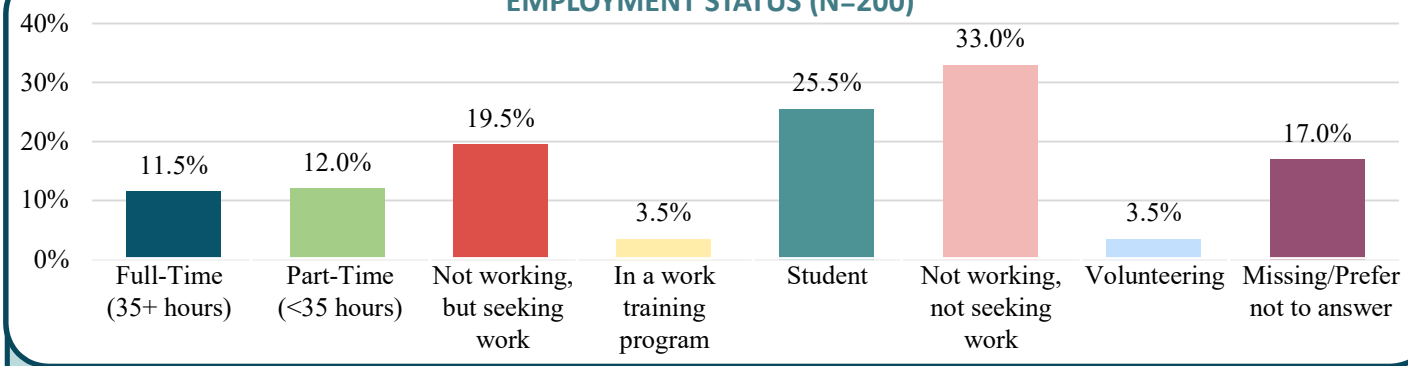


Most participants identified either as African American (49.0%) or Hispanic or Latino (31.5%). Totals may exceed 100% since participants could indicate more than one race/ethnicity.

[1] *Percentages may not total to 100% due to rounding.*

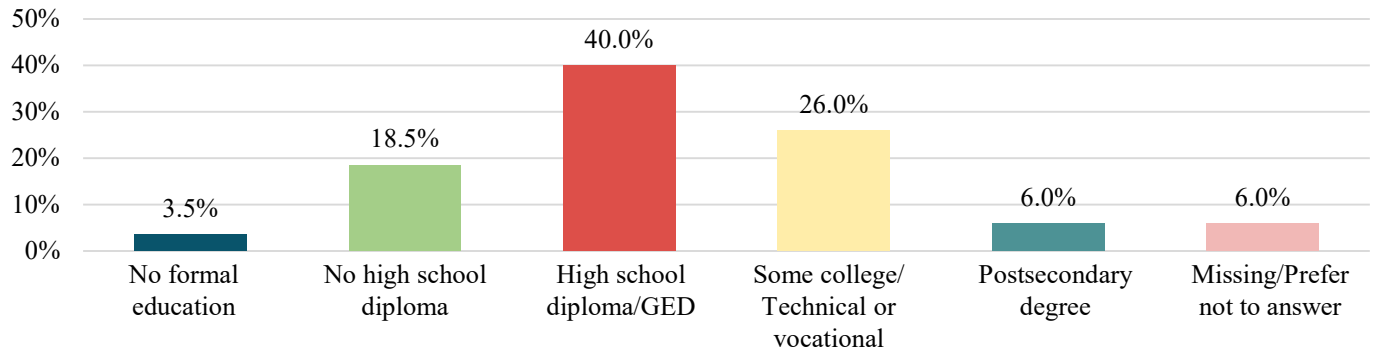
PARTICIPANT CHARACTERISTICS (CONTINUED)

EMPLOYMENT STATUS (N=200)



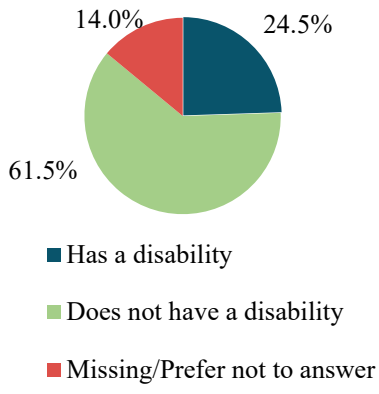
About 25% of participants indicated that they were working (11.5% full-time and 12.0% part-time) and 19.5% were not working, but seeking work. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=200)



Close to two-thirds (62.0%) of participants indicated they had a high school diploma/GED or lower level of education. 26.0% indicated they had some college/technical or vocational education.

DISABILITY[2] STATUS (N=200)



Approximately one-quarter (24.5%) of participants reported having some type of non-SMI disability.

The majority (90%) of participants had never served in the military.

TYPE OF DISABILITY (N=200)

Type	n	%
Seeing	18	9.0
Hearing	< 5	< 2.5
Other Communication	< 5	< 2.5
Learning	23	11.5
Developmental	< 5	< 2.5
Other Mental	< 5	< 2.5
Physical	< 5	< 2.5
Chronic Health	5	2.5
Other	5	2.5

This table indicates the non-SMI disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

[2] A disability was 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 (SMI).

KEY EVALUATION FINDINGS

BHS BEHAVIORAL HEALTH SERVICE UTILIZATION PATTERNS OF URBAN BEATS PARTICIPANTS

The utilization of behavioral health services by Urban Beats participants was examined 180 days before and 180 days after starting the Urban Beats program. To ensure that everyone included in the analyses had the entire 180 days to be observed for any behavioral health service utilization after starting Urban Beats, the analyses only included participants (n=438) who started the Urban Beats program at least 180 days prior to the end of the reporting period (6/30/2019).

As shown in Table 1, nearly one-quarter (23.3%) of the 438 Urban Beats 'life-of-program' participants included in the 180-day analyses had attended at least one behavioral health outpatient visit within the 180 days prior to starting the Urban Beats program. Approximately thirteen percent (12.8%) participated in Assertive Community Treatment (ACT) in the 180 days before entering Urban Beats. There was little change in participation rates for these services in the 180 days after starting the Urban Beats program. There was a small decrease in participation rate for outpatient visits (22.1%), while the participation rate and number of total visits for ACT had a modest increase (13.2%; 2,251 vs 2,451 visits).

While less frequent overall, the findings in Table 1 indicate that acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) contacts, emergency psychiatric hospital visits, inpatient psychiatric hospitalizations, and justice-related mental health services (e.g., services received while in jail or participating in behavioral health court proceedings), were utilized less often after participants had started the Urban Beats program. For example, while 8.0% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 4.8% (a 40% reduction in the hospitalization rate) had a hospitalization after starting Urban Beats (total admissions reduced from 35 to 21). There is also a substantial decrease in admission rate and total number of admissions to crisis residential treatment after starting Urban Beats (4.8% vs 1.1%; 21 vs 5 admissions).

Given the relatively low utilization rates of most acute/crisis care oriented services, these findings should be interpreted with caution; however, the overall pattern suggests that participation in Urban Beats is associated with lower utilization of public mental health acute/crisis care oriented services.

TABLE 1. BEHAVIORAL HEALTH SERVICE UTILIZATION BEFORE AND AFTER STARTING URBAN BEATS

	180 Days Before Start Urban Beats (n=438)			180 Days After Start Urban Beats (n=438)		
	Persons with at least one session	% of Urban Beats population	Sum of visits	Persons with at least one session	% of Urban Beats population	Sum of visits
Outpatient Visits	102	23.3	1,168	97	22.1	1,149
Assertive Community Treatment (ACT)	56	12.8	2,251	58	13.2	2,451
Case Management	0	-	0	0	-	0
Urgent Outpatient	29	6.6	47	21	4.8	29
Crisis Stabilization	19	4.3	25	8	1.8	14
Psychiatric Emergency Response Team (PERT)	22	5.0	28	12	2.7	17
Justice-Related Mental Health Visit	15	3.4	55	8	1.8	28
	Persons with at least one admission	% of Urban Beats population	Sum of admissions	Persons with at least one admission	% of Urban Beats population	Sum of admissions
Inpatient Psychiatric Hospital Admit	35	8.0	69	21	4.8	37
Crisis Residential Treatment	21	4.8	26	5	1.1	5

URBAN BEATS PARTICIPANT BELIEFS

Urban Beats participants were asked to complete a Wellness Survey, which includes select items from the Recovery Markers Questionnaire (RMQ), at the start of class, 6 weeks later, and at the end of the 20-week program. To identify areas of change, the responses from participants who completed both a baseline and a follow-up survey are listed in Table 2. The table presents the average rating at baseline and most recent follow-up for everyone involved in the program with both baseline and follow-up data (n=117). Additionally, to examine the potential for differing participant perspectives based upon their self-reported mental health status at baseline, findings are presented separately for those who indicated low mental heath (i.e., poor or fair; n=36) and high mental health (i.e., good, very good, or excellent; n=81).

Overall, at baseline, the most commonly endorsed statements (i.e., those with the highest means) focused on participants' beliefs about their self-efficacy (#11) and pursuit of goal achievement (#5). Participants appeared to be less enthusiastic about their stress management capabilities (#10) and having sufficient income (#3). These findings indicate that Urban Beats was enrolling TAY who were generally goal-oriented and optimistic about what they can accomplish, but who were also concerned about their ability to handle stress and having sufficient financial resources—two key issues addressed by the Urban Beats program.

TABLE 2. URBAN BEATS PARTICIPANT BELIEFS—BASELINE AND FOLLOW-UP COMPARISONS

		Overall (n=117)		Baseline Mental Health: Low (n=36)		Baseline Mental Health: High (n=81)	
#	Item	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean	Initial Mean	Follow Up Mean
1	I have at least one close mutual relationship	4.0	4.1	3.7	3.9	4.1	4.2
2	I am involved in meaningful, productive activities	3.8	4.0	3.4	3.9*	4.0	4.0
3	I have enough income to meet my needs	2.9	3.1	2.4	2.8*	3.1	3.3
4	I am using my personal strengths, skills, or talents	3.8	3.9	3.4	3.6	4.0	4.1
5	I have goals I'm working to achieve	4.2	4.3	3.8	4.1	4.4	4.4
6	I contribute to my community	3.6	3.8	3.4	3.6	3.7	3.9
7	I have a sense of belonging	3.7	3.8	2.9	3.2	4.0	4.1
8	I feel hopeful about my future	4.0	4.1	3.6	3.9	4.2	4.2
9	I treat myself with respect	3.8	4.0*	3.0	3.4	4.2	4.2
10	I am able to deal with stress	3.3	3.6*	2.7	3.2*	3.6	3.8
11	I believe I can make positive changes in my life	4.1	4.3*	3.7	4.2*	4.3	4.4
12	Mental health services can effectively improve mental health	3.6	4.0*	3.6	4.0*	3.7	4.0*
13	I would feel comfortable talking to a mental health professional	3.5	3.9*	3.6	4.0*	3.5	3.9*

** Statistically significant change in mean rating scores, p<.05.; Scale values: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly agree.*

Participants who self-reported having lower mental health at baseline typically also indicated lower baseline values across other Wellness Survey items. At follow-up, ratings across all items stayed the same or increased for both groups of participants, with the persons who indicated lower baseline mental health generally demonstrating larger improvements. Statistically significant changes unique to this group were evident in their participation in meaningful activities (#2), having sufficient income (#3), ability to manage stress (#10), and beliefs about personal positive self-efficacy (#11). These findings suggest that participants who felt more negative about their mental health upon entry into Urban Beats were typically able to experience significant improvements in multiple domains central to the goals of the program and persons who entered Urban Beats with more favorable beliefs about their mental health were able to maintain or slightly improve their already more positive outlook on these domains. For both groups, their attitudes regarding mental health services significantly improved, with initial scores of around 3.5 (i.e., neutral/agree) and follow-up scores around 4.0 (i.e., agree) in their sense that mental health services can improve mental health (#12) and feeling comfortable talking to a mental health professional (#13). These findings reflect success at improving perceptions about mental health services.

PARTICIPANT ASSESSMENT OF THE URBAN BEATS PROGRAM

As shown in Table 3 below, the vast majority (84.0%) of Urban Beats participants with follow-up Wellness Survey data indicated that they were satisfied with the Urban Beats program (#1; 38.0% agreed and 46.0% strongly agreed) and a similar percentage (82.9%) felt appropriately supported by the Urban Beats staff (#2; 36.4% agreed and 46.5% strongly agreed). Participants who indicated that they had lower mental health upon program entry tended to be slightly more favorable about their experiences with Urban Beats, particularly in regards to feeling appropriately supported by staff (96.3% agreed/strongly agreed as compared to 77.8%). This suggests that while Urban Beats staff effectively engaged with most participants, they were especially skilled at connecting with and supporting participants who were experiencing mental health related difficulties when they entered the Urban Beats program.

The majority indicated that as a result of participating in the Urban Beats program, they knew where to get help (#3; 82.0%), felt more comfortable seeking help (#4; 69.7%), dealt more effectively with daily problems (#5; 62.0%), and were less bothered by symptoms (#6; 61.0%). The results were fairly similar between the two group of Urban Beats participants, however, a slightly larger proportion of the participants who entered the program with more favorable perceptions of their mental health indicated they agreed or strongly agreed with experiencing these outcomes. These findings suggest that while most youth experienced a range of positive benefits from participating in the Urban Beats program, there continues to be a need for improvements, particularly among youth who enter the program with more significant mental health difficulties.

TABLE 3. URBAN BEATS PARTICIPANT ASSESSMENT OF URBAN BEATS PROGRAM

		Overall (n=100)			Baseline Mental Health: Low (n=27)			Baseline Mental Health: High (n=73)		
#	Item	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean	Agreed Total	Agree (Strongly Agree)	Mean
1	Overall, I am satisfied with the services I received	84.0%	38.0% (46.0%)	4.3	92.5%	44.4% (48.1%)	4.4	80.8%	35.6% (45.2%)	4.2
2	I felt appropriately supported by staff when I encountered challenges	82.9%	36.4% (46.5%)	4.2	96.3%	40.7% (55.6%)	4.5	77.8%	34.7% (43.1%)	4.1
As a result of the program…										
3	I know where to get help when I need it	82.0%	46.0% (36.0%)	4.1	74.1%	51.9% (22.2%)	4.0	84.9%	43.8% (41.1%)	4.2
4	I am more comfortable seeking help	69.7%	40.4% (29.3%)	3.9	66.7%	51.9% (14.8%)	3.8	70.8%	36.1% (34.7%)	3.9
5	I deal more effectively with daily problems	62.0%	46.0% (16.0%)	3.7	59.3%	51.9% (7.4%)	3.6	63.0%	43.8% (19.2%)	3.8
6	My symptoms are bothering me less	61.0%	35.0% (26.0%)	3.7	55.5%	40.7% (14.8%)	3.6	63.0%	32.9% (30.1%)	3.8

Scale values: 1=Strongly disagree, 2=Disagree, 3=Neutral, 4=Agree, and 5=Strongly agree.

UTILIZATION OF TECHNOLOGY TO EXPAND REACH OF URBAN BEATS PROGRAM

URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

The Urban Beats program focused on increasing their social media utilization as a means for dissemination information about Urban Beats events and for distributing media products developed by Urban Beats participants. Table 4 lists the website (https://www.sdurbanbeats.org/) and other social media activities for the program.

