COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Fiscal Year 2019-20 Annual Update



Behavioral Health Services

August 5, 2019

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

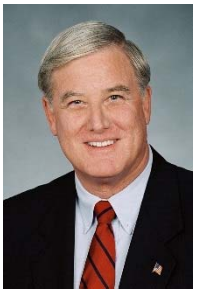
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This report provides an update to the County of San Diego Health and Human Services Agency's Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan for Fiscal Years (FYs) 2017-18 through FY 2019-20 (MHSA Three-Year Plan).

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A LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR



The Mental Health Services Act (MHSA) Fiscal Year (FY) 2019-20 Annual Update (MHSA Annual Update) is an opportunity for the County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) department to inform stakeholders, partners, clients, community members, and the Board of Supervisors of highlights and accomplishments in FY 2017-18, along with changes to the MHSA Three-Year Plan in FYs 2018-19 and 2019-20. For FY 2019-20, the approved Operational Plan (budget) for BHS is $708.5 million with MHSA programs comprising nearly one third of the total budget.

Among my primary objectives for the Department of BHS is that we better identify true need in the community and implement the most effective programs with the greatest model fidelity possible. Moreover, it is increasingly important that we invest in systems that will coordinate services longitudinally, across programs, providers, and episodes of clinical care. The continued provision of MHSA services remains critical in achieving an integrated, seamless, and outcome-oriented behavioral health continuum.

I want to take a moment to highlight some of the tremendous efforts made by BHS over the last fiscal year to enhance and advance care coordination:

- Implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS) program to transform and enhance the delivery of substance use disorder (SUD) services by improving access to services, quality of care, and care integration and coordination to ensure adequate services are available for individuals struggling with SUD.
- Convening the Board Conference entitled *Caring for People in Psychiatric Crisis* and subsequent assessment of the state of inpatient psychiatric care in the region, and the identification of immediate and long-term strategies to address gaps in emergency and inpatient psychiatric resources.
- Continuing to expand prevention services to reduce serious mental illness (SMI) or serious emotional disturbance (SED), and/or SUD-related symptoms for our unserved, underserved, and general populations.
- Collaborating with the Behavioral Health Advisory Board (BHAB) resulting in key recommendations to further engage the community in the design of behavioral health services.

Moving forward, we look forward to collaborating with key partners, stakeholders, consumers, and other community members to build a system that achieves the most collective impact so all residents of the region 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

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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 over 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 (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 an MHSA 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 Annual Update provides an overview of the recent Community Planning Process (CPP), summarizes outcomes for FY 2017-18, and outlines adjustments to the three-year plan in FYs 2018-19 and 2019-20.

INVESTMENT OF RESOURCES

The proposed MHSA spending plan for FY 2019-20 is $214.5 million as outlined in the chart below, reflecting an increase of over $30 million from the original MHSA Three-Year Plan budget for FY 2019-20. By the end of FY 2019-20, it is estimated that the County will have invested nearly $1.6 billion in MHSA programs since its inception.

MHSA Component	*Three Year Plan FY 2019-20 Budget*	*Annual Update FY 2019-20 Budget*	*Variance*	*Percent of MHSA Budget*
Community Services and Supports (CSS)	$136,822,442	$172,678,404	$35,855,961	80.5%
Prevention and Early Intervention (PEI)	$31,923,785	$26,761,835	($5,161,950)	12.5%
Innovation (INN)	$12,099,668	$11,117,846	($981,822)	5.2%
Workforce Education and Training (WET)	$3,296,741	$3,589,906	$293,166	1.7%
Capital Facilities and Technological Needs	$0	$347,868	$347,868	0.2%
Total	**$184,142,635**	**$214,495,859**	**$30,353,223**	**100.0%**

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The MHSA budget and program adjustments for FY 2019-20 are based on priorities identified during the CPP in conjunction with staff recommendations. The primary reductions were due to delays in the implementation of several INN programs. Additionally, the State Department of Health Care Services (DHCS) issued new guidance for the distribution of MHSA revenue, which will require the County to reduce the amount of revenue allocated to the PEI component. This will result in a reduction in the PEI budget, as reflected above.

A summary of the proposed expenditures by MHSA component for FY 2019-20 is available in Appendix A. Summaries of all programs funded with MHSA dollars are available in Appendix C.

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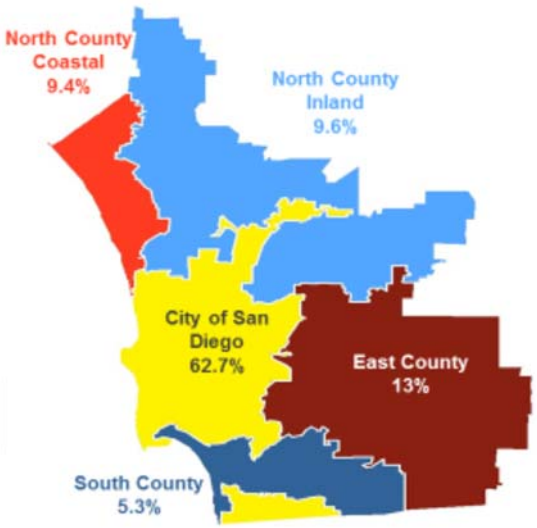
Implementation of the MHSA demonstrates the County's commitment to the *Live Well San Diego* vision of achieving a healthy, safe, and thriving region. BHS is committed to providing accessible, community-based, and customer-oriented services to all six Health and Human Services Agency (HHSA) service regions, which include the North Coastal, North Inland, North Central, Central, East, and South Regions. 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 2017-18, MHSA funded programs provided services to over 77,000 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

Housing is critical in achieving health and wellness for individuals who are experiencing homelessness or at risk of experiencing homelessness, and struggling with serious mental illness (SMI). In January 2019, more than 1,500 volunteers and outreach workers across San Diego County participated in the 2019 Point-in-Time Count, an annual

effort to identify the number of persons experiencing homelessness in San Diego County. According to the 2019 WeAllCount Annual Report[1], an estimated 8,102 (4,476 sheltered and 3,626 unsheltered) men, women, and children identified as experiencing homeless in San Diego County. Of those identified as experiencing homeless, 10 percent are veterans, 36 percent reported having a physical disability, 12 percent are under the age of 24, and 3 percent are families with at least one child. This count included changes in the 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.



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, 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 March 31, 2019, 852 individuals experiencing homelessness were housed and received BHS services through POFA.

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM (SNHP)

The County has dedicated over $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 the approximately 377 permanent supportive housing units. Of the 377 units, 282 have been operationalized, 22 units are scheduled to begin leasing by fall 2019, 68 units are planned for development, and 5 additional units are anticipated for development.

Status	*# of Housing Units*
Operationalized	282
Scheduled to be Leased	22
Planned for Development	68
Anticipated for Development	5
Total Housing Units	**377**

NO PLACE LIKE HOME (NPLH)

On July 1, 2016, Governor Brown signed NPLH into legislation. The program dedicates $2 billion in bond proceeds to invest in the development of permanent supportive housing for persons with serious mental illness (SMI) who are experiencing homelessness or at risk of experiencing homelessness. NPLH funds may be used to finance capital

[1] 2019 WeAllCount Annual Report: https://www.rtfhsd.org/wp-content/uploads/2019/04/Pages-from-2019-General-Fact-Sheet-0429199_final.pdf [as of June 12, 2019]

costs of assisted units in rental housing developments, including costs associated with the acquisition, design, construction, rehabilitation, or preservation of assisted units. 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.

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION

Many MHSA programs provide access and support for individuals either entering or exiting juvenile detention, jails, or the 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 2019-20, the total estimated investment in justice-related MHSA programs will be over $36 million.

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

MHSA PRUDENT RESERVE

In April 2019, Senate Bill (SB) 192 (Chapter 328, Statutes 2018) and Department of Health Care Services (DHCS) Mental Health & Substance Use Disorder Services (MHSUDS) Information Notice 19-017 established new MHSA prudent reserve parameters. Under the new guidelines, counties must establish a prudent reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) revenue received in the preceding five years. Based on the new methodology, the County identified a total of $8,714,934 in excess funds that will be transferred from the prudent reserve by June 30, 2020. As required, $6,953,674 will be transferred to CSS and $1,761,260 will be transferred to the Prevention and Early Intervention (PEI) to ensure funds remain in proportion to the original allocation transferred to the prudent reserve from each MHSA component. The prudent reserve must be reassessed and certified every five years as part of the MHSA three-year plan or annual update.

See Appendix E for the FY 2019-20 MHSA Prudent Reserve Assessment.

THE ROAD AHEAD

BHS continues to collaborate with community partners, stakeholders, and consumers to improve care coordination, expand access to services, and strengthen the behavioral health continuum of care. The County maintains its concerns around efforts at the State legislature to divert MHSA funds away from local county control. BHS will continue to move forward positive, impactful change to ensure all residents have the opportunity to Live Well.

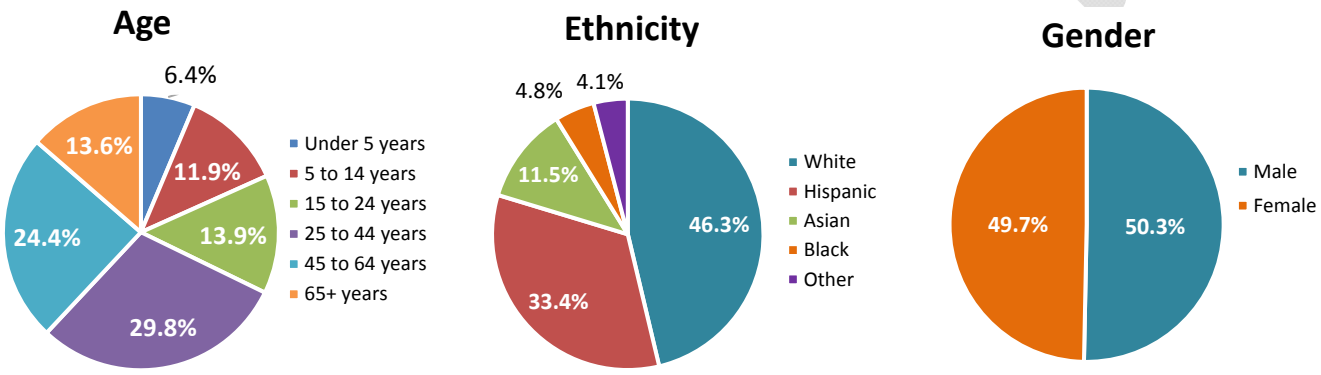
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DEMOGRAPHICS

San Diego County, California is located near the Pacific Ocean in the far southwest 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 is land and 319 square miles is water. San Diego County's estimated population for 2018 was 3,337,685[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 2017 data from the US Census were as follow



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 F.

[2] Based on US Census Bureau estimated population estimate as of July 1, 2017

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, 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 2018 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. Between September and December 2018, nine community forums, a community survey, and two focus groups were conducted. The first six forums focused on services for people experiencing a mental health crisis, substance use among youth and young adults, and school violence. The remaining three forums focused on developing new, innovative approaches in the areas of homelessness, mental health disorders with co-occurring developmental delays, and an open forum for participants to brainstorm about any behavioral health topics. A total of 307 people attended the community forums; 18 people participated in focus groups, and 285 people completed the community survey for a total of 610 unique points of engagement. 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 2018 Community Engagement Report can be found in Appendix G.

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD

A draft of the FY 2019-20 MHSA Annual Update was posted on the BHS website and the Clerk of the Board of Supervisors website. 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 FY 2019-20 Annual Update are available in Appendix R. 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 H.

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MHSA ACCOMPLISHMENTS AND CHANGES

The section below summarizes programmatic accomplishments in FY 2017-18, and budgetary changes from the MHSA Three-Year Plan for programs in FYs 2018-19 and 2019-20. Changes are outlined for each of the five MHSA components, including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN).

A detailed budget by component may 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 2019-20, the estimated total MHSA budget for CSS programs is $172,678,404, reflecting a total increase of $35,855,961 from the MHSA Three-Year Plan funding priorities for FY 2019-20.

In FY 2019-20, up to $2.8 million of CSS funds will be transferred to the Workforce Education and Training (WET) component to continue funding programs identified in the WET section of this report.

In FY 2018-19, approximately $2,000,000 of CSS funds were transferred to the Technological Needs (TN) component for the data exchange (interoperability) project outlined in the TN section of this report. The County continues to work to develop interfaces with local private health information exchanges (HIEs) and San Diego Health Connect to securely connect providers, patients, and others to improve the quality of care in our community through improved data sharing and care coordination. The exact dollar amount will be determined upon completion of the FY 2018-19 MHSA Annual Revenue and Expenditure Report (RER).

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), counties "*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 2019-20.

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

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

CSS PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES



CSS programs for children, youth, and families (CYF) serve children and adolescents 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 outcome report for children and adolescents is available in Appendix J.

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

In FY 2019-20, the estimated total MHSA budget for CY-FSP programs is $26,663,908. In FY 2019-20, the estimated cost per unduplicated client served in CY-FSP programs is $9,916, inclusive of all funding, and the estimated number of unduplicated clients to be served is 5,297.

HIGHLIGHTS FROM FY 2017-18:

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

School-based FSPs provide culturally sensitive outpatient services in easily accessible locations throughout the county, including clinics, schools, homes, and in the community. Services include individual therapy, family therapy, case management, 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.

In FY 2017-18, North County Lifeline program provided services to 397 children and youth. Of those who received services, 254 were engaged in family therapy, and during outpatient treatment 99 percent of all youth avoided psychiatric hospitalization or re-hospitalization.

In FY 2017-18, the Douglas Young program, located in the Central and North Central Regions of the county, provided services to 680 unique clients, 447 of whom also participated in family therapy. Ninety two percent of the clients discharged whose episode lasted three weeks or longer showed improvement in at one or more areas of their level of functioning.

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FAMILY THERAPY (CY-FSP)

The family therapy program utilizes parent partners with lived experience, to increase caregiver participation in family therapy for children and youth with SED. The program educates caregivers on the benefits of being actively engaged in the treatment process. In FY 2017-18, a total of 4,172 parent partner visits were provided to the caregivers of 850 children receiving behavioral health treatment services through six contracts in San Diego County.



ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

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

Children's FSPs provide a full range of outpatient mental health services to children and youth with SED who are experiencing homeless, and their families. These comprehensive services are trauma informed, data driven, and integrated, and include co-occurring SUD treatment. In FY 2019-20, the budget for one of the FSP programs was increased by a total of $100,757 for one-time start-up costs, as needed, related to the execution of a new contract.

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

In FY 2019-20, a new FSP housing program adding short-term, overnight shelter for TAY and runaway youth will begin, resulting in a total increase of $1,200,000 related to the execution of the new services.

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

In FY 2019-20, the budget for the school-based FSP programs was increased by a total of $3,333,853 due to capacity expansion, the execution of new contracts, and, if needed, the addition of one-time start-up costs.

THERAPEUTIC BEHAVIORAL SERVICES (TBS) (CY-FSP)

The TBS program provides intensive, individualized, one-on-one coaching to children and youth, up to age 21, who are experiencing an emotional or behavioral challenge. In FY 2019-20, the budget was increased by a total of $486,500 for the addition of one-time start-up costs, if needed, and the execution of new contracts.

WRAPAROUND SERVICES – 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 in order to facilitate the youth in returning home from a congregate care setting or staying in their home or home-like setting. In FY 2019-20, the budget was increased by $3,642,399 due to the execution of new contracts, and, if needed, estimated one-time start-up costs.

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

In FY 2019-20, the estimated total MHSA budget for CY-OE programs is $1,624,096. In FY 2019-20, the estimated cost per unduplicated client served in CY-OE programs is $937, inclusive of all funding, and the estimated number of unduplicated clients to be served is 1,734.

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HIGHLIGHTS FROM FY 2017-18:

SOUTHEAST FAMILY AND YOUTH PARTNERSHIP – PARENT PARTNER SERVICES (CY-OE)

The Southeast Family and Youth Partnership program provides outreach and engagement services to Latino, Asian, and African American children, youth, and their families in the Southeastern community of San Diego. The program provides culturally responsive family and youth support partners, and case management services to low income, uninsured and underserved, children, TAY, and their families. The program supports wellness and resiliency, assists with access and linkage to services and resources, provides advocacy, and supports the continuity of treatment to ensure underserved youth are connected to the appropriate services. In FY 2017-18, the program served 86 children and youth in the Southeast area of San Diego County and conducted focus groups at schools to identify youth obstacles to mental health treatment access.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

There were no budgetary changes to report.

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

In FY 2019-20, the estimated total MHSA budget for CY-SD programs is $12,281,778. In FY 2019-20, the estimated cost per unduplicated client served in CY-SD programs is $5,427, inclusive of all funding, and the estimated number of unduplicated clients to be served is 3,811.

HIGHLIGHTS FROM FY 2017-18:

OUR SAFE PLACE - MENTAL HEALTH SERVICES FOR LGBTQ (CY-SD)

Our Safe Place provides clinical and supportive services to lesbian, gay, bisexual, transgender, and questioning (LGBTQ) youth, and their families. The program operates a community-based outpatient mental health clinic that provides individual, family, and group therapy, psychiatry, and medication management, and 24-hour support. The clinic is located in Hillcrest but provides services countywide to LGBTQ youth up to age 21 who have Medi-Cal, are uninsured, or are underinsured. Our Safe Place also partners with two other community service providers to provide four drop-in centers throughout the county. The drop-in centers offer supportive services to LGBTQ youth and their families. Services include clinical case management, school and employment support, weekly support and psychoeducation groups for youth and families, support with transitioning, advocacy, mentorship and leadership opportunities, and community events and activities. In FY 2017-18, the program collectively served 381 unduplicated and 1,787 duplicated youth.

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San Pasqual Academy – 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 foster 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, how to facilitate growth toward independence, and how to strengthen self-confidence. In FY 2017-18, the program served 102 unique clients and 100 percent of youth avoided psychiatric hospitalization or re-hospitalization while receiving outpatient services. Of the youth who attended the program, 19 successfully graduated high school and 100 percent planned to attend either community college or four-year university in the following year.

San Pasqual Academy A Personal Story

A young man with a history of aggressive behavior, delinquency, and substance abuse entered the San Pasqual Academy (SPA) from an out of state placement. Through collaboration between his Court Appointed Special Advocate, his previous placement team, the clinical team, and the residential team this young man made a successful transition to SPA. He faced challenges along the way, yet the team provided daily support and was able to collaborate to help the young man find outlets for his emotions, primarily in the form of exercise and involvement in sports. After a few months at SPA he became one of the leaders of the football team, made improvements in his communication, became a role model for younger youth in the program, and received high grades in his classes.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

BHS Children, Youth and Families (CYF) Liaison (CY-SD)

The CYF Liaison collaborates with BHS administrative staff to ensure the needs of its children and youth clients, and their families, are incorporated into service development, implementation plans, and service delivery. In FY 2018-19, the budget was increased by $150,000 due to the development and utilization of cloud-based applications (apps) designed to provide behavioral health outreach and engagement services to all ages county wide.

Crisis Action and Connection (CY-SD)

The Crisis Action and Connection program provides children and youth who have had a recent psychiatric episode with intensive support and linkage to services and community resources. In FY 2018-19, this program was transformed to be entirely funded through MHSA with a total MHSA increase of $1,715,718.

Emergency Screening Unit (ESU) (CY-SD)

The new ESU facility, now fully operational for over one year, expanded the number of crisis beds for children and youth from 4 to 12. This state-of-the-art facility, located in Hillcrest, provides emergency screening services to children and adolescents experiencing a psychiatric crisis. In FY 2018-19, this program was transformed to be entirely funded through MHSA with a total MHSA increase of $1,054,618.

Incredible Families - Child Welfare Services (CWS) (CY-SD)

The Incredible Families program provides outpatient mental health treatment and support services for children and families involved in CWS. In FY 2019-20, the budget was enhanced by $264,220 due to estimated one-time startup costs, if needed, related to the execution of new contracts.

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INCREDIBLE YEARS (CY-SD)

The Incredible Years ChildNET program provides individual, group, and family services in preschools, homes, and clinic locations to children up to age five, who are experiencing SED and meet medical necessity, and their families. The program utilizes a team approach and offers case management and family partner support. In FY 2019-20, the budget was increased by $39,049 for one-time funds, if needed, related to the execution of new contracts.



TELEMEDICINE (CY-SD)

Telemedicine provides video, secure email, and phone consultation in various mental health services locations to improve accessibility of care in underserved and rural areas. It provides technological infrastructure for the mental health system to ensure high-quality, cost-effective services, and supports for clients and their families. Services are provided to community-based providers in clinical outpatient, residential, and school-based settings in dozens of locations. In FY 2019-20, due to the consistent spend down of Technological Needs (TN) funds, funding of telemedicine equipment was moved from TN to the Community Services and Supports-System Development (CSS-SD) work plan for continued funding to support CYF programs. In FY 2019-20, the budget for this equipment increased by $21,300.

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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) or co-occurring disorders, and their families. Programs provide integrated, recovery-oriented mental health treatment services, outreach and engagement, case management and linkage to other services, and vocational support.

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

The FSP ACT outcome report for TAY, adults and older adults is available in Appendix K. The FY 2018-19 Update to the Five Year BHS Housing Plan is available in Appendix L. Details of the housing projects funded through MHSA CSS funds are available at: http://sandiego.camhsa.org/files/BHS-Five-Yr-HousingPlanSumm091814.pdf.

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

In FY 2019-20, the estimated total MHSA budget for TAOA-FSP programs is $52,266,182. In FY 2019-20, the estimated cost per unduplicated client served in TAOA-FSP programs is $13,301 for TAY and adults, and $11,532 for older adults, inclusive of all funding. The estimated number of unduplicated clients to be served is 4,625 and 743, respectively.

Highlights from FY 2017-18:

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 for criminogenic needs and risk factors. The program aims to improve the behavioral health and quality of life of participants and prevent recidivism into the criminal justice system. In FY 2017-18, the program served 70 unduplicated individuals.

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FSP/ACT and Project One for All (POFA) Programs (TAOA-FSP)

FSP/ACT programs, including POFA programs, provide intensive highly individualized services to help clients with SMI who are experiencing homelessness or at risk of experiencing homelessness, 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, PERT services, 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 2017-18, 2,578 unduplicated clients were served by the 14 ACT programs resulting in a 50 percent overall reduction in emergency services from pre to post assessment. Additionally, there was a 67 percent reduction in the mean number of days spent and a 59 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.

FSP/ACT POFA
A Personal Story

Shortly after Action Central, an FSP/ACT program opened its doors in Central Region, staff began receiving referrals from the psychiatric hospital, crisis houses, and the Psychiatric Emergency Response Team (PERT). One referral from PERT was for a 24-year-old homeless male with a history of SMI and substance use. This man had previously had multiple encounters with PERT and the Homeless Outreach Team (HOT) typically resulting in hospitalization or incarceration. Action Central staff provided outreach to this individual to engage him in treatment and provide housing and other services to support him in his journey to recovery. Since being engaged he has clinically stabilized and demonstrated significant progress. He continues to actively attend group and maintains a medication regime prescribed by his psychiatrist.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

Adult Residential Treatment (TAOA-FSP)

The adult residential treatment program provides services, including psycho-educational and wellness groups, peer support, mentoring, and employment and education screening and readiness skill development in an open residential environment. Additional services offered include physical health screening, consultation, linkage, referrals, and follow-up with primary care professionals. In FY2018-19, the budget was increased by $61,320 due to increased bed day rates for clients enrolled in the program.

Behavioral Health Court (TAOA-FSP)

In FY 2019-20, the budget for Behavioral Health Court was increased by $116,000 due to additional housing costs for clients enrolled in the program.

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 contracted services as an alternative to hospitalization or step down from acute inpatient care within a hospital. In FY 2018-19, the budget was enhanced by $30,000 for increased facility security costs. In FY 2019-20, the budget was enhanced by an additional $44,825 to fund increased costs for specialty staff.

FSP/ACT Programs (TAOA-FSP)

The Agewise program provides FSP/ACT services to adults ages 60 years and older who are experiencing SMI, and who may be on Lanterman–Petris–Short (LPS) conservatorship, or have needs that cannot be adequately met by a lower level of care. In FY 2018-19, the budget for Agewise was increased by $1,255,106 due to increased operating costs and for one-time start-up costs related to the execution of a new contract.

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FSP/ACT - TRANSITIONAL RESIDENTIAL PROGRAM (TAOA-FSP)

The FSP/ACT transitional residential program known as Safe Haven provides residential support, crisis intervention, and transitional housing services to individuals with SMI who are experiencing homelessness. In FY 2019-20, the budget was increased by $53,500 due to increased operating costs.

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

In FY 2019-20, the estimated total MHSA budget for TAOA-OE programs is $768,625. In FY 2019-20, the estimated cost per unduplicated client served in TAOA-OE programs is $548, inclusive of all funding, and the estimated number of unduplicated clients to be served is 2,266.

HIGHLIGHTS FROM FY 2017-18:

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

The non-residential SUD treatment and recovery programs assist adults with SUD, including co-occurring SMI and SUD, in achieving recovery through mental health screenings and linkage to mental health services. In FY 2017-18, 2,266 unduplicated individuals were served by six programs located throughout San Diego County.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

In FYs 2018-19 and FY 2019-20, there were no changes to TAOA-OE programs.

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

In FY 2019-20, the estimated total MHSA budget for TAOA-SD programs is $43,652,825. In FY 2019-20, the estimated cost per unduplicated client served in TAOA-SD programs is $2,005, inclusive of all funding, and the estimated number of unduplicated clients to be served is 39,210.

HIGHLIGHTS FROM FY 2017-18:

CLUBHOUSES (TAOA-SD)

Clubhouses provide rehabilitative, recovery, and vocational services, and support to adults throughout the county. The program assists members with improving social skills, reducing isolation, identifying areas of personal, cultural, vocational, intellectual, and recreational interest, and to achieve independent functioning. The Mariposa Clubhouse, located in the North Coastal Region, is one of 13 member-operated facilities. Along with traditional support and education groups, the Mariposa clubhouse members participate in mindfulness groups, music appreciation, arts and craft classes, and a weekly “express yourself” dance class. Members also attend social outings to the beach, parks, and events with members of other clubhouses. In FY 2017-18, 242 new clients enrolled at the Mariposa Clubhouse and daily attendance for the entire fiscal year was 5,312.

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Biopsychosocial Rehabilitation (BPSR) Recovery Centers (TAOA-SD)

BPSR recovery centers provide outpatient mental health rehabilitation medication management, care coordination, recovery services, and employment support at multiple locations throughout the county to adults with SMI, including those with co-occurring SUD. There are specific programs dedicated to TAY, and older adult geriatric specialists who provide integrated, cultural and age appropriate services.

In FY 2017-18, Heartland, one of the BPSR recovery centers, served 783 adults and 205 TAY clients. Overall, 85 percent of clients served showed functional improvement or stabilization and 81 percent showed clinical improvement or stabilization.

New Leaf BPSR
A Personal Story

A 43-year-old woman who was a client of the New Leaf Recover Center had been unable to break her cycle of addiction. During one of her group meetings a counselor informed attendee that entering detox may be the most appropriate next step in addressing their addiction. The woman realized that she would not be able to care for her beloved dog if she had to enter detox. This motivated her so greatly that she was able to complete the program at New Leaf and graduate with her dog by her side.

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. Staff are co-located at two BHS outpatient clinics to engage clients who are experiencing homelessness and help them find them housing. In FY 2017-18, 222 individuals were engaged and assessed for housing, 163 were engaged in services to locate housing or maintain current housing, and 74 were placed into permanent housing. Within the first three months of enrollment, 55 percent of clients were housed. The program also engaged with 102 landlords as part of the program's landlord recruitment efforts, resulting in 68 new rental units.

In-Home Outreach Team (IHOT) (TAOA-SD)

IHOT teams are comprised of mobile clinicians who visit individuals with SMI that are reluctant to seek treatment. IHOT teams visit individuals in their own home and assess and engage them with the goal of reducing the negative impacts of untreated mental illness. Connection through IHOT is also the initial engagement point for individuals who may become court-ordered through Laura's Law Assisted Outpatient Treatment (AOT) in all six regions of San Diego County. In FY 2017-18, 654 total clients were accepted into IHOT, and of those clients, 146 individuals were identified as possible Laura's Law clients potentially eligible for assisted outpatient treatment (AOT) services. For these clients, emergency psychiatric unit visits were reduced by 42 percent on average.

North Inland Mental Health Centers (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 people with co-occurring SUD. In FY 2017-18, the four locations in the North Inland Region provided services to 1,420 unduplicated clients.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

Augmented Services Program (ASP) (TAOA-SD)

ASPs provide additional services to individuals with SMI in licensed residential care facilities, referred to as board and care facilities, to help them maintain or improve functioning in the community and to prevent or minimize institutionalization. In FY 2019-20, the budget was increased by a total of $1,264,271 due to the

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addition of approximately 100 new beds and increased operating costs related to the execution of new contracts.

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. In FY 2019-20, the budget was decreased by $61,500 due to a minor contract adjustment.

BIOPSYCHOSOCIAL REHABILITATION (BPSR) (TAOA-SD)



In FY 2018-19, the BPSR program was increased by $2,655,952 due to increased operating costs and for one-time start-up costs related to the expansion of the Jane Westin program in Central Region.

In FY 2019-20, the BPSR program budget was increased by a total of $517,564 due to increased operating costs, and for one-time start-up costs related to the execution of new contracts to ensure a seamless transition from the previous providers.

CLUBHOUSES (TAOA-SD)

In FY 2019-20, the budget for clubhouses was increased by a total of $132,286. The enhancement is due to increased operating costs and for one-time start-up costs related to the execution of new contracts.

CRISIS STABILIZATION UNITS (CSU) (TAOA-SD)

The CSUs provide treatment services in an outpatient setting to reduce risk of a psychiatric hospitalization. The hospital-based CSUs provide 24/7 services to vulnerable patients in a safe setting under the direct constant supervision of behavioral health staff. Patients have access to emergency department services if medical crises arise. In 2018-19, CSU services located in the North Coastal Region of the county were terminated resulting in a budget decrease of $3,253,767, and reduction of an additional $590,022 in FY 2019-20. These funds will be repurposed to provide new CSU services in the North Region to ensure adequate crisis stabilization services are available for residents of North San Diego County. Additionally, on June 24, 2019, the Board approved the augmentation of an existing contract with Palomar Health to enhance hospital-based crisis stabilization services in North San Diego County to address unmet, immediate needs resulting in a FY 2019-20 budget increase of $4,400,000.

FAITH-BASED SERVICES (TAOA-SD) (FORMERLY INN-13 FAITH-BASED INITIATIVE)

Formerly under INN-13 Faith Based Initiative, the 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 in-reach ministry that operates countywide. In FY 2019-20, the budget was increased by a total of $1,474,471 for increased operating costs related to the execution of new contracts. Due to the success of this program it transitioned from MHSA INN funding to CSS funding.

HOME FINDER (TAOA-SD)

In FY 2019-20, the budget was increased by a total of $64,733 to fund an additional housing navigator.

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

The ICM program serves older adults with SMI who are in a locked setting to support their reintegration into the community. In FY 2019-20, the ICM budget was decreased by $53,599 due to reduced operating costs.

JUSTICE DISCHARGE PLANNING (TAOA-SD)

The Justice Discharge Planning program provides short-term transition services primarily to at-risk African American and Latino adults and TAY, who are experiencing SMI and who are incarcerated. In FY 2018-19, jail in-reach services that were previously provided through INN-13, the Faith Based program, were added to the justice discharge planning program for ongoing funding and to better meet the needs of clients, resulting in a budget increase of $155,000.

MENTAL HEALTH ADVOCACY SERVICES (TAOA-SD)

The Mental Health Advocacy program provides outpatient education and advocacy services to clients receiving outpatient and non-residential services. In FY 2019-20, the budget was enhanced by $302,748 due to increased operating costs related to the execution of a new contract.



NO PLACE LIKE HOME – BEHAVIORAL HEALTH SERVICES (TAOA-SD)

To facilitate planning and support the implementation of the No Place Like Home initiative, funding for new County positions under BHS was added. In FY 2019-20 the budget was increased by $520,936.

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

To facilitate planning and support the implementation of the No Place Like Home initiative, funding for required environmental reviews conducted by DPW was added. In FY 2018-19, the budget was increased by $12,500, and in FY 2019-20 an additional $15,000 was added.

NO PLACE LIKE HOME - HOUSING AND COMMUNITY DEVELOPMENT SERVICES (HCDS) (TAOA-SD)

To facilitate planning and support the implementation of the No Place Like Home initiative, funding for new County of San Diego positions under the County of San Diego Health and Human Services Agency, Housing and Community Development Services (HCDS) was added. In FY 2018-19, the budget was increased by $589,669, and in FY 2019-20 an additional $609,486 was added.

PEER-ASSISTED SUPPORT SERVICES (TAOA-SD) (FORMERLY INN-15 PEER ASSISTED TRANSITIONS)

Formerly under INN-15 Peer Assisted Transitions, the peer-assisted support services program provides peer specialist coaching, incorporates shared decision making, and facilitates active social supports. Services are focused on individuals with SMI who have a limited social network and limited support and are unlikely to be connected to services. In 2019-20, the budget was increased by a total of $897,061 due to operating costs related to the execution of new contracts. Due to the success of this program it transitioned from MHSA INN funding to CSS funding.

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

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have been referred by the Court. In FY 2018-19, the budget was increased by $32,056 due to increasing salaries as outlined in the County of San Diego's Compensation Ordinance.

SAN DIEGO EMPLOYMENT SOLUTIONS (TAOA-SD)

The San Diego Employment Solutions program provides an array of job opportunities to help adults with SMI obtain competitive employment. The program uses a comprehensive approach that is community-based, client and family driven, and culturally competent. In FY 2018-19, the budget was increased by $186,300 and in FY 2019-20 the budget was increased by $660,800 due to increased operating costs, and to fund one-time start-up costs related to the execution of new contracts. Additionally, some services previously provided under the INN-14 Ramp Up to Work program will continue under this program in FY 2019-20.

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

The START programs provide urgent services to individuals in the North Coastal, Central, East, and South Regions who are experiencing a mental health crisis and may have a co-occurring SUD. The programs provide crisis residential services as an alternative to hospitalization or step down from acute inpatient care within a hospital. In FY 2019-20, the budget was enhanced by $468,409 to increase the number of available beds.

SHORT-TERM BRIDGE HOUSING (TAOA-SD)

Short-term bridge housing, formerly referred to as emergency shelter beds, 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. In FY 2019-20, the budget was enhanced by $49,715 to increase the number of available beds.

TELEMEDICINE (TAOA-SD)

In FY 2019-20, due to the consistent spend down of Technological Needs (TN) funds, the budget for telemedicine equipment was moved out of the TN component and into the CSS component of MHSA for continued funding to support adult programs. In FY 2019-20, the budget for this equipment was increased by $152,097 under CSS and reduced by the equivalent amount in the TN component.

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CSS PROGRAMS FOR ALL AGES (ALL)

These programs 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 2019-20, the estimated total MHSA budget for ALL-OE programs is $3,570,570. In FY 2019-20, the estimated cost per unduplicated client served in ALL-OE programs is $1,807, inclusive of all funding, and the estimated number of unduplicated clients to be served is 2,036.

HIGHLIGHTS FROM FY 2017-18:

BEHAVIORAL HEALTH SERVICES AND PRIMARY CARE INTEGRATION SERVICES (ALL-OE)

This program facilitates the integration of behavioral health and primary health care services by providing evidence-based treatment for behavioral health interventions to individuals in primary care settings. In FY 2018-19, 756 clients were served at seven community clinics, including 668 adults and 88 older adults.

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

The program improves access to mental health services for victims of trauma and torture who are experiencing or at risk of SMI or SED, through culturally specific outreach and education. In FY 2017-18, a total of 108 adults and children received services, including case management, rehabilitation, and medication management.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

BEHAVIORAL HEALTH SERVICES AND PRIMARY CARE INTEGRATION SERVICES (ALL-OE)

In FY 2019-20, the budget was increased by $722,288 due to increased operating costs, the execution of a new contract, and, if needed, the addition of one-time startup costs.

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

This program provides outpatient mental health services, case management, and integrated SUD treatment and rehabilitation to individuals with SMI who are deaf and/or hard of hearing, to achieve a more adaptive level of functioning. In FY 2019-20, the budget was increased by $20,000 due to increased operating costs related to the execution of a new contract.

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

In FY 2018-19, the budget increased by $75,000 due to the additional need for interpreter services.

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CLUBHOUSE FOR THE DEAF AND 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 2019-20, the budget was increased by $9,171 due to increased operating costs related to the execution of a new contract.

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2019-20, the estimated total MHSA budget for ALL-SD programs is $6,129,398. In FY 2019-20, the estimated cost per unduplicated client served in ALL-SD programs is $1,274, inclusive of all funding, and the estimated number of unduplicated clients to be served is 8,028.

HIGHLIGHTS FROM FY 2017-18:

CHALDEAN AND MIDDLE EASTERN SERVICES (ALL-SD)

This program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle Eastern descent 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, a total of 220 clients received services and 25 percent of individuals who received treatment reported progress toward employment goals.

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

The PERT program connects law enforcement officers with clinicians to serve children and adults experiencing psychiatric emergencies throughout the County. PERT improves collaboration between the mental health and law enforcement systems with the goal of humane, safe, and effective de-escalation of situations involving law enforcement officers and people suffering from SMI or SED. In FY 2017-18, PERT conducted 9,714 crisis intervention contacts and 8,263 community service contacts for a total of 17,977 contacts. PERT was also engaged in 4,284 additional attempted contacts in which the individual refused or was no longer at the scene when the team arrived.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

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

In FY 2018-19, the County piloted a new program that pairs two licensed mental health clinicians with emergency medical technicians (EMTs) to determine the best treatment and service options for persons with SMI who are needing assistance. In FY 2018-19, the budget for this program was reduced by $257,803 due to a mid-year start but will be annualized in FY 2019-20.

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

In FY 2018-19, 20 additional PERT teams were added mid-year and the budget was increased by $69,062 due to the successful outcomes of the program. In FY 2019-20, the budget for the additional PERT teams will be annualized resulting in an estimated budget increase of $965,984.

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CSS PROPOSED EXPENDITURE PLAN AND ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2019-20, 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 2019-20 Proposed Budget (All Funding)*	*FY 2019-20 Estimated Number of Unduplicated Clients*	*FY 2019-20 Estimated Cost Per Client*
CY-FSP	Children, Youth	$52,526,795	5,297	$9,916
CY-OE	Children, Youth	$1,624,096	1,734	$937
CY-SD	Children, Youth	$20,682,101	3,811	$5,427
TAOA-FSP	Adults, TAY	$61,515,246	4,625	$13,301
TAOA-FSP	OA	$8,568,550	743	$11,532
TAOA-OE	TAY, Adults, OA	$78,615,687	39,210	$2,005
TAOA-SD	TAY, Adults, OA	$1,242,195	2,266	$548
ALL-OE	ALL	$3,678,658	2,036	$1,807
ALL-SD	ALL	$10,226,555	8,028	$1,274
Total CSS		**$238,679,884**		

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 2019-20, estimated cost per client figures are based on the total proposed FY 2019-20 budget divided by the actual clients served in FY 2017-18, plus the estimated new unduplicated clients to be served in FY 2018-19 and FY 2019-20. FY 2017-18 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 2019-20 will vary from the number of unique clients served in Appendix I, J and K because some programs no longer exist, and new programs will be added in FY 2019-20. Additionally, clients may receive one or more different services, so there may be duplication of clients across work plans.

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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 2019-20, the estimated total MHSA budget for PEI programs is $26,761,835, representing a total decrease of $5,161,950 from the MHSA Three-Year Plan funding priorities for FY 2019-20. The reduction is due to services being funded through other revenue sources in association with the implementation of the Drug Medi-Cal – Organized Delivery System (DMC-ODS). PEI programs were not enhanced due to component funding being maximized in previous fiscal years. Additionally, the State Department of Health Care Services (DHCS) issued new guidance for the distribution of MHSA revenue which will require the County of San Diego to reduce the amount of revenue allocated to the PEI component. This will result in a reduction in the PEI budget.

As required by MHSA, a majority of funding for PEI programs must be directed to persons less than 25 years of age. In FY 2019-20, 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 2017-18 PEI system-wide summary report can be found in Appendix M and the Three-Year PEI Evaluation Report can be found in Appendix N.

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

HIGHLIGHTS FROM FY 2017-18:

CAREGIVER SUPPORT FOR ALZHEIMER'S AND 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 to 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 2017-18, 465 caregivers were assessed to determine prevalence of clinical depression and other mental health issues, and 158 were assessed as clinically depressed and received brief intervention services or were referred for longer-term care, if needed.

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

Check Your Mood is an annual event held on October 11, 2018, in conjunction with National Depression Screening Day. The program engages and encourages San Diegans to monitor and assess their emotional well-being. Organizations across the county provide free mental health resources, information, and Check Your Mood screenings to the community to help raise awareness of and reduce stigma related to mental health.

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County of San Diego Health and Human Services Agency, Behavioral Health Services (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. During the week of the event 2,497 individuals accessed information from a resource table and 1,440 individuals completed a Check Your Mood depression-screening tool.

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 2017-18, EMASS provided services to 478 clients, 123 of whom avoided emergency department services.

FRIENDS IN THE LOBBY – FAMILY AND PEER SUPPORT (PS-01)

The Family and Adult Peer Support program provides 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. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the County. In FY 2017-18, volunteers engaged 3,364 family members in nine psychiatric unit waiting rooms. Of 1,154 surveys completed, 97 percent reported that the service was helpful.

FRIENDS IN THE LOBBY
A PERSONAL STORY

Bringing your child to a psychiatric hospital can be an overwhelming experience. One family brought their daughter into a local hospital because she was experiencing psychiatric symptoms. They were immediately greeted by the warm, friendly volunteers of the Friends in the Lobby program who provided educational materials and information about support groups conducted in Spanish, which was their preferred language. The volunteers also had personal experience in the mental health system. The family expressed appreciation of their genuine compassion and felt a sense of comfort upon leaving the hospital after being engaged with the Friends in Our Lobby volunteers.

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

The North Coastal 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 North Coastal services are located in classrooms at four elementary schools in Oceanside and two elementary schools in Vista. These locations provide services, including 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 2017-18, the North Coastal School-Based PEI program served 1,995 children in classroom lessons, 751 children in small groups, and 167 parents in the parent group.

SCHOOL-BASED SUICIDE PREVENTION PROGRAM - 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. During the 2017-18 school year, the HERE Now team worked with 21 school districts and 87 schools in San Diego County, presented the program to 32,494 students in classroom presentations, and referred 509 students to outpatient mental health services.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

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 stigma reduction 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 2019-20, BHS will contribute $400,000 of MHSA or other funds to CalMHSA for statewide PEI programs.

Integrated Peer and 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. In FY 2018-19, the budget was increased by $9,315 for one-time costs associated with upgrading computer equipment.

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. In FY 2019-20, the budget was increased by $50,258 for one-time costs and increased operating costs related to the execution of a new contract.

Veterans and 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. In FY 2019-20, the budget was increased by $280,000 to add case managers.



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PEI Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2019-20, 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 2019-20 Proposed Budget (All Funding)*	*FY 2019-20 Estimated Number of Unduplicated Clients*	*FY 2019-20 Estimated Cost Per Client*
CO-02 Co-Occurring Disorders	ALL	$160,880	1,400	$115
CO-03 Integrated Peer & Family Engagement	ALL	$2,546,750	997	$2,554
DV-03 Alliance for Community Empowerment	Children, Youth	$402,200	413	$974
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$502,758		
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$1,106,050	9,867	$112
FB-01 Early Intervention for Prevention of Psychosis (Kick Start)	Children, TAY	$1,784,763	250	$7,139
NA-01 Native American Prevention and Early Intervention (Dream Weaver)	ALL	$1,754,597	1,714	$1,024
OA-01 Elder Multicultural Access & Support Services (EMASS)	OA	$572,283	900	$636
OA-02 Home Based Services - For Older Adults (Positive Solutions)	OA	$581,742	1,150	$506
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$1,086,704	7,220	$151
PS-01 Education and Support Lines	ALL	$5,055,613	260,822	$19
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$1,402,673	1,021	$1,374
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$301,650		
SA-01 School Based Prevention and Early Intervention	Children, Youth	$6,334,650	15,854	$400
SA-02 School Based Suicide Prevention & Early Intervention (Here Now)	Children, Youth, TAY	$1,809,900	17,945	$101
VF-01 Veterans & Family Outreach Education (Courage to Call)	ALL	$1,287,040	4,033	$319
Total PEI		**$26,690,253**		

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 2019-20 estimated cost per client figures are based on the total proposed FY 2019-20 budget divided by the actual number of clients served in FY 2017-18, plus the estimated new clients to be served in FYs 2018-19 and 2019-20. FY 2017-18 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 2019-20 will vary from the number of unique clients served in Appendix M.

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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 2019-20, the estimated INN expenditures will be $11,117,846, reflecting a total decrease of $981,822 in MHSA funding from the MHSA Three-Year Plan funding priorities for FY 2019-20. The decrease is primarily due to the delays in executing several INN programs services and due to the transition of several programs to CSS, to continue services.

A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix O. A detailed annual INN report with evaluation results is available at: http://sandiego.camhsa.org/innovation.aspx.

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

HIGHLIGHTS FROM FY 2017-18:

URBAN BEATS (INN-16)

The Urban Beats program engages TAY, ages 16 to 25, who can be resistant to traditional mental health approaches through the visual arts, spoken word, videos, and performances. This peer-support, early-intervention program increases engagement and access to treatment, reduces stigma, enhances cultural expression, and provides strength-based messages to the TAY population. Participants are enrolled in 20-week academies that focus on engagement and artistic exploration. In FY 2017-2018, 177 new clients enrolled in the program and over 80 percent of participants reported being satisfied with the program, indicating that they knew better where to get help, were more comfortable seeking help, could more effectively deal with problems, and were less bothered by symptoms after participating in the program. More than 950 individuals attended the community performances.

MOBILE HOARDING INTERVENTION - COGNITIVE REHABILITATION AND EXPOSURE/SORTING THERAPY (CREST) (INN-17)

The CREST program seeks to diminish long-term hoarding behaviors in older adults by combining an adapted cognitive-rehabilitation therapy with hands-on training and support. A mobile treatment team provides clients with psychiatric assessments, neuropsychological testing, cognitive training, exposure therapy, peer support, aftercare, family groups, and care management. Through connections to resources older adults can reduce hoarding behaviors, avoid evictions, and improve their quality of life. The program was expanded from 30 to 90 clients in order to provide services countywide. In FY 2017-18, CREST responded to 89 individual referrals and provided services to 22 individuals, including eviction prevention, five of which were averted, assistance with health and safety inspections, and increased socialization.

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ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

INNOVATION EVALUATION

In FY 2019-20, Innovation programs reflecting a budget increase or decrease in the program budget will also reflect a corresponding adjustment to the evaluation budget for required data collection and evaluation. Evaluation budgets are embedded within each Innovation program.

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

The ReST program engages TAY who are discharged from acute emergency mental health care, and are experiencing homelessness or at risk of experiencing homelessness. The goal is to prevent future emergency care by providing short-term (up to 90 days) comprehensive, on-site services to link clients to permanent housing, ongoing mental health services, and other needed resources. In FY 2018-19, the budget for this program was decreased by $331,729 due to a delay in execution of the program.

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. In FY 2018-19, the budget for this new program was increased by $157,576, and in FY 2019-20, the budget was increased by an additional $89,572 to execute this new program.

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INN ESTIMATED COST PER CLIENT

The table below represents the estimated cost per client for FY 2019-20, 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 2019-20 Proposed Budget (All Funding)*	*FY 2019-20 Estimated Number of Unduplicated Clients*	*FY 2019-20 Estimated Cost Per Client*
INN-15 Peer Assisted Transitions	TAY, Adults, OA	$55,878	0	$0
INN-16 Urban Beats	TAY	$970,144	200	$4,851
INN-17 Mobile Hoarding Intervention Program (CREST)	OA	$1,320,075	90	$14,667
INN-18 Peripartum Program	TAY, Adults	$1,069,349	300	$3,564
INN-19 Telemental Health	ALL	$1,129,266	250	$4,517
INN-20 ROAM Mobile Services	ALL	$1,890,635	200	$9,453
INN-21 ReST Recuperative Housing	TAY (ages 18-25)	$1,070,515	48	$22,302
INN-22 Medication Clinic	Children, Youth	$1,984,308	510	$3,891
INN-24 Early Psychosis Evaluation and Learning Health Care Network	Youth, TAY	$228,397	245	$932
Total		**$9,718,566**		

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 2019-20, estimated cost per client figures are based on the total proposed FY 2019-20 budget divided by the estimated proposed number of clients to be served in FY 2019-20, based on estimates from the programs.
- INN-15 served no clients because the program ended as planned. The remaining funds are for evaluation services.
- The estimated average cost per client is a summary by work plan.

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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 2019-20, the estimated WET expenditures will be $3,589,906, reflecting a budget increase of $293,166 in MHSA funding from the MHSA Three-Year Plan funding priorities for FY 2019-20.

In FY 2019-20, approximately $2.8 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.

HIGHLIGHTS FROM FY 2017-18:

BEHAVIORAL HEALTH TRAINING CURRICULUM (FORMERLY BEHAVIORAL HEALTH EDUCATION AND TRAINING ACADEMY (BHETA) (WET-02)

The Behavioral Health Training Curriculum provides behavioral health training curriculum to community behavioral health providers and County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) staff. Formerly known as BHETA, the program changed its name to Responsive Integrated Health Solutions (RIHS) in FY 2018-19. The curriculum provides awareness, knowledge, and skill-based trainings for behavioral health staff, and features state-of-the-art techniques and instruction. Training topics included cognitive behavioral therapy (CBT), dialectical behavioral therapy (DBT), a TAY series, motivational interviewing, relapse prevention, compassion fatigue, Pathways to Well Being, trauma-focused CBT, therapy and evaluation resource management (TERM), enhanced case management, withdrawal management, engaging the refugee community, working with immigrant communities, a geriatric training series, and a CYF training series and conference. In FY 2017-18, BHETA provided in-person trainings to 1,459 individuals and eLearnings to 11,266 individuals, including County employees and contracted staff.

COMMUNITY PSYCHIATRY RESIDENCY TRAINING (WET-04)

The community psychiatry residency training program partners with the University of California, San Diego (UCSD) School of Medicine to recruit and train leaders in the psychiatry field and enhance interest in working in the public behavioral health system. The program provides training and clinical supervision in community psychiatry for psychiatry residents and psychiatric nurse practitioner trainees with the goal of increasing qualified personal working within the public behavioral health sector, which has long experienced a severe personnel shortage. In FY 2017-18, the program included four psychiatry residents and ten psychiatric mental health nurse practitioners. Through this innovative model, the nurse practitioners work collaboratively with

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psychiatry residents throughout the entire program where they are engaged in multidisciplinary treatment teams and are provided formal and informal supervision from experienced staff of various disciplines.

PUBLIC MENTAL HEALTH ACADEMY (WET-03)

The public mental health academy program is provided by the San Diego Community College District (SDCCD) to facilitate workforce development and career pathways in public mental health. The program provides an academic counselor to support student success in the community-based public mental health certificate program, to assist individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be admitted into an associates and/or bachelor's degree program. In FY 2017-18, 94 students were enrolled in the program and 36 students completed the certificate as of June 2018.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

CULTURAL COMPETENCY ACADEMY (WET-02)

The Cultural Competency Academy was implemented in FY 2018-19 to build awareness and knowledge, and provide skill-based trainings to both BHS and BHS providers. The academy focuses on clinical and recovery interventions for multicultural populations, while ensuring that all trainings focus on being trauma-informed from environmental to clinical applications. The training academy works closely with the Cultural Competence Resource Team to develop the curriculum that ensures culturally competent services are provided. In FY 2019-20, the budget for this program was increased by $39,797 to enhance training.

BEHAVIORAL HEALTH EDUCATION AND TRAINING ACADEMY (BHETA) (WET-02)

In FY 2018-19, the budget was increased by $15,387 due to additional enhanced training needs.

COMMUNITY PSYCHIATRY RESIDENCY TRAINING (WET-04)

In FY 2018-19, the budget increased by $200,000 to further expand the program to include a fellowship program for public mental health nurse practitioners (PMHNPs). The enhancement will provide additional psychiatry faculty to supervise the PMHNP trainees to build a stronger behavioral health workforce and engage additional PMHNPs to work in the public sector or community-based organizations.

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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 must be spent by June 30, 2018; however, due to the State's new reversion guidelines, the deadline was extended June 30, 2020 so counties would have an opportunity to complete CFTN projects using unspent funds.

The estimated CFTN expenditures for FY 2019-20 will be $347,868, reflecting a budget increase of $347,868 in MHSA funding from the MHSA Three-Year Plan funding priorities for FY 2019-20. The increase is due to delays in facility and TN projects that were planned to be completed in prior years but are expected to be completed in FY 2019-20.

In FY 2018-19, approximately $2,000,000 of CSS funds were transferred to the Technological Needs (TN) component for the Data Exchange (Interoperability) project as described below.

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

TECHNOLOGICAL NEEDS (TN)

HIGHLIGHTS FROM FY 2017-18:

PERSONAL HEALTH RECORD (SD-3)

The County of San Diego's current management information system, Cerner Community Behavioral Health (CCBH), is an electronic health record and billing application used by staff and contracted providers to coordinate client care, perform required State reporting requirements, and bill Medi-Cal and other payers. The County continues to work with CCBH to establish a portal that allows clients to view their health information, providing ease of access and speedy communication with their provider. In FYs 2017-18 and 2018-19, the program underwent extensive testing and is expected to go live in FY 2019-20.

DATA EXCHANGE (INTEROPERABILITY) (SD-8)

Through the Data Exchange project the County continues to improve data sharing and care coordination to increase efficiency, improve the quality and continuity of care, and improve health outcomes for clients. Outcomes from the project include creating a San Diego County domain to host the electronic health record allowing BHS and other County departments to coordinate care. Work continues on the development of interfaces with local private health information exchanges (HIEs) and San Diego Health Connect to securely connect providers, patients, and others to improve the quality of care in our community.

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ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

PERSONAL HEALTH RECORD (SD-3)

In FY 2019-20, the budget for this program, as described above, will be increased by $62,000 due to annual service costs.

TELEMEDICINE (SD-5)

Telemedicine provides video, secure email, and phone consultation in various mental health services locations to improve accessibility of care in underserved and rural areas. It provides 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 2019-20, due to the consistent spend down of TN funds, the telemedicine equipment budget of $173,396 was moved to CSS-SD for continued funding to support adult and children's MHSA programs.

MANAGEMENT INFORMATION SYSTEM (MIS) EXPANSION (SD-6)

The current electronic health record application for mental health services will be integrated into the overall Cerner Millennium solution by the year 2024. BHS will continue planning for integration into the new system through engagement of a transition team of approximately six subject matter experts who will provide support and project management Remaining funds budgeted in FY 2018-19 will rollover to FY 2019-20 resulting in a budget increase of $22,836 to continue implementation of the new system.

DATA EXCHANGE (INTEROPERABILITY) (SD-8)

The interoperability project will aggregate data from various systems to create a comprehensive patient record shared across the continuum of care. It also supports the ConnectWellSD program that is continuing development to support health information exchanges (HIE). Interoperability is vital for effective, person-centered care because it allows programs to share information to better serve clients. In FY 2018-19, the budget was increased by approximately $2,000,000 to continue data sharing efforts, increase efficiency, improve the quality and continuity of care, and improve health outcomes for clients. TN funds were utilized to enhance the communication platform to connect internal and external health information sources across the healthcare continuum, while still strictly adhering to patient privacy laws and requirements. The platform will integrate and aggregate data from a variety of clinical, financial, and operational sources, and through an automated process that leverages algorithms and predictive models, will identify gaps in care and predict potential risk. The solution will allow the County to effectively manage care transitions to improve the health of our population. In FY 2019-20, the budget increased by a total of $6,000 to continue support for this project.

BHS FINANCIAL MANAGEMENT SYSTEM (SD-9)

The BHS financial management system is a cloud-based, multi-dimensional database in which BHS staff will manage the MHSA budget, expenditures, and projections to ensure the most effective use of MHSA funds. The software provides business intelligence, performance management and analytics functionality in a centralized platform. The system includes management dashboards, customized reports to show trending in various contracts and funding and includes various other features. The implementation of the BHS financial management system will strengthen long-term financial planning to ensure sustainability and allow for more effective resource planning. Remaining funds budgeted in FY 2018-19 will rollover to FY 2019-20 resulting in a budget increase of $5,000 to complete system implementation.

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CAPITAL FACILITIES (CF)

HIGHLIGHTS FROM FY 2017-18:

NORTH COASTAL MENTAL HEALTH CENTER (CF-2)



In FY 2017-18, the North Coastal Mental Health Center, co-located in the North Coastal Live Well Center, opened its doors to increase accessibility to services for persons living in North County. Co-located with Public Health Services and other supportive services, the facility offers counseling, case management, employment services, and outpatient mental health medication management to individuals with SMI, along with a clubhouse program. The facility also includes a Military and Veterans Resource Center that connects veterans with resources and benefits, along with several community-based organizations dedicated to assisting veterans and active duty military. Co-locating multiple services allows for person-centered service delivery and more effectively coordinate care.

ENHANCEMENTS AND CHANGES FOR FYS 2018-19 AND 2019-20:

NORTH COUNTY MENTAL HEALTH FACILITY (CF-2)

In FY 2019-20, the budget was increased by $186,658 to complete the project.

NORTH INLAND CRISIS RESIDENTIAL FACILITY (CF-4)

The North Inland Crisis Residential facility is a short-term crisis residential facility for adults with SMI and co-occurring disorders that became operational in 2016. In FY 2019-20, the budget was increased by $10,000 to complete minor facility work.

EMERGENCY SCREENING UNIT (ESU) FACILITY (CF-5)

In late 2017, BHS opened the new ESU facility in a centralized location of San Diego County to enhance crisis stabilization service accessibility for children and youth. The ESU was relocated from its previous location and expanded services from 4 to 12 crisis stabilization beds. In FY 2019-20, the budget was increased by $10,000 to complete minor facility work.

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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 at risk of SED.

HEALTH SERVICES RESEARCH CENTER

The Health Services Research Center (HSRC) is a non-profit research organization located within the Department of Family and Preventive Medicine at UCSD. 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 F, I, J, and K.

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APPENDICES

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Appendix A
MHSA Expenditure Plan

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Funding Summary

County: San Diego

		MHSA Funding						
		A	B	C	D	E	F	G
		Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Totals
A. Estimated FY 2019-20 Funding								
1.	Estimated Unspent Funds from Prior Fiscal Years	$ 48,214,329	$ -	$ 21,356,121	$ 989,898	$ 347,868		**$ 70,908,215**
2.	Estimated New FY 2019-20 Funding*	$ 132,652,231	$ 33,155,763	$ 8,752,027				**$ 174,560,021**
3.	Transfer to JPA in FY 2019-20	$ -			$ -	$ -	$ -	**$ -**
	Transfer to WET in FY 2019-20**	$ (2,800,000)			$ 2,800,000	$ -	$ -	**$ -**
	Transfer to CFTN in FY 2019-20**	$ -			$ -	$ -	$ -	**$ -**
	Transfer to Prudent Reserve in FY 2019-20**	$ -			$ -	$ -	$ -	**$ -**
4.	Access Local Prudent Reserve in FY 2019-20	$ -	$ -				$ -	**$ -**
5.	Prudent Reserve Assessment***	$ 6,695,396	$ 1,695,842				$ (8,391,238)	**$ -**
6.	Estimated Available Funding for FY 2019-20	$ 184,761,956	$ 34,851,605	$ 30,108,148	$ 3,789,898	$ 347,868		**$ 253,859,474**
B. Estimated FY 2019-20 MHSA Expenditures		**$ 172,678,404**	**$ 26,761,835**	**$ 11,117,846**	**$ 3,589,906**	**$ 347,868**		**$ 214,495,859**
C. Estimated FY 2019-20 Unspent Fund Balance		**$ 12,083,552**	**$ 8,089,770**	**$ 18,990,302**	**$ 199,991**	**$ (0)**		**$ 39,363,616**

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	$ 42,193,120
2. Contributions to the Local Prudent Reserve in FY 2019-20	0
3. Distributions from the Local Prudent Reserve in FY 2019-20	(8,391,238)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	$ 33,801,882

* Estimated new funding from State consultant estimates in April 2019 + estimated interest

** 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.

*** Pursuant to Senate Bill (SB) 192 (Chapter 328, Statutes 2018) and the Department of Health Care Services (DHCS) MHSUDS Information Notice 19-017, Mental Health Services Act: Implementation of Welfare and Institutions (W&I) Code Sections 5892 and 5892.1, each county must establish a prudent reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) component revenue of the Mental Health Services Act (MHSA) funds received in the preceding five years.

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP) Housing	$ 1,206,600	$ 1,206,600				
Children's Full Service Partnership (FSP)	$ 1,106,811	$ 621,985	$ 484,826			
Children's School Based Full Service Partnership (FSP)	$ 36,298,769	$ 15,179,005	$ 16,524,511	$ 4,595,252		
Family Therapy	$ 1,083,340	$ 1,083,340				
Therapeutic Behavioral Services (TBS)	$ 5,380,933	$ 3,015,082	$ 2,365,851			
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 7,450,343	$ 5,557,897		$ 1,892,446		
TAOA-FSP Full Service Partnerships for Ages 18-60+						
Adult Residential Treatment	$ 703,478	$ 703,478				
Assisted Outpatient Treatment (AOT)	$ 1,436,980	$ 1,238,445	$ 198,535			
Behavioral Health Court	$ 1,886,318	$ 1,456,889	$ 429,429			
County of San Diego - Institutional Case Management (ICM)	$ 490,000	$ 291,465	$ 2,535	$ 196,000		
County of San Diego - Probation	$ 901,690	$ 541,014		$ 360,676		
Crisis Residential Services - North Inland	$ 1,763,559	$ 1,146,263		$ 617,296		
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 42,271,814	$ 27,098,852	$ 12,951,719	$ 2,221,244		
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 11,657,936	$ 11,657,936				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,024,063	$ 2,024,063				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,120,663	$ 2,120,663				
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 2,765,125	$ 2,655,125		$ 110,000		
North Coastal Mental Health Center and Vista Clinic	$ 337,046	$ 206,232	$ 130,814			
Payee Case Management Services	$ 125,688	$ 125,688				
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 748,548	$ 537,460	$ 211,088			
Strengths Based Case Management (SBCM)	$ 850,887	$ 462,609	$ 388,278			
TOTAL Full Service Partnership (FSP) Programs	**$ 122,610,591**	**$ 78,930,090**	**$ 33,687,586**	**$ 9,992,914**	**$ -**	**$ -**
Non-FSP Programs						
ALL-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 467,911	$ 467,911				
Behavioral Health Services and Primary Care Integration Services	$ 1,594,231	$ 1,594,231				
Behavioral Health Services for Deaf & Hard of Hearing	$ 367,008	$ 258,920	$ 108,088			
Clubhouse - Deaf or Hard of Hearing	$ 290,089	$ 290,089				
Psychiatric and Addiction Consultation and Family Support Services	$ 959,419	$ 959,419				
ALL-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 538,948	$ 189,525	$ 349,423			
Emergency Medical Technician (EMT) - Mental Health Clinician Team	$ 258,414	$ 258,414				
Psychiatric Emergency Response Team (PERT)	$ 9,429,194	$ 5,681,459		$ 3,747,735		
CY-OE Outreach & Engagement for Children & Youth						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Women	$ 1,242,195	$ 1,242,195				
Family & Youth Partnership	$ 381,901	$ 381,901				
CY-SD System Development for Children & Youth						
Administrative Services Organization (ASO) - TERM	$ 355,608	$ 355,608				
Adolescent Day Rehabilitation	$ 100,550	$ 60,550		$ 40,000		
BHS Children, Youth and Families (CYF) Liaison	$ 553,025	$ 553,025				
Bridgeways	$ 563,080	$ 334,085	$ 4,995	$ 224,000		
Commercially Sexually Exploited Children (CSEC)	$ 1,005,500	$ 474,006	$ 31,494	$ 500,000		
County of San Diego - Juvenile Forensic Services	$ 1,100,000	$ 1,100,000				
County of San Diego - Probation	$ 278,554	$ 167,132		$ 111,422		
Crisis Action and Connection	$ 2,162,238	$ 1,644,934	$ 3,440	$ 513,864		
Emergency Screening Unit (ESU)	$ 5,877,889	$ 3,961,441		$ 1,916,448		
Incredible Families	$ 2,124,906	$ 744,848	$ 602,370	$ 777,688		
Incredible Years	$ 510,431	$ 269,206	$ 241,225			
Medication Support for Wards and Dependents	$ 851,659	$ 368,427	$ 144,432	$ 338,800		
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,508,250	$ 821,385	$ 86,865	$ 600,000		
Peer Mentoring	$ 80,440	$ 48,440		$ 32,000		
Placement Stabilization Services	$ 2,250,351	$ 693,953	$ 661,181	$ 895,217		
Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adolescent	$ -					

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2019-20					
	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
Rural Integrated Behavioral Health and Primary Care Services	$ 125,688	$ 75,688		$ 50,000		
Supplemental Security Income (SSI) Advocacy Services	$ 301,650	$ 181,650		$ 120,000		
Telemedicine	$ 21,300	$ 21,300				
Walk-In Assessment Clinic and Mobile Assessment Team	$ 910,983	$ 406,100	$ 142,483	$ 362,400		
TAOA-OE Outreach & Engagement for Ages 18-60+						
Non-Residential Substance Use Disorder (SUD) Treatment & Recovery Services - Adult	$ 1,242,195	$ 768,625		$ 473,570		
TAOA-SD System Development for Ages 18-60+						
Augmented Services Program (ASP)	$ 2,472,773	$ 2,472,773				
Behavioral Health Assessors	$ 688,768	$ 390,168		$ 298,600		
Bio-Psychosocial Rehabilitation (BPSR)	$ 21,976,046	$ 7,014,199	$ 7,598,579	$ 7,363,267		
Client Liaison Services	$ 366,271	$ 366,271				
Client Operated Peer Support Services	$ 752,516	$ 752,516				
Clubhouse	$ 5,007,418	$ 5,007,418				
Crisis Stabilization - North Coastal	$ -	$ -				
Crisis Stabilization - North Inland	$ 8,145,326	$ 3,391,350	$ 3,519,834	$ 1,234,142		
Faith Based Services	$ 1,482,581	$ 1,482,581				
Family Mental Health Education and Support	$ 96,930	$ 96,930				
Home Finder	$ 758,737	$ 758,737				
In-Home Outreach Teams (IHOT)	$ 4,274,248	$ 4,274,248				
Inpatient and Residential Advocacy Services	$ 570,349	$ 570,349				
Institutional Case Mgmt (ICM) - Older Adults	$ 503,021	$ 300,796	$ 1,016	$ 201,208		
Justice System Discharge Planning	$ 927,767	$ 619,767		$ 308,000		
Mental Health Advocacy Services	$ 447,836	$ 447,836				
North Coastal Mental Health Center and Vista Clinic	$ 3,371,940	$ 221,948	$ 2,539,531	$ 610,460		
North Inland Mental Health Center	$ 3,377,693	$ 605,164	$ 1,982,941	$ 789,588		
NPLH BHS	$ 520,936	$ 520,936				
NPLH Dept Pub Works Envir Svcs Unit	$ 27,500	$ 27,500				
NPLH Housing & Community Dev Svcs	$ 1,199,155	$ 1,199,155				
Peer Assisted Support Services	$ 901,995	$ 901,995				
Public Defender - Behavioral Health Assessor	$ 247,173	$ 163,995		$ 83,178		
San Diego Employment Solutions	$ 1,304,760	$ 857,640		$ 447,120		
San Diego Housing Commission	$ 120,000	$ 108,000		$ 12,000		
Short Term Acute Residential Treatment (START)	$ 9,966,050	$ 6,188,799		$ 3,777,251		
Short-Term Bridge Housing	$ 1,199,396	$ 1,199,396				
Supplemental Security Income (SSI) Advocacy Services	$ 502,750	$ 502,750				
Telemedicine	$ 371,296	$ 288,635	$ 82,660			
Tenant Peer Support Services	$ 1,524,360	$ 1,372,758		$ 151,602		
Walk-In Assessment Center	$ 5,510,099	$ 4,745,967	$ 764,132			
Total Non-Full Service Partnership (FSP) Programs	**$ 116,069,293**	**$ 71,225,043**	**$ 18,864,690**	**$ 25,979,560**	**$ -**	**$ -**
CSS Administration	**$ 22,523,270**	**$ 22,523,270**				
CSS MHSA Housing Program Assigned Funds	**$ -**	**$ -**				
Total Community Services and Supports (CSS) Estimated Expenditures	**$ 261,203,154**	**$ 172,678,404**	**$ 52,552,276**	**$ 35,972,474**	**$ -**	**$ -**
FSP Programs as Percent of Total (Includes all funding sources, excludes Admin & Housing)*	**51.4%**					

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

Program Type, Work Plan and Program Name	Fiscal Year 2019-20 A: Estimated Total Mental Health Expenditures	B: Estimated PEI Funding	C: Estimated Medi-Cal FFP	D: Estimated 1991 Realignment	E: Estimated Behavioral Health Subaccount	F: Estimated Other Funding	PEI Category
PEI Programs							
CO-02 Co-Occurring Disorders							EI
Adult Drug Court Treatment and Testing	$ 160,880	$ 96,880		$ 64,000			EI
CO-03 Integrated Peer & Family Engagement	$ 2,546,750	$ 2,296,750		$ 250,000			P
DV-03 Alliance for Community Empowerment	$ 402,200	$ 402,200					P
DV-04 Community Services for Families - Child Welfare Services	$ 502,758	$ 502,758					P
EC-01 Positive Parenting Program (Triple P)	$ 1,106,050	$ 666,050		$ 440,000			P
FB-01 Early Intervention for Prevention of Psychosis (Kick Start)	$ 1,784,763	$ 434,060	$ 640,703	$ 710,000			EI
NA-01 Native American Prevention and Early Intervention (Dream Weaver)	$ 1,754,598	$ 1,056,598		$ 698,000			P
OA-01 Elder Multicultural Access & Support Services (EMASS)	$ 572,283	$ 344,622		$ 227,661			P
OA-02 Home Based Services - For Older Adults (Positive Solutions)	$ 581,743	$ 581,743					P
OA-06 Caregiver Support for Alzheimer & Dementia Patients	$ 1,086,704	$ 1,086,704					P
PS-01 Education and Support Lines							
ACES Prevention and Family Functioning	$ 251,375	$ 251,375					S&D
Breaking Down Barriers (BDB) Initiative	$ 440,208	$ 440,208					S&D
County of San Diego - Community Health Promotion Specialists	$ 620,703	$ 372,422		$ 248,281			P
Family Peer Support Program	$ 199,652	$ 199,652					P
Inreach Services	$ -						P
Mental Health First Aid	$ 502,750	$ 502,750					P
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 2,286,540	$ 2,059,137		$ 227,403			S&D
Suicide Prevention Action Plan	$ 502,750	$ 502,750					SP
Supported Employment Technical Consultant Services	$ 251,634	$ 251,634					P
RC-01 Rural Integrated Behavioral Health and Primary Care Services	$ 1,402,673	$ 1,402,673					EI
RE-01 Independent Living Association (ILA)	$ 301,650	$ 301,650					O
SA-01 School Based Prevention and Early Intervention	$ 6,334,650	$ 6,334,650					P
SA-02 School Based Suicide Prevention & Early Intervention (Here Now)	$ 1,809,900	$ 1,809,900					SP
VF-01 Veterans & Family Outreach Education (Courage to Call)	$ 1,287,040	$ 1,287,040					A
Total Prevention and Early Intervention (PEI) Programs	**$ 26,690,253**	**$ 23,184,205**	**$ 640,703**	**$ 2,865,346**	**$ -**	**$ -**	
PEI Administration	**$ 3,477,631**	**$ 3,477,631**					
PEI Assigned Funds	**$ 400,000**	**$ 100,000**	**$ -**	**$ 300,000**	**$ -**		
Total Prevention and Early Intervention (PEI) Estimated Expenditures	**$ 30,567,884**	**$ 26,761,835**	**$ 640,703**	**$ 3,165,346**	**$ -**	**$ -**	
Percentage of PEI Funding Assigned to Clients <25 Years of Age	**58.9%**						

PEI CATEGORIES:

A - Access to Treatment
EI - Early Intervention
O - Outreach
P - Prevention
S&D - Stigma & Discrimination Reduction
SP - Suicide Prevention
Individual programs may serve more than one area. Categories above are primary PEI categories

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2019-20							
	A	B	C	D	E	F	Approval Dates	
Innovation Cycle and Program Name	**Estimated Total Mental Health Expenditures**	**Estimated INN Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**	**Board of Supervisors Approval Date**	**MHSOAC Approval Date**
INN Programs (Cycle 3)								
INN-12 Family Therapy Participation	$ -						10/28/2014	2/26/2015
INN-13 Faith Based Initiative	$ -						10/28/2014	2/26/2015
INN-14 Ramp Up to Work (Noble Works)	$ -						10/28/2014	2/26/2015
INN-15 Peer Assisted Transitions	$ 55,878	$ 55,878					10/28/2014	2/26/2015
INN-16 Urban Beats	$ 970,144	$ 970,144					10/28/2014; 4/25/17; 10/10/17; 6/19/18	2/26/2015; 10/26/17; 12/15/17
INN-17 Mobile Hoarding Intervention Program (CREST)	$ 1,320,075	$ 1,320,075					10/28/2014; 4/25/17; 10/10/17; 6/19/18	2/26/2015; 10/26/17; 12/15/17
INN Programs (Cycle 4)								
INN-18 Peripartum Program	$ 1,069,349	$ 1,069,349					4/25/2017	Pending
INN-19 Telemental Health	$ 1,129,266	$ 1,129,266					4/25/2017	10/26/2017
INN-20 ROAM Mobile Services	$ 1,890,635	$ 1,890,635					4/25/2017	5/25/2027
INN-21 ReST Recuperative Housing	$ 1,070,515	$ 1,070,515					4/25/2017	5/25/2027; 2/23/18
INN-22 Medication Clinic	$ 1,984,308	$ 1,933,434	$ 50,874				4/25/2017	5/25/2017
INN-23 Human Centered Design	$ -						9/25/2018	4/26/2018
INN-24 Early Psychosis Evaluation and Learning Health Care Network	$ 228,397	$ 228,397					11/13/2018	12/17/2018
Total Innovation (INN) Programs and Evaluation	**$ 9,718,566**	**$ 9,667,692**	**$ 50,874**	**$ -**	**$ -**	**$ -**		
INN Administration	**$ 1,450,154**	**$ 1,450,154**						
Total Innovation (INN) Estimated Expenditures	**$ 11,168,719**	**$ 11,117,846**	**$ 50,874**	**$ -**	**$ -**	**$ -**		

Up to 5% for evaluation for each INN program is included in INN evaluation contract.