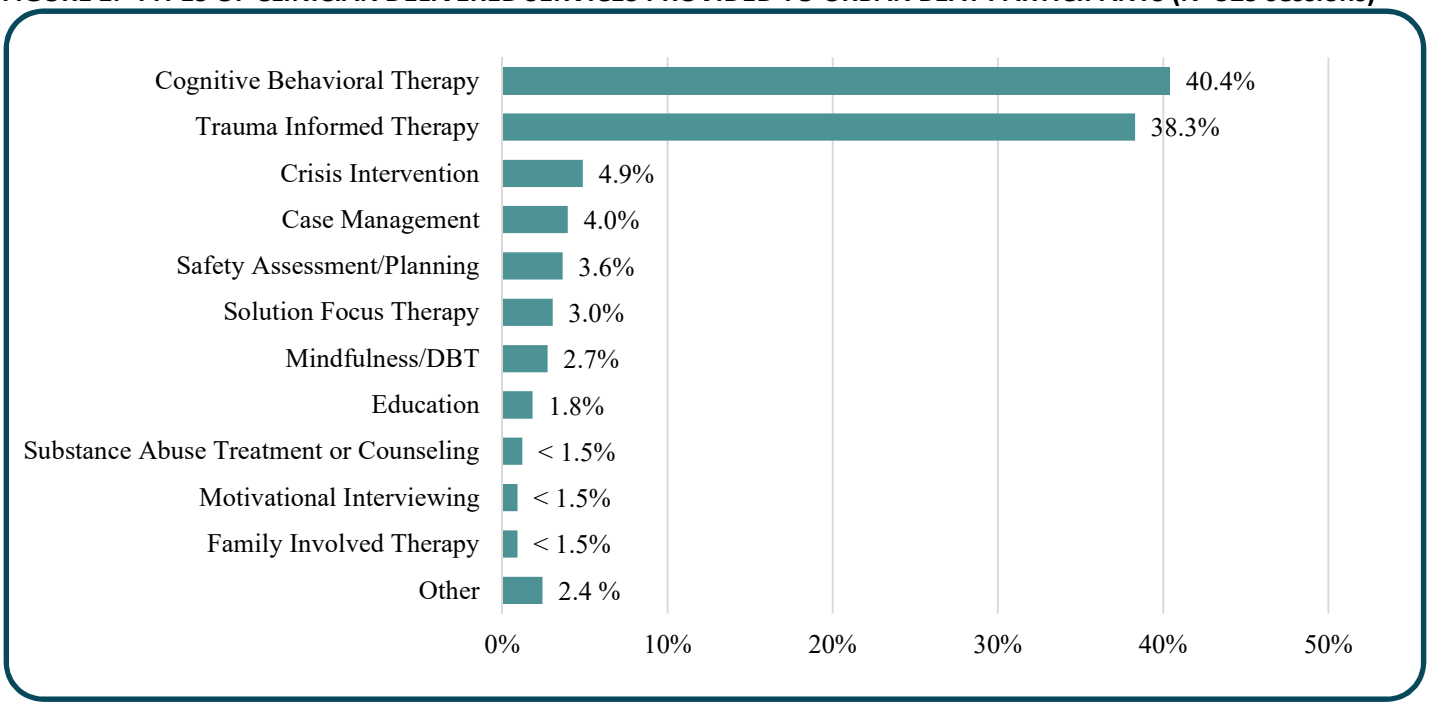
TABLE 4. URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

Type	Fiscal Year 2018-19	Type	Fiscal Year 2018-19
New Instagram Followers	254 (1,005 Total)	Facebook	
New Twitter Followers	9 (145 Total)	• Page Likes	91
Website Visits	3,297	• Post Likes	1,042
SoundCloud Plays/Likes	304	• Reach (unique views)	4,777

UTILIZATION OF THERAPUETIC SERVICES PROVIDED BY THE URBAN BEATS CLINICIAN

Based on experiences during the early years of the Urban Beats program, particularly the ongoing challenges of connecting youth to formal behavioral health services when needed, the Urban Beats program added an "in-house" behavioral health clinician (pre-licensed) who could meet directly with Urban Beats participants. A total of 40 Urban Beats youth participated in 329 sessions with the clinician (median number of sessions = 5). As shown in Figure 1, a wide variety of services were provided during sessions and more than one service type could be provided in a single session. Cognitive Behavioral Therapy was the most common service provided (40.4%), followed closely by Trauma Informed Therapy (38.3%). Approximately 5.0% of all sessions were directly related to providing crisis intervention services (4.9%). Of the 40 Urban Beats youth participating in sessions with the clinician, 75.0% (n=30) had at least one session of Trauma Informed Therapy. This indicates a high need for trauma informed care among Urban Beats youth.

FIGURE 1. TYPES OF CLINICIAN DELIVERED SERVICES PROVIDED TO URBAN BEAT PARTICIPANTS (N=329 sessions)



Note: percentages total up to more than 100% since multiple services could be provided during a single session with the clinician.

Based on an examination of San Diego County BHS service utilization data, only about 25% of the youth who had sessions with the Urban Beats clinician also participated in other San Diego County outpatient clinical services. This indicates that for the majority of youth, it is likely that their interactions with the Urban Beats clinician were the only form of therapeutic support they were receiving.

UTILIZATION OF URBAN BEATS VAN FOR TRANSPORTATION ASSISTANCE

The Urban Beats van was utilized for a total of 172 trips during FY 2018-19, for a total of 3,753 miles driven. Primary destinations included:

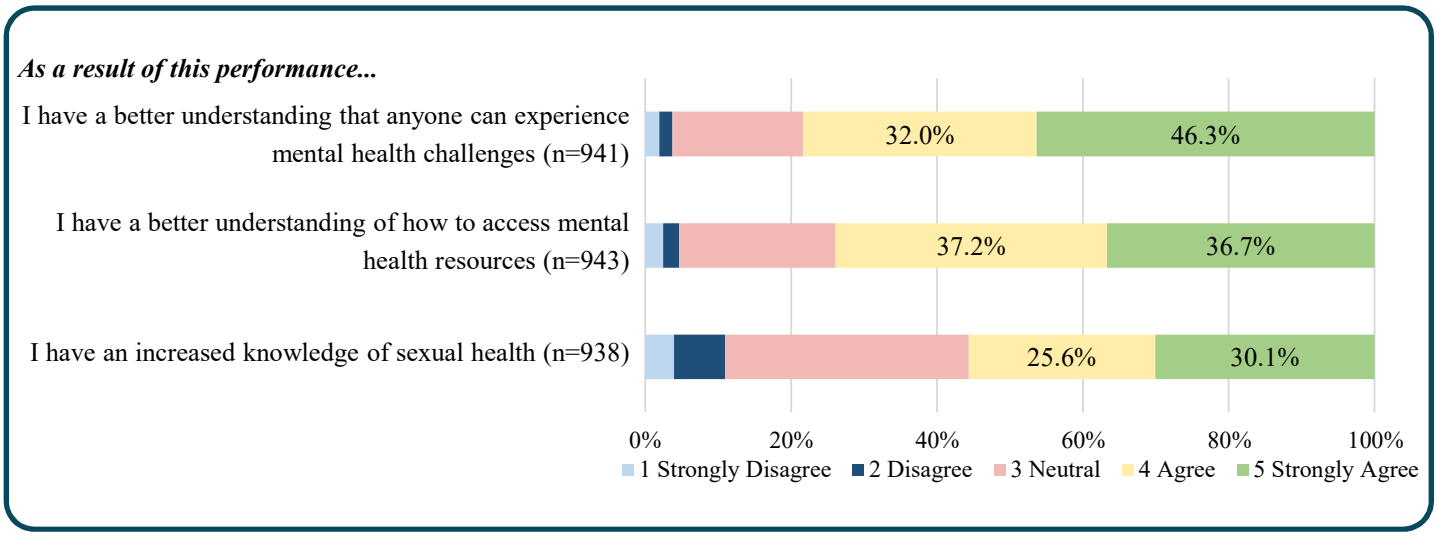
- Urban Beats and community partner youth performances
- Transportation to/from Urban Beats locations for program activities
- Transportation to/from other community partners and/or for other needed services
- Outreach events in the community
- Picking up supplies for activities/events
- TAY Academy

Urban Beats staff reported the van had an important logistical impact on the program, allowing them to transport people and equipment to events throughout the community. They also indicated the van made it possible for participants to attend more activities than was possible in previous years, without the van.

COMMUNITY PERFORMANCE OUTCOMES

During Year 4, the Urban Beats program hosted or co-hosted 42 community performances, up from 28 performances during FY 2017-18. It is estimated that over 2,000 persons attended these performances, and 958 audience members completed an outcome survey (note: surveys were not able to be distributed at all events). Transitional age youth (ages 16-25) comprised 72.7% (n=696) and persons younger than 16 comprised another 10.6% (n=102) of the audience. Participants were asked to indicate the extent to which they agreed or disagreed with each statement on a 5-point scale. As shown in Figure 2, a majority of all respondents (78.3%) agreed or strongly agreed that as a result of the performance they had a better understanding that anyone can experience mental health challenges. A similar percent (73.9%) also agreed or strongly agreed that they had a better understanding of how to access mental health resources, while somewhat fewer agreed or strongly agreed that the performance increased knowledge of sexual health (55.7%).

FIGURE 2. ASSESSMENT OF COMMUNITY PERFOMANCE ATTENDEE LEARNING



The response patterns between TAY (i.e., aged 16-25) and persons older than TAY who attended the performances were fairly similar for the three outcome questions. For the persons younger than 16, the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" was also similar (i.e., approximately 75%), however in comparison to TAY they indicated slightly lower rates of "better understanding how to access mental health resources" (64.7% compared to 75.7%), and substantially lower rates of "increased knowledge of sexual health" (38.2% compared to 58.0%) as a result of the performance.

SUMMARY OF STAFF PERSPECTIVES – ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2018-19, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 7 respondents from the 11 persons invited to participate in the survey, a response rate of 64%. 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.

1. *Major program goals identified by staff:*
    a. Stigma reduction and mental health education.
    b. Artistic expression.
    c. Engagement with transitional age youth.
    d. Increase service access.
    e. Improve coping skills.
2. *Factors that helped the program achieve goals:*
    a. Art as a focus.
    b. Performances/ showcases/ workshops.
    c. Staff skills.
    d. Engaging curriculum.
    e. Resources for participants.
    f. Collaboration outside of program (i.e. partnerships).
3. *Factors that inhibited the program from achieving goals:*
    a. Leadership issues.
    b. Staff turnover.
    c. Unprepared staff.
    d. Lack of materials/supplies.
    e. Low staff pay.
    f. Low staff morale.
4. *Recommendations to help the program better achieve goals*:
    a. More staff training.
    b. More staff/resources/supplies.
    c. Leadership improvement (i.e., advocate for staff, connections with other programs, goal setting).
    d. Better communication.
    e. Better program foundation/implementation.
    f. Change outreach strategies (i.e., more outreach, review current outreach, target TAY-specific activities).
    g. Higher pay for staff.
5. *Types of needed supports, tools, and/or trainings:*
    a. More training (i.e., motivational interviewing, peer support training, mental health first aid).
    b. Tools and materials for data collection.
    c. More staff.
    d. Connections to community organizations/artists.
    e. Supplies (i.e., furniture, white boards, filing cabinets, stencil cutting machine).
    f. Funding.
6. *Types of desired supports, tools, and/or trainings:*
    a. Additional training (i.e. new art mediums, attending art therapy events, DBT, resource awareness).
    b. More staff.
    c. Music studio, more music therapy options.
    d. Supplies (i.e., furniture, white boards, filing cabinets, stencil cutting machine).
    e. Counseling opportunities for staff.
    f. Higher pay.

SUMMARY OF STAFF PERSPECTIVES – ANNUAL STAFF FEEDBACK SURVEY (CONT.)

7. *Key strengths of the program:*
    a. Use of creative/ artistic expression.
    b. Connections with the community.
    c. Engaging, passionate staff.
    d. Youth engagement.
    e. The approach of the program (i.e., strengths-based, client focused, trauma-informed).
    f. Creativity in interventions.
    g. Making mental health a fun/approachable topic.
    h. Program flexibility.
    i. The music studio.
8. *Effective ways to identify and recruit potential TAY participants:*
    a. Community outreach/performances.
    b. Connect with other organizations that serve TAY.
    c. Social media outreach.
    d. In-person recruitment.
    e. Recruit youth involved in other services.
    f. Expand to new areas (i.e. North Central, Ocean Beach).
9. *Types of engagement strategies and resources used to facilitate participation:*
    a. Focus on building trust, rapport building.
    b. Offer resource information.
    c. Offer food.
    d. Go to their location (i.e. pop-up workshop).
10. *Benefits of changing cohort schedules from 20-hours over 20-weeks to 20-hours over a few weeks:*
    a. Higher attendance/retention/completion rates.
    b. Progress is based on individual commitment to the program.
    c. Incentives are awarded faster.
    d. Easier to engage quickly.
    e. Deadlines are realistic.
11. *Barriers to linking Urban Beats TAY with needed mental health services:*
    a. Participant is not ready or interested, or doesn't follow through.
    b. Previous negative experiences or lack of trust with treatment.
    c. Housing issues.
    d. Process is overwhelming to participant.
    e. Stigma.
    f. Wait lists.
    g. Lack of fitting program service requirements.
    h. Lack of culturally competent services.
    i. Lack of information/consolidated information about resources.
12. *Additional recommendations:*
    a. Additional support/staff (i.e., volunteers or interns).
    b. More space (i.e., for brainstorming).
    c. Flexibility in implementation.
    d. Ongoing curriculum development (i.e., trying more innovative approaches).
    e. Leadership advocacy for staff.
    f. More funding.
    g. Incentives.

CURRENT YEAR KEY PROGRAM "LEARNINGS"

1. Approximately 20% of Urban Beats participants had at least one session with the "in-house" clinician.
2. The majority of participants who had sessions with the Urban Beats clinician were not participating other San Diego County outpatient or ACT therapeutic care services.
3. Many participants who had sessions with the clinician received some form of trauma informed therapy.

YEAR 4 PROGRAM CHANGES

During FY 2018-19 the Urban Beats program continued to evolve to meet the needs of TAY and has expanded the ways that youth can participate in the program. In addition to the cohorts that involve a 20-hour structured curriculum and mentorship related to their chosen form of artistic expression, select Urban Beats locations offered shortened one-day workshops which included the structured curriculum, studio time, and other activities that allow youth to interact with Urban Beats staff and other youth actively participating in the program.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Change cohorts from 20 weeks to a curriculum with a total of 20 hours spread across fewer weeks to facilitate TAY retention and allow for more community collaborations through the ability to customize program schedules.

   Status: The Urban Beats program has successfully developed and utilized a 20-hour version of the curriculum that covers the same content as the original 20-week cohort format, but in fewer sessions. The shorter number of weeks facilitates participation and allows for more frequent cohorts. Programs now have the option of running either version of the curriculum for their cohorts.

2. Establish a location for the North Central office in order to better serve the target population (e.g., ability to host classes).

   Status: During FY 2018-19 the Urban Beats program was successfully able to open a new location.

CURRENT YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Urban Beats program and support the achievement of program objectives:

1. Implement a structured process for follow up with enrolled TAY to encourage on-going participation and engagement of services after program completion.
2. Work with the Urban Beats clinician to explore mandatory clinical services.
3. Attend or participate in at least one health fair in San Diego per quarter.
4. Incorporate specialized services for TAY that are not interested in cohorts or other "in-house" services (e.g., homeless TAY whose immediate needs are housing, food, and medical needs).
5. Create/implement a modified cohort curriculum to reach unique TAY populations (e.g., a curriculum that is sensitive to cultural/religious beliefs or specific socioeconomic backgrounds).
6. Consider the option of omitting Twitter and Sound Cloud from data tracking.

For additional information about the INN–16 Urban Beats program
and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

COGNITIVE REHABILITATION AND EXPOSURE/ SORTING TREAMENT (CREST) PROGRAM (INNOVATIONS-17)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES ANNUAL REPORT YEAR 3 (1/1/18 – 12/31/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). CREST is designed to reduce hoarding behaviors among adults age 60 and older through a unique treatment approach that integrates cognitive training and exposure therapy combined with care management, peer support, linkages to community services, and periodic in-depth assessments and evaluations to track progress. To facilitate engagement in and completion of the 26-session treatment program, services were provided in the participant's home. CREST services are provided by a team of UC San Diego psychologists, social workers, care managers, and peer support specialists.

Key innovations of the CREST program include the use of a structured in-home evidence-based cognitive training and exposure therapy treatment approach. Another important innovation of CREST is the addition of a peer specialist with successful treatment experience to provide additional support to CREST participants. CREST clinicians use a whole person approach, informing the treatment through a combination of both psychotherapy and care management. Through the combined effect of the treatment sessions, peer specialist support, and comprehensive care management, it is expected that CREST participants will reduce their hoarding behaviors, resulting in improved mental health, well-being, housing stability, and safety.

EXECUTIVE SUMMARY

The Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) is a 26-session in-home program designed to reduce hoarding behaviors among adults age 60 and older. The unique treatment approach integrates cognitive training and exposure therapy with care management, peer support, and periodic in-depth assessments to track participant progress. The services are provided by a team of psychologists, social workers, care managers, and peer support specialists.

- Due to expanding countywide, admissions into the CREST program increased from 12 persons in 2017 to 45 persons in 2018. Of the 107 persons screened during 2018 almost all met criteria for hoarding disorder (98.1%), but only 30.8% met all eligibility requirements (i.e., Medi-Cal/uninsured). A total of 13 persons successfully completed CREST during 2018.
- Of the 45 new enrollees, the average age was 68 (range = 59 to 81) and nearly three-quarters (71.1%) were female. The majority identified as white (73.3%), nearly all reported English as their primary language (91.1%), and over half (51.1%) had a post-secondary degree.
- Over 75% reported having at least one disability unrelated to mental health (e.g., physical disability or pain) and the majority had at least one comorbid psychiatric diagnosis in addition to hoarding disorder (e.g., major depression).
- During 2018 a total of eight evictions were prevented.
- Following CREST program completion participants demonstrated reductions in clutter, functional impairment, mobility impairments, and risk for homelessness.
- While demonstrating improvements, 61.5% of the persons who completed the 26-sessions during 2018 still met criteria for hoarding disorder and required additional treatment.
- Key factors identified by CREST staff that helped achieve program goals: 1) using an evidence-based treatment protocol, 2) skill/training of therapists, 3) having supportive and collaborative community partners, 4) expanding service provision countywide, and 5) having coordinated, full-service care provided by a multi-disciplinary team.

RECOMMENDATIONS

Primary recommendations include: 1) expand insurance eligibility requirements to accept low income Medicare clients, 2) lower the age requirement (e.g., to over age 50 or 55), 3) establish city/county process to refer to treatment prior to punitive measures by code enforcement/Section 8/HUD, 4) provide training opportunities for volunteers and clinicians, and 5) expand family support and education groups.

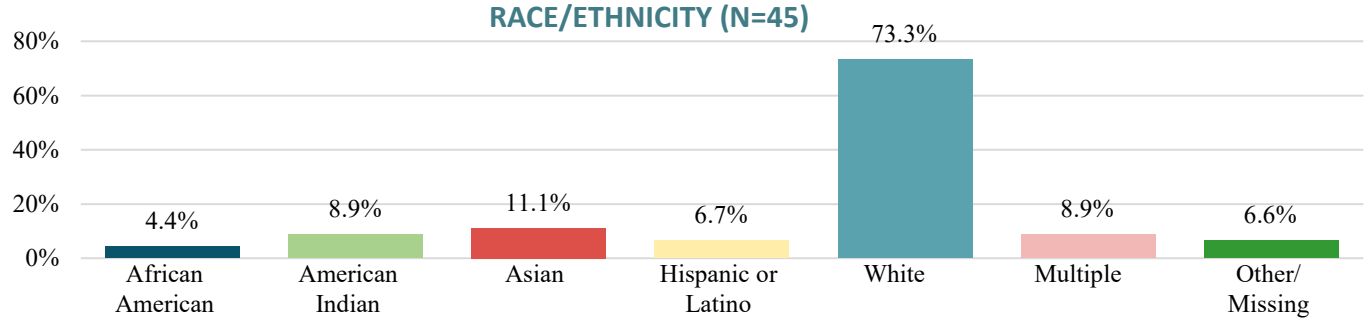
PARTICIPANT CHARACTERISTICS

The following data elements were collected via a participant self-report survey administered at the start of the CREST program.

- During 2018, 107 new persons were screened for CREST program eligibility. 105 (98.1%) met criteria for hoarding disorder and 33 (30.8%) met all eligibility requirements.
- The 45 new enrollees during 2018 included 12 individuals who were screened in previous years and had become eligible following the countywide expansion of services or they were allowed as Medicare exceptions.
- During 2018 a total of 60 clients actively participated in the CREST program (i.e., 12 had enrolled in 2017).

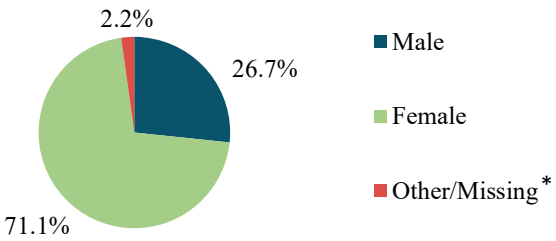
- Participants ranged in age from 59 to 81, with an average age of 68.
- Most participants (91.1%) reported English as their primary language with 8.9% reporting another primary language.
- Most participants (82.2%) reported never having served in the military, 13.3% reported having previously served, and 4.4% reported either other/missing.

RACE/ETHNICITY (N=45)



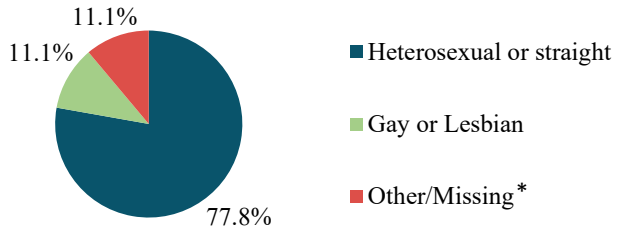
The majority of participants identified as White (73.3%) with 11.1% identifying as Asian. Totals may exceed 100% as participants could indicate more than one race/ethnicity.

GENDER IDENTITY (N=45)



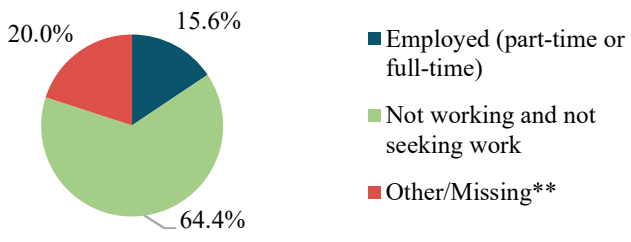
Nearly three-quarters of participants identified as female (71.1%) and 26.7% identified as male.

SEXUAL ORIENTATION (N=45)



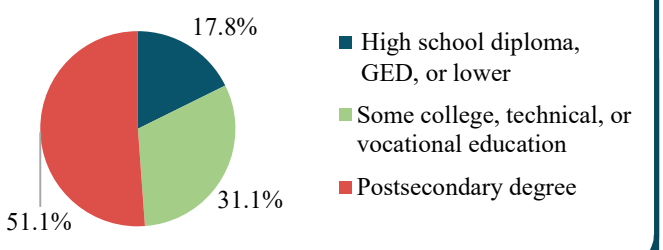
Over three-quarters (77.8%) of participants reported their sexual orientation as heterosexual and 11.1% reported as gay or lesbian.

EMPLOYMENT (N=45)



Approximately two-thirds (64.4%) of participants were not employed and were not seeking employment.

EDUCATION (N=45)

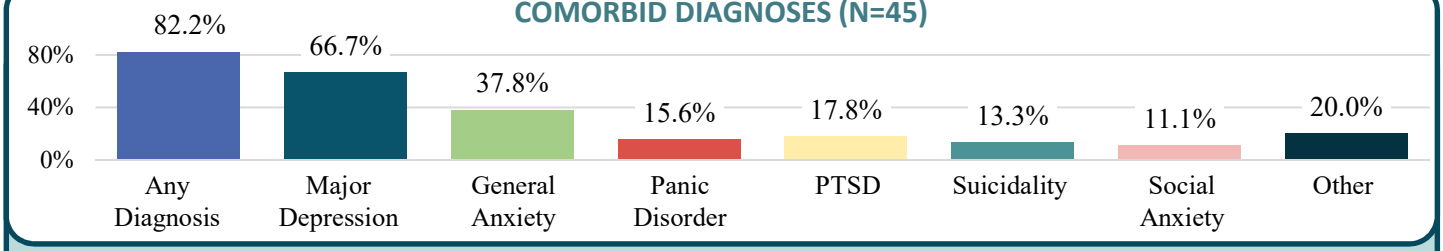


Over half (51.1%) of participants had completed a postsecondary degree.

** Other may include bisexual, pansexual, sexually fluid, unsure of sexuality, or questioning. ** Other may include seeking work or other situations.*

CREST PROGRAM PARTICIPANT CHARACTERISTICS (CONTINUED)

COMORBID DIAGNOSES (N=45)



Most participants (82.2%; n=37) had at least one comorbid mental health related diagnosis with over half (66.7%) of the participants having comorbid major depression.

DISABILITY[1] STATUS (N =45)

Type	n	%
Seeing	5	11.1%
Hearing	6	13.3%
Mental (e.g., learning)	9	20.0%
Physical	16	35.6%
Chronic Health Issues	12	26.7%
Other	20	44.4%

The distribution of disabilities is listed above. Totals may exceed 100% as participants could indicate more than one.

HOMELESSNESS RISK FACTORS (N=45)

40.0%	Have poor credit history
35.6%	Ever homeless/not have a home of own
64.4%	Without somewhere to stay/without plan for housing if lost current housing
51.1%	Have at least one barrier to getting or keeping their home, including: lack of employment (11.1%), lack of transportation (24.4%), and lack of financial assistance (35.6%).

Homelessness risk factors were prevalent with approximately one-third indicating they had previously been homeless.

FIGURE 1. PARTICIPANT HOARDING RATING SCALE RESPONSES AT BASELINE

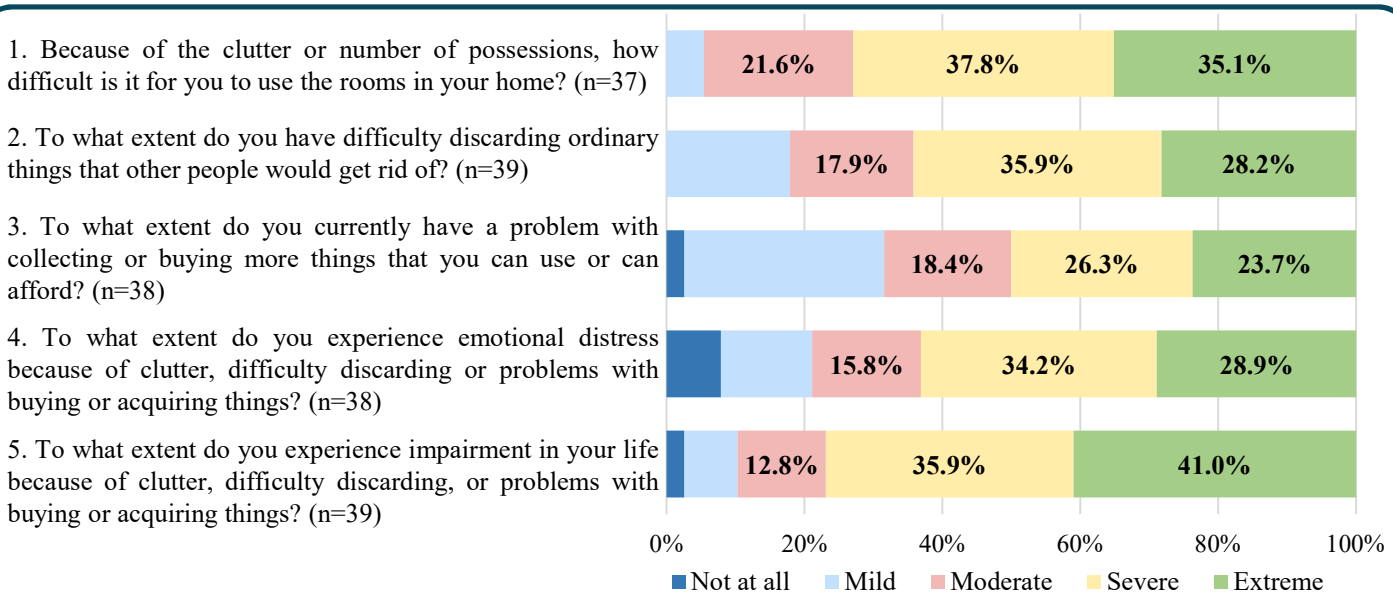


Figure 1 presents baseline responses to the Hoarding Rating Scale (HRS) questions for participants enrolled during 2018. Overall, results indicated substantial negative effects on the lives of CREST participants due to clutter in their home, with 94.5% reporting moderate to extreme difficulty using rooms in their house, 78.9% reporting moderate to extreme emotional distress, and 89.7% reporting moderate to extreme impairment in their life.

Participants also completed the Activities of Daily Living in Hoarding (ADL-H) scale. The ADL-H is a 9-item measure used to rate the ease with which a set of common activities (e.g., prepare food, use bath/shower, etc.) can be completed. The response options of the 5-point scale range from 1 (Can do it easily) to 5 (Unable to do). The average baseline ADL-H score was 2.5 (little difficulty/moderate difficulty) with a key mobility item, "move around inside the house" rated 3.1.

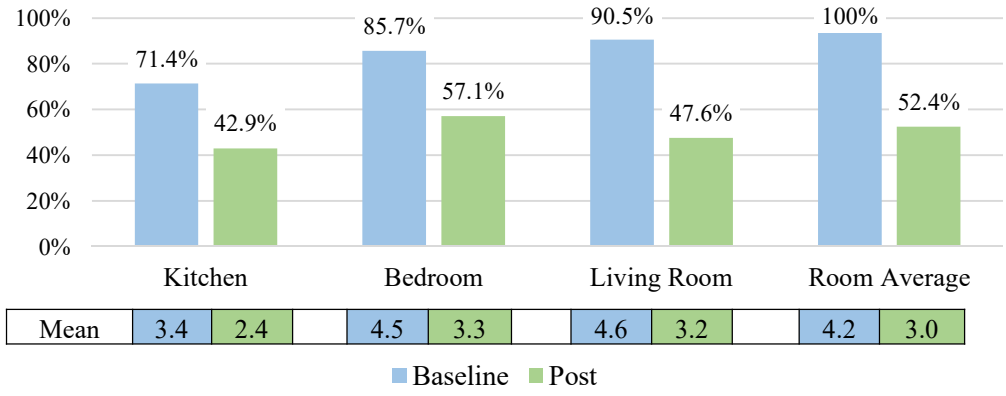
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a Serious Mental Illness (SMI).*

KEY EVALUATION OUTCOMES

REDUCTIONS IN CLUTTER

The Clutter Image Rating (CIR) scale is a tool used to rate clutter levels on a scale from 1 to 9 (most cluttered = 9), by selecting the image that most closely resembles someone's living spaces (i.e., kitchen, living room, bedroom; see example CIR images below). Figure 2 presents the percentage of participants who had a CIR value **greater than 2** before or after treatment (mean CIR values listed below the chart). Of participants with CIR ratings at both time points (n = 21), substantially fewer had CIR values greater than 2 after receiving CREST treatment services. Mean CIR scores decreased as well for each room individually and the overall room average decreased from 4.2 to 3.0. These findings of decreased clutter are consistent with improved symptom management due to CREST program participation.

FIGURE 2. PARTICIPANT CLUTTER IMAGE RATINGS AT BASELINE AND POST



CIR Living Room Rating #2

CIR Living Room Rating #4

REDUCTIONS IN HOMELESSNESS RISKS

Upon entering the CREST program, participants completed the Homelessness Risk Screener designed to assess their personal risk for homelessness. Questions include such items as asking participants about their current and past living situations, the types of environments they have lived in, if they rely on family for financial support, and what types of barriers they face when it comes to housing stability. This same questionnaire is then completed again when participants discharge from the program.