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

Program Type, Work Plan and Program Name	Fiscal Year 2019-20					
	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						
WET-02 Training & Technical Assistance						
Behavioral Health Training Curriculum (BHTC)	$ 1,069,762	$ 1,069,762				
Cultural Competency Academy	$ 219,667	$ 219,667				
Training and Technical Assistance	$ 525,825	$ 525,825				
WET-03 Mental Health Career Pathway Programs						
Consumer & Family Academy	$ 241,266	$ 241,266				
Public Mental Health Academy	$ 75,413	$ 75,413				
WET-04 Residency and Internship Program						
Community Psychiatry Fellowship	$ 1,457,975	$ 1,457,975				
Total Workforce Education and Training (WET) Programs	**$ 3,589,906**	**$ 3,589,906**	**$ -**	**$ -**	**$ -**	**$ -**
WET Administration*	**$ -**	**$ -**				
Total Workforce Education and Training (WET) Estimated Expenditures	**$ 3,589,906**	**$ 3,589,906**	**$ -**	**$ -**	**$ -**	**$ -**

*WET programs do not have Administrative costs

FY 2019-20 Annual Update Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

Program Type, Work Plan and Program Name	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Capital Facilities (CF) Projects						
CF-2 North County Mental Health Facility	$ 186,658	$ 186,658				
CF-4 North Inland Crisis Residential Facility	$ 10,000	$ 10,000				
CF-5 Emergency Screening Unit (ESU) Facility	$ 10,000	$ 10,000				
Technological Needs (TN) Projects						
SD-3 Personal Health Record	$ 62,000	$ 62,000				
SD-5 Telemedicine	$ -					
SD-6 Management Information System (MIS) Expansion	$ 22,836	$ 22,836				
SD-8 Data Exchange (Interoperability)	$ 6,000	$ 6,000				
SD-9 Financial Management System	$ 5,000	$ 5,000				
Total Capital Facilities (CF) and Technological Needs (TN) Programs	**$ 302,494**	**$ 302,494**	**$ -**	**$ -**	**$ -**	
CFTN Administration	**$ 45,374**	**$ 45,374**				
TotalCapital Facilities (CF) and Technological Needs (TN) Estimated Expenditures	**$ 347,868**	**$ 347,868**	**$ -**	**$ -**	**$ -**	**$ -**

Appendix B
CERTIFICATIONS AND MINUTE ORDER

Pending approval by the San Diego County Board of Supervisors

Appendix C
MHSA Program Summaries

Community Services and Support (CSS)

Acronym	Name
MHSA Work Plan	Work Plan Name
ALL-OE	Outreach & Engagement for All Ages
ALL-SD	System Development for All Ages
CY-FSP	Full Service Partnerships for Children & Youth
CY-OE	Outreach & Engagement for Children & Youth
CY-SD	System Development for Children and Youth
TAOA-FSP	Full Service Partnerships for Ages 18-65+
TAOA-OE	Outreach & Engagement for Ages 18-65+
TAOA-SD	System Development for Ages 18-65+

Prevention and Early Intervention (PEI)

Acronym	Name
MHSA Work Plan	Work Plan Name
CO-02	Adult Drug Court
CO-03	Integrated Family Engagement
DV-03	Community Violence Services
DV-04	Point of Engagement
EC-01	Positive Parenting Program
FB-01	Early Intervention for Prevention of Psychosis
NA-01	Native American Prevention and Early Intervention
OA-01	Elder Multicultural Access & Support Services
OA-02	Home Based Services
OA-06	Caregiver Support
PS-01	Education and Support Lines
RC-01	Rural Integrated Care
RE-01	Independent Living Association
SA-01	School Based Program
SA-02	School Based Prevention
VF-01	Veterans & Family Outreach

Innovation (INN)

Acronym	Name
MHSA Work Plan	Work Plan Name
INN-15	Peer Assisted Transitions
INN-16	Urban Beats

INN-17	Cognitive Rehabilitation and Exposure/Sorting Therapy (CREST) Mobile Hoarding Units
INN-18	Peripartum Program
INN-19	Telemental Health
INN-20	Roaming Outpatient Access Mobile (ROAM) Services
INN-21	Recuperative Services Treatment (ReST) Recuperative Housing
INN-22	Medication Clinics (Center for Child and Youth Psychiatry)
INN-23	Human Centered Design
INN-24	Early Psychosis Evaluation

Workforce, Education and Training (WET)

Acronym	Name
MHSA Work Plan	Work Plan Name
WET-02	Training & Technical Assistance
WET-03	Mental Health Career Programs
WET-04	Residency and Internship Program

Technological Needs (TN)

Acronym	Name
MHSA Work Plan	Work Plan Name
SD-3	Personal Health Record
SD-6	Management Information Systems Expansion
SD-8	Data Exchange
SD-9	Financial Management System

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
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

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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)	TBD	TBD	TBD	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

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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

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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 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	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	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	4
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 Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118 North County Lifeline Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900	3, 5

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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)	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 homeless 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
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

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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 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 homeless children, youth and their families	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-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)	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 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	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	San Ysidro Health Center Youth Enhancement Services 3025 Beyer Blvd., Suite E-101 San Diego, CA 92154 (619) 428-5533	1
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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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	TBD	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
CY-OE	Parent Partner Services	Family/Youth Support Partnership Services	TBD	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	TBD	4

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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	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 up to 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	TBD	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	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	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 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.	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 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	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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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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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 as-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults 18-59 who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co-occurring condition of substance use in the Central and North Central Regions of San Diego	• Linkage to food, housing and/or physical health services • Medication management •Vocational services • Substance use disorder services • Includes housing component	IMPACT 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156 Downtown IMPACT 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156	1, 4
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, 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

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TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Project One-for-All POFA - South Region (100 SMI Slots) Housing	Full Service Partnership Assertive Community Treatment team and recovery services Program will use a "Housing First" approach	Ensure clients are provided access to good quality housing in the South Region of San Diego County	Transition Age Youth, adults 18 and older who are homeless, have serious mental illness and who may have a co-occurring diagnoses of substance abuse	• Supportive Housing	Community Research Foundation (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 398-0355	1
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

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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
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

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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
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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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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

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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
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

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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
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

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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
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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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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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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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 mental illness	• 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

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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	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
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 curriculumn 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 copping 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 curriculumn 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 ad 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 habilitative 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 habilitative 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 habilitative 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 habilitative 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 evidenced 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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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	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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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

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Work Plan	RER Program Name	Program Name	Program Description	Program Goal	Population Focus	Services Offered	Contact Information	Districts
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
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

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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
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 its 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 • 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 2019-2020
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 • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Indian Health Council, Inc. 50100 Golsh Road Valley Center, CA 92082 (760) 749-1410	2, 5
INN-20	ROAM Mobile Services	Roaming Outpatient Access Mobile Services (ROAM) - Southern Indian Health Council	Mobile clinics provide culturally appropriate mental health services in rural areas	Increase access to and usage of mental health services through deployment of cultural brokers in mobile clinics on tribal lands	Native Americans in rural areas of San Diego County in the East Regions	• Outreach and engagement • Telemedicine • Counseling and clinic services • Telemedicine • Traditional interventions via cultural brokers	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
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 2019-2020
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	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- one for adult psychiatry residents and fellows and the second for child and adolescent psychiatry residents and fellows. 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	TBD	The Cultural Competency Academy will provide awareness, knowledge, and skill based trainings that focus on clinical and recovery interventions for multi-cultural populations while ensure in that all trainings focus on being trauma informed from environmental to clinical applications	TBD	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

MHSA Program Summaries Fiscal Year 2019-2020
Technological Needs (TN)

Work Plan	RER Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-3	Personal Health Record	Personal Health Record	The Personal Health Record embedded in the InteliChart Patient Portal enables patients to both securely view and update their records in a timely manner	Children, Transition Age Youth, Adults/Older Adults	• PHR is constructed from patients existing behavioral health medical record. InteliChart provides and supports mobile apps that enable patients to make appointments, view lab results, and securely communicate with their healthcare providers conveniently using mobile technology	Cerner Corporation 2800 Rockcreek Pkwy. North Kansas City, MO 64117 (816) 201-1989	All
SD-5	Telemedicine	Community Research Foundation-Crossroads	Provides technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Utilizing telemedicine for psychiatry services by offering: Video conferencing, secure email, phone consultation	Community Research Foundation Crossroads Family Center 1679 E. Main St., Suite 102 El Cajon, CA 92021 (619) 441-1907	2
SD-5	Telemedicine	Community Research Foundation-Douglas Young	Provides technological support for telemedicine at Douglas Young Youth and Family Services Outpatient Children's Mental Health Services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance criteria	• Utilizing telemedicine for psychiatry services by offering: Video conferencing, secure email, phone consultation	Community Research Foundation 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0822	3, 4
SD-5	Telemedicine	Community Research Foundation-Mobile Adolescent Service Team (MAST)	Provides technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Utilizing telemedicine for psychiatry services by offering: Video conferencing, secure email, phone consultation	Community Research Foundation Mobile Adolescent Services Team 1202 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-3261	All
SD-5	Telemedicine	Community Research Foundation-Nueva Vista	Provides technological support for telemedicine for youth and children receiving outpatient mental health services	Children and youth up to age 21 who meet medical necessity and serious emotional disturbance (SED) criteria	• Utilizing telemedicine for psychiatry services by offering: Video conferencing, secure email, phone consultation	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	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	• Clinic services supported: Outpatient mental health services, case management, and substance use disorder services are provided for deaf and hard of hearing adults	Deaf Community Services of San Diego, Inc 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Heartland Bio-Psychosocial Rehabilitation WRC	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder. Includes Probation-funded AB 109 component	• Clinic services supported: Outpatient mental health clinic providing 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	Community Research Foundation Heartland Center 460 N. Magnolia Ave. El Cajon, CA 92020 (619) 440-5133	2
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at South Region Biopsychosocial Rehabilitation Wellness Recovery Center	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 AB109 component	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults 18 years and older Transition Age Youth & AB109 who have serious mental illness, including those who may have a co-occurring substance use disorder	Community Research Foundation Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1

MHSA Program Summaries Fiscal Year 2019-2020
Technological Needs (TN)

Work Plan	RER Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	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, AB109	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, recovery, and SBCM services to adults 18 years and older	Community Research Foundation South Bay Guidance Wellness and Recovery Center 835 3rd Ave., Suite C Chula Vista, CA 91911 (619) 427-4661	1
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Union of Pan Asian Communities	Monolingual and/or limited English proficient Asian/Pacific Islander adults 18 years and older with a serious mental illness who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient case management, vocational support services for indigent clients with a serious mental illness	Union of Pan Asian Communities Mid-City 5348 University Ave., Suites 101 & 120 San Diego, CA 92105 (619) 229-2999 Serra Mesa 8745 Aero Dr., Suite 330 San Diego, CA 92123 (619) 268-0244	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at North Central Region Adult/Older Adult Bio- Psychosocial Rehabilitation Wellness Recovery Center	Children, Transition Age Youth, Adults/Older Adults	• Clinic services supported: Outpatient mental health rehabilitation and recovery services, an urgent walk- in component, case management; and long-term vocational support	Community Research Foundation Douglas Young Center 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	3, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Project Enable	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Stabilization and recovery services with the expectation that with treatment, clients will effectively recover and graduate from the program	Neighborhood House Association 286 Euclid Ave., Suite 102 San Diego, CA 92114 (619) 266-9400	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services	Southeast Mental Health Center 3177 Ocean View Blvd. San Diego, CA 92113 (619) 595-4400	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	•Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older	Mental Health Systems, Inc. North Coastal Mental Health Center 1701 Misson Ave. Oceanside, CA 92058 (760) 967-4475 Vista 550 West Vista Way, Suite 407 Vista, CA 92083 (760) 758-1092	4

MHSA Program Summaries Fiscal Year 2019-2020
Technological Needs (TN)

Work Plan	RER Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an outpatient psychiatric medication services clinic	Children, Transition Age Youth, Adults/Older Adults	• Clinic services supported: Outpatient psychiatric medication services to consumers utilizing Telehealth practices and technology	Exodus Recovery, Inc. 524 W. Vista Way Vista, CA 92083 (760) 758-1150 1520 S. Escondido Blvd. Escondido, CA 92025 (760) 871-2020	3, 5
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Walk-in Outpatient mental health assessments and psychiatric consultation, medication management services; crisis intervention, and case management brokerage	Community Research Foundation, Jane Westin Wellness & Recovery 1045 9th Ave. San Diego, CA 92101 (619) 235-2600	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services	East County Mental Health Center 1000 Broadway, Suite 210 El Cajon, CA 92021 (619) 401-5500	2
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services, including those who may have a co-occurring substance use disorder	North Central Mental Health Clinic 1250 Morena Blvd. San Diego, CA 92110 (619) 692-8750	4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at short-term, acute residential treatment clinics	Voluntary adults who have a serious mental illness, including those who may have a co-occurring substance use disorder, are experiencing a mental health crisis and in need of intensive, non-hospital intervention	• Clinic services supported: 24-hour, 7-day a week 365 day a year crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have a co-occurring substance use conditions, and are residents of San Diego County	Vista Balboa 545 Laurel Ave. San Diego, CA 92101 (619) 233-4399 New Vistas 734 10th Ave. San Diego, CA 92101 (619) 239-4663 Halcyon 1664 Broadway El Cajon, CA 92021 (619) 579-8685 Turning Point 1738 S. Tremont St. Oceanside, CA 92054 (760) 439-2800 Jary Barreto 2865 Logan Ave. San Diego, CA 92113 (619) 232-4357 Del Sur (formerly ISIS) 892 27th St. San Diego, CA 92154 (619) 575-4687	All

MHSA Program Summaries Fiscal Year 2019-2020
Technological Needs (TN)

Work Plan	RER Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Areta Crowell	Adults 18 years and older who have a serious mental illness	• Clinic services supported: Outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support, including those who may have a co-occurring substance use disorder	Community Research Foundation Areta Corwell Center 1968 4th Ave. San Diego, CA 92101 (619) 233-3432	1, 4
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at North Inland Crisis Residential	Voluntary adults 18 years and older with acute and a serious mental illness including those who may have a co-occurring substance use disorder and are residents of San Diego County	• Clinic services supported: Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9939	All
SD-5	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at an adult outpatient mental health clinic, including video, secure email, and phone consultation	Transition Age Youth, Adults/Older Adults, including those who may have a co-occurring substance use disorder	• Clinic services supported: Outpatient mental health clinic providing treatment, rehabilitation, and recovery services to adults 18 years and older	Mental Health Systems, Inc. North Inland Mental Health Center 125 W. Mission Ave., Suite 103 Escondido, CA 92025 (760) 747-3424 Kinesis Wellness & Recovery Center 474 W. Vermont Ave., Suite 101 Escondido, CA 92025 (760) 480-2255 Fallbrook Satellite 1328 S. Mission Rd. Fallbrook, CA 92028 (760) 451-4720 Ramona Satellite 1521 Main St. Ramona, CA 92065 (760) 736-2429	3, 5
SD-6	Management Information System (MIS) Expansion	Road Map into the Millennium	This project integrates the core information system, Cerner Community Behavioral Health (CCBH), used by virtually all providers in the extended system of care, including all clinical and billing information, into the grand scale Cerner Millenium application	The main users of the system will be County of San Diego employees, County Service Providers, Administrative Support Organizations (ASO's) and Fee For Service Providers	• BHS has developed a master plan to implement Cerner Millennium on a San Diego County domain hosted by Cerner. This domain will contain Millennium for all of BHS including the San Diego County Psychiatric Hospital, Outpatient Services, and Edgemoor for long term care. BHS will roadmap Cerner Community Behavioral Health (CCBH) into the Cerner Millennium product as part of this effort as CCBH will sunset and become fully integrated into Millennium by 2024	Cerner Corporation 2800 Rockcreek Pkwy. North Kansas City, MO 64117 (816) 201-1989	All
SD-6	Telemedicine	Telepsychiatry	Provides technological support for telemedicine at Esperanza Center	Voluntary adults 18 years and older with acute and a serious mental illness including those who may have a co-occurring substance use disorder and are residents of San Diego County	•Clinic services supported: Crisis residential services as an alternative to hospitalization or step down from acute in-patient care within a hospital, including those who may have a co-occurring substance use conditions	Community Research Foundation 490 N. Grape St. Escondido, CA 92025 (760) 975-9940	4

MHSA Program Summaries Fiscal Year 2019-2020
Technological Needs (TN)

Work Plan	RER Program Name	Program Name	Program Description	Population Focus	Services Offered	Contact Information	Districts
SD-8	Data Exchange (Interoperability)	Data Exchange (Interoperability)	The project offers a unique opportunity to link behavioral health data with disparate systems to build an integrated longitudinal health record. This information will become available at the point of care to increase communication and coordination and to improve efficiencies, continuity, and quality of care and patient health outcomes. All data sharing will be planned and implemented in compliance with HIPAA privacy and security requirements. Interoperability ensures that health-related information flows seamlessly from system to system. It requires technology to exchange key pieces of health information securely. The goal is obtaining and sharing the right information in the right context	All	• Data sets include everything from lab test results, vital signs, and blood pressure readings, to patient demographic information, discharge instructions for hospitals, and provider contact information. Information follows the client regardless of geographic, organizational, or vendor boundaries. Specifically, Interoperability refers to the architecture or standards that make it possible for diverse electronic health record (EHR) systems to work compatibly in a true information network	N/A	All
SD-9	BHS Financial Management System	Financial Management System	The Financial Management System will ensure operational efficiency and cost effectiveness in mental health administration by creating a centralized financial system capable of day-to-day budget management, year-to-date revenue and expenditure monitoring, contract tracking and business analytics tools, including standard reporting, dashboards and queries	The business areas and programs served including the following: Registration/ Administration; Service Recording; Electronic Health Record; Medi-Cal Billing; Other Billing; Managed Care Functionality	• This system will streamline financial data collection and reporting, including potentially assisting with the annual Mental Health Services Act Revenue & Expenditure Report (RER), maintain the integrity of data with system securities and prevent duplication of effort to ensure resources are fully maximized	County Information Technology Behavioral Health Services 3255 Camino del Rio South. San Diego, CA 92120 (619) 563-2700	All

Appendix D
MHSA Justice Involved Programs

Population Served	*Program Name and Description*	*FY 2019-20 MHSA Annual Update 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.	$ 9,377,617	CSS
Youth	The **Bridgeways** program is a newly redesigned juvenile justice program that provides comprehensive services to address the behavioral health needs of justice involved youth or youth at risk of justice involvement. The program provides outpatient clinical services, field supportive services, and institutional services with the primary goal of establishing a unified continuum of care that allows for coordination of services within and outside the detention facilities.	$ 560,000	CSS
Youth	The **County of San Diego Juvenile Forensics** team provides mental health and case management services to children and youth in juvenile detention facilities to ensure they are able to successfully reintegrate into the community and to reduce recidivism.	$ 1,100,000	CSS
Youth	**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	**Drug Court/Reentry Court** is an outpatient substance use disorder (SUD) treatment, case management and drug testing program that provides services to adult offenders who have been referred to Re-Entry Court Services Program.	$ 160,000	PEI
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		**$ 36,833,716**	

*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.

FY 2019-20

Appendix E
MHSA Prudent Reserve Assessment

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: San Diego County

Fiscal Year: FY 2019-20

Local Mental Health Director

Name: Luke Bergmann, Ph.D.

Telephone: 619-515-6923

Email: Luke.Bergmann@sdcounty.ca.gov

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Luke Bergmann — 6/19/19

Local Mental Health Director (PRINT NAME) | Signature | Date

[1] Welfare and Institutions Code section 5892 (b)(2)

COUNTY OF SAN DIEGO

HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Fiscal Year 2019-20 Five Year Prudent Reserve Assessment

Behavioral Health Services

6/18/2019

INTRODUCTION

Pursuant to Senate Bill (SB) 192 (Chapter 328, Statutes 2018) and the Department of Health Care Services (DHCS) MHSUDS Information Notice 19-017, *Mental Health Services Act: Implementation of Welfare and Institutions (W&I) Code Sections 5892 and 5892.1*, each county must establish a prudent reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) component revenue of the Mental Health Services Act (MHSA) funds received in the preceding five years. The prudent reserve level must be reassessed every five years and the county must certify the reassessment as part of the Three-Year Program and Expenditure Plan or Annual Update required pursuant to section 5847.

Each county must electronically submit its calculation of the maximum prudent reserve level and submit a completed MHSA Prudent Reserve Assessment/Reassessment (DHCS 1819 (10/18)) (Enclosure 1) form to DHCS at MHSA@dhcs.ca.gov and MHSOAC at MHSOAC@mhsoac.ca.gov, by June 30, 2019, and include the signed form in the FY 2019-20 Annual Update.

DHCS previously released guidance to counties regarding prudent reserve funding levels through MHSUDS Information Notice 18-033. The notice required counties to maintain a prudent reserve balance that did not exceed 33 percent of the largest MHSA distribution in a fiscal year. In addition, a county that maintained an amount larger than the 33 percent level was not required to transfer money out of the prudent reserve, but could not transfer additional funds into the prudent reserve until its balance was below the 33 percent level. DHCS will no longer enforce the maximum prudent reserve level requirements described above and in MHSUDS Information Notice 18-033.

FY 2019-20 METHODOLOGY AND ASSESSMENT

To comply with the new requirements, each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS component over the last five years, or FYs 2013-14, 2014-15, 2015-16, 2016-17, and 2017-18. To determine the average amount allocated to the CSS component over those five fiscal years, a county must calculate the sum of all MHSA distributions between July 2013 and June 30, 2018, multiply that sum by 76 percent, the revenue allocation to the Community Services and Supports (CSS) component, and divide that product by five. See the result in the table below.

FY 2018-19 MHSA Prudent Reserve Balance		
Component	*Prudent Reserve Balance*	*% to Component*
Community Services and Supports (CSS)	$ 33,666,025	79.79%
Prevention and Early Intervention (PEI)	$ 8,527,095	20.21%
Total	**$ 42,193,120**	**100.00%**

If the amount of money in a county's prudent reserve exceeds the 33 percent maximum level, the county must decrease its prudent reserve funding level to meet the 33 percent maximum level by June 30, 2020. Based on this guidance, the minimum and maximum balances allowed for the County of San Diego are as follows:

Actual MHSA Revenue Received Through FY 2017-18		
FY	*Total MHSA Revenue Received*	*76% CSS Allocation*
2013-14	$99,885,353	$75,912,868
2014-15	$139,163,806	$105,764,492
2015-16	$116,270,664	$88,365,704
2016-17	$149,844,250	$113,881,630
2017-18	$162,263,869	$123,320,541
5 Year Average	**$133,485,588**	**$101,449,047**
33% Max Prudent Reserve		**$33,478,186**
23% Minimum Prudent Reserve		**$23,333,281**

In FY 2018-19, the County's prudent reserve exceeds the 33 percent requirement. Therefore, in FY 2019-20, the County will transfer funds from the prudent reserve to CSS and PEI components at a level proportional to the amount the County transferred from the CSS component to the prudent reserve through FY 2018-19 and PEI component to the prudent reserve in FY 2007-08 as follows:

FY	*Using 76% CSS Allocation*
Total Amount to Redistribute	**$8,714,934**
To CSS Component 79.79%	$6,953,674
To PEI Component 20.21%	$1,761,260

This transfer of funds from the prudent reserve to the CSS component and PEI component is reflected in the FY 2019-20 MHSA Annual Update to the Three-Year Program and Expenditure Plan and will be reported in the FY2019-20 MHSA Annual Revenue and Expenditure Report.

REVERSION

Funds transferred from the prudent reserve to the CSS component and PEI component are subject to reversion. The applicable reversion period for these funds begins in the fiscal year when the county transferred the funds from the prudent reserve to the CSS component and PEI component. In this instance, the applicable fiscal year is FY 2019-20.

FUTURE REASSESSMENT

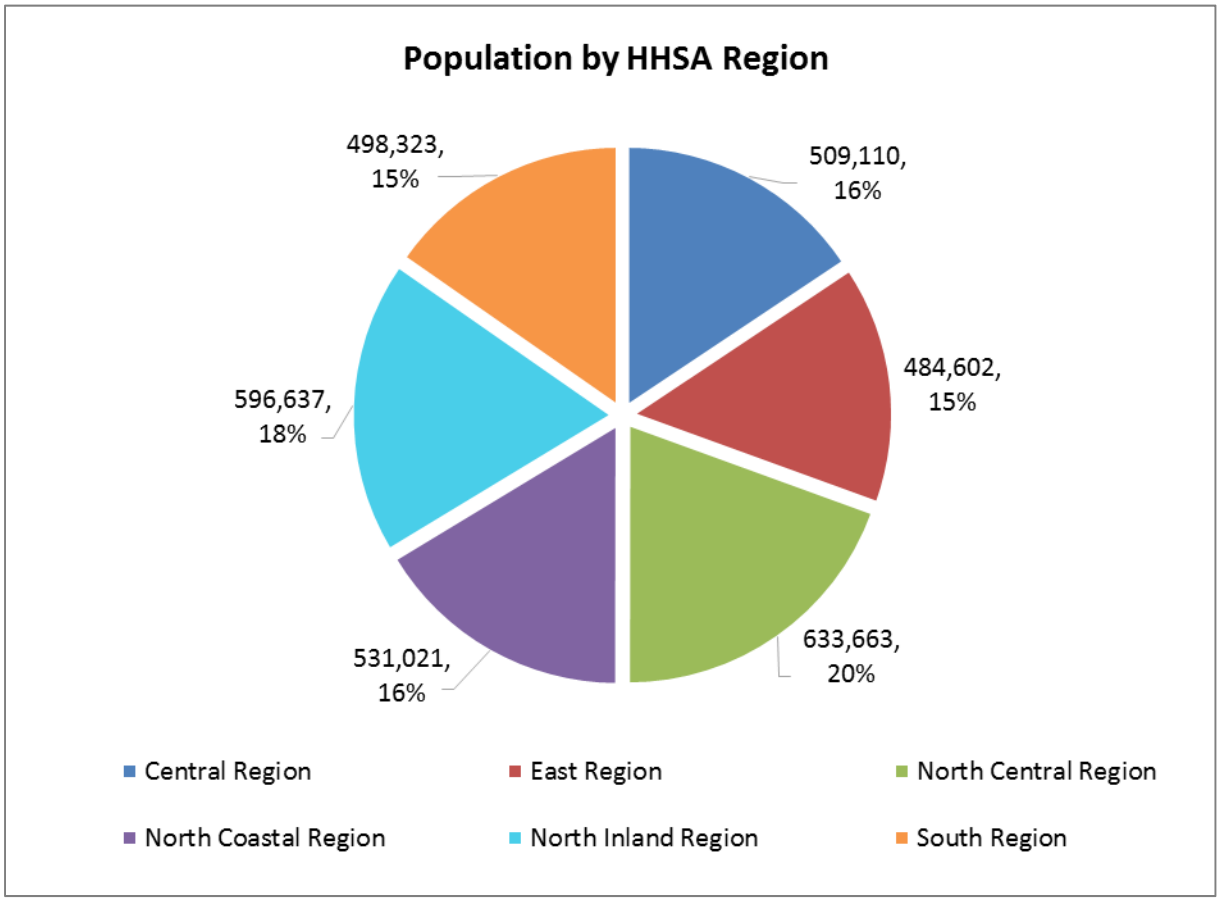
Each county must reassess its maximum prudent reserve funding level every five years. To reassess the maximum prudent reserve funding level, counties must complete the MHSA Prudent Reserve Assessment/Reassessment (DHCS 1819 (10/18)) form and submit it to DHCS and MHSOAC by June 30, 2024, as part of the FY 2024-25 three-year program and expenditure plan or annual update.

Appendix F
County of San Diego Demographics

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	19%
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

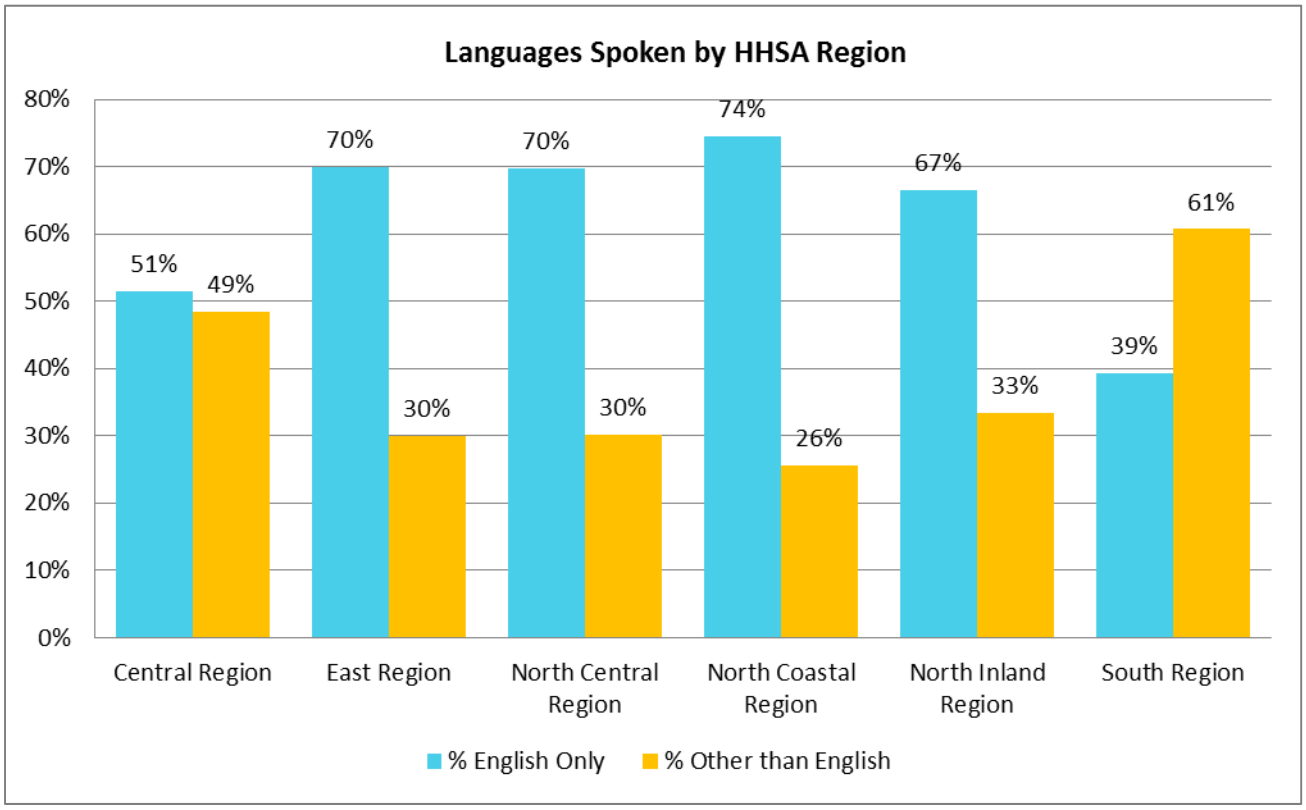
RACE/ETHNICITY

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 (5 YEARS OLD AND GREATER)

HHSA Region	*Total Population 5 Years Old and Greater*	*English Only (5 Years Old and Greater)*	*% English Only*	*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**	

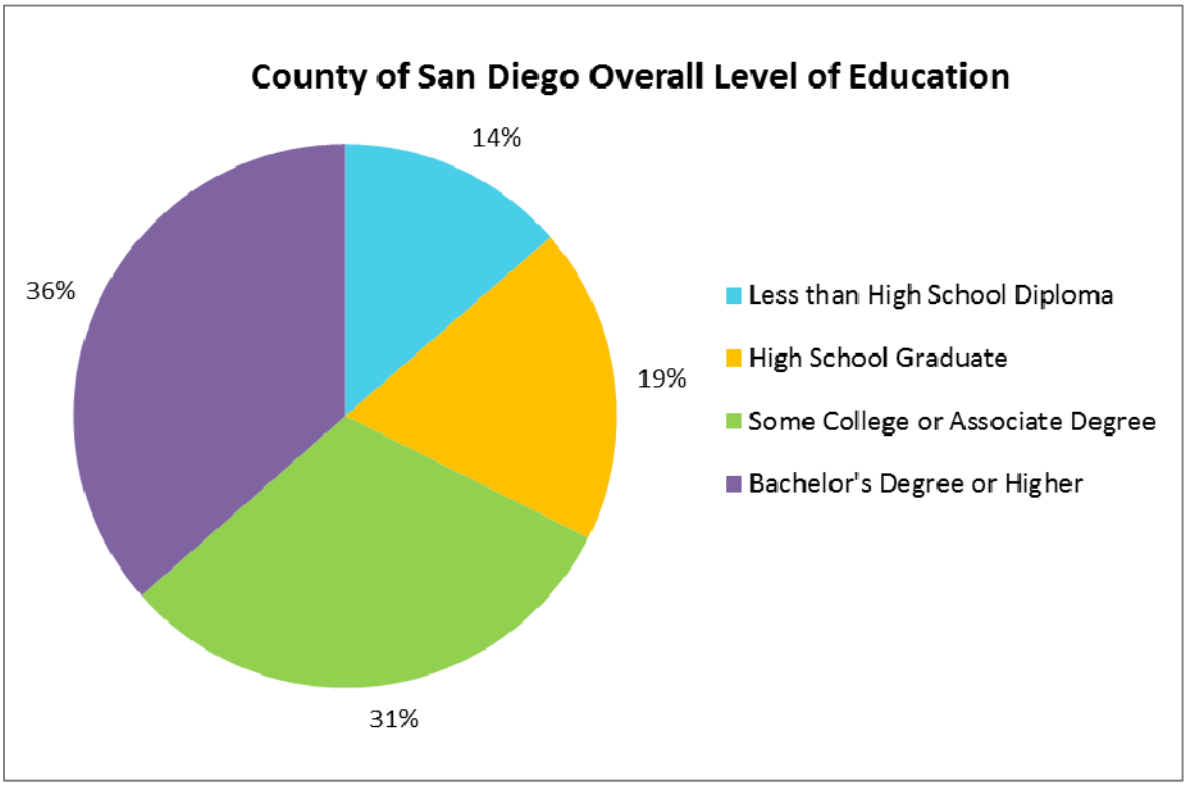


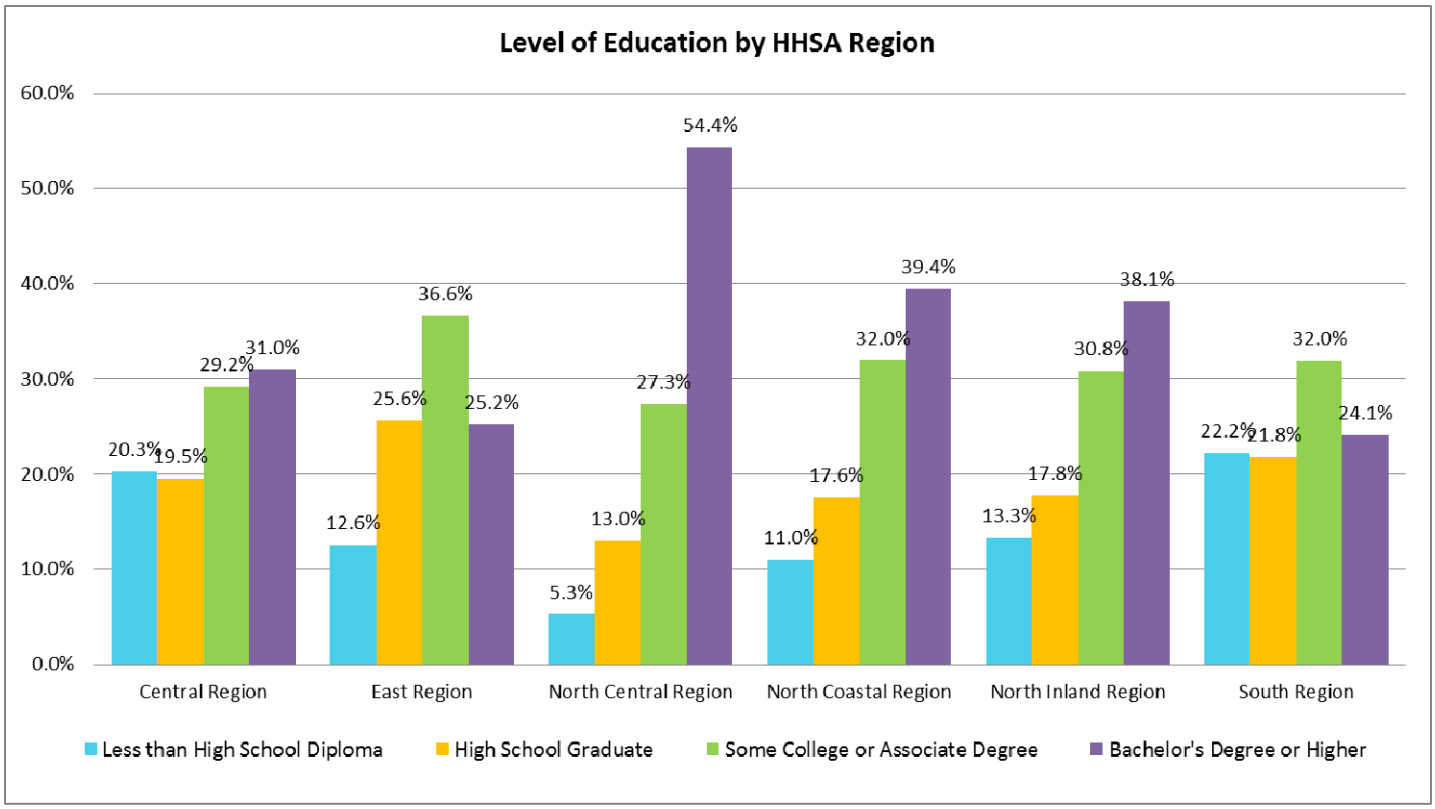
Source: Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

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%

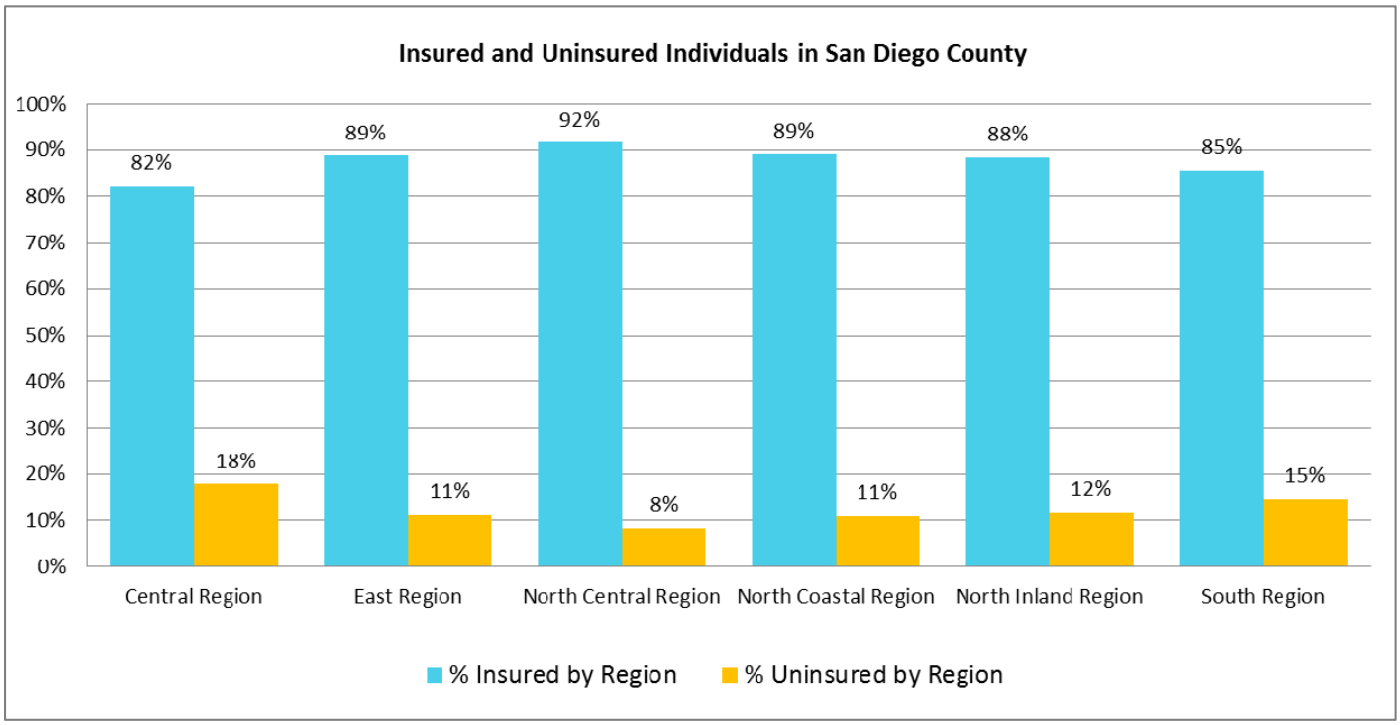




Source: Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

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

Appendix G

Community Engagement Report 2018

County of San Diego
Health and Human Services Agency
Behavioral Health Services
Community Engagement Report
2018

Reported by

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

January 2019

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Executive Summary

County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) offers a wide range of substance use and mental health services to the county's 3.3 million residents. BHS is committed to improving the well-being of the San Diego County community and to offering services that are responsive to community needs.

Each year, BHS undertakes a community engagement process, as required by the Mental Health Services Act, to solicit in-depth feedback from community members about perceived gaps in services and ideas for new services. This feedback then informs the development of new programs and the modification of existing programs. The needs of unserved and underserved populations are at the center of the process, which further aligns with *Live Well San Diego* goals and values.

For the 2018 community engagement process, BHS contracted with the Institute for Public Health (IPH) at San Diego State University to coordinate and facilitate the community dialog. IPH conducted nine community forums, two focus groups, and an online and paper-and-pencil community survey between September and December 2018.

The nine forums included six general forums that focused on: (1) services for people experiencing a mental health crisis; (2) substance use among youth and young adults; and (3) school violence. Three forums were innovation focused and designed to develop new approaches. Of the three Innovation forums, one focused on homelessness; the second focused on mental health disorders that co-occur with developmental delays; and the third was an open forum for participants to brainstorm about any behavioral health topic. In addition to the nine forums, two focus groups targeted specific populations: (1) peer support workers; and (2) formerly incarcerated individuals who had been diagnosed with mental illness.

A total of 307 people attended forums. Eighteen people participated in focus groups, and 285 people completed the community survey for a total of **610 unique points of engagement**. Participants were actively involved in the events and expressed a high degree of satisfaction with the engagement process.

Several themes recurred across each engagement event. San Diegans identify **prevention** efforts as key to improving mental health and decreasing mental health crises, substance use disorders, school violence, and homelessness. Efforts need to include community engagement and recreation in addition to meeting people's basic needs for stable housing, food, and employment. Wellness classes and education, and trauma-informed care for children are essential, as is the provision of urgent care services before a crisis strikes. Finally, all community members need to be better informed about signs and symptoms of mental illness and substance use, risk factors for violence, and how to report and respond in an effective manner.

Next, community members appreciate existing services and prioritize the **expansion** of services, particularly Psychiatric Emergency Response Teams (PERT) and inpatient psychiatric care. These

valuable services need to be easily accessible 7 days-a-week, 24 hours-a-day. Barriers to access, such as transportation and childcare, were described as essential for expansion.

A third theme, better care **coordination,** was identified as an important step to avoid the fragmentation of professional "silos." Appropriate transitional care after a crisis was noted as particularly challenging. Forum participants offered two primary ways to improve care coordination: 1) through the creation of "one-stop" resource centers and 2) through further cross-disciplinary educational and networking opportunities.

Finally, a recurring theme across engagement events was that programs need to be more **culturally and linguistically competent.** Ideally, programs should be **community-based**. Stakeholders recognize the diversity of San Diego's population. The design and implementation of programs that are relevant to and effective for people from all different backgrounds is critically important.

IPH staff were impressed by and appreciative of community members' willingness to give their time and openly discuss their experiences. The collective feedback and insights are valuable for helping prioritize and modify future programming.

Annual Results Comparison

Comparing results from the past three years (2016, 2017, and 2018), several similarities were apparent. Care Coordination was prioritized in each year, although different aspects were emphasized. In 2016, the community identified seamless integration of care across systems. In 2017, system simplification and stronger case management services were underlined. In the current report, the feedback highlighted crisis transitional care, one-stop access, and cross-discipline training.

Cultural Competency was another theme that was prioritized in all three years. Similar aspects were emphasized, including the preference for services based within neighborhoods. In this report, linguistic competence was identified as a priority component of Cultural Competency. Inclusion of peer service providers was a shared theme in each report.

For a full chart of priorities for each of the past three years and a list of similarities, differences, and trends, see page 25 in the Results section.

Introduction

The County of San Diego Health and Human Services Agency (HHSA) is committed to making recovery possible for people with mental illness and substance use disorders. Through the provision of prevention, treatment, and intervention services, BHS strives to improve the well-being of San Diego County's 3.3 million residents.

BHS offers 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.

One requirement of MHSA is for counties to gather feedback from community stakeholders through a Community Program Planning process. For BHS, a key component of this planning process is to facilitate annual community engagement events during which community members can discuss challenges related to behavioral health services in San Diego. BHS emphasizes identifying and prioritizing the needs of underserved populations. The process examines gaps in services across the continuum of care and on the generation of innovative solutions.

In addition to meeting MHSA requirements, this community engagement process aligns with San Diego County's *Live Well San Diego* vision of "building better health, living safely, and thriving" and with the HHSA 10-Year Road Map for BHS that was based on feedback from previous community engagement efforts.

Insights from the community are used to inform the development of new programs and services and to improve those that already exist. In 2018, for example, substance use disorder treatment was substantially expanded when the County of San Diego opted into the statewide waiver for the Drug Medi-Cal Organized Delivery System (DMC-ODS). Community insights about the need for more services was an important consideration.

Programs such as the Psychiatric Emergency Response Team (PERT), which pairs law enforcement and mental health professionals to respond to people in crisis, are a direct result of ideas gathered during this process. The PERT program was expanded last year to 70 teams, guided in part by community feedback. Other modifications with a genesis in the Community Program Planning process include: (1) the Emergency Screening Unit for youth was moved to a central location to provide easier access; (2) the number of long-term care beds available for people suffering from mental illness was increased; (3) Urban Beats, an expressive arts program for Transition Age Youth (TAY), was expanded; (4) Our Safe Place, a drop-in center for LGBTQ youth, was opened to offer case management and support services for this population; and (5) homeless outreach workers are now embedded in substance use disorder programs to promote stable housing connections.

For the 2018 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. IPH is directed by Corinne McDaniels-Davidson, PhD, MPH, CHES. Dr. McDaniels-Davidson is an Assistant Adjunct Professor in the SDSU School of Public Health and has expertise in qualitative and quantitative community-based research methods. For this engagement, BHS tasked the Institute with developing, promoting, and facilitating community-wide forums and focus groups and distributing community surveys to gather input about the BHS Continuum of Care. The IPH was also responsible for all data collection and analysis, and for drafting this report.

The 2018 community engagement process included nine community forums, two focus groups, and an online and paper-and-pencil community survey; the engagement spanned September through December 2018. The methods used by the IPH and the results gathered are presented in the first section of this report. Common themes across events are identified and discussed in the second section of the report. The third section presents summarized conclusions. Community members evaluated the forums in short satisfaction surveys, which are presented in final section of this report.

Process and Methodology

BHS and the IPH began planning for the community engagement process in August 2018. The *ListenToSanDiego.org* registration and promotion website was launched on September 26, 2018. The first community forum was held on October 8, 2018. The engagement process officially concluded on December 7, 2018.

Collaborative Planning

In collaboration with BHS and community stakeholders, IPH selected dates and locations for events, and determined best approaches for promotion, recruitment of community members, facilitation of forums and focus groups, data collection and analysis.

Initial meetings focused on convenient scheduling and venues that would be amenable to high rates of community participation. Subsequent meetings focused on details, including recruitment, promotion, data collection, logistics, and facilitation.

The IPH attended a BHS management-threading meeting to solicit input about the areas of focus for the forums. Leadership staff brainstormed about gaps in knowledge to inform program development. Leaders outlined several key areas for the engagement process, including: mental health services for people in crisis; substance use disorders for young people; school violence; homelessness; co-occurring mental illness and developmental disabilities; and innovative approaches to addressing these issues. The group identified two priority populations for focus groups: justice-involved individuals with mental health needs and peer support workers.

The Cultural Competency Resource Team (CCRT) hosted IPH staff to ensure a culturally sensitive process. The CCRT meets monthly and is made up of BHS staff, county contractors, and other community stakeholders. The goal is to advocate for services to be delivered in a culturally competent manner. IPH staff presented the draft plan for the 2018 community engagement process and solicited feedback from the team members about best practices.

Community Forums

Topics

In order to accommodate all of the topics chosen by BHS staff for the 2018 engagement process, BHS decided to host nine forums. Six would be "general" forums, during which three topics would be discussed: (1) services for people with a mental health crisis; (2) substance use among youth and young adults; and (3) school violence. The other three forums were designated as innovation forums. One of these would focus on innovative approaches to homelessness. Another would focus on developmental delays co-occurring with mental health disorders. A final would be an "open" forum for participants to brainstorm about innovative ways to address any behavioral health issues.

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 in an attempt 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 compliancy, and availability of free parking. Once forum locations were selected, IPH staff worked with venue staff to complete the reservation process. The first forum was scheduled during a regularly occurring HHSA BHS Combined Councils meeting. The schedules for the general and innovation forums are found in Tables 1 and 2.

Table 1. General Forum Schedule

Date: Monday, October 8, 2018 Time: 10am to 12pm	National University 9388 Lightwave Avenue, San Diego, CA 92123
Date: Wednesday, October 10, 2018 Time: 2pm to 4pm	Ronald Reagan Community Center 195 Douglas Avenue, El Cajon, CA 92020
Date: Monday, October 15, 2018 Time: 9am to 11am	Tubman Chavez Community Center 415 Euclid Avenue, San Diego, CA 92114
Date: Thursday, October 25, 2018 Time: 6pm to 8pm	Norman Park Senior Center 270 F Street, Chula Vista, CA 91910
Date: Wednesday, October 31, 2018 Time: 10am to 12pm	QLN Conference Center 1938 Avenida Del Oro, Oceanside, CA 92056
Date: Friday, November 9, 2018 Time: 1pm to 3pm	Park Ave Community Center 210 E. Park Avenue, Escondido, CA 92025

Table 2. Innovation Forum Schedule

Topic: New approaches to behavioral health services	
Date: Wednesday, October 10, 2018	San Diego Youth Services
Time: 10am to 12pm	3845 Spring Drive, Spring Valley, CA 91977
Topic: New approaches to addressing homelessness	
Date: Monday, October 15, 2018	Malcolm X Library
Time: 2pm to 4pm	5148 Market Street, San Diego, CA 92114
Topic: New approaches to co-occurring mental health disorders and developmental delays	
Date: Wednesday, October 17, 2018	San Diego Regional Center
Time: 3pm to 5pm	2727 Hoover Ave #100, National City, CA 91950

Registration

To track the number of participants attending each forum and to estimate supply and catering needs, forum participants pre-registered online at *ListenToSanDiego.org,* an ADA compliant website developed by IPH staff. Participant data received through *ListenToSanDiego.org* were stored to a secure IPH-developed database. Some participants pre-registered by phone. Registration phone numbers and the website address were provided on all printed promotional materials. IPH translated all materials and surveys into the County's threshold languages.

Participants who attended a forum without pre-registering were considered "walk-in" participants. All walk-in attendees completed a paper registration form at check-in. The information from the paper forms was digitally merged with the data collected online. See the Appendix, Page A2, for a sample registration form.

Registrants provided basic demographic information, including their gender identity, age, ZIP code, and identification with listed community groups and special populations. For general forums, they choose which of the three designated topics they wanted to discuss. The summarized demographic data recorded through registration is in the Results section.

Promotion

The community forums were advertised through a variety of promotional avenues 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 distribution.

Listen to San Diego website

IPH designed, deployed, and hosted a user-friendly, visually appealing promotional website that allowed for online registration and gave detailed information about the community engagement process. Visitors were also able to complete an online version of the Community Survey on the website. The website was available in the County of San Diego's five threshold languages: Spanish, Farsi, Tagalog, Vietnamese, and Arabic. (See the Appendix, Page A4, for an example).

Promotional flyers

IPH staff created a promotional flyer (see Appendix, Page A5) translated (through a subcontract with Native Interpreting) into the County's five designated threshold languages. The PDF version of the flyer included clickable hyperlinks for electronic promotions.

The flyer included all forum dates, times, and locations and indicated whether each forum was a "general" or an "innovation" forum and which topic/s would be discussed at each forum. Registration instructions, including the website address and registration phone numbers, were provided. The flyer included information about refreshments and a $5 gift card for eligible participants.

Flyers were posted in public places (e.g. libraries and recreation centers) and in locales where people with behavioral health issues might congregate, such as therapeutic clubhouses. 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. Over 1,000 flyers, in multiple languages, were distributed through this method. In addition, BHS distributed 1,200 flyers at the *Live Well Advance* conference on October 2, 2018.

Canvassing

IPH staff and BHS worked together to compile a list of more than 100 organizations to canvass. Targeted organizations included any that provided prevention or treatment services for individuals with behavioral health issues or support services for their loved ones. These organizations were then canvassed in person, through cold calling, or through email. The engagement process was discussed with the person contacted, and flyers provided. When possible, the organizations received both hard copy and electronic versions of the flyers to enable easier distribution to their clients. See the Appendix, Pages A6-A7 for a list of organizations.

Press releases and media buys

The forums were promoted through a press release as well as print and digital media buys. The HHSA Media office drafted and distributed a press release. Print ads were run in the Oceanside and Escondido editions of Coastal News, a local news outlet serving the North County areas. Advertising ran in OsideNews.com, a digital newspaper serving the Oceanside area. OsideNews.com also agreed to publish an article about the community engagement forums. This was posted on 10/20/2018, and may be found at https://www.osidenews.com/2018/10/20/sdsus-institute-for-public-health-to-hold-north-county-community-engagement-forums/. Advertising ran in La Prensa, a weekly bilingual (English/Spanish) print and digital newspaper and in San Diego Voice and Viewpoint, the leading African American newspaper in San Diego. See the Appendix, Pages A8-A9, for a listing of media advertisements and examples.

Social media

The following groups agreed to post flyers on their social media accounts, including Facebook, Twitter, and Instagram:

- Live Well San Diego
- SDSU Graduate School of Public Health
- SDSU School of Social Work
- CSU San Marcos - Social Work Coalition
- Mental Health America of San Diego County (MHASD)
- Chula Vista Community Collaborative
- NextDoor.com in several neighborhoods
- San Carlos Neighborhood Connection

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 the event was posted with all event details. Forum events were posted to the following online calendars:

- News: CBS 8/KMFB 760 Community Events Calendar
- KPBS Community Events Calendar
- KUSI Community Events Calendar
- 211SanDiego.org Events Calendar
- Nextdoor.com (Neighborhood App)
- Malcolm X Branch Library online events calendar

Email and listservs

Email was shared with BHS staff to distribute forum information with their professional and personal networks. Several other groups also agreed to share the promotional flyer on their internal or public listserv. These groups included:

- SDSU Graduate School of Public Health
- SDSU School of Social Work
- CSU San Marcos - Social Work Coalition
- San Diego Regional Center
- SAY San Diego
- City Heights Roundtable
- The Center

Facilitation

IPH used a modified world café method to facilitate the forums. 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 assigned tables as well as a whole group dialogue and prioritization of issues. The main objectives of the community forums were to: (1) identify key challenges associated with the topics presented; (2) Identify potential solutions to the top challenges; and (3) prioritize challenges and solutions.

The IPH provided small group facilitators trained to lead small-group discussions. Each table consisted of 4-8 community members and one trained facilitator. Large group discussions were led by the IPH director, Dr. McDaniels-Davidson, or another senior IPH staff, both of whom have 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, Page A10), and access to requested audiovisual (AV) equipment. Staff also arranged catering and hosting supplies for each event. Healthy snacks including granola bars, fruit, and trail mix were provided as well as coffee, tea, and water. A more substantial meal was provided at the dinner-time forum in Chula Vista.

Each general forum had pre-arranged table assignments based on the topic selected on the registration form. Tables were organized into groups of 4 to 8 participants. Participants of the innovation forums, however, were randomly assigned to a table. Table tickets, indicating the participant's table number, were given to each participant during check-in to simplify seating navigation.

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
• Sign-in sheets • Blank registration forms (for those unable to pre-register) • Table tickets • Pens • Flyers • Handouts (i.e. County Roadmap)	• Easel and flip chart • Table numbers • Markers • Index cards • Pencils and pens • Gift cards and gift card tracking forms • iClickers • Community survey • Satisfaction survey	• Portable PA system • iClicker base and software • Laptop • Projector

Event structure

The forums were scheduled for a two-hour block of time. IPH staff arrived early to set up the room, equipment, and tables. A detailed agenda (see Appendix, Page A11) was created to help staff and facilitators manage time appropriately.

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 completed a

paper registration form and received a table assignment. After checking in, participants were encouraged to enjoy refreshments before sitting at their table.

Once at their table, guests were greeted by a trained table facilitator who explained the forum process and the purpose of the materials at each seat, which included:

- *The Community Survey.* This tool provided anonymous feedback about County of San Diego Health and Human Services, Behavioral Health Services.
- *A Satisfaction Survey.* This short questionnaire gathered participant feedback about the structure and organization of the community event.
- *Index cards.* These blank cards were 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.

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.

Participants were assured that their feedback, regardless of the modality in which they provide it, would be incorporated into a comprehensive report (this report). They were also assured that their feedback would remain anonymous.

Welcome

After registration, participants were welcomed to the forum by Alfredo Aguirre, Director of BHS, or Holly Salazar, the Assistant Director of Operations for BHS. The welcome included an overview of HHSA's Ten-Year Roadmap for Behavioral Health Services. The roadmap, which was provided as a handout at the forums, defines strategies and goals for improvements in 12 priority areas. Mr. Aguirre and Ms. Salazar discussed new services offered by the County as the result of previous community engagement efforts and emphasized the importance of community feedback.

The Process

After the welcome message, the event moderator explained the format and process of the event to the group, as follows:

Identifying Key Challenges

First, the table facilitator would ask their group specific questions about their topic to initiate a discussion about needs or challenges related to the identified topic. For example, the facilitator at a table focused on *services for people with a mental health crisis* would ask, "What are some of the greatest needs in San Diego for people who are experiencing a mental health crisis?" The group would then brainstorm 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 of needs related to the topic, the facilitator would ask the group to prioritize the challenges 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 one or two challenges with the highest number of votes on a pre-printed form. This form was delivered to the moderator. The moderator would then type the key challenge or challenges submitted by each table into a pre-formatted PowerPoint presentation.

Key needs/challenges were organized by topic and presented on a large projector screen to the entire group. Needs were discussed with the whole group, and table participants were asked to clarify or provide details as necessary. At most forums, participants then used the iClicker remotes to vote on the challenges/needs they felt were the most important for each topic. At two of the smaller forums, participants voted with a show of hands. By allowing the entire group to choose priority needs/challenges, all participants were able to give feedback about all topics. The challenge receiving the most votes became the "top challenge." After the voting session, each group discussed solutions for the top challenge identified for the topic at their table.

Identifying Solutions

The process for identifying top solutions was similar to the process for the needs/challenges. First, the facilitator would present questions to their group to initiate a discussion about solutions. For the innovation forums, groups were asked to discuss solutions or develop an innovative program to address the top challenge. 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 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 (or a show of hands at smaller forums), for what they considered to be highest priority solution for each challenge presented. The solution with the highest number of votes became the "top solution."

Forum Interpreters and Special Assistance

Although interpretive services were available by request for all forums, they were requested for only one, the general forum in East County at the Ronald Reagan Community Center. Six participants utilized Arabic interpretive services. At the two forums hosted in North County, Spanish interpretive services were available on site. Special assistance provided for only one participant at the Norman Park Senior Center in the South Bay who requested a comfortable chair due to physical disabilities.

Debriefing and forum modifications

At the conclusion of each forum, IPH staff held two brief meetings. The first meeting was a short check-in with table facilitators to discuss what worked well and what modifications were needed. The second was a de-briefing with the BHS staff to gather their feedback about the forum. IPH staff noted all input. IPH staff also reviewed satisfaction survey results for each forum and met before each subsequent forum to make improvements to the process. An IPH team huddle prior

to each forum explained any modifications. In this way, forums were continuously improved throughout the engagement process.

Data Collection and Analysis

Demographic information about forum participants was recorded in the IPH learning management system. 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 on each table, was recorded on sortable Excel spreadsheets. Several IPH staff reviewed these data, and coding categories were created so that the data could be organized.

Voting results were recorded on iClicker software or, for the two forums where iClickers were not utilized, on paper. These results were reviewed for common themes and were clustered using an inductive qualitative analysis process. Top needs/challenges and highest priority solutions are presented in the Results section.

Participant Evaluations

In collaboration with BHS, IPH created a one-page satisfaction survey for each forum participant to complete before leaving the forum (see Appendix, Page A12). Participants expressed 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. Satisfaction survey results were entered into and analyzed with SPSS (v25) software. Results are presented in the Participant Evaluations for Events section of this report.

Focus Groups

In addition to the nine community engagement forums, IPH planned and facilitated two focus groups to allow for in-depth conversation about behavioral health in San Diego. In consultation with BHS and its stakeholders, it was determined that the focus groups would target two specific populations: 1) justice-involved individuals; and 2) peer support workers.

The first focus group was conducted at the Center Star Assertive Community Treatment (ACT) Center and engaged seven justice-involved individuals. Center Star ACT provides behavioral health and vocational services to individuals who have been diagnosed with a serious mental illness and who are involved in the justice system. The second focus group was held at Recovery International (RI) and involved eleven peer-support workers. RI offers services to individuals suffering from mental health issues through a cognitive-behavioral, peer-to-peer, self-help training system.

Focus groups were conducted in a semi-structured manner. Trained IPH facilitators used predetermined questions to generate conversation, and discussions then flowed in a conversational manner. Broad themes were covered at each focus group: (1) the services the participants received or provided and their benefits; (2) the needs/challenges related to behavioral health participants observed in San Diego; and (3) how gaps in services in San Diego should be addressed. Focus group participants completed the community survey. An IPH note-taker 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 $10 Target gift card for his/her participation.

For each focus group, IPH staff reviewed notes and clustered similar responses. Themes were identified for each topic covered. The feedback shared in the focus groups is documented in the Results section of this report.

Community Surveys

In addition to forums and focus groups, feedback about behavioral health needs in San Diego was gathered via a community survey. The survey was provided by BHS to IPH and translated into the five HHSA designated threshold languages. IPH distributed the survey at all forums and focus groups. It was also available online at the *ListenToSanDiego.org* website.

The community survey included an introduction that defined behavioral health issues and described behavioral health services, utilizing specific examples about preventive and treatment services. Respondents were assured of anonymity and asked to imagine that they, or someone they loved, were in need of behavioral health services. The initial set of questions focused on respondents' opinions about how they would find resources and the kinds of services or programs that might help them access care. They were also asked questions about what might prevent people from receiving the care they need. In the next section of the survey, respondents were asked to share their own, or a loved one's, personal experiences with behavioral health services in San Diego. Finally, respondents were asked to provide some basic demographic information. See the Appendix, Pages A13-A18 for copy of the community survey. For a complete list of responses, see the Appendix, Pages A44-A49.

Community survey answers were entered into REDCap and analyzed using SPSS v25. Findings from this survey are presented in the Results section of this report.

Results

Community Forums

Forum Participants

A total of 307 people attended nine community forums. This total includes 222 attendees at the six "general" forums, which each focused on three designated topics (services for people with a mental health crisis; substance use disorders among youth and young adults; and school violence). An additional 85 community members attended three "Innovation" forums (one focusing on general behavioral health needs, one on solutions to homelessness, and one on needs and interventions for those with co-occurring mental illness and developmental disabilities). Ninety-seven 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 3. Participants by Forum

Date	Time	Region	Location	Pre-registered	Walk-In	Attended
10/08	Morning	North Central	National University	33	68	101
10/10	Morning	East	San Diego Youth Services*	7	15	22
10/10	Afternoon	East	Ronald Reagan Community Center	18	15	33
10/15	Morning	Central	Tubman Chavez Community Center	6	15	21
10/15	Afternoon	Central	Malcolm X Library*	16	26	42
10/17	Afternoon	South	San Diego Regional Center South Bay*	5	16	21
10/25	Evening	South	Norman Park Senior Center	3	9	12
10/31	Morning	North Coastal	QLN Conference Center	14	15	29
11/09	Afternoon	North Inland	Park Ave Community Center	10	16	26
			Total	112	195	307

* Innovation Forums

All promotional materials encouraged pre-registration for forums at *listenToSanDiego.org.* Those who pre-registered and attended are represented in Table 3 above along with those who attended but did not pre-register (walk-in). Upon registration, forum participants provided demographic information. Online registration required demographic fields to be completed. Some of those who registered using paper forms as walk-ins did not respond to all questions, resulting in varied sample sizes in the data summarized below.

Demographic information includes: gender, age, identification with special populations, identification with selected community groups, and ZIP code.

Most forum participants identified as female (80%; n=246). Nineteen percent identified as male (n=59). See the Appendix, Page A22, for a detailed table of forum attendance by gender. The average age of forum participants was 44 years (standard deviation = 13.6). Most participants (83%) were between the ages of 18-59 years old, with an additional 17% aged 60 years or older. Six percent (6%) of participants were "transitional age youth," defined as 16-25 years old. Adult and TAY categories are overlapping so percentages do not sum to 100%. Summaries of age categories by forum are presented in the Appendix, Page A18. It should be noted that a high proportion of walk-in participants (n=21; 7%) refused to provide their age upon registering.

Table 4. Forum Participant Age Groups (n=286) [1, 2]

Age	n	%
Adult 18-59	237	83%
Older Adult 60+	49	17%
Transitional Age Youth (TAY) 16-25	16	6%

[1] A total of 286 individuals provided their age; n=21 "walk-in" registrants that completed paper forms did not.

[2] As age groups are not mutually exclusive (those 18-25 years old are both adult and TAY), numbers will not sum to 286 and percentages will not sum to 100%.

When registering, participants selected special populations with which they might identify, as listed in Table 5. Each registrant could choose as many categories as were applicable. See the Appendix, Page A23, for details about special populations by forum.

Table 5. Forum Participant Racial/Ethnic Groups (n=307)[1]

Special Population Groups	n	%
Latino	64	21%
Asian/Pacific Islander	42	14%
African American	20	7%
Native American/American Indian	15	5%
Chaldean	6	2%
African	6	2%

[1] The number and proportion for each row represent the number of participants (out of 307) that chose to identify with that group. Participants could select none, one, or more than one group so numbers will not sum to 307 and percentages will not sum to 100%.

Table 6. Forum Participant Special Population Groups (n=307)[1]

Special Population Groups	n	%
LGBTQI	29	9%
Veterans/Military	16	5%
Immigrant	11	4%
Homeless	9	3%
Refugee	8	3%

[1] The number and proportion for each row represent the number of participants (out of 307) that chose to identify with that group. Participants could select none, one, or more than one group so numbers will not sum to 307 and percentages will not sum to 100%.

Participants also selected which community groups they represented, as listed in Table 6. Each registrant could again choose as many categories as applied. The Appendix, Page A23, includes a table with details about community groups by forum.

Table 7. Forum Participant Community Groups (n=307) [1]

Group	n	%
Community Member	158	51%
Consumer	37	12%
Family Member of Consumer	21	7%
Law Enforcement	6	2%
School Personnel	12	4%
None of the Above	118	38%

[1] The number and proportion for each row represent the number of participants (out of 307) that chose to identify with that group. Participants could select none, one, or more than one group so numbers will not sum to 307 and percentages will not sum to 100%.

Forum attendees provided their ZIP codes, which are grouped into six San Diego County HHSA-defined regions in Table 7. The North Central region had the most representation, and the South region had the least. The Appendix, Page A24, contains a detailed table about participant home region by forum. The Appendix, Page A25, includes a San Diego County map with the six HHSA regions outlined and labeled, forum locations indicated by stars, and shading indicating the number of forum attendees from each ZIP code.

Table 8. Forum Participant Region (n=290) [1, 2]

Region	n	%
Central	68	23%
North Central	71	24%
East	60	21%
North Coastal	35	12%
North Inland	23	8%
South	**33**	**11%**

[1] Those individuals that provided a valid ZIP code (n=290) are represented in this table.
[2] Percentages may not sum to 100% due to rounding.

General Forum Findings

Six of the nine community forums focused on the following topics: (1) services for people with a mental health crisis; (2) substance use disorders among youth and young adults; and (3) school violence. Forum attendees selected the topic discussed at their table, and brainstormed the greatest community needs related to the topic, as well as ways to address those needs.

Services for people experiencing a mental health crisis: needs and challenges

Forum attendees chose this topic most frequently. A complete list of needs and challenges discussed at the forums (through table brainstorming and notes written on provided index cards) is in the Appendix, Page A26-A28.

Several issues emerged as the most pressing for people with a mental health crisis in San Diego County, including:

1. Limited availability of services
2. Challenges to accessing services
3. Lack of care coordination
4. Inadequate preventive services
5. Insufficient culturally, linguistically competent, trauma-informed services

Discussions about the **limited availability of services** defined several primary problems. First, forum participants noted that mental health crises often occur outside of business hours and that very few services are available at night, on the weekends, and on holidays. Participants emphasized the need for immediately available, easily accessible "after-hours" crisis care. Second, a frequent theme was the inadequate number of in-patient psychiatric and crisis beds. Forum participants observed that people in crisis often end up in emergency departments that are not designed to address mental health and are, at times, over-crowded. They suggested that receiving care in an emergency department is expensive and economically impactful on the community. Third, forum attendees indicated that too few services are available that are tailored for the unique needs of vulnerable populations, such as children, adolescents, refugees, homeless individuals, and people with co-occurring mental health issues and substance use disorders. Fourth, participants frequently mentioned a need for a greater number of Psychiatric Emergency Response Teams (PERT) teams. Finally, forum participants expressed the belief that the limited availability of mental health services is caused in part by a shortage in San Diego County of qualified mental health providers, including psychiatrists, psychologists, case workers, and social workers.

Participants also asserted that San Diego residents experience **challenges to accessing services.** Primary challenges outlined included: (1) a lack of public knowledge about available services, how to find them, and what steps are necessary to receive them; and (2) long waiting lists, which prohibit the timely receipt of services. Other barriers to accessing care cited included lack of health insurance coverage, unstable housing, and difficulty obtaining transportation and child care. Participants emphasized that accessing and navigating care is especially difficult for people who are in crisis.

Lack of care coordination was chosen as another priority issue for San Diego residents. Participants discussed the issue mostly in terms of "step-down" services and follow-up care for people who have in-patient, psychiatric hospitalizations. Participants noted that these individuals need, but do not often receive, comprehensive case management services not only to address mental health issues but also to address social needs such as housing and transportation. Often times, participants explained, no transitional services are available at discharge from an inpatient psychiatric hospitalization. One forum attendee commented: "there are too few post-acute care services for Medi-Cal patients. This leads to an increase in days patients spend unnecessarily in in-patient care." In addition, it was noted that care is seldom integrated across physical and

mental health services. Providers do not often do "warm hand-offs" to other providers to ensure that their clients experience continuity of care.

San Diego community members emphasized **preventive services** that might lessen residents' risk of experiencing a mental health crisis. Perceiving the system as more reactive rather than proactive, participants suggested greater effort on identifying high-risk, vulnerable individuals who are not yet in crisis and providing services to them.

Finally, forum attendees strongly expressed that the services provided in San Diego are too often not **culturally and linguistically competent or trauma-informed.** Conversations about this issue tended to center on law enforcement personnel; however, attendees felt that people of color, refugees, immigrants, and LGBTQI individuals experience discrimination from a variety of mental health providers. This discrimination, whether actual or perceived, they explained, erodes trust between community members and mental health service providers, which creates further barriers to care. Of particular note was that in-person translation services are rarely available for people who do not speak English. Trauma-informed care was identified as a particular need for children, adolescents, transitional-age youth, and refugees.

Services for people experiencing a mental health crisis: solutions

Forum attendees enthusiastically brainstormed ways to address behavioral health needs in San Diego (See Appendix, Page A28-A30, for complete list). Solutions chosen as most important tended to address more than one of the needs identified above. Highest priority solutions included:

1. Expand, diversify, and improve mobile teams
2. Expand community-based mental health, recreational, and social services
3. Create one-stop, stand-alone facilities in each region
4. Develop public awareness campaigns

The **expansion, diversification, and improvement of mobile teams** for crises would address the availability, accessibility, and quality (including cultural and linguistic competence and trauma-informed care) of services, according to results. Forum attendees advocated for coordinated mobile response teams to be available to residents on a 24-hour/7 day-a-week basis. While many argued for PERT expansion, others suggested the creation of mobile teams that do not include law enforcement personnel. Attendees also felt that mobile service publicity should de-stigmatize asking for help. Finally, attendees felt strongly that mobile teams, regardless of composition, needed to receive in-depth and ongoing training to ensure that the services they provide are culturally and linguistically sensitive and trauma-informed.

The **expansion of community-based mental health, social, and recreational services** was a priority solution with two key components. First, participants felt that if mental health services were more frequently community/neighborhood-based and at least partially staffed with people from that community, access would be improved, trust would be deepened, and residents would be more likely to seek care before a crisis. Employing community members would enhance cultural and linguistic competency. Using patient navigators would help ensure the coordination

of care across the continuum. Second, participants indicated that having an array of available social services and activities is a necessary component to addressing mental health. For example, anxiety and depression symptoms could decrease with more recreation centers to provide free opportunities for entertainment and activities. Assistance with affordable housing and addressing tenant rights was discussed, with an emphasis on rent control or other housing policies.

The **creation of one-stop, stand-alone facilities in each region of the County** was another approach embraced by forum participants. Participants would like facilities to offer integrated medical, mental health, and social services; to be open 24 hours a day; and to ensure the coordination of care across service providers working collaboratively to meet clients' needs. Members of the community would assist with case management and follow-up care and serve as patient advocates. These types of facilities would improve availability, accessibility, and coordination of care, and help prevent mental health crises. In addition, the use of community members as patient advocates would help ensure culturally and linguistically competent service.

Finally, forum attendees advocated for the establishment of a **public awareness campaign about mental health and available services.** The stigma of mental illness and the uncertainty about how to get services were viewed as significant barriers to people seeking care before a crisis occurs. By providing information through a variety of media in diverse settings (through the media, at schools, in community establishments), mental illness could be demystified. Classes for middle and high school students and on college campuses could provide knowledge about wellness, recognition of symptoms of mental illness, and how to find services. Mobile applications could be developed for smart phones, including interactive flow charts to help users navigate services and recognize early signs of mental health concerns. Residents could become more willing to discuss mental health, more aware of mental health issues, and better able to access appropriate services.

Substance use disorders among youth and young adults: needs and challenges

This topic was the second most frequently chosen by forum attendees. A complete list of needs and challenges discussed at the forums (through table brainstorming and notes written on index cards) is in the Appendix, Page A30-A32.

Issues that emerged as the most critical for youth and young adults with substance use disorders in San Diego County included:

1. Easy access to drugs and alcohol, particularly marijuana
2. Lack of knowledge and understanding of potential harm
3. Deficiency of evidence-based, standardized drug treatment services tailored for youth and for targeted sub-populations

Much of the discussion about substance use among youth and young adults centered on the theme that youth, starting at very young ages, have **easy access to drugs and alcohol, particularly marijuana.** This was chosen as the most critical issue at half of the forums. Participants were especially concerned about the impact of the legalization of marijuana, making it easier for youth

to get. Participants also discussed the prevalence of heroin, fentanyl, and other opioids, as well as crystal methamphetamine, and the abuse of prescription drugs such as Xanax. Another area of concern was the increasing use of vaping devices, including vape pens and other electronic devices.

Forum participants expressed that one underlying issue related to substance use is that parents and youth **lack knowledge and understanding about the potential harms** of marijuana and alcohol use, in particular. Participants noted that these substances are romanticized and normalized in media – on television, in movies, and in social media. The information that youth receive from peers and on social media is often inaccurate, and there are very few educational programs available.

Finally, forum participants identified the **deficiency of evidence-based, standardized treatment services tailored for youth and specific sub-populations** as a priority issue in San Diego County. Participants communicated concern about the lack of detox programs and the limited availability of in-patient and outpatient affordable rehabilitation programs for youth. Participants were not confident that available services are evidence-based and standardized. Forum attendees suspected treatment designed for adults might be ineffective for youth. They also noted that most clinical interventions available do not include specially tailored programs for sub-populations of youth such as those who have co-occurring mental health disorders, those who have experienced trauma (including sexual abuse and commercial sexual exploitation), those who have been justice-involved, pregnant and parenting teens, immigrants and refugees, and those who identify as LGBTQI.

Substance use disorders among youth and young adults: Solutions

A wide range of solutions was discussed to address substance use among youth and young adults (See Appendix, Page A32-A34, for a complete list). Solutions that attendees chose as the most important included:

1. Create and expand prevention and early intervention efforts
2. Establish a county-wide media campaign
3. Design, implement, and expand community-based treatment programs

The **creation and expansion of prevention and early intervention efforts** was named as a high priority to address substance use among youth and young adults. These efforts were seen as key to increasing knowledge about potential harm, providing tools to resist pressure from peers and social media, and, ultimately, to reducing drug and alcohol use among this age group. These programs should be school-based, start at a young age, and include outreach to parents.

A county-wide media campaign was designated as a critical solution to consider. This campaign would use billboards, radio and television advertisements, and social media to educate the community not only about the potential harms of substance use but also about where to find resources for treatment. Social media campaigns would be designed specifically for youth. Confidentiality and the ability to receive services without legal consequences would be emphasized.

Similar to the participants' ideas about the provision of mental health services, **the design, implementation, and expansion of community- based treatment programs** was viewed as a critical component to addressing substance use among youth and young adults. These programs would need to make use of community, peer, school, and cultural partners to be effective. For indigenous youth and for immigrants, partnerships with traditional "healers" and shamans would be vital. Overall wellness and engaging the youth in the healing process would be emphasized. Services would involve the whole family and meet their basic needs (such as for food and housing). Finally, programs would include interventions specifically designed for vulnerable populations, such as individuals with co-occurring mental health disorders, those who have been traumatized, those who have been justice-involved, those who are pregnant or parenting teens, immigrants and refugees, and those who identify as LGBTQI.

School violence: Needs and challenges

This topic was chosen the least frequently by forum attendees; at two of the forums, no participants chose to discuss school violence. Nevertheless, participants generated an extensive list of challenges and needs (See the Appendix, Page A34-A36). The following were designated as the most critical:

1. Lack of school resources to protect students and address the root causes of violence
2. Risk of suicide, self-harm, and violence among students who are bullied and/or disconnected
3. Bullying based on sexual orientation, gender identity, and/or race/ethnicity

Conversations about challenges related to school violence often included acknowledgement that school resources and funding are limited. In fact, a primary issue was that **schools lack the resources to protect students or to address the root causes of violence.** Participants acknowledged that most schools do not have in-house mental health services and that counseling services are limited. They also discussed that art, athletics, music, and after-school enrichment programs have been cut. Staffing for security was noted as deficient, and some participants felt that schools lack standardized protocols and policies about how to respond to threats, bullying, and violence. In addition, cyberbullying and threats were described as continuously present and exceptionally challenging for schools to address since they occur offsite.

Bullying is a particularly concerning form of school violence, according to attendees. A critical challenge is the **risk of suicide, self-harm, and violence among students who are bullied and/or disconnected.** Participants asserted that anxiety, self-injury, and suicide attempts among students, particularly among those who are disconnected from peers and adults, are on the rise; students who are victims of bullying are also at risk of carrying out violent acts themselves.

The last challenge detailed by participants was a greater incidence of **bullying based on sexual orientation, gender identity, and/or race/ethnicity.** Participants stated that factors that contribute to this problem include increased cultural acceptance of racism and other forms of discrimination, and the lack of school resources to build adequate cultural sensitivity and acceptance among students and parents.

School violence: Solutions

Discussions about solutions to school violence focused primarily on prevention. As described by participants, prevention needs to work in two ways: (1) by addressing the underlying, root causes of violence such as disconnection and isolation; and (2) by creating greater recognition of early warning signs of potential violence (See Appendix, Page A36-A38, for a full list). The highest priority solutions included:

1. Build community at schools so that every child and parent feels connected
2. Educate students, parents, teachers, and other school staff to recognize and report the warning signs for violence, including self-harm and student-to-student
3. Provide mental health services and enrichment activities at school

Efforts to **build community at school so that every child and parent feels connected** were seen as crucial for violence prevention. These efforts should include training school staff and peer mentors to recognize when students are disconnected and to engage them in positive interactions. Specific programs such as "No one sits alone" and those that incentivize high school seniors as mentors were discussed. Participants felt that parents should be engaged in multiple ways, including offering a greater number of parent-teacher conferences, hosting forums and social events at schools, offering resources to address pressing social and economic issues, implementing home visiting programs, and making use of parent volunteers as mentors and school monitors.

Programs to **educate students, parents, teachers, and other school staff to recognize and report the warning signs for violence** were considered one of the most important efforts to address school violence. Prevention education should begin in elementary school and standardized protocols for reporting concerns implemented in all schools.

The final priority method chosen to reduce school violence was to **provide mental health services and enrichment activities at school.** Participants emphasized the importance of both onsite "walk-in" crisis services as well as long-term counseling. Classes on physical and mental health that center on wellness and low- or no-cost extracurricular activities, such as gaming, art, and music could reduce idle time, increase intellectual challenges, and reduce isolation. Participants felt that offering services and programs of interest to families and students would engage them with the school, meet a variety of needs, and reduce the likelihood of violence on students.

Annual Results Comparison

Care Coordination was prioritized in each of the past three years (2016, 2017, and 2018) with different emphases. Cultural Competency was another theme that was prioritized in all three years, emphasizing similar aspects, such as having services located within neighborhoods. In this report, linguistic competence was identified as a priority component of Cultural Competency. Inclusion of peer service providers was a shared theme in each report.

Seamless integration of care across systems appeared as a priority in 2016. System simplification and stronger case management services were highlighted in 2017. This year, as noted earlier in

this section, the feedback highlighted crisis transitional care, one-stop access, and cross-discipline training.

Below are summary comparisons from the most current years.

Similarities

- Care Coordination was prioritized all three years (priority 2, 3, and 3, respectively)
    - 2016 emphasized seamless continuum of care, connectivity, and integration across systems
    - 2017 emphasized simplification, case managers, and linkage
    - 2018 emphasized crisis transitional care, one-stop access, and cross-discipline training
- Cultural Competency was prioritized all three years (priority 4, 4, and 4, respectively)
    - Similar emphases across years; 2018 singled out linguistic competence
    - Local service delivery received growing emphasis

Differences

- Each year had a different priority identified first
- 2018's first priority, prevention, emphasized children's mental health; prevention was a subcategory in 2016's third priority, identified as Children's Mental Health
- Housing and transportation were mentioned in 2016 as cutting across all other priorities
- Housing was mentioned in 2018 as a prevention method
- In 2017, the first priority, Service Navigation, was related to its second and third priorities, Barrier Reduction and Care Coordination, respectively (not singled out in 2016 or 2018)

Trends

- In 2018, prevention services for Children's Mental Health coalesced as a top priority
- In 2018, expansion of services was listed for the first time
- In 2018, Prevention was highly prioritized and singled out for the first time
- Community Engagement, prioritized in 2016, received less focused attention in 2017 and 2018

The following page is a chart of themes from 2016, 2017, and 2018 forum priorities, starting with the themes listed first in each year.

2016	2017	2018
Community Engagement • Deeper and sustained participation in Planning Process • Additional engagement activities • Consumer and provider awareness of BHS programs, and ongoing co-leveraging collaboration across services	**Service Navigation** • More dedicated resources	**Prevention** • Community engagement and recreation • Meet basic needs for stable housing, food, and employment • Wellness classes and education, and trauma-informed care • For children the provision of urgent care services before a crisis strikes • Public awareness: signs and symptoms, risk factors for violence, effective response
Care Coordination • Seamless continuum of care • Greater connectivity within the provider community and with BHS, • Education and information sharing • Integration of services across systems	**Reduce Barriers** • Simplify eligibility • Ensure that there truly is a "no wrong door" approach • A system treating individuals with complex behavioral health diagnoses (acute and urgent episodes) needs to be easier to navigate	**Expansion of Services** • PERT • Inpatient psychiatric care • 7 / 24 access • Transportation and childcare
Children's Behavioral Health • Access to services • Education and awareness • Home-based services • Services embedded in schools • Education and campaigns targeting parents, teachers, staff, and students • Normalize and destigmatize • Teaching skills	**Care Coordination** • System simplification • More case managers • Accurate and accessible linkage resources	**Care Coordination** • Appropriate transitional care after a crisis • Creation of "one-stop" resource centers • Further cross-disciplinary educational and networking
Cultural Competence • Consumer-driven • Peer-led • Stigma reduction • Public education • Mobile and one-stop centers	**Cultural Competence** • Delivered in the local community • Peer workers	**Cultural Competence** • Culturally and linguistically • Community-based
Housing and Transportation • Cuts across all priority areas		

Findings from the "Innovation" Forums

Three forums focused on the goal of eliciting innovative solutions. Innovations are defined as new programs and services that have not yet been tried. Innovation may include approaches that have worked in other places that might be adapted for San Diego County. The first Innovation forum had no pre-determined topic. At this "open Innovation" forum, participants were asked to first list the most urgent behavioral health problems in San Diego and then to generate ideas for how to address these issues. At the second innovation forum, the focus was on homelessness, and at the final innovation forum, the focus was on mental health disorders that co-occur with developmental disabilities.

Open innovation forum: Behavioral health needs and challenges

Table discussions at the open forum covered a wide range of behavioral health needs and challenges across the lifespan - from the need for more services for preschool children to the shortage of resources specifically tailored to seniors. Participants had lively discussions about substance use, school expulsions, culturally competent services, bullying and cyberbullying, the dearth of crisis beds, increasing suicide rates, services for transitioning to adulthood, and stigma, among others. See the Appendix, Page A38-A39, for a comprehensive list of needs. When asked to prioritize the needs in San Diego, participants chose the following as the most critical to address:

1. Lack of services for children who have experienced trauma
2. The prevention of homelessness
3. The promotion of awareness about mental health issues and services

Participants expressed the strong belief that the prevention of behavioral health problems begins in childhood and that many behavioral health issues arise from the **lack of services for children who have experienced trauma.** They cited increasing rates of early childhood school expulsions, early age of initiation of substance use, and higher rates of self-harm and suicide attempts among very young children as evidence that traumatized children have many unmet needs. If children received trauma-informed care starting early in childhood, many adult behavioral health problems, the participants asserted, would be avoided.

The prevention of homelessness was named one of San Diego's most critical issues. The cost of housing, shortage of shelter beds, lack of digital resources for homeless individuals, and inability of transitional age youth to secure stable housing were all cited as factors underlying a high rate of homelessness in the County.

Lastly, participants felt that many people, particularly those from vulnerable populations, such as those living in low income communities, immigrants, and refugees, do not have adequate knowledge about mental health issues, including recognizing signs and symptoms and what services are available. They felt that **the promotion of awareness about mental health issues and services** is vitally important to the well-being of San Diego residents.

Open innovation forum: New approaches to behavioral health needs and challenges

Attendees at this innovation forum generated many creative ideas to address San Diego's pressing behavioral health needs. See the Appendix, Page A39-A40, for a full list. Participants chose the following solutions as the highest priority for development and implementation:

1. Implement school-based, trauma-informed services for children and their families
2. Build tiny home communities for homeless individuals
3. Create an educational/public awareness campaign about mental health issues

Because children spend many of their daytime hours at school, the **implementation of school-based, trauma-informed services for children and their families** was prioritized. Participants suggested these programs include mental health services by licensed professionals; however, participants also felt that all school personnel should undergo training about trauma-informed care. This would increase their sensitivity and ability to interact positively with traumatized children. Older children should have access to walk-in clinics at school for mental health care as well as enrichment programming such as creative arts programs to enhance wellness.

Participants were enthusiastic about the idea of **building a tiny home community for homeless individuals.** Forum participants outlined specific components of a tiny-home community, including the provision of on-site medical care and community-based social services. The use of digital resources and applications, such as a technology platform to match homeless roommates, was also considered.

Lastly, participants advocated for **the creation of an educational/public awareness campaign about mental health issues** for special populations. The campaign should focus on marginalized and vulnerable communities, such as low-income neighborhoods and those with a high density of refugees and immigrants. The campaign should include culturally and linguistically competent messages about mental health. In this way, knowledge of mental health risk factors would be increased, stigma and fear could be decreased, and access to mental health services could be improved.

Innovation forum: New approaches to addressing homelessness

Participants at this innovation forum focused on generating new ideas about how to approach the issue of homelessness. Each table spent several minutes brainstorming ideas, then chose one or two of these to discuss in depth. These ideas were then presented to the larger group who voted on which programs they would most like to see implemented. See the Appendix, Page A40-A42, for a complete list.