While the sample sizes were too small for definitive conclusions, in general, there were fewer participants who were at risk for homelessness after completing the CREST program. In particular, 35.7% of the 14 participants who completed the Current Homelessness Risk Screener were either homeless, living in temporary housing, or facing eviction upon entering CREST, whereas none (0.0%) indicated these conditions after completing the CREST program. At both time points, the majority of participants indicated not having a place to stay and/or plan for housing if they lost their current housing. This suggests that while immediate risks for homelessness have been reduced, many of those served by the CREST program remain vulnerable to future housing disruptions.

KEY EVALUATION OUTCOMES (CONTINUED)

Reductions in Hoarding Behaviors and Impairment

Participants also completed the Hoarding Rating Scale (HRS) upon entering the CREST program and at the time of program completion (n=22). This 5-item scale asks participants to rate the extent to which they experience each hoarding related behavior or impairment on a 9-point scale ranging from 0 (not at all) to 8 (extremely). As shown in Table 1, each hoarding related item was perceived to be significantly less of a problem following the completion of the CREST program. The overall average rating was reduced from 4.9 (moderate/severe) at baseline to 2.8 (mild/moderate) at the end of the program.

TABLE 1. PARTICIPANT HOARDING RATING SCALE AT BASELINE AND POST CREST PARTICIPATION

Hoarding Behavior Effects	Baseline	Post CREST
1. Because of the clutter or number of possessions, how difficult is it for you to use the rooms in your home?	4.7	2.5
2. To what extent do you have difficulty discarding ordinary things that other people would get rid of?	5.1	3.3
3. To what extent do you currently have a problem with collecting or buying more things that you can use or can afford?	4.6	2.0
4. To what extent do you experience emotional distress because of clutter, difficulty discarding or problems with buying or acquiring things?	4.9	3.3
5. To what extent do you experience impairment in your life because of clutter, difficulty discarding, or problems with buying or acquiring things?	5.3	2.7
Average HRS Score	**4.9**	**2.8**

Reductions in Fall Risk

Participant responses to the Activities of Daily Living in Hoarding scale at baseline and after completion of the CREST program provide evidence of reduced fall risks. In particular, average ratings (n=21) for the "Move around inside the house" item decreased significantly from 2.6 (little/moderate difficulty) at baseline to 1.7 (easily/little difficulty) following CREST program completion.

ADDITIONAL PROGRAM OUTCOMES

- In 2018, the CREST program helped eight participants avoid evictions.
- While many participants experienced functional and behavioral improvements, eight participants who completed the CREST program during 2018 (61.5% of the 13 CREST program completers in 2018) still met criteria for hoarding disorder at the end of the 26-session program.

ADDITIONAL CREST PROGRAM ACTIVITIES

- In 2018, the CREST program held 108 outreach and engagement presentations and educated 903 individuals about the CREST program and issues related to hoarding behaviors.
- The team continued to revise a County-wide resource guide specifically for clients with hoarding disorder symptoms. As of 12/31/2018 there were over 2,800 community resources listed.
- Drafted a referral process in partnership with the San Diego Hoarding Collaborative.
- The CREST Program Director, Dr. Catherine Ayers, continued to lead the San Diego Hoarding Collaborative.
- Trained undergraduate volunteers to assist with advanced exposures to discarding.
- Trained geriatric psychiatrists to consult on Hoarding Disorder cases.

KEYS TO CREST PROGRAM SUCCESS: RELATIONSHIP BUILDING

CREST Program Relationships: Collaborating with Community Partnerships

Cases of hoarding disorder often require a broad and diverse group of organizations to address needs not always applicable to hoarding, but key in reducing hoarding impairments. In 2018 CREST collaborated significantly with service providers to address co-occurring mental health issues, substance use disorders, case management, housing programs, interpreting services, waste removal, home repairs, and physical health. In many of these cases addressing issues outside of CREST's scope directly led to increased engagement with hoarding treatment and associated decreases in impairments. The San Diego Hoarding Collaborative identified a network of providers integral to the diverse needs of hoarding sufferers, and is developing a handbook to coordinate collaboration on these cases.

CREST Participant Relationships: Increasing Social Connectivity

CREST program participants often experience social isolation and lack of family support which leads to increased emotional distress and contributes to hoarding behaviors including excessive acquisition and difficulty parting with possessions. CREST clinicians work to involve family members in treatment whenever possible through educational family groups and family therapy sessions. This has led to increase support and improved outcomes including healing significant relationships through enjoying time together that is not associated with acquiring possessions and partnering to help with sorting, discarding, and organizing possessions.

EXAMPLE OF CREST PROGRAM CLUTTER REDUCTION

Before CREST program participation

After CREST program participation

SUMMARY OF STAFF PERSPECTIVES – ANNUAL STAFF FEEDBACK SURVEY

At the end of the third year of providing INN-17 Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program services, administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the CREST Program. All potential survey participants (n=11) responded to the survey for a response rate of 100%.

1. *Major program goals as identified by CREST program personnel:*
    a. Provide comprehensive evidence-based treatment and care management services to reduce hoarding.
    b. Improve home safety, prevent evictions, and reduce risk of homelessness.
    c. Provide wraparound services and connect participants to needed resources and services.
    d. Increase community engagement to strengthen knowledge of hoarding and supports to persons with hoarding disorder.

2. *Factors that helped the CREST program achieve these goals (Helping Factors):*
    a. Existing evidence-based training (CREST) and protocol in place.
    b. Therapist skills and training (e.g., bilingual training).
    c. Outreach efforts and supportive stakeholders, contract representatives, and local community.
    d. Expansion of service area.
    e. Multidisciplinary care coordination.

3. *Specific challenges to reaching program goals (Inhibiting Factors):*
    a. Eligibility/exclusion criteria limited amount of participants.
    b. Lack of staff physical resources (e.g., office space, computers).
    c. Referral process – potential clients fall "through the cracks" because they have to be the one to ask for help.

4. *Key program innovations:*
    a. Evidence-based treatment and characteristics of that treatment.
    b. Using peer support as part of the program.
    c. Multi-disciplinary, wraparound care coordination.
    d. Mobility of treatment team.
    e. Meeting with the client in their home.
    f. Involve client family members (e.g., support groups).

5. *Benefits of using peer supports:*
    a. Establishes a relationship with someone who can understand barriers/struggles better than anyone else.
    b. Normalizes treatment program.
    c. Provides emotional support and hope/evidence of success.
    d. Provide additional opportunities for client to practice skills.
    e. Keeps progress moving forward.

6. *Participant characteristics or circumstances that make it challenging to effectively provide services:*
    a. Co-occurring health problems in addition to hoarding disorder including mental or physical conditions.
    b. Avoidance, lack of motivation or desire to change.
    c. Participants may not always have reliable transportation.

KEY YEAR 3 PROGRAM "LEARNINGS"

1. Removing ZIP code restrictions during 2018 substantially increased CREST program enrollment.
2. Approximately 10-15% of individuals seeking treatment were between the ages of 50 and 60. Lowering the age requirement for participation in the CREST program (e.g., to over age 50 or 55), would further increase enrollment and help address Hoarding Disorder earlier in the lifespan and prevent negative consequences for older adults.

KEY YEAR 3 PROGRAM CHANGES

During the third year of service provision (1/1/2018 – 12/31/2018), CREST implemented changes related to program expansion into all regions of San Diego County. The program also implemented the use of family support and education groups when appropriate as another tool to help individuals and their families address hoarding related concerns. During the third year of service provision, the CREST program added two Spanish-speaking clinicians in an effort to reach additional clientele in San Diego County. Two new offices were opened in San Marcos and south San Diego and four new clinicians were hired as part of this expansion. Additionally, CREST developed a community "on-the-spot" screening process to better engage individuals in the community.

STATUS OF PRIOR YEAR RECOMMENDATIONS

1. Modify eligibility and inclusion criteria to allow interested persons to participate, particularly those enrolled in Medicare.

   Status: Eligibility and inclusion criteria are unmodified due to contract stipulations, but the program consistently advocates for clients not on Medi-Cal but could not otherwise access services.

2. Improve media outreach and community engagement to recruit more participants and strengthen relationships with mental health providers and local partners.

   Status: Outreach and community engagement have been primarily focused on presenting in regions of county newly serviced by CREST program. San Diego Hoarding Collaborative continues to organize majority of primary community partnerships.

3. Address need for home repairs or removal services by allocating funding or partnering with local business or organizations.

   Status: Additional funds were allocated in the expansion contract to address junk removal needs. Home repair needs are primarily addressed via community partnerships and programs (i.e., SDG&E, JFS Fix-IT, ElderHelp).

4. Incorporate family groups into treatment model.

   Status: Family groups are now being facilitated as needed based on clients' family willingness to participate.

5. Increase flexibility regarding length of stay in the CREST program.

   Status: Implemented additional assessment and treatment sessions for individuals meeting medical necessity for ongoing treatment at the end of 26 sessions.

6. Add yearly income to the CREST program screening tool to identify potential clients with incomes over the Medi-Cal threshold who still may have limited resources and find it difficult to acquire needed treatment services.

   Status: Screening now includes estimated monthly income to identify individuals minimally over Medi-Cal eligibility.

YEAR 3 PROGRAM RECOMMENDATIONS

1. Expand insurance eligibility requirements to accept low income Medicare clients to enable CREST program enrollment for the many applicants (approximately 70%) who meet criteria for Hoarding Disorder, but not the insurance requirements.
2. Explore lowering age requirements (e.g., to over age 50 or 55) to address Hoarding Disorder earlier in life and better prevent such impairment among older adults.
3. Establish city/county process to refer to treatment prior to punitive measures by code enforcement/Section 8/HUD.
4. Provide training opportunities for undergraduate volunteers, psychologists, and geriatric psychiatrists.
5. Expand family support and education groups into North and South regions as the number of clients/graduates increase.

ROAMING OUTPATIENT ACCESS MOBILE (ROAM) (INNOVATIONS-20)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 1 (7/1/18 - 6/30/19)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Roaming Outpatient Access Mobile (ROAM) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). ROAM was developed to provide fully mobile mental health clinics to Native American individuals of all ages in the North Inland and East County regions of San Diego. Services are provided through Southern Indian Health Council (SIHC) and the Indian Health Council (IHC).

Efforts by ROAM are intended to improve access to and utilization of mental health services for Native American children, Transitional Age Youth (TAY), adults, and older adults residing on tribal reservations and rural communities in San Diego County. 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. To facilitate better access to care services, the program will provide at least some services at night and/or on the weekends. Each mobile unit will be staffed with culturally competent licensed and unlicensed professionals who can provide a variety of care services. A key innovative component of the ROAM program is the use of telemental health for on-going and continuing mental health needs. The usage of telemental health in conjunction with, rather than in lieu of, face to face services is expected to be a key factor in minimizing barriers to treatment and is intended to allow for further mental health engagement.

YEAR-ONE ACTIVITIES

During Year 1 of the ROAM program (FY 2018-19), the primary implementation related activities included the following:

1. Obtained approval for ROAM service activities from Tribal Councils.
2. Designed, procured, and tested the mobile health units.
3. Reviewed, selected, and obtained authorization for the specific telemental health platform (OTTO Health).
4. Hired and trained staff.
5. Conducted outreach to inform community leaders and members of the new service delivery options.
6. Established key points of contact throughout the community for coordination of services.
7. Established plans/schedule for mobile unit location rotation throughout the week.
8. Developed ROAM promotional materials (e.g., brochures and flyers).
9. Identified and set up administrative office space.
10. Created policies and procedures to guide ROAM team activities (e.g., safety protocols, business operations, etc.).
11. Researched and identified outcome measurement tools.

All of these actions were intended to help prepare for the utilization of ROAM to expand the reach of behavioral health services, particularly psychiatry, to underserved rural communities.

FUTURE DIRECTIONS

In Year 2, each program will fully implement the ROAM mobile unit and telemental health technologies to provide expanded behavioral health care services to Native Americans living in the North Inland and East regions of San Diego County.

JUST BE U
(INNOVATIONS-21)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 1 (7/1/18 - 6/30/19)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Just Be U (JBU) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The goals of the program include improved mental health and quality of life outcomes for Transitional Age Youth (TAY; 18-25 years old), 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.

The specific objectives of JBU include the provision of short-term housing (up to 90 days), in a supportive environment that seeks to reduce stigma and behavioral health challenges while instilling hope for recovery and independence. JBU whole-health services target healthy eating, exercise, sleep, and a range of holistic interventions to support rehabilitation and promote improved social connections with family, peers, and the community. The program also seeks to utilize technology in creative ways to promote engagement with TAY. Throughout these interactions with TAY, JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on TAY centric whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging TAY.

EXECUTIVE SUMMARY

The Just Be U (JBU) program was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY), 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 TAY in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions.

Outreach Efforts

- JBU staff attempted to contact 100% (n=120) of eligible TAY, according to strict county eligibility requirements.
- Staff successfully contacted 30.8% of eligible TAY (n=37).

Enrollment

- A total of 22 TAY were enrolled in the program.

TAY Characteristics

- Enrolled TAY are between the ages of 18-25 and racially diverse.
- 100% of enrollees have an SMI diagnosis, but the majority are non-compliant with prescribed medications.
- The majority of JBU TAY have a history of co-occurring Substance Use Disorders (SUD).
- Over a quarter of JBU TAY reported having a disability beyond SMI.

JBU Provision of Holistic Services

- JBU staff and external partners provided a wide range of services/trainings focused on self-regulation and wellness (e.g. meditation, biofeedback, yoga).
- Approximately 40-80% of JBU TAY attended holistic services each week.

Participant Outcomes

- Pre-Post holistic services data collection revealed positive trends regarding: (1) Sense of belonging, (2) Feeling hopeful for the future, and (3) Sense of program practices helping them feel better.

Linkages to Services

- A total of 107 linkages to services were made across mental health, housing, and substance abuse domains, with multiple linkages per youth to provide individualized treatment plans.

Staff Survey

- Staff reported holistic service offerings and connections to the community as the factors which best supported JBU goals.
- Increased access to SUD and mental health treatment were most commonly cited as factors which would benefit the program.

Year 1 Data Trends

While the number of youth with completed baseline and follow-up data was relatively small during the JBU program start-up year, the findings from participant self-report and provider surveys suggested that desired changes were occurring in multiple areas of program emphasis (e.g., social connectedness, mental wellbeing, engagement in treatment). The trends in positive directions indicate the program appears to be achieving desired outcomes. The UCSD Innovations Evaluation team will monitor data trends as enrollment continues to increase.

PROGRAM DESCRIPTION

Using County of San Diego Behavioral Health Services Electronic Health Record (EHR) data, BHS personnel identify youth (age 18-25) who appear to be eligible for JBU services (i.e., multiple acute/crisis related BHS service contacts, 100% have diagnosis of SMI, and unconnected to behavioral health services). Once JBU receives these names, intensive outreach efforts are made by JBU staff to locate and make contact with each TAY using available contact information provided by County databases, street searches, and coordination with other County and support agencies.

Once eligible TAY have been contacted, given an explanation about the program's offerings, and enrolled in the program, JBU provides short-term (up to 90 days) 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 on one floor, JBU TAY can access a centralized kitchen, cooking and nutritional classes, and holistic health care services and classes all within the same building in downtown San Diego. During their 90 days in the program TAY will receive recuperative, integrative, and holistic wellness services such as acupuncture, yoga, massage therapy, Reiki, chiropractic care, and meditation, as well as mindfulness education, biofeedback therapy, 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 TAY into short-term housing for up to 90 days while providing holistic, TAY-centered recuperative services, and then link these TAY to ongoing treatment, housing, and supportive services; thereby improving their mental health and quality of life in the community and breaking the cycle of homelessness early in the process by which TAY may otherwise harden 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, de-stigmatization 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 on 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 de-stigmatization, 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.

EVALUATION PLAN

The key evaluation findings are based on a comprehensive set of assessment tools used by JBU. TAY at JBU complete an integrated self-assessment, the Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS), which includes the Patient-reported Outcomes Measurement Information System (PROMIS) Global Health scales (mental health and physical health) as well as items measuring substance use, suicidality, satisfaction, and impact of symptoms on daily activities. In addition, the CHAMPSSS form includes four items measuring satisfaction and participant outcomes, which have been used extensively across a wide range of programs in San Diego County. JBU TAY also complete the Recovery Markers Questionnaire (RMQ), and respond to questions both before and after engaging in holistic health practices.