The highest priorities as ranked by the forum attendees are as follows:

1. Develop one stop-shopping resource centers/shelters
2. Create housing for single father families
3. Implement school-based mobile services for homeless children and families

Forum attendees strongly advocated for the **development of one-stop shopping resource centers/shelters.** They specified that at least one center should be opened in each of the HHSA

regions, ideally one in each ZIP code (one suggestion for North County was that it could be in the location of an old drive-in theater). Participants felt that comprehensive, culturally competent services would need to be available and include medical and behavioral health services, wrap-around case management, housing navigation, employment readiness services, and domestic violence services. A short-term shelter would be an important component. For the shelter, people could stay there free for up to six months, while working and saving money for their own place. In addition, in a separate building on the same campus, the center would offer detox programs. Funding for the programs would come from the County, grants, private donations, or the city, and employees would be subcontractors to the County. Medical and mental health services could be provided by community health centers in the area. Faith-based partners could be included. The goal would be to take all cases and turn no one away.

Creating housing for single-father families was chosen as a high-priority solution to homelessness. The group detailed a "Fathers Helping Fathers" program that would be short-term (6 months or less) shared housing for single fathers. Fathers who are no longer homeless would serve as mentors, and a house manager would provide case management. The mentor would help with parenting skills, childcare, rules, and structure. Educational advocates would help fathers oversee their children's education. Rent would be 30% of the father's income, and the fathers would be required to save 20% of their income. For those without jobs, they would perform work within the house. Forum participants favored programs being established in each of the regions of the County. Participants imagined that both local and federal agencies could support the program.

The **implementation of school-based mobile services** for homeless children and their families was the third innovative approach chosen as a high priority by forum attendees. This would be a mobile resource center in the parking lots of schools that would offer services such as transportation, childcare, case management, peer support, and counseling. The County would run the program in collaboration with the school districts. The only eligibility requirement would be for the family to be homeless. Data about which schools serve the most homeless students would be utilized to determine where the mobile services should be offered.

Innovation forum: new approaches to addressing co-occurring mental health issues and developmental disabilities

This innovation forum was one of the smaller forums, yielding in-depth conversations about the needs of individuals with co-occurring mental health issues and developmental disabilities. At the conclusion of the forum, the participants unanimously chose a single innovative approach as the highest priority for this population. See the Appendix, Page A42-A44, for complete listings of needs and solutions identified.

Top challenges identified included:

1. Lack of culturally sensitive assessments and interventions
2. Need for innovative, coordinated, holistic practices
3. Difficulty of adapting interventions to individual needs

The **lack of culturally sensitive assessments and interventions** for individuals with co-occurring mental health issues and developmental disabilities was discussed extensively. Participants noted that while San Diego has an exceptionally culturally and linguistically diverse population, developmental and mental health assessments are generally conducted using tools that were designed for English-speaking, Caucasian individuals. In addition, participants pointed out a shortage of bilingual, culturally competent providers. They noted that when a provider does not speak a client's language or understand his/her culture, trust is much harder to build, creating barriers. Appropriate services for immigrants and refugees was noted.

The **need for innovative, coordinated, holistic practices** was chosen as another high priority. Because this population tends to have needs across multiple domains, they receive services from providers in several different specialties. Not having the time or resources to discuss client needs with other specialties, providers were described as working in 'silos.' This makes appropriate diagnosis difficult and effective treatment a challenge.

Finally, the **difficulty of adapting interventions to individual needs** emerged as an important challenge. The population of people with co-occurring mental health issues and developmental disabilities has a wide range of diagnoses with differing symptoms, impacts on daily life, effects on the community, and needs for treatment and intervention. Each individual needs a personalized plan for to meet his/her particular needs. This kind of individualized care is challenging to offer, given limited resources.

Participants voted unanimously on one solution they felt would be most effective in addressing the needs discussed:

1. Develop, provide, and require an enhanced provider training and continuing education program with crossover between disciplines

Participants at this forum advocated for the **creation and provision of a required enhanced training and continuing education program with crossover between disciplines.** Discussion centered on developing trainings based on research about the best practices in each domain, including time for networking and collaboration. Mental health providers, health care providers, and Regional Center staff would attend and learn together. The trainings would be held on a regular basis (perhaps quarterly), with the goal of creating multi-disciplinary systems of coordinated care. In this way, providers would regularly leave their "silos" and work together to meet the needs of this special population; participants felt strongly that providers would welcome this opportunity.

Focus Groups

A total of 18 people attended two focus groups. The first included 11 peer support workers from Recovery International. The second included seven justice-involved individuals diagnosed with a mental illness who were receiving services from Center Star Assertive Community Treatment (ACT). In order to protect privacy, demographic information was not collected.

Peer Support Workers/Recovery International

Held in the offices of Recovery International (RI), 11 peer support workers were asked to describe the work they do, the benefits of their work, the greatest gaps in services/needs for people with behavioral health needs, and ideas for filling these gaps. Peer support workers are individuals with lived experience who now work in mental health support roles.

The mission of Recovery International is "to use the cognitive-behavioral, peer-to-peer, self-help training system developed by Abraham Low, MD, to help individuals gain skills to lead more peaceful and productive lives." Recovery International, San Diego, offers recovery education classes, peer employment training, employment assistance, and peer liaison services.

Description of the work of Recovery International Peer Support Workers

The peer support workers described their work in several ways, including:

- Serving as messengers between their peers and the County
- Providing on-site education at clubhouses and START programs about available services
- Advocating for those who are not yet ready to advocate for themselves
- Teaching people to advocate for themselves
- Encouraging empowerment and self-advocacy
- Listening when people need to talk
- Facilitating classes, including Wellness Recovery Action Plan (WRAP) classes, that teach people to take control over their lives
- Sharing stories of their own recovery to show people it is possible

Participants described the benefits of their work as helping people to:

- Take control over their own lives
- Figure out what their "triggers" are
- Get to know themselves
- Get accurate diagnoses
- Understand effective use of and benefits of medication, when necessary
- Create healthy habits
- Take the first steps to recovery
- Advocate for themselves with service providers
- Overcome stigma
- Retain a sense of hope

This group noted that one of the most important elements to their work is that they are able to quickly establish trust, allay fears, and serve as examples of how recovery is possible. As peers,

they are able to build rapport as someone who truly understands what clients are going through. This understanding is therapeutic.

Primary gaps/needs in behavioral health care

RI peer workers identified several critical problems, including:

1. Transitional housing and treatment options are in short supply
2. Transportation is challenging
3. Drug recovery programs are too short
4. There are too few board and care facilities; quality varies greatly
5. People in recovery lack basic life skills
6. There are too few affordable housing options
7. People who are released from custody do not receive adequate services
8. Stigma creates barriers to care
9. Services are not culturally relevant

Transitional housing and treatment options are in short supply. Short Term Acute Residential Treatment (START) programs are too short. The group explained that most people are still in crisis at discharge and have no place to go. Once on medication, sufficient time has not passed for the medication to take effect. The average wait time to get into long-term care programs is 4-6 weeks. People tend to cycle repeatedly through START programs. While those at great risk of harm may be able to gain immediate access to care through hospitalization, it is much harder for people in crisis but not suicidal or homicidal.

Transportation is challenging: People are unable to get to appointments and to clubhouses, and public transportation is expensive.

Drug recovery programs are too short: Participants felt strongly that the standard 90-day inpatient programs are too short to adequately address addiction issues. They expressed concern that timelines will be reduced further. Accessing in-patient programs, especially those of high quality, was also identified as a problem.

Too few board and care facilities: Facilities **vary greatly in quality**. The group suggested that in many facilities, drugs are rampant, which jeopardizes recovery. There may be little or inadequate oversight. Closing violators is appropriate but contributes to the shortage. House managers, often in recovery, face their own challenges.

People in recovery lack basic life skills: Inability to accomplish tasks, such as bill-paying or managing utilities, causes increased anxiety, which can jeopardize recovery.

There are too few affordable housing options: Waiting lists for Section 8 housing are long, and it can take up to 10 years to get a spot. Many people do not have access to email or a phone and may not be responsive about keeping their spot on the list.

P**eople who are released from custody do not receive adequate services:** There is a high proportion of people with mental health issues who end up incarcerated. When individuals are

released from jail or prison and lacking a good support system, they may get caught in a "vicious cycle."

Stigma creates barriers to care: Crises often occur because people are embarrassed by their symptoms and do not want to admit they have a problem. Negative stereotypes may be reinforced by families or friends. One participant noted that "parents don't get a handbook on how to be a parent." Regardless of good intentions, parents may fail to address their children's mental health needs effectively.

Services are not culturally relevant: Most services were created with mainstream culture in mind. To effectively reach people from different cultures, particularly newer immigrants, services need to expand beyond traditional psychiatric/medication approaches and "talk therapy."

Possible solutions and approaches to addressing behavioral health needs

Peer workers brainstormed about ways to meet the needs of San Diego residents. Their ideas included:

1. Host all services in one place
2. Utilize "undercover" licensing officials in Board and care facilities
3. Focus on prevention
4. Further efforts to reduce stigma
5. Create tiny home communities

Host services in one place: Having all services available in one location would simplify access and contribute to the integration and continuity of care. Participants noted that integrated services, as tried in some European countries, led to a reduction in recidivism for people released from prisons.

Utilize "undercover" licensing officials for board and care facilities: Licensing officials would get a more realistic picture of the quality of a facility if inspections were unannounced and anonymous.

A focus on prevention: Participants felt strongly that prevention efforts should begin at a very young age. Schools could teach about emotions, wellness, mental health, and coping skills. Everyone should learn the skills to address inevitable trauma in healthy ways. Participants advocated for teaching people to recognize when they are not doing well, emphasizing that it's ok to ask for help. "All children should feel worthy and be able to recognize their own strengths," one participant summarized.

Furthering efforts to reduce stigma: Participants wanted the general public to hear about people who are doing well after dealing with mental health challenges. Including cultural and community leaders as spokespeople would help normalize mental illness. One participant suggested that children's books about mental health would be a wonderful addition.

Creating tiny home communities: The group would like revised zoning requirements so property owners can install tiny homes for minimal rent. Currently, permit fees may be unaffordable.

Justice-Involved Consumers with Mental Illness/Center Star Assertive Community Treatment

The seven individuals who participated in this focus group, held in the Center Star, Assertive Community Treatment (ACT) offices, offered insights into their experiences and the services they receive. They discussed the kinds of services they receive, what they liked best about them, and the greatest needs related to behavioral health services.

The Center Star (ACT) program is an intensive, comprehensive program for people with severe and persistent mental illness who have criminal backgrounds. Center Star ACT offers supportive housing, employment readiness training, medication management, monitoring, therapy, drug and alcohol counseling, case management, vocational rehabilitation, peer counseling and support, and housing services. These services are community-based. Support workers are available 24 hours a day for crisis intervention.

Help for clients at Center Star sometimes falls outside typical mental health categories. One woman described how staff helped her visit her imprisoned son, including securing the right paperwork. Another described how Center Star staff accompanied her to court hearings and helped navigate her case. Focus group participants expressed gratitude for the services and staff. One individual, said, "They gave me the tools to stay grounded and be productive." The group was particularly appreciative of the non-judgmental and compassionate approach of the program.

Behavioral Health Needs in San Diego

Participants shared what they saw as the most pressing needs. Their ideas included:

1. Supportive housing needs to be drug-free
2. Transportation is expensive and telecare is limited
3. More affordable housing options are needed
4. Urgent care options for mental health are insufficient
5. Interventions with youth are ineffective
6. Services for people who are released from custody are inadequate
7. Need more shelters for families where they do not have to leave during the day

Supportive housing needs to be drug-free: Participants discussed the prevalence of drugs in independent living facilities, sober living homes, and board and care facilities. They noted that, often, these types of housing are located in neighborhoods with a high density of drug dealers. Although recovery in this type of environment is not impossible, they said, it creates unnecessary challenges to remaining sober.

Transportation is challenging and telecare is limited: Receiving a host of services from different providers in different areas, participants said they sometimes miss appointments. Help is available but challenges remain.

Limited options for affordable housing: Discussed at length, participants were grateful to Center Star for available services. They would like to see single-resident only options expanded.

Lack of urgent care options for mental health: Participants described a desire for clinics, like detox centers for drugs and alcohol, where people could go who had urgent mental health needs that did not yet require inpatient hospitalization.

Interventions with youth are ineffective: Participants described the approach to juvenile offenders as punitive, rather than rehabilitative. A priority is examining the "pipeline from juvenile hall to prison."

Services for people who are released from custody are inadequate: Participants outlined several needs in this area: more job training programs to learn skills that are in need locally, more mentoring programs, and more programs like Center Star.

More shelters are needed that do not require people to leave during the day. Participants identified this as a particularly urgent need for women with children. Families need services inside the shelter and to not be required to wander the streets during daytime hours.

Community Surveys

Community surveys were developed by BHS, translated by IPH into each of the threshold languages, and made available online at *ListenToSanDiego.org*. Final survey instruments can be found in the Appendix, Pages A13-A14. In addition to being available online, surveys were distributed at each forum and focus group. A total of 285 individuals submitted community surveys. The vast majority of these were completed at events (n=272, 95%); only 13 (5%) were submitted online. Sample sizes for each survey item below vary as not all respondents completed each question. For a complete list of responses, see the Appendix, Pages A41-A45.

Community Survey Respondents

Survey respondents were asked to provide the following demographic information: (1) age; (2) gender; (3) ZIP code; (4) primary language; (5) race/ethnicity; (6) household income; (7) type of health insurance coverage; (8) number of people living in household; (9) identification with special populations; (10) highest level of education; (11) employment status; and (12) representation of community groups. Demographics of survey participants are summarized below.

Respondent ages ranged from 19-82 years with a mean age of 44 years (n=246). Ages were categorized into groupings used by BHS (Table 9): 82% of respondents were adults (ages 18-59), 18% were older adults (ages 60+), and 6% represented transitional age youth (ages 16-25). Note that these categories are overlapping and do not sum to 100%. Age data were not provided by 39 (14%) respondents.

Table 9. Survey Respondent Age (n=246) [1, 2]

Age	n	%
Adult 18-59	201	82%
Older Adult 60+	45	18%
Transitional Age Youth 16-25	16	6%

[1] A total of 246 respondents provided their age; n=39 did not.
[2] As age groups are not mutually exclusive (those 18-25 years old are both adult and TAY), numbers will not sum to 246 and percentages will not sum to 100%.

As with forum participants, the majority of the respondents (79%) for the survey identified as female (Table 10).

Table 10. Survey Respondent Gender (n=270) [1, 2, 3]

Gender	n	%
Female	212	79%
Male	21	21%
Other[1]	1	<1%

[1] A total of 270 respondents provided their age; n=15 did not and are not represented in this table.
[2] Percentages may not sum to 100% due to rounding.
[3] One respondent wrote in "gender queer/non-binary"

Survey respondents were asked to indicate their ZIP code. This information was then categorized based on HHSA region. As shown in Table 11, all of the six regions of the County were represented in the survey results. Higher proportions of respondents were observed from the North Central (25%), Central (24%), and East (18%) regions. The fewest responses were received from people living in the South region of the County. Notably, 57 respondents did not provide a valid ZIP code.

Table 11. Survey Respondent Region (n=228) [1, 2]

Region	N	%
North Central	58	25%
Central	55	24%
East	42	18%
North Coastal	25	11%
North Inland	26	11%
South	22	10%

[1] Only those individuals that provided a valid ZIP code (n=228) are represented in this table.
[2] Percentages may not sum to 100% due to rounding.

Participants were asked to indicate the main/primary language they use at home, though they were instructed to select all responses that applied. Most respondents selected only one language; 14% selected more than one. Therefore, the percentages presented in Table 12 represent the number selecting the listed language divided by 270 (those that responded to the question. Most respondents indicated that the primary language used in their home was English, followed by Spanish and Arabic.

Table 12. Survey Respondent Primary Language at Home (n= 270) [1]

Primary Language	n	%
English	245	91%
Spanish	33	12%
Arabic	8	3%
American Sign Language	4	2%
Farsi	3	1%
Tagalog	2	1%
Other: Indonesian	2	1%
Other: Chaldean	2	1%
Other: Native American	2	1%
Other: Amharic	1	<1%
Other: Czech	1	<1%
Other: Ilacano	1	<1%
Hebrew	1	<1%
Italian	1	<1%
Japanese	1	<1%
Korean	1	<1%
Polish	1	<1%
Vietnamese	1	<1%

[1] The number and proportion for each row represent the number of participants (out of 270 that responded to the question) that selected that language. Participants could select one or more than one language so numbers will not sum to 270 and percentages will not sum to 100%.

The racial/ethnic identity of the survey respondents was diverse (Table 13). Again, participants were encouraged to select all responses that applied to them so the denominator is all of those who responded to the question. Most of those responding (86%) selected only one race/ethnicity. Nine percent selected two and 5% selected three or more.

Table 13. Survey Respondent Race/Ethnicity (n= 242) [1, 2]

Race/Ethnicity	n	%
White	147	61%
Hispanic/Latino	31	13%
Mexican	28	12%
African American/Black	7	3%
American Indian/Alaskan Native	10	4%
Asian	10	4%
Filipino	10	4%
European	8	3%
Pacific Islander	6	3%
Iraqi	5	2%
Chinese	5	2%
Middle Eastern	4	2%
African	3	1%
Asian Indian/South Asian	3	1%
Vietnamese	3	1%
Native Hawaiian	3	1%
Japanese	2	1%
Puerto Rican	2	1%
Caribbean	1	<1%
Samoan	1	<1%
South American	1	<1%
Other[1]	15	6%

[1] The number and proportion for each row represent the number of participants (out of 242 that responded to the question) that chose to identify with that group. Participants could select one or more than one race/ethnicity so numbers will not sum to 242 and percentages will not sum to 100%.

[2] Other responses included: Middle Eastern (n=3); Indonesian (n=2); Armenian/German; Israeli; Italian; Jewish; Mixed; Persian; and Portuguese (n=1 each)

Survey respondents were economically diverse in terms of household income, as shown in Table 14 below. Most of the respondents (61%) had household incomes under $100,000, with 32% of respondents reporting household incomes under $50,000. It should be noted that 57 respondents elected to not answer this question, resulting in a sample size of only 228 (out of 285 total respondents).

Table 14. Survey Respondent Household Income (n=228) [1, 2]

Income	n	%
Less than $20,000	20	9%
$20,000-$34,999	19	9%
$35,000-$49,999	32	14%
$50,000-$74,999	37	17%
$75,000-$99,999	28	13%
$100,000-$149,999	43	19%
$150,000-$199,999	30	14%
$200,000 and up	13	6%

[1] A total of 228 respondents provided their household income; n=57 did not and are not represented in this table.

[2] Percentages may not sum to 100% due to rounding.

Participants were asked how they get their health insurance coverage and encouraged to select all options that applied to them (though only 18 respondents selected more than one option). Table 15 shows that of those that responded (n=260), most (70%) have health insurance coverage from an employer, nearly 20% reported having Medi-Cal, and a minority reported being insured through Medicare (7%), Tricare/VA (5%), or coverage they purchased themselves (5%).

Table 15. Survey Respondent Source of Health Insurance (n=260) [1, 2]

Source	n	%
Coverage from Employer	182	70%
Medi-Cal	44	17%
Medicare	17	7%
Tricare/VA	13	5%
Coverage I Buy Myself	13	5%
No coverage	1	<1%
Other[1]	13	5%

The number and proportion for each row represent the number of participants (out of 260 that responded to the question) that selected each insurance source. Participants could select one or more than one source so numbers will not sum to 260 and percentages will not sum to 100%.

[2] Other responses included spouse's or parents' employer-sponsored plans (n=3) and *supplement* (n=1)

Survey respondents were queried about the size of their household. The average household size was 2.9 people and the median was two (n=224). Approximately 17% of respondents reported living alone, 36% lived with one other person, and 38% had three to four people in their household. Nine percent reported five or more people in their household.

Survey respondents were asked if they identified with several groups. Percentages shown are out of the entire sample except those who selected *prefer not to answer* (n=272) as lack of a response likely indicates that respondents did not feel that they belonged to a listed group (Table 16).

Table 16. Survey Respondent Special Populations (n=272) [1, 2]

Group	n	%
LGBTQI	34	13%
Veteran	24	9%
Immigrant	21	8%
Justice-Involved	16	6%
Homeless	11	4%
Refugee	10	4%
Deaf	4	2%
Other[1]	20	7%

[1] The number and proportion for each row represent the number of participants (out of 272 that responded to the question) that chose to identify with that group. Participants could select none, one, or more than one source so numbers will not sum to 272 and percentages will not sum to 100%.

[2] Other responses included: social worker (n=1); senior citizen (n=2); client (n=1); disabled (n=1); gender non-conforming (n=1); traumatic brain injury and chronic pain (n=1); mental health and alcohol addiction (n=1); parenting TAY (n=1); mental health provider at a community-based social service organization (n=1); mental health care (n=1); combined family household (n=1); formerly homeless & justice involved (n=1); Asian/Pacific Islander (n=1); recipient of mental health services (n=1); parent (n=1); and my grandfather was retired army (n=1)

In terms of education, survey respondents were highly educated, with most (55%) holding graduate degrees, and 27% holding college degrees (Table 17).

Table 17. Survey Respondent Highest Level of Education Completed (n=263) [1, 2]

Level of Education	n	%
High School/GED	12	5%
Some College	36	14%
College Degree	70	27%
Graduate Degree	145	55%

[1] A total of 263 respondents provided their educational information; n=22 did not and are not represented in this table.
[2] Percentages may not sum to 100% due to rounding.

Survey respondents were also queried about their employment status and directed to check all options that applied. The vast majority of survey respondents reported that they were working full-time (Table 18).

Table 18. Survey Respondent Employment Status (n=260) [1, 2]

Employment Status	n	%
Working Full-time	206	79%
Working Part-time	30	12%
Student, Full-time or Part-time	20	8%
Retired	10	4%
Looking for Work	8	3%
Other[1]	12	5%

[1] The number and proportion for each row represent the number of participants (out of 260 that responded to the question) that selected each employment status. Participants could select none, one, or more than one status so numbers will not sum to 272 and percentages will not sum to 100%.
[2] Other responses included: disabled (n=2); job pending (n=1); business owner (n=1); some volunteer work to improve resume (n=1); unable to work due to chronic pain and brain injury (n=1); work half-time and watch my granddaughter and son (n=1); taking care of family needs (n=1); and community healthcare volunteer (n=1).

The final question on the Community Survey, "I am a:" asked respondents to check all listed groups to which they applied. Percentages shown below are out of the entire sample except for those who selected *prefer not to answer* (n=277) since lack of a response likely indicates that respondents did not feel that they belonged to a listed group. About a third of respondents selected two or more groups. Nearly half (48%) indicated that they were service providers, 42% identified as community members, 20% indicated that they were consumers or clients, 18% were family members or caregivers, and 17% were stakeholders or advocates. Nine percent of respondents took the opportunity to define their own group (results shown in Table 19).

Table 19. Community Group Representation (n=277) [1, 2]

Community Group	n	%
Provider	132	48%
Community Member	117	42%
Consumer or Client	54	20%
Family member or caregiver	50	18%
Stakeholder or Advocate	46	17%
School Personnel	9	3%
Law Enforcement	6	2%
Other[1]	24	9%

[1] The number and proportion for each row represent the number of participants (out of 277 that responded to the question) that chose to identify with each group. Participants could select none, one, or more than one group, so numbers will not sum to 277 and percentages will not sum to 100%.

[2] Other responses included: County staff (n=3); do not like the term consumer – it's degrading – I am a human with mental health challenges using services (n=1); patient advocate (n=1); public health employee (n=1); contractor with the County of San Diego (n=1); patient on disability (n=1); PEI educator (n=1); Adult Council (n=1); Researcher (n=1); non-profit providing services to survivors of suicide loss (n=1); peer support specialist (n=1); health plan MediCal managed care (n=1); government agency (n=1); peer (n=1); an employee in a health center (n=1); entrepreneur (n=1); mental health advocate (n=1); community social service employee (n=1)

Community Survey Opinions

In addition to requesting demographic information, survey respondents were asked their opinions about access to and barriers to behavioral health care in San Diego. In the first opinion question, respondents were asked to rate, on a scale of *very unlikely* to *very likely* listed reasons for why people who need it might not access behavioral health services. The answer most frequently chosen as *very likely* (by 62% of respondents) was *they are embarrassed, ashamed or worried about what people will think about them*. The majority of respondents rated all of other suggested reasons for failing to access care as either *somewhat likely* or *very likely*. See Table 20.

Table 20. Why do you think someone might not be getting the care they need for mental health or substance abuse disorders? [1, 2]

Reason	Sample size	Very unlikely	Somewhat unlikely	Somewhat likely	Very likely
They do not know they can afford help	281	3%	10%	41%	46%
They do not know if their insurance will cover care, or if they can qualify for a public program	283	3%	8%	39%	50%
They do not know that there are services that could help them	280	3%	10%	40%	47%
They think it will take too long to get help	280	3%	11%	47%	39%
They are embarrassed, ashamed or worried about what people will think about them	281	3%	6%	30%	62%
They do not have transportation to get care	281	3%	11%	39%	48%
They do not know where to get care	279	3%	7%	32%	58%
They cannot take time off work or get child care	280	5%	10%	39%	45%

[1] Only those participants who responded to each item are represented in the table; therefore, sample sizes will vary.

[2] Percentages may not sum to 100% due to rounding.

The next question asked respondents to rate, on a scale of "very unhelpful" to "very helpful," a list of supports that might help someone get the behavioral health care they need. The choice with the highest percent of "very helpful" response was "you are a part of the team making decisions about your care and get a say in how you get care" (71%). All other suggested supports were rated as "somewhat helpful" or "very helpful" by the vast majority of respondents. See Table 21.

Table 21. What could better support you, a friend, a family member, or loved one in getting care for mental health or substance use disorders? [1, 2]

Support	Sample size	Very unhelpful	Somewhat unhelpful	Somewhat helpful	Very helpful
You have someone to help you keep track of appointments and medications, remind you about appointments, and make sure that you can get to the appointment or pharmacy	284	3%	5%	35%	57%
You are part of the team making decisions about your care, and get a say in how you get care	282	3%	4%	22%	71%
You can get care or help from someone who has had similar experiences and understands your situation	278	3%	4%	36%	57%
You have someone who helps you with other needs like food, housing, childcare, or transportation	278	4%	4%	23%	70%

[1] Only those participants who responded to each item are represented in the table; therefore, sample sizes will vary.
[2] Percentages may not sum to 100% due to rounding.

Respondents were asked whether there might be other ways to better support those getting care for mental health or substance use disorders. These responses included those that would augment or add to existing services: housing (inclusive of families) or a safe place to sleep while receiving care or while medicated [n=7]; culturally responsive, holistic medical care [n=6]; language translation or multilingual staff [n=5]; care and system navigation or coaching [n=3]; access to transportation [n=3]; elimination of financial burden [n=2]; coordinated wrap-around care [n=2]; group therapy and support [n=2]; peer support [n=2]; linkages to social outlets and others to talk to [n=2]; increased access to detox services; reduced wait for appointment times; direct linkage; nonjudgmental care; individualized treatment; evaluation of treatment rather than patient-blaming when no progress is being made; increased care options; mobile psychiatric and medication services; prevention services; access to care for mild and moderate mental illness; assistance with daily activities; and employment support. Respondents also mentioned that better support could come from changes in knowledge and perceptions: reduced stigma in receiving services [n=2] and education about available services.

The survey explained that the County of San Diego Health and Human Services Agency, Behavioral Health Services considers several issues when they are creating a plan and budget for serving the community. Respondents were asked to rank the priority of each of the issues. Results

are summarized from highest priority to lowest priority in Table 22, with the mean and median values listed (1=low priority, 6=high priority)

Table 22. Ranked issues to consider for planning and budget [1, 2]

Issues to consider for planning and budget	Mean	Median
If people who need help are getting the right kind of help in a timely manner	5.5	6
If people are happy with the care they are getting and how they are being treated	5.3	6
If doctors and other health care providers are giving people care based on what they know works best	4.9	5
If people can get help from "peers"	4.7	5
If it uses resources wisely, for example, giving people a service that costs less, or will mean fewer costs down the road, or helps save money to provide more services and serve more people	4.7	5
If it makes San Diego County healthier overall	4.5	5

[1] Only those participants who responded to each item are represented in the table; therefore, sample sizes will vary.
[2] Percentages may not sum to 100% due to rounding.

Community Survey Experiences

Respondents who had accessed (or had a family member access) care were asked a series of questions about their experiences. Reported wait times were relatively evenly split between less than a week, 1-2 weeks, less than a month, and more than a month. Twelve percent of respondents reported waiting more than three months to get care (Table 23).

Those with experience (or family member experience) receiving care were asked to indicate their level of satisfaction with the care they had received. More than half of respondents reported being *satisfied* or *very satisfied* with their care. Less than 20% reported being *not very satisfied*.

Table 23. Experiences accessing care [1, 2, 3]

Question *Response Options*	Percent
On average, how long did it take you or your family member to get care? (n=165)	
Waited less than a week	21%
Waited 1-2 weeks	19%
Waited less than a month	25%
Waited more than a month	22%
Waited more than 3 months	12%
Were you satisfied with your experience? (n=167)	
Very satisfied	25%
Satisfied	31%
Somewhat satisfied	24%
Not very satisfied	19%
Other[1]	2%

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

[2] Only those participants who responded to each item are represented in the table; therefore, sample sizes will vary.

[3] Other responses to satisfaction question included: "in process"

Consumers are linked to care through a variety of different sources. Understanding these sources can help BHS to direct promotional materials and resources appropriately. Survey respondents were asked how they found out about the program or place where they received care. Responses were open-ended and were grouped into categories summarized in Figure 2. The most common referral source was through the health care setting, including insurance and individual clinicians.

Respondents were asked what other resources should be available and/or would have been helpful. Figure 3 lists these suggested services grouped into two main categories: improving access and adding new services. Suggestions about improving access included making it easier to identify available services, expanding existing services, reducing wait times, and reducing barriers to care.

Lastly, respondents were asked whether they had any other comments, questions, or concerns. These responses are listed in the Appendix, pages A45-A49.

Figure 2. Care referral sources

- Healthcare industry (n=62)
    - Insurance (Kaiser, Employee Assistance Program, etc.) [n=31]
    - Healthcare provider (PCP, clinic, VA) [n=23]
    - Hospital/Emergency Department [7]
    - Therapist [1]
- Referrals from self, friend, or system (n=54)
    - Word of mouth [n=22]
    - Online [n=19]
    - Phone referral (211 San Diego, Access Line) [n=9]
    - Email [n=2]
    - Directory [n=1]
    - Driving by [n=1]
- Service providers and governmental organizations (n=24)
    - Non profit organization (NAMI, Alpha Project, Chaldean Association, UPAC, Catholic Charities, etc.) [n=12]
    - County Agency (child welfare services, mental health services) [n=7]
    - Church (minister, jail chaplain, church program) [n=4]
    - CalWorks [n=1]
- Mandated Care (n=6)
    - Court [n=2]
    - Law enforcement/PERT [n=2]
    - Involuntary commitment [n=2]
- Other (n=2)
    - Paid out of pocket for private practice
    - Had to go out of state to receive appropriate care/services for teenaged son

Figure 3. Are there other resources that you think should be available and/or would have been helpful?

- Accessing services
  - Finding available services
    - Easy to use and well-known referral system
    - More awareness of helplines like 211 and the access and crisis line.
    - More Public information about who to call, where to go, and we need more funding for treatment, ongoing counseling, support, etc.
    - Please make it easier to find services.
    - Bed Locator at all Hospitals
  - Expanding existing services
    - More PERT officers
    - More detox beds
  - Reducing wait times
    - Timely care and less paperwork.
    - Quicker access to counseling
    - More experienced psychiatrists with less wait times
  - Reducing barriers to care
    - Mentoring, cheaper counseling, more community based rehab program that don't cost thousands of dollars, targeting select low income neighborhoods, providing cheaper care for struggling parents, etc.
    - Please make it more accessible for low income single parent households
    - Lower legal barriers to medical care for former workman's comp cases.
    - MTS should have low fare for disabled including those currently seeking treatment like honored citizen
- Additional services
  - Housing for low income and better homeless services.
  - I think having someone follow up 24 hours after an attempted suicide or release from mental health facility, jail or prison would be useful.
  - Wrap around expansion; longer services
  - Long term, no cost, peer advocacy
  - direct help with insurance issues
- Other
  - Families should be more involved in the process
  - Yoga. Healthy food. Healthy lifestyle

Conclusions

The IPH was honored to be chosen to help the County of San Diego implement the community program planning process. Community members and service providers from across the county came together to identify high priority needs and generate new ideas about approaches to behavioral health. Community program forums attracted hundreds of people to participate allowing for a wide breadth of discussion. Smaller focus groups allowed for in-depth feedback from people who have lived experiences with receiving and providing behavioral health services. Community surveys, filled out by nearly 300 people, provided quantitative data and another means through which to gather input. Participants in the forums expressed a high level of satisfaction with the process, the venue choices, the days and times chosen, and the topics discussed.

Participants in the group events seemed truly engaged. Conversations were lively and productive and often continued after the events had officially ended. The IPH was impressed with the willingness of community members to give their time, share their own experiences, actively listen to other participants' feedback, and work collaboratively to come up with ways to solve San Diego's most concerning behavioral health problems. A wealth of valuable information and insights was collected.

Remarkably similar themes emerged from each type of engagement effort. Recurring themes included *prevention, expansion, coordination, and culture/community.*

Prevention

At each engagement event, prevention was identified as crucial to improving the behavioral health of San Diegans. Current services were described as reactive, rather than proactive, and community members frequently expressed a belief that too few preventive services are offered.

Both primary and secondary prevention efforts were deemed important. A recurring idea was that primary prevention services must include, at their core, services to address the basic needs of community members, such as the stress of unstable housing, food insecurity, neighborhood violence, unemployment, and other social issues. It was emphasized that lack of basic services contributes to worsening mental health and the initiation of substance use. Repeatedly, prevention of and addressing homelessness was named as one of the most important ways to improve community health. When these kind of social issues are not addressed, they pointed out, prevention cannot really occur.

Effective prevention, participants asserted, must start at a very young age. School-based wellness programs, in which healthy habits are taught, mental health is discussed, social skills are learned, and coping skills are emphasized were viewed as a key component of prevention. In order to be demystified and to reduce stigma, mental health needs open discussion. Accurate, but nonjudgmental, information about the potential harms of substance use, particularly marijuana, vapes, and alcohol needs to be given frequently. For children who have experienced trauma,

effective, timely, non-punitive trauma-informed therapy would go far to prevent behavioral health problems in adulthood.

Prevention also includes engaging people in community institutions (like schools) and in enjoyable, no-cost social and recreational activities. For both children and adults, participants emphasized that feeling connected to other people and having the opportunity to relax by participating in art, music, athletics, and other recreational activities are necessary to good behavioral health.

In terms of secondary prevention, professionals and lay people alike need to recognize the signs and symptoms of a mental health crisis and substance use disorders. At several events, participants advocated for ongoing, large scale, public awareness campaigns, utilizing mass media and social media, to create awareness and reduce stigma around mental illness. These campaigns should also include information about where and how to report concerns and access services. Better education about how to identify high-risk individuals for parents, teachers, health care professionals, and mental health service providers would help ensure that people get services before a crisis occurs.

Finally, the provision of easily accessible “urgent care” mental health and substance use services was deemed important. Too often, participants noted, this kind of care is not always available; rather, to receive timely services, an individual must already be in crisis.

Expansion

Another common theme across events was that while the community appreciates the services that are available, these services need to be expanded, both in terms of how many services are available and when they are available.

Two specific services were discussed most frequently: (1) PERT teams; and (2) inpatient psychiatric hospitalizations. PERT teams were discussed at length. While some felt that these teams need to be improved to become more culturally sensitive and trauma-informed, the universal belief seemed to be that more PERT teams would be valuable and that these teams need to be available 24 hours a day, seven days a week.

Another problem identified at nearly every event is the shortage of in-patient, psychiatric beds. This issue, the community reported, is compounded by the shortage of transitional housing programs and services for those who are ready to discharge from a psychiatric hospitalization. Wait times for these “step-down” programs are long; individuals with limited resources ended up remaining hospitalized after they are ready for release. This, in turn, exacerbates the shortage of beds for people in crisis.

The expansion of services to reduce barriers to care was also identified as crucial. The provision of more services for transportation, childcare, and assistance with enrolling in public and private health insurance programs would improve access.

Finally, the community expressed frustration to the challenge to access services outside of regular business hours. Behavioral health crises occur at all hours of the day and, many believe, are more likely to occur at night, on weekends, and on holidays. Services are often not available at these times. People in crisis then end up in emergency departments, where care is expensive, and effective resources for behavioral health problems are limited.

Coordination

Of particular concern to San Diegans is the lack of coordination of care across services. Although providers and lay people alike agree that physical, social, and mental well-being are interdependent, care was described as occurring in "silos" both within and across these domains. Service providers too often do not know a consumer's medical or psychiatric history or enough about their overall well-being and available support systems. Providers are generally unable to access this information and are almost never able to communicate with each other about an individual client/patient. Ideally, each person would have a team of care providers who were informed of their history and who together with the client/patient would create a multi-disciplinary care plan.

The lack of care coordination was also discussed extensively in terms of transitional services. People leaving custody, drug treatment programs, and inpatient psychiatric hospitalizations, are often discharged without adequate supports in place like housing, access to food, employment assistance, transportation, and medication management. This lack of support makes maintaining good physical and mental health challenging. This, then, leads to a vicious cycle wherein an individual receives crisis services, gets discharged, and ends up back in crisis shortly thereafter.

Participants in the engagement process were emphatic that care providers would welcome the opportunity to collaborate and to coordinate a patient/client's care. Consumers themselves indicated, particularly in the community survey, that the opportunity to participate on a team to make decisions about their own care would make them far more likely to obtain services. The lack of coordination, then, seems to arise from constraints on time and resources. However, it was noted these efforts would make care more efficient and less expensive in the long-term. Offering cross-discipline educational and networking opportunities was discussed as one way to approach improved care coordination and collaboration.

Another solution, suggested several times, was the creation of one-stop resource centers (within each HHSA region) where community members could receive a wide-range of well-integrated care, from seeing a physician, to assistance with housing, to counseling for a mental health issue. The center could include walk-in clinics for urgent care needs. This would not only increase access to care for community members, but would also allow for easier professional collaboration and care coordination.

Culture/Community

At every engagement event, participants discussed the need for more culturally and linguistically competent care. San Diego County was recognized as a diverse community with a large refugee and immigrant population. Many religions, cultures, and traditions are represented. The care that is offered, however, is often designed for "mainstream" culture and given by providers who do not know the consumer's language or understand his/her culture. This mismatch between providers, services, and the consumer can contribute to misunderstandings and a lack of trust. This, in turn, makes people hesitant to seek out care.

In addition to having services like translators available, participants thought that basing services within communities was an important step toward addressing this issue. Residents want, they asserted, to receive care in their own neighborhoods. Lay people from within the community could be hired, or brought on as volunteers, to serve as navigators and patient advocates. By immersing themselves in the community, providers would learn about the community's needs and become more sensitive to them. Cultural leaders could be involved in the design of the programs and services and in promoting them and traditional "healers" could be involved in care provision.

Another option discussed was to have more "mobile units" that travel to different communities and offer care and services on-site at places like schools. While this was seen as a less desirable option, this would, at least, improve access and be an opportunity for residents to receive "quasi" community-based care.

Creating tiny home communities was another approach discussed at several engagements. Making these communities available to low-income, unstably housed, and homeless individuals was seen as a viable option to preventing and addressing homelessness. In order to build a sense of community and ensure access to services, these communities would need to include clinics to provide a wide-range of services, as well as recreational facilities, and opportunities for socialization and entertainment.

Finally, participants expressed a need for further education and training of providers and parents. Providers would like to enhance their own cultural competency and to be informed about best practices for specific groups of people. Parents would like to better understand their children's needs. And everyone felt that understanding how to meet the needs of particular subpopulations, including immigrants, refugees, homeless individuals, people with co-occurring issues, teens, and LGBTQI individuals, among others, is crucial to improving San Diego's behavioral health.

Participant Evaluations for Events

Community Forum Participant Evaluations

Forum participants were asked to complete evaluations assessing their satisfaction with the event; results are summarized herein. Overall satisfaction was high (Table 23) and satisfaction improved over time as improvements were made based on preceding forums and ranged from a 80% of participants reporting being *satisfied* or *very satisfied* at the first (Combined Council) forum to 95% of participants at the Innovation Forum in National City related to co-occurring disease (Table A3). See the Appendix, Pages A19-A20 for Tables A3-A8.

Forum participants were asked about convenience of the event location. The Innovation Forum in Spring Valley received the lowest marks, with only 73% of participants rating it as *convenient* or *very convenient*. The QLN Conference Center in Oceanside was polarizing, as 11% rated it *not at all convenient* while 82% found it *convenient* or *very convenient* (Table A4).

Overall, participants found the selected days of the week good fits or their schedules. The lowest rated forum was held on a Friday in Escondido; only 88% of participants *agreed* or *somewhat agreed* that the day of the week was a good fit (Table A5).

Participants were also asked about whether the time of the event was a good fit for their schedule. An evening forum was held in order to accommodate those who work jobs with traditional hours. Interestingly, the evening forum (Chula Vista) received the lowest overall marks on time of day and was the forum with the lowest number of attendees. Mornings tended to be well rated. Afternoons and evenings were less well rated (Table A6).

Forum participants were asked whether the topics covered at the event were useful. The general forums covered three topics: services for those experiencing a mental health crisis, school violence and threats of violence, and drug and alcohol use among teens and young adults. These general forums were well rated, with all attendees (with the exception of a handful at the Combined Council meeting) agreeing or somewhat agreeing that the topics were useful. There was broad agreement regarding the Innovation Forum topics as well; no fewer than 97% of attendees at each of the Innovation Forums *agreed* or *somewhat agreed* that the topics were useful (Table A7).

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 A8).

Participants were also asked to provide suggestions for how the events could be improved. These responses were qualitatively coded into themes. The most common responses focused on logistics and the absence of some community-members. Many participants took the opportunity to recognize the organization and thank the facilitators. These comments and complaints are listed in Figure 6 in the Appendix, Page A21.

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL
SAN DIEGO

Appendix

County of San Diego
Health and Human Services Agency
Behavioral Health Services
Community Engagement Report
2018

SAN DIEGO STATE UNIVERSITY
Institute for Public Health

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Registration Form



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

The County of San Diego Wants to Hear From You!

Event Registration Date: ____/____/2018 ☐ AM ☐ PM

* Required Fields

Email *

Name * First Name Last Name

Gender * ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

Age *

ZIP Code *

Please review the list below and check the box(es) of the groups you identify with. (Select all that apply)

- ☐ African
- ☐ African American
- ☐ Asian/Pacific Islander
- ☐ Chaldean
- ☐ Homeless
- ☐ Immigrant
- ☐ Latino
- ☐ LGBTQI
- ☐ Native American/American Indian
- ☐ Refugee
- ☐ Veterans/Military

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

- ☐ Community Member
- ☐ Consumer/Client
- ☐ Family Member of Consumer
- ☐ Law Enforcement
- ☐ School Personnel
- ☐ None of the above

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 for attending events during normal business hours.

- ☐ Yes
- ☐ No

Please select the topic that you wish to discuss at this event. *

(We encourage you to attend more than one event if you'd like to discuss more than one topic.)

- ☐ Services for people experiencing mental health crises
- ☐ Drug or alcohol use among teens and young adults
- ☐ School violence and threats (from kindergarten through community colleges)

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
- ☐ No

ListenToSanDiego.org Website



LIVE WELL SAN DIEGO | HHSA

The County of San Diego Wants to Hear From You!
Events & Community Feedback Survey

Please join us at any of the events below to share your ideas about Behavioral Health Services in San Diego!

Topics for discussion

- Drug and alcohol use among teens and young adults
- School violence and threats
- Services for people experiencing a mental health crisis

Monday, October 8, 2018

10 am - 12 pm

National University

9388 Lightwave Avenue,
San Diego, CA 92123

Register »

Wednesday, October 10, 2018

2 pm - 4 pm

Ronald Reagan Community Center

195 Douglas Avenue,
El Cajon, CA 92020

The following Language translation services will be available at this event:
Arabic

Register »

Monday, October 15, 2018

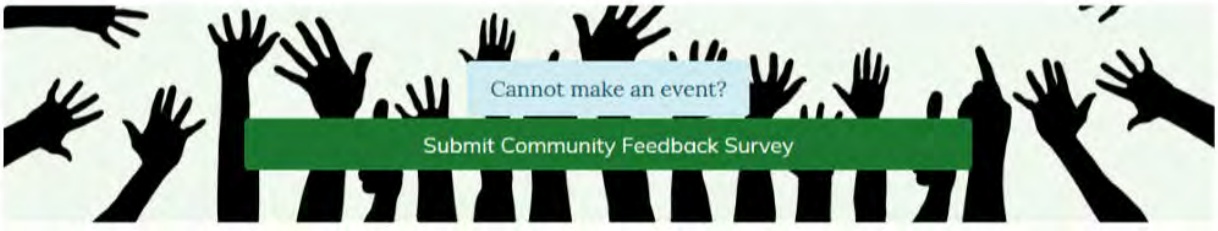
9 am - 11 am

Tubman Chavez Community Center

415 Euclid Avenue,
San Diego, CA 92114

Register »

Refreshments will be provided. Community members will receive a $5 gift card for participating.





LIVE WELL SAN DIEGO | HHSA

ترغب مقاطعة سان دييغو أن تسمع منكم
استبيان نتائج المجتمع

نرجو الانضمام الينا لأحدى المناسبات ادناه لغرض تبادل افكاركم عن الصحة السلوكية

مواضيع للنقاش

- تعاطي المخدرات والكحول بين المراهقين وصغار البالغين
- العنف المدرسي والتهديدات
- خدمات للأشخاص الذين يعانون من أزمة الصحة العقلية

الأثنين، 8 تشرين الأول 2018

10 am - 12 pm

National University

9388 Lightwave Avenue,
San Diego, CA 92123

سجل

الأربعاء، 10 تشرين الأول 2018

2 pm - 4 pm

Ronald Reagan Community Center

195 Douglas Avenue,
El Cajon, CA 92020

ستتوفر اللغات التالية في هذا الحدث : العربية

سجل

الأثنين، 15 تشرين الأول 2018

9 am - 11 am

Tubman Chavez Community Center

415 Euclid Avenue,
San Diego, CA 92114

سجل

سيتم توفير المرطبات. سيحصل اعضاء المجتمع المؤهلين على بطاقة هدية بقيمة 5 دولارات لمشاركتهم



Community Forum Flyer

The County of San Diego Wants to Hear From You!

Please join us at any of the events below to share your ideas about Behavioral Health Services in San Diego!

We want your input on:

- Drug and alcohol use among teens and young adults
- School violence and threats
- Services for people experiencing a mental health crisis

Register at ListenToSanDiego.org

Special accommodations, including interpretation services, **must** be requested through your registration

Date: Monday, October 8, 2018 Time: 10am to 12pm	National University 9388 Lightwave Avenue, San Diego, CA 92123
Date: Wednesday, October 10, 2018 Time: 2pm to 4pm	Ronald Reagan Community Center 195 Douglas Avenue, El Cajon, CA 92020
Date: Monday, October 15, 2018 Time: 9am to 11am	Tubman Chavez Community Center 415 Euclid Avenue, San Diego, CA 92114
Date: Thursday, October 25, 2018 Time: 6pm to 8pm	Norman Park Senior Center 270 F Street, Chula Vista, CA 91910
Date: Wednesday, October 31, 2018 Time: 10am to 12pm	QLN Conference Center 1938 Avenida Del Oro, Oceanside, CA 92056
Date: Friday, November 9, 2018 Time: 1pm to 3pm	Park Ave Community Center 210 E. Park Avenue, Escondido, CA 92025

You can also join us to discuss **new approaches** to the topics listed below!

Topic: New approaches to behavioral health services

Date: Wednesday, October 10, 2018 Time: 10am to 12pm	San Diego Youth Services 3845 Spring Drive, Spring Valley, CA 91977

Topic: New approaches to addressing homelessness

Date: Monday, October 15, 2018 Time: 2pm to 4pm	Malcolm X Library 5148 Market Street, San Diego, CA 92114

Topic: New approaches to co-occurring mental health disorders and developmental delays

Date: Wednesday, October 17, 2018 Time: 3pm to 5pm	San Diego Regional Center 2727 Hoover Ave #100, National City, CA 91950

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Refreshments will be provided. Community members will be eligible to receive a $5 gift card for participating.

For questions or to register by phone, call 619-594-4409

Can't make an event? Give us your input through our community survey at ListenToSanDiego.org



Promotional Canvassing

Table A1. Organizations Targeted by Promotional Canvassing

Method	Targeted Organization
Cold-calling	BHS Mental Health Clubhouses
	City Heights Roundtable
	CSU San Marcos - Dept of Social Work
	CSU San Marcos - Psychology Student Org
	Cuyamaca College - Psychology Dept
	Grossmont College - Dept of Behavioral Health Sciences
	Mira Costa College Dept of Psychology
	Operation Samahan
	Palomar Outpatient Behavioral Health
	San Diego City College - Dept of Psychology
	San Diego Regional Center - National City Office
	San Diego Regional Center - Santee Office
	San Diego Unified School District MHRS
	San Ysidro Health Center
	SAY San Diego – Social Advocates for Youth
	SDSU Dept of Psychology
	SDSU Dept of Psychology - Psychology Clinic
	SDSU School of Public Health
	SDSU School of Social Work
	SDSU/UCSD Joint Doctoral Psychology Program
In-person flyer delivery	Bayview Behavioral Health Hospital
	Bayview Clubhouse
	Boys and Girls Club
	Boys and Girls Clubs of Oceanside
	BPSR Escondido Clubhouse
	BPSR Kinesis North
	Chavez Resource Center
	Chula Vista Family Counseling Center
	Chula Vista Family Health Center
	Chula Vista Psychological Services
	Chula Vista Public Library Civic Center Branch
	Crown Heights Community Resource Center
	Escondido Public Library
	Joe Balderrama Recreation Center
	John Landes Recreation Center
	Junior Seau Recreation Center
	Library - Georgina Cole, Carlsbad
	Library - Oceanside Public Library Mission Branch
	Mariposa Clubhouse
	Melba Bishop Recreation Center
	MHS - Family Force
	MHS Family Recovery Center
	NAMI North Coastal

Method	Targeted Organization
	National Alliance on Mental Illness
	NCHS Oceanside Health Center
	Neighborhood Healthcare
	Norman Park Senior Center
	North County Crisis and Intervention Response Team
	North County Health Services
	North County Lifeline – Oceanside Office
	North County Psychological Center
	North Inland Mental Health Center (MHS)
	North Star ACT
	Oceanside Public Library
	Oceanside Senior Citizen Center
	Otay Recreation Center
	Palomar Family Counseling Services
	Palomar Family YMCA
	Park Avenue Community Center
	QLN Conference Center
	South Bay Community Services
	Southwestern College
	Strength Based Case Management Centers
	Third Avenue Comprehensive Treatment Center
	Welcome Home Ministries

Media Advertisements

Table A2. Media Advertisements

Method	Media Resource
Media buys	OsideNews.com
	Coastal News
	La Prensa San Diego
	San Diego Voice and Viewpoint
Organizations targeted for social media campaigns	County of San Diego HHSA
	Live Well San Diego
	SDSU Graduate School of Public Health
	SDSU School of Social Work
	CSU San Marcos Social Work Coalition
	Mental Health America of San Diego County (MHASD)
	Chula Vista Community Collaborative
	NextDoor.com
	San Carlos Neighborhood Connection
Online calendars	News: CBS 8/KMFB 760 Community Events Calendar
	KPBS Community Events Calendar
	KUSI Community Events Calendar
	211SanDiego.org Events Calendar
	Malcolm X Branch Library online events calendar

Media Buy Examples

Figure 1. San Diego Voice & Viewpoint newspaper advertisement



IN OTHER NEWS

12 THURSDAY, OCTOBER 11, 2018 * The San Diego Voice & Viewpoint * www.sdvoice.info

HEALTHY LIVING:

UNHAPPY GUT? SOME PEOPLE SUFFER FOR YEARS BEFORE SEEING A DOCTOR

By StatePoint

Abdominal pain? Diarrhea? An estimated 16 million Americans live with a type of irritable bowel syndrome called IBS-D (the D stands for diarrhea), and it affects both men and women almost equally. However, only 30 percent of individuals consult a physician about their symptoms.

Why is that?

"People who experience symptoms of IBS-D can feel like their symptoms are not severe enough to seek medical attention or that there isn't anything doctors can do to help," says Dr. Howard Franklin, vice president of medical affairs and strategy at Salix Pharmaceuticals. "But doctors want to hear about everything you are feeling so they can determine the underlying cause of your discomfort and help you find a treatment plan that is right for you."

A closer look at IBS-D

Symptoms of IBS-D, which are different in everyone, include stomach pain and cramping, frequent diarrhea, gas, bloating and an urgency to use the bathroom. Many people experience feeling frustrated, missing out on activities because of symptoms and avoiding situations where there is no bathroom nearby.

IBS-D can be diagnosed based on symptom history, including:

- Abdominal pain at least one day a week during the last three months
- More than 25 percent of bowel movements are loose or watery (diarrhea), and less than 25 percent are hard or lumpy (constipation)
- Symptoms started at least six months ago

What could be the cause?

While the exact cause of IBS-D is unknown, and people may have IBS for more than one reason, an imbalance in the usual numbers and proportions of normally healthy bacteria in the digestive system (the gut microbiota) has been found in many people with IBS-D. The microbiota help digest and absorb food and work with the immune system as a barrier against other microorganisms that can cause disease.

"One study of 109 patients with IBS showed that 73 percent had an imbalance in their gut microbiota, compared with only 16 percent of healthy people," says Dr. Franklin. "Other potential reasons may include previous gastrointestinal infection or food poisoning, communication problems between the brain and digestive system, a family history of IBS and other causes."

Treatment options

There is currently no cure, but there are treatments that can help with the symptoms of IBS-D. Lifestyle changes, such as eliminating certain foods and increasing exercise, could help.

"Studies have shown that between 50 and 70 percent of patients failed to respond to either fiber or antispasmodics as a treatment therapy," says Dr. Franklin. "There are different types of prescription treatments for IBS-D. If one isn't working, it's important that patients ask their healthcare professional about trying a different medicine to find what treatment is right for them."

For more information, visit IBSDiagClassic.com.

If you're experiencing symptoms of IBS-D, don't be afraid to talk to your doctor about all of them. This is the first step toward helping find a treatment plan and getting relief.

HEALTHY COUNT… INPUT O… ABUSE… HEALT…

By Jose A. Alvarez

Drug abuse. Mental ill…

If you've been affected… behavioral health issu… Services Agency wa…

A series of nine, tw… throughout the regio… of services needed in… issues.

The County's goal is t… experience with behav… other issues, includi… issues who are experi… wants to hear from the… providers and commu…

You need to register, a… when registering. Reg… by calling (619) 594-… the forums. Comm… $5 gift card for part…

The information ga… to spend federal and… Services Act funding, w… in 2004. The Act impos…

The County of San Diego Wants to Hear From You!

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We want your input on:
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EDUCATION:

SAN DIEGO UNIFI… MAGNET SCHOOL… APPLICATION WIN… OPENS FOR 2019

More than 10,000 area studen…

Voice & Viewpoint Newswire

SAN DIEGO - Monday, October 1st marked the start of the school choice window for the 2019-20 school year at San Diego Unified School District. School Choice gives students the chance to enroll next year in magnet programs or schools outside their neighborhood boundaries. The program is open to all existing San Diego Unified students, as well as out-of-district students, and students attending schools in other settings such as private or charter schools.

The priority application deadline is November 13. After that date, any applications received are processed in timeliness order of receipt. School Choice enrollment is determined through a computerized lottery system, with weight given to factors such as sibling enrollment and magnet program continuity.

Each year, more than 10,000 area students apply for the choice program to attend one of the 170 schools in San Diego Unified. Last year, approximately 75 percent of all students were seated at one of their three choices of schools.

"All of our schools provide students with an education that will prepare them for college or career," said Superintendent Cindy Marten.

Figure 2. The Coast News newspaper advertisement



THE COAST NEWS

FOOD&WINE

A 'ristobar' is born in Carmel Valley

taste of wine

frank mangio

AMICI'S RISTOBAR

AMICI'S RISTOBAR is in the hands of owners Louisa Lisckiewski, left, and Citrix Lisckiewski, with a menu created by Chef Roelle Gabriel.

Wine: A fundraising helper

Once again, winemakers have come through for worthy causes, providing them with the resources to raise funds for direct support for needy members of our community. One of my favorites is the annual Make A Wish benefit in San Diego and Imperial counties, through the auction of fine and silent auctions

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

You're Invited!

The County of San Diego Wants to Hear From You

Please join us and share your ideas about:
- Drug and alcohol use among teens and young adults
- Services for people experiencing a mental health crisis
- School violence and threats

EVENT INFO

WEDNESDAY	FRIDAY
October 31, 2018 10am to 12pm	November 9, 2018 1pm to 3pm
QLN Conference Center 1938 Avenida Del Oro Oceanside, CA 92056	Park Ave Community Center 210 E. Park Avenue Escondido, CA 92025

Register at ListenToSanDiego.org

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For questions or to register by phone, call 619-594-4409

Gift Card

Can't make an event? Give us your input through our community survey at ListenToSanDiego.org

The Cros…

Anxiety? D… Your S…

Transcrani… Stimulation (T… Therapy with …

FDA AP… NON-INVASI…

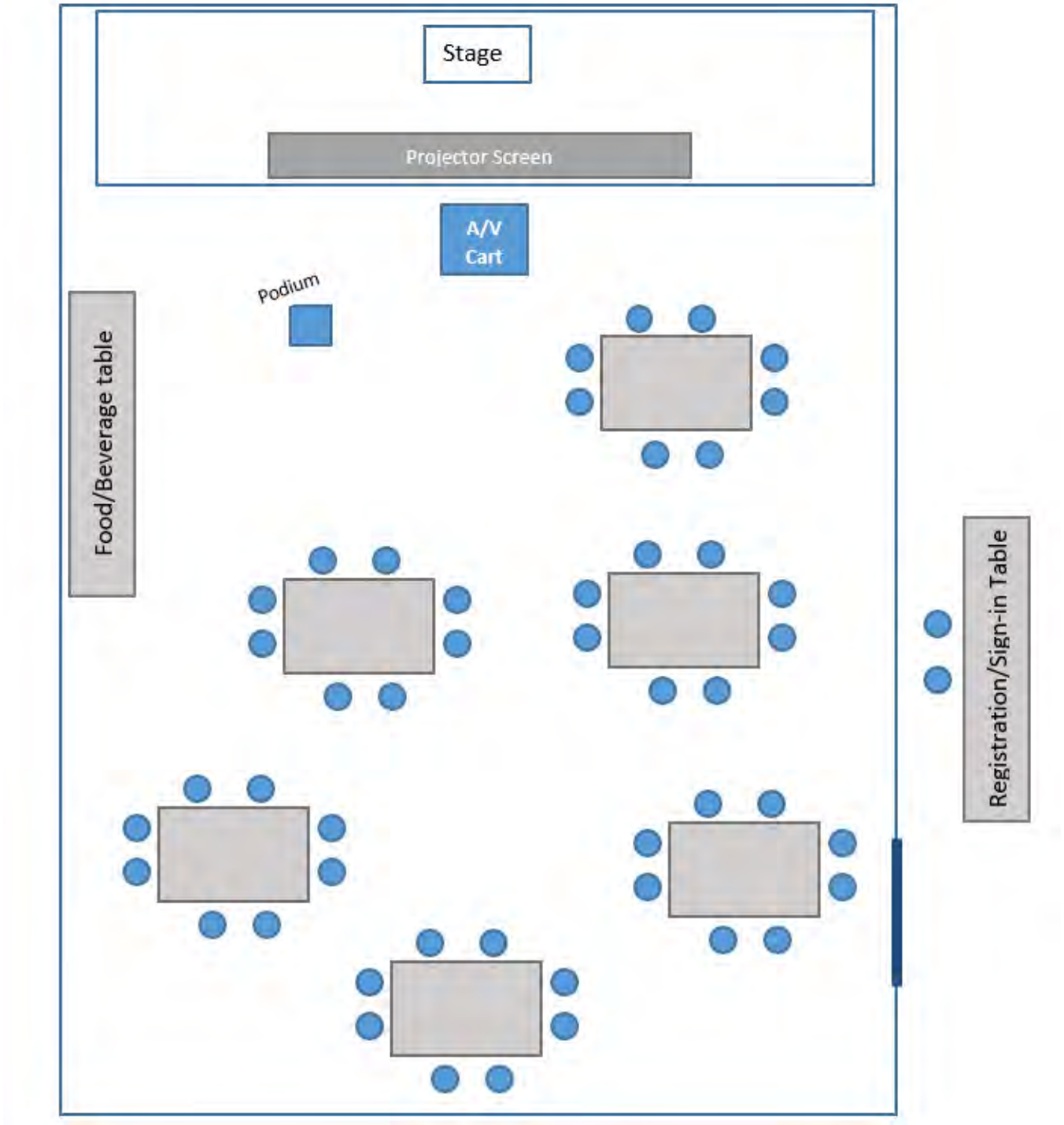
Restore Your He…

(760)…

WWW…

Forum Layout

Figure 3. Room Design



Forum Agenda

Behavioral Health Community Engagement Forum

November 9, 2018 1-3 p.m. Park Ave Community Center

Agenda

☐ Noon – 12:45	**SET-UP**
☐ 12:45 – 1:10	**REGISTRATION**
☐ 1:10 – 1:25	**GUEST SPEAKERS AND ANNOUNCEMENTS** Greet and seat late arrivals
☐ 1:25 – 1:30	**INTRODUCTIONS & GROUND RULES**
☐ 1:30 – 1:50	**ASK "KEY CHALLENGE" QUESTIONS & TAKE NOTES**
☐ 1:50 – 2:00	**PRIORITIZE THE PROBLEMS/NEEDS/CHALLENGES**
☐ 2:00 – 2:10	**BREAK** Encourage your table to fill out their community survey
☐ 2:10 – 2:15	**IDENTIFY "KEY CHALLENGE" – ICLICKER VOTE**
☐ 2:15 – 2:35	**ASK "SOLUTION" QUESTIONS & TAKE NOTES**
☐ 2:35 – 2:40	**PRIORITIZE IDEAS/SOLUTIONS**
☐ 2:40 – 2:45	**BREAK** Encourage your table to fill out their community survey
☐ 2:45 – 2:50	**IDENTIFY "TOP SOLUTION" – ICLICKER VOTE**
☐ 2:50 – 3:00	**GIFT CARD DISTRIBUTION AND THANK PARTICIPANTS**
☐ 3:00 – 3:30	**CLEAN UP**

Satisfaction Survey



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:_____/_____/2018 ☐ 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: _____
   - ☐ Other: _____

Do you have suggestions for how these events could be improved? [open ended]

BHS Community Survey (pgs. A13-A18)

Community Feedback Survey

Thank you for taking the time to participate in this survey. This survey is part of a larger initiative by the County of San Diego Health and Human Services Agency, Behavioral Health Services to gather feedback from community members and consumers on behavioral health programs and services.

What are behavioral health services? Behavioral health services include mental health services and substance use disorder services. These are services to help people improve their health and well-being.

Mental health services help people manage and/or recover from mental health conditions such as depression, anxiety, and/or schizophrenia. They can include:
- Individual or group counseling or therapy;
- Medication management;
- Inpatient (overnight) treatment at a hospital for a serious or urgent mental health issue.

Substance use disorder services help people manage or recover from an alcohol or drug addiction and can include:
- Outpatient treatment like an appointment with a doctor or health counselor;
- Medication-assisted therapy to treat addiction;
- Inpatient (overnight) treatment, such as in a rehab or detox facility.

Preventive behavioral health services help raise awareness about mental health and substance use disorder services. They also help people learn healthy living habits and address issues before they become serious. Substance use disorder prevention services work with residents to advocate for change in their communities to reduce youth access to alcohol and other drugs.

The County of San Diego Health and Human Services Agency, Behavioral Health Services provides these types of services to people in our community who need behavioral health care.

This survey is managed by an independent company working on behalf of the County of San Diego.

We want to hear from you

All responses will remain strictly anonymous. There is no right or wrong answer to any of the questions. The survey will take about 10 minutes to complete.

As you take this survey, imagine that you, a close friend, or a family member needs one or more of these types of care. Try to put yourself in the shoes of the people served by the County of San Diego Health and Human Services Agency, Behavioral Health Services.

1. Why do you think someone might not be getting the care they need for mental health or substance use disorders?

Rate from very unlikely to very likely.	**Very Unlikely**	**Somewhat Unlikely**	**Somewhat Likely**	**Very Likely**
They do not know they can afford help.	☐	☐	☐	☐
They do not know if their insurance will cover care, or if they can qualify for a public program.	☐	☐	☐	☐
They do not know that there are services that could help them.	☐	☐	☐	☐
They are embarrassed, ashamed or worried about what people will think about them.	☐	☐	☐	☐
They think it will take too long to get help.	☐	☐	☐	☐
They do not have transportation to get care.	☐	☐	☐	☐
They do not know where to get care.	☐	☐	☐	☐
They cannot take time off work or get child care.	☐	☐	☐	☐

2. People with mental health or substance use disorders can get better. Treatment and recovery are ongoing processes that happen over time. Think about what types of services might help people get the care they need to get better. What could better support you, a friend, a family member, or loved one in getting care for mental health or substance use disorders?

Rate from very unhelpful to very helpful.	**Very Unhelpful**	**Somewhat Unhelpful**	**Somewhat Helpful**	**Very Helpful**
You have someone to help you keep track of appointments and medications, remind you about appointments, and make sure that you can get to the appointment or pharmacy.	☐	☐	☐	☐
You are part of the team making decisions about your care, and get a say in how you get care.	☐	☐	☐	☐
You can get care or help from someone who has had similar experiences and understands your situation.	☐	☐	☐	☐
You have someone who helps you with other needs like food, housing, childcare, or transportation.	☐	☐	☐	☐
Other:	☐	☐	☐	☐

3. The County of San Diego Health and Human Services Agency, Behavioral Health Services thinks about the following issues when they are creating a plan and budget for serving the community. What do you think are the most important things for them to consider?

Rate from low priority to high priority.	**Low Priority 1**	**2**	**3**	**4**	**5**	**High Priority 6**
If people are happy with the care they are getting and how they are being treated.	☐	☐	☐	☐	☐	☐
If people can get help from "peers." (Peers are other people who have gone through the same experiences as the clients they work with, such as living with a mental illness or being in recovery from a substance use disorder).	☐	☐	☐	☐	☐	☐
If it makes San Diego County healthier overall.	☐	☐	☐	☐	☐	☐
If people who need help are getting the right kind of help in a timely manner.	☐	☐	☐	☐	☐	☐
If doctors and other health care providers are giving people care based on what they know works best.	☐	☐	☐	☐	☐	☐
If it uses resources wisely, for example, giving people a service that costs less, or will mean fewer costs down the road, or helps save money to provide more services and serve more people.	☐	☐	☐	☐	☐	☐

Share your experience

Have you or a family member received mental health or substance use disorder care in the San Diego region? If so, please tell us about your experience:

4. On average, how long did it take you or your family member to get care?
   - ☐ Waited less than a week.
   - ☐ Waited 1- 2 weeks.
   - ☐ Waited less than a month.
   - ☐ Waited more than a month.
   - ☐ Waited more than 3 months.

5. How did you find out about the program or the place where you received care?

6. Were you satisfied with your experience? (Select one)
   - ☐ Very satisfied.
   - ☐ Satisfied.
   - ☐ Somewhat satisfied.
   - ☐ Not very satisfied.
   - ☐ Other (please specify).

7. Are there other resources that you think should be available and/or would have been helpful? (Select one)
   - ☐ No.
   - ☐ Yes. Please share below.

8. Do you have any other comments, questions, or concerns?

About you

All responses will remain strictly anonymous.

9. What is your age?=

10. What is your gender?
    - ☐ Female
    - ☐ Male
    - ☐ Prefer not to answer
    - ☐ Other (please specify)

11. What is your zip code?

12. What is the main/primary language you speak or use at home? (Select all that apply)
    - ☐ American Sign Language
    - ☐ Arabic
    - ☐ Armenian
    - ☐ Cambodian
    - ☐ Cantonese
    - ☐ English
    - ☐ Farsi
    - ☐ French
    - ☐ Hebrew
    - ☐ Hmong
    - ☐ Ilocano
    - ☐ Italian
    - ☐ Japanese
    - ☐ Korean
    - ☐ Lao
    - ☐ Mandarin
    - ☐ Mien
    - ☐ Polish
    - ☐ Portuguese
    - ☐ Russian
    - ☐ Samoan
    - ☐ Spanish
    - ☐ Tagalog
    - ☐ Thai
    - ☐ Turkish
    - ☐ Vietnamese
    - ☐ Prefer not to answer
    - ☐ Other (please specify)

13. What is your race or ethnicity? (Check all that apply)
    - ☐ African American/Black
    - ☐ American Indian / Alaskan Native
    - ☐ African
    - ☐ White I Caucasian
    - ☐ Asian
    - ☐ Chaldean
    - ☐ Asian Indian I South Asian
    - ☐ European
    - ☐ Cambodian
    - ☐ Iraqi
    - ☐ Chinese
    - ☐ Middle Eastern
    - ☐ Filipino
    - ☐ Hispanic I Latino
    - ☐ Hmong
    - ☐ Caribbean
    - ☐ Japanese
    - ☐ Central American
    - ☐ Korean
    - ☐ Cuban
    - ☐ Laotian
    - ☐ Dominican
    - ☐ Mien
    - ☐ Mexican / Mexican-American / Chicano
    - ☐ Vietnamese
    - ☐ Puerto Rican
    - ☐ Pacific Islander
    - ☐ Salvadorian
    - ☐ Native Hawaiian
    - ☐ South American
    - ☐ Samoan
    - ☐ Prefer not to answer
    - ☐ Other {please specify)

14. What is your approximate average household income?
    - ☐ less than $20,000
    - ☐ $20,000-$34,999
    - ☐ $35,000-$49,999
    - ☐ $50,000-$74,999
    - ☐ $75,000-$99,999
    - ☐ $100,000-$149,999
    - ☐ $150,000-$199,999
    - ☐ $200,000 and up
    - ☐ Prefer not to answer

15. How do you get your health insurance coverage? (Select all that apply)
    - ☐ Medi-Cal
    - ☐ Coverage from my employer
    - ☐ Medicare
    - ☐ Tricare I VA
    - ☐ Coverage I buy myself
    - ☐ No coverage
    - ☐ Prefer not to answer
    - ☐ Other (please specify)
16. Including yourself, how many people live in your household?
17. Do you identify with any of these groups? (Select all that apply)
    - ☐ Immigrant
    - ☐ Refugee
    - ☐ Veterans I Military
    - ☐ Homeless
    - ☐ LGBTQI
    - ☐ Deaf I Hard of hearing
    - ☐ Justice-involved
    - ☐ Prefer not to answer
    - ☐ Not applicable
    - ☐ Other (please specify)
18. What is the highest level of education you have completed?
    - ☐ High School/GED
    - ☐ Some College
    - ☐ College Degree
    - ☐ Graduate Degree
19. Tell us about your employment or school status. (Check all that apply)
    - ☐ Working full-time
    - ☐ Student, full-time or part-time
    - ☐ Working part-time
    - ☐ Retired
    - ☐ Looking for work
    - ☐ Prefer not to answer
    - ☐ Other (please specify)
20. I am a: (Select all that apply)
    - ☐ Consumer or Client
    - ☐ Community Member
    - ☐ Family Member or Caregiver
    - ☐ Provider
    - ☐ Law Enforcement
    - ☐ Stakeholder or Advocate
    - ☐ School Personnel
    - ☐ Prefer not to answer
    - ☐ Not applicable
    - ☐ Other (please specify)

Thank You

Thank you for participating in the County of San Diego Health and Human Services Agency, Behavioral Health Services Community Input survey. Your feedback is important to us.

Forum Participant Evaluations

Table A3. Overall satisfaction with the event

Forum Location	Percent within each category[1]				
	n	*Not at all Satisfied*	*Somewhat Satisfied*	*Satisfied*	*Very Satisfied*
Kearny Mesa (10/08)	110	4%	16%	54%	26%
El Cajon (10/10)	33	3%	3%	49%	46%
Mid-City (10/15)	21	0%	10%	48%	43%
Chula Vista (10/25)	11	0%	18%	9%	73%
Oceanside (10/31)	28	0%	14%	32%	54%
Escondido (11/09)	25	0%	8%	38%	54%
Spring Valley (10/10)[2]	19	5%	11%	42%	42%
Mid-City (10/15)[2]	35	0%	11%	31%	57%
National City (10/17)[2]	18	0%	6%	33%	61%

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

Table A4. Convenience of location

Forum Location	Percent within each category[1]				
	n	*Not at all Convenient*	*Somewhat Convenient*	*Convenient*	*Very Convenient*
Kearny Mesa (10/08)	110	3%	7%	34%	56%
El Cajon (10/10)	33	3%	6%	36%	55%
Mid-City (10/15)	21	0%	0%	29%	71%
Chula Vista (10/25)	11	0%	18%	27%	55%
Oceanside (10/31)	28	11%	7%	32%	50%
Escondido (11/09)	25	0%	12%	24%	64%
Spring Valley (10/10)[2]	19	0%	26%	47%	26%
Mid-City (10/15)[2]	35	3%	11%	34%	51%
National City (10/17)[2]	18	0%	17%	33%	50%

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

Table A5. Day of the week was a good fit for schedule

Forum Location	Percent within each category[1]				
	n	*Disagree*	*Somewhat disagree*	*Somewhat agree*	*Agree*
Kearny Mesa (Monday, 10/08)	110	0%	0%	14%	86%
El Cajon (Wednesday, 10/10)	33	0%	0%	15%	85%
Mid-City (Monday, 10/15)	21	0%	0%	5%	95%
Chula Vista (Thursday, 10/25)	11	0%	0%	27%	73%
Oceanside (Wednesday, 10/31)	28	0%	0%	21%	79%
Escondido (Friday, 11/09)	25	4%	8%	24%	64%
Spring Valley (Wednesday, 10/10)[2]	19	0%	0%	5%	95%
Mid-City (Monday, 10/15)[2]	35	0%	0%	14%	86%
National City (Wednesday, 10/17)[2]	18	0%	6%	11%	83%

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

Table A6. Time of event was a good fit for schedule

Forum Location	Percent within each category[1]				
	n	*Disagree*	*Somewhat disagree*	*Somewhat agree*	*Agree*
Kearny Mesa (10/08, 10:00am)	110	0%	2%	7%	91%
El Cajon (10/10, 2:00pm)	33	0%	0%	27%	73%
Mid-City (10/15, 9:00am)	21	0%	0%	5%	95%
Chula Vista (10/25, 6:00pm)	11	0%	9%	9%	82%
Oceanside (10/31, 10:00am)	28	4%	0%	7%	89%
Escondido (11/09, 1:00pm)	25	4%	4%	8%	84%
Spring Valley (10/10, 10:00am)[2]	19	0%	0%	11%	90%
Mid-City (10/15, 2:00pm)[2]	35	0%	3%	11%	86%
National City (10/17, 3:00pm)[2]	18	0%	6%	22%	72%

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

Table A7. Topics covered at event were useful

Forum Location	Percent within each category[1]				
	n	*Disagree*	*Somewhat disagree*	*Somewhat agree*	*Agree*
Kearny Mesa (10/08)	110	1%	5%	23%	72%
El Cajon (10/10)	33	0%	0%	27%	73%
Mid-City (10/15)	21	0%	0%	0%	100%
Chula Vista (10/25)	11	0%	0%	27%	73%
Oceanside (10/31)	28	0%	0%	11%	89%
Escondido (11/09)	25	0%	0%	0%	100%
Spring Valley (10/10)[2]	19	3%	0%	6%	91%
Mid-City (10/15)[2]	35	0%	3%	14%	83%
National City (10/17)[2]	18	0%	0%	11%	89%

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

Table A8. How attendee learned of event

Forum Location	Percent within each category[1]				
	n	*Flyer*	*Word of mouth*	*Email*	*Other*
Kearny Mesa (10/08)	110	7%	16%	51%	28%
El Cajon (10/10)	33	6%	30%	39%	36%
Mid-City (10/15)	21	10%	24%	38%	43%
Chula Vista (10/25)	11	18%	18%	46%	9%
Oceanside (10/31)	28	21%	21%	50%	14%
Escondido (11/09)	25	16%	20%	56%	16%
Spring Valley (10/10)[2]	19	21%	16%	47%	21%
Mid-City (10/15)[2]	35	11%	23%	57%	9%
National City (10/17)[2]	18	17%	39%	33%	17%

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

Figure 6. Suggestions for improving community forums

- Suggestions for future forums
  - Logistics
    - Secure larger rooms/increase spacing [n=9]
    - Offer a variety of times at same location [n=7]
    - Break up into smaller groups
    - Fix microphone issue
    - Host more forums
    - Improve time management
    - Include parking information on flyer
  - Outreach and attendance
    - Improve community member and consumer input [n=10]
    - Increase engagement with younger generations [n=3]
    - Increase incentives [n=2]
    - Analyze who else needs to be at the table
    - Have community leaders present to hear from participants
    - Have live music at all events to encourage community members to attend
    - Share on social media
    - Survey service providers separately
  - Format
    - More time to go into depth [n=5]
    - Send out prompts ahead of forum to give time to ponder [n=4]
    - Use top two answers to brainstorm solutions [n=2]
    - Allow time for networking [n=2]
    - Allow each table to discuss all three questions
    - Separate needs and challenges in first vote
    - Streamline iClicker steps and instructions when two letters are needed
  - Facilitation
    - Use staff to facilitate [or train facilitators more] to interpret nuance and jargon [n=5]
    - Facilitators should be more assertive to focus conversations
    - Provide more context
  - Miscellaneous suggestions
    - Conduct follow-up forums for community activation
    - include substance use as co-occurring with developmental disabilities
- Kudos (n=27)
  - Examples included: *great job!; on-topic and helpful; great size and mix of attendees; great time – will attend more; great facilitator; enjoyed iClickers and voting; well-organized*
- Complaints (n=11)
  - Examples included: *hard to hear* [n=4], *staff stifled brainstorming* [n=3], *discussions strayed from mental health crisis into housing* [n=2], *facilitators not effective, inconvenient time, exclusion of BHS staff from some portions was confusing and disheartening, topic questions were too similar, traffic was a challenge, disorganized; facilitators over-interpreted what was said, registration did not include providers, ethnicities and special populations were not all-inclusive*

"This was very efficient and well-facilitated. I have participated every year. This was the best."

Supplementary Community Forum Results

Supplementary Tables

Table A9. Participant Gender by Forum

Forum Date	Region	Location	Total	Female		Male		Other	
			n	n	%	n	%	n	%
10/8/2018	North Central	National University	101	77	76%	24	24%		
10/10/2018	East	San Diego Youth Services*	22	18	82%	4	18%		
10/10/2018	East	Ronald Reagan Community Center	33	26	79%	7	21%		
10/15/2018	Central	Tubman Chavez Community Center	21	18	86%	3	14%		
10/15/2018	Central	Malcolm X Library*	42	31	74%	10	24%	1	2%
10/17/2018	South	The San Diego Regional Center South Bay*	21	21	100%		0%		
10/25/2018	South	Norman Park Senior Center	12	9	75%	3	25%		
10/31/2018	North Coastal	QLN Conference Center	29	26	90%	3	10%		
11/9/2018	North Inland	Park Ave Community Center	25	20	80%	5	20%		
		Total	**306**	**246**	**80%**	**59**	**19%**	**1**	**0%**

Table A10. Participant Age Categories by Forum

Forum Date	Region	Location	Total	Adult (18-59)		Older Adult (60+)		TAY (16-25)		Children/Youth (<18)	
				n	%	n	%	n	%	n	%
10/8/2018	North Central	National University	92	87	95%	5	5%	7	8%	0	0%
10/10/2018	East	San Diego Youth Services*	19	16	84%	3	16%	2	11%	0	0%
10/10/2018	East	Ronald Reagan Community Center	32	24	75%	8	25%	2	6%	0	0%
10/15/2018	Central	Tubman Chavez Community Center	21	19	90%	2	10%	1	5%	0	0%
10/15/2018	Central	Malcolm X Library*	39	32	82%	7	18%	0	0%	0	0%
10/17/2018	South	The San Diego Regional Center South Bay*	21	17	81%	4	19%	1	5%	0	0%
10/25/2018	South	Norman Park Senior Center	11	7	64%	4	36%	1	9%	0	0%
10/31/2018	North Coastal	QLN Conference Center	28	21	75%	7	25%	2	7%	0	0%
11/9/2018	North Inland	Park Ave Community Center	23	14	61%	9	39%	0	0%	0	0%
		Total	**286**	**237**	**83%**	**49**	**17%**	**16**	**6%**	**0**	**0%**

Table 11 Special Populations in Attendance by Forum

Forum Date	Region	Location	Total Attendees	African	AA	API	Chaldean	Homeless	Immigrant	Latino	LGBTQI	NA/AI	Refugee	VET
10/8/2018	North Central	National University	101	1	4	24	1	3	7	18	13	3	1	4
10/10/2018	East	San Diego Youth Services*	22	0	1	1	0	1	0	5	1	0	1	2
10/10/2018	East	Ronald Reagan Community Center	33	1	2	6	5	0	2	4	1	2	6	2
10/15/2018	Central	Tubman Chavez Community Center	21	1	4	1	0	0	0	7	2	2	0	1
10/15/2018	Central	Malcolm X Library*	42	2	3	6	0	3	0	14	3	3	0	3
10/17/2018	South	The San Diego Regional Center South Bay*	21	0	1	1	0	0	0	7	3	2	0	0
10/25/2018	South	Norman Park Senior Center	12	0	4	1	0	0	0	6	1	2	0	0
10/31/2018	North Coastal	QLN Conference Center	29	1	1	1	0	0	2	2	3	0	0	3
11/9/2018	North Inland	Park Ave Community Center	26	0	0	1	0	2	0	1	2	1	0	1
		Total n	307	6	20	42	6	9	11	64	29	15	8	16
		%	**100%**	**2%**	**7%**	**14%**	**2%**	**3%**	**4%**	**21%**	**9%**	**5%**	**3%**	**5%**

Table A12. Community Groups in Attendance by Forum

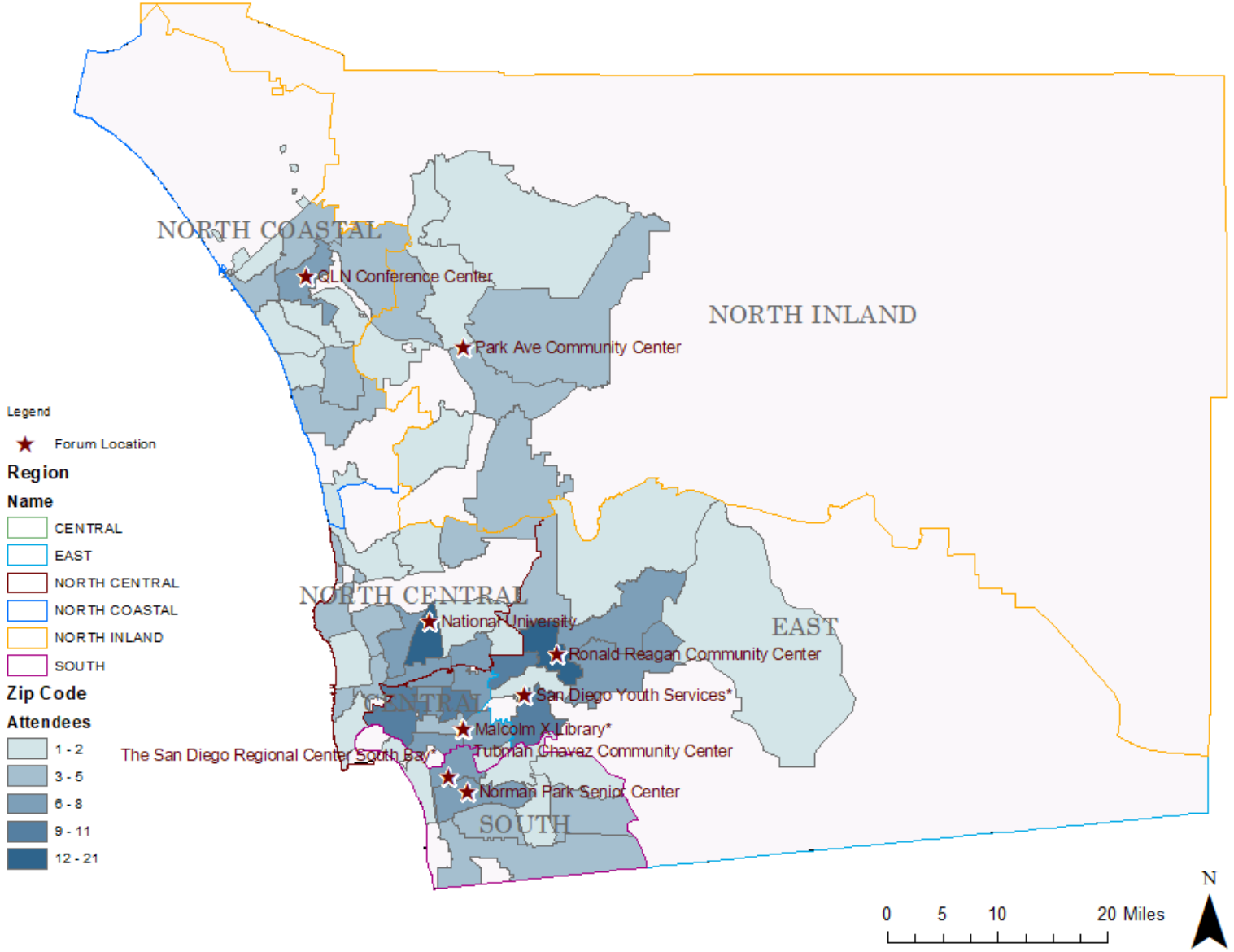
Forum Date	Region	Location	Total	Community Member		Consumer		Family Member		LE		School Personnel		None	
			n	n	%	n	%	n	%	n	%	n	%	n	%
10/8/2018	North Central	National University	97	47	48%	9	9%	5	5%	1	1%	6	6%	42	43%
10/10/2018	East	San Diego Youth Services*	20	10	50%	0	0%	0	0%	0	0%	1	5%	9	45%
10/10/2018	East	Ronald Reagan Community Center	33	15	45%	8	24%	3	9%	0	0%	2	6%	11	33%
10/15/2018	Central	Tubman Chavez Community Center	20	12	60%	2	10%	3	15%	0	0%	0	0%	6	30%
10/15/2018	Central	Malcolm X Library*	42	23	55%	8	19%	2	5%	2	5%	0	0%	20	48%
10/17/2018	South	The San Diego Regional Center South Bay*	21	10	48%	2	10%	2	10%	0	0%	0	0%	11	52%
10/25/2018	South	Norman Park Senior Center	12	7	58%	4	33%	0	0%	1	8%	0	0%	3	25%
10/31/2018	North Coastal	QLN Conference Center	29	18	62%	1	3%	3	10%	1	3%	1	3%	10	34%
11/9/2018	North Inland	Park Ave Community Center	24	16	67%	3	13%	3	13%	1	4%	2	8%	6	25%
		Total	**298**	**158**	**53%**	**37**	**12%**	**21**	**7%**	**6**	**2%**	**12**	**4%**	**118**	**40%**

Table A13. Participant Home Region by Forum

Forum Date	Region	Location	Total	Central		East		North Central		North Coastal		North Inland		South	
			n	n	%	n	%	n	%	n	%	n	%	n	%
10/8/2018	North Central	National University	94	28	30%	11	12%	37	39%	2	2%	5	5%	11	12%
10/10/2018	East	San Diego Youth Services*	22	7	32%	6	27%	5	23%	2	9%		0%	2	9%
10/10/2018	East	Ronald Reagan Community Center	32	4	13%	22	69%	4	13%		0%		0%	2	6%
10/15/2018	Central	Tubman Chavez Community Center	20	10	50%	6	30%	2	10%		0%		0%	2	10%
10/15/2018	Central	Malcolm X Library*	39	10	26%	7	18%	9	23%	5	13%	3	8%	5	13%
10/17/2018	South	The San Diego Regional Center South Bay*	21	4	19%	3	14%	7	33%	1	5%		0%	6	29%
10/25/2018	South	Norman Park Senior Center	11	2	18%	1	9%	3	27%		0%		0%	5	45%
10/31/2018	North Coastal	QLN Conference Center	29	3	10%	1	3%	4	14%	19	66%	2	7%		0%
11/9/2018	North Inland	Park Ave Community Center	22		0%	3	14%		0%	6	27%	13	59%		0%
		Total	**290**	**68**	**23%**	**60**	**21%**	**71**	**24%**	**35**	**12%**	**23**	**8%**	**33**	**11%**

Supplementary Map

Figure 7. Map of San Diego County Displaying Distribution of Forum Attendees by Zip Code



Supplementary Lists

List 1. Challenges Facing People Experiencing a Mental Health Crisis (Reference: See Report Narrative, Page 19)

- Services need to be available 24 hours-a-day, on weekends, and on holidays.
- There are too few mental health crisis beds.
- There are too few respite homes.
- Need more in-patient beds across the continuum of care for people of all ages.
- Need more crisis beds, such as stabilization beds for less than 24-hour stays.
- Need more walk-in clinics for behavioral health services with same day services
- People who are having a crisis need case management help.
- Need more early childhood mental health services to address issues stemming from trauma and attachment. These would help prevent issues like school violence, arrests, and the "prison pipeline."
- Need more mental health service care providers.
- Need more mental health services specifically for TAY.
- Need more services for those who are mentally ill and homeless.
- Need to reduce the cycle of ER, short treatment, home, back to ER. It's expensive and uses many resources.
- Mental health issues and substance use often co-occur and need to be treated together.
- Services need to be more individualized.
- It's difficult to access treatment centers and other types of services.
- Need shorter waits for services.
- Need emergency childcare services for people experiencing a mental health crisis.
- Need better transportation to services.
- People do not know how to access services.
- People need more information about how to get mental health treatment. And what happens to you once you go there (e.g. commitment level, cost, time, transportation, how much it would help).
- People need more information about how to enroll in Medi-Cal.
- Community services are not publicized well.
- Need more personal guidance for people who need behavioral health services.
- People with mental health issues need help navigating the system.
- Need more culturally sensitive/competent services.
- Translation services need to be available for appointments, including Arabic, Farsi, Dari, and Chaldean.
- People of color and immigrants with mental health issues experience cultural/racial discrimination.
- More people of color need to work in mental health services.
- More mental health service provider positions should be available for people who do not have degrees and who are not proficient in English.
- Psychiatric symptoms are worsened by the difficulty of finding affordable housing.
- Financial issues make people with mental health crises feel overwhelmed and worsens their symptoms.
- There are financial barriers to receive high quality mental health services
- Need low income supportive housing for stabilized persons. Board and Care facilities are not enough. Many consumers are stable and on SSI but need help finding an affordable place to live.

- There are too few post-acute care services for Medi-Cal patients. This leads to increase in days patients spend unnecessarily in inpatient care.
- Lack of step-down services including comprehensive case management and addressing social needs such as housing and transportation.
- Lack of continuity of care.
- Need warm hand-offs.
- Trainings that are already provided in the community for free need to be more widely promoted and funded (e.g. American Foundation for Suicide Prevention, San Diego Chapter).
- There are too few preventative health services; need to be proactive rather than reactive.
- Mental health issues need to be destigmatized.
- Need single payer healthcare.
- Need more PERT teams; need teams 24/7/365.
- PERT teams need cultural competency training.
- PERT teams should come in "plain clothes."
- Law enforcement needs more mental health training; should be added to standard training, like firearms and driving training.
- Need more Assertive Community Treatment programs.
- Law enforcement needs to be trauma-informed.
- Need more clinicians in schools.
- Mental health service providers need to be trauma-informed.
- Need mobile mental health services.
- Lack of in-home preventative services: need mobile, collaborative teams to go into homes to help diagnose a loved one prior to a mental health crisis.
- Need a housing program for families involved in child welfare services which includes a therapeutic community to provide mental health services. The focus would be on attachment work with the families.
- Lack of services to address the devastating impact on those left behind after a loved one commits suicide.
- 5150 rules need to be clarified as "danger to self or others" or "gravely disabled" are far too broad making it hard to get a loved one into a mental health facility.
- HIPAA laws prevent loved ones finding where their family member has been hospitalized, sharing information about what medication is helpful, what diagnosis she/he has and what medications or treatment should be followed up on his/her release.
- Need better evaluations and assessments to get a proper diagnosis.
- Need more medication management services.
- People are scared and embarrassed to call for help.
- Families of people with mental health issues need more support.
- Need more attention to the health of the caregivers.
- Need more telehealth options.
- Need long-term transitional housing.
- Need to do better at identifying high risk populations.
- Lack of job opportunities for people with mental health issues.
- Jails are overcrowded.
- Emergency Departments are overcrowded.

- Health insurance policies related to mental health services need to be expanded.
- There are too many qualifying factors.
- Individuals often refuse care.
- Quality of care for those with mental illness is poor.
- Need integrated care.
- County services are not well integrated.
- Support centers are often unsanitary.
- Lack of trust between clients and mental health service providers.

List 2. Solutions to Challenges Facing People Experiencing a Mental Health Crisis (Reference: See Report Narrative, Page 21)

- Advertise crisis response teams to junior high, high school, and college students on campus.
- Teach students about mental health and mental health care.
- Provide transportation services to engage people more in social activities and increase social supports.
- Provide more recreation centers and entertainment services for adults. This will help reduce psychiatric symptoms.
- Provide transportation to medical appointments.
- Develop apps for smart phones that create pop-ups on teens' phones when teens are using drug words or words about self-harm.
- Make a 211 app.
- Require and provide more education for primary care doctors about basic mental health issues such as anxiety and depression.
- Provide more funding for post-acute care and for crisis stabilization units.
- Create more access to mind and body wellness services, like yoga, medication, acupuncture, and massage.
- Have a publicity campaign using famous public figures who have openly discussed their mental heath conditions which will make it more likely for people to seek help before a crisis.
- Provide training for law enforcement.
- Make it possible for law enforcement and other mental health service providers to consider input from credible 3rd parties like other service providers, families and friends when a person is in distress.
- The County needs a comprehensive flow chart on how and when to use county services delineated by issue (e.g. mental health and substance use, etc.) and by age. This should not be a resource list but should be a way to walk yourself through the process.
- Better training for dispatchers. Their perception of an emergency is sometimes narrow; they don't understand why a person might need a quick response. How calls are prioritized influences the subsequent response.
- Coordinate all Police Departments to work thought one department so mental health response is standardized and coordinated.
- All of San Diego County needs more beds available for mental health problem individuals so PERT teams don't make decisions based on bed availability and instead make the on the actual mental health problem.
- Drug testing in federal buildings can get drug dealers caught sooner so they can be stopped when drugs reach schools or federal buildings. Can catch killers, gangsters, and terrorists. Can even help free people who are enslaved physically or mentally.

- Empower local communities to participate in mental health – pay them for their services – translators in community that don't require a professional degree – pay undocumented translators – paying/compensation shows their services are institutionally valued vs appreciated – services that are primarily non-English – encourage non-English speakers to give culturally competent services – including communities to "help" reduces stigma and increases knowledge.
- More community-based, effective, residential services.
- Tiny home communities for families are the cheapest way to build communities and improve mental health.
- Utilize institutions (e.g. schools, libraries, etc.) for outreach about available services in the community.
- Allow people from within the community to work in the community.
- Train family members to provide care and compensate them.
- County should consider using reserve funds to help contracts provide services in all threshold languages (i.e. augment the contracts).
- Create programs where fathers help fathers.
- Giving more access to entertainment and recreational activities will decrease anxiety and depression symptoms; these can be life-changing environments.
- Create television and radio public information slots about mental health and services.
- Coordinate services between housing navigators.
- Improve 211 consistency and accuracy.
- Have more transportation available.
- Have more translation services available.
- Advertise available services.
- Increase mobile mental health collaborative teams.
- Do a needs assessment of advocate-driven residents.
- Have crisis stabilization units available for up to 72 hours.
- Create more mental health, in-patient beds.
- Have a campaign to de-stigmatize mental illness.
- Increase the number of case managers available for those in crisis.
- Create collaborative teams, across schools, medical providers, cultural services, therapists, community agencies, first responders, clinicians.
- Have network standalone clinics 24/7 that take walk-ins.
- Have more County partnerships with the public, community, and teachers.
- Create opportunities to share best practices.
- Offer cultural competency training for all first responders.
- Have psychiatric urgent care available.
- Offer elective classes starting in middle school about mental health.
- Educate the public about mental health.
- Educate people to address the fear of applying for services.
- Create employment opportunities with livable wages.
- Create peer-to-peer employment opportunities.
- Designate stand-alone facilities in each region of the county.
- Provide financial assistance for board and care facilities.
- Increase funding for discharge follow up care.
- Shift funding to focus on community and home-based services.

- Prioritize services in schools.
- Expand landlord rental incentive grants.
- Create more affordable and supportive housing.
- Make the classes for citizenship less complicated.
- Increase percent of low-income housing.
- Need affordable and fast housing services for refugees.
- Need more Arabic translators.
- Need more signs up around the city telling people if they need help, where to call or go.
- Need more mobile psychiatric assessment teams.
- Need free resources for music, art, and reading to reduce stress.
- Conduct targeted advertising with teens according to what they are following.
- Use telemedicine to triage people.
- Have peer support available with PERT.
- Expand PERT.
- Provide resources for housing disputes.
- Increase patient navigators.
- Create a culture of compassion and safety.
- Create more services for family members.
- Create specialized in-home services.
- Have safe spaces and confidential services for youth.
- Create long-term behavioral health services.
- Programs need to go deeper rather than just providing a band-aid.
- Create more walk-in clinics with same day care.
- Have more social workers working in community.
- Change language and terminology about mental health to focus on wellness and self-care.
- Make it easier to get appointments with providers.
- Provide in-home therapy.
- Create more early intervention services.
- Have cross-training opportunities for mental health and physical health providers.

List 3. Needs and Challenges Related to Substance Use Disorders Among Teens and Young Adults (Reference: See Report Narrative, Page 22)

- Kids are being introduced to drugs at younger ages.
- There is easy access to drugs and they are accessible to everyone.
- All drugs are used earlier.
- Heroin use has increased in people 18 and older.
- Alcohol has increased in ages 17and below.
- Fentanyl has become a serious problem for young adults.
- Meth use is high in San Diego.
- Alcohol use is normalized.
- The dark web is a problem.
- Drugs are marketed to youth.
- Drugs are romanticized.
- Teens need resources to find help and get educated.

- Need more SUD treatment beds.
- More services need to be offered in schools.
- Treatment is not affordable.
- There are cultural barriers and language barriers to treatment.
- Lack of evidence-based treatment for youth.
- There are no services for the deaf and hard of hearing.
- There are too few detox centers.
- There are limited prevention and treatment resources.
- Need peer support groups for SUD.
- Youth don't have access to in-patient care.
- Lack of support available after leaving rehab.
- There's no follow-up after release from rehab to ensure they have enough food, housing, etc.
- Lack of a coherent substance use disorder treatment system.
- For teens who use drugs, they need help to cope with trauma and homelessness.
- We need to focus on children/ adults who are involved in child welfare.
- Developmental trauma contributes to SUD.
- Adverse childhood events contribute to SUD.
- We need support for youth who are transitioning out of juvenile hall to help prevent recidivism.
- The community needs more education, including parents.
- Need public awareness campaign to let clients know there is help for SUD (e.g. billboards, tv, social media).
- The community needs more services and more education through medical/school/cultural/athletics providers.
- Lack of community education and prevention.
- Parents need more information on all drugs.
- Need for SUD prevention in schools and then treatment that will take people under 18.
- Offer preventive information and resources. Assist the population at a younger age, as kids are introduced to drugs at a younger age.
- For marijuana, is harm reduction rather than total abstinence possible? What about treatment that includes marijuana for those that use it as an alternative drug for pain-relief instead of opioids or other drugs? Should marijuana use be acceptable reason for services to be terminated?
- Marijuana is now easily accessible.
- Establishments sell marijuana to kids.
- Marijuana is perceived as harmless.
- People think marijuana is not addictive.
- The normalization of marijuana is a problem.
- There are very few programs specifically for marijuana.
- Kids are using vape pens.
- Vaping is a gateway drug.
- Vaping is perceived as harmless.
- The concentration of beer is too high.
- Kids binge drink once they turn 21.
- We need to learn how to "speak their language."
- Lack of money for food when using.

- Not enough youth are involved in conversations about SUD.
- Need to have drug testing at events.
- Create screening programs for children at young ages.
- Drug testing should be mandated to play sports.
- Need more dual treatment for people who have SUD and SMI.
- Need more education about impaired driving.
- Gang membership influences SUD.
- Families of people with SUD need more support.
- Whole family needs to be engaged in treatment.
- Lack of family involvement is a barrier to successful treatment.
- People are afraid of shame and judgment related to addiction.
- People who are addicted end up without food or housing.
- We send youth who are addicted to jail rather than treating them.
- All drugs need to be legalized.
- Kids get high at school.
- Need more mentors for young people.
- It's hard for people to admit they have a problem.
- School attendance becomes an issue.
- Kids don't know how to respond to peer pressure.
- Youth think they are invincible.
- Drugs are over prescribed.
- Quality of care for drug treatment needs to be standardized.
- Staff turnover at drug treatment services is high and leads to a lack of continuity of care.
- Cross-border smuggling is a problem.
- Services need to be gender-specific.
- Anti-drug campaigns are a challenge.

List 4. Solutions to Challenges Related to Substance Use Disorders Among Teens and Young Adults (Reference: See Report Narrative, Page 23)

- Advertise crisis response teams to junior high, high school, and college students on campus.
- Teach students about mental health and mental health care.
- Provide transportation services to engage people more in social activities and increase social supports.
- Provide more recreation centers and entertainment services for adults. This will help reduce psychiatric symptoms.
- Provide transportation to medical appointments.
- Develop apps for smart phones that create pop-ups on teens' phones when teens are using drug words or words about self-harm.
- Require and provide more education for primary care doctors about basic mental health issues such as anxiety and depression.
- Provide more funding for post-acute care and for crisis stabilization units.
- Create more access to mind and body wellness services, like yoga, medication, acupuncture, and massage.
- Have a publicity campaign using famous public figures who have openly discussed their mental health conditions which will make it more likely for people to seek help before a crisis.

- Provide training for law enforcement.
- Make it possible for law enforcement and other mental health service providers to consider input from credible 3rd parties like other service providers, families and friends when a person is in distress.
- The County needs a comprehensive flow chart on how and when to use county services delineated by issue (e.g. mental health/substance use, etc.) by age (child/youth/adult). This should not be a resource list but should be a way to walk yourself through the process.
- Better training for dispatchers. Their perception of an emergency is sometimes narrow; they don't understand why a person might need a quick response. How calls are prioritized influences the subsequent response.
- More community-based, effective, residential services.
- Tiny home communities for families are the cheapest way to build communities and improve mental health.
- Utilize institutions (e.g. schools, libraries, etc.) for outreach about available services in the community.
- Allow people from within the community to work in the community.
- Train family members to provide care and compensate them.
- County should consider using reserve funds to help contracts provide services in all threshold languages (augment the contracts).
- Create programs where fathers help fathers.
- Giving more access to entertainment and recreational activities will decrease anxiety and depression symptoms – these can be life-changing environments.
- Create television/radio public information slots about mental health and services.
- Coordinate services between housing navigators.
- Have more transportation available.
- Have more translation services available.
- Advertise available services.
- Increase mobile mental health collaborative teams.
- Do a needs assessment of advocate-driven residents.
- Have crisis stabilization units available for up to 72 hours
- Create more mental health, in-patient beds
- Have a campaign to de-stigmatize mental illness
- Increase the number of case managers available for those in crisis
- Create collaborative teams, across schools, medical providers, cultural services, therapists, community agencies, first responders, clinicians.
- Have network standalone clinics 24/7 that take walk-ins.
- Have more County partnerships with the public, community, and teachers.
- Create opportunities to share best practices.
- Offer cultural competency training for all first responders.
- Have psychiatric urgent care available.
- Offer elective classes starting in middle school about mental health.
- Educate the public about mental health.
- Educate people to address the fear of applying for services.
- Create employment opportunities with livable wages.
- Create peer-to-peer employment opportunities.
- Designate stand-alone facilities in each region of the county.

- Provide financial assistance for board and care facilities.
- Increase funding for discharge follow up care.
- Shift funding to focus on community and home-based services.
- Prioritize services in schools.
- Expand landlord rental incentive grants.
- Create more affordable and supportive housing.
- Make the classes for citizenship less complicated.
- Increase percent of low-income housing.
- Need affordable and fast housing services for refugees.
- Need more Arabic translators.
- Need more signs up around the city telling people if they need help, where to call or go.
- Need more mobile psychiatric assessment teams.
- Need free resources for music, art, and reading to reduce stress.
- Conduct targeted advertising with teens according to what they are following
- Use telemedicine to triage people.
- Have peer support available with PERT.
- Expand PERT.
- Provide resources for housing disputes.
- Increase patient navigators.
- Create a culture of compassion and safety.
- Create more services for family members.
- Create specialized in-home services.
- Have safe spaces and confidential services for youth.
- Create long-term behavioral health services.
- Programs need to go deeper rather than just providing a band-aid.
- Create more walk-in clinics with same day care.
- Have more social workers working in community.
- Change language and terminology about mental health to focus on wellness and self-care.
- Make it easier to get appointments with providers.
- Provide in-home therapy.
- Create more early intervention services.
- Have cross-training opportunities for mental health and physical health providers.

List 5. Needs and Challenges Related to School Violence and Threats (Reference: See Report Narrative, Page 24)

- Lack of housing causing so many problems.
- Children with complete chronic trauma are continuing to struggle when entering school.
- Disconnection is a key problem at schools. Youth don't feel connected.
- Teachers need to receive trauma informed training.
- More services need to be focused on foster youth.
- Need more funding for behavioral supports for the 0-5 age group.
- Bullying at school.
- Bomb threats.

- Untreated behavioral health needs lead to school violence.
- Students bully other kids because of differences (e.g. LGBTQI, ethnicity).
- Kids are continuously exposed to bullying because of social media.
- Schools don't or can't intervene when violence and bullying occur outside of school.
- Cyber bullying is prevalent.
- Cyber bullying allows for a lack of accountability/anonymity.
- Increased access to social media has made cyber bullying easier.
- Bullying occurs based on race and gender.
- Bully occurs towards immigrants.
- Schools don't address bullying.
- Schools don't communicate with parents about violence.
- Communities don't have discussions about school violence.
- Violence in mainstream culture and media is acceptable.
- Drugs contribute to school violence.
- Gang violence comes into schools.
- Easy access to drugs contributes to school violence.
- Schools don't teach socio-emotional skills.
- There's no socioemotional curriculum in school.
- The lack of vocational opportunities and emphasis on college leaves some students feeling disconnected.
- Need more parent education about school violence.
- Kids miss school because of fear.
- Kids act on impulse.
- Violence is normalized.
- Prevalence of violence in the media; it's looked at as normal behavior.
- The music kids listen to incites violence.
- Violent video games contribute to the problem.
- Kids who are violent get a false sense of notoriety and significance.
- Kids who are violent often have a history of trauma.
- We now have a high number of expulsions among very young children (pre-K and kindergarten) due to aggression and inability to regulate.
- Funding cuts have led to a lack of positive after school programs, leaving kids with too little to do.
- Gangs retaliate in school.
- Gun violence has become a problem.
- Easy access to firearms has increased violence.
- Increased access to all weapons.
- Kids have increased access to weapons.
- Kids are more often bringing weapons to school to protect themselves.
- Kids' mental health issues are not be addressed.
- Lack of consistent mental health care in schools.
- Have seen an increase in self harm and suicide attempts.
- Have seen an increase in the prevalence of anxiety.
- Anxiety is contagious.
- Anxiety about violence leads to internalizing and externalizing behaviors.

- Kids are experiencing secondary trauma when their friends experience violence.
- Kids who experience trauma and instability (e.g. foster care) having a hard time in school.
- Adolescents lack positive role models.
- Need more positive male influence.
- Parents don't have time to spend with their kids.
- The mental health of teachers, administrators, and school personnel is not addressed.
- Parents are unaware of what is happening in schools.
- Parents are not involved in school or the community.
- Problems at home can lead to violence, poverty, domestic violence, too much time unsupervised).
- Kids are under too much pressure (e.g. related to academics).
- Parents and kids are unaware of programs that are offered, like after school programs.
- There are not enough inclusive student organizations.
- Schools lack resources and ability to protect students from all types of violence on site and off site.
- Resources like counseling are inconsistent in schools.
- There are waitlists for mental health and other social services that prevent people from getting what they need.
- Kids return to school too quickly after crisis interventions.
- The pathway to services is too complicated.
- Girls are being sexually assaulted.
- Kids who go to school without social competence end up being easy targets.
- Students are not challenged enough and have too much idle time.
- A lack of consequences for violent actions of students.
- Teacher/student ratios are too high so that students can't oversee every student.
- Schools are overcrowded.
- Violence and threats now start at earlier ages (1st grade).
- Kindergarten is now very academic and competitive which leads to stress early on in childhood.
- Kids work the system to avoid school responsibilities.
- Human/sex trafficking is a problem.
- School personnel are not trained to work with children who have trauma/ACEs
- Schools lack protocols to deal with threats and violence.
- Teachers are not trained to deal with threats and violence.

List 6. Solutions to Challenges Related to School Violence and Threats (Reference: See Report Narrative, Page 25)

- Services need to be interconnected across systems (e.g. police, child welfare, hospitals/healthcare).
- More parent/teacher meetings.
- Interventions should all be in the context of culture and community.
- Grant scholarships to male students for degrees in education.
- Educate the community about warning signs of school violence.
- Educate parents about social media.
- Educate parents about warning signs.
- Educate parents about treatment options.
- Have parenting forums at school.
- Conduct parenting education on social media platforms.

- Have forums at school related to social media usage – make them mandatory.
- Have elementary school level "bystander" education for students.
- Put in supports and procedures for addressing bullying in schools.
- Give more money to schools so there are more resources to create new programs and help existing programs.
- Provide positive roles models to reach out to disconnected youth.
- Give scholarships to seniors to be peer mentors.
- Incentivize male mentorship.
- Minimize access to drugs and alcohol by requiring clear backpacks.
- Increase monitoring.
- Use parent volunteers to monitor violence and drug use.
- Normalize the idea of men talking about emotions.
- Engage uninvolved parents.
- Create opportunities for parents to get involved.
- Build community at school.
- Social media campaigns on Facebook, Instagram, and snapchat.
- Create a mobile prevention unit, similar to Riversides' post parenting bus unit.
- Pay youth mentors with gift cards to look for disconnected youth and invite them to sit with them at lunch.
- Create integrated programs to teach teachers and youth about violence.
- We need programs to teach about social interactions and positive behavior.
- Train all staff (front office, janitors, cafeteria staff, teachers, and principals) to engage students, build relationships, be interested in their lives.
- Start early addressing family issues at the beginning of every school year.
- Help the family = help the youth.
- Need to incentivize more young males into mentorship programs and to work as staff at social services.
- Develop no one sits along chapters at all San Diego high schools – offer incentives to those that help.
- Develop peer buddies at school to look out for kids not connected to others.
- Teachers should develop seating charts each week and ask: 1. Who do you want to sit with next week? 2. Who would you nominate as an exceptional student? And then the teachers can look for patterns of kids who are not mentioned.
- School breakfasts.
- Create non-traditional extracurricular activities (e.g. artistic expression, gaming, music).
- Crate low-cost, directed and challenging activities to reduce idle time.
- Have anonymous reporting available at schools.
- Have a "call-in" line for students to report violence and drug use.
- Implement restorative practices.
- Have home visiting programs – parent outreach by non-teachers (e.g. community partners).
- Schools should encourage socializing in person rather than online.
- Have an app that shows pop-up something like "are you sure you want to post that?"
- Standardize protocols and practices, including about notifying families.
- No phones at school.
- Educate youth about mental health disorders.
- Create walk-in centers for youth peer education and support.

- Early prevention and intervention start at preschool with a curriculum that focuses on empathy, social connectedness – for students, family, and personnel.
- Have more school based mental health treatment.
- Connect youth to groups or resources to help them feel more connected.
- Identify kids who need more support early.
- Schools can host TED talks.
- Address socio-economic issues.
- More training and psychoeducation for school staff.
- Host classes for all youth about total health – physical and mental.

List 7. Needs Identified at the "Open Topic" Behavioral Health Innovation Forum (Reference: See Report Narrative, Page 28)

- Lack of awareness of Medi-Cal options.
- Medi-Cal treatment information doesn't get to the people who need it.
- PERT for seniors.
- Alzheimer's social workers.
- Increase community awareness about addiction.
- Reduce fear about addiction.
- Need more crisis beds.
- Need more support to clinicians to help with discharge planning.
- Need more immediate in-patient care beds.
- Bullying and cyber bullying.
- Treatment for co-occurring disorders.
- Lack of community building in schools.
- Lack of culturally competent and linguistically diverse mental health providers.
- Lack of culturally competent translators.
- Need to change cultural views to make behavioral health a priority.
- Need to educate emergency department staff.
- Need to educate politicians.
- Increase in pre-school expulsions.
- Need parents to be involved in therapy for school aged children.
- How to get to the community who is not able to have the outdoor life.
- Funding.
- Long term behavioral health care (e.g. Camarillo).
- The discharge process is not personalized.
- Racism, oppression, and discrimination are stressors that cause behavioral health issues.
- The treatment continuum needs to be expanded.
- Treatment needs to be more integrated.
- Need earlier intervention.
- Homelessness and risk of homelessness.
- Housing costs and availability of housing
- Lack of digital resources in areas where homeless congregate (e.g. navigation center, library). For example, phone chargers.
- Lack of knowledge about barriers to mental health service access

- Need moderate care mobile units to go to high-density areas to provide mental health transportation, etc.
- Suicide rates are increasing.
- Educators need mental health "first-aid" training.
- Need a simple, targeted online navigation system.
- Need more navigators.
- Need for music therapy, art therapy, nature-based therapy to be more accessible.
- Empower people to find services until a bed is available.
- Target the pharmaceutical businesses and doctors.
- Need informed evidence-based research for trauma to implement in practice.
- Rent control and specialized housing opportunities (LBGTQ, POC, Aging).
- Need to normalize mental health.
- Lack of knowledge on resources to help undocumented community.
- Long waits for services.
- Stigma needs to be reduced about mental health issues and addiction to prescription drugs.
- The opioid crisis has expanded to benzos.
- Substance abuse is prevalent.
- Substance use is starting at earlier age.
- Transition to adulthood for TAY and foster youth.
- Need better training for MH workforce.
- Lack of trauma informed care in schools (Pre-K and up).
- Intergenerational trauma.
- Need more resources for children who have experienced trauma.

List 8. New Approaches to Challenges Identified at the "Open Topic" Behavioral Health Innovation Forum (Reference: See Report Narrative, Page 29)

- Create more access at local recreation centers and transportation.
- Increase after school programs (and access to those programs).
- Have advocates/community members help assess for mental health disability/needs when registering for school.
- Raise awareness of the needs of people with mental health issues.
- Create campaigns and programs to destigmatize mental health issues.
- Treat mental health issues as a community concern.
- Pay closer attention to contributing factors.
- Implement socio-emotional curriculum at public schools.
- Provide financial education and trade training in high school.
- Create a toolkit from an early age to normalize feelings people want to avoid.
- Have walk-in centers at schools.
- Improve trauma-informed care for school professionals/staff (perhaps workshop, policy/procedure change).
- Create collaborative programs with other organizations, like those for the homeless.
- Create communal living opportunities (like the Family Independence Initiative, FII, in San Francisco).
- Create virtual mental health services, especially for the homeless.
- Create a "match.com" for homes roommates technology platform; solicit donations.

- Create a community of tiny home and having accessible services in the tiny house community (300 square-foot, mobile).
- Create a housing navigation app.
- Create shared housing for community support.
- Increase transitional housing.
- Increase opportunities for peer support.
- Create a policy that focuses on the pharmaceutical companies to avoid "pill pushing" and create a more conscious approach on coordination of care in substance abuse and mental health.
- Provide safe places to park.
- Have holistic professionals out in the community.
- Utilize athletic clubs (increase physical activity).
- Create more mindful meditation opportunities.
- Have centers for youth and families (trauma-informed health professionals and process trauma) with activities for youth.
- Create more youth programming to reduce stigma around mental health.
- Create mentorship programs for TAY youth with previous TAY youth.
- Create partnerships with companies for employment training of TAY youth.
- Provide wrap-around services to TAY youth.
- Host pop-up booths around the county at events to discuss drug addiction, particularly prescription and benzo addictions to create dialogue.
- Create and market a PERT team specifically for seniors.
- Open a mental health facility in East County with different levels of care and different kinds of services.
- Train, educate, and sponsor politicians to get mental health issues on the political agenda.

List 9. New Approaches to Addressing Homelessness (Reference: See Report Narrative, Page 29)

- Provide case management services to help homeless get through it.
- Hire more providers to help identify problems and offer help.
- Integrate of mental health and primary care.
- Develop a system so that all providers can see what services individuals have visited.
- Put mental health professionals in the field at time of assessment.
- Use culturally responsive methods to address homelessness.
- Educate people so that they know how to treat people with mental health disorders.
- Make homeless people need to be a part of regional committees.
- Conduct homeless outreach should be conducted in schools.
- Coordinate funding agencies.
- Teach homeless people need to learn basic life skills.
- Make it easier for homeless people to access any services.
- Provide better transitional services for incarcerated individuals.
- Supply more job training programs.
- Offer better transportation to services.
- Advertise available services.
- Open more emergency services and shelters.
- Offer mobile services at schools.

- Create a street program that is a program for outreach and assessment.
- Open more detox beds.
- Open more psych beds.
- Shorten waiting times to get people into shelters.
- Expand shelters for women with children.
- Offer shelter to families with 5+ children to go.
- Open pet friendly shelters.
- Offer homeless services for children and youth.
- Open shelters specifically for transitional age youth (TAY).
- Implement more rent control.
- Have more housing for people with mental health issues.
- Increase SSI income.
- Give incentives to homeowners who rent out their rooms to homeless/street people.
- Prioritize seniors: PITC trends are showing more seniors are homeless.
- Prioritize youth.
- Offer more affordable housing options for men and women with children.
- Open more sober living homes in 92113.
- Have families temporarily "adopt" families in need.
- Have churches adopt five families.
- Make contracts with the developers for affordable housing.
- Make housing caps.
- Change the housing codes.
- 5-25% of housing should be rent-controlled.
- Create a specific program that would increase beds and shelter for accessibility and availability countywide. It would break down barriers. It would increase safety.
- Create more peer support programs.
- Give people jobs. This would give them integrity/dignity and would promote sobriety.
- Clean up the streets.
- Offer permanent supportive housing for families.
- Reduce evictions through use of case management.
- Identify schools that have homeless students and use that as a starting point.
- Have schools involved.
- Give homeless people intensive case management and support.
- Create a position for a response dispatcher.
- Give the homeless transportation to services.
- Develop a one-stop shop/drop in center to help with housing, case management, mental health services, employment, life skills, medical issues – all in one office.
- Have a mobile medication clinic.
- Have a mobile family resource center in school parking lots.
- Create transitional places for patients to go who are just released from hospitals.
- Use big properties that are not being used to shelter the homeless.
- Open more boys and girls clubs.
- Get seniors more involved.
- Shorten section 8 wait time.

- Make homes out of vacant buildings – put the homeless to work fixing up the buildings to live in.
- Virtual mental health for everyone.
- Virtual whole health connections using facetime. Meets individuals where they are vs making office appointments only.
- Create a "meet me where I am" mobile app that would include shelter, crisis, food, drop-in, legal health, hotline, education, transportation (employment resources in the palm of your hand in 6 threshold languages."
- Sober living for men with children and more resources for men with children.
- Employ the people on the streets for cleanup projects focused on areas with higher homeless populations. Similar to the Seattle Clean Up initiative.
- Stop taking the homeless' cars and giving them tickets and fines they can't pay for.
- Self-built owned housing with connections to employment – program has own warehouse, land for agriculture. Close to resources with transportation access.
- Tiny home community for child welfare-involved families. Instead of sending kids to foster care, send family to tiny home program where mental health, SUD, and wrap around services are able to support the family.
- Create mobile services and resources for everyone.
- Create more community gardens.
- Create a homeless choir.
- Unite homeless people with similar hobbies – give them a space to expression their passion.
- Utilized faith-based community sponsorship.
- Teach social enterprise in every treatment program.
- Have a program that creates connection between counselors and students to help children from homeless families.
- Train police to treat homeless people with respect and kindness.
- Create a mentorship program that works with groups of homeless individuals.
- Create a support group for families experiencing homelessness.
- Create a volunteer program/work program that gives homeless people necessary life skills.
- Create a fathers helping fathers program that assists single fathers with children.
- Develop a specific program for people to own a house.
- Have 2-3 centers per each Live Well region. It would have a data based system. One stop to receive resources, other housing access to other services.
- Use the old drive-in theater in Oceanside to create a one stop shelter.
- Compile a county-wide pool of landlords to take Section 8.
- Use hold hotels to house the homeless.
- Tiny homes with tiny loans.
- Tiny homes that are shipping containers.

List 10. Challenges Related to Co-occurring Mental Health Disorders and Developmental Delays (Reference: See Report Narrative, Page 30)

- Diagnostic overshadowing: may have depression/bipolar disorder but diagnosed as DD because of behavioral presentation.
- People with SUD disorders are isolated because of stigma.

- Systems operate in silos. This often leads to people with co-occurring disorders to fall through the cracks.
- The families of children with co-occurring disorders are suffering.
- Individuals with learning disabilities often go undiagnosed.
- Need to get families, particularly adults with co-occurring disorders connected to Regional Center.
- Often these families are financially unstable and have unstable or no housing.
- Students struggle in school even with an IEP.
- These individuals have difficulty finding employment.
- These individuals often end up in the criminal justice system.
- They have low self-esteem and learned helplessness.
- They are very vulnerable to both drug and sex trafficking.
- They are high risk for sexually transmitted infections.
- They are not able to make decisions.
- They typically are very isolated.
- Their health is often neglected.
- Refugees with co-occurring disorders need services and they are hard to access.
- It takes a long time to get an accurate diagnosis.
- The social skills of these individuals are poor.
- It is difficult to find appropriate services for individuals with both diagnoses.
- Hard to find resources for the aging population.
- We need culturally sensitive assessments and interventions.
- We lack healthcare providers for these individuals.
- We lack bilingual providers.
- These individuals often experience financial abuse.
- Emergency department staff aren't trained to help these individuals.
- We need individualized services.
- Lack of supportive living services for people with these disorders.
- Communities don't want the disabled living around them.
- It's hard to place people with developmental disorders.
- Housing is hard for people with DD.
- People are often misdiagnosed.
- We lack multidisciplinary approaches.
- Need innovative and holistic practices.
- Need more outreach and communication.
- Need more research about what the evidence based best practices are for this group.
- Need more step-down programs from inpatient setting.
- Need more outpatient treatment options with providers who expertise in both diagnoses.
- Need to provide more support to parents.
- Need more crisis stabilization units.
- Hard for these individuals to access social activities.
- Need supportive childcare that will take children after they've been traumatized.
- Instead of having an age cut-off, services should extend over a lifetime.
- We lack services for undocumented individuals.
- Care is uncoordinated.

- Need more information about what is working in other states.
- Need to adapt interventions for individual needs.
- Providers lack training and education about treating these clients.
- Transportation is a challenge.

List 11. New Approaches to Challenges Related to Co-occurring Mental Health Disorders and Developmental Delays (Reference: See Report Narrative, Page 31)

- Identify and implement culturally sensitive assessments and interventions.
- Provide education to families.
- Develop peer-support programs.
- Encourage cross-education across disciplines.
- Implement person-centered treatment planning.
- Conduct specialized homeless outreach for this population.
- Create specialized, supportive housing for this population.
- Have smaller crisis shelters with just 3-6 people so it is more comfortable.
- Create comprehensive care with a multi-disciplinary approach.
- Develop step-down programs for those transitioning from an in-patient setting.
- Have board and care facilities that are super-augmented with mental health services.
- Extend services over a lifetime.
- Teach people to use the transportation systems in a way that is not overwhelming.
- Reduce stigma through education and outreach.
- Create systems of coordinated care.
- Utilize EHRs to share information about clients.
- Utilize community strengths.
- Use cultural brokers/peers to help this population.
- Implement human centered engagement to learn what will be effective with this population.
- Open more short-term residential facilities for kids.
- Expand wrap programs for kids.
- Designate safe spaces for kids.
- Reduce the cost of extra-curricular/leisure activities.
- Have inter-generational involvement/programming.
- Have evidence-based inclusive clubhouses.
- Expand arts therapy programs.
- For adults have IOP/PHP for Medi-Cal dual diagnosis (intensive outpatient program /partial hospitalization program).
- Open more urgent care facilities to address adult needs.
- Make better use of trauma-focused cognitive behavioral therapy.
- Host collaborative meetings for clinicians once a month so that people working with different groups can share information and exchange ideas.
- Require extra hours of training through BHETA or WET.

Supplementary Community Survey Results

List 12. Community Survey Comments, Questions, and Concerns (Reference: See Report Narrative, Page 16)

- Local services organized by zip codes- -Resources should reflect the culture of the communities.
- Increase access to detox, many people don't connect with services because they can't get into detox. 2. Expand capacity of START programs.
- Would be extremely helpful to have an overall flow chart on how to manage available resources (e.g. age/illness, what to do 1st, who to contact, what resources for what steps in process, etc.). There a multitudes of county resources, but if you are just beginning the process, there is no good way to simply understand system/process and where to go at what stages. 2. School support was large issue- not from counselors or teachers- but principals are not as educated or don't buy in or are more concerned w/ dollars than student care. 3. Many county programs are for low income/no insurance- we wanted to use some resources and couldn't even if we could have paid.
- 12-step programs have been crucial for my loved one. Are they available in schools?
- A "One Stop" Authority to listen to the situation and to point me (the Caregiver) in the proper directions quickly.
- A shorter wait time especially in time of crisis.
- Additional beds. More psychiatrists.
- An Arabic medical interpreter is needed during doctor's appointments. The rent is so high.
- Ancestral Medicine, Culturally Responsive Healing, Human Centered Healing.
- Arabic interpretation for doctor's appointments- transportation.
- As a Public Health Nurse for COSD, I have repeatedly heard about poor access or long waits to see a therapist or counselor. Clients give up on trying to get help because the process is too complicated or with 3-month wait lists. People with depression/anxiety or other mental health problems need quicker response/ easier access to mental health services.
- As a single parent of a teenager with co-occurring disorder and multiple suicide attempts I feel Residential treatment should be more affordable to low income single parents. After years of trying to get my daughter help in the community and after her multiple suicide attempts and drug and alcohol use it took her breaking the law to get help now she is charged with a felony and it might have been prevented if she got the treatment she needed before anything bad happened. The system is backwards they wait until something bad happens before they get the help they need. It shouldn't be that way. If there are red flags and multiple indicators there should be help before someone dies, kills themselves, kills someone, hurts someone, hurts themselves or breaks the law. After 9 hospitalizations I still had no option because I couldn't afford residential treatment. Now she's away out of state at a residential treatment that is not trained in trauma and cottage staff isn't trained in dealing with people with mental health struggles. And then because of this and because a parent has done all they can like I have and the child breaks the law and is sent by court to a residential treatment they then have to pay child support while the child is gone when if they had all the help they needed in this might not have happened in the first place.
- Being able to provide services when they are needed is very important. When people are placed on wait lists the willingness is replaced by the need to survive or feel differently and we lose the opportunity for a good treatment outcome.
- Better communication with the family/loved ones.

- Better housing opportunities.
- Community exposures.
- Direction for groups in community. Strongly encouraged during waiting.
- Drop in clinics for MH assessment and referral for services.
- Drug testing in federal and public buildings which can help reduce violence, victims and mental health issues.
- Easy ways to find therapist for victim of crimes.
- Even more peer-based mentorship geared toward older adults, 60+. :).
- Expanded capacity for Bridge Housing for those qualifying for a Housing Resource not get available.
- Faster care, better ways to communicate resources to clients.
- Follow-ups.
- Gap Insurance for Uninsured with mental health/ substance abuse issues.
- Group Therapy in Language Asian/Pacific Islander.
- Have someone reach out to me & provide info keep in touch.
- Home EC., competence training for staff.
- Housing.
- Housing in environments that treat the victims of mental health issues as humans. Our son has fear of being in houses in a room with an individual that was twice his age and had possessions stolen by others. He was ridiculed by other residents and became more paranoid the longer he stayed. The environment caused him to run away.
- Housing please.
- Housing. Long term support. Specific services for pregnant/parenting TAY.
- I am a nurse in an emergency department. Waited more than a month for output care. (NOTE: not used service but info by a provider side).
- I am not sure how the Health and Human Services Agency works. However, it appears to me that the homeless situation in San Diego, maybe part of a larger aspect of mental health services available in San Diego. Maybe there needs to be more outreach in that community and in low income communities to ensure no community is lacking treatment due to lack of funds or resources.
- I came to San Diego through Conrep. Services were provided by them.
- I ended up going to the McDonald Center in LA Jolla in 2001, and it saved my life. After countless smaller issues, then losing some very close friends early on, DUI Oct. 98, sick for 2yrs up to 2001, still daily functioning drinker (1.5 liters/vodka/day or full blown DT's 24/7), had no clue what an alcoholic was, didn't care, I just wanted to feel better and not alone. Finally, at 28 I was on trauma floor of Scripps Hillcrest, almost dead from acute pancreatitis, followed by a short stint on the basement 3rd floor after going insane from withdrawal and IV morphine that 1.5 weeks. That was the start to my recovery, and I am grateful for the care I received back then, the wonderful people I now call friends, no alcohol for 17yrs, my health, being back in my hometown after leaving in 2002, for being willing to help another before myself... And for me, these are all cool new revelations as up until 2001, I really didn't expect to even be here, and I certainly didn't care about any of things I listed. I would like to help in any way I can and have been reaching out when I am able. Thank you for your service, this is an area of opportunity here in SD for sure!
- I need a medical Arabic/Chaldean interpreter during the medical appointments.
- I need a medical interpreter during the appointments.
- I want a house for my son and me because I am his mother. Thank you for being very thoughtful and so I would like if my son could continue to come with you. I see it very motivating.

- I work in mental health, so I have so many resources at my fingertips if I need them, and I can refer people to them as well, but these resources can only do so much of the general public isn't aware of them. Most people I talk to don't know that the things they wish San Diego had already exist.
- In local libraries or common places for the Homeless community to have resources for shelters available.
- Increase & expand PERT teams. Expand language capacity.
- Increased follow up from social worker offer discharge.
- It is disheartening youth can voluntarily leave a treatment facility due to laws w/in CA. Each treatment provider needs to cover dual-diagnosis first More availability of dual diagnosis providers.
- It would be nice to have an indigenous provider who would understand the cultural context of issues discussed.
- It's very important that people who are discharged from the hospital have safe places to go, not back into homelessness.
- Job readiness assistance.
- Knowing someone acting like a coach to give you confidence during your journey is important!
- Learning in psych hospital how to do various activities such as yoga or having the availability to be outside more.
- Less wait time. More access to psychiatrists.
- Looking at the whole person and creating a wraparound system that promotes hope and that they are listened to and not just talked at.
- Looking for help for a family member made me feel like a failure. We tried our insurance and it was so embarrassing we never really found "care". I found some tips online but no one that could "help" to tell me what to do next. Asking for help at school makes me feel like a criminal.
- Make case management to help clients navigate system and to help with logistical concerns (e.g. Housing, occupation, childcare, transportation etc.).
- Mental health advertisements.
- Mental health even with insurance is not great and takes a long time to find a doctor that understands my particular issues.
- Mental Healthcare is poorly funded, and services are not available to those that need it. Wow. And you wonder why people are homeless.
- More access to Psychiatrists & therapists. Difficulty in making an appointment. High turnover. Went through/referred to 3 Psychiatrists in 3 yrs.
- More awareness now. Resources lagging.
- More competent Mental health professionals. From my experience the people working for many of these agencies have the degree but do not have the necessary skill set.
- More crisis-stabilization units.
- More culturally competent staff.
- More mental health education in schools and school staff.
- More mental health/therapy services for homeless individuals on a continuous basis. Not just in emergency situations. We also need more emergency shelters for Families.
- More PEI services.
- More resources. The few programs available have long wait lists, link to clubhouses.
- More services for homeless population.
- More services. Better communication Less wait time More providers. More school services.
- More specialization Increased access to group therapy.

- More Staff on site, faster services, mobile team of Mental Health out in the field.
- More therapy options for low income people. More mental health services for the community.
- More young adult social outlets/programs.
- Multiple pathways to mental health resources. Options for all income levels. Resource directory of providers + services. It would be great to have this survey digital + optimized. Friday afternoon before a 3-day weekend is a bad time to have this event.
- Needed services for teen mild anxiety, had to research, try, and pay out of pocket to find the right fit.
- Never knew there was help for teens using drugs that were not paid (expensive) services.
- Not me or a family member. Yes, ma clients and a few workers- friends daughter obtained excellent privately paid care. Very hard to get into detox.
- Notices (hard copies) in library, laundry matts, grocery stores, etc. that is visible for community residents can see what is available in community.
- On other occasions the wait was 3 months. Many others report long delays as well.
- One-stop "SHOPPING" to effectively and efficiently get the help that is needed-ALL RESOURCES.
- Over 2 years to get our son onto medication. More education of law enforcement about mental illness, better 5150 laws to get people to help right away, change HIPPA laws to allow blood relatives to know where their loved ones have been taken, and open communication with psychiatrists, social workers and medical team- to allow family to provide cohesive follow up at home.
- Peer support through private insurance.
- Peer support.
- People need to learn to be patient.
- Permanent housing.
- Please make funding available for longer term (90 days) transitional housing to access services.
- Provide Mental Health Services/MFT in Arabic & Farsi.
- Reducing "wait times" for services.
- Resources for spirituality. More case managers and housing managers.
- Resources training family & friends on how to handle a mental health crisis.
- Schools, Public Transportation, Programs who work closely with mental health provide Workshops to their services provided.
- Services and treatment must include the whole family... When parents struggle, children struggle. We are significantly under-serving our early childhood population, when interventions can be most impactful and can contribute to significant cost savings down the road. Services must be comprehensive and holistic to truly be helpful, restorative and meaningful.
- Services received-satisfied. Very unsatisfied by the amount of time it took to get an appt. More immediate services available for minors.
- Shared employment & treatment team client plans stand-alone employment + programs, as well as collaboration between voc. Rehab & individualized employment support.
- Signs of depression, suicide for parents. What to watch for. How to support a teen after they are suicidal, depressed etc.
- Sometimes Mental Health providers cause more trauma because they are tired of dealing with one person's many issues.
- Step down MH services for adolescents.
- Support.
- Support groups specific to my identity. Community engagement.

- Support groups.
- Temporary program avail. Until full services in place.
- Thankful for this forum.
- The homeless population is booming. Housing is not. No more breaks for builders. Subsidized housing is necessary. Many do not realize that they have a mental health issue therefore, they don't try to get help. Then we have the homeless drug addicts that steal from the neighborhood to support their addiction. 20 years old or younger living in the Famosa Slough for example. Someone supplies them with meth and heroin in the neighborhood and they break into houses, cars and steal whatever they can and trash the wetlands. They loiter at businesses nearby and leave trash. It's a nightmare EVERY day. These kids should be in training for jobs instead. Many mental health issues could be helped with job training.
- The social aspects of wellness need to be addressed further.
- There are not many places for people with co-occurring disorders to get treatment.
- There are some resources such as the humanitarian organizations, churches and family
- Transportation and the cost of housing are two of the region's biggest barriers to serving the folks who most need care. People who can barely afford housing but aren't then eligible for reduced fare transportation cannot get to the care they need. The county should partner with MTS to provide low-fare transportation to anyone who has a disability, not only those who are mobility impaired. Additionally, there should be additional funding for POFA vouchers that will last through the year, so that those who need MH care can be housed, as they will not seek care if they are living on the streets.
- Transportation to appointment 1st time and perhaps 2nd.
- Universal health care.
- We need interpretation, transportation for doctor's appointments - we need picnics.
- We need more preventative care like Mental health clubhouses. They could use more funding.
- We need transportation for medical appointments, housing with a low rate. Thank you for participating in the community survey of the Health and Human Services Agency of San Diego County - Behavioral Health Services. Your feedback is important to us. We have a lot of people who suffer from mental illness who have many requirements and demands, missing those demands would increase the symptoms of the mental illness and affect their role to be active in the community. Those requirements are: Transportation and Arabic interpreters for their appointments. Naturalizations lessons. High rate of rent while they are a low income.
- Yes, you should not have mental health contractors who use HIPAA against families who are trying to help and be involved in their care. I have a mother who has been homeless in San Diego for the past 17 1/2 years and was diagnosed with schizophrenia over 30 years ago. Since I was 10 years old, my mother has been battling mental illness and the from our experience, the family's involvement depends heavily on the cooperation of the mental health patient. Fostering the disconnect, between the family and the patient, by using HIPAA as an excuse of not including the caregivers in the treatment plans. This leaves families lost, confused, and with no guidance on how to help their loved one. If Grandfather would have the help and guidance that he needed to help my mother, he would not have become so frustrated that he kicked my mother out of the house. She has been homeless ever since and I have been chasing her trying to bring her back home to no avail since she doesn't want to come home after being kicked out. The way the mental health system is managed in this county and country is horrible and broken. The system is broken and the contractors only benefit monetarily while the families are desperate for help. Investigate the inefficiencies of the system before pouring more money into a broken system.
- Young people don't know how or where to get help---- live with their problems in silence.

Appendix H

MHSA Issue Resolution Process

Mental Health Services Act (MHSA) Issue Resolution Process
Updated April 19, 2019

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), and 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 Mental Health Services Act (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 avenue within the system. These avenues may 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

Appendix I

Community Supports and Services (CSS) Annual Report FY 2017-18

FY 2017-18 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

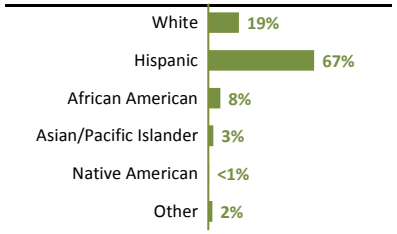
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

CY - Full Service Partnership (CY-FSP; n=9,498)

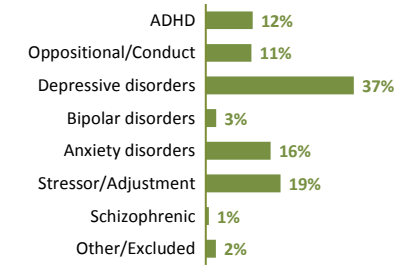
Living Situation	%
House or Apartment	92%
Correctional Facility	1%
Foster Home	3%
Group Home	1%
Residential Trmt Ctr	<1%
Children's Shelter	<1%
Homeless	2%
Other/Unknown	1%

Language	%
English	85%
Spanish	15%
Arabic	<1%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	<1%

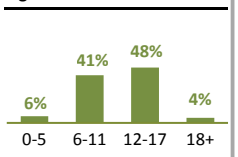
Race/Ethnicity



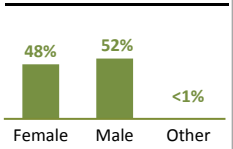
Diagnosis



Age

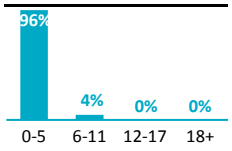


Gender

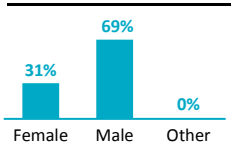


CY - Outreach and Engagement (CY-OE; n=45)

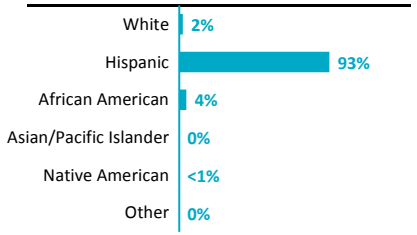
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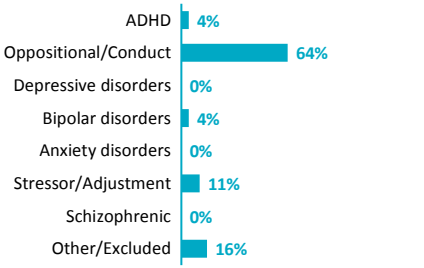
Gender



Race/Ethnicity



Diagnosis



Living Situation	%
House or Apartment	98%
Correctional Facility	0%
Foster Home	0%
Group Home	0%
Residential Trmt Ctr	0%
Children's Shelter	0%
Homeless	2%
Other/Unknown	0%

Language	%
English	49%
Spanish	51%
Arabic	0%
Vietnamese	0%
Tagalog	0%
Farsi	0%
Other/Unknown	0%

CY-FSP **28%** (9,498)

CY-OE **<1%** (45)

Total CSS Clients *(unduplicated)* N = 34,477

CY-SD **8%** (2,748)

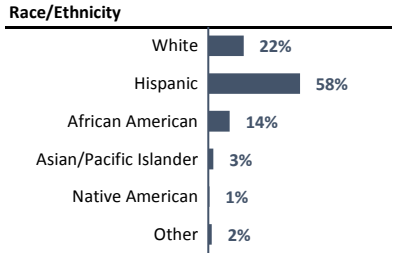
ALL-OE **1%** (193)

CY - System Development (CY-SD; n=2,748)

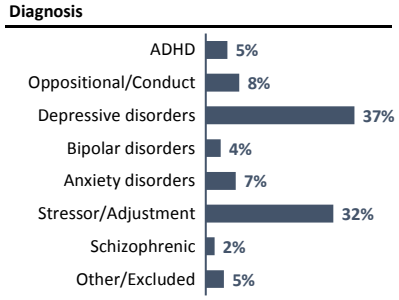
Living Situation	%
House or Apartment	61%
Correctional Facility	19%
Foster Home	10%
Group Home	3%
Residential Trmt Ctr	1%
Children's Shelter	4%
Homeless	1%
Other/Unknown	2%

Language	%
English	90%
Spanish	9%
Arabic	<1%
Vietnamese	<1%
Tagalog	0%
Farsi	0%
Other/Unknown	1%

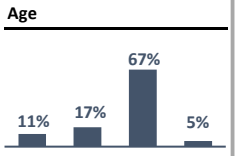
Race/Ethnicity



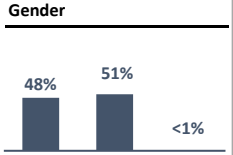
Diagnosis



Age

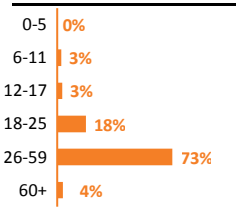


Gender

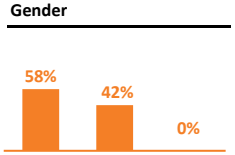


All CSS - Outreach and Engagement* (ALL-OE; n=193)

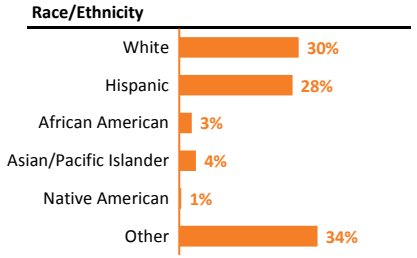
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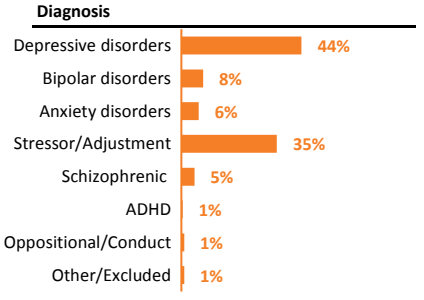
Gender



Race/Ethnicity



Diagnosis



Living Situation	%
Lives Independently	95%
Justice Related	0%
Board & Care	2%
Institutional	0%
Foster Home	1%
Group Home	0%
Residential Trmt Ctr	0%
Children's Shelter	0%
Homeless	2%
Other/Unknown	1%

Language	%
English	15%
Spanish	12%
Arabic	13%
Vietnamese	0%
Tagalog	0%
Farsi	6%
Other/Unknown	55%

**Clients may be duplicated*

Note: Clients may have received service from >1 CSS category within the fiscal year. Only CSS programs that enter 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: 5/07/2019

FY 2017-18 Community Services and Supports (CSS)

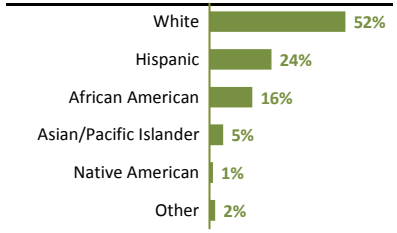
County of San Diego Behavioral Health Services — MHSA CSS Programs

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

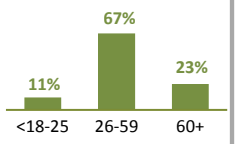
TAOA - Full Service Partnership (TAOA-FSP; n=5,384)

Living Situation	%
Lives Independently	51%
Board & Care	16%
Justice Related	1%
Homeless	13%
Institutional	14%
Other/Unknown	4%

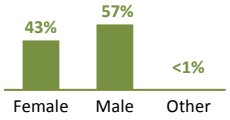
Race/Ethnicity



Age

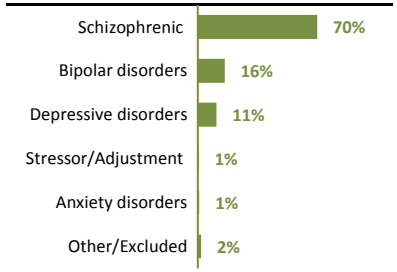


Gender



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

Diagnosis



TAOA-FSP **16%** **(5,384)**

TAOA - Outreach and Engagement (TAOA-OE; n=0)

TAOA-OE programs were not active in FY 2017-18

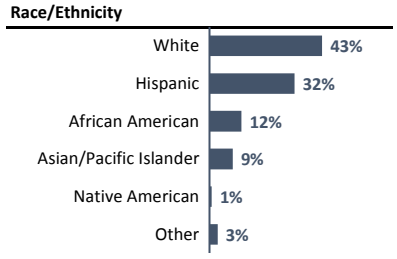
Total CSS Clients *(unduplicated)* N = 34,477

TAOA - System Development (TAOA-SD; n=13,564)

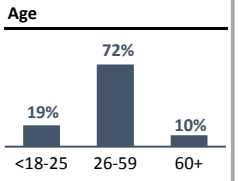
TAOA-SD **39%** **(13,564)**

Living Situation	%
Lives Independently	64%
Board & Care	7%
Justice Related	1%
Homeless	17%
Institutional	1%
Other/Unknown	11%

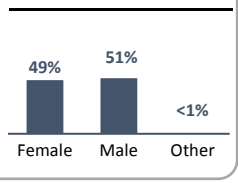
Race/Ethnicity



Age

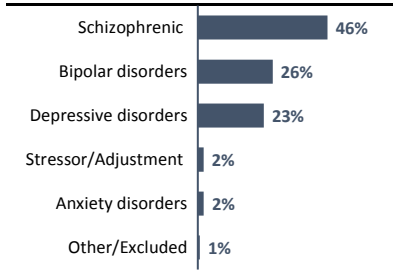


Gender



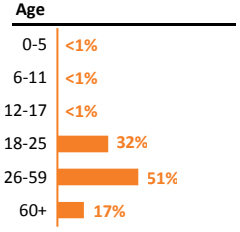
Language	%
English	81%
Spanish	7%
Arabic	1%
Vietnamese	2%
Tagalog	<1%
Farsi	<1%
Other/Unknown	9%

Diagnosis

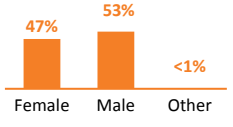


ALL-SD **23%** **(8,044)**

Age

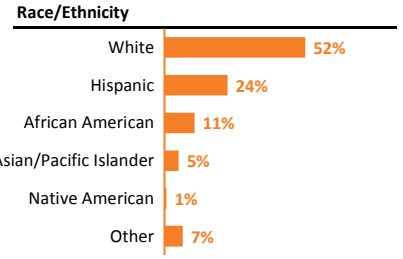


Gender

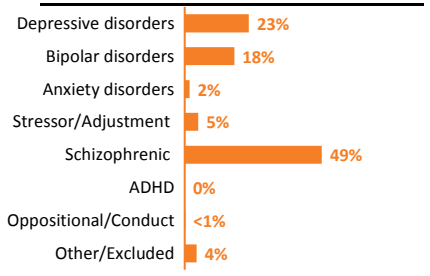


All CSS - System Development† (ALL-SD; n=8,044)

Race/Ethnicity



Diagnosis



Living Situation	%
Lives Independently	71%
Justice Related	1%
Board & Care	4%
Institutional	2%
Foster Home	0%
Group Home	0%
Residential Trmt Ctr	0%
Children's Shelter	0%
Homeless	18%
Other/Unknown	3%

Language	%
English	90%
Spanish	4%
Arabic	4%
Vietnamese	<1%
Tagalog	<1%
Farsi	<1%
Other/Unknown	2%

†Clients may be duplicated

Note: Clients may have received service from >1 CSS category within the fiscal year. Only CSS programs that report 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: 5/07/2019

Appendix J

FSP Outcomes Report FY 2017-18

Children, Youth and Families

Full Service Partnerships OUTCOMES REPORT

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

Children, Youth & Families FSP Summary ***FY 2017-18***

What Is This?

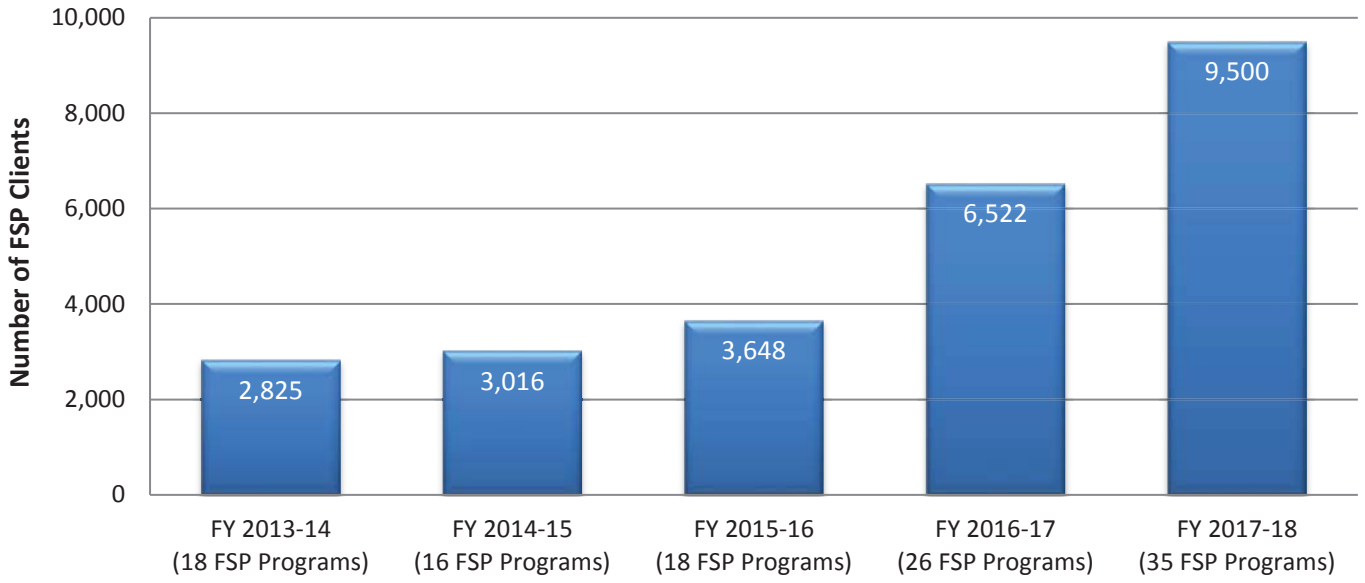
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals and treatment plan and clients can access designated staff 24 hour/7 days a week. FSP services comprehensively address client and family needs through intensive services, supports, and strong connections to community resources with a focus on resilience and recovery. An FSP offers ancillary support(s), when indicated, by case managers, 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 forensic services.

Who Are We Serving?

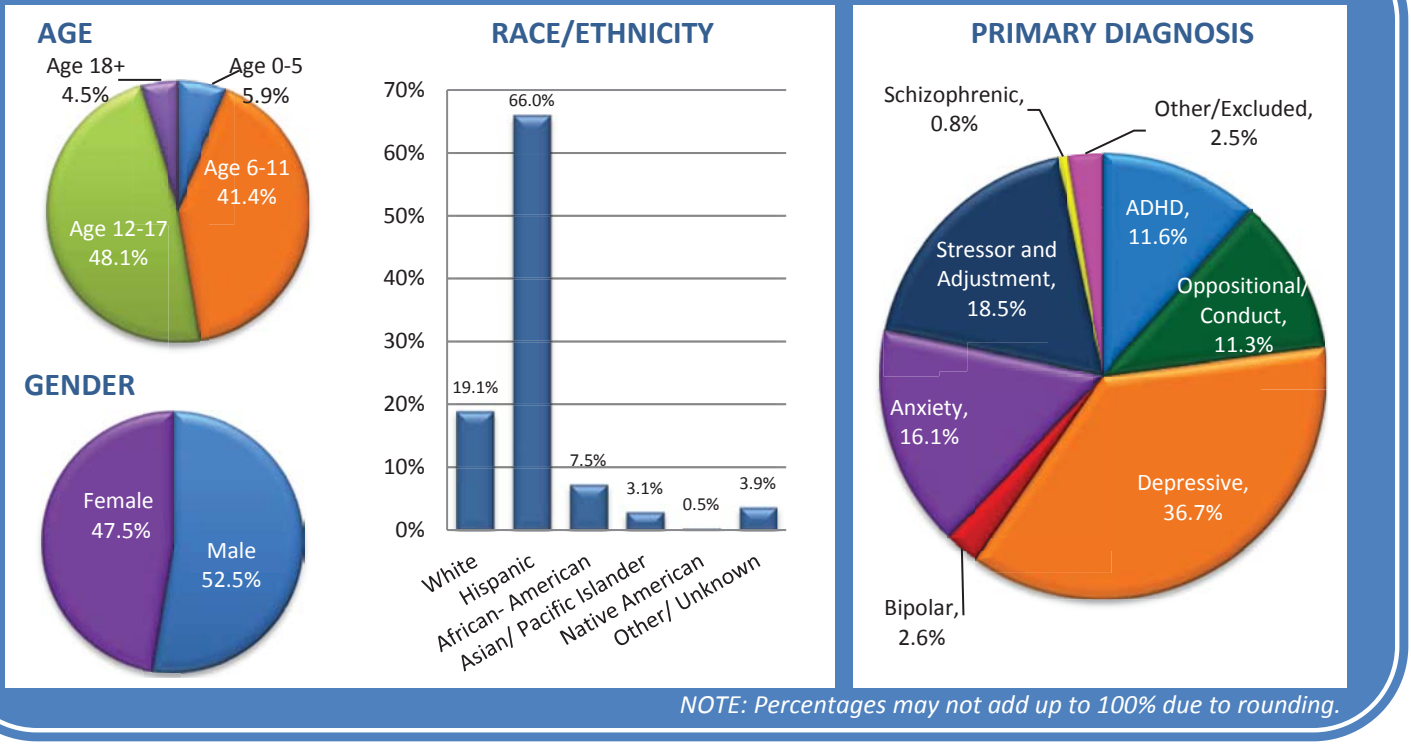
In Fiscal Year (FY) 2017-18, a total of 9,500 unduplicated clients received services through 35 FSP programs, a 46% increase from 6,522 FSP clients served in 26 FSP programs in FY 2016-17.



Who Are We Serving?

In FY 2017-18, FSP clients were more likely to be male and Hispanic. The most common diagnoses among FSP clients was Depressive Disorder.

FSP Client Demographics and Diagnoses (N = 9,500)



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 2017-18.

Referral Sources (n = 5,612)*

FSP referrals for clients with an intake assessment in FY 2017-18 were as follows (in order of frequency): school system (41%), family member (20%), primary care physician (11%), self-referral (8%), mental health facility (6%), social service agency (5%), other County agency (3%), Juvenile Hall (1%), acute psychiatric facility (1%), emergency room (1%), friend (<1%), homeless shelter (<1%), and faith-based organization (<1%). The remaining 2% were referred by an unknown or unspecified source.



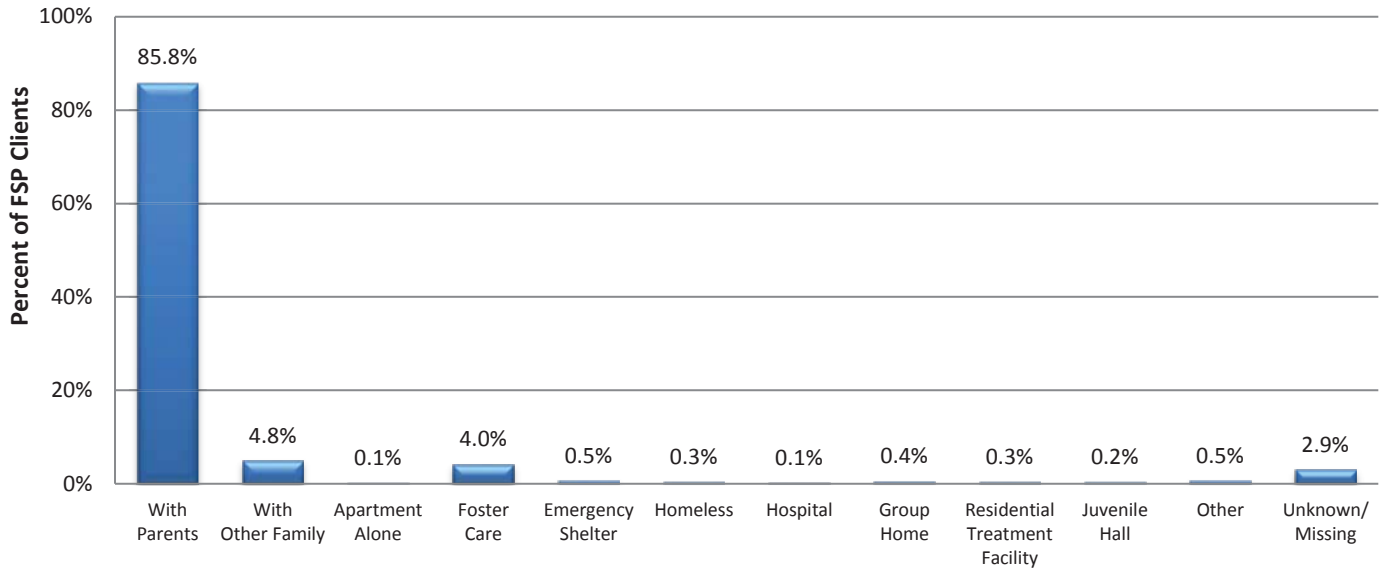
**Clients with intake assessment in the DCR within FY 2017-18.*
NOTE: Percentages may not add up to 100% due to rounding.

Who Are We Serving? (continued)

Living arrangement and risk factors were entered in the DCR for new clients to FSP programs in FY 2017-18.

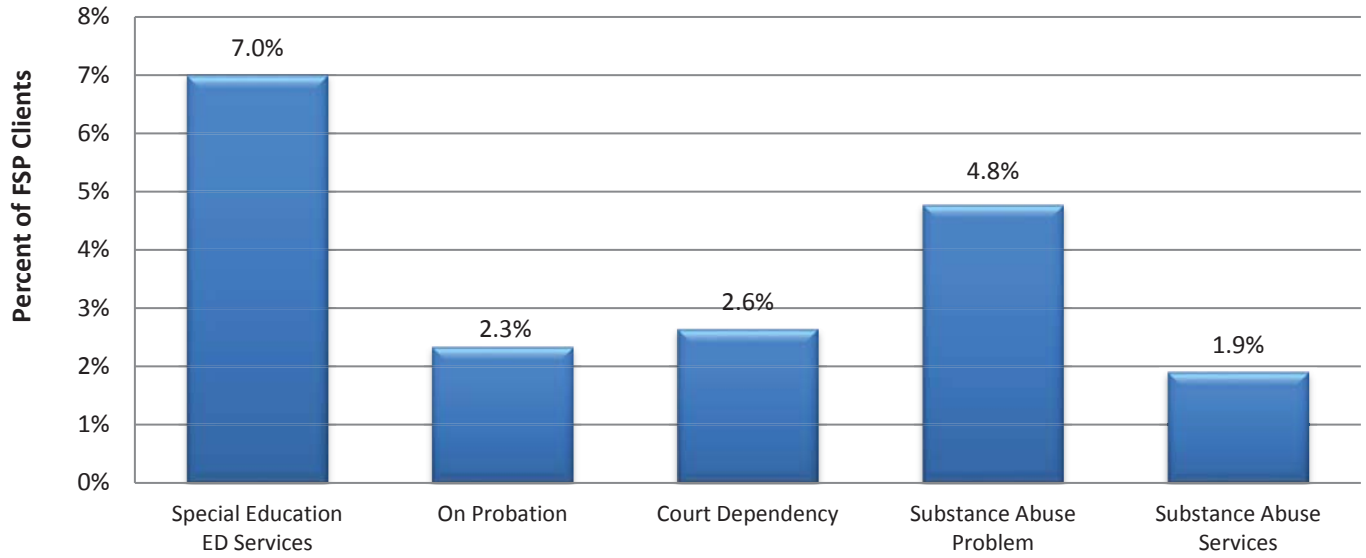
Living Arrangement at Intake (n = 5,612)*

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



Risk Factors at Intake (n = 5,612)*

Data indicates that 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 4,624 (82%) 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 2017-18.*
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 2017-18, a total of 19 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of the 9,500 unduplicated clients who received services from an FSP program in FY 2017-18, 25 (<1%) had at least one inpatient (IP) episode and 43 (1%) had at least one Emergency Screening Unit (ESU) visit during the treatment episode.

Are Children Getting Better?

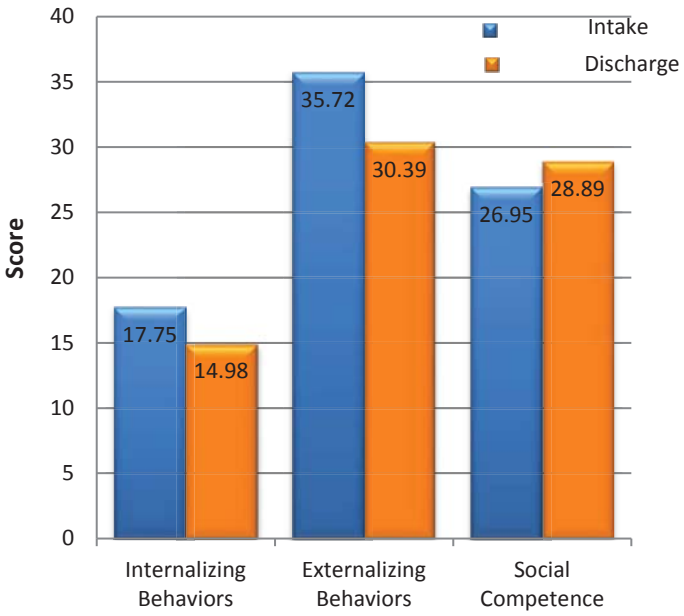
FSP providers collected outcomes data with the Child and Adolescent Measurement System (CAMS) and the Children's Functional Assessment Rating Scale (CFARS). Scores were analyzed for youth discharged from FSP services in FY 2017-18, who were in services at least three weeks (CFARS) or two months (CAMS) and had a maximum of two years between intake and discharge assessment, and who had both intake and discharge scores for all measure domains. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP programs augmented with a Substance Use Disorder (SUD) component in FY 2017-18, who were in services for at least one month.