Additional assessments are administered by staff and other trained health professionals. They include participant demographics, key outcome domains (housing, employment, and critical events), the Global Functioning Scale, the Illness Management and Recovery (IMR) Scale, the Milestones of Recovery Scale (MORS), the Linkage & Referral Tracker, and the Encounter Form. The data are entered into the Mental Health Outcome Management System (mHOMS), an electronic health record system, and then analyzed by the UCSD Innovations evaluation team.

Due to the small number of TAY enrolled in JBU during FY 2018-19, the UCSD Innovations evaluation team determined that reporting on statistical significance of outcomes would not be appropriate. For this reporting cycle, the UCSD Innovations evaluation team highlighted data trends and the direction of behavior changes. Future reports will discuss statistical significance when appropriate.

OUTREACH EFFORTS

After the program was notified of youth who appear to meet strict JBU eligibility criteria set by County of San Diego BHS personnel, substantial efforts were made by the JBU team to locate eligible TAY who might benefit from the program. Where made possible by the availability of sufficient contact information or leads, outreach was directly made to each TAY. In all cases of eligibility, 100% of eligible TAY were sought out for contact. In the event of there being insufficient contact information, the JBU team attempted to reach TAY through other means, such as by direct street canvasing, utilizing the BHS EHR system to alert other programs that the youth was potentially eligible for JBU services, contacting other key service providers connected to the youth (e.g., parole officers, jails, psychiatric hospitals, in-patient rehabilitation centers), and reaching out to other programs in San Diego County.

Of the 120 TAY determined to be eligible during FY 2018-19, 42.5% (n=51) were unable to be reached by JBU due to an unknown location or inability to contact via County-provided information. Twenty-eight TAY (23.3%) were unavailable due to ongoing involvement with the criminal justice system. At the end of FY 2018-19 JBU was ultimately able to successfully contact 37 TAY (30.8%). Of those contacted, nine currently had housing, three were in communication with JBU, two came to tour JBU facilities, and 22 (18.3% of original 120) enrolled in the JBU program.

None of the TAY who were introduced to the program's structure and benefits via an outreach coordinator claimed to be not interested or refused participation, indicating high receptivity.

TABLE 1. OUTCOME OF OUTREACH ATTEMPTS

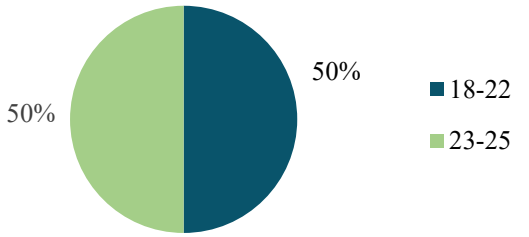
Final Outreach Disposition	n	Percentage of eligible TAY
No contact/location unknown	51	42.5
Located: Unavailable- criminal justice facility	28	23.3
Located: Unavailable- other restrictive program	4	3.3
Contacted: Has housing	9	7.5
Contacted: Not interested/refused JBU services	0	0.0
Contacted: Active Outreach- Established communication	3	2.5
Contacted: Active Outreach- Visited JBU	2	1.7
Contacted: Lost contact	1	0.8
Contacted: Enrolled in JBU	22	18.3
Total Outreach	120	100.0

The data regarding JBU outreach efforts indicate of TAY who still required housing at time of JBU contact, nearly all enrolled in the JBU program, or were in discussions regarding enrollment as of the end of FY 2018-19. This is noteworthy, as this cohort of TAY experiencing homelessness are historically among the most difficult to contact, recruit, or retain in a stable program.

PARTICIPANT CHARACTERISTICS

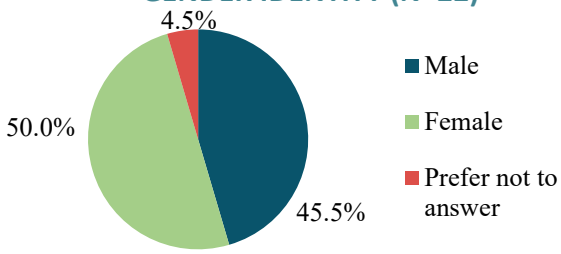
The following self-reported characteristic data were collected from TAY during the enrollment process.[1]

AGE (N=22)



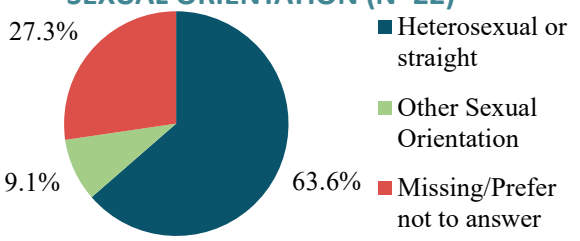
TAY were equally represented in the 18-22 and 23-25 age ranges, with 50% of TAY in each.

GENDER IDENTITY (N=22)



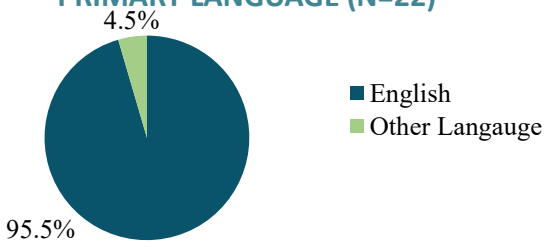
Half of TAY enrolled with JBU identified as female.

SEXUAL ORIENTATION (N=22)



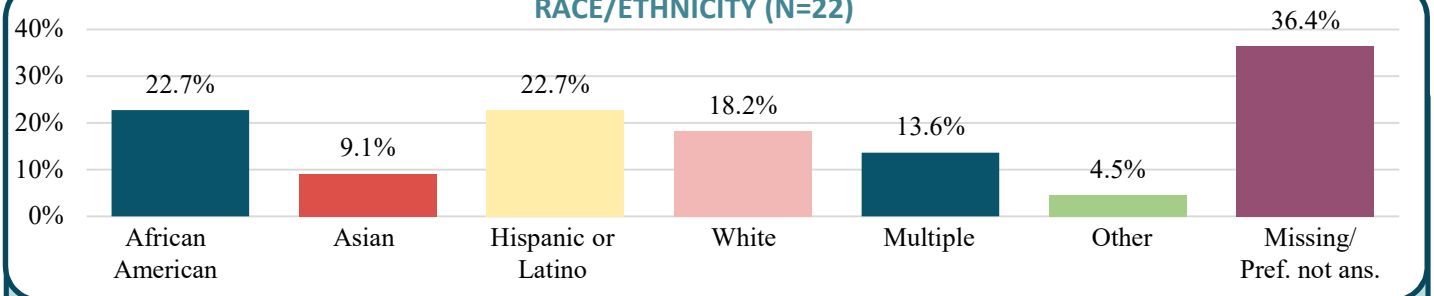
The majority (63.6%) of TAY identified as heterosexual or straight.

PRIMARY LANGUAGE (N=22)



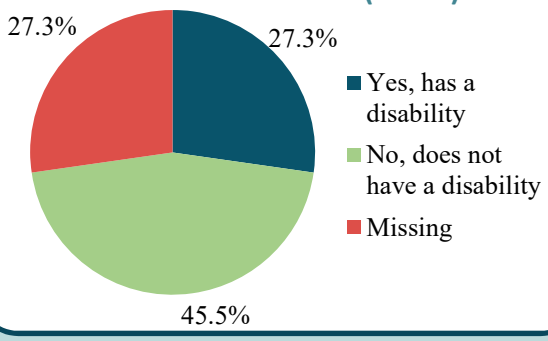
The majority (95.5%) of TAY spoke English as their primary language.

RACE/ETHNICITY (N=22)



About a quarter of TAY identified as Hispanic (22.7%) or African American (22.7%) with 18.2% identifying as White. Total may exceed 100% as participants were able to indicate more than one race.

DISABILITY[2] STATUS (N= 22)



All TAY reported SMI, and more than a quarter (27.3%) had an additional non-SMI-related disability.

TYPE OF DISABILITY (N=22)

Type	n	%
Hearing	< 5	< 22.7
Learning	< 5	< 22.7
Developmental	< 5	< 22.7

This table indicates the specific types of non-SMI related disabilities reported as a percentage of all participants (i.e., including those without a disability). Participants may have indicated more than one non-SMI disability.

[1] Percentages may not total to 100% due to rounding. [2] A disability was 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 (SMI).

PROGRAM ATTENDANCE

During the last three months of FY 2018-19, an average of 50 group sessions and 71 individual sessions were offered per month. When analyzed according to enrollment reports, this represents a 40% rate of attendance by enrolled TAY (average of 2.4) in each group session. An average of four individual and/or group sessions were offered per day throughout the April-June reporting period.

Cooking classes had the highest mean attendance rate, at 80% of enrolled TAY (average of 4.8 TAY per session), with 12 sessions offered during the three month reporting period. Among the group sessions, Yoga and Meditation drew the most TAY throughout the April-June reporting period, with 66 attendees across the 38 offered group sessions. Meditation was offered in group and individual settings for a total of 75 sessions.

Among the individual sessions, Biofeedback was most highly attended, with an average of nearly one individual session provided every day of the three month period. Biofeedback sessions comprised psychoeducation, personalized holistic health planning, self-regulation and attention training, and physiological monitoring and training of stress-triggers, autonomic reactivity, and/or habitual stress reactions (e.g., shifts in and learned control of heart rate, breath dynamics, and muscle tension).

TABLE 2. HOLISTIC SERVICES ATTENDANCE RATES (APRIL-JUNE 2019)

April 2019-June 2019				
Services	**Group Sessions**	**Group Attendees**	**Group Mean Attendance**	**Individual Sessions**
Yoga	38	66	1.7	-
Reiki	13	30	2.3	-
Acupuncture	12	27	2.3	-
Grocery Shopping	14	44	3.1	-
Cooking Classes	12	57	4.8	-
Fitness Classes	12	35	2.9	-
Group Outings	11	33	3	-
Meditation	38	66	1.7	37
Massage	-	-	-	40
Biofeedback	-	-	-	83
Chiropractic Fitness	-	-	-	54
Totals	150	358	2.4	214

KEY EVALUATION FINDINGS

PARTICIPANT RATED OUTCOMES

Pre/Post Holistic Practice Assessment: TAY answered these six questions on multiple occasions – typically before and after participating in a JBU provided holistic practice (e.g., yoga, massage, biofeedback). Occasionally they were asked the questions without having a corresponding activity occurring in between question administrations to generate "control/no activity" data for comparison purposes. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree. Higher values correspond to higher levels of well-being and/or positive perceptions.

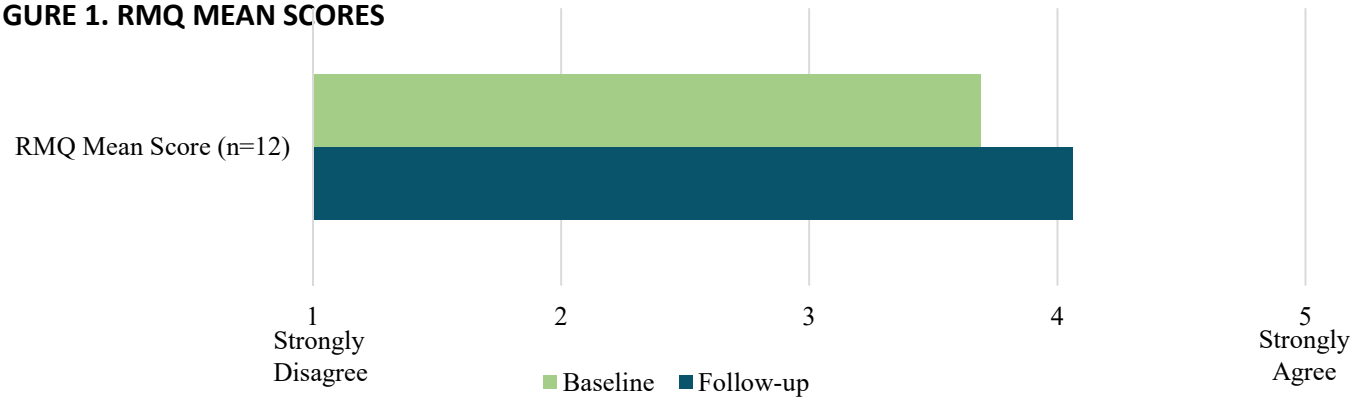
TABLE 3. PRE/POST HOLISTIC PRACTICE ASSESSMENT

Assessment Questions	Any Activity (n=74)		No Activity (n=21)	
	Mean		Mean	
	Pre	Post	Pre	Post
I have a sense of belonging	2.9	3.2	2.6	2.7
I feel hopeful about my future	3.0	3.2	2.6	2.6
I like and respect myself	2.9	3.2	2.5	2.6
I am using my personal strengths, skills, or talents	2.9	3.1	2.7	2.8
The technology I'm using in this program is helping me feel better	3.1	3.3	2.9	3.1
The holistic health practices I'm using in this program are helping me feel better	3.2	3.3	2.9	3.1

Overall, there was a pattern of more favorable ratings after participating in a holistic practice. In comparison, changes were either not evident or more muted when no activity occurred between question administrations. Additionally, the data suggest the potential for an anticipatory priming effect in that "Pre" values were higher when participation in holistic activities was expected than during the no activity controls. These findings suggest that there are positive changes in youth attitudes about themselves and their future due to participating in the range of holistic services provided through JBU.

Recovery Markers Questionnaire (RMQ): The RMQ is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The 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 TAY to answer questions as it is "true for you now." As shown in the chart below, overall RMQ mean scores improved from baseline to follow-up.

FIGURE 1. RMQ MEAN SCORES



KEY EVALUATION FINDINGS CONTINUED

CHAMPSSS: The CHAMPSSS assesses TAY perceptions and experiences that indicate recovery, symptom reduction, and increased self-esteem. Scores range from 1 to 5 and items were coded such that higher scores indicate more positive perceptions and experiences. As such, an increase in scores regarding Suicidality reflect a more positive perception and experience for TAY.

TABLE 4. CHAMPSSS SUBSCALE

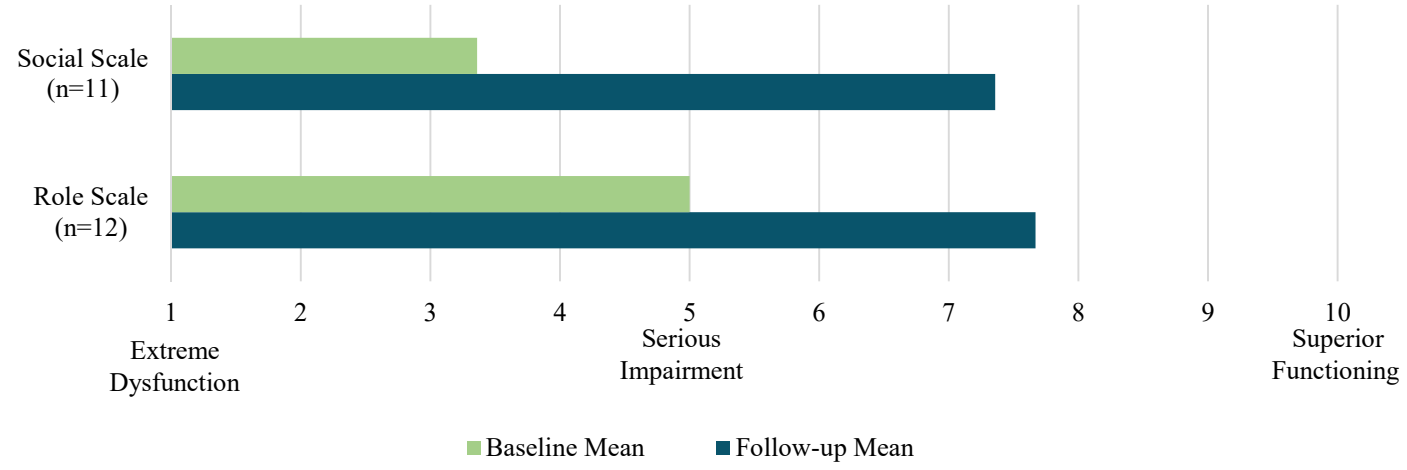
CHAMPSSS Subscale	n	Baseline		Follow-up	
		Mean	SD	Mean	SD
Global Health	12	3.0	0.6	3.4	0.4
Resilience	12	2.9	0.9	3.6	0.7
Depression	12	2.4	1.1	2.9	0.8
Anger	12	2.8	0.9	3.5	1.0
Anxiety	12	2.6	1.0	3.4	1.0
Suicidality	12	3.5	1.2	3.6	1.1
Substance Use	12	2.8	1.3	3.5	0.9
Substance Use Frequency	12	3.5	1.5	4.4	0.9
Memory	12	4.2	0.8	3.8	1.0
Functioning (4 point scale)	11	3.0	1.0	3.6	0.7

The CHAMPSSS findings demonstrated improvement in many different aspects of well-being from baseline. Factors related to substance abuse showed a slight positive trend. Of the nine TAY who were linked to voluntary substance abuse services, 44% (n=4) completed treatment/training, while 56% (n=5) declined.