FSP CAMS Scores

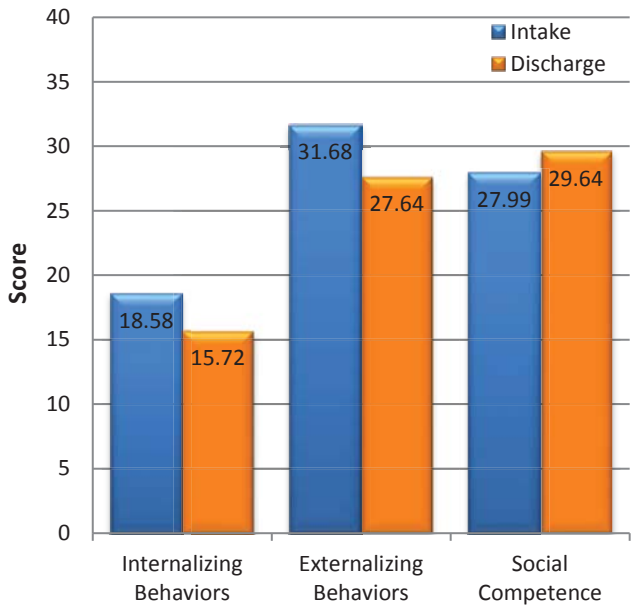
The CAMS measures a child's social competency, behavior and emotional problems; it is administered to all caregivers, and to youth ages 11 and older. A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered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

These CAMS results (n = 2,899 Parent/Caregiver CAMS; n = 1,675 Youth CAMS) revealed improvement in youth behavior and emotional problems following receipt of FSP services.

FSP Parent/Caregiver CAMS (n = 2,899)



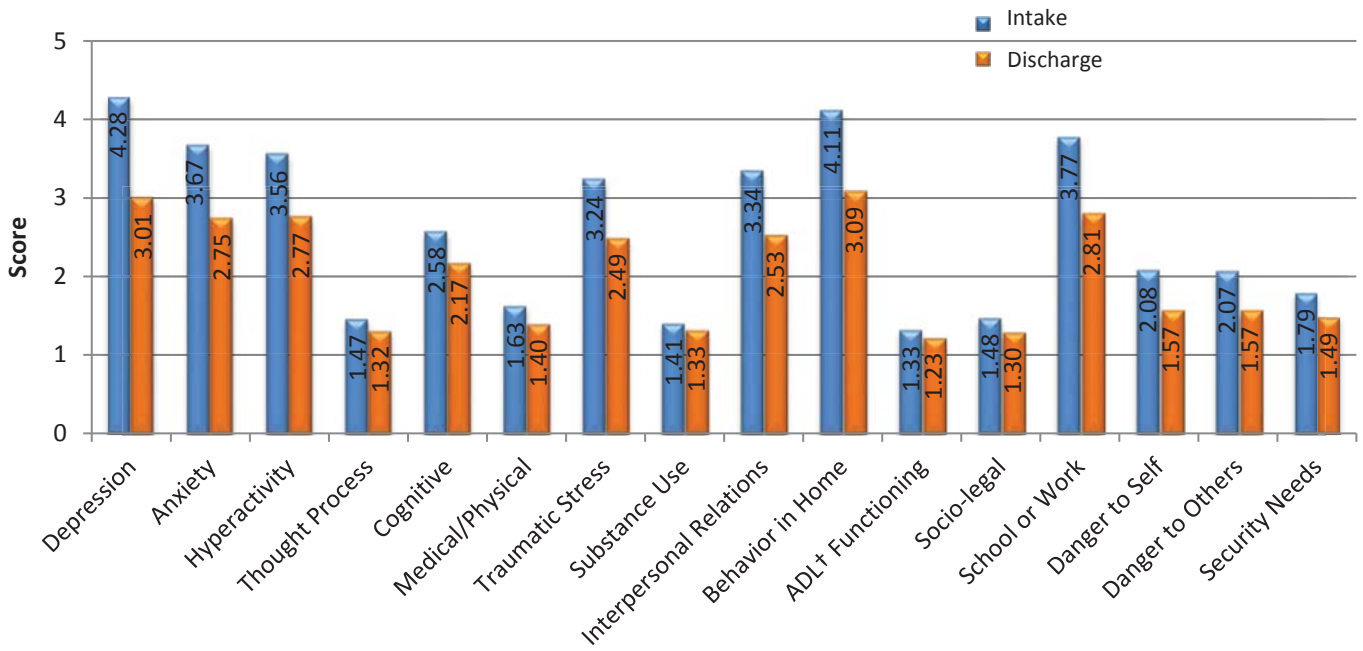
FSP Youth CAMS (n = 1,675)



Are Children Getting Better? (continued)

FSP CFARS Scores (n = 5,784)

The CFARS measures level of functioning on a scale of 1 to 9 and is completed by the client's clinician. A *decrease* on any CFARS item score is considered an improvement. CFARS data were available on 5,784 FSP clients in FY 2017-18 and revealed improvement in youth symptoms and behavior following receipt of FSP services.

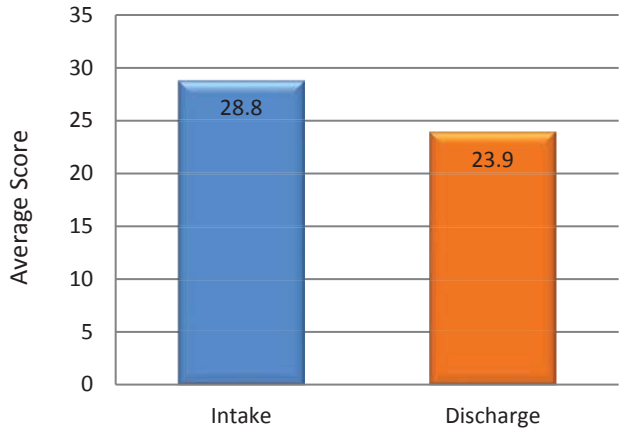


†Activities of Daily Living

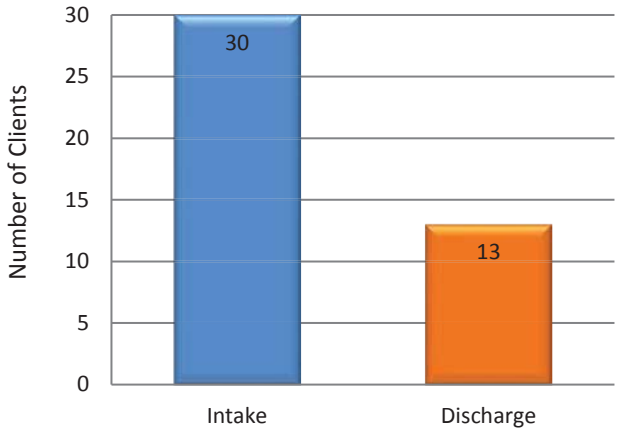
FSP PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their Substance Use Disorder (SUD) counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 96 discharged clients in FY 2017-18.

PESQ Severity Scale (n = 96)



PESQ Clinical Cutpoint

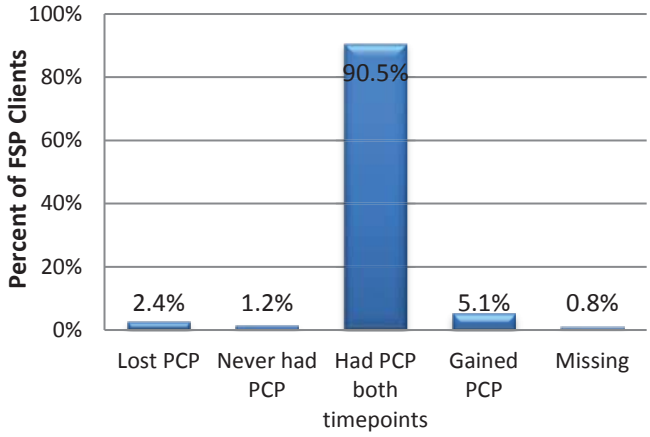


Are Children Getting Better? (continued)

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 = 5,445)

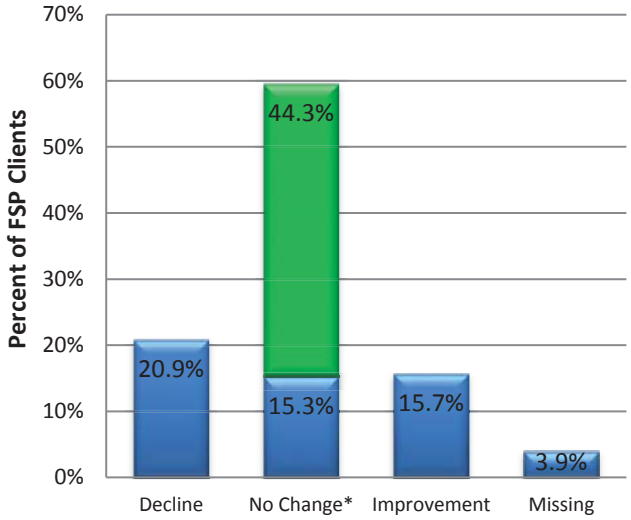
91 percent of FSP clients had and maintained a PCP.





School Attendance (n = 5,445)

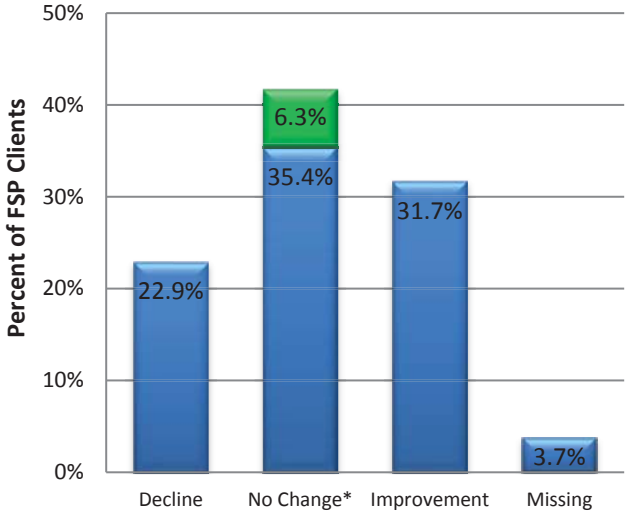
60 percent of FSP clients either improved (16%) or maintained excellent (44%) school attendance at follow-up assessment as



**Of the 60% of clients for whom no change was noted, 44% (green portion of bar) had consistently excellent attendance (intake and discharge assessments indicated the most positive category for school attendance).*

Academic Performance (n = 5,445)

38 percent of FSP clients either improved (32%) or maintained excellent (6%) grades at follow-up assessment as compared to intake.



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

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

What Does This Mean?

- County of San Diego Health and Human Services Agency's Behavioral Health Services Children, Youth & Families System of Care underwent a redesign that enhanced outpatient treatment programs by transforming them into FSP programs in order to promote whole person wellness and overall wellbeing.
- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms, 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 40% of youth FSP clients 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@ucsd.edu or 858-966-7703 x247141.

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

Appendix K

Annual System-wide Assertive Community Treatment (ACT) Report FY 2017-18 - Adult



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 14 ACT programs* in San Diego County during fiscal year (FY) 2017-18.

- 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

  was 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).

Comparisons to data from fiscal year 2016-17 are highlighted, when appropriate.

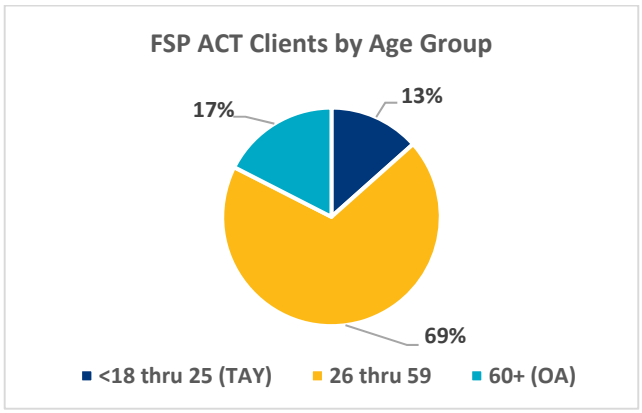
*Data from the following programs are included in this report (program name and sub-unit): CRF Adelante (4341), CRF Downtown IMPACT (3241, 3244, 3245), CRF IMPACT (3401, 3404), CRF Senior IMPACT (3481, 3482), MHS Action Central (4241, 4242), MHS Action East (4251), MHS Center Star (3411, 3413, 3414), MHS City Star (4221), MHS North Coastal (4351), MHS North Star (3361, 3364), Pathways Catalyst (4261, 4264), Telecare Assisted Outpatient Treatment (4211), Telecare Gateway to Recovery (3312), Telecare MH Collaborative Court (4201, 4203), Telecare Project 25 (3315), Telecare PROPS AB109 (4192), and Telecare LTC (3331).

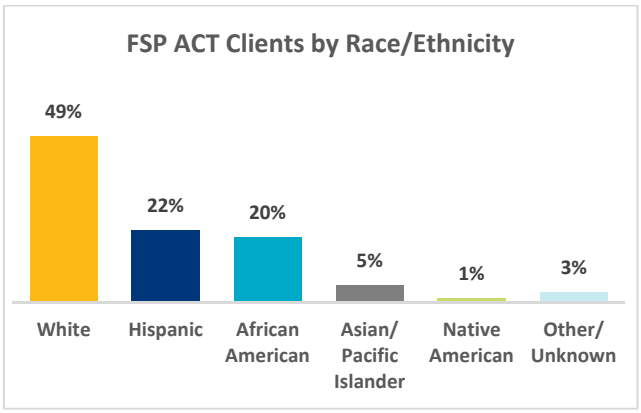
Note: Due to rounding, percentages in this report may not sum to 100%.

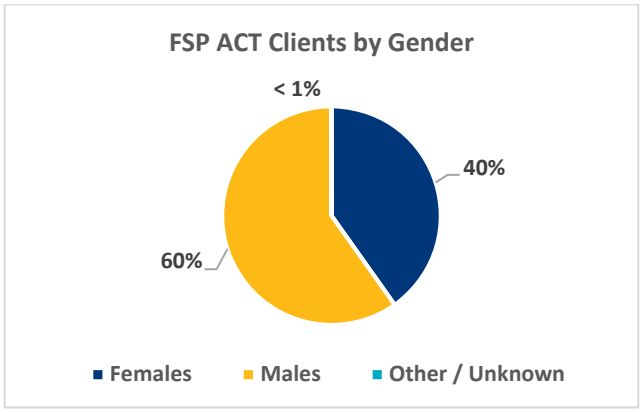
Demographics and Diagnoses

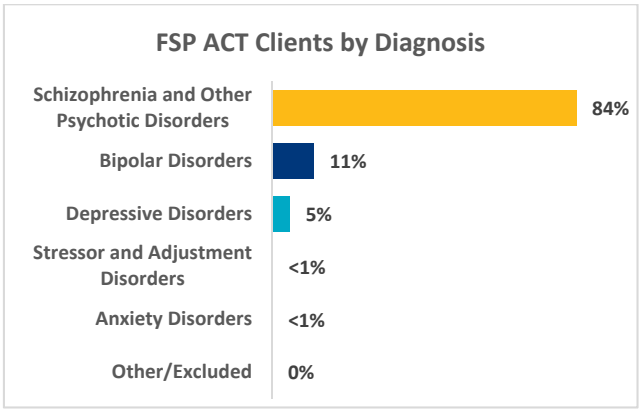
During FY 2017-18, 2,578 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (69%), a majority were male (60%), and a large majority had a primary diagnosis of schizophrenia or another psychotic disorder (84%). The next 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, 81% of FSP ACT clients served during FY 2017-18 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%).

There were 290 more FSP clients served by ACT programs during FY 2017-18 than during FY 2016-17, reflecting an almost 13% increase in the number of FSP clients served by ACT programs since last fiscal year. The distribution of demographics among FSP ACT clients served during FY 2017-18 is similar to the demographics of FSP clients served by ACT programs during FY 2016-17, with a slight increase in the proportion of clients with a diagnosis of schizophrenia or another psychotic disorder (84% in FY 2017-18 compared to 82% in FY 2016-17), and corresponding slight decreases in the proportions of clients with bipolar disorders (12% in FY 2016-17 to 11% in FY 2017-18) and depressive disorders (6% in FY 2016-17 to 5% in FY 2017-18).











Meeting FSP ACT Clients' Basic Needs*

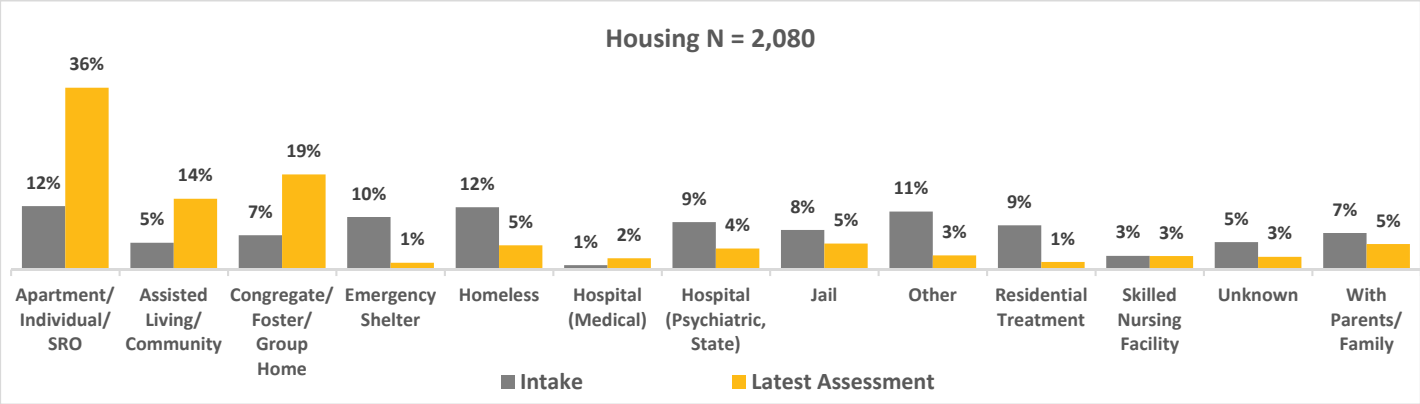
Housing

During FY 2017-18, 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 (12% at intake versus 36% at the latest assessment). Similarly, the proportion of clients living in an assisted living or community setting was almost three times greater at the latest assessment (14%) compared to intake (5%), and the proportion of clients living in a congregate, foster, or group home setting more than doubled from intake (7%) to latest assessment (19%).

Notable decreases in the proportion of clients living in particular 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 4%, and the proportion of homeless clients decreased by more than half from intake (12%) to latest assessment (5%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment/individual/single room occupancy** (SRO) setting **tripled** from intake (12%) to latest assessment (36%).
- 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 **more than half** from intake (12%) to latest assessment (5%).



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.

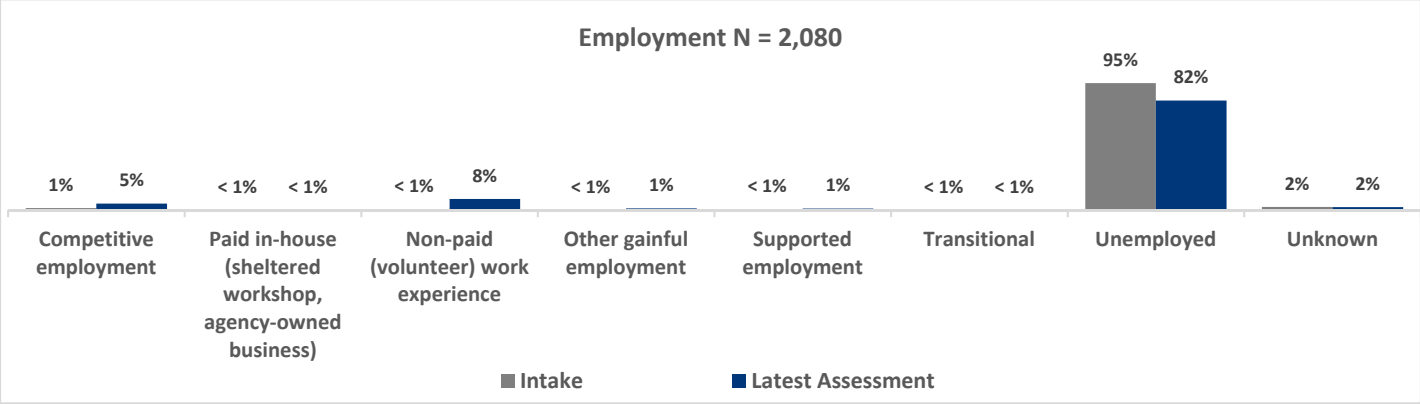
While most clients remained unemployed at the time of the latest assessment (82%), there was a 14% reduction in the number of clients that were unemployed at the latest assessment (1,712 clients) compared to intake (1,985 clients). The most significant increase in

Key Findings: Employment

- There was a 14% **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**, and **supportive** employment settings .

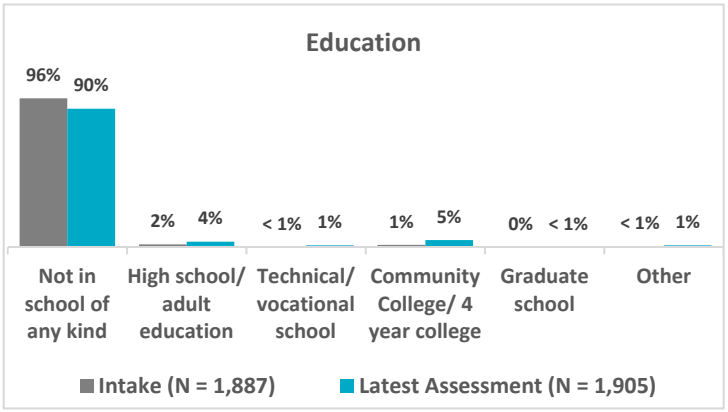
*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2017-18, as of the 12/2018 DHCS DCR download.

employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (7 clients at intake compared to 173 clients at the latest assessment). Additionally, there were almost three and a half times the number of FSP ACT clients employed in a competitive setting at the time of the latest assessment (101 clients) compared to the number employed at intake (29 clients), and more than two and half times the number of FSP ACT clients working in supported employment settings at the time of the latest assessment (23 clients) compared to intake (9 clients).



Education

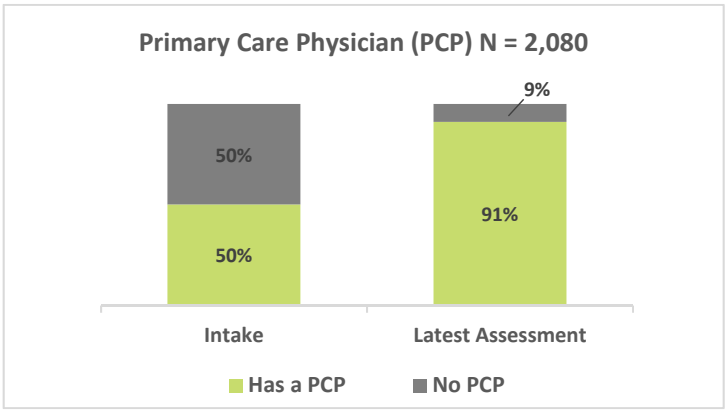
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 1,887 FSP ACT clients with education information available at intake[†], 67 (4%) were enrolled in an educational setting. At the time of the latest assessment, 196 of the 1,905 FSP ACT clients with educational information 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 (1% at intake versus 5% at the latest assessment) and those enrolled in high school or adult education (2% at intake versus 4% at the latest assessment) compared to the other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2017-18, 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. Only half (50%; 1,043 clients) had a primary care physician at intake, while almost all (91%; 1,895 clients) had a primary care physician at the time of their latest assessment.

Overall, changes in FSP ACT clients' basic needs from intake to latest assessment during FY 2017-18 were similar to changes observed during FY 2016-17.



[†]Education information was missing for 193 clients at intake, and 175 clients at the time of the latest assessment.

Changes in Service Use and Setting

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

These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as Crisis Stabilization (CS), Crisis Outpatient (CO), Psychiatric Emergency Response Team (PERT) services, Crisis Residential (CR), and services provided at the psychiatric hospital (IP). Overall, utilization of these types of services decreased by half (50%) from pre to post assessment. Considering specific types of emergency services, utilization of CS services increased by 41% from pre to post assessment while utilization of the more intensive services (PERT, CR, and IP) decreased from pre to post (reductions in utilization of 28%, 77%, and 67%, respectively). The reduction in utilization of CO services between pre and post was marginal (2%).

Key Findings: Use of Inpatient and Emergency Services

- Utilization of **CS** services **increased** among FSP ACT clients from pre to post assessment.
- Utilization of **CO** services among FSP ACT clients remained relatively **stable** from pre to post assessment.
- Utilization of **PERT, CR,** and services provided by the **psychiatric hospital decreased** among FSP ACT clients from pre to post assessment.

Similar to the reduction in overall emergency service utilization, there was a 43% reduction in the number of unique FSP ACT clients who used emergency services from pre to post in FY 2017-18. There was a 32% increase in the number of unique clients who used CS services after enrollment in an ACT program, and reductions in the number of clients who used PERT (27% reduction), CR (73% reduction) and services at the psychiatric hospital (56% reduction).

The simultaneous increase in utilization of CS services and reduction in more intensive emergency services among FSP ACT clients may be indicative of the ACT model functioning as intended. When FSP ACT clients experience a crisis, their connection to the services provided by ACT programs may help facilitate an appropriate connection to CS services instead of reliance on using the more intensive PERT, CR, or psychiatric hospital services.

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2017-18 were similar to reductions in utilization observed among this population during FY 2016-17. CS and CO services were new levels of care that were introduced in FY 2015-16, so there was a greater percent change in utilization from pre to post assessment within these types of services during FY 2016-17 than what was observed during FY 2017-18.

	# OF SERVICES			# OF CLIENTS*			MEAN # OF SERVICES PER CLIENT		
Type of Emergency Service	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
CS	230	324	41%	125	165	32%	1.84	1.96	7%
CO	342	336	-2%	153	150	-2%	2.24	2.24	0%
PERT	636	456	-28%	385	280	-27%	1.65	1.63	-1%
Crisis Residential	720	169	-77%	391	107	-73%	1.84	1.58	-14%
Psychiatric Hospital	1,859	610	-67%	651	286	-56%	2.86	2.13	-26%
Overall	**3,787**	**1,895**	**-50%**	**891**	**505**	**-43%**	**4.25**	**3.75**	**-12%**

**The overall number of clients at Pre (n=891) and Post (n=505) 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=1,702) had an enrollment date ≤ 7/1/2017 and discontinued date (if inactive) > 7/1/2017. Data may include individuals discharged from FSP during the fiscal year but who continued to receive services from a different entity.

‡Pre period data encompasses the 12-months prior to each client's FSP enrollment and are sourced from the 10/2017 CCBH download. The 12/2018 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 FY 2016-17, during FY 2017-18 there were overall decreases from pre to post assessment in the mean number of days spent (67% reduction), and number of FSP ACT clients (59% 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 (96% reduction) and the number of clients who resided in a state hospital (90% reduction). Notable reductions were also observed in the number of days (78% reduction) and the number of clients (74% reduction) residing in long-term care settings from pre to post assessment.

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 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 almost a one and half times increase (141%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 56% 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 2017-18 mirrored the rates observed for these settings during FY 2016-17. One change from last fiscal year is that the mean number of days per FSP ACT client in a jail or prison setting increased by 19% from pre to post during FY 2017-18, but decreased by 8% during FY 2016-17. This phenomenon can be explained by the fact that during FY 2017-18 the number of FSP ACT clients residing in a jail or prison setting decreased by a greater proportion from pre to post than the total number of days FSP ACT clients spent in a jail or prison setting. During FY 2016-17, the opposite was true. Lastly, compared to FY 2016-17, more FSP ACT clients were residing in acute medical hospital settings for a greater number of days at intake during FY 2017-18.

	# OF DAYS			# OF CLIENTS*			MEAN # OF DAYS PER CLIENT		
Type of setting	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change****
Jail/Prison	28,865	17,952	-38%	297	155	-48%	97.19	115.82	19%
State Hospital	6,846	248	-96%	48	5	-90%	142.63	49.60	-65%
Long-Term Care	64,191	14,433	-78%	231	60	-74%	277.88	240.55	-13%
Overall	**99,902**	**32,633**	**-67%**	**534**	**217**	**-59%**	**187.08**	**150.38**	**-20%**
Acute Medical Hospital	4,112	9,922	141%	169	263	56%	24.33	37.73	55%

**The overall number of clients at Pre (n=534) and Post (n=217) 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=1,557) had an enrollment date ≤ 7/1/2017 and discontinued date (if inactive) > 7/1/2017. Clients had to be active throughout the fiscal year to be included.

[§]Data source: DHCS DCR 12/2018 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**).

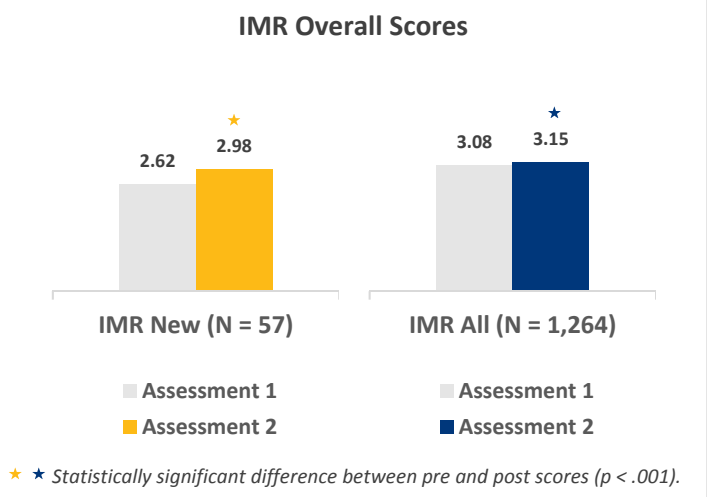
Clients can use the 24-item self-rated RMQ tool to rate their own progress towards recovery. Mean IMR and RMQ scores range from 1 to 5, with higher ratings on both measures indicative of greater recovery.

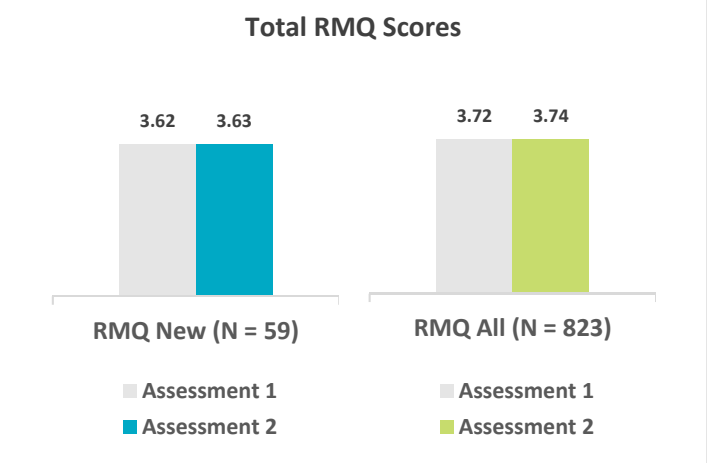
The IMR and RMQ scores displayed in the charts below compared scores of New FSP ACT clients to those of All FSP ACT clients.

- **New** clients are defined as those meeting the following criteria:
  1. started receiving ACT services during 2017 or later,
  2. had two IMR or RMQ assessments during FY 2017-18 (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 2017-18 (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 both New and All clients ($p < .001$), although New clients made greater gains between the two assessment points than All clients. 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 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.





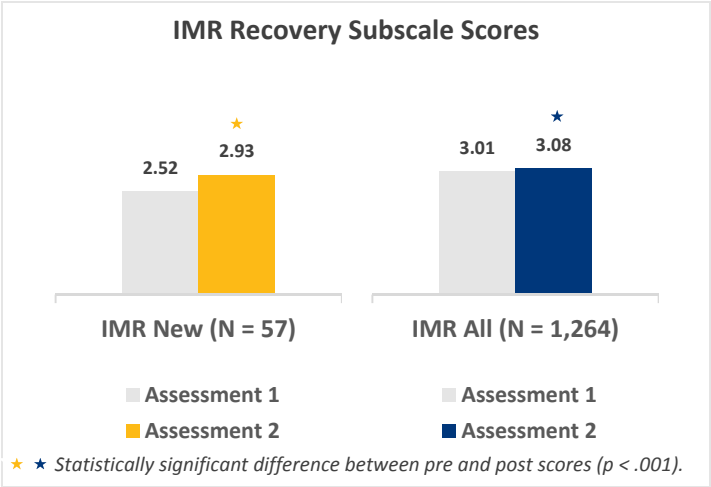
** Outcomes data are sourced from mHOMS FY 2017-18; Data include all mHOMS entries as of 12/15/2018 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2017-18, and who had paired IMR or RMQ assessments within 4 to 8 months apart.

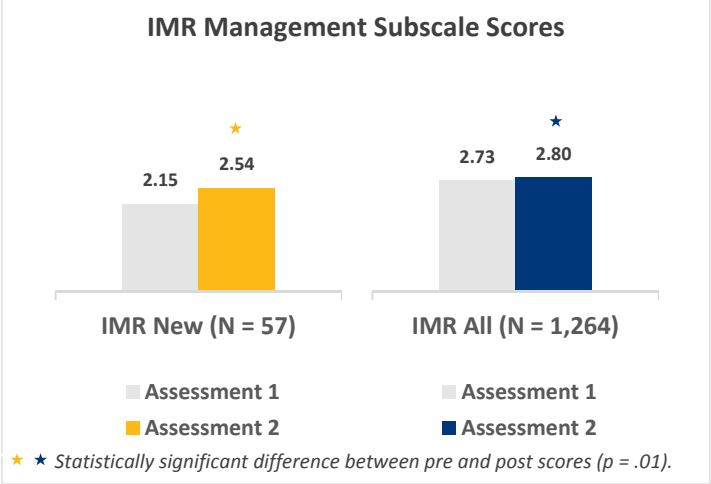
IMR Subscale Means for Assessments 1 and 2

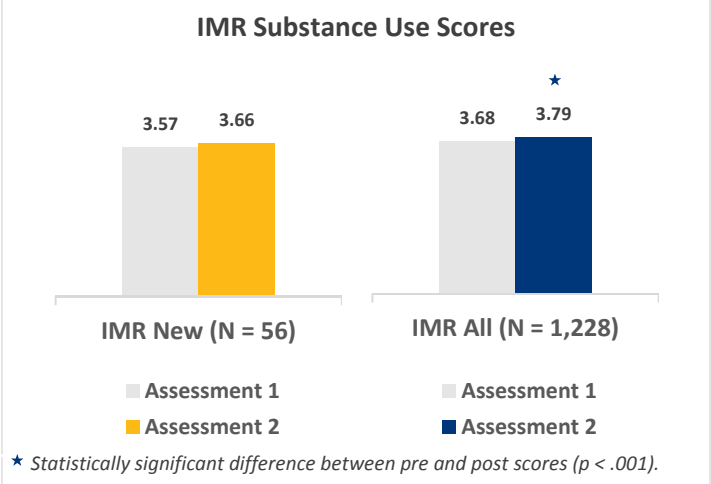
Changes in mean scores on each of the three IMR subscales from assessment 1 to assessment 2 were also analyzed for each group of clients (New and All). On average, both New and All FSP ACT clients had significantly higher mean Recovery subscale ($p < .001$) and Management subscale ($p = .01$) scores at assessment 2 than they did at assessment 1. These data suggest that both New and All clients made significant progress towards recovery and were better able to manage their symptoms from assessment 1 to assessment 2.

Key Findings: Assessment Outcomes

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





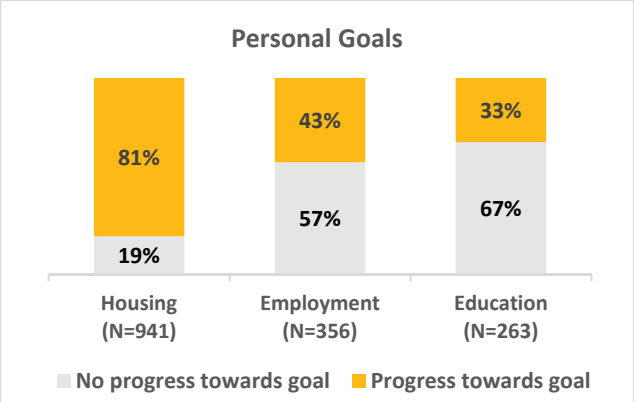


Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or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

Despite initial high scores, on average, All FSP ACT clients had significantly higher Substance Use subscale scores ($p < .001$) at assessment 2 than they did at assessment 1, suggesting that for those clients with impairment due to substance use, their functioning was less impaired at assessment 2 than at assessment 1. While New clients also had higher mean Substance Use subscale scores at assessment 2 compared to assessment 1, the difference in mean scores was not statistically significant, suggesting that more time in substance use treatment may be needed before statistically significant improvements in this area are attained.

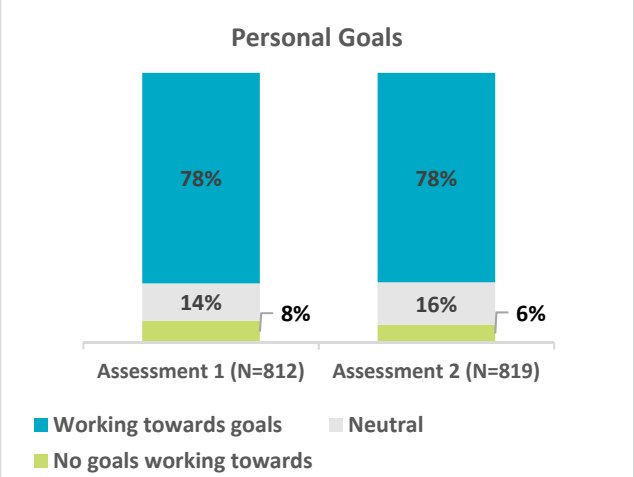
Progress Towards Key Treatment Goals

In their follow-up IMR assessments, clinicians noted client progress towards goals related to housing, education, and employment. Most FSP ACT Clients served during FY 2017-18 (941 clients; 89%) 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 (356 clients; 34%) or education (263 clients; 25%) on their treatment plan, compared to the number with housing related goals. Additionally, less than half of clients with goals related to employment or education made progress towards their goals at the time of the most recent assessment (43% and 33%, 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 questions 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 (78%) and assessment 2 (78%) agreed or strongly agreed that they had a goal (or goals) they were working towards. At assessment 1, 14% of FSP ACT clients reported they were "neutral" about working towards goals, compared to 16% at assessment 2. Only 53 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 eleven clients at assessment 1 and four clients at assessment 2. 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.

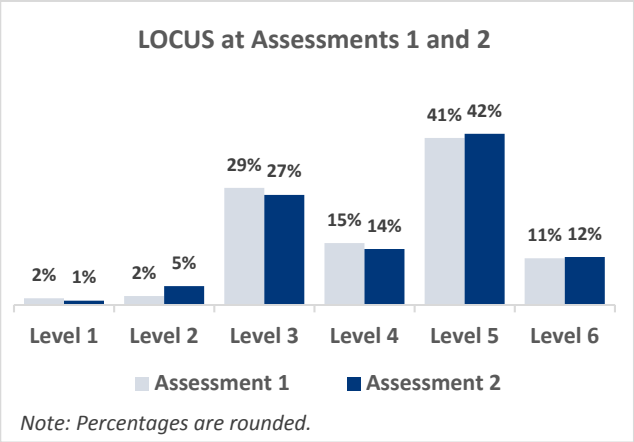
In the LOCUS, levels of care are viewed as levels of resource intensity. Lower numbered levels correspond with lower intensity resources and services.

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 (89%) 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**.
- Clients were most likely to be recommended for a **Level 5** or **Level 3** treatment setting at both times points.



Note: Percentages are rounded.

Similar to LOCUS results from FY 2016-17, the greatest proportion of FSP ACT clients were recommended for medically monitored residential services (Level 5), followed by high intensity community-based services (Level 3) by clinicians at both assessment time points (Level 5, 41% at assessment 1 and 42% at assessment 2; Level 3, 29% at assessment 1 and 27% at assessment 2). Slight reductions in the proportions of clients who were recommended for medically monitored non-residential services (Level 4) and high intensity community-based services (Level 3) were observed from assessment 1 to assessment 2. These reductions may correspond with an increase in the proportion of clients recommended for low intensity community-based services (Level 2; three percentage point increase) from assessment 1 to assessment 2 as FSP ACT clients who initially receive higher intensity services when they initially enter an ACT program may be recommended for lower intensity services as they receive treatment from ACT programs and work towards their treatment plan goals.

Conclusion

With the addition of several new FSP ACT programs in San Diego County 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 SMI, as evidenced by the vast majority of clients served during FY 2017-18 with 1) a housing-related goal (89%), 2) a diagnosis of schizophrenia or another psychotic disorder (84%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 68% at intake).

Similar to trends reported from FY 2016-17, FSP ACT clients served during FY 2017-18 showed progress in the following areas of basic needs: housing, employment, and education. Notably, the proportion of clients living in an apartment/individual/single room occupancy setting tripled from intake (12%) to latest assessment (36%), 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 5% at the latest assessment. There was also a 14% reduction in the number of clients unemployed at 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 50% 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 (67% reduction), and the number of clients housed in these types of settings (59% reduction). Progress towards recovery among FSP ACT clients was also exhibited by 1) significant improvements in clinician-rated IMR scores for both New and All 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 2017-18, mirroring improvements observed among this population during FY 2016-17, and demonstrating a positive effect of services on the lives of clients served by the ACT programs.

Appendix L

Housing Update Executive Summary

County of San Diego
Health and Human Services Agency
Adult/Older Adult Behavioral Health Services

Five Year Behavioral Health
Strategic Housing Plan
FY 2014-2019

FY 2018-2019 Update

Executive Summary

Housing is a critical resource for achieving health and wellness, particularly for people with limited means who struggle with behavioral health issues. The *Five Year Behavioral Health Strategic Housing Plan Fiscal Year 2018-2019 Update* (Plan Update) provides a framework for the current housing needs and outlines the planning process for the development of Five Year Goals that maximize housing options for people with behavioral health issues in San Diego County.

The Five Year Behavioral Health Strategic Housing Plan, FY 2014-2019 (Plan) was developed through a robust stakeholder process that included input from consumers, service providers, housing developers and operators, and funders of housing and services. Updates to the Plan include policy and legislative updates, as well as updated feedback from consumers in the form of focus groups 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 Five Year 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 to undertake over a five year period in order to achieve these goals, as well as a process 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 County.

The Plan Update for Fiscal Year 2018-19 includes current information regarding a variety of housing and services options for people with behavioral health issues in San Diego County. In particular, the Plan Update outlines an unprecedented new opportunity to create significant new supportive housing options under the No Place Like Home initiative.[1] The planning process for the 2018-19 Plan Update includes input from a broad range of stakeholders including: County of San Diego representatives with expertise in behavioral health, public health, probation/ justice system, social services, and housing departments; San Diego's homeless continuum of care; housing and homeless services providers, especially those with experience providing housing or services to those who are chronically homeless; county health plans, community clinics and health centers, and other health care providers; public housing authorities, and representatives of family caregivers of persons living with serious mental illness.

To download the full plan, visit: http://sandiego.camhsa.org/files/SD_BH_StratHousingPlan18-19.pdf

[1] http://www.hcd.ca.gov/grants-funding/active-funding/nplh.shtml

Appendix M
Prevention and Early Intervention (PEI) System-wide Summary

CHILD & ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2017—2018 ANNUAL REPORT

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. With this funding source, the County of San Diego contracted with providers for PEI programs for adults and older adults, 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 contacted in outreach efforts, including but not limited to: presentations, community events, and fairs.

DATA: Child and Adult PEI Programs

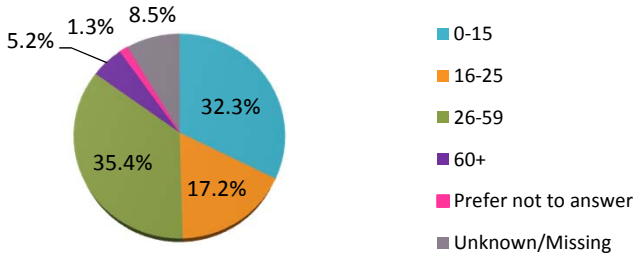
REPORT PERIOD: 7/1/2017-6/30/2018

NUMBER OF PARTICIPANTS WITH DATA IN FY 2017-18: 40,898 (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. Some parts in the report do not have SA02 data.*
†All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.
‡Total number of PEI participants lower than past fiscal year due to restructuring of school-based programs.

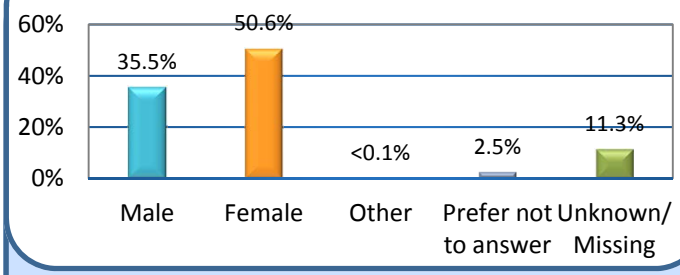
PARTICIPANT SYSTEMWIDE DEMOGRAPHICS

AGE (N=40,898)



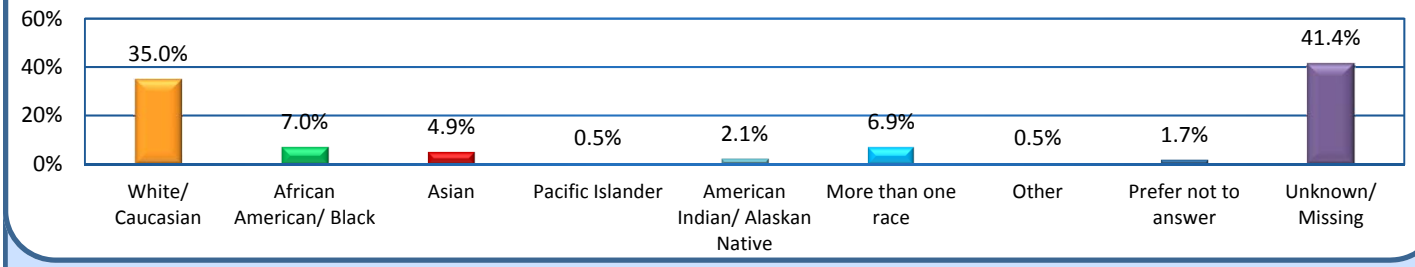
Thirty-two percent of participants were under the age of 16, and thirty-five percent were between the ages of 26-59.

SEX AT BIRTH (N=24,998)



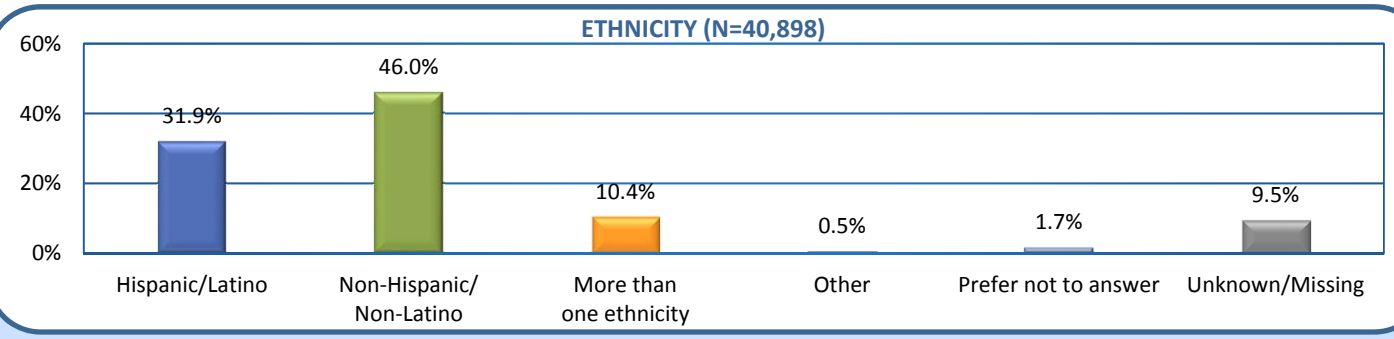
Half of participants who received services identified their sex at birth as female, and thirty-six percent identified as male.

RACE (N=40,898)



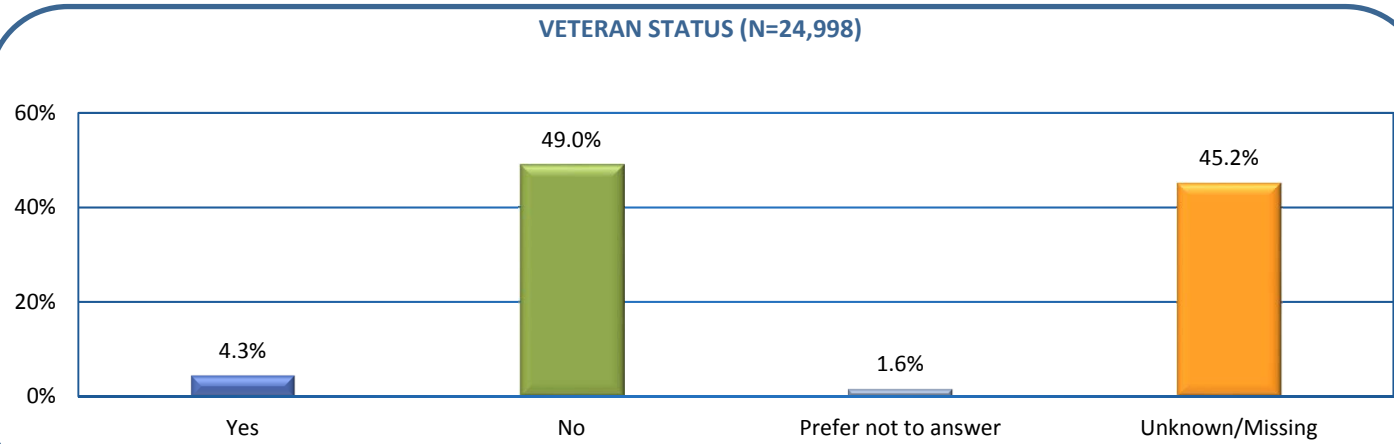
Thirty-five percent of participants who received services identified their racial background as White/Caucasian. Seven percent of participants identified as African American/Black, and another seven percent identified having more than one racial background. The percentage of unknown/missing includes clients who only endorsed being Hispanic/Latino and did not indicate a racial category.

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

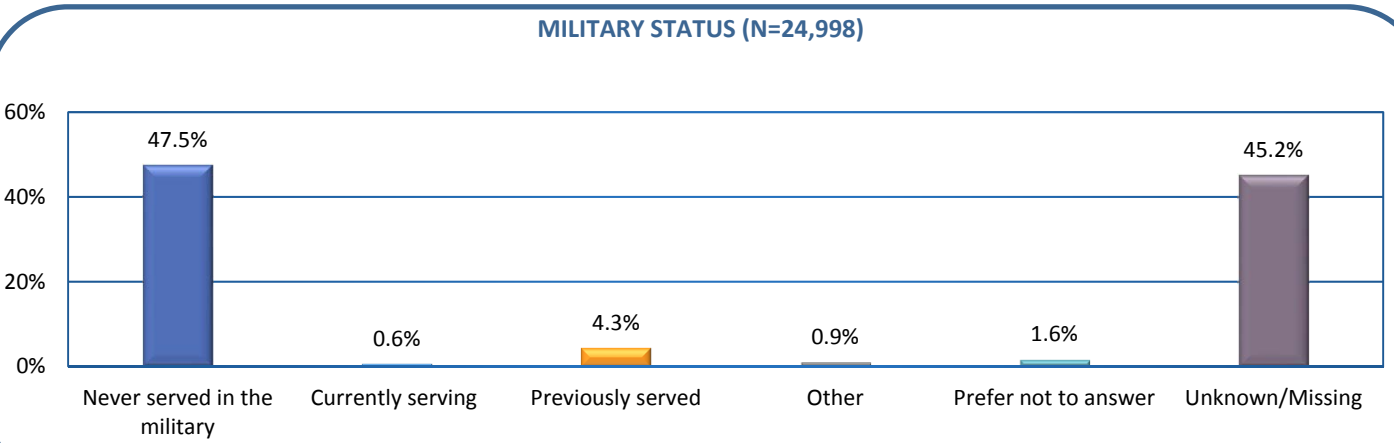


Forty-six percent of participants who received services identified their ethnic background as non-Hispanic/non-Latino. Thirty-two percent of participants identified their ethnic background as Hispanic/Latino. See Appendix A in this report for supplemental data on participant ethnicity.

MILITARY SERVICE



Information on veteran status indicated that four percent of participants had served in the military.

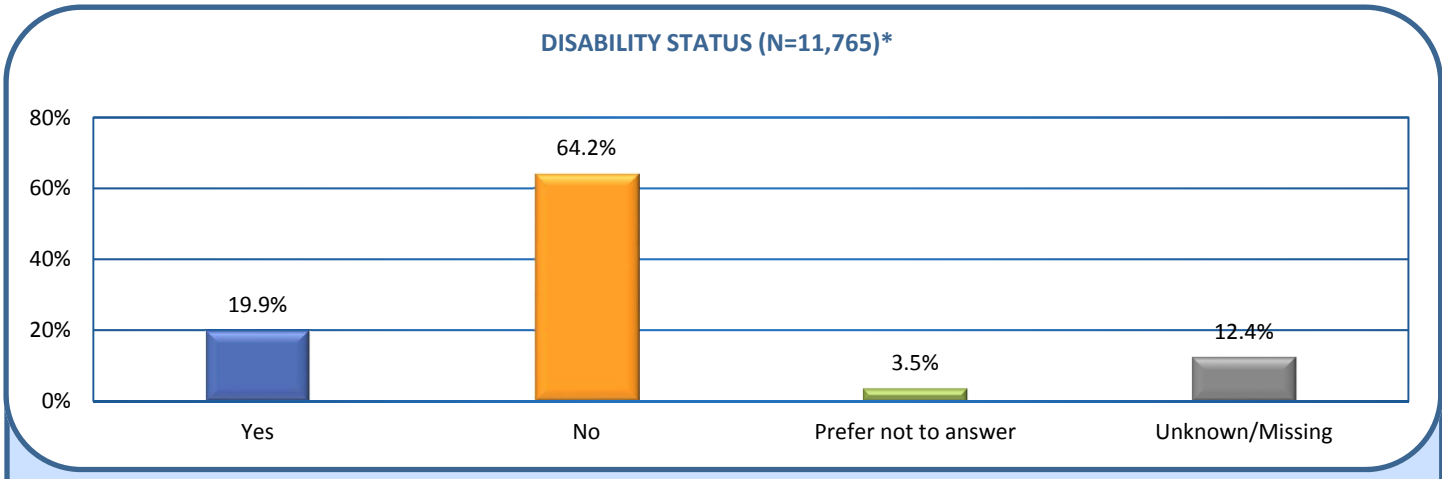


Forty-eight percent of participants had never served in the military while four percent indicated they had previously served in the military.

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

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

DISABILITY STATUS



Sixty-four percent of participants indicated they did not have a disability while twenty percent of participants reported having a disability. Three 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.*

DISABILITY RESPONSES (N=24,998)*†	Count	%
Difficulty seeing	1,277	5.1
Difficulty hearing or having speech understood	550	2.2
Learning disability	729	2.9
Developmental disability	177	2.9
Physical/ mobility disability	1,128	4.5
Chronic health condition/ chronic pain	1,478	5.9
Dementia	76	0.3
Other communication disability	152	0.6
Other mental disability not related to mental illness	695	2.8
Other disability	1,080	4.3
No disability	16,058	64.2
Prefer not to answer	872	3.5
Unknown/ Missing	3,099	12.4

The percentages calculated are based on total participants. Among participants who provided disability responses, 16,058 (64.2%) indicated no disability. Six percent of the participants indicated having a chronic health/chronic pain condition while five percent of participants indicated having difficulty seeing.

**Participants can report having more than one disability so percentages may add up to more than 100%.*

†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.

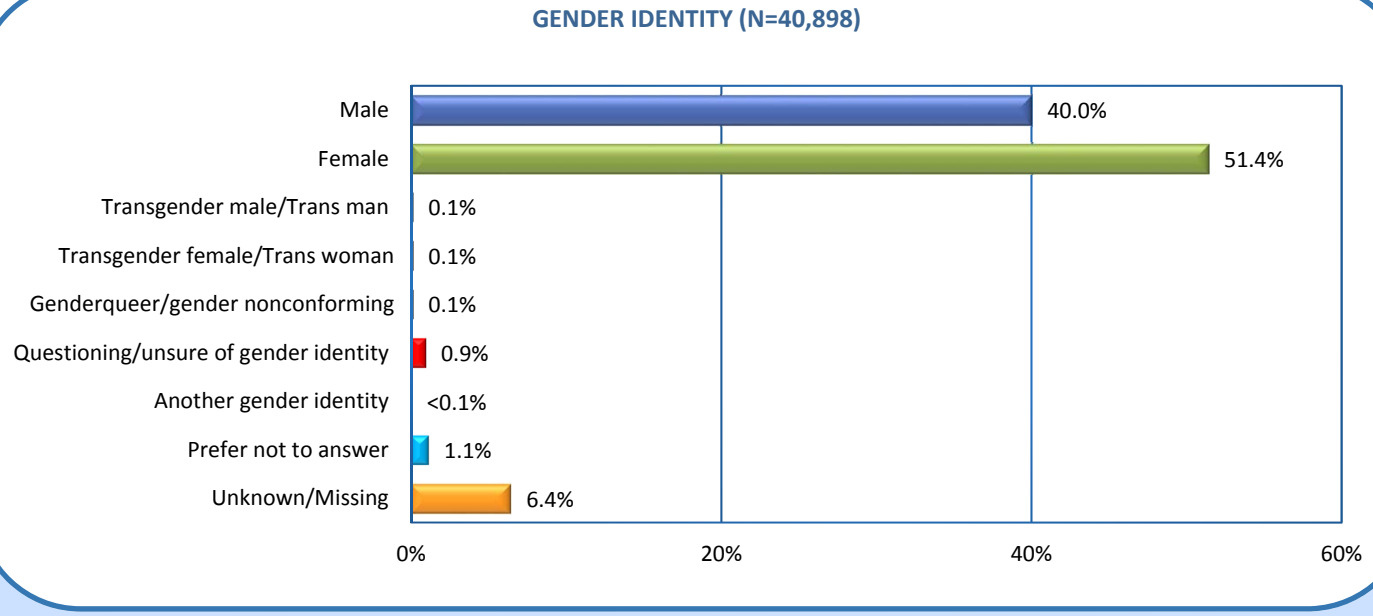
PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

PARTICIPANT LANGUAGE

PRIMARY LANGUAGE (N=24,998)	N	%
English	14,250	57.0
Spanish	6,360	25.4
Armenian	84	0.3
Cantonese	10	0.0
Farsi	50	0.2
Khmer	4	0.0
Korean	9	0.0
Mandarin	19	0.1
Russian	24	0.1
Samoan	13	0.1
Tongan	0	0.0
Prefer not to answer	351	1.4
Missing	2,423	9.7
Other	1,401	5.6

Fifty-seven percent of the participants who received services identified their primary language as English. Twenty-five percent of participants who received services identified their primary language as Spanish.

GENDER IDENTITY AND SEXUALITY

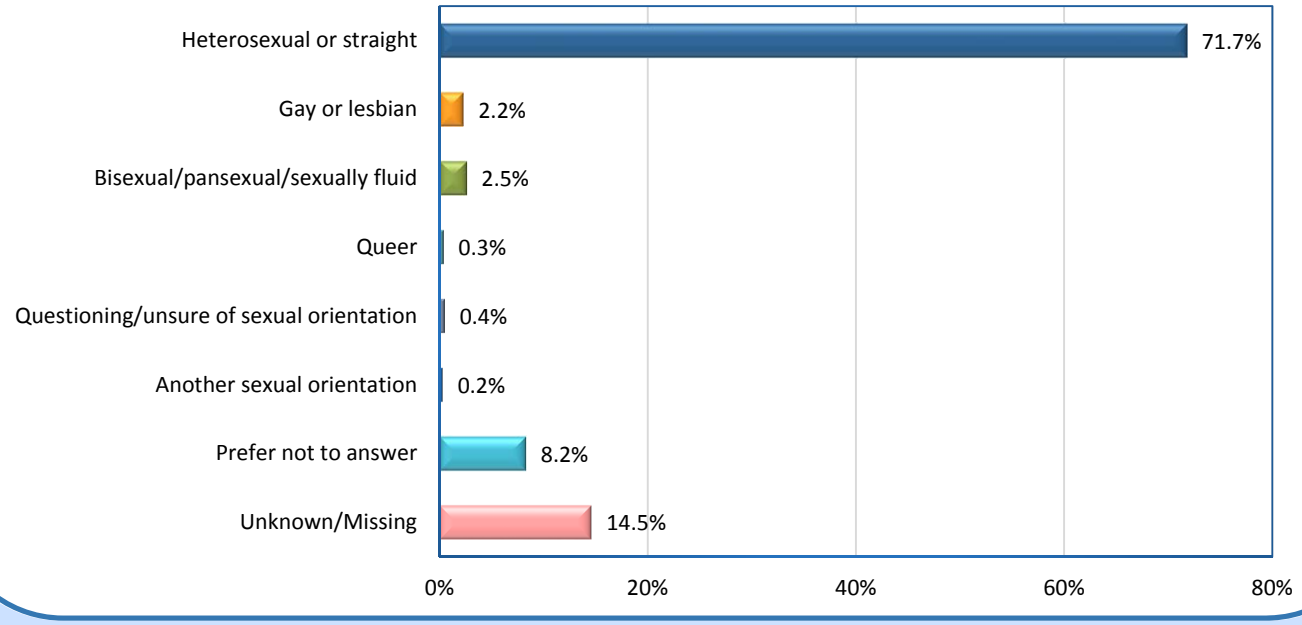


Fifty-one percent of participants who received services identified as female. Forty percent of the participants who received services identified as male.

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

PARTICIPANT SYSTEMWIDE DEMOGRAPHICS - CONTINUED

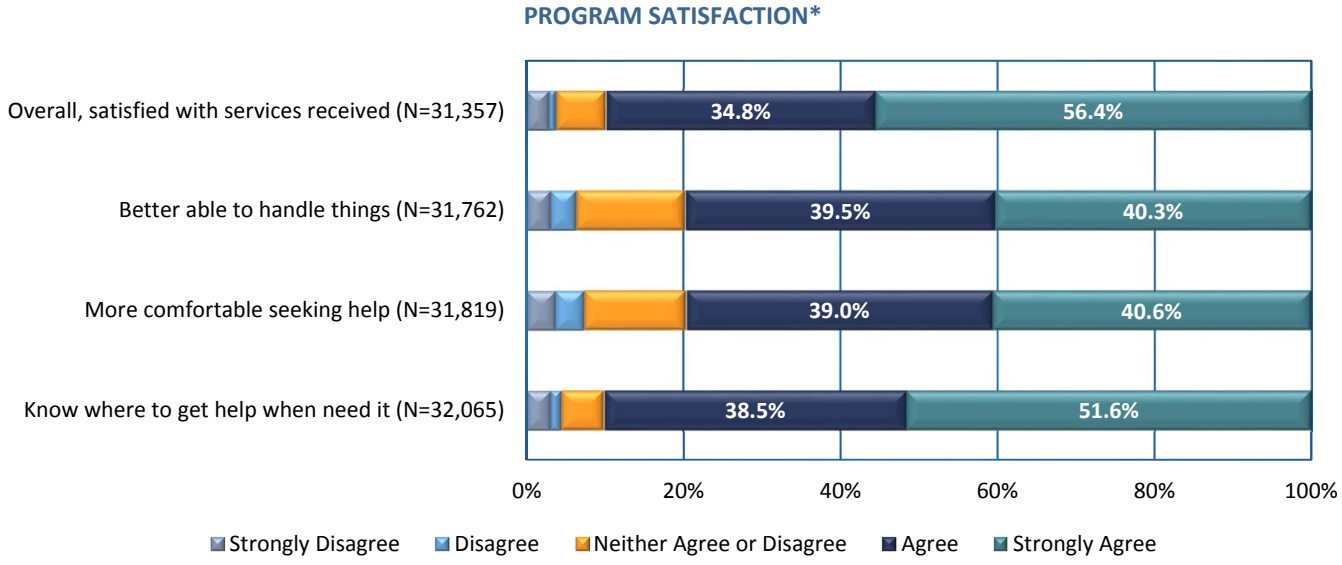
SEXUAL ORIENTATION (N=24,998)



Seventy-two percent of the participants who received services identified their sexual orientation as heterosexual/straight. Three percent of participants who received services identified their sexual orientation as bisexual/pansexual/sexually fluid, and two percent identified as gay or lesbian. Eight percent of participants preferred not to answer this question.

PARTICIPANT SYSTEMWIDE - PROGRAM SATISFACTION

PROGRAM SATISFACTION*



For each satisfaction question, responses were obtained from approximately 77.6% of the participants. Of these participants, ninety percent of the participants agreed and strongly agreed that they knew where to get help when they needed it. Eighty percent of the participants agreed and strongly agreed that they were comfortable seeking help, and another 80% percent of them agreed and strongly agreed that they were better able to handle things and solve problems as a result of the program. Overall, 91% percent of the participants who responded agreed and strongly agreed that they were satisfied with the services they received.

**Satisfaction data not available for all participants.*

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

PARTICIPANT SYSTEMWIDE REFERRAL TRACKING SUMMARY*

In FY 2017-18, County of San Diego Behavioral Health Services (BHS) implemented a referral tracking procedure in order to collect data on referrals made by PEI programs and successful links to services.

A total of 4,496 participants received a mental health referral, and 1,752 of these participants were linked to services as a result of those referrals (Linkage Rate = 39%). Average time between referral and linkage to services was eight days.

**Referral data 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.

APPENDIX A

PARTICIPANT ETHNICITY*		
	N	%
Hispanic or Latino	13,050	31.9
Caribbean	46	0.1
Central American	132	0.3
Cuban	166	0.4
Dominican	0	0.0
Mexican/ Mexican-American/Chicano	11,924	29.2
Puerto Rican	302	0.7
Salvadoran	327	0.8
South American	91	0.2
Other Hispanic/ Latino	1,325	3.2
Other Hispanic Unspecified	2,481	6.1
Non-Hispanic or Non-Latino	18,808	46.0
African American	598	1.5
African	267	0.7
Other African/Black	362	0.9
Asian Indian/ South Asian	152	0.4
Cambodian	140	0.3
Chinese	473	1.2
Filipino	1,466	3.6
Hmong	24	0.1
Japanese	372	0.9
Korean	125	0.3
Laotian	216	0.5
Mien	10	0.0
Vietnamese	310	0.8
Other Asian	337	0.8
Native Hawaiian	222	0.5
Samoan	133	0.3
Other Pacific Islander	335	0.8
Other American Indian	430	1.1
Chaldean	740	1.8
Eastern European	213	0.5
European	821	2.0
Iraqi	1,224	3.0
Middle Eastern	300	0.7
Other White	1,350	3.3
Non-Hispanic Non-Latino Other	8,379	20.5
More than one ethnicity	4,272	10.4
Prefer not to answer	339	0.8
Other	535	1.3
Missing	3,894	9.5
Total	40,898	100.0

*The County of San Diego does not require participants to choose only one ethnicity. Therefore, the number of responses may be greater than the number of participants. The percentages are based on a denominator of total participants.

Appendix N
Three Year PEI Evaluation Report



Background

The Mental Health Services Act (MHSA) system of care approach for the County of San Diego is designed to develop and provide a system where service access is easier and timelier, utilization of out-of-home and institutional care is reduced, and stigma towards individuals with serious mental illness (SMI) and serious emotional disturbance (SED) is removed. The County of San Diego's MHSA Three-Year Plan was developed based on input from community partners and stakeholders. Specifically, the Prevention and Early Intervention (PEI) component of the MHSA system of care reflects the focused strategies to reduce negative outcomes that may result from untreated mental illness and help bring awareness of mental health into the lives of community members through public education initiatives and training.

Program Descriptions

The County of San Diego provides a variety of PEI programs that run the spectrum of services from outreach and prevention to early intervention and linkage to services. A brief description of the implementation strategy of each of the seven MHSA PEI regulation program types and the corresponding local County of San Diego program names are provided in the following section.

Prevention

(Next Steps, Positive Solutions, Elder Multicultural Access to Services Support (EMASS), Family Peer Support Program, It's Up to Us, Project In-Reach/Enable, Alliance for Community Empowerment (ACE), Community Services for Families (CSF), Positive Parenting, Dreamweaver, and PEI school-based programs)

The prevention programs for the County of San Diego's PEI program offer a wide range of public outreach, education, support lines, and direct services from a Countywide media campaign focused on suicide prevention to a recovery-oriented peer and family support program housed at the County psychiatric hospital. Many of these programs provide prevention resources and education, along with short-term early intervention mental health services and linkage to mental health treatment programs. Whether aiding families and individuals impacted by acts of violence, clients in mental health and substance use

recovery, children and families involved with the Child Welfare System, incarcerated individuals with co-occurring disorders, or American Indian populations in the County, each program seeks to prevent the onset of serious mental health problems. Services for these programs include psychoeducation, screening, assessment, and referral, as needed.

Early Intervention

(Co-Occurring Disorders, Caregivers of Alzheimer's Disease Support, Smart Care, PEI school-based programs)

The early intervention programs are focused on reducing mental health risk factors and improving access to mental health services, information, and support. This is accomplished by providing psychoeducation, assessments, and referrals to appropriate mental health or substance use programs, as needed. The programs serve a broad range of participants including, youth at the PEI school-based programs utilizing the evidence-based Incredible Years curriculum, clients at residential and intensive outpatient Substance Use Disorder program (e.g., justice-related treatment programs), individuals living in rural communities who may be at risk for or in the early stages of mental illness, and the caregivers of older adults.

Outreach

(Mental Health First Aid and Independent Living Association Project)

While many of the PEI programs in the County of San Diego have outreach components, there are two programs that specifically focus on outreach and education. Mental Health First Aid provides a free certification training giving participants the tools to respond to mental health emergencies until professional first-responders arrive. As such, this program aims to improve mental health literacy. The settings for these trainings include churches, universities, high schools, medical centers and hospitals, non-profit organizations, city and county governmental agencies, youth camps, casinos, clubhouses, amusement parks, military behavioral health departments, fire departments, Police Cadet Academies, Indian Health Clinics, and in partnership with Native American reservations.

Funding from PEI also supports the Independent Living Facility Association (ILA), which is a voluntary member organization of Independent Living facility operators, individuals, families, discharge planners, and care coordinators who are seeking quality housing resources for adults with severe mental illness. The ILA promotes high quality home environments for clients. The members adhere to a comprehensive set of quality standards and best practices defined as critical components of independent living settings.

Access and Linkage to Treatment

(Next Steps and Courage to Call)

These are two programs that specifically include a focus on access and linkage to treatment. Next Steps utilizes both the PEI regulation program types of prevention and access and linkage to treatment. As such, the program recognizes that most of the clients referred from the psychiatric hospital or who enter the program via the County mental health clinics will need additional services and referrals that will be addressed outside of the scope of the program. Next Steps heavily emphasizes the importance of developing holistic treatment plans and ensuring connection to the resources and services recommended to support the client in their recovery journey. This is reflected in the annual data provided to the State, which shows a high volume of mental health and substance use referrals made by this program.

The County of San Diego has a comprehensive Access and Crisis Line (211) that receives thousands of calls each month regarding suicide prevention, mental health resources, crisis intervention, community resources, and alcohol and drug support services. To provide confidential peer support and access to resources to veterans, active duty military, reservists, national guard enlistees and their family members, the County of San Diego has a specific hotline named Courage to Call, which is funded by PEI. The hotline provides information and linkage to mental health resources and services, screening tools, and lists of other appropriate resources, as needed.

Stigma and Discrimination Reduction

(Family Peer Support Program and Breaking Down Barriers/Father2Child)

The County of San Diego PEI programs under the program category of stigma and discrimination reduction include the Family Peer Support Program and Breaking Down Barriers/Father2Child. The Family Peer Support Program provides educational information and seeks to promote social and emotional wellness for adults, older adults, and their family members and friends. This educational information is presented by community members who share their personal stories about living with mental illness and achieving recovery. Additionally, the Family Peer Support Program shares written information on mental health and recovery for friends and family members whose loved ones are hospitalized with a mental illness. This personalized connection is available in the waiting area of the hospital.

The second program in this category, Breaking Down Barriers/Father2Child, has two components. The first is Breaking Down Barriers, which conducts training and outreach to engage specific groups throughout the County including Hispanic/Latino, Native American, lesbian, gay bisexual transgender and queer (LGBTQ), African American, immigrant, and unserved or underserved populations. This aspect of the program uses the Cultural Broker Outreach model to collaborate with various groups, clients, family members, and other stakeholders to, provide education, outreach, and engagement to the populations noted above; implement and evaluate strategies to reduce mental health stigma; and create effective collaborations with other agencies, community groups, clients, and family member organizations from these communities. The other component is a parenting program called Father2Child, which provides a free 12-week parenting curriculum to African American and Hispanic fathers and caregivers. The educational series offers parenting techniques and skills that emphasizes the importance of the role of the father in the life of the child and promotes the idea of creating stronger bonds between the father and child.

Suicide Prevention

(Suicide Prevention Council and HERE Now)

In the County of San Diego, MHSA PEI funds help support the extensive efforts of the Suicide Prevention Council (SPC) and Stigma Reduction Media Campaign. The SPC is responsible for the development and implementation of the Countywide Suicide Prevention Action Plan. This plan incorporates action items that are aimed to increase understanding and awareness of suicide, while implementing prevention strategies.

One of the most extensive prevention efforts in conjunction with SPC is the HERE Now program that serves thousands of high school students throughout the County of San Diego. This program partners with schools in the County to provide educational information aimed at helping students understand mental health, explains that suicide is preventable, assists students in identifying potential suicidality in a friend

or loved one, addresses bullying and bystander roles, and provides students with mental health resources and suicide prevention tools. Specifically, HERE Now uses the SOS Signs of Suicide Prevention Program® for youth in 7th through 12th grade. When applicable, HERE Now also provides assessment and referral services for students who are at higher risk for suicidal behaviors.

How Were the PEI Outcomes Chosen?

Outcome measures were created based on the MHSA's goals for PEI programs. These goals aim to: increase access to services; reduce stigma and discrimination towards mental illness; and increase positive coping skills. Additionally, there was a desire to determine participants' level of satisfaction with the PEI services provided.

Research specialists at the Health Services Research Center (HSRC) and the Child and Adolescent Services Research Center (CASRC), in collaboration with staff at the County of San Diego Health and Human Services Agency's Behavioral Health Services Department facilitated diverse stakeholder group discussions to gather community input on mapping MHSA's goals for PEI to appropriate outcome survey questions. The stakeholder groups represented the focus areas and priority populations listed in Table 1.

Table 1: Focus Areas and Priority Populations Represented in Stakeholder Interviews

Focus Areas	Priority Populations
• Native American Communities • Veterans and Their Families • Dual Diagnosis Adults, Older Adults, and Youth • Early Childhood/Education-Based Services • Individuals Exposed to Community/Domestic Violence • First Break of Mental Illness • Rural East, North Inland and Mountain Communities • Services for Older Adults	• Trauma-Exposed Individuals • Individuals Experiencing Onset of Serious Psychiatric Illness • Children/Youth in Stressed Families • Children/Youth at Risk for School Failure • Children/Youth at Risk for Juvenile Justice Involvement

By using a participatory approach with stakeholders, research specialists and BHS staff were able to assess, rank/prioritize, and create four outcome measures that reflected the MHSA goals. The responses to the following outcome survey questions comprise a scale from "s*trongly disagree"* to "*strongly agree".*

- Outcome 1 (Access to Services): "I know where to get help when I need it."
- Outcome 2 (Reduced Stigma): "I am more comfortable seeking help."
- Outcome 3 (Coping Skills): "I am better able to handle things."
- Outcome 4 (Satisfaction): "Overall, I am satisfied with the services I receive here."

Research Methods

The evaluation of the County of San Diego's PEI program is conducted in collaboration with two research centers at UC San Diego. CASRC coordinates the evaluation efforts for programs for children, youth and families. HSRC is responsible for the evaluation of the adult and older adult PEI programs.

Due to the diverse nature of the County of San Diego's PEI programs, there are two types of data collection methods for the demographics and outcome questions. Programs that focus on outreach, training and one-point-in-time contact with participants provide the PEI survey to participants, which includes the MHSA required demographic items and the four outcome questions at the conclusion of multi-day and one-time events. For instance, programs that have mental health training provide the survey to attendees at the end of the training session, along with mental health resources.

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

Programs have the option to use one of a few data collection systems based on their own program needs. Many of the programs utilize the Mental Health Outcomes Management System (mHOMS) developed by HSRC for data capture and reporting. Other programs use Teleforms, which are scanned into a database using the Teleform System. Teleforms are used by some of the children's programs. Lastly, programs that use their own electronic health record (EHR) or data collection system to export their data into Excel and share with the research centers for analysis.

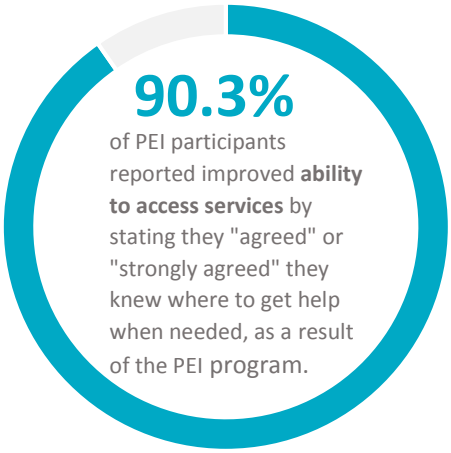
Those programs that use mHOMS also have access to automated reports that aggregate demographic and outcome data based on date range. These reports provide for timely review of outcomes and demographics. They are used by programs to share feedback to program staff and improve services to underrepresented populations. For instance, recently one of the Native American programs used the data from the demographic questions on gender identity and sexual orientation to support the decision to increase the services addressing the needs of the LGBTQ population. Other programs run the automated report for outcomes on a monthly basis to share the aggregated responses with staff and provide them with positive feedback on the percentage of participants satisfied with the program. Ultimately, this demonstrates that the data obtained not only assists in evaluation efforts, but also provides useful information for program planning and clinical utility for program managers and staff.

PEI Outcome Results

This section provides the results of the four County of San Diego's PEI outcomes combined for fiscal years 2016-17 and 2017-18. Sometimes participants did not answer all the survey questions thus, in this section, the total number of responses is shown for each outcome question.

The most significant outcome was regarding access to services, which was defined by participants reporting that as a result of the PEI program, they knew where to get help when they needed it. Of the nearly 60,000 respondents, 90 percent stated they "agreed" or "strongly agreed".

Figure 1: Participant-reported Access to Services Outcomes (N=59,355)



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

There were also positive results in each of the other three outcomes regarding satisfaction, reduced stigma, and coping skills. Figure 2 shows the results of each of these outcome questions. Nearly 90 percent stated they "agreed" or "strongly agreed" they were satisfied with the PEI program. Likewise, 80 percent reported they "agreed" or "strongly agreed" that they were more comfortable seeking help and better able to handle things as a result of the PEI program.

These positive outcomes help demonstrate the effectiveness of the PEI programs and strategies in supporting children, youth, families, adults, and older adults who are addressing their mental health concerns early on.

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



The results of all four County of San Diego's PEI outcome questions are included in Table 2. This table includes both the count of responses for each outcome and the percentage who reported "strongly disagree or disagree," "neutral," or "agree and strongly agree".

Table 2. PEI Outcome Questions* (As a result of the program…)	N	Strongly Disagree & Disagree	Neutral	Agree & Strongly Agree
Access to Services: I know where to get help when I need it.	59,355	4.2%	5.5%	90.3%
Reduced Stigma: I am more comfortable seeking help.	58,981	7.2%	12.7%	80.2%
Coping Skills: I am better able to handle things.	58,849	6.1%	13.8%	80.1%
Satisfaction: Overall, I am satisfied with the serviced I received here.	58,925	3.8%	6.9%	89.3%

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

Conclusion

The County of San Diego serves a variety of populations, ages, and participants with varying degrees of mental health concerns. The positive results of the implementation of PEI in the County are demonstrated by most participants reporting that, as a result of the program, they know where to get help when needed. This shows that the County of San Diego's PEI program is effective in providing access to treatment and linking participants to the mental health and substance use resources and services that may be needed.

Appendix O
Innovation Report

CAREGIVER WELLNESS PROGRAM (INNOVATIONS-11)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT (7/1/15 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Caregiver Wellness Program (CWP) was funded through the Innovations (INN) component of the Mental Health Services Act. CWP was designed to provide screening, needs assessments, linkage to services and resources, as well as therapeutic, educational, and support groups for caregivers of children receiving services through KidSTART clinic, a comprehensive program for children ages 0-5 with multiple and complex socio-emotional, behavioral health, and developmental needs. While Medi-Cal funding allows for attending to caregiver needs as they relate to the child's diagnosis, attending to the specific well-being of the caregiver is outside the scope of billable services. CWP services were expected to improve the well-being of caregivers so that they could better care for themselves and their child/children. CWP and KidSTART clinic services were provided through Rady Children's Hospital Chadwick Center for Children and Families.

A primary innovation of CWP was the addition of Parent Care Coordinators (PCCs) to the KidSTART clinic treatment team. After completing detailed family needs assessments, the PCCs provided emotional support and worked to link caregivers with appropriate services and resources including their own behavioral health care. Additionally, therapeutic, educational, and support groups were developed and offered directly through CWP in multiple San Diego County locations.

EXECUTIVE SUMMARY

The Caregiver Wellness Program (CWP; INN-11) was designed to support parents/caregivers of children receiving treatment services through the BHS KidSTART clinic by assessing caregivers and then providing linkages to needed mental health, alcohol and drug, or other services, as well as directly providing therapeutic, educational, and support groups. A Parent Care Coordinator (PCC) role was created to provide caregivers with individualized case management following the completion of a detailed in-home family needs assessment.

- A total of 142 caregivers participated in the CWP program.
- The CWP program employed two PCC FTEs.
- Caregiver participation in CWP was associated with positive child outcomes (e.g., improved child behaviors).
- Most caregivers identified as female (75.4%). The primary language for 20.0% of the caregivers entering CWP was Spanish with 41.1% indicating an Hispanic origin.
- The in-home needs assessments highlighted many caregiver needs. About half of respondents indicated a need for more parenting knowledge (51.2%), more emotional support (49.4%), and to meet with a professional to discuss problems (47.6%). Other needs included financial (35.7%), housing (32.1%), or legal matters (30.1%).
- A total of 73.2% of participants received at least one CWP case management visit and 38.7% attended at least one structured psycho-education support group session provided by CWP. The average number of group sessions attended was 10.2, which suggests a high level of caregiver interest.
- CWP was successful at engaging commonly underserved populations (e.g., males and Spanish-language speakers).
- Consistent with program goals, at follow-up, caregivers were significantly more likely to indicate being actively involved in addressing their own problems.
- Through the work of the PCCs, most caregivers (71.1%) had at least one linkage to other behavioral health services (e.g., individual or family therapy, NAMI support groups).
- Additionally, 64.1% of the caregivers had at least one non-behavioral health linkage (e.g., financial, food, shelter).
- Caregivers indicated high levels of satisfaction with CWP and that most received a range of emotional, educational, and tangible supports from their PCCs.
- CWP staff were able to successfully develop, implement, and refine the core CWP practices of caregiver assessment, individualized care coordination, linkage to external resources, and provision of structured psycho-educational support groups during this three-year pilot project. Given ongoing challenges with linking to external treatment services, future versions of a CWP-type program may want to consider including an individual therapy component.

FUTURE DIRECTIONS

Based on the positive findings from the INN-11 Caregiver Wellness Program pilot study, BHS sustained the CWP programming by dedicating available Substance Abuse and Mental Health Service Administration (SAMHSA) resources. This funding allowed the structure and operations of the CWP program to continue uninterrupted. In addition, the program was able to allocate funds to begin supporting the provision of a limited amount of individual therapy within the program, a recommendation originating from the pilot study.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To establish and implement a novel approach for increasing access to mental health services for the caregivers of children in treatment for complex emotional, behavioral, and developmental issues.

Using the MHSA Innovations funding, the Caregiver Wellness Program (CWP) was successfully developed, implemented, and refined to provide services to caregivers of children receiving services through KidSTART clinic, a comprehensive program for children ages 0-5 with multiple and complex socio-emotional, behavioral health, and developmental needs. The primary components of CWP consisted of: 1) a comprehensive needs assessment, which was often conducted "in-home," 2) provision of emotional support and individualized linkages to behavioral health and other community services by a Parent Care Coordinator (PCC), and 3) a range of structured multi-week therapeutic, educational, and support groups developed specifically for CWP caregivers. Of the 142 caregivers enrolled in CWP, 41.1% identified as Hispanic, a frequently underserved population. Staff identified the implementation of CWP as introducing a cultural shift throughout the entire KidSTART clinic in that raising awareness of and attending to caregiver needs became integral to their overall treatment approach. Primary CWP services were provided by two PCC FTE's with 0.5 therapist FTE for the groups.

2. To provide education about the impact of caregiver stress on personal and family well-being.

In addition to providing emotional support and facilitating linkages to needed services, over 80% of caregivers indicated that the PCC helped them understand the importance of getting services for emotional or drug or alcohol problems. All of the structured, multi-week group CWP classes had a primary emphasis on educating caregivers on how to better care for themselves and/or their children. Approximately 40% of CWP participants attended at least one of the classes. Of those who attended any classes, the average number of sessions attended was 10.2, suggesting a high degree of interest in and engagement with the classes developed by and offered through CWP.

3. To engage caregivers in their own mental health treatment and improve access to needed care.

There was a statistically significant increase in the extent to which caregivers indicated they were "actively working on my problems on my own" between when they entered CWP and the follow-up assessment. In addition to engaging in the services provided directly by the CWP, 71.1% of the caregivers had at least one behavioral health linkage facilitated by the PCC for services such as individual or family therapy, support groups, co-occurring mental health and substance abuse treatment, or connections to domestic violence support services. To further support engagement in mental health treatment, a recommendation that emerged from the experience with CWP was to add direct individual therapy for caregivers as a new service component, which builds upon existing trust developed with caregivers and increases access to treatment.

4. To improve caregiver well-being.

Approximately 90% of caregivers indicated that as a result of participating in CWP, they were "better able to handle things," were "more comfortable seeking help," or knew "where to get help when I need it." Caregivers also reported receiving a wide range of emotional and tangible supports from their PCC that were intended to improve caregiver well-being. As evidenced by the results of the comprehensive needs survey, many caregivers also had substantial needs not directly related to behavioral health services. Through the work of the PCCs, the majority of caregivers (64.1%) had a least one non-behavioral health linkage completed by the PCC to help meet basic needs (e.g., financial, food, shelter, clothing), or to help with other supports such as legal assistance. Working to address caregivers non-behavioral health needs was identified by staff as an important step for building trust and facilitating discussions related to potential linkages for caregiver behavioral health needs.

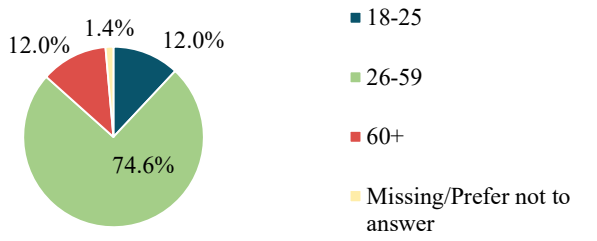
5. To improve outcomes for children whose caregivers improved their own well-being/became engaged in their own care.

CWP services were highly individualized to identify and address the specific, unique needs of a wide range of caregivers (e.g., biological, kin foster, non-kin foster, and adoptive parents). Most caregivers (90.6%) reported that the PCC helped them "feel better able to help my child/children." Qualitative feedback from caregivers identified three primary ways in which CWP services helped them improve the care of their children: 1) increased parenting skills and knowledge, 2) recognition of impact of their own mental health on their ability to care for their children, and 3) becoming more emotionally resilient and confident parents to help address the complex needs of their children. Quantitative analyses indicated that children whose caregivers participated in CWP were more likely to have successful KidSTART clinic discharges (i.e., completed treatment) and to experience greater behavioral improvements compared to children whose caregivers did not participate in CWP.

CAREGIVER WELLNESS PROGRAM PARTICIPANT DEMOGRAPHICS

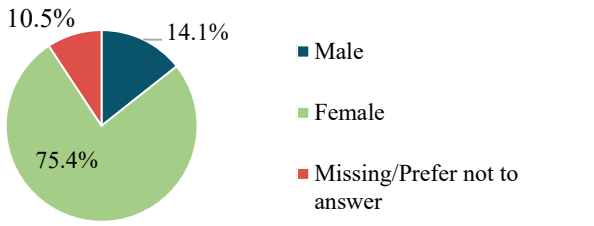
The following demographic data were collected from a participant self-report survey administered at the start of the CWP program.[1]

AGE (N=142)



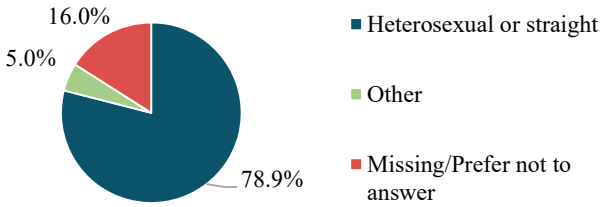
The majority of participants (74.6%) were between the ages of 26 and 59.

GENDER IDENTITY (N=142)



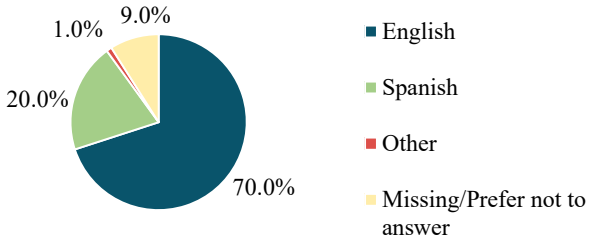
About three-quarters of participants were female (75.4%) and 14.1% of participants were male.

SEXUAL ORIENTATION(N=142)



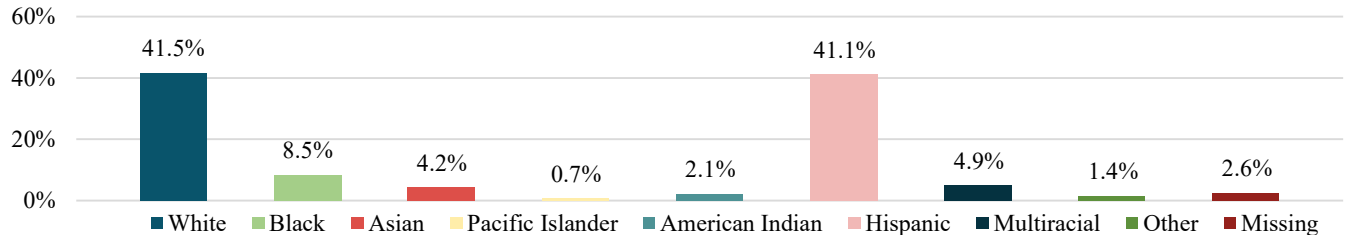
Most (78.9%) participants were heterosexual or straight and 16.0% of participants did not provide a response.

PRIMARY LANGUAGE (N=142)



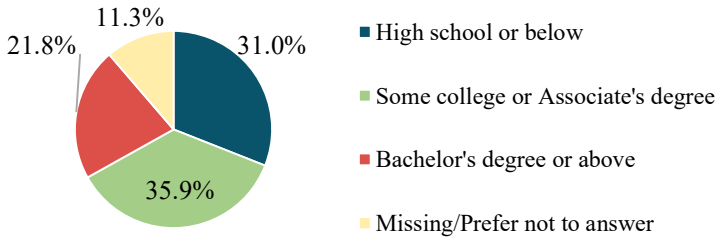
English was the primary language of most participants (70.0%) followed by Spanish (20.0%).

RACE/ETHNICITY (N=142)



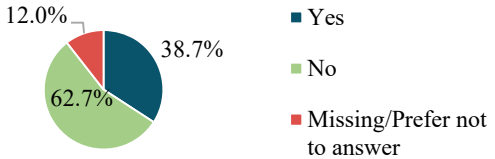
Forty-two percent of participants identified themselves as White, followed by 41.1% who identified as Hispanic. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

EDUCATION LEVEL (N=142)



Participants' educational level were split between broad categories, the largest being some college or Associate's degree (35.9%).

DISABILITY STATUS[2] (N=142)



Thirty-nine percent of participants reported having some form of non-SMI related disability.

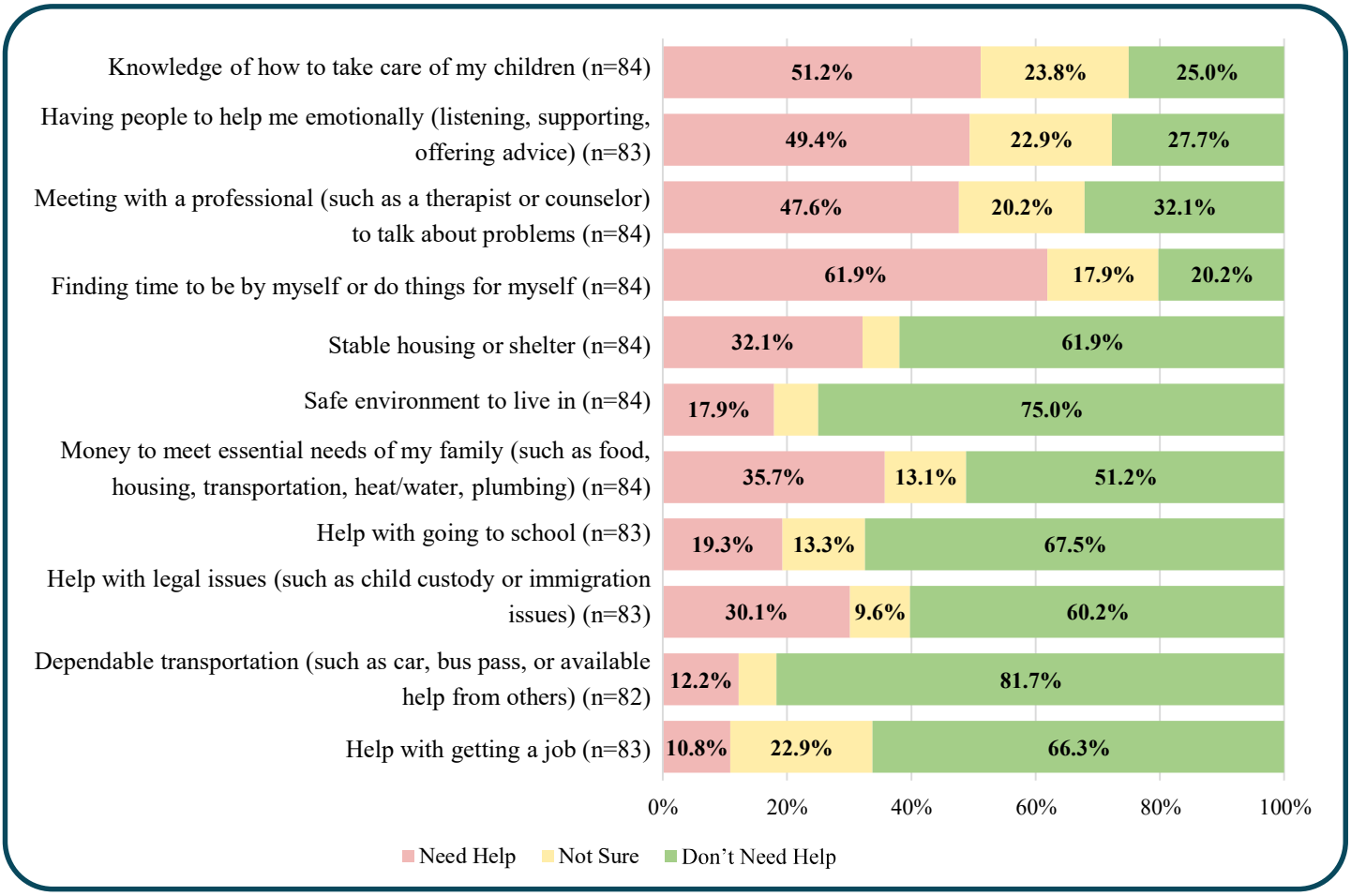
Approximately 5% (4.9%) indicated they had served in the military.

[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).

CAREGIVER NEEDS

As shown in Figure 1, select items from the comprehensive baseline family needs assessment indicated a wide range of potential family needs. Consistent with the caregiver's openness to and interest in receiving mental health and/or alcohol and drug services noted below, nearly half (49.4%) indicated needing assistance with finding "people to help [them] emotionally," and nearly half (47.6%), indicated that they needed help "meeting with a professional…to talk about problems." Additionally, over half (51.2%) wanted help increasing their "knowledge of how to take care of [their] children." Needing help with other issues such as housing, finances, and legal matters were each expressed by about one-third of all caregivers entering CWP.

FIGURE 1. FAMILY NEEDS ASSESSMENT AT ENTRY INTO THE CAREGIVER WELLNESS PROGRAM

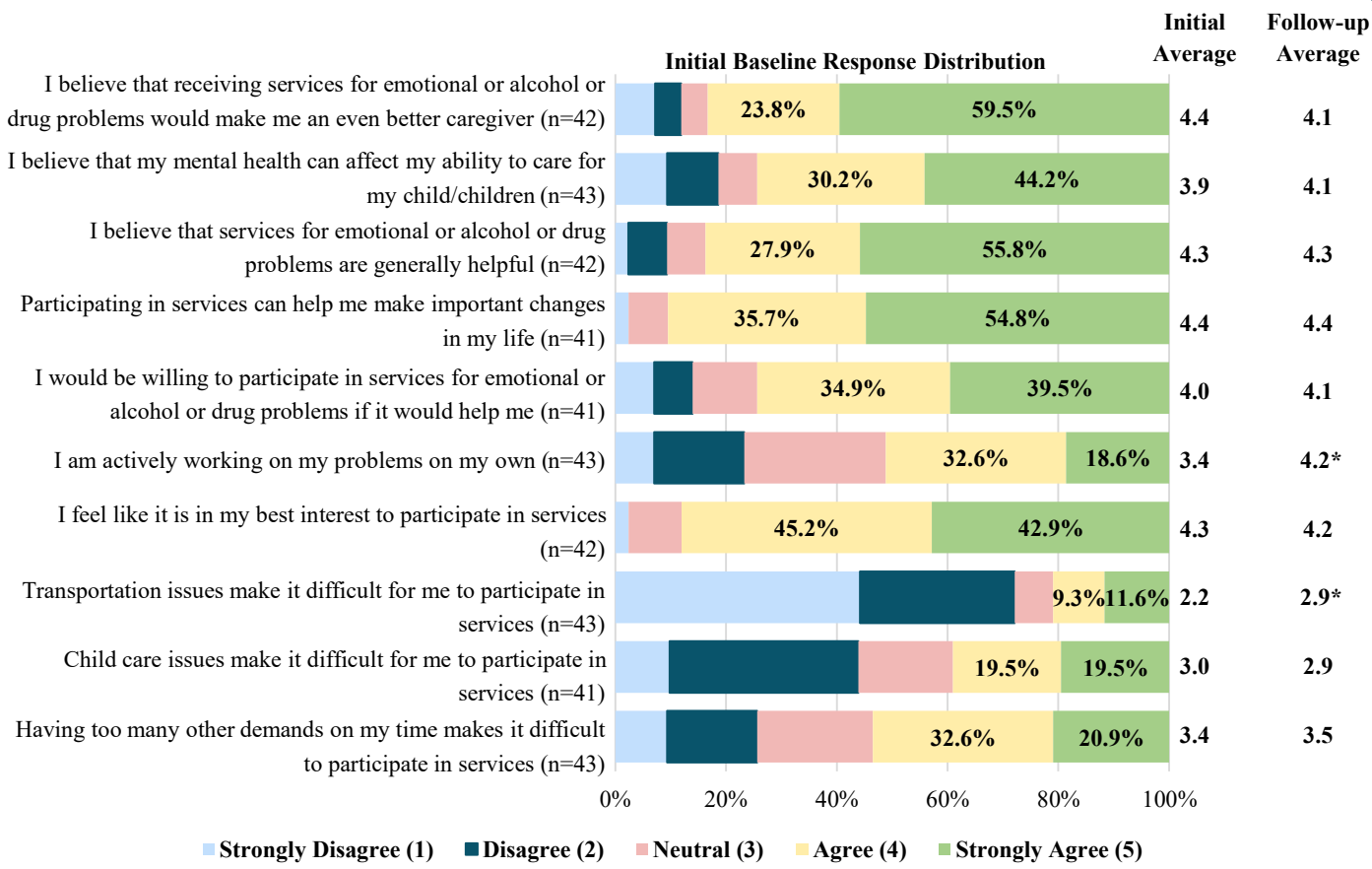


CAREGIVER ATTITUDES

Except where noted in Figure 2, average responses across CWP participants did not change much between initial assessment and follow-up measurements (every 90 days after entering CWP). Upon entering CWP, caregivers typically expressed favorable attitudes about the value of and need for receiving additional support services for emotional health and/or alcohol and drug problems. For example, at initial entry into CWP over 80% agreed or strongly agreed that "receiving services…would make [them] an even better caregiver" (83.3%), that such services were "generally helpful" (83.7%), that "participating in services can help [them] make important changes" (90.5%), and that it is in their "best interest to participate in services" (88.1%). Relatively few (20.9%) thought that transportation issues would make it difficult to participate in services, but concerns about childcare or other demands on their time were more prevalent (39.0% and 53.5%, respectively).

One area of significant change was the extent to which persons indicated they were "actively working on [their] problems." The average score across CWP participants increased from 3.4 to 4.2 on a 5-point scale ranging from Strongly Disagree (1) to Strongly Agree (5). This type of increase is consistent with a primary goal of CWP to get more persons engaged in efforts to address their own emotional health and/or alcohol and drug challenges. Another area of change related to whether transportation issues were expected to inhibit participation in services. Whereas relatively few thought transportation issues would be a problem initially (average score of 2.2), this was perceived to be more of a problem when measured at follow-up (average score of 2.9). One potential interpretation is that CWP participants increased their awareness of the various types of services that were available and/or were needed during their involvement with CWP staff and then indicated they had underlying transportation barriers that inhibited participation in those desired services.

FIGURE 2. INITIAL AND FOLLOW-UP CAREGIVER ATTITUDES



** Statistically significant difference between initial measurement and follow-up (p<.05).*

PARTICIPATION IN CWP CASE MANAGEMENT AND WELLNESS GROUP CLASSES

Through 6/30/2018, the CWP staff provided a total of 933 case management sessions to the 142 persons enrolled in the CWP program and these caregivers participated in a cumulative 562 psychoeducational support group sessions. As shown in Table 1, 73.2% (n=104) of all caregivers participating in the CWP had received at least one case management visit (average of 9.0 case management visits among those with any visits), and 38.7% (n=55) had participated in at least one psycho-educational support group session (average of 10.2 group sessions among those who attended any group sessions).

TABLE 1. CAREGIVER WELLNESS PROGRAM SERVICE UTILIZATION PATTERNS

	Received CWP Case Management Services		Attended Any CWP Group Sessions	
	%	n	%	n
Overall Total (n=142)	73.2	104	38.7	55
Gender				
Male (n=20)	75.0	15	50.0	10
Female (n=107)	72.9	78	40.2	43
Primary Language				
English (n=99)	68.7	68	36.4	36
Spanish (n=29)	86.2	25	55.2	16
Education				
HS or less (n=44)	81.8	36	52.3	23
Some College (n=51)	68.6	35	35.3	18
Bachelors Degree or above (n=31)	64.5	20	38.7	12
Work/Student Status				
Working or student (n=63)	65.1	41	34.9	22
Not working (n=63)	81.0	51	47.6	30
Receiving Behavioral Health Services at Start of CWP				
Yes (n=42)	83.3	35	40.5	17
No (n=89)	68.5	61	37.1	33
Elevated Need (PTSD/ Substance Abuse)				
Yes (n=35)	88.6	31	40.0	14
No (n=96)	67.7	65	37.5	36

Table 1 demonstrates that even though there were fewer male than female participants overall (n=20 vs. n=107), males participated in CWP services (i.e., case management and group psychoeducational support sessions) at similar to slightly higher rates than females.

Additionally, the participation rates of those who indicated Spanish as their primary language was substantially higher than primary English language speakers for both case management (86.2% vs. 68.7%) and group sessions (55.2% vs. 36.4%). Persons with lower levels of education and those not working were also more likely to participate in the case management and group sessions.

Persons receiving behavioral health treatment and/or medication at the time they enrolled in the program were more likely to engage in CWP case management sessions than those who were not receiving any behavioral health treatment (83.3% vs. 68.5%), but participation rates in group sessions were relatively similar (40.5% vs. 37.1%).

Overall, these findings suggest that CWP successfully connected with persons from population groups who might traditionally be less likely to engage in behavioral health-related services (e.g., males, Spanish language speaking individuals, persons who have never received behavioral health-related services). In particular, the high rates of engagement among persons whose primary language is Spanish highlights the importance of the Spanish language capabilities and cultural sensitivities of the CWP team members.

TYPES OF CAREGIVER WELLNESS GROUPS

CWP staff developed and provided structured, multi-week, group classes that covered a range of topics relevant to helping caregivers with their own well-being and/or that of their child. All of the classes integrated both educational and emotional support components. The types of classes included:

- Psychoeducation Group
- Therapeutic Play Group
- Empowerment: Therapeutic Group for Caregivers
- Success Group (e.g., education and support for foster and kinship/relative caregivers)
- Early School Readiness Group
- Executive Function Group
- Social Emotional Children's Group (provided to children while caregivers were in one of the adult wellness groups).

ASSESSMENT OF CHILD OUTCOMES AND CAREGIVER WELLNESS PROGRAM PARTICIPATION

To assess whether there were beneficial child-level outcomes associated with caregiver participation in CWP, three different data elements were examined: 1) KidSTART clinic discharge reasons, 2) Eyberg Child Behavior Inventory (ECBI) scores, and 3) Children's Functional Assessment Rating Scale (CFARS) scores. A total of 248 children with 257 treatment episodes were included after being enrolled and discharged from the KidSTART clinic within the INN-11 implementation timeframe (7/1/2015-6/30/2018).

REASON FOR DISCHARGE OF CHILD FROM KIDSTART CLINIC PROGRAM

Based on an analysis of children who were enrolled in KidSTART clinic for at least 60 days (i.e., a more conservative comparison of discharge reason with more equivalent groups; n = 113 in CWP and n = 118 not in CWP), the KidSTART clinic discharge reason was significantly associated with CWP participation. For instance, failure to return for treatment was more prevalent among children whose caregivers were not enrolled in CWP compared to children whose caregivers did participate (30.5% vs. 11.5%). Moreover, a greater proportion of children with caregivers in CWP attained a satisfactory status at discharge (71.7% vs. 52.5%). The proportion of cases discharged for other reasons, such as moving out of area, was similar in both groups of children.

CHANGE IN CHILD BEHAVIOR SYMPTOMS REPORTED BY CAREGIVERS

Disruptive behaviors in the children were assessed using the 36-item ECBI (Eyberg & Pincus, 1999), where parents/caregivers rated perceived behavioral issues (e.g., noncompliance and aggressiveness) on Intensity and Problem scales.

TABLE 2. ECBI ASSESSMENT OF CHILDREN IN KIDSTART CLINIC

	Caregiver not in CWP n = 59		Caregiver in CWP n = 82		
	Mean at intake	Mean at discharge	Mean at intake	Mean at discharge	Sig. diff.
ECBI Intensity Scale	134.3	118.3	143.9	112.9	*
ECBI Problem Scale	11.7	9.0	16.5	8.8	*

*$p < .05$

Mean score changes on the ECBI were investigated from intake to discharge using repeated measures analysis of variance (ANOVA). As shown in Table 2, all children on average demonstrated a significant decrease from intake to discharge on both the Intensity and Problem Scales. However, children with a caregiver enrolled in CWP experienced a greater reduction in the number of problematic behaviors and the frequency of behavioral issues compared to children without a caregiver in CWP.

CHANGE IN CHILD BEHAVIOR SYMPTOMS REPORTED BY CLINICIANS

Children were also assessed by clinicians using the CFARS tool (Ward, 1999). Sixteen domains, grouped into 4 index scores (relationships, safety, emotionality & disability), were rated on a scale of 1 to 9 ("no problem" to "extreme problem"). Changes on the CFARS were assessed using repeated measures ANOVA. The results were similar across all 4 index scores, with more detailed findings presented below from the relationships and emotionality domains. Children typically experienced improvements from intake to discharge, but children with a caregiver enrolled in CWP showed greater improvements.

TABLE 3. CFARS ASSESSMENT OF CHILDREN IN KIDSTART CLINIC

	Caregiver not in CWP n = 125		Caregiver in CWP n = 112		
	Mean at intake	Mean at discharge	Mean at intake	Mean at discharge	Sig. diff.
CFARS Domain - Relationships	3.0	2.4	3.2	2.3	*
Hyperactivity	3.9	3.1	3.9	3.1	
Work or School	2.1	1.9	2.4	1.8	
Interpersonal Relations	3.2	2.5	3.4	2.1	*
Cognitive Performance	2.3	2.0	2.7	2.2	
Behavior at Home	4.4	3.3	4.4	2.7	*
Danger to Others	2.0	1.7	2.6	1.7	*
CFARS Domain – Emotionality	3.1	2.3	3.2	2.2	*
Anxiety	3.2	2.3	3.5	2.5	
Traumatic Stress	3.5	2.6	3.7	2.4	*
Depression	2.5	2.0	2.4	1.7	

*$p < .05$; Note: CFARS values of 2 = "Less than Slight Problem", 3 = "Slight Problem", and 4 = "Slight to Moderate Problem"

Many individual domains also had significantly larger improvements in severity scores among children with caregivers in CWP. For example, children with enrolled caregivers saw a greater improvement in interpersonal relations than children without caregivers in CWP (mean improvement of 1.3 points vs. 0.7 points).

In summary, children whose caregivers participated in CWP were more likely to have a successful discharge and to experience greater behavioral improvements compared to children whose caregivers did not participate. This is consistent with initial CWP design expectations that the additional tools and resources provided to caregivers would lead to improved outcomes for their children.

These positive findings should be viewed with a note of caution. A "self-selection" bias may be influencing results in that caregivers open to and ultimately enrolled in CWP services may have already been more engaged and fluent in the treatment needs of their children, which potentially contributed to better treatment outcome independent of CWP participation.

ASSESSMENT OF CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION

UTILIZATION OF BEHAVIORAL HEALTH SERVICES PRIOR TO CWP

As shown in Table 4, at the time of enrollment into CWP, 14.5% of caregivers indicated that they had ever been hospitalized or in a residential treatment for mental health or substance abuse issues. Approximately half (52.3%) reported that they had ever participated in some form of therapy/counseling for emotional problems. At the time of enrollment into CWP, slightly less than one-quarter (22.3%), indicated that they were participating in therapy/counseling and 20% indicated they were taking some form of prescription medication for emotional health needs. Prior and current participation in treatment for alcohol or drug problems was much less common (5.3% and 2.3%, respectively).

TABLE 4. CAREGIVER BEHAVIORAL HEALTH SERVICE UTILIZATION PRIOR TO THE CAREGIVER WELLNESS PROGRAM

	% Yes	n
Ever admitted for an overnight stay in a hospital or other facility to receive help for problems with emotions, nerves, mental health, or use of alcohol or drugs. (n=131)	14.5	19
Ever had one or more sessions of psychological counseling or therapy for emotional problems with any type of professional. (n=130)	52.3	68
Currently receiving or on a waitlist for psychological counseling or therapy for emotional problems with any type of professional. (n=130)	22.3	29
Ever used a prescription medicine for emotions, nerves or mental health from any type of professional. (n=131)	35.1	46
Currently using a prescription medicine for emotions, nerves or mental health from any type of professional. (n=131)	19.8	26
Ever visited a clinic or doctor about an alcohol or drug problem. (n=131)	5.3	7
Currently going to or on a waitlist for a clinic or doctor for an alcohol or drug problem. (n=129)	2.3	3

Based on a review of available data, it was determined that very few CWP participants had any contact with the publicly funded County of San Diego BHS system. For example, only 5.6% of CWP participants had attended at least one BHS outpatient visit within the 90 days ***prior*** to starting CWP. Additionally, there were no identified interactions with the BHS acute/crisis care oriented services such as Psychiatric Emergency Response Team (PERT) visits, crisis stabilization visits, or inpatient hospitalizations.

CAREGIVER BEHAVIORAL HEALTH AND OTHER SERVICE LINKAGES FACILITATED BY CWP

LINKAGES TO COMMUNITY BEHAVIORAL HEALTH-RELATED SERVICES

A primary objective of the CWP program was to connect caregivers with appropriate behavioral health-related services. While very few CWP participants were identified as having needs that would make them eligible for services within the formal BHS system (i.e., BHS primarily serves persons with serious mental illness who are on Medi-Cal/have no insurance), the majority of CWP participants, 71.1% (n=101), had at least one behavioral health linkage facilitated by the CWP team as of 6/30/2018. Types of behavioral health-related linkages included:

- individual behavioral health therapy through community based agencies, health care agencies, and private providers
- family counseling services
- NAMI (National Alliance on Mental Illness) support groups
- services for co-occurring mental health and substance use concerns
- domestic violence support services

LINKAGES TO OTHER COMMUNITY SERVICES

Many CWP participants had other, non-behavioral health-related needs identified through the comprehensive needs assessment and/or the ongoing care management interactions with the PCC. The PCCs worked to meet as many of these other needs as possible as a way of improving the overall well-being of the caregiver and family circumstances and building supportive relationships with the caregiver. The majority of CWP participants, 64.1% (n=91) had a least one form of non-behavioral health linkage completed by the CWP to address caregiver/household needs. Types of non-behavioral health-related linkages included:

- food resources (such as food banks)
- clothing resources
- legal assistance
- financial aid/assistance
- educational resources (for caregiver)
- housing related services

ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES

As shown in Figure 3, almost all caregivers who completed a satisfaction survey (n=57), indicated they were satisfied with the CWP services received (89.5% agreed or strongly agreed with this item). Most respondents indicated that as a result of their participation in CWP they "know where to get help" (89.5%), are "more comfortable seeking help" (84.2%), and are "better able to handle things" (91.2%).

FIGURE 3. CAREGIVER ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES

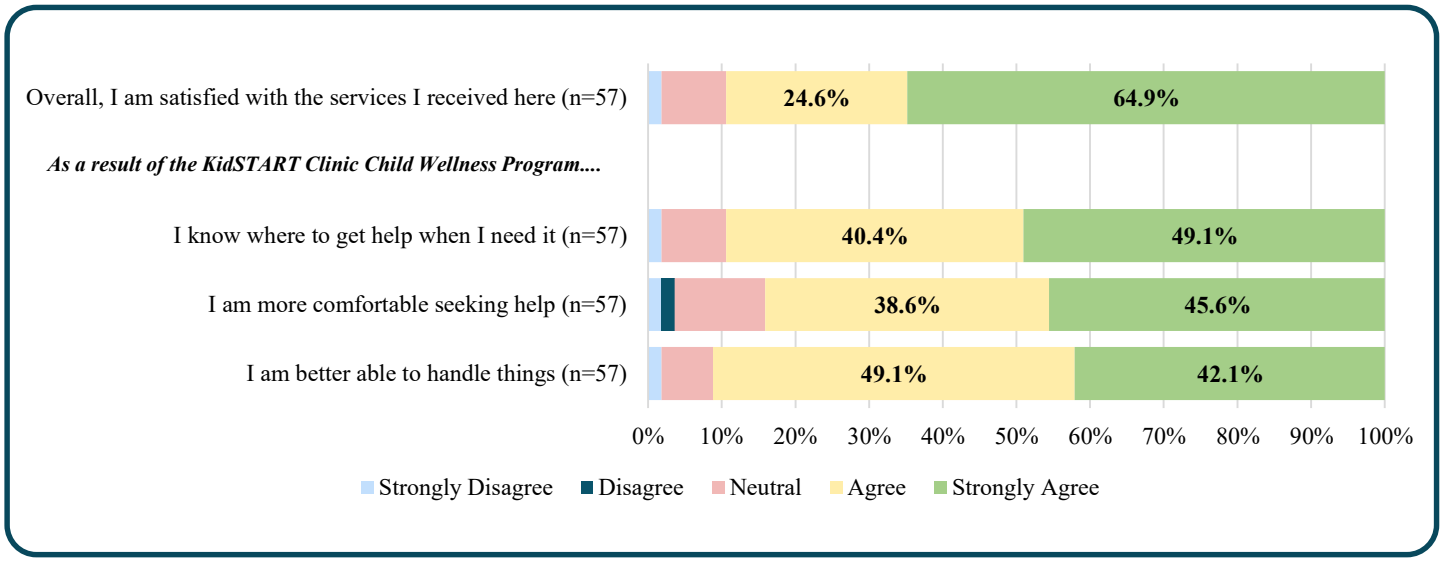
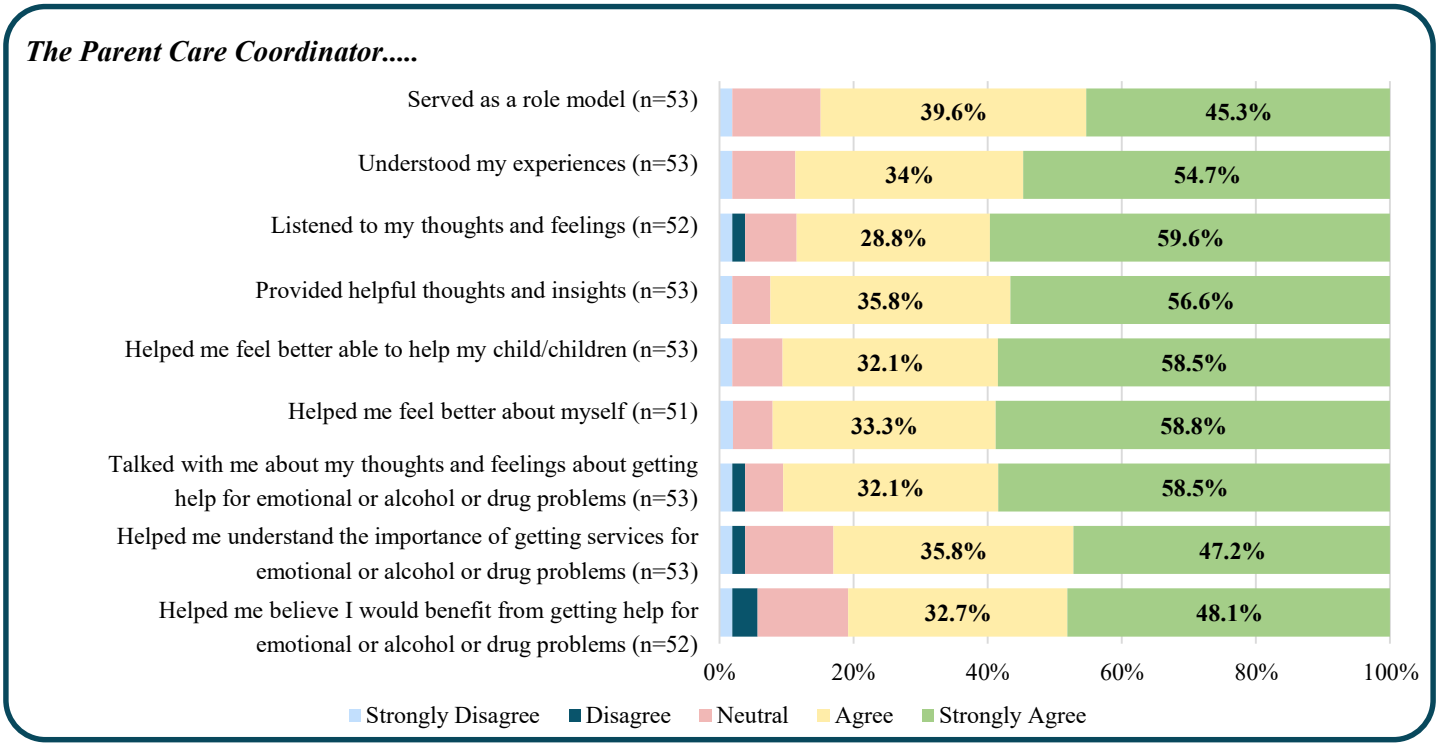


Figure 4 shows that at follow-up, caregivers nearly universally "agreed" or "strongly agreed" that their PCC provided a range of emotional and educational supports, including "listening to [their] thoughts and feelings," helping them "understand the importance of getting services for emotional or alcohol or drug problems," and helping them "feel better able to help [their] child/children."

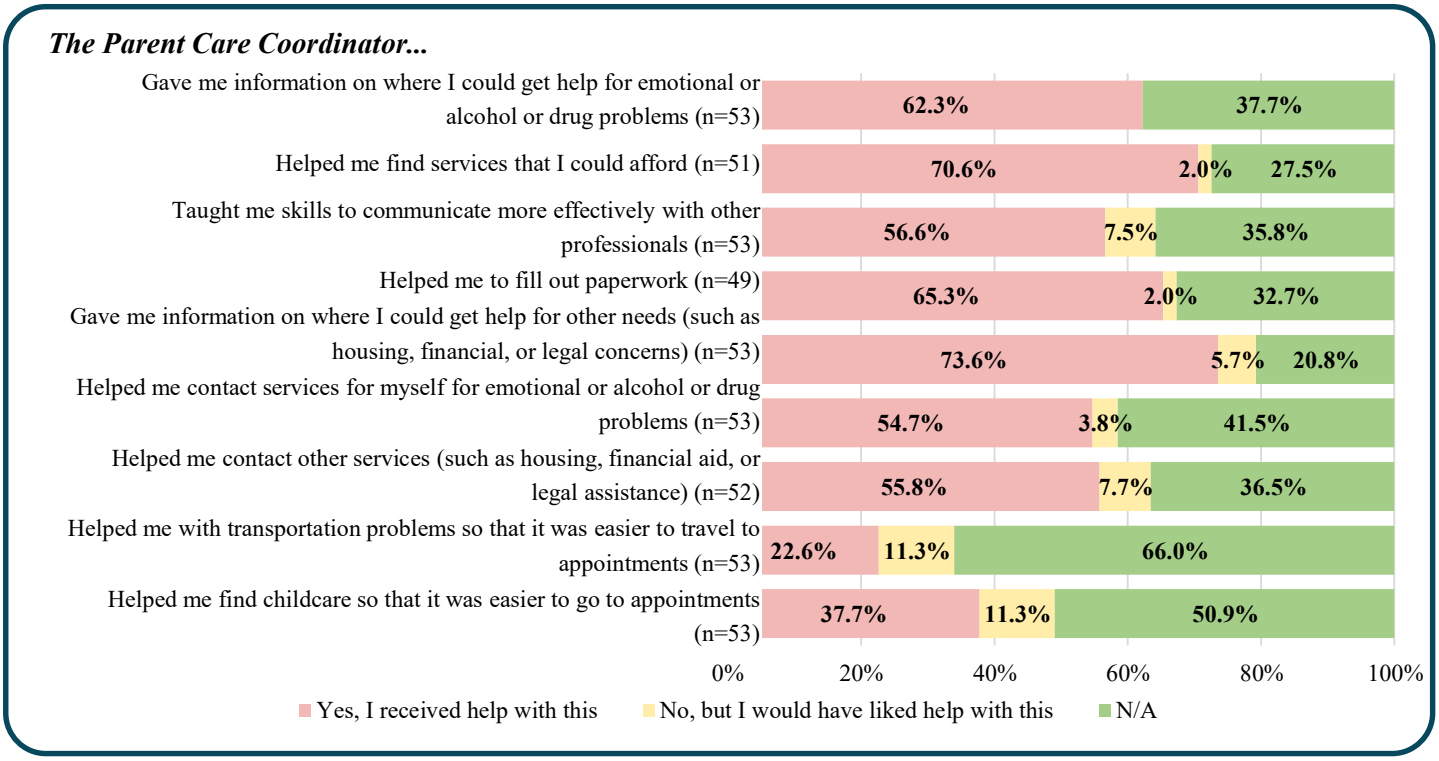
FIGURE 4. CAREGIVER PERCEPTIONS OF PARENT CARE COORDINATOR SUPPORTS



ASSESSMENT OF CAREGIVER WELLNESS PROGRAM SERVICES (CONTINUED)

Additionally, as shown in Figure 5, PCCs provided a range of specific services to those who needed them, such as giving caregivers information about where to get help, teaching about effective communication, assisting with paperwork, and empowering caregivers to contact other needed support services. Few caregivers indicated having a specific need but not receiving help for that need from their Parent Care Coordinators. This indicates that the program is generally effective at identifying needs and providing relevant services to help address those needs.

FIGURE 5. TYPES OF SERVICES PROVIDED TO THE CAREGIVERS BY THE PARENT CARE COORDINATOR



CAREGIVER QUALITATIVE SURVEY RESPONSES REGARDING PERCEIVED IMPACT ON CHILD

Caregivers reported that the Caregiver Wellness Program helped develop their parenting skills and knowledge.

- "I have learned how to be a better parent and utilize the tools I have learned with my child."
- "…lots of coping skills in our tool box now and knowledge of conditions and diagnoses."
- "It's helped me develop my skills as a parent when it comes to communicating with my child and validating her feelings."
- "As a young mother that has no parenting skills it has been very helpful to have the therapists and Parent Care Coordinator hold my hand and guide me to be the mother my son needs."
- "The classes offered at KidSTART clinic help me realize how my child needs me to be present for him."

Caregivers reported that participation also encouraged them to improve their own mental health to better help their child.

- "Having attended the groups has taught me first that I have to be well in order to help my child. I realized that I needed professional help for my mental health in order to process my own trauma and help my child with his own."
- "The parent coordinator was very helpful and she encouraged me to sign up for school, and encouraged me to get help with my anxiety."

The Caregiver Wellness program helped caregivers to be better emotionally resilient and confident parents.

- "I never felt judged nor received negative feedback from the Therapist or Parent Care Coordinators that I was a bad parent due to my child's mental and emotional needs. On the contrary, I was embraced, empowered and educated on how to be emotionally present as parent for my child."
- "They emotionally were able to help me as a mother and my child. I was ready to give up and consider myself a horrible parent and now I feel confident."
- "I felt validated and understood by the KidStart Parent Care Coordinator. Knowing that there was someone else that had struggled with their own child and overcame their child's challenging and defiant behavior made me feel that I can do it too."

CAREGIVER WELLNESS PROGRAM—CASE REPORTS

Participants in CWP come from a variety of backgrounds and family situations. Through CWP, caregivers receive support in understanding and meeting the needs of both their children and themselves. Caregivers have received assistance in pursuing and maintaining services for their own needs, have gained the knowledge and skills to advocate for their children, and have found meaningful social support through psycho-educational support groups and visits with their PCCs. The following brief case reports present examples of the types of situations and outcomes commonly experienced by CWP participants.

Case Report 1—Improved Caregiver Mental Health

A PCC assisted a caregiver with bipolar disorder by assessing needs and supporting goal achievement. These included changing mental health providers and improving interactions with their family. The PCC accompanied the caregiver to an appointment and witnessed the disrespect by the caregiver's psychiatrist. Together they found a different doctor and the PCC attended the first session with the nervous caregiver. The PCC encouraged the caregiver to try this provider for at least five sessions. After five sessions, the caregiver told the PCC that they felt better and were confident in the doctor's understanding of their disorder. The caregiver learned about triggers and warning signs and learned to trust others. The caregiver's symptoms are more manageable now and they now see asking for help when needed as the right thing to do. The caregiver continued to have sessions with the new doctor and attended support groups to interact with others. The caregiver appeared much better emotionally and physically and indicated that the "journey" is easier with the new support system.

Case Report 2—Improved Child Outcomes

A family approached KidSTART clinic regarding their child who engaged in destructive and impulsive behaviors. The parents learned about triggers and ways to help their child communicate. Their child began to verbalize feelings, but reports of harmful behaviors for unidentifiable reasons continued. During this time, parents had a greater understanding of the importance of their own mental health for their child's well-being. They joined CWP, which helped to improve their outlook on their situation and their understanding of themselves. They were able to understand their child's need for certain types of activities and supports (e.g., therapy and medication) to reduce impulsivity and angry responses. The parents were able to see their child's empathy, kindness and helpfulness and used these strengths to build the child's self-esteem and reduce the effect of triggers. The parents began advocating at school and among family members and their child is now known as a happy, empathic, energetic, and charismatic child. The parents feel empowered and proud of the changes they have seen in their child.

Case Report 3—Family Reunification

One caregiver was a single parent who was previously incarcerated and whose children were in foster care. The PCC worked to help the parent understand their emotional needs and hopes for the future. The parent expressed feeling no hope of making the positive life changes that would allow for reuniting with the children, particularly the difficulty in finding employment. The PCC suggested career training to network and obtain a license in the desired field as well as mentoring others in similar situations. The parent became emotional and stated that they had never thought about how their experiences could actually be used to help themselves and others. The parent was encouraged to seek individual therapy to help deal with personal traumas and fortunately, they completed all therapy sessions, gained career skills, and demonstrated the desire to be a good parent. Because of this, the courts looked favorably on the situation and reunited the family. The parent was very happy and expressed heartfelt gratitude for all the support and caring received from the PCC and the entire CWP team.

Case Report 4—Service Linkage Challenges

One caregiver in CWP had experienced domestic violence. During CWP services, the PCC discussed the benefits of self-care and how meeting one's own needs can benefit their children. The caregiver expressed the desire to pursue behavioral health services at a specific agency; however, they had not returned the caregiver's phone calls. The caregiver and PCC then left multiple voicemails. The PCC was contacted by someone at the agency and informed that the caregiver could be assessed that week. Unfortunately, when the caregiver attempted to schedule an assessment, they were told that there was no availability and no new clients would be accepted for months. The caregiver and PCC had spent much time trying to link to a needed service at a time when the caregiver was ready and motivated for services. This is an example of how waitlists and miscommunication across systems pose significant barriers to accessing needed services and can result in failed connections to treatment.

SUMMARY OF STAFF PERSPECTIVES – FOCUS GROUP THEMES

At the end of the second year of providing Caregiver Wellness Program (CWP) services, therapists, PCCs, and supervisors (n=8), participated in a focus group to discuss their experiences with, perceptions about, and recommendations for CWP.

1. *Caregivers in CWP have varying levels of mental health needs:*

    - Some caregivers may express that they experience symptoms related to mental health, but their current priority is the child (e.g., caregivers reported or exhibited PTSD, schizophrenia, bipolar disorder, depression, anxiety).
    - Caregivers who do not have a mental health diagnosis are still often in stressful situations and can benefit from stress reduction through self-care strategies and support groups.

2. *Different types of services and assistance provided to caregivers:*

    - Help with pursuit of education or career training, such as locating financial assistance or completing applications.
    - Childcare has been identified as a barrier to caregivers receiving treatment themselves. PCCs assist with locating childcare and preschool options.
    - Staff assist with distributing donations of food, clothing, and toys.
    - Legal and financial assistance: government documentation such as social security and taxes.

3. *Staff utilize a variety of strategies in enabling caregivers to seek and receive mental health services:*

    - "Mental health" as a phrase might not be received well. Instead, staff may tailor their discussions with caregivers to focus on symptoms (e.g., anxiety, troubled sleep, stress) and self-care techniques.
    - Normalize receiving behavioral health services by discussing with caregivers that people take care of their physical health by seeing a doctor or their appearance by getting a haircut. Therefore, seeking support for behavioral health is one way to take care of the mind.
    - Providers emphasize that the child is more likely to improve if the caregiver's well-being is also addressed. **"We value you as much as the child."**
    - Some caregivers had previously been encouraged to obtain services, but did not. Providers speculate that maybe the "warm handoff" was missing. In other words, the caregivers were told to go, or were informed of various resource, but did not get support, or have the motivation to go. Providers state importance of "following-up" with caregivers.
    - One provider noted that the first visit is the hardest and often needs support. **"Instead of saying 'you need to go,' I say, 'We will go together and I will help you.'"**
    - Prior negative experiences may need to be addressed since some caregivers have already been in treatment, and it was either not successful or they did not like it.

4. *Caregivers may want to continue with the program even if their children have improved and/or completed the program:*

    - There are situations where the child completes treatment, but the parent is not ready to let go. They have had access to a team that listens to and understands them. After establishing a relationship with the team, and experiencing positive outcomes in CWP, it can feel like a difficult loss for the caregiver.
    - PCCs are informed that a child's treatment will be ending and to try and address any remaining needs of the caregiver and family before then.
    - PCCs try to assist families with contacting or transitioning to external services so that when the PCC is no longer available to the family, they already have some relationship with another service provider or organization.
    - Another strategy used by therapists and PCCs to ease the transition towards caregiver program completion is by spacing remaining visits further apart.
    - Providers have expressed concerns about how the adult mental health system will differ from the caregiver's experiences with the children's system.
    - One provider expressed concern about the time gap until an appointment is available: **"They get the initial linkage, but I'm worried about them not getting continued care."**

5. *The caregiver program has led to positive experiences among providers, caregivers and children:*

    - Improved demeanor and communication between caregiver and child. **"The mother talks differently with the child because her outlook on life has improved."**
    - Providers agreed that if parents are struggling with their mental health, the child will not do well in their treatment and daily life. One PCC shared this sentiment from a caregiver: **"Without the wellness program, she said she would not have been able to provide a stable home for her child."**
    - Increased interactions between providers (therapists and PCCs) and families (caregivers and children) builds rapport and encourages engagement in the treatment process.
    - Support groups lead to social relationships that provide informal support that may extend beyond time in CWP.
    - Support groups can help normalize and contextualize some childhood behaviors as well as demonstrate that other caregivers may have similar feelings and experiences.

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 CWP. 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 CWP goals:*

- Good collaboration and communication between program leadership, Parent Care Coordinators (PCCs) and therapists
- Ability to provide comprehensive in-home assessments
- PCCs' ability to form supportive and trusting relationships with caregivers
- Region specific PCCs with detailed expertise in locally available resources
- Structured curricula for psycho-education support groups designed to improve caregiver functioning and well-being
- Overall staff "buy-in" to importance of caregiver well-being for improving child behaviors
- Efficient and effective program operations (e.g., offer services to all caregivers, streamlined assessments, familiarity with community resources)
- Provision of childcare while caregivers participate in CWP services
- Having Spanish language staff available to provide CWP services

2. *Primary factors that inhibited achieving CWP goals:*

- Not being able to provide individual psychotherapy directly through CWP to caregivers
- Caregivers who are not ready to work on their own needs (e.g., low interest/motivation and/or low insight due to SMI/active substance abuse)
- Caregivers who may be interested, but have many other competing demands or other tangible CWP participation barriers (e.g., transportation and timing)
- Ongoing challenges linking caregivers to appropriate community resources and treatment services
- Ineligibility for public mental health services and lack of insurance or financial means to pay for care

3. *Primary factors needed to engage and maintain caregiver participation in CWP:*

- Providing caregivers with individualized and beneficial resources, linkages, and information
- Offering psycho-education support groups that are of interest to caregivers
- Frequent, positive interactions with PCCs and the rest of the team
- Prompt engagement with PCCs and delivery of services after initial enrollment
- Educating caregivers about connections between their own behavioral health and their child's well-being
- Coordinating communication between caregiver, child's therapist, and PCC
- Providing CWP services at times and locations that are convenient for caregiver participation

4. *Primary perceived caregiver benefits of psycho-education support group participation:*

- Increased understanding of the importance of caregivers' wellness to their child
- Empowered caregivers with additional knowledge through psycho-education
- Provided emotional support and comfort in a "safe space"
- Created opportunities for "light bulb" moments/important realizations about caring for themselves and/or their child
- Facilitated the development of peer-support social relationships with others in similar situations
- Helped to normalize situation and reduce anxiety by seeing other caregivers with similar challenges

5. *Primary strategies used to link caregivers with recommended behavioral health services:*

- PCCs collaborative approach to service linkages (e.g., calling places together, attending initial appointments)
- PCCs offering support and encouragement from their "lived experience"
- Educating caregivers about how their behavioral health affects their child
- Having PCCs with knowledge of available programs (e.g., locations, service types, eligibility and cost requirements)
- Providing ongoing support and education until caregiver is ready to change

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

The following items were identified as important learnings related to CWP outcomes and operations throughout the three year CWP MHSA Innovations-funded study. These findings can help inform any potential future initiatives to implement a CWP program in other communities.

1. *CWP participant recruitment and engagement:*

   - Need to ensure identification of all caregivers who may benefit from CWP services without creating overly lengthy or cumbersome screening and assessment processes.
   - Prompt development of the caregiver wellness plan and provision of PCC coordination and support services after completing the needs assessment was important for retaining and promoting caregiver CWP participation.
   - The many other child-related meetings and treatment sessions caregivers had to attend as well as other commitments of daily life substantially limited the time that caregivers were available to participate in services directed toward their own well-being.
   - Once caregivers decided they were interested in receiving CWP services, retention was typically high, with many not wanting to discontinue CWP services following the discharge of their child from KidSTART clinic.

2. *Role of the comprehensive needs assessment and the Parent Care Coordinator (PCC):*

   - Providing a comprehensive in-home needs assessment was crucial for obtaining a thorough understanding of the range of potential caregiver needs and often facilitated rapport building and caregiver "buy-in" to the CWP.
   - It was useful to start behavioral health-related conversations early in relationship building process (e.g., while addressing non-behavioral health needs), to help normalize those discussions and facilitate participation in CWP services and external linkages.
   - The PCC role facilitated both emotional support and education of caregivers, as well as identifying and connecting with needed external resources and services.
   - The life situations for biological, adoptive, kin-based foster, and non-kin-based foster parents may differ significantly, which requires a detailed and individualized understanding of the family unit needs and resources in order to tailor CWP services appropriately.
   - Need for specialized care supports, preferably within the CWP team, to focus on unique and complex challenges such as substance abuse and domestic violence (e.g., someone with knowledge of legal system/relevant laws).

3. *Benefits of offering therapeutic, educational and support groups:*

   - Offering therapeutic, educational and support groups directly within the CWP was an effective strategy for providing needed and desired caregiver-focused behavioral health services.
   - Group sessions and PCC support increased caregiver awareness of the importance of receiving their own services to promote their wellness and the well-being of their children.
   - Caregiver participation rates in the groups provided within CWP were similar (about 50%) regardless of whether caregivers were also receiving other behavioral health services. This indicated that the groups were capable of both expanding access to needed information for those without any other behavioral health supports as well as supplementing any existing behavioral health care.
   - Caregivers form social connections with other caregivers in similar circumstances during the CWP group sessions that can provide social supports that last beyond their participation in CWP.

4. *Challenges linking to external behavioral health services:*

   - Prior negative experiences with mental health treatment are common and need to be discussed prior to new linkages.
   - The first visit to a behavioral health-related service can be hardest for a caregiver. Important to match caregiver needs with appropriate level of PCC supports (e.g., from providing a phone number to attending the visit with caregiver).
   - Challenging to find behavior health-related services that are 1) substantively appropriate, 2) feasible to participate in, and 3) of interest to the caregivers. All three conditions must be met for successful external linkages to occur.
   - CWP behavioral health-related linkages were typically not to BHS outpatient treatment services, but to other community programs, private counselors, or other resources.
   - Need additional Spanish-speaking therapists in the community for behavioral health treatment referrals from the CWP.

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS" (CONTINUED)

5. *Caregiver experiences within CWP:*
   - Spanish-speaking PCCs and therapists were vital to delivering CWP services.
   - CWP was successful at getting persons from commonly underserved populations (e.g., males, Spanish-language speakers) to participate in the CWP case management and psycho-education support group sessions.
   - Caregivers often want to continue receiving CWP services even after child is no longer in KidSTART clinic program. Need to plan for transition with caregiver to help promote ongoing and relevant linkages for caregiver.
6. *Impact on KidSTART clinic culture/treatment approaches:*
   - Offering CWP services to all caregivers with children in KidSTART clinic improved CWP operations (e.g., staff buy-in, consistency/coordination, recruitment), as a fully integrated program rather than a separate sub-program only for some caregivers.
   - CWP program has allowed for a "culture shift" within KidSTART clinic program by providing resources (e.g., PCC services, group sessions), that allow therapists to work much more effectively at the "family level" to promote long-term child well-being.
   - CWP participation enhanced KidSTART clinic therapists' knowledge of caregiver strengths and needs, which facilitated caregiver engagement in child-caregiver dyadic treatment services and informed child treatment strategies.

PROGRAM CHANGES FROM INITIAL DESIGN

The overall design of CWP did not fundamentally change over the course of the MHSA Innovations funding period (7/1/2015-6/30/2018). Throughout the duration of CWP, primary services included: 1) a comprehensive needs assessment (often conducted "in-home"), 2) provision of emotional support and individualized linkages to external resources by a Parent Care Coordinator (PCC), and 3) a range of therapeutic, educational, and support groups developed specifically for CWP caregivers.

However, there were some strategic adaptations in response to initial and ongoing program operations. CWP was originally intended to serve the subset of KidSTART clinic program caregivers who were identified via clinical assessments to have elevated psychiatric distress/needs. This initial round of screening and assessment was found to add substantial time to the intake process and delayed efforts to engage with caregivers. It was also found that while stress, anxiety, and depression were evident within the KidSTART clinic caregiver population, clinically identified psychiatric needs related to serious mental illness were not common.

Based on these findings, it was determined that instead of focusing only on a subset of caregivers who met select clinical threshold criteria, CWP services would be offered to all KidSTART clinic caregivers. This decision had two positive effects, 1) it lessened time between enrollment in KidSTART clinic and engagement with CWP services, and 2) it changed the culture throughout the KidSTART clinic program such that CWP services, and caregiver wellness concerns more generally, were more explicitly incorporated into the treatment approach of KidSTART clinic therapists. This encouraged greater coordination and communication between the CWP staff and KidSTART clinic treatment teams.

One change that was considered, but not implemented during the CWP program was the provision of individual therapy to caregivers enrolled in CWP. Given the many logistical and stigma-related challenges of linking caregivers to external behavioral health services, it was recommended that individual therapy be provided within the CWP program. This was expected to further improve access to behavioral health care given that the program could build upon the trusting relationships that had been developed and the fact that caregivers were often already "on-site" while their children were participating in treatment. This design change was implemented into the version of CWP that continued on after the MHSA Innovations funded project ended.

FUTURE DIRECTIONS

Based on the positive findings from the INN-11 Caregiver Wellness Program pilot study, BHS dedicated ongoing Substance Abuse and Mental Health Service Administration (SAMHSA) funding to sustain the CWP programming. This funding allowed the structure and operations of the CWP program to continue uninterrupted. In addition, the program was able to allocate some of the funds to begin supporting the provision of a limited amount of individual therapy within the program (as opposed to always needing to make a linkage to an external agency). This adaptation was based on a recommendation that emerged during the INN-11 CWP Innovations pilot project.

For additional information about the INN–11 Caregiver Wellness Program and/or this report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAMILY THERAPY PARTICIPATION ENGAGEMENT (INNOVATIONS-12)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
FINAL REPORT (7/1/15 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Family Therapy Participation Engagement (FTPE) programs were funded through the Innovations (INN) component of the Mental Health Services Act. FTPE was designed to increase parent and caregiver engagement in the treatment of their child through the innovative use of Parent Partners to encourage participation in family therapy. Note, we use the term "caregiver" in the remainder of this report to signify either the parent or other caregivers of the child receiving treatment.

Parent partners were required to have prior lived experience caring for children receiving behavioral health services to facilitate their role as peer supports for caregivers in similar situations. Parent partners were expected to enhance caregivers' understanding of the importance of active involvement in their child's treatment and to encourage caregiver participation in family therapy sessions. Parent partners were expected to offer short-term supports (i.e., typically 2-4 visits, but more if needed), with Motivational Interviewing (MI) techniques providing the guiding framework for how parent partners engage with caregivers. Parent partner staff were integrated into six existing Child, Youth, and Family (CYF) programs operating throughout the County of San Diego.

EXECUTIVE SUMMARY

The Family Therapy Participation Engagement (FTPE; INN-12) program was designed to increase caregiver participation in family therapy visits. This was accomplished by using peer-support parent partners who were trained in MI techniques to enhance caregivers' understanding of the importance of active participation in their child's treatment and to encourage participation in family therapy sessions. These parent partner services were provided at six behavioral health treatment programs throughout San Diego County.

- Overall, the utilization of family therapy increased and individual therapy decreased following implementation of the six FTPE programs.
- During "peak" FTPE implementation (FY 2016-17), the average number of family therapy sessions per child receiving treatment increased to 4.3 as compared to 3.6 pre-FTPE (a 19.4% increase). During this same time period the ratio between the number of family therapy sessions provided for each individual therapy session provided increased from 0.36 to 0.53 (a 47% increase).
- During "peak" FTPE implementation (FY 2016-17), at least 1 family therapy session occurred in half (51.1%) of all months that a child received any form of therapy and at least 2 family therapy sessions occurred in 17.3% of the months. Both of these indicators reflected substantial increases compared to pre-FTPE (a relative increase of 27.1% and 43.0%, respectively).
- Based on available caregiver demographics (n=1,081), most FTPE caregivers were female (81.2%), the majority spoke Spanish as their primary language (51.0%), and 71.0% identified as Hispanic. Over half of caregivers had a high school education or less and 12.1% were unemployed but seeking work.
- Caregivers reported very high overall levels of satisfaction with the parent partner services (96.5%). Over 90% agreed or strongly agreed that parent partners "understood [their] experiences," "helped [them] understand the importance of family therapy," and made them "feel [they] could help [their] child," in addition to providing other forms of support.
- Specific challenges to further increasing family therapy participation identified by FTPE staff included: 1) low caregiver motivation/ambivalence regarding importance of participation in therapy, 2) lack of caregiver resources (e.g., time, transportation, etc.), 3) caregiver personal challenges (e.g., substance abuse), 4) FTPE program limitations (e.g., not enough parent partner hours, staff turnover, etc.), and 5) general stigma associated with mental illness and participating in therapy.

FUTURE DIRECTIONS

Based on the promising outcomes from the MHSA funded INN-12 FTPE program, BHS has continued to support the structure and operations of FTPE (i.e., the Parent Partner model) at the initial six agencies by using MHSA Community Services and Support (CSS)/Full-Service Partnerships (FSP) funding.

OVERALL ASSESSMENT OF PRIMARY PROGRAM OBJECTIVES

1. To establish and implement a novel approach that utilized Parent Partners (i.e., persons with direct "lived-experience" of being the caregiver of a child who received public sector emotional, behavioral health, or developmental services) to increase caregiver participation in family therapy.

Using MHSA Innovations funding, the Family Therapy Participation Engagement (FTPE) program was successfully implemented to provide parent partner services to caregivers of children receiving services at six existing Child, Youth, and Family (CYF) programs operating throughout the County of San Diego. The primary component of this program included the use of parent partners who provided education, encouragement, and other tangible supports where possible to promote caregiver participation in family therapy. While there were no substantial changes in program design over the three year project, program staff indicated there were some challenges defining the specific roles of the parent partner and keeping them distinct from those of a traditional case manager. However, FTPE program administrators indicated that the parent partners became integral parts of the overall treatment team and often coordinated their efforts to engage caregivers in family therapy with the therapists.

During the "peak" FTPE implementation year (FY 2016-17), approximately 50% (46.5%) of all children receiving any therapy (i.e., 1,015 out of 2,183 unduplicated children) had a caregiver who received at least one parent partner visit. Of those with any parent partner visits during FY 2016-17, the average number of visits was 4.6. Program staff indicated that they needed to "ration" the parent partners since there were not enough parent partner FTEs to see all caregivers who might have benefited from their services.

Caregivers reported being very pleased with the parent partner services (96.5% satisfied) and over 90% indicated receiving a range of positive benefits from their parent partner, including emotional support, education about benefits of family therapy, and connection to other resources that facilitated participation in family therapy.

One aspect of the FTPE program that was a challenge to consistently implement across the six agencies and throughout the three-year project was the utilization of MI techniques by the parent partners. While assessment of MI fidelity was beyond the scope of this evaluation, program staff acknowledged difficulty providing motivational interviewing training and supervision, especially as new parent partners were hired over the three year project. Additional attention to and support of MI training, ongoing supervision, and MI fidelity assessment might contribute to further achievement of program objectives.

2. To increase overall participation in family therapy.

Based on a multi-year assessment of the provision of therapy services at the six programs with FTPE parent partner services, it appears that FTPE substantially increased overall family therapy participation. The total number of family therapy sessions increased from 5,294 pre-FTPE (FY 2014-15) to 7,159 at peak FTPE implementation (FY 2016-17), an increase of 35.2%. The average number of family therapy sessions per child in treatment also rose from 3.6 to 4.3 (a 19.4% increase). In contrast, while still the primary treatment modality during the same time period, individual therapy sessions dropped from 14,792 to 13,552 (a decrease of 8.4%). The reversal of the trend in FY 2017-18 toward greater family therapy and less individual therapy coincided with a reduction in parent partner FTE and service hours. This pattern actually provides additional evidence to the likely efficacy of the parent partner model in that some of the gains toward greater family therapy participation were diminished when the parent partner support was not as prevalent during the end of the FY 2017-18 period.

3. To increase the extent to which caregivers participate in family therapy at least twice per month.

To assess whether caregivers participated in at least two family therapy sessions per month, the overall number of treatment months for each fiscal year was calculated (i.e., the sum of the calendar months, per child, during which any individual or family therapy was received), and then the number of months that included at least two family therapy sessions was identified. The results of these analyses indicated that the percentage of treatment months with at least two family therapy sessions increased from 12.1% pre-FTPE in FY 2014-15 to 17.3% during peak FTPE implementation (FY 2016-17; a relative increase of 43.0%). For the four years included in the analyses, it appears that at least two therapy sessions of any type were received in approximately two-thirds (i.e., 66.6%) of all treatment months. These findings indicate that there were opportunities to increase the extent to which caregivers participated in family therapy at least twice per month, but that the FTPE program substantially increased the achievement of this treatment goal.

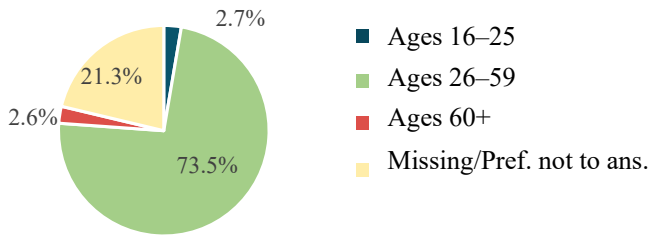
4. To engage underserved populations such as Latinos and African Americans.

The program successfully engaged the traditionally underserved Latino population by utilizing Spanish speaking parent partners. Based on the available demographic information, over half (51.0%) of the persons who received any parent partner services indicated that Spanish was their primary language and 71.0% indicated they were Hispanic. The success of engaging African American caregivers using the parent partner model was less clear, with about 4% of the persons who received any parent partner services indicating they were African American.

FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS

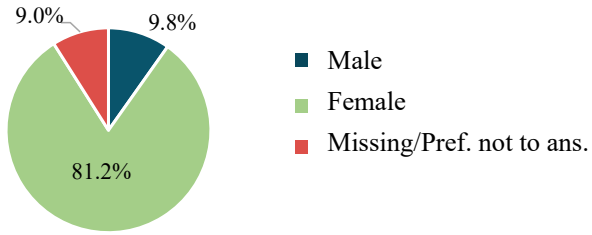
The following demographic data were collected from a caregiver self-report survey administered at the start of the FTPE program.[1]

AGE (N=1,081)



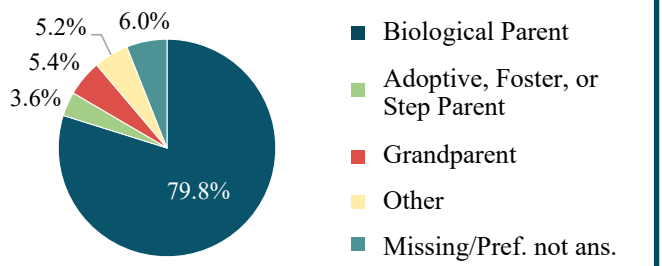
The majority of caregivers (73.5%) were between the ages of 26 and 59.

GENDER IDENTITY (N=1,081)



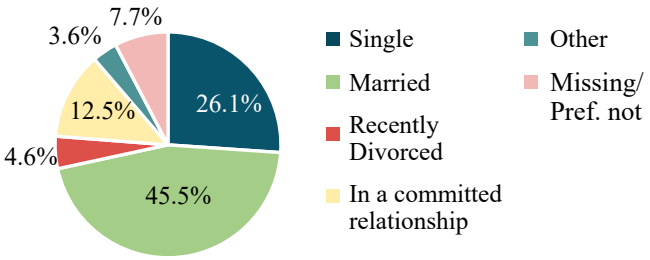
Most caregivers were female (81.2%).

RELATIONSHIP TO CHILD (N=1,081)



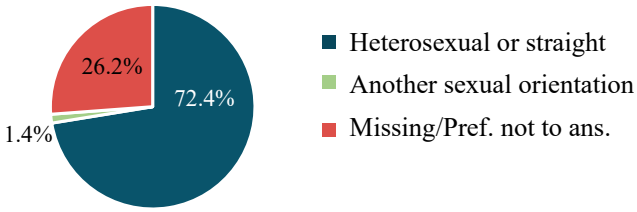
Most caregivers were a biological parent of the child receiving services (79.8%).

RELATIONSHIP STATUS (N=1,081)



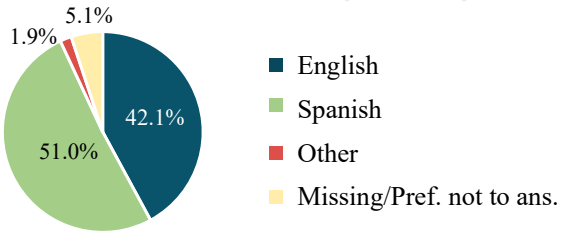
Almost half of the caregivers were married (45.5%), and about one-quarter (26.1%) were single.

SEXUAL ORIENTATION (N=1,081)



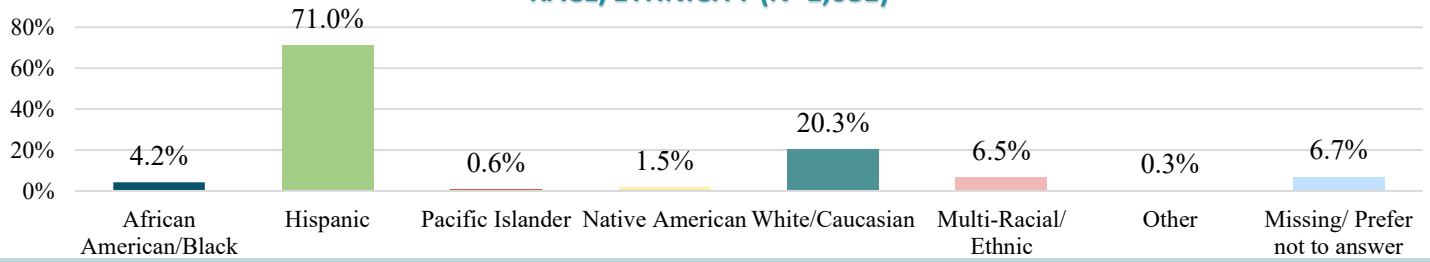
Most caregivers (72.4%) indicated they were heterosexual or straight.

PRIMARY LANGUAGE (N=1,081)



Spanish was the primary language for about half of the caregivers (51.0%).

RACE/ETHNICITY (N=1,081)

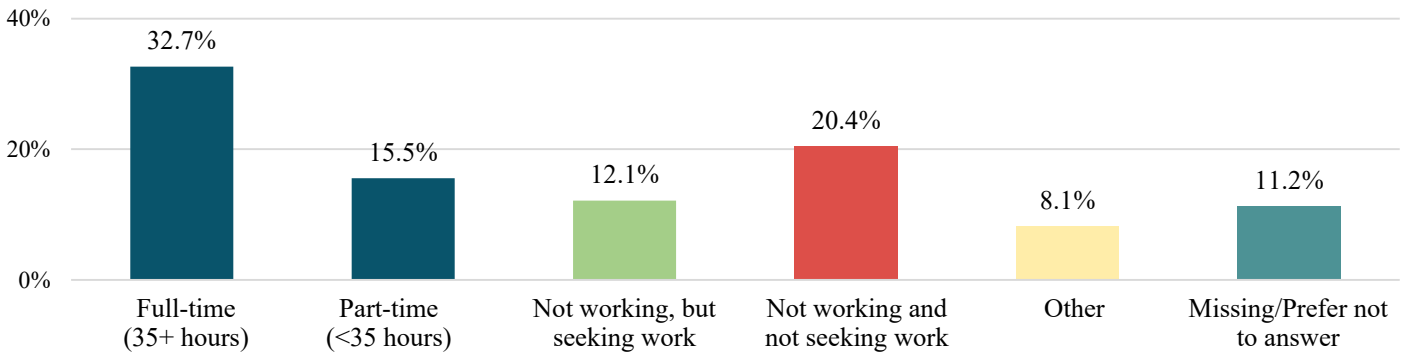


The majority of caregivers identified themselves as Hispanic (71.0%), and 20.3% identified as White. Totals may exceed 100% as caregivers were able to indicate more than one race/ethnicity.

[1] *Percentages may not total to 100% due to rounding.*

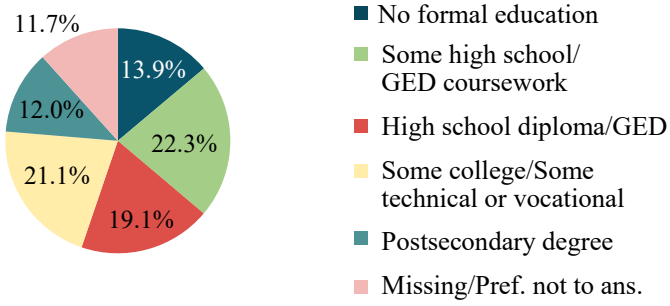
FAMILY THERAPY PARTICIPATION ENGAGEMENT CAREGIVER DEMOGRAPHICS (CONTINUED)

EMPLOYMENT STATUS (N=1,081)



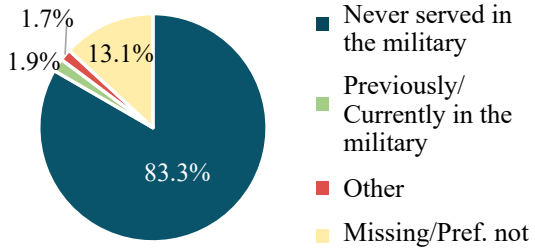
Approximately one-half of the caregivers indicated that they were employed (32.7% full-time and 15.5% part-time), and another 12.1% were not working, but seeking work (a higher unemployment rate than the 4-5% for San Diego County).

EDUCATION LEVEL (N=1,081)



Over half (55.3%), of the caregivers had a high school diploma/GED or a lower level of education.

MILITARY STATUS (N=1,081)



Very few caregivers (1.9%), indicated they had served in the military.

DISABILITY[2] STATUS (N=1,081)



Nearly 14% of caregivers had some type of non-SMI related disability.

TYPE OF DISABILITY (N=147)

Type	n	%
Communication	25	17.0
Mental (e.g., learning)	43	29.2
Physical	69	46.9
Chronic Health	51	34.7
Other	24	16.3

This table lists the type of disability indicated by caregivers. Totals may exceed 100% as caregivers could indicate more than one type of 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).*

OVERALL SERVICE UTILIZATION BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

Table 1 presents aggregated service utilization data from the six INN-12 FTPE programs during the four years that highlight service provision before FTPE implementation, during initial FTPE implementation, and after full FTPE implementation. The three types of services included in Table 1, individual therapy, family therapy, and parent partner sessions, are the most relevant to assessing FTPE program goals and operations. Overall, there was a slight increase in the total number of therapy sessions provided and children served across these years. The average number of therapy sessions each child received was fairly constant (approximately 9.5). There was initially a small decrease in the number of individual therapy sessions provided following the implementation of the FTPE program, but by FY 2017-18 individual sessions had increased slightly. The average number of individual therapy sessions received remained slightly lower in FY 2017-18 than in FY 2014-15 (i.e., 7.2 compared to 7.6 sessions per child).

TABLE 1. SERVICE UTILIZATION PATTERNS BEFORE, DURING, AND AFTER FTPE PROGRAM IMPLEMENTATION

	FY 2014-15* (7/1/14 - 6/30/15)	FY 2015-16** (7/1/15 - 6/30/16)	FY 2016-17 (7/1/16 - 6/30/17)	FY 2017-18 (7/1/17 - 6/30/18)
Any Therapy (Individual or Family) **Total Therapy Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**20,086** **2,099** **9.7**	**20,110** **2,144** **9.4**	**20,711** **2,183** **9.5**	**21,770** **2,313** **9.4**
Individual Therapy **Total Individual Therapy Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**14,792** **1,944** **7.6**	**13,502** **1,931** **7.0**	**13,552** **1,975** **6.9**	**15,155** **2,100** **7.2**
Family Therapy **Total Family Therapy Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**5,294** **1,480** **3.6**	**6,608** **1,598** **4.1**	**7,159** **1,656** **4.3**	**6,615** **1,689** **3.9**
Parent Partner Sessions **Total Parent Partner Sessions:** **Number of Unduplicated Children:** **Average Sessions per Child:**	**-**	**2,604** **596** **4.4**	**4,681** **1,015** **4.6**	**4,172** **890** **4.7**
Ratio of Family Therapy Sessions per each Individual Therapy Sessions	**0.36**	**0.49**	**0.53**	**0.44**
Total Parent Partner FTE / Parent Partner Billable Service Hours	**0 / 0**	**10.0 / 2,730**	**11.7 / 5,032**	**11.0 / 4,630**

** Pre-INN-12 FTPE implementation; ** INN-12 FTPE implemented during FY 2015-16*

The service utilization changes related to family therapy sessions were initially more pronounced. The number of family therapy sessions provided increased from 5,294 to 7,159 (an increase of 1,865 sessions [35.2%]), between FY 2014-15 and FY 2016-17, but then reduced to 6,615 in FY 2017-18. The number of children whose caregivers participated in at least one family therapy session increased throughout the entire four years from 1,480 to 1,689. The average number of family therapy sessions per child who received any family therapy sessions increased from 3.6 to 4.3 sessions (a 19.4% increase), before reducing again in FY 2017-18. These service utilization pattern changes resulted in the ratio between family and individual services delivered increasing from 0.36 family sessions per individual session delivered during FY 2014-15 to 0.53 during FY 2016-17 (a 47.2% increase). These overall shifts in utilization of individual and family therapy were consistent with the timing of FTPE program implementation. As the FTPE program was implemented during FY 2015-16 and parent partners began to encourage and support participation in family therapy, provision of family therapy services increased and individual therapy decreased. The decrease in family therapy during FY 2017-18 corresponded to a slight decrease in parent partner FTE and service hours.

Comparisons between the initial FTPE implementation year (FY 2015-16) and the first full year after FTPE implementation (FY 2016-17) highlight several key findings. First, parent partners dramatically increased the number of families they served during the first full year after FTPE implementation (from 596 families to 1,015 families; a 70.3% increase), but the average number of ses-sions received was fairly similar during both years (approximately 4.5 sessions). Secondly, while more family therapy sessions were provided during FY 2016-17 than in the prior year, the increase was less pronounced in absolute and relative terms (an increase of 551 sessions, [8.3% increase]) than demonstrated in the preceding year-over-year comparison (an increase of 1,314 sessions, [24.8% increase]). This substantial reduction in the rate of increase during the year in which FTPE was fully implemented and the slight decrease during FY 2017-18 (when there was a drop in FTEs) indicates that FY 2016-17 data represented the maximum impact of FTPE on the distribution of family and individual therapy. Achieving further increases in family therapy participation would likely require additional enhancements to the current strategy and resource level of the FTPE program.