PROVIDER RATED OUTCOMES

Global Functioning: Following a semi-structured interview, the provider rated the Role and Social Functioning of JBU TAY on a 10 point scale (1 = Extreme Dysfunction; 5 = Serious Impairment; 10 = Superior Functioning). For both scales, baseline mean values were typically in the 3-5 range (indicative of substantial impairment).

FIGURE 2. GLOBAL FUNCTIONING



Mean values increased to approximately 7.5, which is indicative of mild impairment/good functioning.

KEY EVALUATION FINDINGS CONTINUED

Illness Management and Recovery (IMR) Scale: To measure clinician 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 known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery.

TABLE 5. ILLNESS MANAGEMENT AND RECOVERY SCALE ITEMS AND SUBSCALES

IMR Item or Subscale	n	Baseline		Follow-up	
		Mean	SD	Mean	SD
Involvement of family and friends in his/her mental health treatment	12	2.0	1.2	3.0	1.4
Time in structured roles	11	1.7	1.0	3.5	1.4
Psychiatric hospitalizations	7	2.4	1.8	3.4	1.3
Using medication effectively	10	3.2	1.9	4.5	1.0
IMR Recovery Subscale	12	2.8	0.8	3.8	0.7
IMR Management Subscale	12	2.3	0.9	2.0	1.1
IMR Substance Abuse Subscale	7	2.9	1.6	2.9	1.4
Overall	12	2.6	0.4	2.9	0.7

The overall IMR scores indicated substantial improvements from baseline based on provider perceptions of the TAYs' recovery. The Recovery subscale demonstrated the largest area of improvement.

Milestones of Recovery Scale (MORS): 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.

TABLE 6. MILESTONES OF RECOVERY SCALE (Pre-post; n=12)

		Baseline		Most recent	
1	Extreme Risk	8.3%		0.0%	
2	High Risk/Not Engaged with mental health providers	16.7%	33.3%	0.0%	16.7%
3	High Risk/Engaged with mental health providers	8.3%		16.7%	
4	Poorly Coping/Not Engaged with mental health providers	41.7%	41.7%	8.3%	8.3%
5	Poorly Coping/Engaged with mental health providers	0.0%		8.3%	
6	Coping/Rehabilitating	8.3%	25.0%	33.3%	75.0%
7	Early Recovery	16.7%		8.3%	
8	Advanced Recovery	0.0%		25.0%	

The findings indicate that upon entering JBU, the majority of TAY were in the lower categories (i.e., "higher risk"), whereas at follow-up there is a trend towards greater engagement and improved coping/rehabilitation.

LINKAGES TO SERVICES

The following tables indicate the linkages to external community services made across several key domains: mental health, substance abuse, and housing. These linkages were facilitated by JBU staff according to the individual and unique needs of JBU TAY. In total, 107 linkages were made, with 57 of the linkages (53.3%) connecting TAY to mental health services. Of substance abuse linkages, 18 (64.3%) were to residential or outpatient substance abuse services. These linkages reflect other evaluation data points indicating substance abuse as a substantial issue facing JBU TAY. Totals may exceed 100% due to multiple linkages.

MENTAL HEALTH	Unique TAY	Total Linkages
Linkage Type*	n=18	n=57
Independent psychiatrist	< 5	< 5
Private counselor/therapist	6	8
Specialty mental health clinic	9	13
Behavioral health within primary care clinic	< 5	< 5
Inpatient treatment	< 5	< 5
Crisis house	< 5	< 5
Self-help groups (e.g., WRAP, Roadmap to Recovery – these may be offered outside of clinics)	5	5
Clubhouse	< 5	< 5
Assertive Community Treatment	7	12
Psychiatric Evaluations	< 5	< 5
Medication Management	5	6

**Linkage defined as being 'linked' or 'successfully connected' to the service/resource.*

SUBSTANCE ABUSE	Unique TAY	Total Linkages
Linkage Type*	n=9	n=28
Outpatient substance abuse services	7	11
Substance abuse recovery self-help group (12 Step)	< 5	< 5
Residential AOD treatment	< 5	7
Sober living	< 5	< 5
Detox	< 5	< 5
Inpatient hospital treatment (includes medical detox)	< 5	< 5

**Linkage defined as being 'linked' or 'successfully connected' to the service/resource.*

HOUSING	Unique TAY	Total Linkages
Linkage Type*	n=14	n=22
Housing assistance voucher program (Section 8, Shelter Plus Care, CalWORKS, etc.)	5	5
Emergency Shelter	< 5	< 5
Apartment/House	< 5	5
Independent Living Facility (ILF)	< 5	< 5
Resources to assist obtaining a living environment (e.g., Housing Prioritization Assessment)	9	11

**Linkage defined as being 'linked' or 'successfully connected' to the service/resource.*

ANNUAL FEEDBACK SURVEY – JBU STAFF

At the end of FY 2018-19 (6/30/2019), staff for the Just Be U Program were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 5 respondents from the 9 staff members invited to participate in the survey, a response rate of 55.5%. 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.

1. *Primary goals of this program during this past year:*
    a. Improve mental health of TAY.
    b. Decrease stigma around mental health issues.
    c. Utilize a holistic approach to mental health.
    d. Supportive housing.

2. *Factors that helped the program achieve goals:*
    a. Service offerings (i.e., massage, needling, biofeedback, classes, etc.).
    b. Connection/outreach with community (i.e., jails and hospitals).
    c. Holistic nature of services.
    d. Peer support.

3. *Factors that inhibited the program from achieving goals:*
    a. SUD behavior/lack of counseling available.
    b. Youth attendance/retention/engagement.
    c. Need for more/more frequent mental health services.

4. *Recommendations to better achieve program goals:*
    a. Increased access to SUD services.
    b. More/more frequent mental health services.
    c. Attendance/retention/engagement efforts.
    d. Change the eligibility requirements.
    e. Medication services.

5. *Supports, tools, and/or trainings needed to do job well:*
    a. SUD resources.
    b. More training (i.e., peer support, mental health, WRAP, WHAM, case management).
    c. Group therapy.
    d. Group communications for community building.
    e. On-site mental health services.

6. *Key strengths of this program:*
    a. Staff factors (i.e., dedication, relatability).
    b. Holistic approach of the program.
    c. The variety of offerings.
    d. Provision of basic needs (i.e., food, shelter).

7. *Primary barriers or challenges to achieving objectives with JBU participants:*
    a. SUD issues (use/abuse, or lack of services available).
    b. SMI issues.
    c. Medication/psychiatric service issues (i.e., med compliance, lack of psychiatric follow-up).
    d. Lack of mental health resources.

ANNUAL FEEDBACK SURVEY – EXTERNAL SERVICE PROVIDERS

At the end of FY 2018-19 (6/30/2019), external service providers (e.g., yoga instructors, chiropractors, etc.) for the Just Be U Program were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. There were 6 respondents from the 7 providers 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.

1. *Primary goals of the JBU program:*
    a. Calm/relaxation.
    b. Youth personal development, self-discovery.
    c. Provide a safe space.
    d. Provide support.

2. *Factors that helped the program achieve goals:*
    a. Service offerings (i.e. massage, needling, biofeedback, classes, etc.).
    b. Staff factors (i.e. supportive, encourage participation, etc.).
    c. Space factors (i.e. comfortable, quiet, etc.).
    d. Leadership factors.

3. *Factors that inhibited the program from achieving goals:*
    a. Youth attendance/retention/engagement.
    b. Fear of needles.
    c. Scheduling issues.
    d. Provider issues (i.e. training, biases, etc.).

4. *Recommendations to better achieve program goals:*
    a. Attendance/retention/engagement efforts.
    b. Community collaboration.
    c. Scheduling changes (i.e. times that services are offered).
    d. Promotion efforts.

5. *Key strengths of this program:*
    a. Staff factors (i.e. dedication, relatability).
    b. Holistic approach of the program.
    c. The variety of offerings.
    d. Leadership factors.

6. *Supports, tools, and/or trainings would you want more of to work well with the JBU program:*
    a. Additional training (i.e. mental health, at-risk youth, etc.).
    b. Guidance and mentorship from leaders.

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Addressing substance use is a substantial challenge for most JBU enrollees.

2. Finding and making contact with potentially eligible youth is difficult due to limited or old contact information, and restrictive program eligibility criteria.

3. Program design is uniquely appealing to this difficult-to-reach populations as evidenced by a 100% receptivity rate, with nearly all youth contacted by JBU becoming either enrolled or awaiting enrollment by the end of the Year 1 reporting period.

4. The holistic practices appear to have an immediate positive effect on youth attitudes about themselves and outlook for future.

5. Non-compliance with prescribed medications for severe mental illness is common and presents challenges to TAY's behavioral and mental stability, and with staff's ability to improve engagement with services. The majority of TAY have or had prior prescriptions for psychiatric medications, 100% have severe mental illness, but very few are able or willing to comply with an oral drug regimen. TAY who were receptive to long-acting injections (e.g., once per month) experienced greater benefit from this ease-of-compliance, however the qualification process for this drug-delivery option is difficult, such that oral prescriptions remain the norm despite low compliance rates.

6. The primary inputs to homelessness in this population appear to be unaddressed severe mental illness and co-occurring substance abuse disorders, and not simply the unavailability of material resources or access to social services.

7. A high level of daily engagement and incentivizing by staff is required to link TAY to available outside services, despite the importance of such services to ongoing well-being, including healthcare, housing, education, and employment. This seems to reflect TAY's low expectations of success and low levels of sustained effort to recall or arrive at scheduled service appointments.

8. The characterization of being "independent living" capable among the TAY defined as eligible for this program should be more carefully considered and professionally assessed in each case, given the tenacity of the mental illness and substance use disorders observed in this cohort. A high-touch approach, with regular supervision and monitoring by staff has been required to link and sustain services and functioning for all the initial graduates of the program.

9. The human factors among staff, such as warmth, friendliness, compassion, advocacy, flexibility/forgiveness, and availability/willingness to respond to TAYs' pressing needs account for the highest success rates in retaining and linking TAY to services. Following a breach of program rules, our TAY typically expect and quickly resign themselves to an expectation of immediate rejection from the program/community. They are usually surprised, however, by the flexibility and individual case considerations applied by staff. This non-rejection, and the trust born of well-established rapport, consistently arises as a central causative factor in beneficial outcomes.

10. The 90-day period of enrollment passes quickly from both the perspective of the staff and TAY, and both consider that a longer period would be more beneficial, especially given the importance of both establishing mental/sobriety stabilization and cultivating trust/rapport with staff to deliver the best outcomes.

YEAR 1 PROGRAM CHANGES

1. Enrollment criteria, which had been predominantly limited by the requirement of five prior crisis/acute care contacts per TAY, was, in the final two months of the year, relaxed to four such contacts, to incrementally expand the eligibility pool and counteract the insufficiency or out-datedness of the available contact information provided to outreach staff.

2. JBU maintains engagement with youth after leaving JBU facility for 60 days to facilitate and support the connections made to other community programs/resources.

3. JBU encourages program graduates to return and participate in services and to motivate current enrollees.

4. Streamlined visual and audio feedback to TAY during biofeedback sessions to improve focus and make more clear the moment, direction, and magnitude of shifts (e.g., muscle tension, heart rate). Reduced complexity of virtual reality-based feedback to render the visual and audio feedback more accessible and apparent via dedicated biofeedback software.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Explore options for additional substance abuse-related education and treatment supports, including on-site resources.

2. Increase rapid access to psychological/psychiatric evaluations for TAY demonstrating behaviors consistent with SMI and probable non-adherence to previously prescribed medication, undiagnosed SMI issues, and need for psychoeducation/destigmatization of psychiatric medication use/effects, as appropriate.

3. Discuss reducing current enrollment criteria to fewer prior crisis/acute care contacts to ensure maximal enrollment and provision of services to homeless TAY.

4. Expand capabilities of web-based Administrator Portal for management of biometric measurements data, services scheduling/reminders, community participation, push-notification of TAY self-assessment quizzes, tracking of incentive point system, and delivery and tracking of use-patterns of training tools within JBU App (e.g., guided meditations, paced breathing, psychoeducation modules, motivational messaging, resources directory); expansion of same to web- and Android-based platforms to improve adoption by TAY.

5. Improve participation and program compliance through greater individualization of holistic health plans, use of written behavior/program-expectations contracts, improved staff use of shared data on compliance (e.g., status of required data input, services attendance, key linkages attended, housing/employment/education track progress, personal goals, community participation, incentives earned), and use of creative incentivizing of TAY.

6. Increase group trainings/events to further deepen community connections among JBU and affiliated programs' TAY.

7. Elevate awareness among TAY of nature as a resource for maintaining balance, perspective, and sense of well-being through increased exposure to natural environments, natural cycles, nature-reverence, and engagement with professionally trained/certified facility animals and handlers.

8. Explore potential for extending JBU services beyond the initial 90-day period to further increase the rapport and trust between TAY and staff that strongly determined successes to date, as well as to accommodate timeframes for key linkage implementation (e.g., housing, SUD training, SMI stabilization).

For additional information about the INN–21 Just Be U program and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (INNOVATIONS-22)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 1 (7/1/18 - 6/30/19)

The County of San Diego Health and Human Services Agency's 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). CCYP was developed to provide medication support to children and youth who have completed behavioral health treatment yet require ongoing monitoring by a psychiatrist of psychotropic medications essential for their sustainable wellness and stability.

Treatment and education efforts by CCYP are intended to increase access to and knowledge of appropriate behavioral health services for underserved persons who are not able to be monitored by their primary care physician. Services are to be provided through a variety of means, including a centrally located psychiatric clinic, remote telepsychiatry, and a specialty medical clinic for youth with complex medical problems. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full service clinics, schools, primary care physicians), and the communities they serve.

A San Diego-based community organization, New Alternatives, was contracted to provide CCYP services, which included: 1) recruiting psychiatrists, care coordinators, and other program staff, 2) providing psychiatric evaluation and treatment, and 3) providing psychoeducation services to families. An innovative feature of this program is the provision of remote telepsychiatry services to support clients throughout San Diego county.

EXECUTIVE SUMMARY

The Center for Child and Youth Psychiatry was designed to provide psychiatric evaluation and treatment to children and youth with complex medication needs who have completed behavioral health treatment yet require ongoing medication monitoring to support stability. Staff include psychiatrists and care coordinators who provide services both at clinics and remotely via telepsychiatry. Psychoeducation is also provided to family members of clients.