MONTHLY SERVICE UTILIZATION BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

The assessment of the extent to which family therapy was provided at the six FTPE programs at the desired goal of at least two sessions per month required several steps. First, for each child receiving therapy services at one of the six FTPE programs, the number of calendar months during which the child received any therapy (individual or family) was summed to determine the total number of "treatment months" in a given fiscal year. For example, a child that received any type of therapy service (individual or family) in 5 different calendar months during a fiscal year would contribute the value of "5" to the number of "total treatment months" for that fiscal year. The "total treatment months" equals the total number of calendar months that children received any therapy services in a fiscal year. From the total treatment months, we can then assess the number (and percent) of the months during which the desired threshold of at least two sessions per month was achieved for any therapy and then separately for individual and family therapy. Table 2 presents the results of those analyses for the four years that span immediately before, during, and after full FTPE implementation. For comparison purposes, analyses related to a 1 session per month threshold are also included.

TABLE 2. MONTHLY SERVICE THRESHOLDS (I.E., TOTAL MONTHS OF TREATMENT REACHING EACH THRESHOLD)

	FY 2014-15* (Total Tx. Months=9,313)		FY 2015-16** (Total Tx. Months=9,096)		FY 2016-17 (Total Tx. Months=9,494)		FY 2017-18 (Total Tx. Months=10,197)	
Any Therapy (includes Individual or Family)	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
At least 1 session/month	100.0	9,313	100.0	9,096	100.0	9,494	100.0	10,197
At least 2 session/month	67.8	6,318	68.4	6,223	68.0	6,453	65.9	6,718
Individual Therapy								
At least 1 session/month	82.8	7,710	78.6	7,147	76.8	7,295	78.2	7,975
At least 2 session/month	48.4	4,507	44.8	4,073	43.2	4,099	45.1	4,596
Family Therapy								
At least 1 session/month	40.2	3,744	49.5	4,503	51.1	4,850	45.0	4,591
At least 2 session/month	12.1	1,126	16.7	1,520	17.3	1,640	14.6	1,485

** Pre-INN-12 FTPE implementation; ** INN-12 FTPE implemented during FY 2015-16*

The findings from Table 2 reveal that across the four years examined, at least two therapy sessions were received in approximately two-thirds of the months during which any therapy sessions were received. Given that a treatment episode might start or end part-way through a calendar month and that some months might be affected by disruptions to intended treatment plans, it is not realistic to expect that 100% of treatment months would attain the desired threshold of two therapy session per month. Therefore, based on the results presented in Table 2, it appears that receiving at least two therapy sessions in about 66.6% of all treatment months represents a "real world" level of service intensity for these programs.

For individual therapy, close to half (48.4%) of the treatment months met the threshold of at least two sessions per month. There was initially a slight downward trend across the years that reversed itself in FY 2017-18. In contrast, family therapy demonstrated an upward trend in the number and percent of months that achieved two sessions per month during the early years of the FTPE program, which then turned slightly downward during FY 2017-18. The percentage of treatment months with at least two family thera-py sessions increased from 12.1% to 17.3% (a relative increase of 43.0%). Similarly, while 40.2% of treatment months included at least 1 family therapy session during FY 2014-15, slightly more than half (51.1%), met this threshold by FY 2016-17 (a relative increase of 27.1%).

Most of the year-over-year changes occurred between FY 2014-15 (i.e., before FTPE implementation) and FY 2015-16 (i.e., during initial FTPE implementation). Slight changes continued during FY 2016-17, before changing direction during FY 2017-18. This change of direction during FY 2017-18 coincided with a slight reduction in parent partner FTE and service hours. The changes shown in Table 2 for individual and family therapy are consistent with the direction of the expected service utilization shifts following the implementation of the FTPE program and the corresponding increase in the provision of parent partner visits.

SERVICE UTILIZATION DISTRIBUTION BEFORE, DURING, AND AFTER FTPE IMPLEMENTATION

Table 3 presents the distribution of total family therapy and parent partner sessions received during child treatment episodes that completed during each of four years of interest. A treatment episode was defined as a course of treatment for a child that contained at least one individual or family treatment session. Consistent with prior analyses, the results indicated a shift towards greater utilization of family therapy following the implementation of the FTPE programs. This is most evident when comparing pre FTPE (FY 2014-15) to "peak" FTPE implementation (FY 2016-17). Between these two time periods the percentage of episodes with no family therapy visits decreased from 26.7% to 20.7% (a relative decrease of 22.5%) and the percentage of episodes with at least six family therapy visits increased from 15.6% to 27.1% (a relative increase of 73.7%). The pattern reversed to some extent in FY 2017-18 as there was a slight reduction of parent partner FTE and service hours. Approximately half of all treatment episodes included at least one visit with a parent partner following full FTPE implementation in FY 2016-17 and about 25-30% had at least three parent partner visits.

TABLE 3. TOTAL SERVICE UTILIZATION THRESHOLDS FOR COMPLETED TREATMENT EPISODES

	FY 2014-15* (Total Completed Treatment Episodes=1,563)		FY 2015-16** (Total Completed Treatment Episodes=1,983)		FY 2016-17 (Total Completed Treatment Episodes=1,660)		FY 2017-18 (Total Completed Treatment Episodes=1,993)	
Family Therapy Sessions	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**
None	26.7%	417	25.3%	501	20.7%	344	23.2%	463
1 to 5	57.7%	902	56.8%	1,126	52.2%	866	54.2%	1080
6 to 11	13.2%	206	14.8%	294	20.7%	343	16.2%	322
12+	2.4%	38	3.1%	62	6.4%	107	6.4%	128
Parent Partner Sessions								
None	100%	1,563	85.4%	1,694	51.6%	857	50.9%	1014
1 to 2	-	-	6.9%	136	22.7%	376	19.1%	381
3 to 5	-	-	4.0%	79	12.0%	200	12.8%	256
6+	-	-	3.7%	74	13.7%	227	17.2%	342

** Pre-INN-12 FTPE implementation; ** INN-12 FTPE implemented during FY 2015-16*

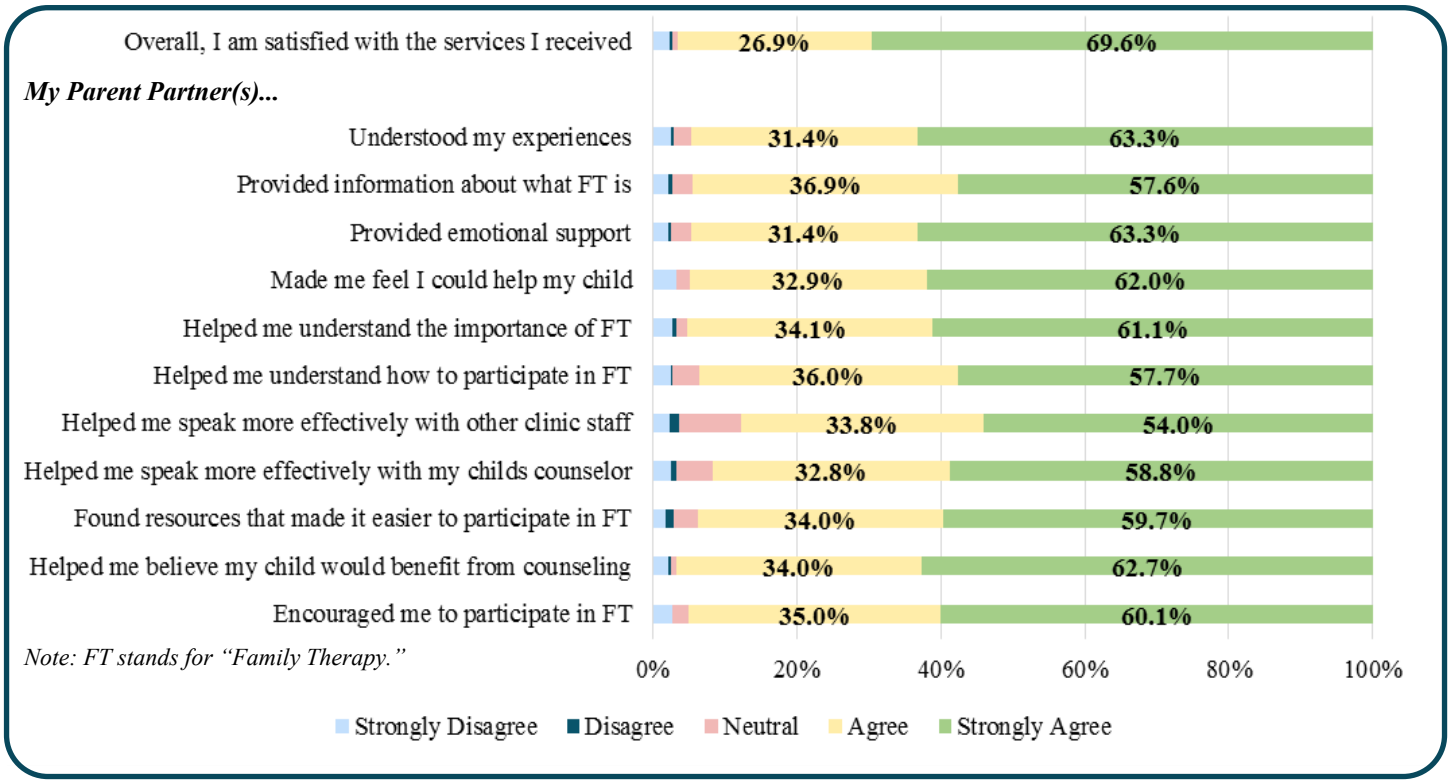
SERVICE AREAS OF PROGRAMS PARTICIPATING IN FTPE

Program	*Service Area*
Vista Hill Foundation	**Escondido and North Inland; Escondido, Borrego Springs, Julian, Ramona, Spencer, & Warner School Districts**
North County Lifeline, Inc	**North County; Oceanside & Vista Unified School Districts**
Family Health Centers	**Central & East Region; La Mesa-Spring Valley School Districts**
Community Research Foundation: Crossroads	**Alpine, Jamul-Dulzura, & Mountain Empire School Districts**
Community Research Foundation: Nueva Vista	**South Region; Chula Vista Elementary, National, and Sweetwater Union School Districts**
Community Research Foundation: MAST	**San Diego County Office of Education, Juvenile Court and Community Schools**

CAREGIVER SATISFACTION AND FEEDBACK REGARDING PARENT PARTNER SERVICES

At the conclusion of receiving short-term parent partner support services, caregivers were asked about their experiences with the parent partners. In particular, caregivers were asked about their satisfaction with the parent partner services and their perceptions of the parent partner(s). Based on the results presented in Figure 1 (n=370), caregivers were typically very satisfied with the parent partner services they received (96.5% indicated agreement or strong agreement with the satisfaction statement). Overall, the vast majority of caregivers agreed or strongly agreed that they received each type of support listed in Figure 1 from their parent partners. The peer-support aspect of the parent partners likely contributed to the fact that almost all caregivers indicated (94.7% agreed or strongly agreed) that the parent partners "understood their experiences."

FIGURE 1. CAREGIVER ASSESSMENT OF PARENT PARTNER SERVICES



QUALITATIVE CAREGIVER FEEDBACK REGARDING PARENT PARTNER SERVICES

An analyses of the open-ended qualitative responses that caregivers provided about their experiences with parent partners highlighted that emotional support was perceived as one of the most important services provided by the parent partners. Caregivers also emphasized the parenting support and education they received from parent partners as well as the resources and referrals specifically related to their unique caregiver needs (e.g., job assistance). Additionally, when asked how the parent partners could have served them better, a common caregiver response was to have had more time and interaction with the parent partners.

Overall, caregivers reported high levels of satisfaction with their parent partners and that they typically received a wide range of emotional, educational, and tangible resources from the parent partners to facilitate family therapy participation. These findings suggest a high level of caregiver acceptability of and interest in the parent partner role within the CYF treatment teams.

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 FTPE. The following represent key findings identified via qualitative analyses of the open-ended staff survey responses from the three annual surveys. response themes.

1. *Major program goals identified by respondents:*
   a. Increasing caregiver participation in family therapy and in treatment more generally
   b. Improving child and family outcomes
   c. Providing education and advocacy for families
   d. Increase case management/support services utilization by decreasing barriers
   e. Increase caregiver participation in Parent Partner services
   f. Developing rapport and increasing engagement with parents and family
   g. Providing education to increase engagement in family therapy
2. *Factors that helped the FTPE program achieve these goals:*
   a. The services that the Parent Partners provided (e.g., support, education, resources, working on obstacles)
   b. The training Parent Partners received on Motivational Interviewing and other important topics
   c. Sharing the Parent Partners' lived experience
   d. Availability of flexible scheduling, mobile or home-based options, and bilingual Parent Partners
   e. The collaborative nature of the team approach to care (which included Parent Partners)
   f. The use of both Parent Partners and other program supports/services
3. *Specific challenges to reaching the program goals:*
   a. Low caregiver motivation/caregiver ambivalence about the importance of therapy
   b. Lack of resources (e.g., transportation, housing, time, availability)
   c. Caregivers' personal challenges (e.g., low literacy, substance abuse, mental illness, family dynamic/relationships, etc.)
   d. Program barriers and Parent Partner factors (e.g., staff turnover, insufficient hours, paperwork demands, Cerner, program availability, County demands, trainings, turnover, etc.)
   e. The general stigma of communicating about mental illness and being in therapy
4. *Parent Partner roles/activities:*
   a. Providing emotional support to the caregivers
   b. Teaching caregivers about the importance of being involved in their child's treatment
   c. Working to reduce family barriers by helping provide resources
   d. Building rapport with caregivers
   e. Identifying caregiver needs and promoting participation in needed services
   f. Sharing personal experiences
   g. Engaging in community outreach
5. *Primary recommendations for how to successfully develop and implement a Parent Partner type program:*
   a. Hire a sufficient number of Parent Partners who fit in with population, are bilingual and diverse, and are culturally competent
   b. Connect with the caregiver consistently and early on in the program and facilitate Parent Partner connection with clients from the beginning and emphasize their value to staff
   c. Develop rapport between caregiver, Parent Partner, and therapist/treatment team
   d. Offer training opportunities for staff & parent partners
   e. Provide education to caregivers about topics like the benefits of family therapy and what to expect in treatment
   f. Consider individual caregiver factors in engaging families, not everyone will engage
   g. Additional programmatic support (e.g., recruit more Parent Partners and case managers, increased community outreach)

KEY PROGRAM IMPLEMENTATION AND OPERATIONAL "LEARNINGS"

1. Primary roles of the parent partner

- Key parent partners roles included providing: emotional support, education about value of family therapy, encouragement/ motivation to participate in family therapy, and resources to remove/reduce barriers to participation in family therapy.
- While parent partner roles may overlap that of a case manager, the parent partner was intended to focus specifically on issues that had a direct influence on participation in family therapy.

2. Utilization of parent partners

- Some programs tried to include at least one parent partner visit at the start of treatment to introduce the parent partners in-person to the caregivers in person and to assess for motivational and/or tangible barriers to family therapy participation.
- For some caregivers not initially engaging in family therapy, multiple parent partner visits may be needed to build trust and start to remove motivational and/or tangible barriers to family therapy participation.
- Not enough parent partners were available to cover all families, so programs regularly evaluated family situations and tried to end parent partner services when no longer determined to be needed to free up parent partners to serve other families.
- With agency support and encouragement (e.g., allowing time for provider planning meetings), parent partners played an important role in a team-based, collaborative care model in which therapists, case managers, and parent partners communicated with each other about how best to provide treatment, encouragement, and other support services to children and their caregivers.

3. Importance of having parent partners who can establish a connection with caregivers

- Having parent partners who spoke Spanish was essential to meeting the service needs of the large population of San Diego County residents who primarily speak Spanish.
- The "lived experience" or peer support model in which parent partners were required to have personal experience with the children's behavioral health system was perceived to be an important component leading to successful caregiver engagement.
- Where possible, helpful to have multiple parent partners with different backgrounds and characteristics to help connect with and support a diverse caregiver population (e.g., sometimes the therapist is substantially younger than the caregiver, so parent partners who are similar in age can help bridge any perceived gap in understanding).
- Motivational Interviewing and other trainings were crucial for equipping parent partners with the skills and tools they needed to connect with and support caregivers.

4. Program/staffing challenges

- The "lived experience" requirement, unique skill sets needed, and salary limitations made it challenging to identify and hire parent partners.
- It was challenging and expensive to provide ongoing opportunities for motivational interviewing and other trainings for newly hired parent partners following staff turnover.
- The ability to provide childcare (onsite or with an offsite-partner) was identified by FTPE staff as one of the most important resources that needed to be added to the parent partner model to further increase participation in family therapy.

5. Caregiver challenges

- Even with parent partner supports, it was often still challenging for caregivers to participate in family therapy. Caregivers served by parent partners often faced many challenges to participating in family therapy, such as needs for child care, transportation, food assistance, employment, and other supportive services.

FUTURE DIRECTIONS

Based on the promising outcomes from the MHSA funded INN-12 FTPE program, BHS has continued to support the structure and operations of FTPE (i.e., the parent partner model) at the initial six programs by using MHSA Community Services and Support (CSS)/Full-Service Partnerships (FSP) funding.

For additional information about the INN–12 Family Therapy Participation Engagement program and/or this report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

FAITH BASED INITIATIVE (INNOVATIONS-13): #1 FAITH BASED ACADEMY

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Faith Based Academy is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) that comprises the County of San Diego Health and Human Services Agency's Behavioral Health Service (BHS) Faith Based Initiative. The overall goals of the Faith Based Initiative include improved communication and collaboration between the BHS system, local faith leaders, and the congregations and communities they serve. These efforts are 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 include 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 is the explicit emphasis on "cross education" of both faith leaders and behavioral health providers such that each group of participants is expected to develop a better understanding of the strengths and resources of the other. This two-way education is intended to improve relationships and reduce uncertainty and stigma between faith communities and behavioral health providers. Participants interested in sharing the information they learned are connected with another faith based initiative organization that utilizes 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.

- During FY 2017-18, a total of 170 persons participated in a Faith Based Academy.
- Most (74.1%) participants were between the ages of 26-59 and the majority were female (80%). Slightly over half (51.2%) identified as Hispanic, with 33.5% indicating Spanish as their primary preferred language.
- Faith leaders and behavioral health providers both reported favorably about the information learned and confidence gained 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.

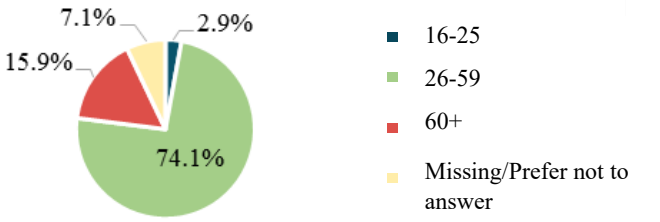
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) develop more opportunities for faith leaders and behavioral health providers to interact during and after Academy participation, 2) identify additional mechanisms for spreading awareness about and recruitment for the Academies among both faith leaders and behavioral health providers, 3) attempt to increase male participation in the Academies, 4) continued need for communication and coordination with other Faith Based Initiative partners (e.g., Community Education providers).

PARTICIPANT DEMOGRAPHICS

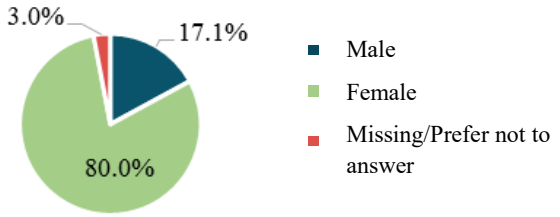
The following self-report demographic data were collected from Academy participants.[1]

AGE (N=170)



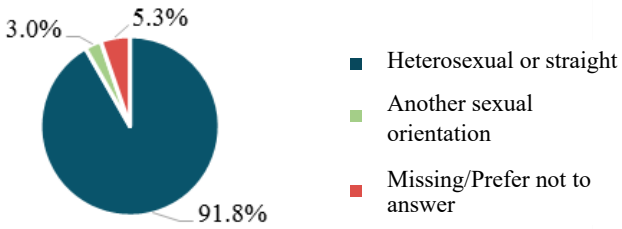
The majority (74.1%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=170)



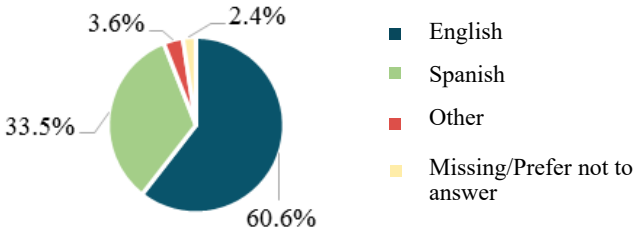
Over three-quarters (80%) of participants were female.

SEXUAL ORIENTATION (N=170)



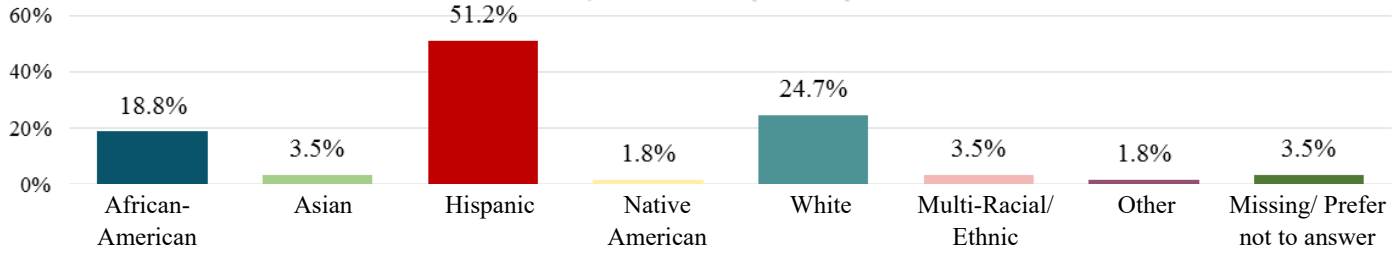
Almost all participants (91.8%) indicated a heterosexual or straight sexual orientation.

PRIMARY LANGUAGE (N=170)



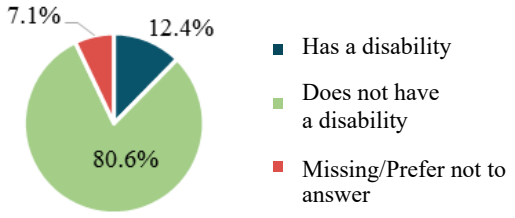
About one-third (33.5%) of participants spoke Spanish as their primary preferred language.

RACE/ETHNICITY (N=170)



About half (51.2%) of participants identified as Hispanic and 24.7% of participants identified as White. Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[2] STATUS (N=170)



Around twelve percent of participants reported having some type of non-SMI related disability.

The majority (94.7%) of participants had never served in the military.

TYPE OF DISABILITY (N=21)

Type	n	%
Communication	3	14.3
Mental (e.g., learning, developmental)	8	38.1
Physical	4	19.0
Chronic Health	5	23.8
Other	5	23.8

The table above describes the types of disabilities participants reported. 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).

POST-TRAINING SURVEY RESULTS

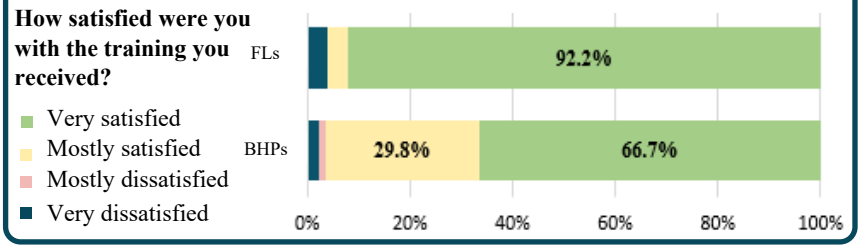
A total of 171 persons completed a Faith Based Academy training and a post-training survey (82 faith leaders and 89 behavioral health providers). As shown in Table 1, while the ratings regarding the content and impact of the trainings were generally favorable, the mean score differences between the two 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 (n=82): "As a result of this training…"	*Faith Leaders* Means	*Behavioral Health Providers* Means	**Behavioral Health Providers (n=89):** "As a result of this training…"
I know where to get help regarding mental health conditions and wellness for children/adolescents	4.5	4.3	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.	4.5	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	4.5	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	4.5	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	4.6	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	4.6	4.4	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	4.6	4.2	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	4.6	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	4.6	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	4.7	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 (92.2%) of Faith Leaders reporting being "very satisfied" with the training they received compared to about two-thirds (66.7%) 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 Behavioral Health Providers (BHPs) or Faith Leaders (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?"

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 are helpful
      2. Significant interest in exploring other mechanisms such as regular "alumni" events, communication/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, there was 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

ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18 (6/30/2018), 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 11 respondents from the 17 persons invited to participate in the survey, a response rate of 65%. 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. For each item, the survey responses are listed in order of declining prevalence (i.e., most frequently provided responses are listed first).

1. *The major program goals identified by staff:*
    a. Facilitate connections between mental health service providers and community clergy
    b. Educate faith leaders in the community 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. Educate faith community about mental health and substance abuse

2. *Factors that helped the program achieve goals:*
    a. The interactive nature and participant engagement in the trainings
    b. Well written curriculum with plenty of mental health information
    c. Contributors bringing diverse expertise and experiences to the program and presentations
    d. The frequency of meetings
    e. Excellent program staff
    f. The quality of the presentations and the information provided
    g. The networking opportunities that the trainings provide

3. *Factors that inhibited the program from achieving goals:*
    a. Time challenges/difficulties fitting necessary material into available time for presentations
    b. The faith-based organizations that participated did not represent the diversity of religions practiced in San Diego County
    c. Lack of buy-in about spirituality and mental health services
    d. Challenges in understanding the importance of learning about each other

4. *Recommendations to help the program better achieve goals*:
    a. More preparation time for locating personnel & developing the curriculum
    b. Increase outreach efforts made to places of worship/agencies from a wide variety of religions
    c. Offer workshops to the public for wider access
    d. Increase outreach efforts made to engage faith-based leaders and mental health providers
    e. Provide the opportunity for presenters to change their topics from year to year
    f. Add additional years to the program
    g. Provide more time for each training
    h. Survey participants about their availability to increase attendance
    i. Offer continuing education opportunities

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" funded 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

ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

6. *Key strengths of this program:*
    a. Experienced contributors/presenters
    b. Successful efforts to reduce the divide between faith-based and mental health based world-views
    c. Sharing resources
    d. Enthusiasm of the participants
    e. Addresses community needs
7. *Key "innovations" making this program unique:*
    a. The facilitators and panelists
    b. That the goal is education and not clinical or case management
    c. Presenters sharing their personal experiences
    d. The Resource Guide
    e. Participant engagement in exercises
    f. The quality of the presentations
    g. The commitment level of participants
    h. Different types of individuals are welcomed and community team building is encouraged
8. *Successful strategies to identify and recruit faith community members:*
    a. Trying out new workshop times during the week to improve attendance
    b. Using people who took the training to "advertise" their experience
    c. One day of training that includes both faith-based and behavioral health providers
    d. Having groups meet at the end of the year to share challenges/successes
    e. Personal referrals
    f. Stipends
9. *Successful strategies to identify and recruit behavioral health providers*:
    a. Behavioral health providers are easy to recruit because they are interested in this type of training
    b. Stipend
    c. Information about the value and purpose of the certification
    d. Flexible scheduling
10. *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. Recruitment can be hard but do not give up
    d. Simplify the curriculum
    e. Have lots of resources
    f. Use presenters with lived experience
11. *Strategies used the past year to increase interactions between faith leaders and behavioral health providers*:
    a. Providing opportunities for the cohort to network with each other
    b. Interactive activities
    c. Incentives
    d. Meals (e.g., breakfasts, luncheons)
    e. Conferences with a mental health professional
12. *Additional strategies to increase interactions between faith leaders and behavioral health providers:*
    a. More social events
    b. More opportunities for participants to share their stories/testimonials
    c. Additional training opportunities
    d. More community panels or conferences
    e. Pair together the passionate participants

KEY YEAR 1 PROGRAM "LEARNINGS"

1. 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.
2. Existing community partners/networks helped facilitate and provided credibility to the curriculum development process.
3. It is challenging to fit the required and desired content into a reasonable length for Academy (e.g., 12-15 hours of training).
4. Need to balance presentation of enough content to educate attendees on each topic while also allowing sufficient time for attendees to engage with each other and discuss the material.
5. Scheduling is often limited by availability of targeted faith leaders (typically Saturdays) and behavioral health providers (typically weekdays).
6. Finding available and qualified presenters can be challenging, but it is 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.
7. 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.
8. Although the Faith Based Academies were open to persons from all faiths, content language was more oriented towards the religious perspectives common among the initial target populations the initial target populations (i.e., Latinos and African Americans). Explicit acknowledgment of this orientation and expressed openness to other faiths may facilitate comfort with core material by members of different faiths.
9. Important to keep class size small enough to allow for active discussion/participation (target = 20 participants).
10. Good coordination and communication is needed with the programs providing the Community Education component of the Faith Based Initiative to facilitate identification and recruitment of appropriate "Faith Champions".
11. 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.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. 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).
2. 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.
3. 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.
4. 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.
5. Presenters acting as facilitators rather than lecturers/teachers allowed participants to demonstrate their own expertise.
6. Team building exercises helped in getting faith leaders and behavioral health providers to work together and get to know one another.
7. 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, etc).

YEAR 2 PROGRAM CHANGES

There were no fundamental changes to the INN-13 Faith Based Initiative #1, Faith Based Academy, during Year 2 that differed substantially 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.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Create more opportunities for faith leaders and behavioral health providers to interact with each other.
    a. *Programs have created a range of post-Academy events (e.g., breakfast/luncheons with speakers and other "alumni" gatherings) to promote continued interaction and engagement between faith leaders and behavioral health providers.*
2. Adapt content/presentation material to improve fit with San Diego's diverse faith communities.
    a. *Presentation content with a more inclusive basis has been developed and successfully utilized.*
    b. *When presentation content that has not yet been modified to be inclusive of San Diego's many faiths is utilized, efforts to generalize core meanings to other faith contexts are provided.*
3. Increase outreach activities to key faith leaders (e.g., clergy, pastors, rabbis, imams).
    a. *Networking through personal relationships of Academy staff, utilization of Academy alumni as recruitment "ambassadors", participation in ongoing community/faith meetings, and distribution of physical and electronic fliers related to upcoming Academies are all used to expand awareness of the Academies among faith leaders and other potential participants.*
4. Improve communication and coordination with other Faith Based Initiative partners (e.g., Community Education provider).
    a. *Meetings between the Faith Based Initiative program partners has increased communication and coordination, and representatives from the Community Education program often attend the Academy to help identify potential "champions" who may want to engage in further community outreach activities.*

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Develop more opportunities for faith leaders and behavioral health providers to interact during and after Academy participation (e.g., incorporate "partnership shadowing", organize get-togethers outside of class, creatively utilize emails/blogs to facilitate ongoing dialogue about key issues, encourage behavioral health providers to visit a place of worship or attend a service with one of the faith leaders, etc.) .
2. Identify additional mechanisms for spreading awareness about and recruitment for the Academies among both faith leaders and behavioral health providers.
3. Work on increasing male participation in the Academies.
4. Continued need for communication and coordination with other Faith Based Initiative partners (e.g., Community Education provider).

For additional information about the INN–13 Faith Based Initiative #1, Faith Based Academy and/or this annual report, please contact:
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FAITH BASED INITIATIVE (INNOVATIONS-13): #2 COMMUNITY EDUCATION

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

Community Education is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprise 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 include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally under-served persons, particularly within African-American and Latino communities. The specific objectives of the Community Education program include 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 the Community Education program is utilization of graduates of 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, supports 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 are 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 helps develop relationships with community faith leaders to expand opportunities and locations for delivering the educational workshops. These activities are intended to reduce behavioral health stigma in faith communities and increase knowledge about available resources.

- During FY 2017-18, a total of 866 persons attended 42 different Community Education behavioral health-related workshops, a substantial increase from the prior year (n=295).
- Compared to the prior year, Central Region presentations substantially increased attendance by males (24.1% to 42.3%), Hispanics (13.6% to 25.4%), and older adults (16.6% to 34.1%)
- Across both regions, over 40% of attendees (41.9%) indicated Spanish as their primary language.
- These changes in attendee demographic profiles were facilitated, in part, by greater utilization of community centers as locations to hold community presentations.
- Based on post-training survey responses, most attendees (91%) agreed or strongly agreed that the training increased their knowledge about relevant behavioral health issues and available resources. Of particular interest, the majority (86.2%) agreed or strongly agreed that they were committed to increasing awareness in their community.
- 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.

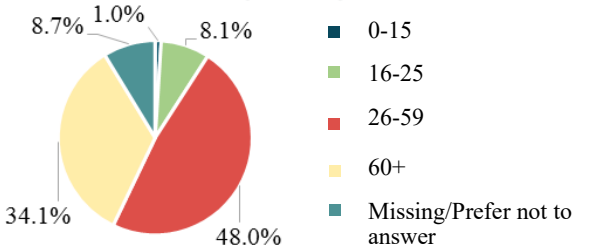
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify new locations for community presentations based on recommendations/connections of the Faith Academy participants, 2) establish more relationships with other community organizations (e.g., Suicide Prevention Council) and behavioral health systems, and 3) include an American Sign Language signer for presentations where possible.

PARTICIPANT DEMOGRAPHICS - CENTRAL REGION PRESENTATIONS

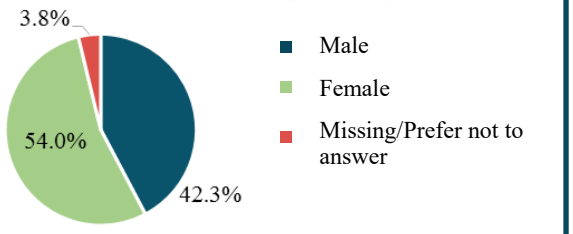
The following demographic data were collected from an audience self-report survey administered at the community presentations.[1]

AGE (N=504)



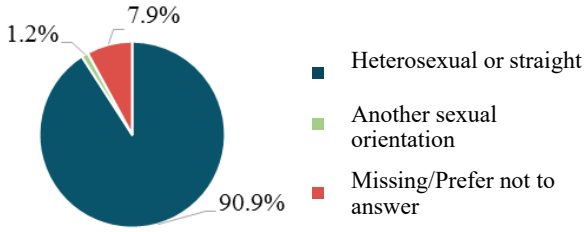
34.1% of participants were age 60 or above., as compared to the prior year in which only 16.6% were age 60 or above.

GENDER IDENTITY (N=504)



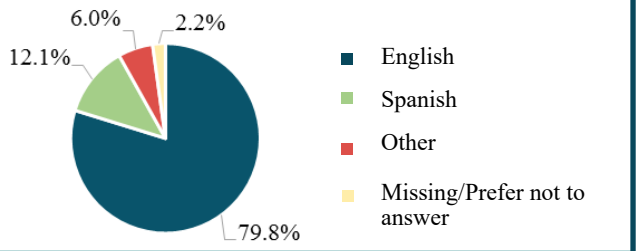
Fifty-four percent of participants identified as female.

SEXUAL ORIENTATION (N=504)



Almost all participants (90.9%) indicated they were hetero-sexual or straight.

PRIMARY LANGUAGE (N=504)



Most participants (79.8%) spoke English as their primary preferred language.

RACE/ETHNICITY (N=504)

	n	%
African-American	287	56.9
Hispanic	128	25.4
White	49	9.7
Multi-Racial/ Ethnic	22	4.4
Other	38	7.5
Missing/ Prefer not to answer	25	5.4

Over half of participants (56.9%) identified as African-American. Totals may exceed 100% since attendees were able to indicate more than one race/ethnicity.

TYPE OF DISABILITY[2] (N=103)

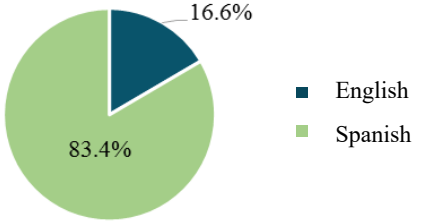
	n	%
Communication	38	36.9
Mental (e.g., learning, developmental)	18	17.5
Physical	31	30.1
Chronic Health	36	34.9
Other	31	30.1

Twenty percent of the attendees (n=103) indicated having a non-SMI related disability. The sum of the disability types may exceed 100% since attendees could indicate more than one.

PARTICIPANT DEMOGRAPHICS - NORTH INLAND REGION PRESENTATIONS

Primary language was the only demographic information collected from attendees of North Inland region presentations during FY 2017-18.

PRIMARY LANGUAGE (N=362)



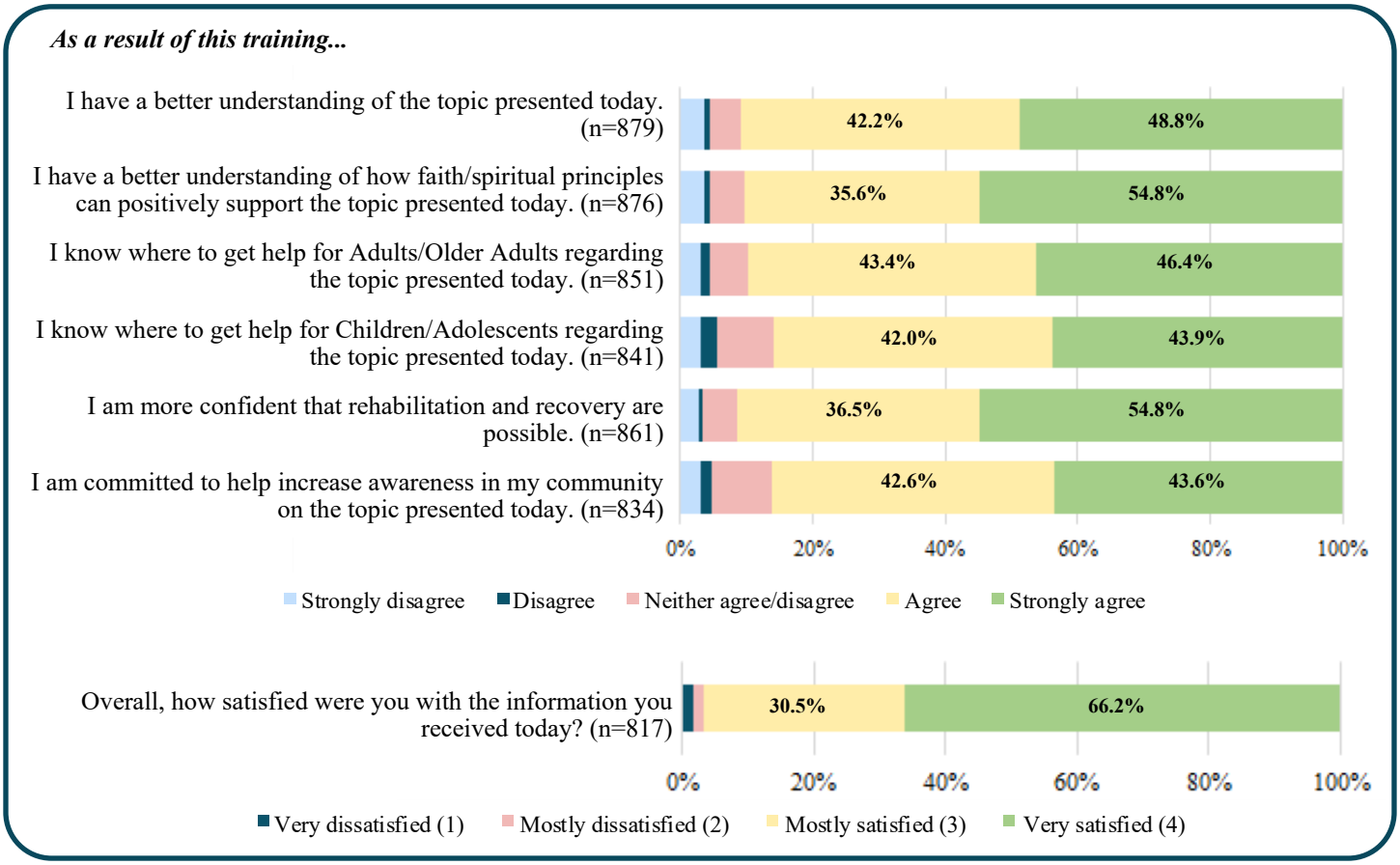
Most participants (83.4%) spoke Spanish as their primary preferred language.

[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).

POST-TRAINING SURVEY RESULTS

During FY 2017-18, the programs provided a total of 42 different behavioral health-related Community Education presentations. As shown in Figure 1, the vast majority of community attendees (85% or more) at educational presentations agreed or strongly agreed that as the 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 (86.2%) agreed or strongly agreed that they were committed to increasing awareness within their community. This provides some evidence to suggest 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), which is then leading to attendees of those presentations indicating 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 (30.5% were mostly satisfied and 66.2% were very satisfied).

FIGURE 1. COMMUNITY EDUCATION POST-PRESENTATION OUTCOMES AND SATISFACTION



ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18 (6/30/2018), 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 nine respondents from the 16 persons invited to participate in the survey (56% 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. For each item, the survey responses are listed in order of declining prevalence (i.e., most frequently provided responses are listed first).

1. The major program goals identified by staff:

a. Provide the community with resources
b. Raise awareness on mental health matters in Latino and African American communities
c. Emphasize the role of faith in mental health recovery
d. Educate the community about mental health issues
e. Increase the awareness of mental health while decreasing stigma
f. Bridge the gap between faith and mental health issues
g. Encourage people to use resources without fear
h. Ensure equality of education between Latino and African American communities
i. Identify community resources
j. Increase rapport between faith leaders and behavioral health providers
k. Increase understanding of professional help
l. Provide free mental health education

2. Factors that helped the program achieve goals:

a. Facilitator aspects (e.g., interactive, knowledgeable about topics and accessing resources)
b. Resources (e.g., list of counseling services, an app that has resource recommendations)
c. Presentation aspects (e.g., varied topics, good information)
d. Staff aspects (e.g., preparedness, flexibility, adaptability, patience)
e. The relationships within the community
f. The lived experience of presenters
g. Meeting the community in their local area
h. San Diego County helping to extend educational resources
i. The quality of the collaboration of all involved
j. The positive reputation of NAMI
k. The marketing and promotion efforts

3. Factors that inhibited the program from achieving goals:

a. Time constraints (time of presentations, time allowed for project, time for paperwork)
b. Stigma about mental health illness and accessing mental health services
c. Not making plans or collaborating with the other related faith-based "Innovation" funded programs
d. Not having enough presenters for the Spanish-speaking community
e. Lack of communication with the faith community
f. Slow/inefficient marketing that was not highly visible
g. Limited church hours (i.e., it made coordination difficult)
h. Lack of trust by the faith communities

4. Recommendations to help the program better achieve goals:

a. Increase marketing and hire a professional marketing service
b. Increase interagency communication (e.g., between COR, NAMI, and SD County, and also between Task Orders)
c. Increase funding (for staff hours, printing, office supplies, etc.)
d. Simplify paperwork
e. Have more Spanish-speaking staff & facilitators
f. Target the information more directly at the immediate needs of recipients
g. Do not limit facilitators to only Task Order 1 graduates
h. Target younger audiences

ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

5. *Desired supports, tools, and/or trainings for the program:*
    a. Resource information for emergency assistance
    b. More funding
    c. Expand to more areas of the local community
    d. Increased participation in the Faith breakfast
    e. Public speaking training
6. *Key strengths of the program:*
    a. Strong facilitators and staff
    b. Involvement of the Faith community
    c. The support to the community it provides
    d. The community relationships it produces
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 others
    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. Reviewing organizational listings
    g. Encouraging referrals
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. Relatability of presenters
    j. Timeliness of presentations
    k. Time after presentations for attendees to mingle
10. *Primary impacts/outcomes of your activities within the community:*
    a. Mental illness stigma reduction
    b. Increased mental health awareness & education
    c. Increased hope about mental health recovery
    d. Faith entities having more knowledge about mental health
    e. Increased community openness to address mental health
    f. Awareness of the importance in connecting Faith and mental health
    g. Rapport between Faith leaders and mental health providers
    h. Participants utilizing resources provided

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Need to develop trusting relationships with faith leaders in order to gain access to congregations.
2. Managing program logistics requires substantial time (e.g., finding venues, facilitating marketing/outreach, facility preparation).
3. Existing credibility and relationships in the community are crucial for program success.
4. Presenters need to be knowledgeable and good communicators.
5. Program relies on dedicated and passionate staff committed to achieve program objectives.
6. Role plays are effective tools for teaching about commonly diagnosed mental illnesses.
7. Importance of meeting community members in the community (e.g., go to where they already are).
8. Potentially sensitive or uncomfortable topics requires respectful and supportive communication.
9. Often difficult to find appropriate, local resources for community member referrals.
10. 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).

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Working with local community centers increased the number of presentation opportunities.
2. Community centers can facilitate access to priority populations such as males and Latinos.
3. 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.
4. When possible it is beneficial to match experienced and new presenters together to support ongoing presenter training.
5. 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.
6. 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).
7. 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.
8. 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.
9. 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.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #2, Community Education, during Year 2 that differed substantially from the initial program design.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Explore potential for adding a post-presentation "follow-up" component in which someone can contact audience members who request additional information/help with connecting to resources.
   a. *While a structured "follow-up" component was determined to be beyond the scope of this initiative, presentation staff continued to provide attendees with relevant referral information as needed (e.g., programs distributed resource packets at the presentations that contain information about other relevant community programs).*
2. Identify more Spanish speaking staff/facilitators.
   a. *Additional Spanish speaking program staff were added, which contributed to numerous Spanish language presentations (as evidenced by over 40% of all attendees during FY 2017-18 who indicated Spanish as their primary language).*
3. Expand marketing/outreach for community presentations (e.g., churches, schools, military bases).
   a. *Marketing/outreach activities expanded during FY 2017-18 to include community centers. Schools have expressed interest in presentations, but they have not yet been utilized as locations for these presentations.*
4. Continue to find additional venues for presentations.
   a. *Networking and personal connections were used to find additional venues for presentations.*
   b. *Connections with community centers increased the number of venues for presentations.*
5. Increase the number of males attending community presentations.
   a. *More presentations were given at community centers with a greater male presence.*
   b. *More presentations were offered at a wider range of times and days.*
   c. *This contributed to the percentage of Central Region attendees who identified as male to increase from 24.1% last year to 42.3% this year.*
6. Increase the number of Latinos attending community presentations.
   a. *More presentations were given at community centers that were oriented towards Latinos.*
   b. *More presentations were offered at a wider range of times and days.*
   c. *This contributed to the percentage of Central Region attendees who identifies as Latinos to increase from 13.6% last year to 25.4% this year.*

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Try to identify new locations for community presentations based on recommendations/connections of the Faith Academy participants.
2. Establish more relationships with other community organizations (e.g., Suicide Prevention Council) and behavioral health systems.
3. Include an American Sign Language signer for presentations where possible.

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
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Crisis Response Team is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprise 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 include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are intended to increase knowledge of and access to appropriate behavioral health services for traditionally under-served persons, particularly within African-American and Latino communities. The specific objectives of the Crisis Response Team include the provision of faith-based support services to individuals and families experiencing crisis situations (e.g., attempted or completed suicides, homicides, domestic violence, etc.), to improve their behavioral health and wellbeing.

Two community organizations, Stepping Higher and Interfaith Community Services, provided Crisis Response Team 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 is 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 are expected to improve the behavioral health and wellbeing of those receiving Crisis Response Team services.

EXECUTIVE SUMMARY

The Crisis Response Team was designed to support individuals and families during and after experiencing crisis events (up to 90 days). The team has faith leaders and behavioral health professionals who can respond quickly to crisis situations whenever needed. The initial contacts are expected to help de-escalate challenging situations and the follow-up services are designed to promote longer-term recovery and well-being.

- During FY 2017-18, 149 people received crisis team services.
- Fifty percent of the persons served by the Crisis Response Teams were female and 48% were between the ages of 26 and 59. Participants identified primarily as Hispanic/Latino (68%).
- Over 95% reported being satisfied with their overall experience with the Crisis Response Team. 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.
- Nearly two-thirds (61.7%) reported that they know where to get help when needed due to crises team services.
- Key factors identified by staff that helped the program achieve its goals included: 1) resource information, 2) having a team of experienced and knowledgeable clergy and behavioral health professionals, 3) existing relationships within the community, 4) quick crisis response time whenever needed, 5) timely follow-up after initial crisis contact, and 6) team commitment to support others and make a difference in the community.

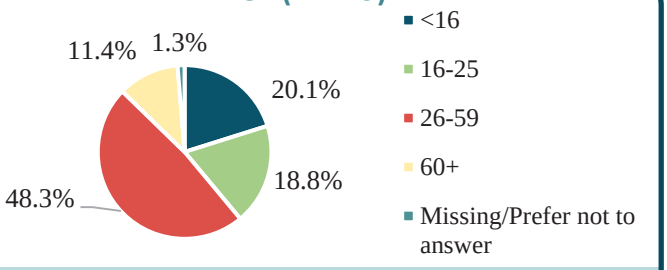
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) increase outreach efforts to community-based organizations in the Escondido area to expand opportunities for referrals to the Crisis Response Team program, 2) identify and utilize staff with additional language capabilities beyond English and Spanish (e.g., French to better serve needs of immigrants from some African nations), 3) identify and utilize community resources that can support persons who do not speak English or Spanish (e.g., French to better serve needs of immigrants from some African nations).

PARTICIPANT DEMOGRAPHICS

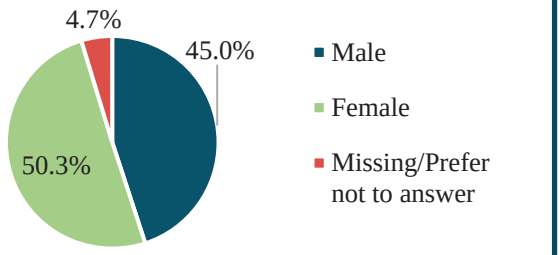
The following self-report demographic data were collected from participants during the initial or follow-up visit.[1]

AGE (N=149)



Most participants (48.3%) were between the ages of 26 and 59, and 18.8% were between ages 16 and 25.

GENDER IDENTITY (N=149)



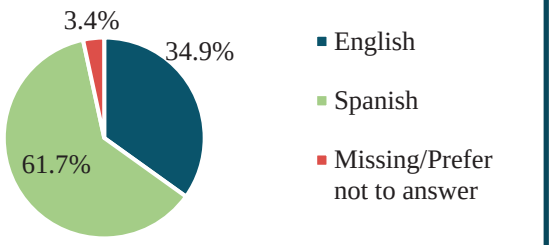
About half (50.3%) of participants were female and 45.0% of participants were male.

SEXUAL ORIENTATION (N=149)



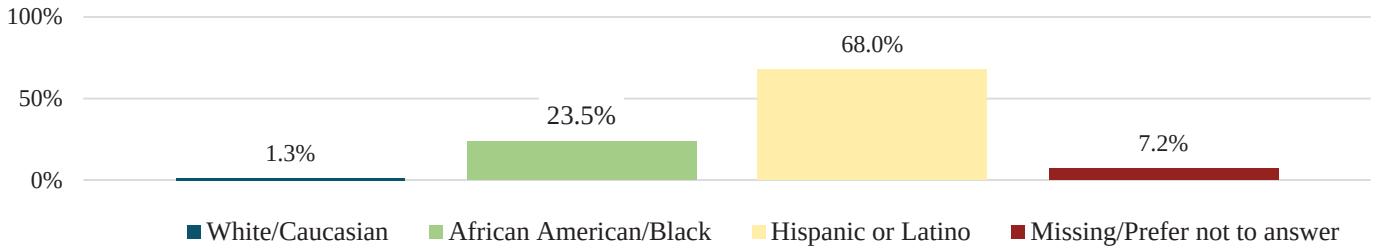
The majority (93.3%) of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=149)



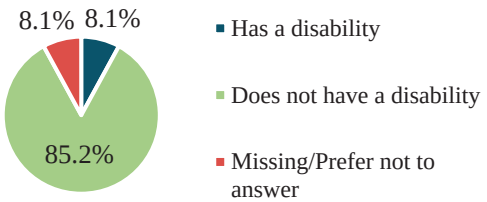
The majority (61.7%) of participants spoke Spanish as their primary language.

RACE/ETHNICITY (N=149)



Most participants identified either as Hispanic (68.0%) or African-American (23.5%) Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[2] STATUS (N=149)



Eight percent of attendees reported having some type of non-SMI disability.

The majority (91.0%) of attendees had never served in the military.

TYPE OF DISABILITY (N=12)

Type	n	%
Visual	3	25.0
Hearing	1	8.3
Learning	2	16.7
Dementia	1	8.3
Chronic Health	3	25.0
Other	2	16.7

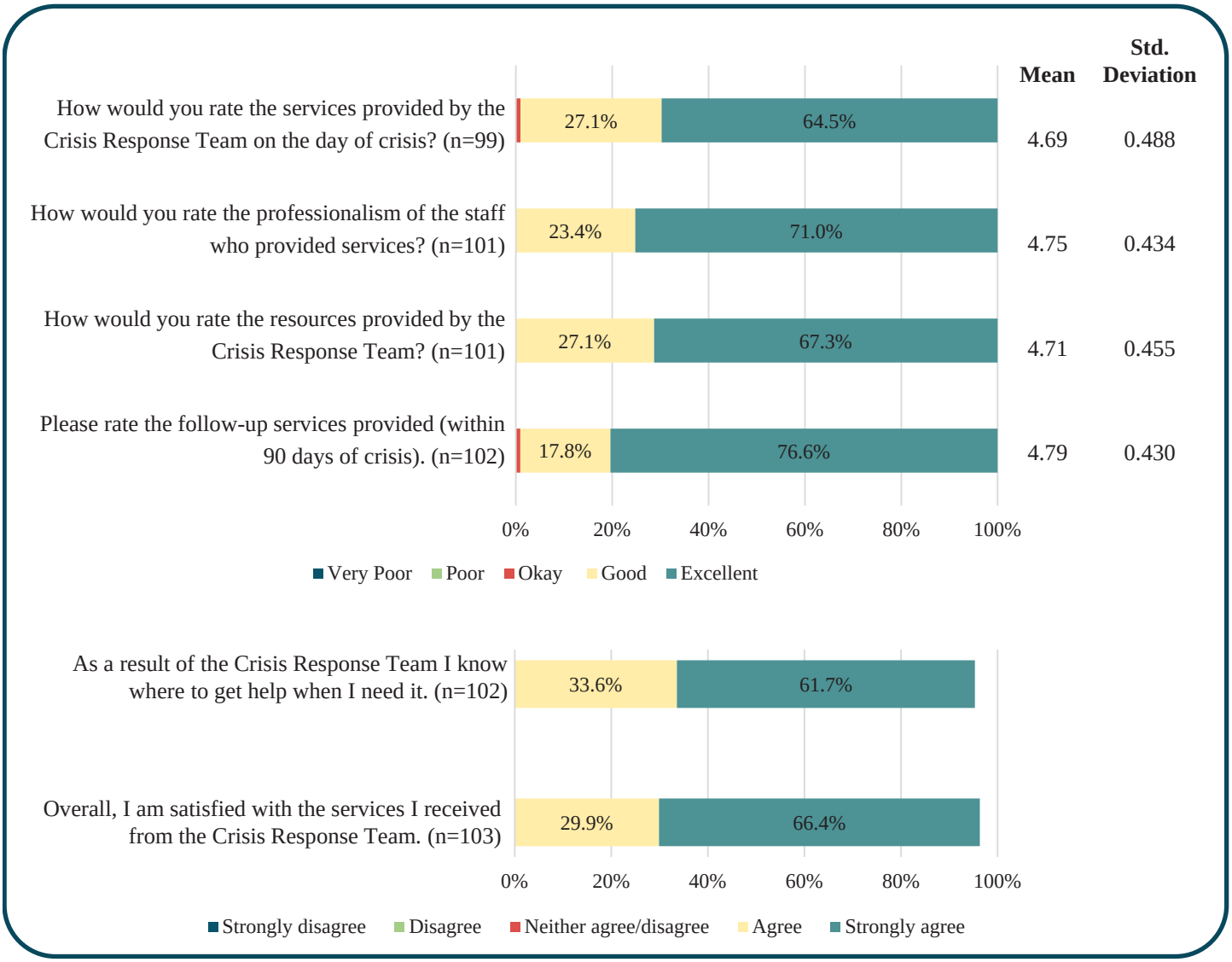
The table above describes the types of disabilities these participants reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

[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).

CRISIS RESPONSE TEAM SERVICES FEEDBACK SURVEY

Persons 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. In general, participants indicated high ratings 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 (29.9%) or strongly agreed (66.4%) with the statement indicating satisfaction with services received.[1]

Figure 1. Crisis Response Team Service Feedback Survey



[1] *Percentages may not total to 100% due to rounding.*

PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18, 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 11 respondents from the 17 persons invited to participate in the survey, a response rate of 65%. 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. The major program goals identified by staff:

a. To provide services that de-escalate crisis situations (e.g., attempted suicides, domestic violence, etc.)
b. To provide resources
c. To restore peace back into people's homes and provide emotional support
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

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, etc.)
e. Existing relationships within the community
f. Responding quickly to hotline calls
g. Team commitment to support others/make difference in the community
h. Timely follow-up (e.g., within days) after crisis contact
i. The team originating from the community in need
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, etc.)
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, etc.)
b. Increased funding
c. Giving the program time to grow
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
g. Ability to receive calls from multiple sources (e.g., pastors, community leaders)

5. Key program strengths:

a. Strength of the team & 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 providing services
f. Community relationships

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/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)

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. Supplies hope & relief
c. Provides a necessary component to connect with the community
d. Faith-based services can increase trust & acceptance
e. Not all providers are open to faith-based aspects

9. Factors that contribute to successful follow-ups after a crisis:

a. Phone contact
b. Provider skill set (e.g., demonstrating caring)
c. Learning and remembering names
d. Timeliness of follow-up
e. Resources specific to client's needs
f. Fulfill any promises made

10. Recommendations on how to educate other service personnel (e.g. police, fire) about Crisis Response Team services:

a. Have presentations/meetings/make phone calls to market to, and educate, police departments and fire departments about the program
b. Distribute materials periodically to remind police departments and fire departments about program
c. Encourage service personnel to work as a team with the faith-based Crisis Response Team

11. Ideas on how to educate the general community about Crisis Response Team services:

a. Work in a team setting
b. Share information with other service providers/agencies
c. Present information at INN Community Education presentations (i.e., Task Order 2)
d. Share information in churches and other faith-based organizations
e. Educate the community about the benefits
f. Develop marketing materials (e.g., a brochure)
g. Conduct prevention trainings (e.g., substance use, domestic violence)
h. Highlight the need for services

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Good faith-based and behavioral health reputation in community promotes credibility of behavioral health organizations.
2. Good intra- and inter-agency coordination and communication is essential for effective program operations (e.g., crisis teams, BHS, PD, FD).
3. Team-based approach relies on collaborative, passionate, and skilled team members.
4. Faith-based approach promotes participant trust and openness.
5. Faith-based approach facilitates crisis de-escalation by utilizing existing beliefs and support mechanisms.
6. Must be able to provide quick response time at all hours to meet participants' needs in time of crisis.
7. Provide full information resource packet to all participants since they may not articulate all needs during initial contact.
8. 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.
9. After initial interaction, some participants contact the program directly if same/similar crisis emerges as a form of 'pre-911' call.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Encouraging people to spread information via 'word of mouth' is an effective way to establish trust in the community.
2. 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.
3. There often are more community resources available for women with children than there are for men with children.
4. After trust has been established in the community, some participants may prefer to contact the Crisis Response Team instead of the police.
5. If police were not contacted prior to involvement by the Crisis Response Teams, knowing the appropriate time to call the police during a crises situation can be difficult and requires ongoing training and discussion.

YEAR 2 PROGRAM CHANGES

During FY 2017-18, the INN-13 Faith Based Initiative Task Order 3 Crisis Response Team program added a new community-based organization, Interfaith Community Services, to provide services to the Escondido community.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Improve interagency coordination and communication (e.g., crisis teams, BHS, PD, FD).
   Status: A business card was created and distributed to community partners that can be carried in a wallet or a pocket that contains relevant Crisis Response Team information which provides a resource for community organizations.

2. Create direct referral mechanism from police and fire departments.
   Status: Establishing direct referrals from police and fire departments was still a work in progress but may not be an ongoing priority if sufficient number of referrals are being generated from faith leaders and direct calls from community members.

3. Identify additional community resources for participants.
   Status: The Crisis Response Teams reported continual updating of their knowledge of local community resources in order to be able to provide accurate and relevant referrals to those who access the Crisis Response Team services.

4. Explore provision of longer-term follow-up care with participants (e.g., additional care and case management services).
   Status: At this time, the programs continue to focus their efforts on short-term support services for up to 90 days after the crisis event and work to connect participants to other community resources for longer-term needs.

5. Explore expansion into other regions/communities.
   Status: Interfaith Community Services was selected to provide Crisis Response Team services to the Escondido community.

6. Develop and implement method for assessing utilization of formal crisis services (e.g., police contacts) after initial visit with crisis response team.
   Status: At this time this is beyond the scope of the evaluation to collect police contact information after the initial visit with staff from the Crisis Response Teams.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Increase outreach efforts to community-based organizations in the Escondido area to expand opportunities for referrals to the Crisis Response Team program.
2. Identify and utilize staff with additional language capabilities beyond English and Spanish (e.g., French to better serve needs of immigrants from some African nations).
3. Identify and utilize community resources that can support persons who do not speak English or Spanish (e.g., French to better serve needs of immigrants from some African nations).

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
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Wellness and Mental Health In-Reach Ministry (WMHIM) is one of four (4) distinct strategies funded through the Innovations (INN) component of the Mental Health Services Act that comprises 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 include improved communication and collaboration between the County of San Diego BHS system, local faith leaders, and the congregations and communities they serve. These efforts are 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 is 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 is 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 are expected to improve the behavioral health and well-being of those receiving services, which should 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.

- During FY 2017-18, a total of 234 inmates enrolled into WMHIM, a more than 100% increase from the prior year (n=103).
- Less than 15% of the persons served were female and about 15% were Transition Age Youth (i.e., age 16-25).
- The program served a diverse population, with 36.8% identifying as White, 19.2% as African-American, and 18.4% as Hispanic.
- Analysis of San Diego County jail data indicated a substantial reduction in re-bookings 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 33.0% before WMHIM to 13.1% and 180-day recidivism dropped from 78.3% to 44.8% before and after enrolling in WMHIM, respectively.
- Similarly, total bookings decreased sharply after involvement with the WMHIM program. Total bookings dropped from 105 before to 36 after WMHIM in the 30-day analyses, and from 400 before to 188 after WMHIM in the 180-day analyses. In both analyses, total bookings dropped by more than 50%.
- 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, and 4) teamwork between religious and non-religious groups 5) coordination within the team and with external partners to maintain contact with participants post-release.

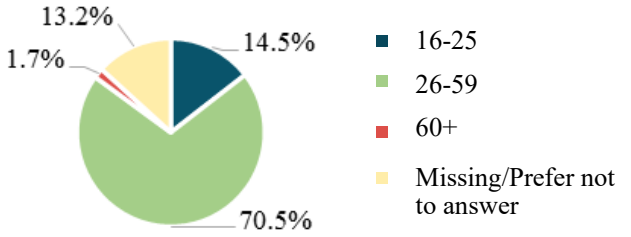
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) identify additional resources for providing and/or linking to safe, affordable housing, and 2) explore options for increasing number of pre-release visits.

PARTICIPANT DEMOGRAPHICS

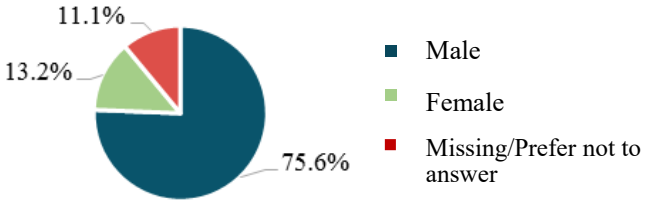
The following demographic data were collected from participants during an initial intake visit.[1]

AGE (N=234)



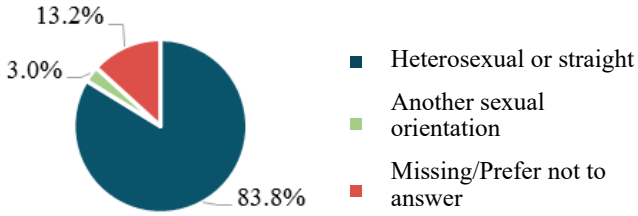
The majority of participants (70.5%) were between the ages of 26 to 59 with 14.5% between ages 16 and 25.

GENDER IDENTITY (N=234)



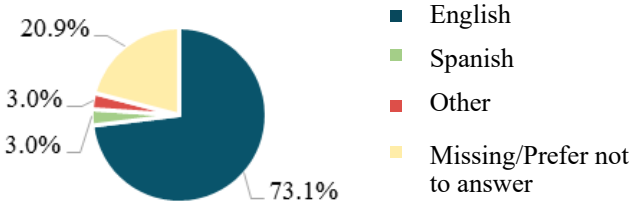
Most participants (75.6%) were male, with females comprising less than one-fifth of those served.

SEXUAL ORIENTATION (N=234)



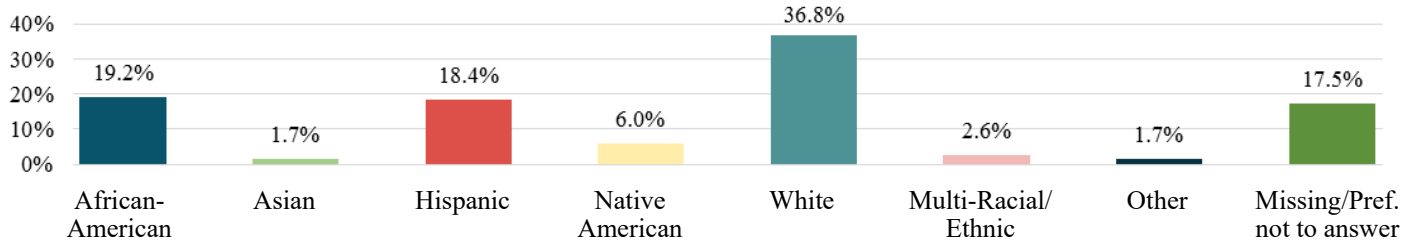
The majority of participants (83.8%) identified as heterosexual or straight.

PRIMARY LANGUAGE (N=234)



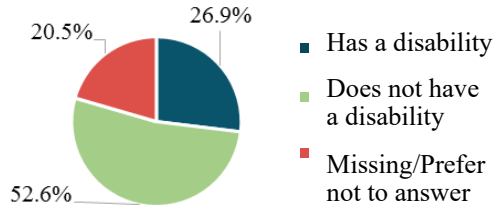
The majority of participants (73.1%) preferred English as their primary language.

RACE/ETHNICITY (N=234)



More than one-third of participants identified as White (36.8%). Similar proportions identified as African-American (19.2%) and Hispanic (18.4%). Totals may exceed 100% since participants were able to indicate more than one race/ethnicity.

DISABILITY[2] STATUS (N=234)



Close to a quarter (26.9%) of the participants indicated some type of non-SMI related disability.

The majority (73.9%) of participants had never served in the military.

TYPE OF DISABILITY (N=63)

Type	n	%
Communication	15	23.8
Mental (e.g., learning, developmental)	12	19.0
Physical	6	9.5
Chronic Health	3	4.8
Other	30	47.6

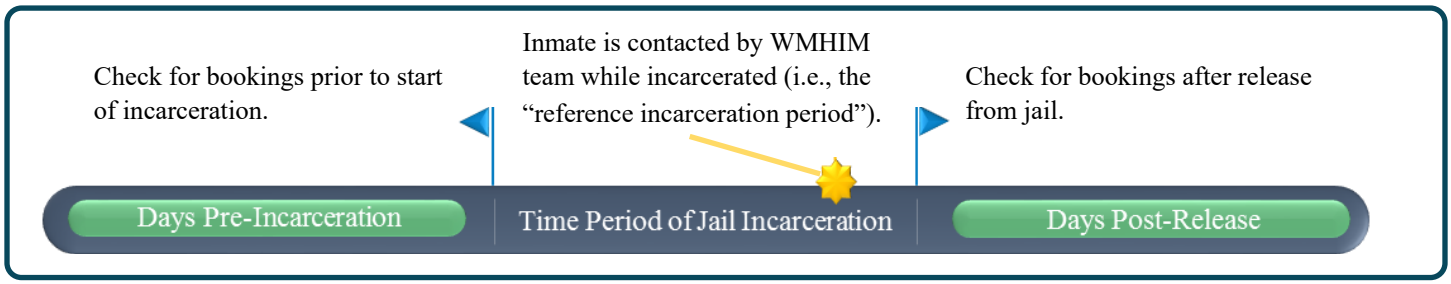
The table above describes the types of disabilities participants reported. Totals may exceed 100% as participants could indicate more than one type of disability.

[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" (i.e., interactions with police that resulted in transportation to jail and the assignment of a booking number) 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 2017-18 (6/30/2018), were included in the recidivism analyses (n=221).

FIGURE 1. ILLUSTRATION OF PROCESS TO COMPARE 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 221 WMHIM participants included in these analyses, 33.0% (n=73) had at least one booking within the 30 days ***before*** their reference incarceration, but only 13.1% (n=29) 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 78.3% (n=173) to 44.8% (n=99), respectively, and total bookings declined from 400 to 188. 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 even 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 = 221)	After Release from Reference Incarceration (Total persons = 221)
At least one bookings within: 30 days	33.0% (n=73)	13.1% (n=29)
Total bookings within: 30 days	105	36
At least one bookings within: 90 days	63.3% (n=140)	31.7% (n=70)
Total bookings within: 90 days	244	97
At least one bookings within: 180 days	78.3% (n=173)	44.8% (n=99)
Total bookings within: 180 days	400	188

ANNUAL STAFF FEEDBACK SURVEY

At the end of FY 2017-18 (6/30/2018), 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 nine respondents from the 13 persons invited to participate in the survey, a response rate of 69%. 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. The major program goals identified by staff:

a. To build positive relationships with inmates pre-release (e.g., encouragement, mental health 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 programs

2. Factors that helped the program achieve goals:

a. Accessing and working with inmates over repeated visits prior to their release date
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. 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. Difficulty meeting eligibility requirements for participation in post-release programs
f. Lack of funding

4. Recommendations to help the program better achieve goals:

a. Identify ways to increase funding for the program
b. Increase the amount of housing available for participants being released from programs/facilities
c. Increase the ability to work with inmates prior to their release date (e.g., increase the number of visits)
d. Expand program referrals and enrollments
e. Improve internal communication and coordination
f. Increase the amount of information received from the jail (e.g., mental health and incarceration histories)
g. Increase the amount of accurate resource information available to provide to participants

5. Affect of the faith-based aspect of the program on services:

a. Develops rapport and understanding of the personal needs of the inmates (e.g., preference for faith-based facility)
b. Provides hope and purpose with shared faith, prayer, and encouragement through scripture

6. Key "innovations" making the program unique:

a. Combination of behavioral health expertise and spiritual, faith-based support
b. Comprehensive support (e.g., transportation, finance, self-improvement, weekend hours)

ANNUAL STAFF FEEDBACK SURVEY (CONTINUED)

7. 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)

8. 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 and individuals 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

9. Primary strategies for connecting/developing relationships with inmates prior to release from jail:

a. Visiting with inmates frequently
b. Listening without judgment and empowering participants with support and encouragement
c. Sharing faith (e.g., personal stories, journeys towards faith, prayer)
d. Offering the potential of safe housing post-release
e. Combining of behavioral health and faith-based approaches

10. Primary strategies for maintaining contact with participants after they were released from jail:

a. Providing or acquiring relevant phone numbers
b. Encouraging and proving logistical support to maintain contact (e.g., regular “check-ins”)
c. Making in-person contacts (e.g., homes, treatment programs, shelters)
d. Keeping track of where the participant is currently living
e. Administrative factors (e.g., internal procedures/defined roles about who will maintain contact)

11. 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

12. Affect of inmate substance abuse (history or current) on linkages/supports:

a. Detox/drug dependency may prevent released inmate from moving forward
b. Easier to obtain services with substance abuse history than with history of mental illness
c. Lack of beds in treatment facilities
d. Substance abuse may affect coherence and willingness to receive help
e. Substance abuse issues requires staff to know more about available treatment and housing resources

13. Recommendations to improve the program:

a. Increase coordination and communication with community programs to ease the process of inmate acceptance/ intake
b. Increase housing facilities with appropriate services
c. Hire more staff to provide support and develop rapport
d. Identify more services that address recidivism for persons with serious mental illness

KEY YEAR 1 PROGRAM "LEARNINGS"

1. Multiple pre-release contacts are important relationship building opportunities that facilitate maintaining post-release connections with participants.
2. Providing post-release transport facilitates maintaining post-release connections with participants.
3. 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 anytime after release.
4. Access to safe post-release housing is often limited, which then becomes a primary post-release focus for participants.
5. Participants often need a range of behavioral health and non-behavioral health-related services after release.
6. 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).
7. Integrating behavioral health knowledge and a faith/spirituality perspective facilitates development of supportive and empowering relationships with inmates with SMI.
8. The personal "lived experience"of program staff and volunteers with the criminal justice and behavioral health system increases credibility with inmates.
9. 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.
10. Initial analyses indicate lower rates of short-term recidivism (i.e., 90-day booking rates) after program participation.
11. Supportive relationships combined with availability of community resources and services appear to be important factors contributing to positive life changes.
12. 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.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Participation in the WMHIM program appears to be associated with substantial a decrease in short-and intermediate-term recidivism rates and total bookings (as demonstrated in 30-,90-, and 180-day recidivism analyses.
2. 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. Establishing a post-release assistance/services plan (e.g., housing, treatment, employment, family reunification, etc.) prior to their actual release helps keep inmates engaged and motivated to work with WHIM after they are released.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-13 Faith Based Initiative #4, Wellness and Mental Health In-Reach Ministry, that differed substantially from the initial service delivery model.

CURRENT YEAR PROGRAM RECOMMENDATIONS

1. Identify additional resources for providing and/or linking to safe, affordable housing.
2. Explore options for increasing number of pre-release visits (e.g., establish regular/specific hours to connect with inmates, etc.).

For additional information about the INN–13 Faith Based Initiative #4, Wellness and Mental Health In-Reach Ministry and/or this annual report, please contact: David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

NOBLE WORKS (INNOVATIONS-14)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 3 (7/1/17 - 6/30/18)

The County of San Diego Health and Human Services Agency's Behavioral Health Services (BHS) Noble Works program is funded through the Innovations (INN) component of the Mental Health Services Act. Noble Works is 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 is expected to also boost participants' sense of empowerment, social connectedness, and overall quality of life. The Union of Pan Asian Communities (UPAC) is the lead agency in the Noble Works collaboration, with Pathways Community Services providing employment services oriented towards transition age youth (TAY) and the National Alliance on Mental Illness San Diego (NAMI SD) providing community presentations and other training supports.

Noble Works utilizes a multi-faceted approach based on Supported Employment principles that target both prospective employers and persons with SMI. Core components of the program include utilization of Employment Specialists, who help participants prepare for and find competitive employment positions of interest, and peer-support Job Coaches, who provide individualized support for maintaining employment. UPAC and NAMI SD conduct community presentations to help reduce stigma and educate potential employers about hiring persons with SMI. Other innovative Noble Works components include: 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 resources to facilitate employment opportunities.

EXECUTIVE SUMMARY

The Noble Works program (INN-14) is 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 include outreach to and education of potential employers to decrease stigma and expand awareness of employment opportunities for Noble Works participants.

- During FY 2017-18, there were 109 first-time program enrollees and 3 from a prior year who re-enrolled (112 total enrollees).
- The majority of new enrollees were male (65.1%) and over half (58.7%), were TAY (i.e., age 18-25). Some were employed (11.9%), but most (70.6%) indicated they were not currently working but seeking work.
- To date, approximately 25% of all Noble Works participants obtained at least one job as of 6/30/2018.
- During FY 2017-18, 31 participants acquired a total of 35 jobs through Noble Works, with an average wage of $14.34/hour and 24.1 hours per week (7 full-time jobs). Participants still employed as of 6/30/2018 or at the time they exited Noble Works had been employed in that job for an average of 149.3 days.
- For those who obtained jobs, job satisfaction was positively associated with other aspects of well-being (e.g., sense of belonging, hopefulness about future, etc.), such that persons with high job satisfaction were more likely to have positive perceptions of other life domains as well.
- Noble Works staff identified the following key factors that helped achieve program goals: 1) successful outreach efforts, 2) staff skills and passion, 3) one on one individualized support with staff, 4) access to tools and resources to support participants (e.g. class curriculum, etc.), 5) participant attitudes (e.g., motivation, engagement, etc.), and 6) intra-and interagency collaborations.
- Primary factors inhibiting achievement of program goals included: 1) challenges maintaining participant engagement, 2) difficulties with job development/outreach efforts, and 3) high staff turnover.

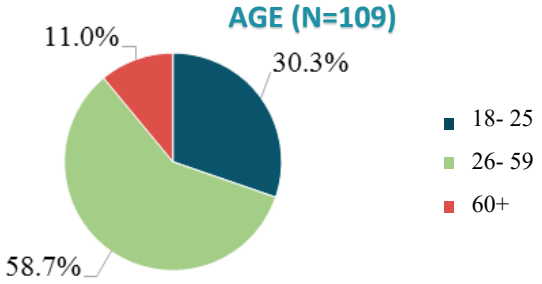
RECOMMENDATIONS

Primary recommendations include: 1) continue transition towards full implementation of the Supported Employment/ Individual Placement and Support service delivery model, 2) continue development and utilization of Neighborhood Enterprise Center employment, training, and business support opportunities, and 3) increased utilization of apprenticeships.

DEMOGRAPHICS: NEWLY ENROLLED NOBLE WORKS PROGRAM PARTICIPANTS

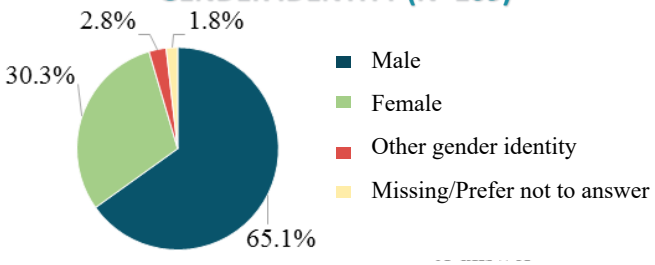
The following demographic data were collected from a participant self-report survey administered when they entered Noble Works.[1]

AGE (N=109)



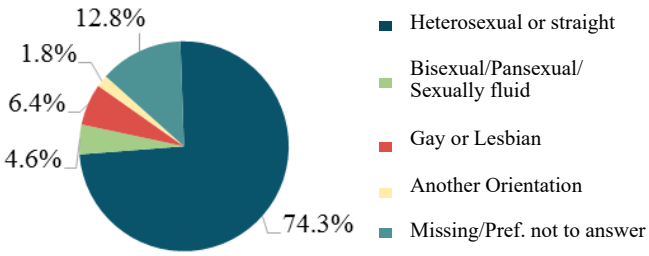
Over half (58.7%) of participants were between the ages of 26 and 59.

GENDER IDENTITY (N=109)



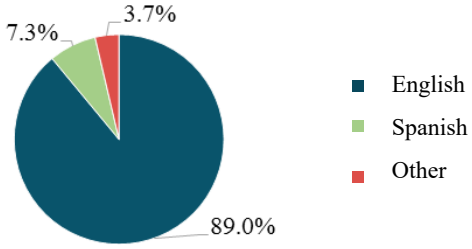
Nearly two-thirds (65.1%) of participants were male and 30.3% were female.

SEXUAL ORIENTATION (N=109)



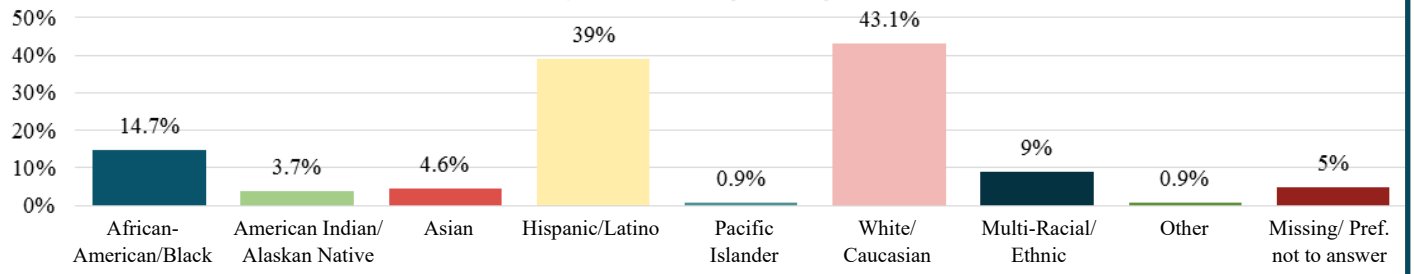
The majority (74.3%) of participants were heterosexual or straight, and 6.4% indicated being gay or lesbian.

PRIMARY LANGUAGE (N=109)



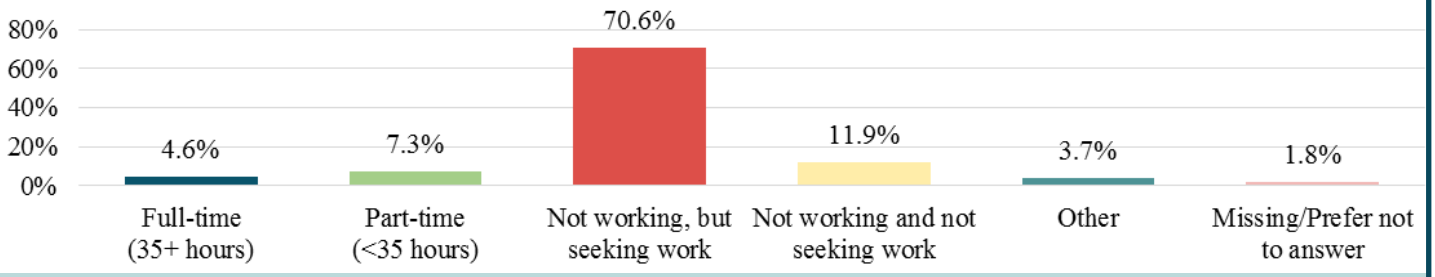
English was the primary preferred language for almost all of the participants (89%).