- During FY 2018-19, 241 clients were enrolled into the CCYP program (program target = 500). Of these, 70.1% were at least 12 years old. Approximately half (51.1%) of the clients served were female and 39.0% reported having a disability that was not mental health-related.
- CCYP served a diverse population: Hispanic or Latino (52.7%), White (35.3%), and African American (14.5%).
- While the CCYP enrollment population is expected to not need ongoing therapy, the baseline assessment results across multiple tools suggest that there still may be needs for behavioral and/or functional improvements for some.
- Consistent with expectations, BHS crisis/acute care services were rarely accessed prior to or after CCYP enrollment. This pattern suggests the program was achieving the primary objective of maintaining stability for clients with complex medication management needs.
- Telepsychiatry was utilized by 25.8% of the CCYP clients for at least some of their medication management visits with a psychiatrist.
- Key factors identified by staff that helped the program achieve its goals included: 1) strong organization, management, and communication, 2) a high performing multidisciplinary team, 3) professional communication with staff, and 4) an easy and prompt referral process.
- Challenges to utilizing telepsychiatry included its perceived impact on the doctor-patient relationship, technological issues, and the time taken by staff to facilitate the telepsychiatry sessions.

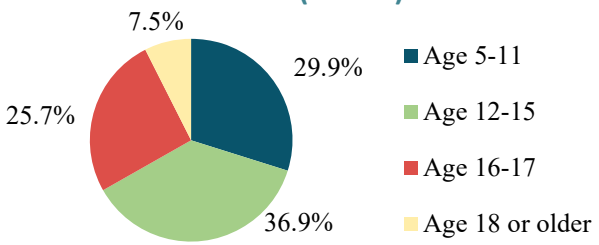
RECOMMENDATIONS

Program recommendations included: 1) continue to pursue options for providing CCYP services to medically complex populations, 2) enhance follow-up data collection to allow for detailed assessment of program outcomes, 3) explore CCYP client preferences for and experiences with telepsychiatry services via surveys and/or interviews and focus groups to determine if opportunities for greater utilization of telepsychiatry exist, 4) enhance internal and external communication regarding the program's ability to incorporate provision of short-term therapy services as needed, and 5) replace the Licensed Vocational Nurse position with a Certified Nursing Assistant to enhance the position's ability to support the care coordinators in facilitating telepsychiatry services.

PARTICIPANT CHARACTERISTICS

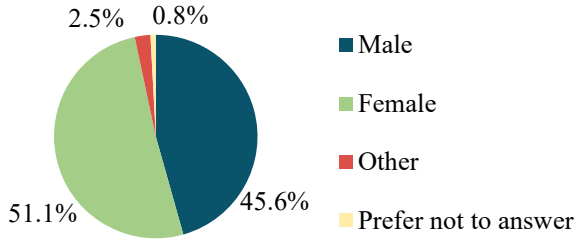
The following self-reported characteristic data were collected from participants during initial enrollment into CCYP.[1]

AGE (N=241)



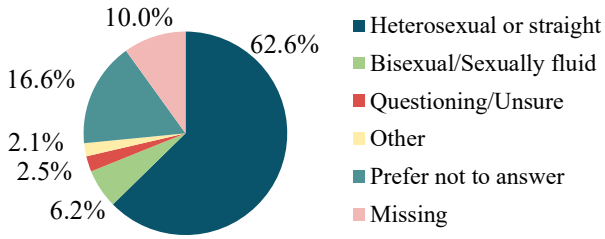
The majority (70.1%) of the participants were at least 12 years old.

GENDER IDENTITY (N=241)



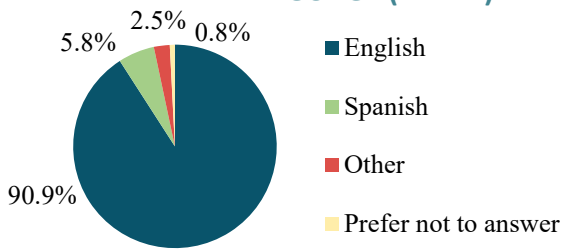
Approximately half (51.1%) of the participants identified as female.

SEXUAL ORIENTATION (N=241)



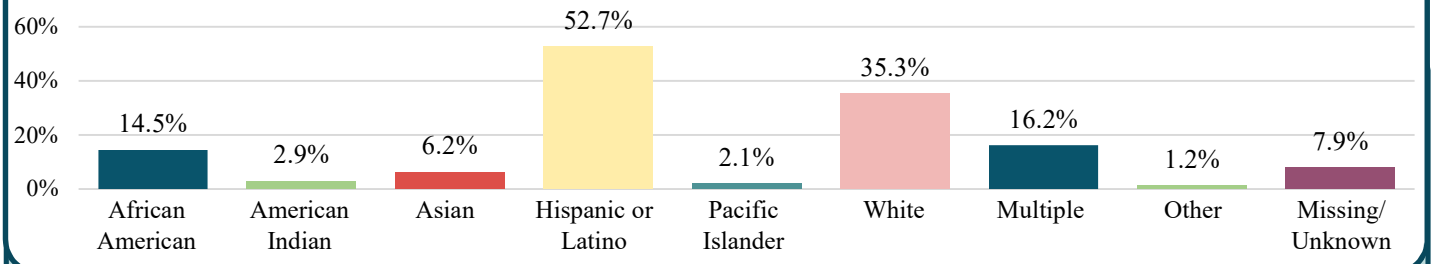
The majority (62.6%) of participants identified as heterosexual or straight with 10.0% not answering question.

PRIMARY LANGUAGE (N=241)



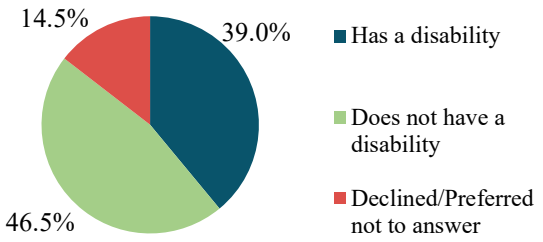
The majority (90.9%) of participants spoke English as their primary language.

RACE/ETHNICITY (N=241)



About half (52.7%) of the participants identified as Hispanic, with 35.3% identifying as White, and 16.2% identifying with multiple racial/ethnic backgrounds. Total may exceed 100% as participants were able to indicate more than one race.

DISABILITY[2] STATUS (N=241)



Nearly 40% of participants indicated having some type of non-SMI related disability.

TYPE OF DISABILITY (N=94)

Type	n	%
Communication (e.g., seeing, hearing)	42	44.7
Mental (e.g., learning)	38	40.4
Developmental	25	26.6
Other Mental	11	11.7
Physical	7	7.4
Other	23	24.5

Totals may exceed 100% as attendees could indicate more than one type of disability.

[1] Percentages may not total to 100% due to rounding. [2] A disability was 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 (SMI).

CCYP ENROLLMENT CATEGORIES

AUTHORIZED AND EXCEPTION CLIENTS

- A total of 241 persons were enrolled into the CCYP program during FY2018-19 (program target = 500). The time needed for initial program implementation was the primary factor inhibiting the achievement of the enrollment target of 500 clients during Year 1. Of the 241 enrollees, 207 (85.9%) were considered "authorized" enrollees who met the standard eligibility criteria (i.e., requiring medication management services but not therapy services), and 34 (14.1%) were considered "exception" enrollees who were approved to receive CCYP services even if they did not meet standard eligibility criteria.
- The primary reason for "exceptions" was to address short-term gaps in the availability of psychiatric care at outpatient clinics throughout San Diego county. These situations typically resulted due to unexpected absences or turnover among psychiatrists at these clinics.
- Providing continuity of psychiatric care in these situations was determined to be an unanticipated, but important role for CCYP to fulfill as a resource to support the overall San Diego County Child, Youth, and Family System of Care.
- Unless otherwise noted, data presented in this report refers to authorized referral cases only.
- Data from exception referrals will be further explored and presented upon separately in future reports.

BASELINE CHARACTERISTIC OF CCYP PARTICIPANTS

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

The Child and Adolescent Needs and Strengths (CANS) is a structured assessment used for identifying actionable needs and useful strengths among youth. It provides a framework for developing and communicating a shared vision by using information from both the youth and family members to inform planning, support decisions, and monitor outcomes. The CANS is completed by providers at baseline, 6-month reassessment, and discharge. During FY2018-19, the CANS was completed at baseline by CCYP providers for 206 youth aged 6 to 21.

As can be seen in Table 1, the CANS assessment measures a variety of domains to identify the strengths and needs of youth. Each domain contains a certain number of questions that are rated 0-3, with twos and threes indicating a specific area that should be addressed in the service or treatment plan. Within a domain, the number of questions rated at least a 2 or a 3 can be counted as a way to see which areas indicate a higher need for support. Table 1 shows the mean, median, and max count of needs. For example, the domain of Behavioral/Emotional Needs contains 9 questions and shows that the average youth in the program had 2.5 questions rated at least a 2 or a 3.

Overall, providers reported the highest mean count of needs for the Strengths (i.e., lack thereof) and the Behavioral/Emotional Needs domains. Moreover, the high median count of needs in the strengths domain is striking compared to the median for the other domains. The lowest mean counts of needs are seen in cultural factors, caregiver resources, and risk behaviors. These ratings suggest that although the target CCYP enrollment population is expected to be not needing ongoing therapy, there were still some areas in their lives that could benefit from improvement.

TABLE 1. CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) AT BASELINE (N=206)

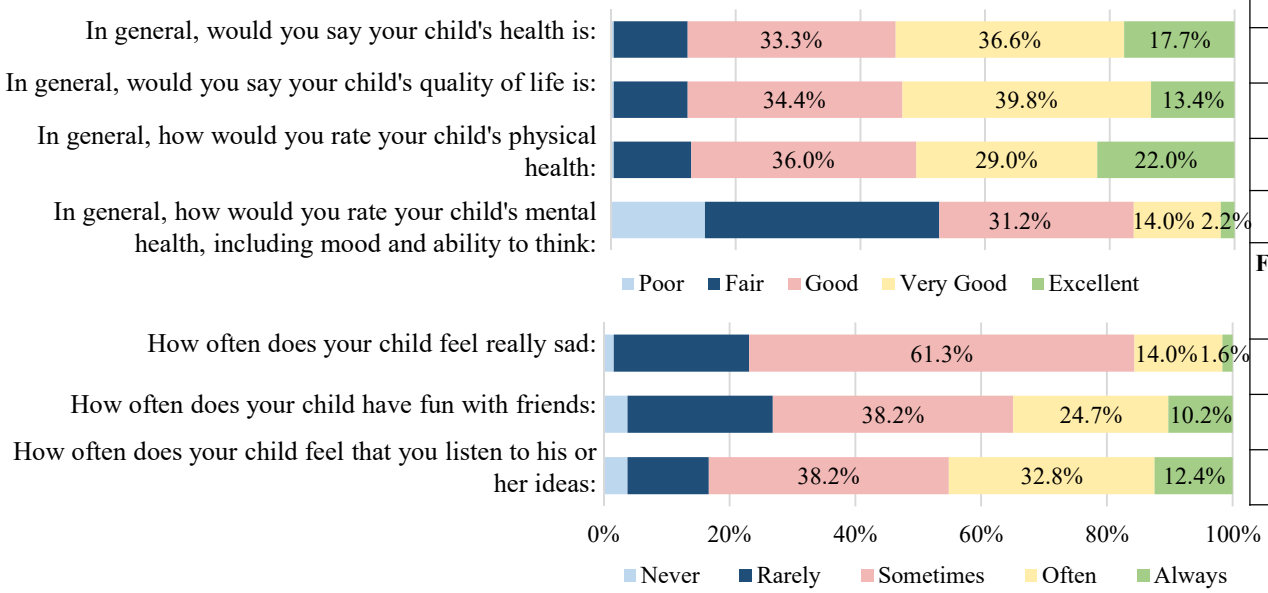
	Baseline CANS			
# of questions in domain	Domain	Mean count of needs (i.e. ratings of 2, 3)	Median count of needs	Max count of needs
9	Behavioral/Emotional Needs	2.5	2	8
10	Caregiver Resources	0.2	0	6
9	Strengths (i.e., lack thereof)	5.3	6	9
11	Life Functioning	1.4	1	8
3	Cultural Factors	0.1	0	3
8	Risk Behaviors	0.3	0	5
50	All items	9.7	10	22

BASELINE CHARACTERISTIC OF CCYP PARTICIPANTS (CONTINUED)

PROMIS GLOBAL HEALTH

The Patient-reported Outcomes Measurement Information System (PROMIS) Global Health measure was administered at baseline, 6-month reassessment, and discharge. Items are rated on a five-point scale with higher scores indicating better health. During FY 2018-19, the PROMIS Global Health – Parent measure was completed at baseline by 186 caregivers of children and youth ages 5 to 21. On average, caregivers reported that the best areas of functioning were children's overall health, physical health, and quality of life, while the poorest areas of functioning were children's overall mental health (e.g., only 47.4% rated mental health as good to excellent) and their degree of sadness (e.g., 76.9% reported their child sometimes to always feels sad).

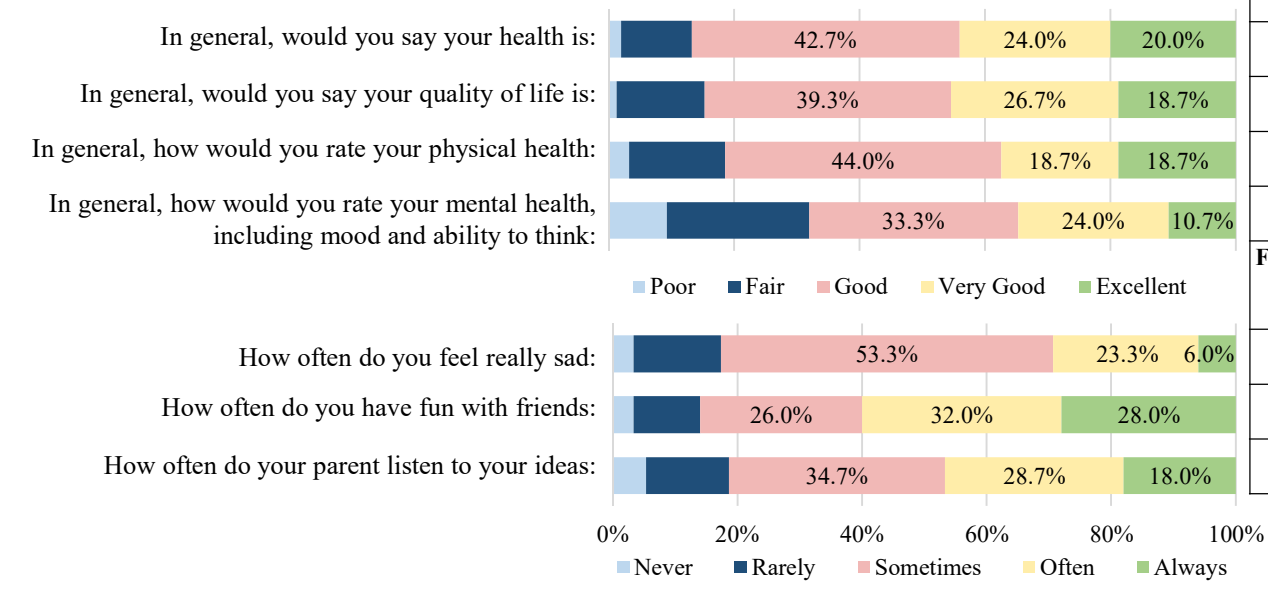
FIGURE 1. PROMIS GLOBAL HEALTH – PARENT AT BASELINE (N=186)



Ratings (%): Good to Excellent
87.6
87.6
87.0
47.4
Frequency (%): Sometimes to Always
76.9
73.1
83.4

During FY 2018-19, the PROMIS Global Health – Youth measure was completed at baseline by 150 children and youth ages 8 to 21. Somewhat similar to their caregivers, children and youth reported on average that the best areas of functioning were their peer interactions, overall health, and quality of life. Similar to their caregivers, children and youth reported on average that the poorest areas of functioning were their overall mental health (e.g., only 68.0% rated mental health as good to excellent) and their degree of sadness (e.g., 82.6% reported they sometimes to always feel sad).

FIGURE 2. PROMIS GLOBAL HEALTH – YOUTH AT BASELINE (N=150)



Ratings (%): Good to Excellent
86.7
84.7
81.4
68.0
Frequency (%): Sometimes to Always
82.6
86.0
81.4

BASELINE CHARACTERISTIC OF CCYP PARTICIPANTS (CONTINUED)

PEDIATRIC SYMPTOMS CHECKLIST (PSC)

The Pediatric Symptoms Checklist (PSC-35) is a screening tool designed to support the identification of emotional and behavioral problems. Parents/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. Cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 2.[1]

In FY2018-19, the PSC-35 was administered at baseline, 6-month reassessment, and discharge. The PSC-Parent was completed by 188 caregivers of children at baseline. The PSC-Youth was completed by 150 youth at baseline. Table 2 shows about half of all youth were above the total cutoff score on both the parent report (51.1%) and youth report (44.0%). Mean scores across the total score and three subscale scores were comparable for caregivers and youth, with the exception of the externalizing subscale (33.0% of caregiver reports were above the cutoff; 8.7% of youth reports were above the cutoff).

TABLE 2. PEDIATRIC SYMPTOMS CHECKLIST AT BASELINE

	PSC-Parent (n=188)				PSC-Youth (n=150)			
	Mean:	Median:	Above cutoff		Mean:	Median:	Above cutoff	
			n	%			n	%
PSC Score	28.6	28	96	51.1	24.5	26	66	44.0
Attention Subscale	5.2	5	64	34.0	4.6	4	35	23.3
Internalizing Subscale	4.5	4	92	48.9	3.8	4	57	38.0
Externalizing Subscale	5.0	5	62	33.0	3.1	3	13	8.7

[1] *PSC Cutoff Scores: Total PSC Score ≥ 28, Attention Subscale ≥ 7, Internalizing Subscale ≥ 5, Externalizing Subscale ≥ 7*

CCYP ENROLLMENT AND SERVICES

CCYP SERVICE UTILIZATION

Of the 155 clients who enrolled by April 1, 2019 (allows for at least 90 days of service provision prior to end of report period), the mean number of total services provided per client was 11.6 (Table 3). The mean number of medication management services provided per client was 3.4, with 2.5 nurse consults and 3.1 other CCYP support service contacts.

TABLE 3. CCYP SERVICE UTILIZATION (N=155)

	Total Services Provided	Mean Services per Client	Maximum Services per Client
Psychosocial assessments	279	1.8	3
Medication assessments	135	0.9	2
Medication management/consults	534	3.4	10
Nurse consults	380	2.5	10
Other CCYP support services	473	3.1	22
All CCYP services provided	1,801	11.6	34

As shown in Table 4, 25.8% of the clients receive some or all of their CCYP psychiatrist medication management visits via video telehealth/telemedicine interactions.

TABLE 4. UTILIZATION OF TELEPSYCHIATRY SERVICES (N=155)

	Number of unique clients	
Only video telehealth/telemedicine	9	5.8%
Only face-to-face	115	74.2%
Combination or video telehealth/telemedicine and face-to-face	31	20.0%

BEHAVIORAL HEALTH SERVICE (BHS) UTILIZATION PATTERNS

SAN DIEGO COUNTY BHS SERVICES 90 DAYS BEFORE AND AFTER CCYP ENROLLMENT

The utilization of behavioral health services by CCYP participants was examined 90 days before and 90 days after starting the program. To ensure that everyone included in the analyses had 90 days to be observed for any behavioral health service utilization after starting CCYP, the analyses only included participants (n=155) who started the program at least 90 days prior to the end of the reporting period (6/30/2019).

Utilization of various BHS acute/crisis care services appeared to be very stable across the pre-CCYP and post-CCYP time periods (Table 5). This pattern was consistent with expectations that CCYP can maintain stability among persons with complex medication management needs.

TABLE 5. BHS UTILIZATION BEFORE AND AFTER CCYP SERVICES (N=155)

Service utilization, among those with enrollment before 4/1/2019	90 Days Pre-CCYP Enrollment		90 Days Post-CCYP Enrollment	
	n	%	n	%
Inpatient hospitalization	< 5*	< 3.2*	< 5*	< 3.2*
Crisis stabilization	< 5*	< 3.2*	5	3.2
Urgent outpatient	< 5*	< 3.2*	< 5*	< 3.2*
PERT[1]	< 5*	< 3.2*	< 5*	< 3.2*
Day treatment	< 5*	< 3.2*	< 5*	< 3.2*
Therapeutic behavioral services	8	5.2	< 5*	< 3.2*

* The exact number of persons was suppressed due to small numbers and the need to minimize risk of potentially identifying individual participants; [1] PERT = Psychiatric Emergency Response Team

OTHER SERVICE UTILIZATION

SELECT NON-MEDICATION SERVICES

Clients were surveyed on various services delivered within and outside of school settings. More than half of all clients reported having an IEP or a 504 plan (65.5% total) at baseline. Less than half (45.3%) reported receiving non-medication services outside of school settings.

TABLE 6. PARTICIPATION IN ADDITIONAL SUPPORT SERVICES AT CCYP ENROLLMENT (N=203)

Service	Yes	
	n	%
Current 504 plan	28	13.8
Current IEP	105	51.7
Non-medication related services outside school	92	45.3

- Examples of non-medication services received outside of school settings included: speech, occupational and physical therapies, special education, social skills, and respite care.

ADDITIONAL EDUCATION / COMMUNITY OUTREACH ACTIVITIES

Education Sessions:
- For FY2018-19, CCYP held 5 education sessions and different locations throughout San Diego.
- The topics included: 1) Psychopharmacology, 2) Medication administration & storage, and 3) Trauma and how it affects the bodies, minds, and behaviors of kids.
- Total attendees = 33

Resource Fair:
- For FY2018-19, CCYP held one resource fair (a four hour event) at a community library.
- Programs in attendance included: Mental Health Systems Families Forward, San Diego Regional Center, Transitional Housing Program, North County Crisis Intervention and Response Team, SmartCare (Vista Hill), Emergency Screening Unit.
- Additionally, brief education sessions were offered throughout the event that covered: 1) Trauma and its effects on behavior, 2) Nutrition, and 3) Medication administration and storage.
- Total attendees = 9

Challenges:
- Getting people in the door for all events.
- Organizing and staffing events with resulting low attendance.
- Because CCYP clients have already completed intensive therapy and medication services prior to coming to CCYP, they appear reluctant to engage in any additional activities outside of their normal psychiatry appointments.

Approaches to Address Challenges:
- CCYP has solicited inputs from families on what motivates them to come to education sessions.
- Childcare and food have been offered, along with topics of interest to parents.
- Locations have been changed to see if distance/accessibility affects attendance.
- Multiple forms of advertising have been used: hard mailings, calls, emails to other programs, and leveraging personal and professional networks, when possible.

ANNUAL PROGRAM STAFF AND PROVIDER FEEDBACK SURVEY

At the end of FY 2018-19, CCYP program staff and external referring providers 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 CCYP staff invited to participate in the survey (a 100% response rate), and 11 respondents from the 41 referring providers invited to participate in the survey (a 27% response rate). 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.

1. *Major program goals identified by respondents:*
   - Both staff and referring providers identified the major program goal as providing medication management, followed by providing education and linkages.

2. *Factors that helped CCYP achieve program goals:*
   - Staff identified the following factors:
     a. Strong organization, management, and communication.
     b. High performing multidisciplinary team.
     c. Psychiatrist availability and motivation to serve this population.
   - Referring providers identified the following factors:
     a. Professional communication with staff.
     b. Easy and prompt referral process.

3. *Factors that made it challenging for CCYP to achieve program goals:*
   - Staff identified the following factors:
     a. Inappropriate referrals.
     b. Internal program challenges regarding protocols and productivity expectations, in particular for care coordinators.
   - Referring providers did not comment on this topic.

4. *Benefits to telepsychiatry:*
   - Both staff and referring providers commented that telepsychiatry provides greater access to services.

5. *Challenges to telepsychiatry:*
   - Both staff and referring providers commented that telepsychiatry can:
     a. Affect the quality of the doctor-patient relationship.
     b. Affect the doctor's ability to assess nuances in client behavior and presentation.
     c. Be impacted by technological issues.
   - Staff also commented that the time taken by licensed care coordinators is not billable and takes time away from service provision.

6. *Recommendations to increase CCYP's ability to achieve program goals in Year 2:*
   - Staff identified several recommendations, including:
     a. Increase marketing to obtain more appropriate referrals.
     b. More support for a minimal psychotherapy component to facilitate maintenance of current level of functioning.
     c. Increase general staff support and resources (e.g., administrative support for scheduling and paperwork).
     d. Enhance care coordinator and psychiatrist ability to link clients to community resources.
     e. Increase continuing education and training opportunities for staff.
     f. Address productivity and staffing challenges for care coordinators.

KEY YEAR 1 PROGRAM "LEARNINGS"

1. CCYP is meeting an important need in the community with almost 250 clients served in the first year of the new program.
2. Findings suggest that CCYP is able to maintain stability among clients as evidenced by low utilization rates of acute/crisis care services both prior to and after enrollment in CCYP.
3. Telepsychiatry is a complex service provision modality and there is more to learn about how to optimize its use for this population. For example, a combination of telepsychiatry and face-to-face utilization was more common than telepsychiatry alone, suggesting that some in-person contact with providers is desired. In addition, only 25% of clients utilized telepsychiatry to receive at least some of their CCYP services, indicating that that families are making efforts to attend sessions in person even when telepsychiatry options are available.
4. CCYP's ability to provide short-term psychotherapy when indicated to maintain stability can be more widely communicated both internally and externally.

YEAR 1 PROGRAM CHANGES

One change to the program in Year 1 involved making exceptions for certain clients who were still in psychotherapy to receive medication management through CCYP. The reason for these exceptions typically was due to filling a need for medication management services when an outpatient clinic had psychiatrist leaves of absence or vacancies. Additionally, the CCYP program was not able to establish a co-located clinic for medically complex children during Year 1 due to a range of inter-organizational challenges and barriers. Providing services to this population will continue to be pursued during Year 2.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Continue to pursue options for providing CCYP services to medically complex populations.
2. Enhance follow-up data collection to allow for detailed assessment of program outcomes.
3. Explore CCYP client preferences for and experiences with telepsychiatry services via surveys and/or interviews and focus groups to determine if opportunities for greater utilization of telepsychiatry exist.
4. Enhance internal and external communication regarding the program's ability to incorporate provision of short-term therapy services as needed.
5. Replace the Licensed Vocational Nurse position with a Certified Nursing Assistant to better fit the position's ability to support the care coordinators in facilitating telepsychiatry services.

For additional information about the INN–22 Center for Child and Youth Psychiatry (CCYP) and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix O
Glossary of Acronyms

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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
BHETA – Behavioral Health Training Academy
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
CCBH – Cerner Community Behavioral Health
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
MORS – Milestones of Recovery
NAMI – National Alliance on Mental Illness
NPLH – No Place Like Home
OE – Outreach and Engagement
PEARLS – Program to Encourage Active and Rewarding Lives
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
SIPS – Structured Interview for Prodromal Symptoms
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

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Appendix P
Glossary of Terms

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Glossary of Terms

Aftercare: is 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): is 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.

Case Management: is 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: is 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 suicide.

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 members.

Exposure Therapy: is 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: is 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 needs.

Family Groups: is 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): is 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.

Hoarding: is a compulsion that involves the persistent collection of useless or trivial items (e.g., old newspapers, garbage, magazines) and an inability to organize or discard these. The accumulation of items (usually in piles) leads to the obstruction of living space, causing distress or impairing function. Any attempt or encouragement by others to discard hoards causes extreme anxiety.

Interoperability: means the ability of health information systems to work together within and across organizational boundaries in order to advance the effective delivery of healthcare for individuals and communities.

Milestones of Recovery Scale (MORS): is an evaluation tool for tracking the process of recovery for individuals with mental illness. MORS is rooted in the principles of psychiatric rehabilitation and defines recovery as a process beyond symptom reduction, client compliance and service utilization. It operates from a perspective that meaningful roles and relationships are the driving forces behind achieving recovery and leading a fuller life.

Motivational Interviewing: is 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.

Neuropsychological Testing: is an evaluation of the presence, nature, and extent of brain damage or dysfunction derived from the results of various neuropsychological tests. It includes any of various clinical instruments for assessing cognitive impairment, including those measuring memory, language, learning, attention, and visuospatial functioning.

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: includes counseling or support by an individual who has experience and/or status equal to that of the client.

Personal Health Record (PHR): is 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: is the basic or general health care a patient receives when he or she first seeks assistance from a health care system. General practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians are known as primary care providers.

Psychiatric Assessments: are 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) Model: is 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): is 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): is 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,

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: is 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): is 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: is an umbrella term used for the collective efforts of local community-based organizations, health professionals and related professionals to reduce the incidence of suicide; reduce factors that increase the risk for suicidal thoughts and behaviors; and increase the factors that help strengthen, support, and protect individuals from suicide.

Supplemental Security Income benefits (SSI): pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. SSI is a Federal income supplement program funded by general taxes. It is designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

Supportive Housing: is 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: is a style of care that accounts for the widespread impact of trauma and the understanding of potential paths for recovery. It includes the recognition of the signs and symptoms of trauma in clients, families, staff, and others. Organizations that are trauma-informed fully integrate knowledge about trauma into policies, procedures, and practices and actively avoid re-traumatization.

Warning Signs of Suicide: include behaviors (examples listed below) that may be signs that someone is thinking about suicide.

- 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.

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Appendix Q
Stakeholder Comments

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Summary	Response
The Peripartum program received five comments in support of the program. The program supports both peri- and post-partum women who are underserved, in both physical and mental health. Families who utilize the program receive much needed support both during pregnancy and immediately after which builds healthy, thriving mothers and their infant children.	Thank you for the comment and support for the program. As outlined, the intent is to support the family unit during the pregnancy and as the family unit welcomes a newborn into their home.
The homeless outreach workers and child therapists for substance use disorder (SUD) programs received support for the positive and beneficial role they play with this underserved population. Additionally, support of funding Innovation programs at the same level was given.	Thank you for the comment and support for the services with recognition for the value of homeless outreach workers and child therapists embedded within SUD Perinatal programs.
A comment addressed multiple points. Comment included support for family-centered approaches, as it is critical to provide whole family care when addressing mental health issues. Flexibility is mentioned to allow families access to the care they need, in a timely manner. Prevention is mentioned as a priority to ensure long-term well being of our residents.	Thank you for the comment and support for family-centered approaches to care. BHS strives to be inclusive of family and community-based services to meet the needs of those across our communities and to ensure availability of services. Prevention services are critical as a part of the full continuum of care and we continue to strive to identify unserved and underserved communities to provide outreach and support.
A comment was received which outlined the lack of involvement of the Behavioral Health Advisory Board (BHAB) within the development of the MHSA Three-Year Plan and subsequent Annual Updates. It also mentions the Community Planning Process (CPP) involvement of stakeholders within the region isn't robust enough and doesn't engage stakeholders throughout the year. Additionally, MHSA unspent funds is mentioned as having lack of accountability of accounting and spending.	Behavioral Health Services (BHS) continues to engage members of the Behavioral Health Advisory Board (BHAB) through monthly meetings, workgroups and the annual retreat. BHS Administration and programs bring throughout the year, presentations on services, seeking and incorporating feedback from advisory board members. This year, BHS also formed a community engagement workgroup with members of BHAB in order to inform engagement strategies as part of the Community Planning Process and will work to expand this workgroup to include stakeholders from multiple groups. BHS continues to engage input throughout the year from five additonal advisory councils representing multiple stakeholder groups with membership inclusive of community organizations, individuals with lived experience, peers, family members and others to gather robust year-round feedback on services and needs. The stakeholder input informs MHSA programming and budget development. At the direction of the San Diego County Board of Supervisors, BHS has been investing aggressively in MHSA programs to ensure critical services are available to individuals in need. Details of planned MHSA programs and budgets, including future projections of unspent funds, are outlined in the MHSA Three Year Plan and subsequent MHSA Annual Updates, which are publicly posted. Additionally, as required, detailed accounts of MHSA funds received and spent by component are included in the MHSA Annual Revenue and Expenditure Reports to the State, which are also publicly posted.