RACE/ETHNICITY (N=109)



Similar proportions of participants identified themselves as White (43.1%) and Hispanic/Latino (39%). Totals may exceed 100% as participants could indicate more than one race/ethnicity.

EMPLOYMENT STATUS (N=109)

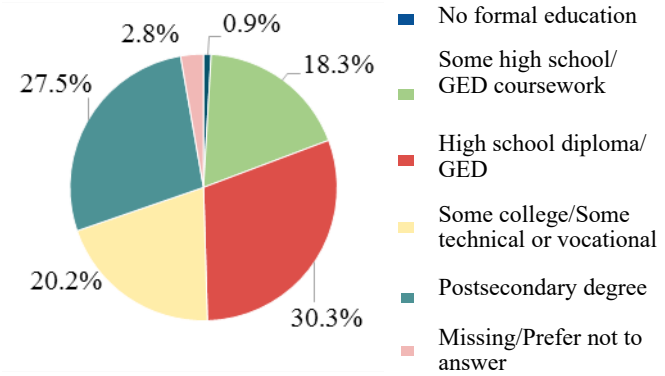


As expected for this type of program, most participants were either not working, but seeking work (70.6%), or in part-time positions (7.3%), when they started Noble Works.

[1] *Percentages may not total to 100% due to rounding.*

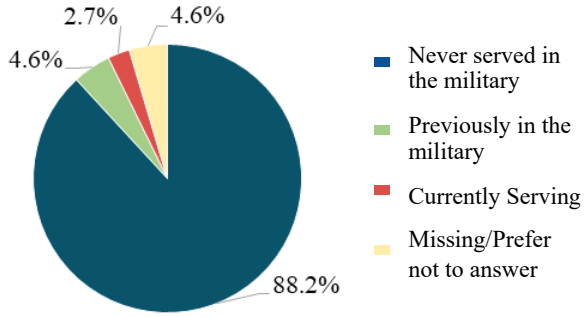
DEMOGRAPHICS: NEWLY ENROLLED NOBLE WORKS PROGRAM PARTICIPANTS (CONTINUED)

EDUCATION LEVEL (N=109)



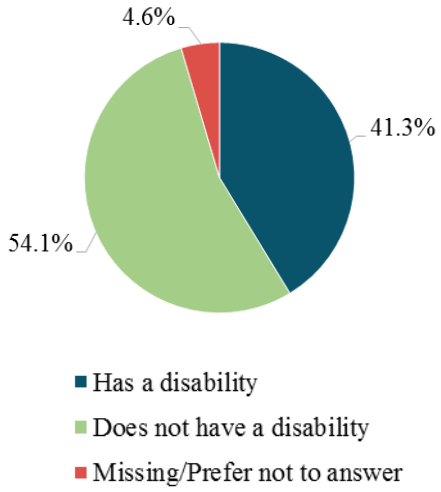
Approximately half of the participants (47.7%) had at least some postsecondary education.

MILITARY STATUS (N=109)



The majority (88.2%), of participants had never served in the military.

DISABILITY[2] STATUS (N=109)



A substantial minority (41.3%) of the participants indicated having some form of non-SMI related disability.

TYPE OF DISABILITY (N=45)

Type	n	%
Physical/Mobility Disability	14	31.1
Learning Disability	11	24.4
Difficulty Seeing	8	17.8
Difficulty hearing/speaking	8	17.8
Chronic Health	8	17.8
Developmental Disability	6	13.3
Other	5	11.1

The table above lists the types of disability participants reported. Totals may exceed 100% as participants could indicate more than one type of 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

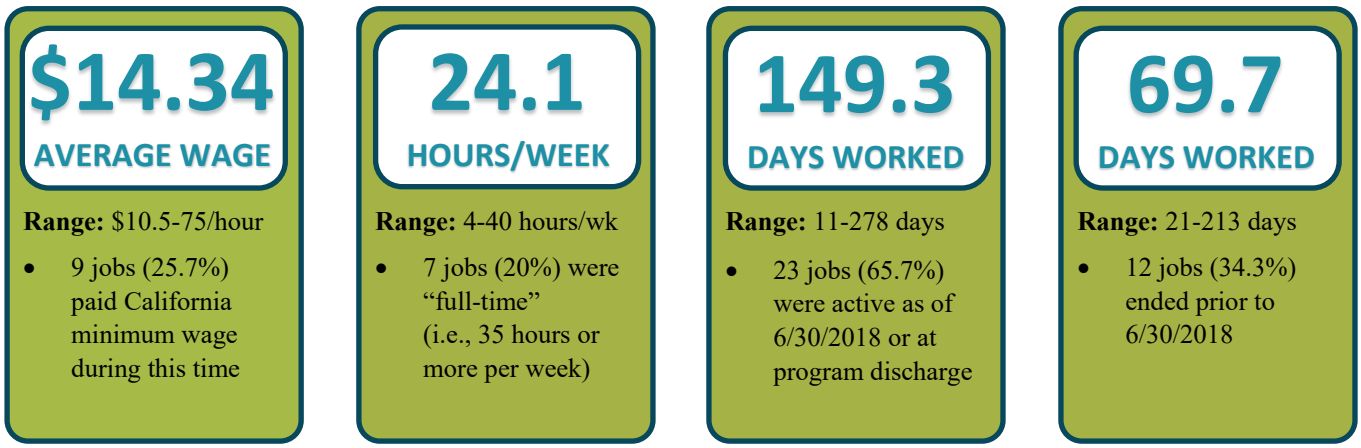
A total of 35 jobs were acquired by 31 people through the Noble Works program during Fiscal Year 2017-2018. As shown in Table 1, the jobs acquired covered a wide assortment of occupations, with the most common positions in the job domains of food preparation and serving (25.7%), office/administrative support (20%), and sales (20%).

TABLE 1. JOB DOMAINS FOR JOBS AQUIRED THROUGH NOBLE WORKS

	n	%
Building and Grounds Cleaning and Maintenance Occupations	5	14.3
Business and Financial Operations Occupations	1	2.9
Community and Social Services Occupations	2	5.7
Food Preparation and Serving Related Occupations	9	25.7
Healthcare Support Occupations	2	5.7
Office and Administrative Support Occupations	7	20.0
Production Occupations	2	5.7
Sales and Related Occupations	7	20.0

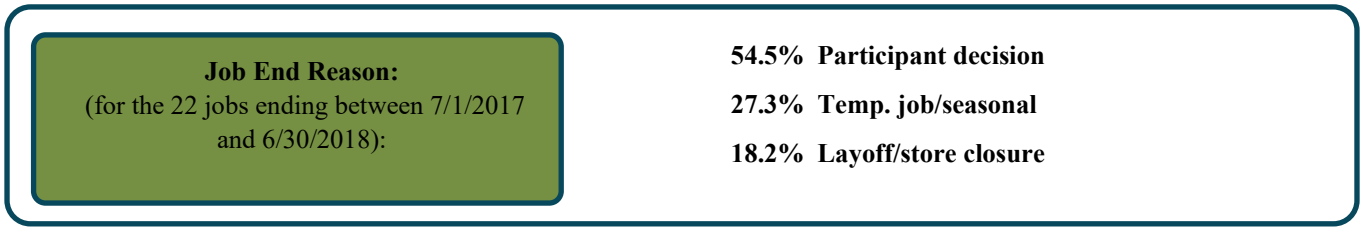
The average wage for these positions was $14.34 per hour. Of the 35 jobs obtained, 20% were full-time. The average number of hours worked per week was 24.1. Of the 23 jobs that were either still active as of 6/30/2018 or active at the time of program discharge, the average duration was 149.3 days.

FIGURE 1. CHARACTERISTICS OF JOBS ACQUIRED THROUGH NOBLE WORKS DURING FISCAL YEAR 2017-2018



As shown in Figure 2, for the majority of jobs that ended during FY 2017-18, the primary reason was due to the participant deciding to leave the position. Of note, there were no reported instances of jobs ending primarily due to performance-related issues.

FIGURE 2. PRIMARY REASONS FOR WHY JOBS ENDED DURING FISCAL YEAR 2017-2018



JOBS ACQUIRED THROUGH NOBLE WORKS

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 (28.6%) or some preparation (51.4%) as shown in Table 2. This is generally consistent with the finding that 25.7% of the jobs started at minimum wage. During this past year 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, which was similar to the percentage of Category 3 or higher job obtained in the prior year.

TABLE 2. O*NET SOC JOB ZONES

	n	%
1 - Occupations that need little or no preparation	10	28.6
2 - Occupations that need some preparation	18	51.4
3 - Occupations that need medium preparation	4	11.4
4 - Occupations that need considerable preparation	2	5.7
5 - Occupations that need extensive preparation	1	2.9

As shown in Figure 3, 10.1% of the participants who enrolled in Noble Works during FY17-18 obtained a job by the end of the year (6/30/2018). Since it typically requires some time to find a job, it is not surprising that the prior year cohort had a higher placement rate (32.0%) given they have been with the program longer. Overall, 24.4% of the 283 unduplicated Noble Works participants had obtained at least one job by 6/30/2018. Notably, TAY appear to be as likely and 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 3 months of entering Noble Works, some participants may take six or more months to find their first job.

FIGURE 3. NOBLE WORKS OVERALL AND COHORT SPECIFIC JOB ACQUISITION DATA

CURRENT YEAR COHORT (7/1/2017 - 6/30/2018)

- 109 new participants
- ***10.1% ever employed*** (as of 6/30/2018); this rate will increase as some get jobs in the next year
- Days to first job was quite varied, but generally it took nearly 3 months, similar to year 2 cohort (average = 83.1 days; SD = 88.1)
- TAY as likely as adults to get jobs (9.1% v 10.5%)

PRIOR YEAR COHORT (7/1/2016 - 6/30/2017)

- 97 new participants
- ***32.0% ever employed*** (as of 6/30/2018)
- Days to first job was quite varied, but generally it took nearly 3 months (average = 82.3 days; SD = 72.1)
- TAY as likely as adults to get jobs (31.6% vs. 32.2%)

LIFE OF PROGRAM (12/1/2015 - 6/30/2018)

- 283 unduplicated participants
- ***24.4% ever employed*** (as of 6/30/2018)
- Time to jobs acquisition in recent years generally occurred more quickly than those who enrolled in Year 1 (average = 155.2 days)
- Difference between TAY and adult job acquisition rates evident in Year 1 has been eliminated

NOBLE WORKS BUSINESS START-UP ACTIVITIES

During Year 3, Noble Works provided financial support and technical assistance to help two participants start businesses.

NOBLE WORKS SOCIAL ENTERPRISE ACTIVITIES

During Year 3, 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 198 participants who entered or were still in Noble Works during the current year, 43.4% had left the program prior to obtaining a job as of 6/30/2018.
- TAY were more likely than adults to leave the Noble Works program prior to getting a job (59.0% to 34.4%).
- Primary reasons for leaving prior to job acquisition were, 1) no longer interested in Noble Works and, 2) loss of contact between Noble Works and the participant.

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 assessment. Starred items had a statistically significant change in mean score from baseline to follow-up ($p<.05$). The overall job satisfaction score (i.e., the average of all six satisfaction items), increased from 2.8 at baseline to 3.5 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 FOLLLOW-UP RATINGS

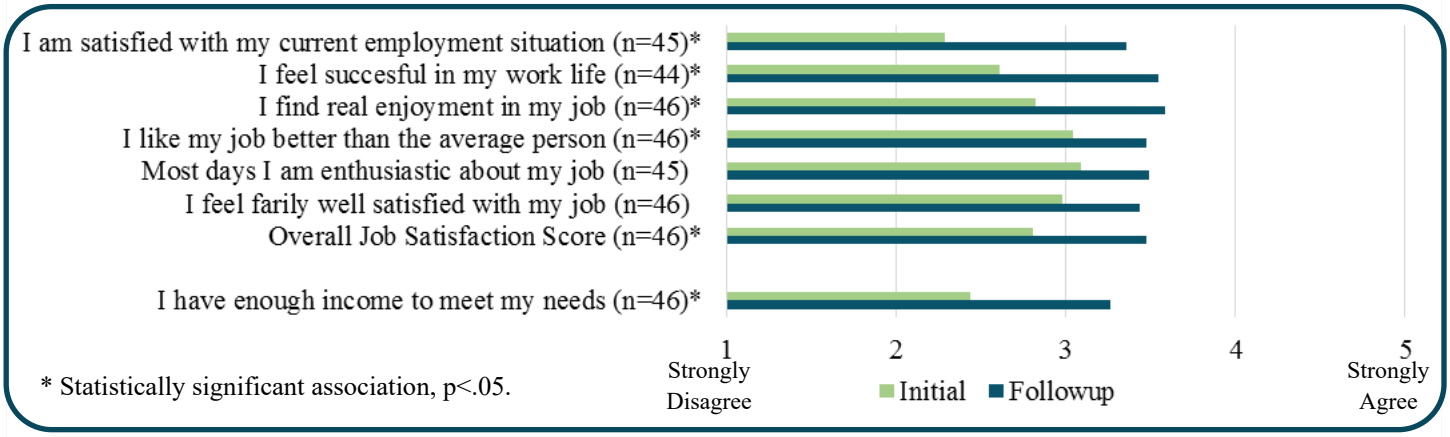


Table 3 presents key associations between overall job satisfaction and items from last completed Recovery Markers Questionnaire (RMQ). These correlations indicated positive associations between how participants felt about their employment situation and a range of other life domains related to their sense of belonging, personal growth, future aspirations, and symptom reduction. While a causal relationship cannot be determined through these analyses, the results suggest a strong correlation between job satisfaction and many of the other life domains that Noble Works is designed to improve through increased and better employment opportunities. These results support the initial premise of the Noble Works program and are consistent with research highlighting the importance of work and job satisfaction on many quality of life aspects for persons with SMI. It is interesting to note that job satisfaction at follow-up was *not* related to participants' beliefs about whether they would be working in 6 months.

TABLE 3. CORRELATIONS BETWEEN RMQ ITEMS AND OVERALL JOB SATISFACTION AT FOLLOW-UP FOR PERSONS WHO AQUIRED A JOB THROUGH NOBLE WORKS

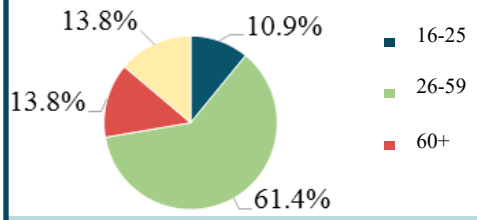
	Overall Job Satisfaction Score
RMQ Responses at Follow-Up	**Correlation**
My symptoms are bothering me less since starting services here (n=46)	.623*
I have more good days than bad (n=46)	.623*
I have enough income to meet my needs (n=46)	.582*
I have a sense of belonging (n=46)	.541*
I feel hopeful about my future (n=46)	.479*
I have goals I'm working to achieve (n=46)	.418*
I am growing as a person (n=45)	.334*
I am learning new things that are important to me (n=46)	.328*
I see myself (still) working in 6 months (n=46)	.264

* Statistically significant association, $p<.05$.

COMMUNITY PRESENTATION DEMOGRAPHICS AND OUTCOMES

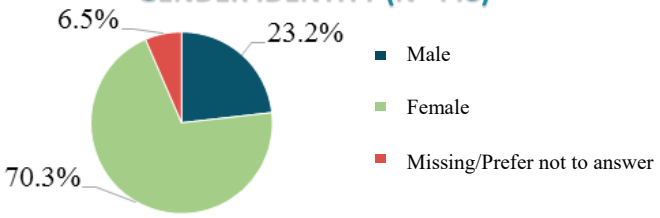
During Year 3 NAMI SD, a Noble Works program partner, conducted 22 "In Our Own Voice" (IOOV) community outreach and education presentations regarding mental illness and recovery in their ongoing efforts to reduce mental health stigma in the community. Either in conjunction with NAMI SD, or independently, Noble Works representatives also conducted 33 "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.[3]

AGE (N=448)



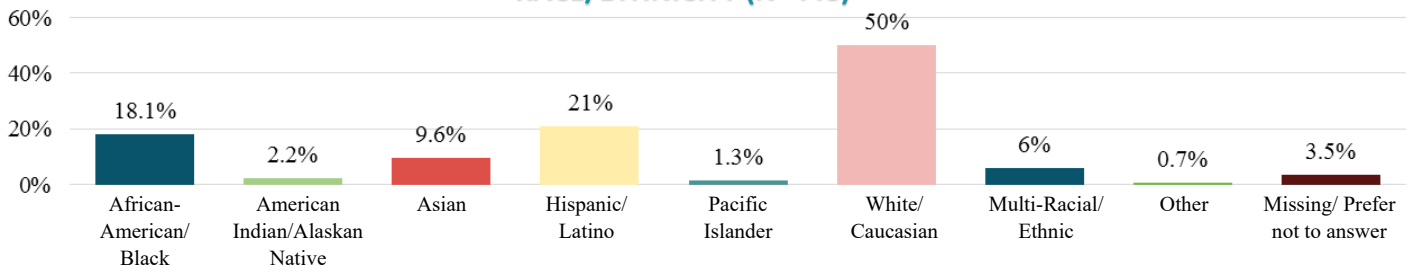
About two-thirds (61.4%) of attendees were age 26-59.

GENDER IDENTITY (N=448)



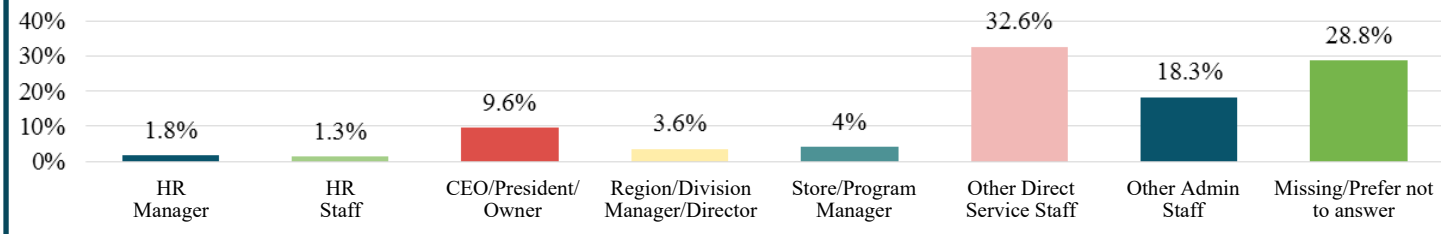
The majority of attendees were female (70.3%).

RACE/ETHNICITY (N=448)



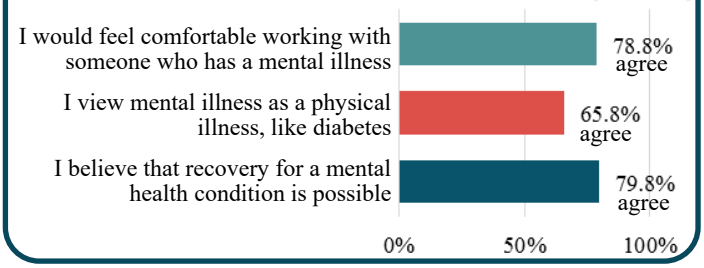
The majority of attendees were White/Caucasian (50%), with 21% indicating an Hispanic/Latino background. Totals may exceed 100% as attendees could indicate more than category.

TYPE OF RESPONDENT (N=448)

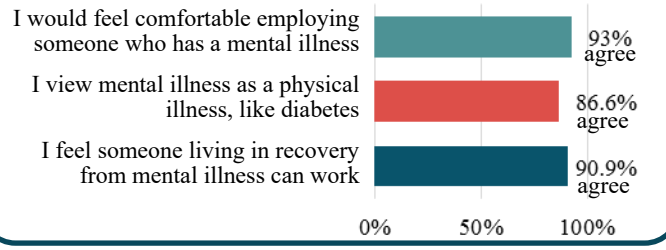


About one-third (32.6%) of the attendees identified themselves as direct service staff, with close to twenty percent (18.3%) identifying as administrative staff.

NAMI SD IOOV PRESENTATION OUTCOMES (N=292)



NOBLE WORKS PRESENTATION OUTCOMES (N=187)



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 65.8% from IOOV indicated viewing mental illness similar to a physical illness.

[3] *Percentages may not total to 100% due to rounding.*

ANNUAL NOBLE WORKS STAFF FEEDBACK SURVEY

At the end of the third 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. There were eight respondents from the 16 persons invited to participate in the survey, for a response rate of 50%. For the open-ended survey questions, at least two evaluators reviewed and coded the responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Concerns about staff turnover continued to be identified as a substantial issue affecting program operations. The majority of respondents (62.5%; n=8) rated staff turnover as a "very challenging" issue for the program (on a 5-point scale ranging from "not challenging at all" to "very challenging").

1. *Primary factors that facilitated the achievement of program goals:*
   a. Outreach efforts (e.g., personalized outreach to small businesses, community presentations)
   b. Staff skills and passion to support participants and work towards program goals
   c. Participants being able to work one on one with either an employment specialist or a job coach
   d. Program tools/resources available to educate and support participants (e.g., employment leads, classes, community backing)
   e. Participant attitudes (e.g., motivation, engagement)
   f. Intra- and interagency collaboration
2. *Factors that inhibited the achievement of program goals*:
   a. Staff uncertainty about job roles/tasks (e.g., communication methods with participants and employers)
   b. Challenges maintaining participant motivation and engagement
   c. Outreach efforts not reaching the right types of businesses, employers, or the community
   d. High staff turnover
   e. Intake process inhibits quick engagement with participants and connections to potential employers
3. *Impact 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 the learning opportunities
4. *Outcomes of employer-oriented community presentations:*
   a. Increased awareness and understanding about SMI
   b. Effectiveness would increase if employers were targeted based on participant needs
   c. Increased credibility of the program
   d. Facilitated community partnerships
5. *Challenges obtaining and maintaining participant employment:*
   a. Participant motivation levels
   b. Participants not properly managing their symptoms
   c. A lack of suitable jobs
   d. Unrefined work skills (e.g., communication skills, appropriate behavior, how to leave a job with grace)
6. *Challenges developing job opportunities with employers:*
   a. Breaking stigma associated with mental health
   b. Resistant employers that are not interested in learning about Noble Works or getting to know clients
7. *Factors that facilitated ongoing consumer engagement:*
   a. Staff efforts to build relationships and maintain supportive contact with participants
   b. The unique program opportunities (e.g., Kitchen Creations, Tech Café)
   c. Resources and incentives for participants
   d. Participants seeing the progress they have made

KEY YEAR 1 NOBLE WORKS PROGRAM "LEARNINGS"

1. High staff turnover was a major challenge to Noble Works' implementation and operations.
2. Program "start-up" issues (e.g., hiring, training, establishing facilities, collaborating with partners, developing trainings) required substantial time commitments during Year 1.
3. Participant satisfaction with their employment situation increased after participating in the Noble Works program.
4. 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).
5. It was challenging to identify jobs that were of interest to as well as a good skills match for Noble Works participants.
6. Identifying and educating potential employers was difficult, but this objective was perceived as crucial for increasing the pool of known employment opportunities.
7. Noble Works staff were passionate and committed to achieving program objectives.
8. Staff trainings, such as in Supported Employment evidence-based practices, supported the achievement of program objectives.

KEY YEAR 2 NOBLE WORKS PROGRAM "LEARNINGS"

1. Staff perceived both benefits (e.g., role expertise/specialization) and challenges (e.g., potential client confusion and relationship disruption with staff) associated with separating the roles of Employment Specialist and Job Coach.
2. Program was successful at identifying a diverse set of jobs for participants.
3. Difficult to maintain participant motivation throughout process.
4. Poor symptom management perceived as a barrier to job acquisition.
5. Job placement timing varied substantially (25% of first jobs found in less than a month in program; another 25% of first jobs found after 6 months in program).
6. Job placement rates improved from Year 1, but were lower than traditional Supported Employment programs.
7. TAY had lower rates of job acquisition then adults/older adults.

KEY YEAR 3 NOBLE WORKS PROGRAM "LEARNINGS"

1. The development of the multi-faceted Neighborhood Enterprise Center has created new opportunities for the Noble Works SMI population for employment and job-specific training and certifications.
2. 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.
3. The development of 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.
4. The Noble Works program has demonstrated the capability for business "start-ups" among the SMI population, but typically only relevant for a small portion of those served by Noble Works.
5. 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).
6. Community presentations with employers appear 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.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Explore opportunities for enhanced coordination/communication with participant's behavioral health treatment providers.

   Status: No new processes related to coordination/communication with behavioral health providers, but this has generally improved as providers are becoming more familiar with Noble Works staff and primary objectives of the program.

2. Consider consolidating Employment Specialist and Job Coach into one role where staff conduct all phases of job search, placement, and support processes.

   Status: The Employment Specialist and Job Coach roles were combined as part of the transition to the Supported Employment/Individual Placement and Support model of service delivery. In this model, each staff person works on all facets of the job identification, placement, and support process.

3. Increase group caseload supervision to occur weekly.

   Status: The program decided not to implement weekly caseload supervision given the other existing opportunities for supervision (caseload review twice a month, individual supervision twice a month, and monthly full team meeting with external partners).

4. Implement system for tracking date of first face-to-face contact with employers.

   Status: Tracking date of first face-to-face contact was implemented during FY17-18.

5. Review closure process to ensure that services and supports are provided as long as desired by participants.

   Status: Program closure process allows for ongoing interaction with participants as desired (no predetermined time period of program participation). If after multiple attempts a participant no longer engages with the program, a letter will be mailed to last known address letting them know their case/account will be closed unless they initiate contact with the program.

CURRENT YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Noble Works program and increase opportunities for employment for persons with SMI include the following:

1. Continue the transition towards full implementation of the Supported Employment/Individual Placement and Support service delivery model.
2. Continue the development and utilization of Neighborhood Enterprise Center employment, training, and business support opportunities.
3. Increased utilization of funded apprenticeships.

YEAR 3 PROGRAM CHANGES

During the end of FY17-18, the INN-14 Noble Works program began a transition 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.

For additional information about the INN–14 Noble Works program and/or this annual report, please contact:

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
ANNUAL REPORT: YEAR 2 (7/1/17 - 6/30/18)

The Peer Assisted Transitions (INN-15 PAT) program, was funded through the Innovations (INN) component of the Mental Health Services Act. This program was subsequently renamed to "PeerLINKS" to better reflect the services it provides and is henceforth referred to by this name. The primary innovation component of PeerLINKS is 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. During Fiscal Year 2017-18, the program received referrals from Scripps Mercy's inpatient unit and emergency department, UC San Diego's inpatient unit, 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 Year 2017-18 a total of 272 participants were newly enrolled in the program.

Participant Demographics

- The majority of participants were between the ages of 26 and 59 (79%), equal percentages of male and female (47%), 76% were heterosexual, English was the primary language for the large majority (96%), and 54% were White/Caucasian. A small number of participants were veterans.
- Half of the participants reported having a non-SMI- related disability. The majority reported other non-SMI-related disabilities (18%) and/or chronic health conditions (16%).

Participant Rated Outcomes and Program Satisfaction

- The large majority of participants were satisfied with the services they received (97.3%), and as a result of the program, 92.5% knew where to get help when needed, 90.5% were more comfortable seeking help, and 82.2% 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 4.9 (not coping successfully/engaged). Eighty-six percent improved on the MORS, 10% remained stable, and 4% of participants decreased.
- **Combined Health Assessment: Mental, Physical, Social, Substance, Strengths (CHAMPSSS):** Pre-post data on the CHAMPSSS showed that participants had 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 increases on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, and Suicidality Scales.

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 symptoms range, with participants showing a higher level of physical health compared to their mental health.
- On average, participants showed 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 43.8% of participants moved into less restrictive and more independent housing. The average housing level improved from 3.3 at baseline to 4.3 at the most recent assessment. Pre-post data on housing outcomes indicate 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 5.8% to 18.1%. The number of participants who identified as unemployed decreased from 87.0% to 64.5%. The majority were unemployed due to mental health symptoms or disability.

Linkages to Services

- Overall, 1,585 successful connections to services or resources were made. Participants could be connected to multiple services. For mental health services, 259 successful connections were made for 119 participants. For substance abuse services, 100 successful connections were made for 52 participants.

Service Utilization

- The number of emergency interventions related to physical health, mental health/substance use, and physical and mental health/substance use decreased from baseline to follow-up assessment based on participant self-report. Participants experiencing a range of critical events in non-psychiatric hospitalization and jail/prison settings also decreased.
- Overall, participant service utilization based on Cerner Community Behavioral Health system data indicate a decrease in psychiatric hospitalization re-admissions. Among the psychiatric hospital cohort (participants with a hospitalization index event), the recurrence rate decreased by 30.0% after starting the program (25.6% vs 17.9% with any recurrence event).

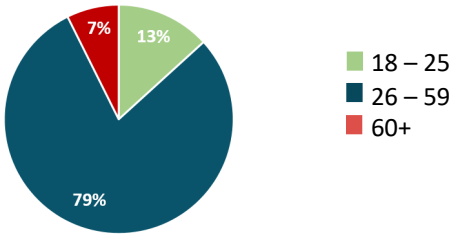
RECOMMENDATIONS

1. To continue to focus on linkages to mental health and substance abuse treatment programs and to improve the tracking of this information, as well as to connect program participants who utilize acute care repeatedly and to connect them to the San Diego County behavioral health system.
2. To systematically capture participants' level of motivation for engaging in the program and working towards their recovery-related goals by adding relevant items to the baseline and follow-up assessments. This information would help the program to explore ways to increase motivation, or support these participants in succeeding despite not being interested in working towards goals.
3. To conduct a "check-in" with discharged participants at approximately three months past discharge and six months, if possible. The check-in will also focus on any changes to the participants' housing situation, employment, and use of emergency services.

PARTICIPANT DEMOGRAPHICS

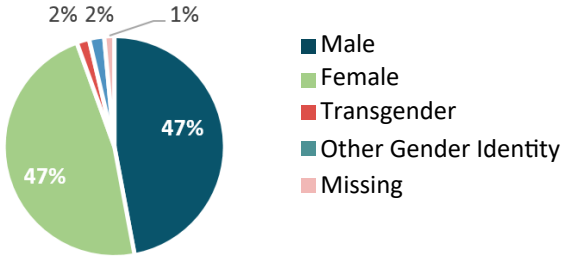
The following demographic data were collected from the intake assessment administered at the start of the program.[1]

AGE (N=272)



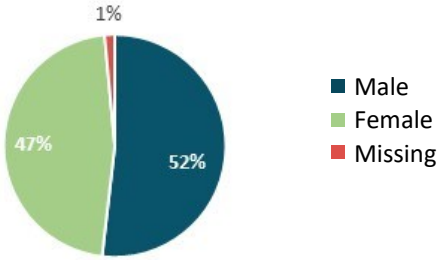
The majority of participants were 26-59 years old (79%), 13% were 18-25 years old and 7% were 60 years or older.

GENDER IDENTITY (N=272)



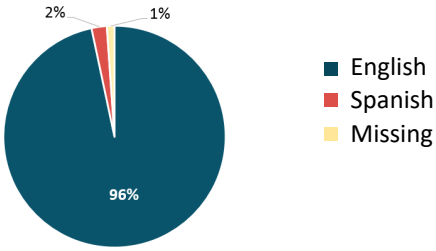
Equal percentages (47%) identified as male and female, and 4% identified as transgender or other gender identity.

SEX AT BIRTH (N=272)



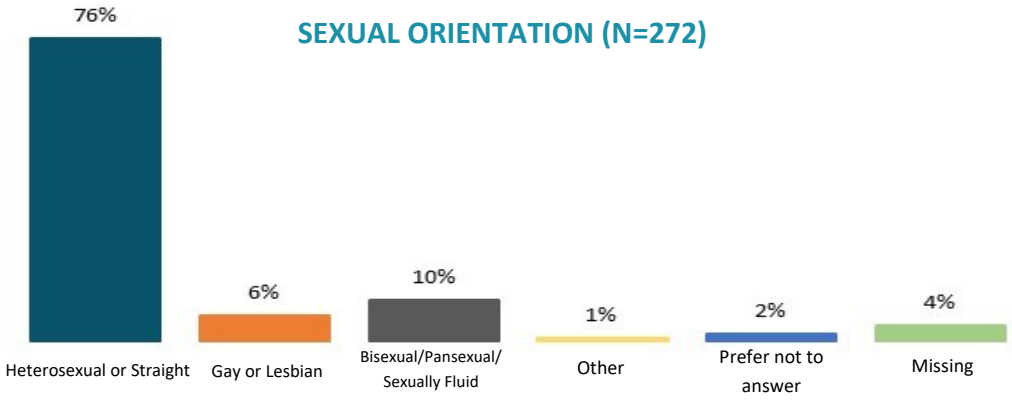
Fifty-two percent were identified as male on their birth certificate and 47% were identified as female.

PRIMARY LANGUAGE (N=272)



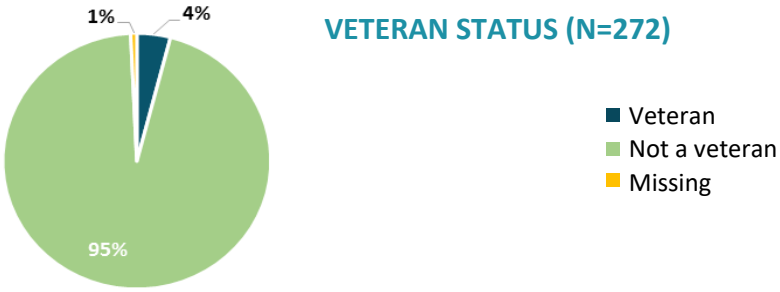
The large majority (96%) of participants spoke English as their primary language.

SEXUAL ORIENTATION (N=272)



Seventy-six percent of participants identified as heterosexual or straight, 6% as gay or lesbian, and 10% as bisexual/pansexual/ sexually fluid.

VETERAN STATUS (N=272)

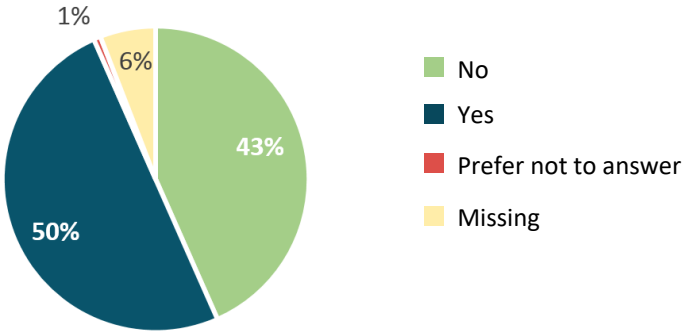


The majority of participants were not veterans (95%) and 4% were veterans.

[1] *Percentages may not total to 100% due to rounding.*

PARTICIPANT DEMOGRAPHICS (CONTINUED)

DISABILITY STATUS (N=272)[2]



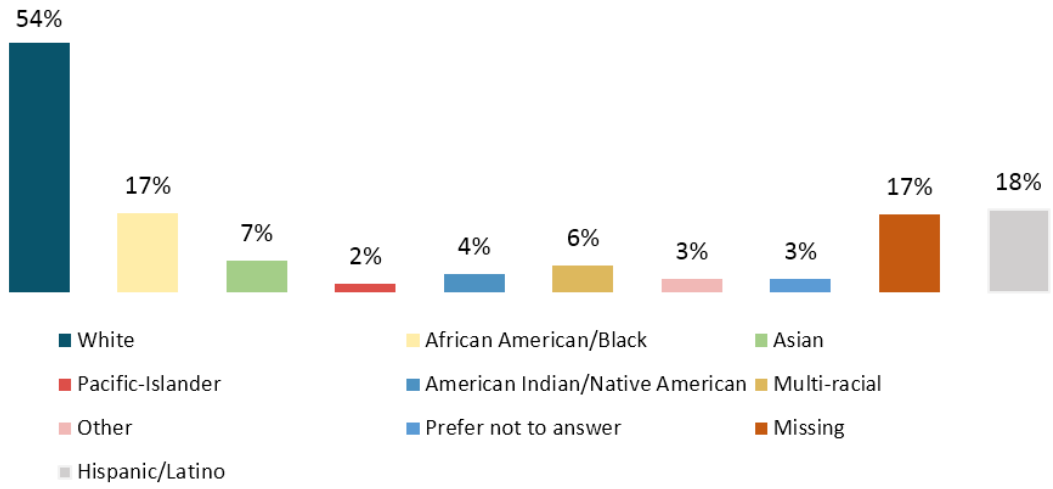
A total of 50% reported having some type of non-SMI-related disability.

TYPE OF DISABILITY (N=136)

Type	N	%
Communication	42	30.9
Mental (e.g., learning)	32	23.5
Physical	31	22.8
Chronic Health Condition	44	32.3
Other	50	36.8

This table describes the type of disability indicated by participants. Totals may exceed 100% as participants could indicate more than one type of disability.

RACE/ETHNICITY (N=272)



The majority of participants were White/Caucasian (54%), 17% were African American/Black, and 18% 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).*

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.

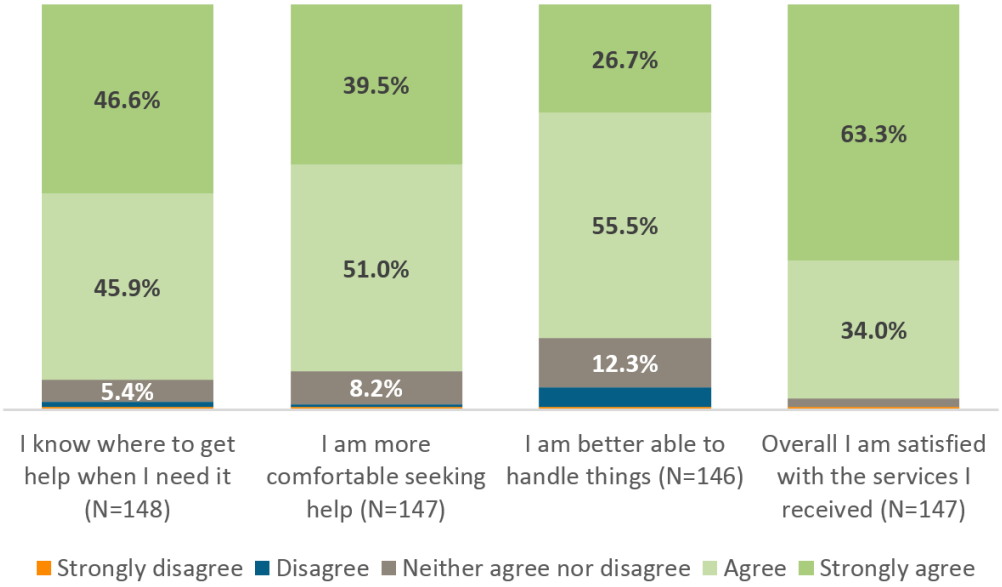
The data are entered into the Mental Health Outcome Management System (mHOMS), an electronic health record system.

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 during FY 2017-18.

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 (92.5%), are more comfortable seeking help (90.5%), and are better able to handle things (82.2%). The large majority of participants agreed or strongly agreed that they were satisfied with the services they received at PeerLINKS (97.3%).

Figure 1: Participant Satisfaction and Participant Rated Outcomes



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.

Changes in MORS Ratings Over Time

A total of 150 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 2017/18) and matched this to the baseline assessment.

Overall, MORS scores from these 150 participants have been increasing from an average of 2.2 to 4.9 (summarized in Figure 2). This increase was statistically significant. Specifically, as shown in Figure 3, 86.0% of participants improved on the MORS and 10.0% remained stable (no change in score). Only 4.0% decreased.

Figure 2: Change in Average MORS Scores (Pre-post, N=150)



Figure 3: Change in MORS Scores (Pre-post, N=150)

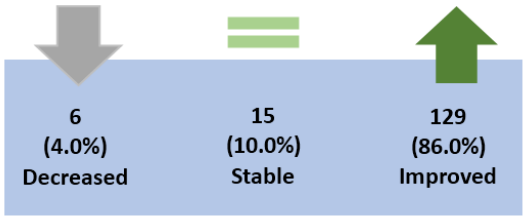


Table 1 compares the distribution of MORS scores at baseline and the most recent follow-up assessment. It is noteworthy that at baseline 87.3% of participants had MORS scores within the extreme risk and high risk categories (scores 1-3) and only 10.0% had scores at or above 5. In contrast, at follow-up, these values were nearly reversed, where only 16.0% had scores in the extreme/high risk categories and 77.3% scored 5 or above.

Table 1: MORS Ratings (Pre-post; N=150)

		Baseline		Most Recent	
1	Extreme risk	41.3%		3.3%	
2	Experiencing high risk/not engaged with mental health providers	19.3%	**87.3%**	2.0%	16.0%
3	Experiencing high risk/engaged with mental health providers	26.7%		10.7%	
4	Not coping successfully/not engaged with mental health providers	2.7%	2.7%	6.7%	6.7%
5	Not coping successfully/engaged with mental health providers	8.7%		47.3%	
6	Coping successfully/rehabilitating	1.3%	10.0%	24.0%	**77.3%**
7	Early recovery	0.0%		4.0%	
8	Advanced recovery	0.0%		2.0%	

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.[2]

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 the items "In general, how would you rate your satisfaction with your social activities and relationships" and "I had contact with people that care about me" were statistically significant.

Table 2: Means (M) and Standard Deviations (SD) of 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)	146	2.0	1.1	2.5	1.1
I had contact with people that care about me. (Item 10)	147	3.3	1.2	3.6	1.0
Outside of health care professionals, how many people actively support you in your recovery? (Item 32)	130	3.0	3.8	4.7	10.4

Changes in CHAMPSSS Subscales

Mean CHAMPSSS subscale scores are displayed in Table 3 below. On average, participants showed improvement in all of the CHAMPSSS subscales. The increases on the Global Health, Resilience, Depression, Anger, Anxiety, Substance Use, Memory/Cognition, and Suicidality Scales were statistically significant.

Table 3: Means (M) and Standard Deviations (SD) of CHAMPSSS Subscale Scores at Baseline and Follow-up (Pre-post)

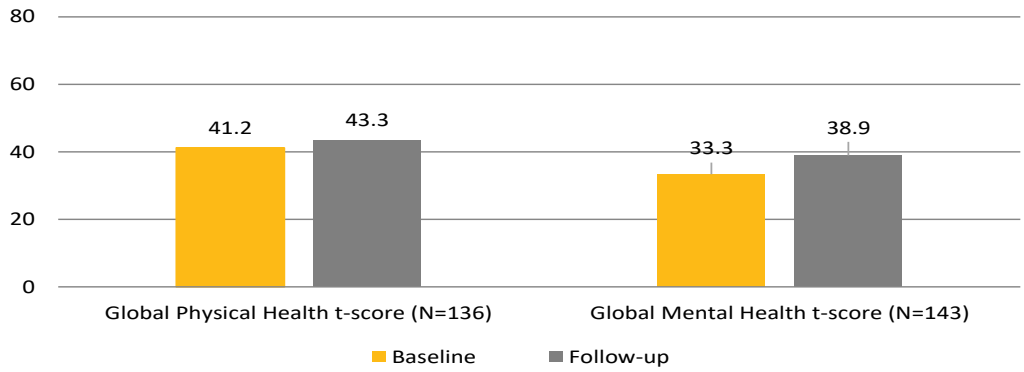
CHAMPSSS Subscale	N	Baseline		Follow-up	
		M	SD	M	SD
Global Health Scale (average of items 1-7, 25, 29, and 30)[2]	149	2.5	0.6	2.9	0.8
Resilience Scale (average of items 8, 9, 10, 11, and 12)	149	3.2	0.8	3.5	0.8
Depression Scale (average of items 13, 14, and 15)	149	2.4	0.8	3.1	1.0
Anger Scale (item 16)	149	3.0	1.1	3.4	1.0
Anxiety Scale (average of items 17, 18, and 19)	149	2.5	0.9	3.1	0.9
Substance Use Scale (average of items 20 and 21)	148	3.7	1.3	4.4	0.9
Memory/Cognition Scale (average of items 22 and 23)	148	3.0	1.1	3.4	1.2
Suicidality Scale (item 24)	148	3.3	1.3	4.2	1.0
Substance Use Frequency Scale (average of items 27 and 28)[3]	146	4.6	0.8	4.7	0.7

[2]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?". [3]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.

PROMIS GLOBAL HEALTH

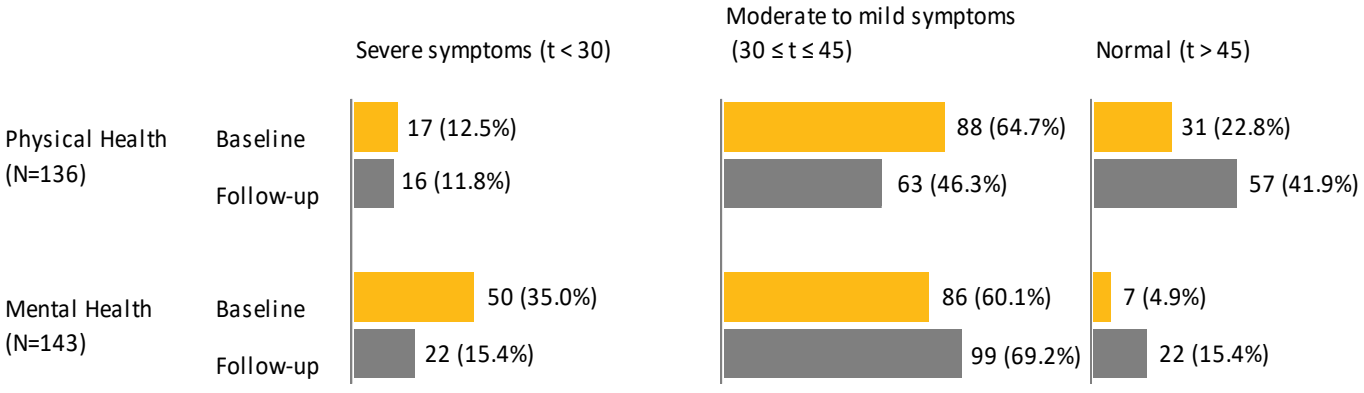
The PROMIS Global Health Scale is a 10-item patient-reported assessment of symptomatology, functioning, and health-related quality of life including physical health, mental health, and social health. PROMIS Global Health scores have been converted into T-score values. T-scores are standardized such that 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.[4]

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. The average T-scores were in the moderate to mild symptoms range, with participants showing a higher level of physical health compared to their mental health. Figure 5 provides additional breakdowns of participant groups by severity of symptoms.

Figure 5: Percentage of Participants by Severity of Symptoms for PROMIS Global Physical Health and Mental Health at Baseline and Follow-up (Pre-post)



[4]http://www.healthmeasures.net/score-and-interpret/interpret-scores/meaningful-change

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 4.7 at the most recent assessment and the improvement was statistically significant.

Table 4: Means (M) and Standard Deviations (SD) of 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.	95	4.6	1.1	4.8	0.7
I had an urge to continue drinking or using substances once I started.	95	4.2	1.4	4.6	0.9
I felt I needed help for my alcohol or substance use.	95	3.9	1.6	4.6	1.0
I took risks when I used alcohol or substances.	95	4.4	1.2	4.8	0.6
I felt guilty when I used alcohol or substances.	92	4.3	1.4	4.7	0.8
Others complained about my alcohol or substance use.	95	4.2	1.3	4.9	0.4
Alcohol or substance use created problems between me and others.	93	4.2	1.4	4.8	0.6
Others had trouble counting on me when I used alcohol or substances.	95	4.2	1.4	4.8	0.7
I felt dizzy after I used alcohol or substances.	94	4.3	1.3	4.8	0.8
Alcohol or substance use made my physical or mental health symptoms worse.	95	4.2	1.5	4.8	0.8
Mean PROMIS-Derived Substance Use (average of items 1-10)	95	4.2	1.1	4.7	0.5

HOUSING

A total of 43.8% of participants moved into less restrictive and more independent housing levels and, for 40.1% of participants, the housing level remained stable. Only 16.1% of participants moved to lower housing levels (summarized in Figure 6).

Figure 6: Housing Levels Summary (Pre-post, N=137, Excluding Other or Unknown Housing Levels)

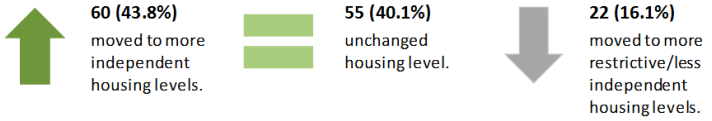


Figure 7 shows the percentage of participants in each housing level as reported for the most recent assessment in comparison to the baseline assessment. The percentages were calculated using a pre-post sample (N=137). The average housing level was 3.3 at baseline and 4.3 at the most recent assessment, indicating that, on average, the housing level improved. This increase was statistically significant.

Figure 7: Housing Levels (Pre-post, N=137, Excluding Other or Unknown Housing Levels)

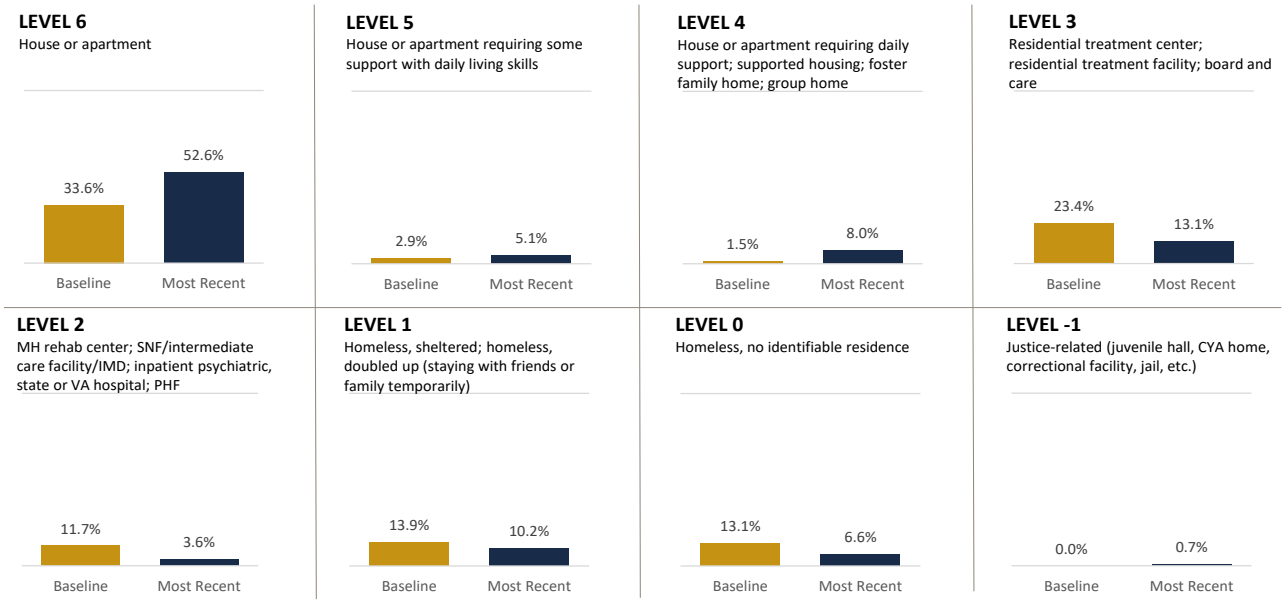


Table 5: Homeless Settings During Past 30 days (Pre-post, Excluding Other or Unknown Homeless Settings)

Unsheltered (living on the streets, camping outdoors, or living in cars or abandoned buildings)	Baseline	Most Recent
# of participants unsheltered at least 1 day	47	15
# of Days	820	356
Total participant responses	124	124
Sheltered (staying in emergency shelters or transitional housing)	**Baseline**	**Most Recent**
# of participants sheltered at least 1 day	42	28
# of Days	737	673
Total participant responses	127	127
Doubled-up (temporarily staying with friends or family)	**Baseline**	**Most Recent**
# of participants doubled-up at least 1 day	22	14
# of Days	445	356
Total participant responses	114	114

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.

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=138). The percentage of participants who selected not employed decreased from 87.0% to 64.5%. The percentage of participants who were competitively employed increased from 5.8% to 18.1%.

Table 6: Employment Levels (Pre-post, N=138)

Employment Level	Baseline		Follow-up	
	N	Percent	N	Percent
Level 0: Not employed	120	87.0%	89	64.5%
Level 1: Volunteer/job training/other gainful/ employment activity	3	2.2%	4	2.9%
Level 2: Paid in-house work	1	0.7%	1	0.7%
Level 3: Transitional employment/enclave/ supported employment	1	0.7%	4	2.9%
Level 4: Competitive employment	8	5.8%	25	18.1%
No employment level: student	2	1.4%	4	2.9%
No employment level: retired	6	4.3%	13	9.4%
No employment level: homemaker	1	0.7%	1	0.7%
Total responses	142	102.9%	141	102.2%
Total number of participants	138	100.0%	138	100.0%

Note: Percentages for total responses exceed 100% due to multiple responses.

Table 7 shows the reasons for unemployment for participants who had been unemployed at both time points where the reason was available (N=53). The majority were unemployed due to mental health symptoms or disability.

Table 7: Reasons for Unemployment (Pre-post, N=53)

Reasons for Unemployment	Baseline		Follow-up	
	N	Percent	N	Percent
Disabled	18	34.0%	18	34.0%
Mental Health Symptoms	37	69.8%	36	67.9%
Other	8	15.1%	3	5.7%
Total responses	63	118.9%	57	107.5%
Total number of participants	53	100.0%	53	100.0%

Note: Percentages for total responses exceed 100% due to multiple responses. Based on pre-post data with missing, un-known/not reported, and item not assessed excluded.

LINKAGES TO SERVICES

PeerLINKS uses the "Linkage and Referral Tracker," 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.[5] The Linkage and Referral Tracker was specifically designed for programs that focus mainly on connecting people with needed services, rather than providing treatment. 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 extent of the successful connections. A total of 1,585 successful connections were made during the reporting period. Specifically, for the mental health dimension, 259 successful connections were made for 119 unique participants. For the substance abuse dimension, 100 successful connections were made for 52 unique participants.

Table 9 shows Mental Health service data based on Linkage and Referral Tracker entries (during 7/1/2017-6/30/2018) for participants who had been in the program for at least 30 days. Overall, 61.8% of participants were referred or linked and were successfully connected to one or multiple mental health services (percentage not shown in table).

Table 8: Successful Connections[5]

Dimension of Wellness	Successfully Connected (Unique Participants)
Physical Health	133 (N=66)
Social Health	178 (N=66)
Mental Health	259 (N=119)
Substance Abuse	100 (N=52)
Housing	175 (N=85)
Occupation/Education	90 (N=47)
Financial Assistance Benefits	127 (N=66)
Transportation	151 (N=84)
Identification	71 (N=46)
Basic Needs	301 (N=155)
Total	1585 (N=247)

Table 9: Mental Health Service Successful Connections for Participants in the Program at Least 30 Days[5]

Type of Mental Health Service	Unique Participants Referred or Linked	Unique Participants Successfully Connected	% Successfully Connected
Independent psychiatrist	15	8	53.3%
Private counselor/therapist	24	7	29.2%
Specialty mental health clinic	90	43	47.8%
Primary care provider	3	1	33.3%
Behavioral health within primary care clinic	26	16	61.5%
Intensive outpatient	19	8	42.1%
Self-help groups (e.g., WRAP, Roadmap to Recovery)	42	10	23.8%
Clubhouse	58	20	34.5%
Inpatient treatment	15	14	93.3%
Crisis house	30	18	60.0%
Other	56	29	51.8%

[5]Definition of successful connection: Provider was able to confirm that the participant actually obtained a specific tool and/or service

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. 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.

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	29	11
# of services	37	21
Total participant responses	120	120
Mental health/substance use related	**Baseline**	**Most Recent**
# of participants with at least 1 service	95	11
# of services	155	30
Total participant responses	131	131
Physical AND mental health/substance use related	**Baseline**	**Most Recent**
# of participants with at least 1 service	24	3
# of services	38	5
Total participant responses	116	116

Table 11: Number of Critical Events During Past 30 days (Pre-post)

Non-psychiatric hospitalization	Baseline	Most Recent
# of participants with at least 1 time	13	3
# of times	21	6
Total participant responses (times)	117	117
# of participants with at least 1 day	5	3
# of days	23	49
Total participant responses (days)	69	69
Jail/prison	**Baseline**	**Most Recent**
# of participants with at least 1 time	8	1
# of times	10	1
Total participant responses (times)	126	126
# of participants with at least 1 day	5	2
# of days	42	44
Total participant responses (days)	67	67

The number of participants in non-psychiatric hospitalization and jail/prison settings decreased from baseline to follow-up (Table 11). The number of times participants experienced critical events also decreased. However, 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.

PEERLINKS PARTICIPANT SERVICE UTILIZATION ANALYSES USING CERNER COMMUNITY BEHAVIORAL HEALTH (CCBH) DATA

The utilization of behavioral health services by PeerLINKS participants was examined 30 days before and after starting the program in order to assess recurrence rates (see Table 12). Participants enrolled in PeerLINKS during calendar year 2017 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.

Among the psychiatric hospital cohort (participants with a psychiatric hospitalization index event; N=117), the recurrence rate decreased by 30.0% after starting the program (25.6% vs 17.9% with any recurrence event). Among the crisis residential cohort (participants with a crisis residential treatment index event; N=129), the recurrence rate remained the same (10.9% vs 10.9% with any recurrence event).

Table 12: 30-Day Recurrence Rates for PeerLINKS Participants (N=246)[6]

	Number of participants included in each cohort	Participants with at least one recurrence event within 30 days prior to PeerLINKS enrollment[7]	30-day recurrence rate prior to PeerLINKS enrollment[7]	Participants with at least one recurrence event within 30 days after PeerLINKS enrollment	30-day recurrence rate after PeerLINKS enrollment[8]
Hospital Cohort	117	30	25.6%	21	17.9%
Crisis Residential Cohort	129	14	10.9%	14	10.9%

Note: [6] Includes participants enrolled in PeerLINKS during calendar year 2017 with an index event (i.e., hospitalization or crisis residential treatment episode) identified in Cerner. [7]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. [8]30-day recurrence rate after PeerLINKS enrollment determined by whether a subsequent admission occurred within 30 days after the end of the index event.

PEERLINKS ANNUAL STAFF FEEDBACK SURVEY

At the end of the second year of providing the program, 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. Thirteen staff participated (87% response rate). For the open-ended survey questions, three evaluators reviewed and coded the responses independently. Any discrepancies were discussed to arrive at a consensus on the key response themes.

STAFF SURVEY FINDINGS

Staff highlighted the main innovative factors and program goals, the factors that helped achieve these goals as well as specific challenges they had experienced during the second year of operation.

Key program "innovations" or factors that make this program unique:

a. Support that is participant-centered
b. Services for participants that come from peers with lived experience
c. Linking participants to community resources and external connections

Major program goals identified by respondents:

a. Linking participants to community resources
b. Providing support to participants
c. Reducing readmission of participants to psychiatric hospitals and crisis homes

Factors that helped the program achieve these goals:

a. PeerLINKS staff being able to rely on a knowledgeable and supportive team
b. Providing peer support to participants
c. Being able to access community services and resources for participants

Specific challenges to reaching the program goals described by respondents:

a. Participant-related characteristics and factors such as losing contact with participants or the participants being disengaged, unwilling (e.g., declining suggestion for referral), or unable to actively participate in their recovery (e.g., due to language barriers)
b. Lack of resources for participants (e.g., emergency services and available housing)
c. Time-related factors such as long wait times for external services
d. Some respondents noted that there were no factors preventing them from achieving program goals

Almost half of the respondents identified that the waitlists for services that participants were referred to (46%) were an issue that was challenging or very challenging for the program during the past year. Additionally, about a third of the respondents found participants not completing referrals for other services (38%) and participant attrition/not completing the program (31%) to be challenging or very challenging.

In addition, staff were asked to provide their feedback on what they believe were the key characteristics of participants who were successful in the program.

Key characteristics of participants that have been successful:

a. Participant is ready and interested to receive help and services
b. Participant maintained communication/engagement with Peer Support Specialist
c. Participant has gained a support system(s)
d. Participant has housing, employment, and/or income

KEY YEAR 2 PEERLINKS PROGRAM "LEARNINGS"

1. **Pool Employee:** The program added a Pool Employee who can cover while other team members are on medical leave or vacation. Depending on budget, the program hopes to continue this arrangement during Year 3.

2. **Connecting to housing services:** The program has now the ability to access information and enter participants into the Homeless Management Information System/Coordinated Entry System (HMIS, CES); this includes the ability to complete the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) and refer participants to a Housing Navigator within CES. Additionally, the program continues to refer participants to housing programs and navigators if the participant is interested in receiving such services.

3. **Homeless Court Program (HCP):** In May of 2018, the PeerLINKS program became a referring agency for the Homeless Court Program, which is "*a special Superior Court session convened in a homeless shelter where homeless participants can voluntarily resolve outstanding misdemeanor offenses and warrants,*" as well as have fines reduced or removed. HCP utilizes alternative sentencing, where the court essentially "credits" participant's engagement and accomplishments in the PeerLINKS program as "time served." Therefore, to be referred to HCP by the program, participants must make substantial progress towards their goals, be engaged with the program for at least two months, and exhibit changes in the behavior or situation that led to their offense. In addition to reducing stress and improving participants' well-being, resolving offenses, and removing warrants help reduce barriers to housing; furthermore, having fines removed or reduced allows participants to use their income towards housing and other essential needs.

4. **Donor funds:** The program obtained a donation to provide items important for participants' recovery and well-being but which cannot be purchased with San Diego County funds; that is, items/activities that do not meet the definition of Flex Funds (Flex Funds are monies of last resort used to assist participants whose recovery would be jeopardized by unmet needs). Examples of ways the program has used these donor funds include: buying home/kitchen/cleaning items for participants who obtained their own apartment/home following lengthy periods of homeless or transitional housing. Other examples include the registration fee for a recovery-related conference, and fun activities such as tickets to attend movies and art shows.

5. **Connecting participants to appropriate level of care**. While many of the participants are connected to the appropriate level of care, the program has found that some of the participants are not interested in receiving services at the appropriate level of care. This is due to various reasons, including: having an appointment made with a federally qualified health center by staff at the inpatient unit prior to discharge; a preference for a clinic that is closer to where participants live; ability to receive physical and mental healthcare at the same location; and/or participants had previous experience with various clinics and developed a preference for specific ones. Additionally, some participants lost interest in being connected with an Assertive Community Treatment (ACT) program or may feel that their mental illness may not be severe enough to be in that program.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. ***Continue outreach and strengthening of connections with external services and sites across San Diego County and specifically, services related to housing, particularly for participants who may be more difficult to connect.*** The PeerLINKS team built and strengthened connections and conducted outreach with a variety of organizations and programs that provide services related to mental health, substance use disorders/co-occurring disorders, vocational training/education, and supportive employment. The team connected with agencies that serve justice-involved populations and agencies that serve individuals experiencing homelessness, including shelters, housing providers and navigators, and agencies that provide food and/or clothing. Specifically, the program team conducted outreach activities with over 40 organizations; presented to over 200 individuals at various council and committee meetings, panels and symposiums; and attended several special events, open houses, trainings, and meetings, where the team took the opportunity to provide information about PeerLINKS and build/strengthen relationships with various programs and providers.
2. ***Refine program materials to provide a clearer description of the program, role, purpose and limits of the program; ensure these materials are provided to and reviewed with all potential participants and staff from the crisis homes/hospitals which the program serves.*** The program created a Partnership Agreement Form which is reviewed with all potential participants before they enroll in PeerLINKS. The form includes the purpose and limits of the program, as well as the role of the Peer/Family Support Specialist. An abbreviated version of the form was reviewed with staff from the crisis homes/hospitals served by the program. A program brochure which provides an overview of the program was also created.
3. ***Promote the role of Peer/Family Support Specialists among participants, service providers, and other stakeholders, to increase ease of access to services.*** The program team took various approaches to address this, including: describing the role of the Peer/Family Support Specialist in detail in the Partnership Agreement Form and the abbreviated version of the form; the team promoted and clarified the role of the Peer/Family Support Specialists during outreach activities and presentations; moreover, the team has continued to clarify the role when communicating and coordinating care with service providers.
4. ***Refine PeerLINKS' enrollment/eligibility to ensure enrollment of participants who are most likely to benefit from the program, given budget limitations.*** The program continued to serve adults living with a Serious Mental Illness, who had multiple acute care visits in the previous year and are not effectively connected to resources/ services or lack a strong support network. Participants receive Medi-Cal or are Medi-Cal eligible and are being referred by one of four sites: Scripps Mercy's inpatient unit and emergency department, UC San Diego's inpatient unit, Vista Balboa Crisis Center, and New Vistas Crisis Center.
5. ***When possible, connect participants with case management services soon after they join the program.*** To increase the team's awareness and understanding of the various case management programs, the program 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.
6. ***Develop strategies to increase the number of closure packets completed by participants who are leaving or graduating from the program. Offering an incentive (e.g., meal, gift card) may be explored.*** The program held various team meetings, where the team identified barriers to collecting assessments, proposed solutions for reducing these barriers whenever possible, and shared their strategies and best practices. The program also explored the option of offering incentives to participants who complete the closure paperwork, however, this is not common practice and the additional expenses were not approved by the County.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS CONTINUED

7. ***Continue the collection of regular participant assessments, and in particular, increase the number of participants who provide feedback on items related to participant satisfaction and participant rated outcomes. In addition, transition towards using electronic documentation rather than hardcopies whenever possible.*** Team members now receive weekly reports that identify their active participants, provide assessment windows for current or upcoming assessment periods, and indicate whether the documentation has been completed. The program implemented quality assurance practices; specifically, the program's Behavioral Health Clinician reviews all paperwork prior to data entry to identify missing items, as well as to identify need for training or coaching for the entire team or specific members. Additionally, the program held various team meetings, where the team identified barriers to collecting assessments, proposed solutions for reducing these barriers whenever possible, and shared their strategies and best practices. A brief incentive strategy was created for the team, which increased the number of assessments being collected; the process also allowed the team to further identify barriers, as well as learn how these had been successfully overcome by the team.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-15 PeerLINKS program that differed substantially from the initial design of the program during the second year of service provision (7/1/2017 to 6/30/2018). Some basic practices and procedures were adjusted over the course of the second year, as described in a number of enhancements to the program under "Key Year 2 PeerLINKS Program Learnings" or "Status of Prior Year Program Recommendations." However, no fundamental or program-wide changes were made.

YEAR 3 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the program and further increase participant services and engagement during Year 3 include the following:

1. To continue to focus on linkages to mental health and substance abuse treatment programs and to improve the tracking of this information. To continue to connect program participants who utilize acute care repeatedly and to connect them to the San Diego County behavioral health system.
2. To systematically capture participants' level of motivation for engaging in the program and working towards their recovery-related goals by adding relevant items to the baseline and follow-up assessments. This information would help the program to explore ways to increase motivation, or support these participants in succeeding despite not being interested in working towards goals.
3. To conduct a "check-in" with discharged participants at approximately three months past discharge and six months, if possible. The check-in will also focus on any changes to the participants' housing situation, employment, and use of emergency services.

For additional information about the INN–15 PeerLINKS program and/or this annual report, please contact: Edith Wilson, Ph.D., at eewilson@ucsd.edu.

URBAN BEATS (INNOVATIONS-16)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
ANNUAL REPORT: YEAR 3 (7/1/17 - 6/30/18)

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 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-week 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 (INN-16) was designed to provide wellness education and social support to TAY with mental health needs through individualized development of TAY artistic expression skills and interests. Artistic expression is expected to reduce stigma in both TAY and the general community through public performances.

- During FY 2017-18, a total of 177 new, unduplicated TAY enrolled in the Urban Beats program.
- Urban Beats participants reflected substantial diversity in race/ethnicity, sexual orientation, and gender identity. The proportion of females increased from last year (18.2% to 41.2%), but still lower than males (50.8%).
- Based on follow-up data from this year (n=45), the findings suggested that Urban Beats participants felt more able to make positive changes in their lives and more comfortable talking to mental health professionals; they were also 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.
- 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).
- The Urban Beats program held a similar number of community performances (n=28) compared to the prior year, with 950 persons in attendance. By contrast, the first program year had only four performances with approximately 250 attendees.
- 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).

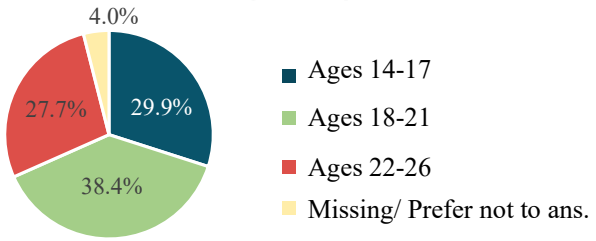
RECOMMENDATIONS

Primary recommendations for service provision improvements include: 1) develop a shorter version of the Urban Beats program (i.e., still 20 hours, but during less than 20 weeks), and 2) establish a location for the North Central office in order to better serve the target population.

URBAN BEATS PARTICIPANT DEMOGRAPHICS

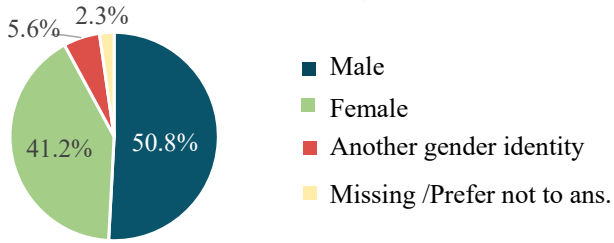
The following demographic data were collected from a participant self-report survey administered when enrolling in the Urban Beats program.[1]

AGE(N=177)



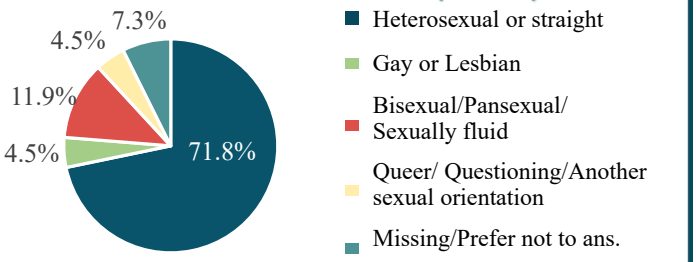
The age distribution was relatively consistent across youth age categories (roughly 30% in each age group).

GENDER IDENTITY (N=177)



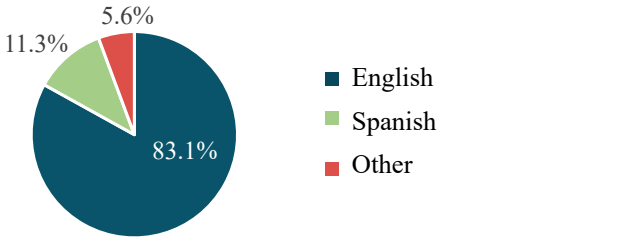
Forty-one percent of participants identified as female, as compared to the prior year in which 18.2% identified as female.

SEXUAL ORIENTATION (N=177)



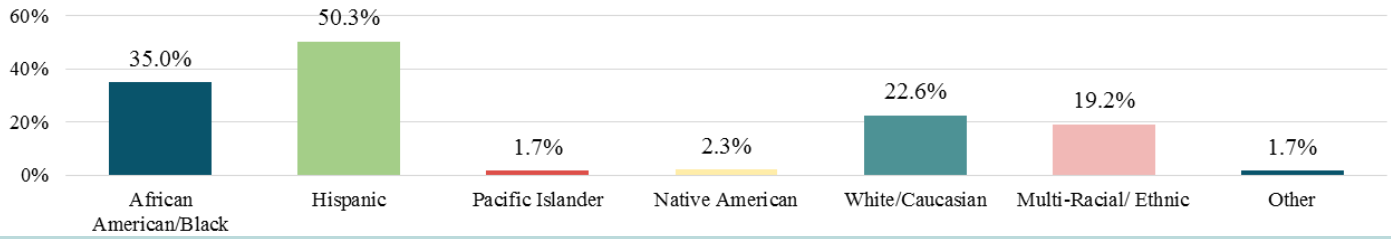
Over half (72%) of participants were heterosexual or straight, and 12% identified as bisexual, pansexual, or sexually fluid.

PRIMARY LANGUAGE (N=177)



The majority (83%) of participants preferred English as their primary language.

RACE/ETHNICITY (N=177)

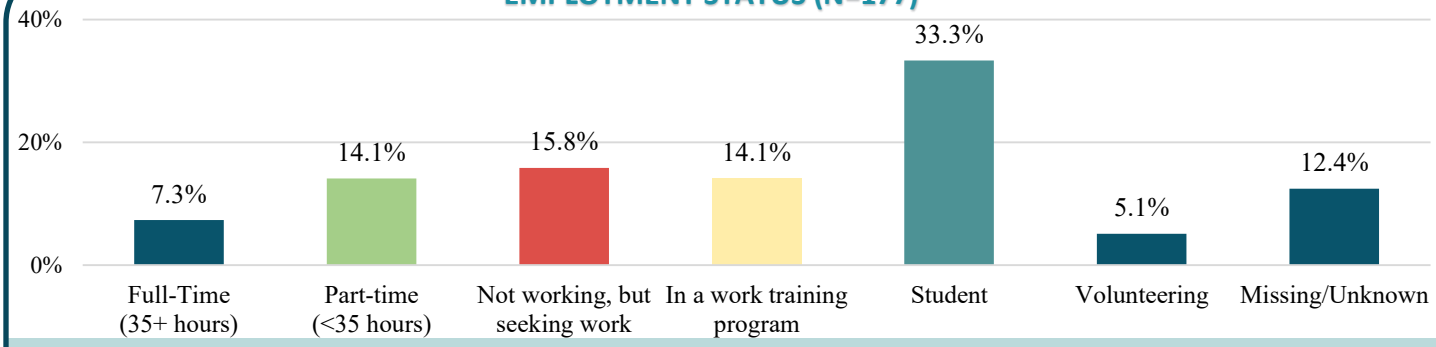


About half (50.3%) of the participants identified as Hispanic, 35.0% as African-American, and 22.6% as White. Another 19.2% identified with multiple racial/ethnic backgrounds. Totals may exceed 100% as participants were able to indicate more than one race.

Percentages may not total to 100% due to rounding.

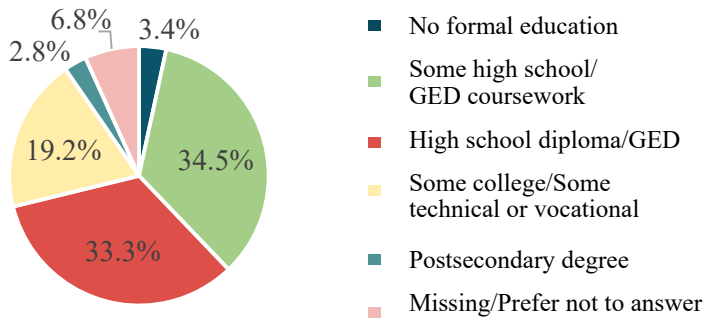
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EMPLOYMENT STATUS (N=177)



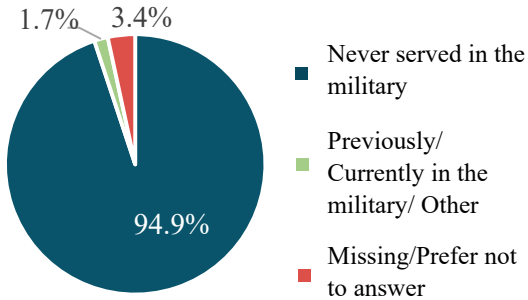
About 20% of participants indicated that they were working (7.3% full-time and 14.1% part-time), 14% were in some form of work training program, and 16% were not working, but seeking work. Approximately 33% indicated they were in school. Totals may exceed 100% as participants could select more than one employment status category.

EDUCATION LEVEL (N=177)



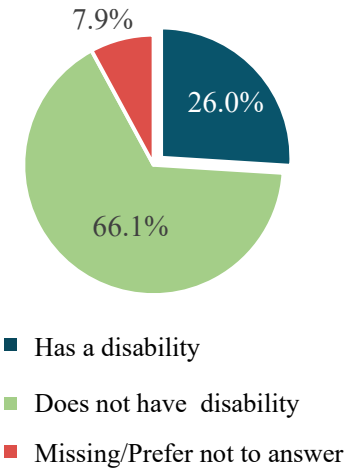
Approximately two-thirds (71.2%) of participants indicated that they had a high school diploma/GED or lower level of education.

MILITARY STATUS (N=177)



Very few participants (1.7%) indicated having served in the military.

DISABILITY[2] STATUS (N=177)



Over a quarter (26%) of participants, indicated having some type of non-SMI related disability.

TYPE OF DISABILITY (N=46)

Type	n	%
Difficulty Seeing	14	30.4
Difficulty Hearing	6	13.0
Learning Disability	19	41.3
Physical	3	6.5
Chronic Health	5	10.9
Other	8	17.4

This table lists the type of non-SMI related disability indicated by participants. Totals may exceed 100% as participants could indicate more than one type of disability. The high percentage of participants indicating difficulty seeing appeared to be related to participants who needed some form of vision correction, such as glasses or contacts.

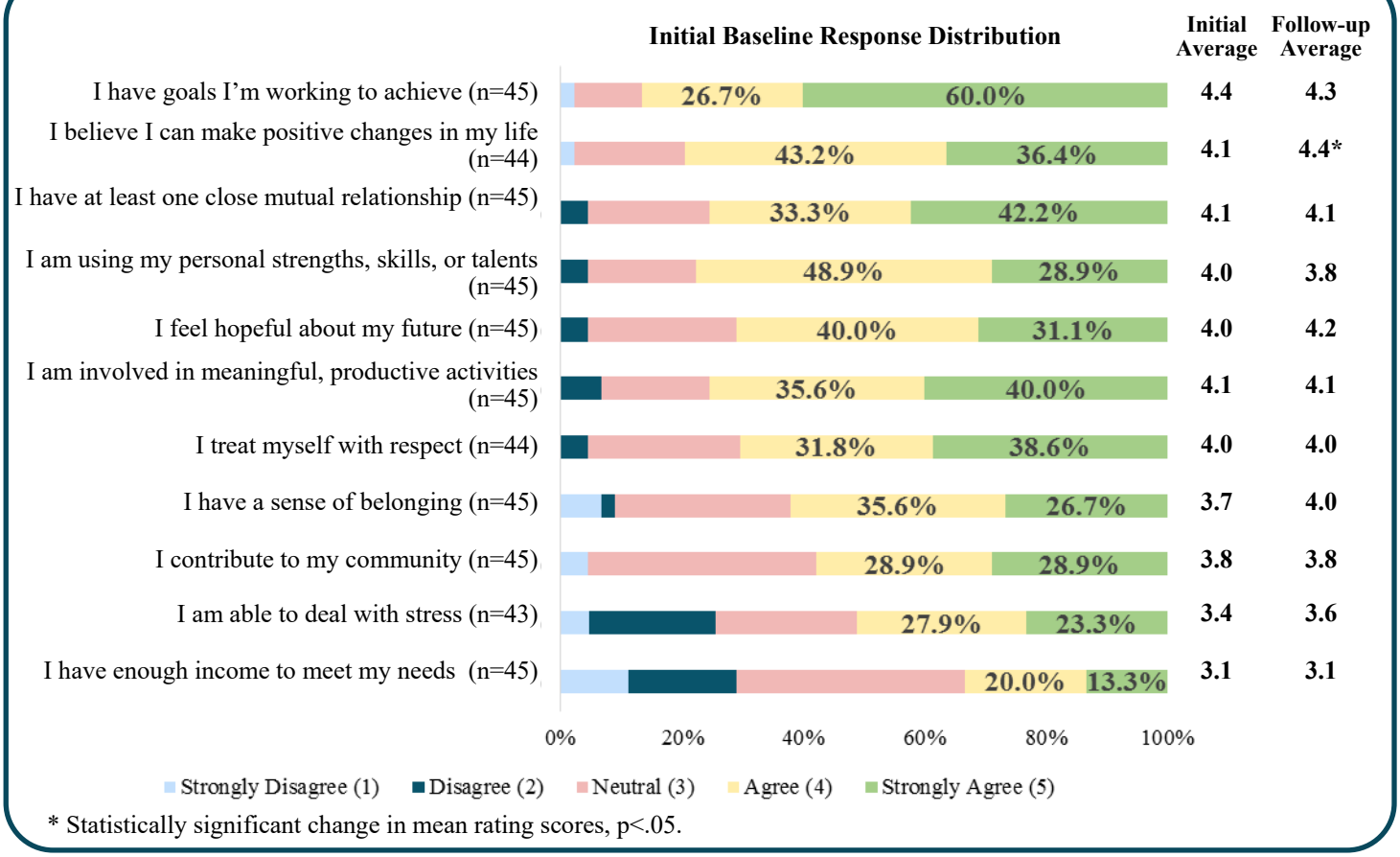
[2] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

URBAN BEATS PARTICIPANT BELIEFS

At the start of each Urban Beats round of classes, participants were asked to complete a Wellness Survey. They were asked again after 6 weeks, and at the end of the 20-week program participants completed a follow-up Wellness Survey. To identify areas of change, the responses from participants who completed both a baseline and a follow-up survey are listed in the following chart. The chart presents the distribution of responses at initial baseline, the average rating at initial baseline, and the average rating at the most recent follow-up. Part of the Wellness Survey included select items from the Recovery Markers Questionnaire (RMQ). Participants included in this chart had a follow-up survey completed during FY 2017-18 (n=45).

At baseline, the most commonly endorsed statements (i.e., at least 75% agreed or strongly agreed) focused on participants' beliefs about their self-efficacy and pursuit of goal achievement. Participants appeared to be less enthusiastic about their stress management capabilities and having sufficient income. 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. The average ratings for all items increased or stayed the same at follow-up, with one item demonstrating a statistically significant difference ("I believe I can make positive changes in my life"). This aspect of well-being is a priority of the Urban Beats program. While we do not see the same increase as last year in ratings for ability to deal with stress and involvement in meaningful and productive activities, the baseline scores for these two items were substantially higher compared to last year's Urban Beats enrollees (e.g., "meaningful and productive activity" was 3.6 at baseline last year as compared to 4.1 at baseline this year). This suggests that this year's participants were potentially at a somewhat higher wellness level on these dimensions than last year's.

FIGURE 1. URBAN BEATS PARTICIPANT BELIEFS—BASELINE AND FOLLOW-UP COMPARISONS



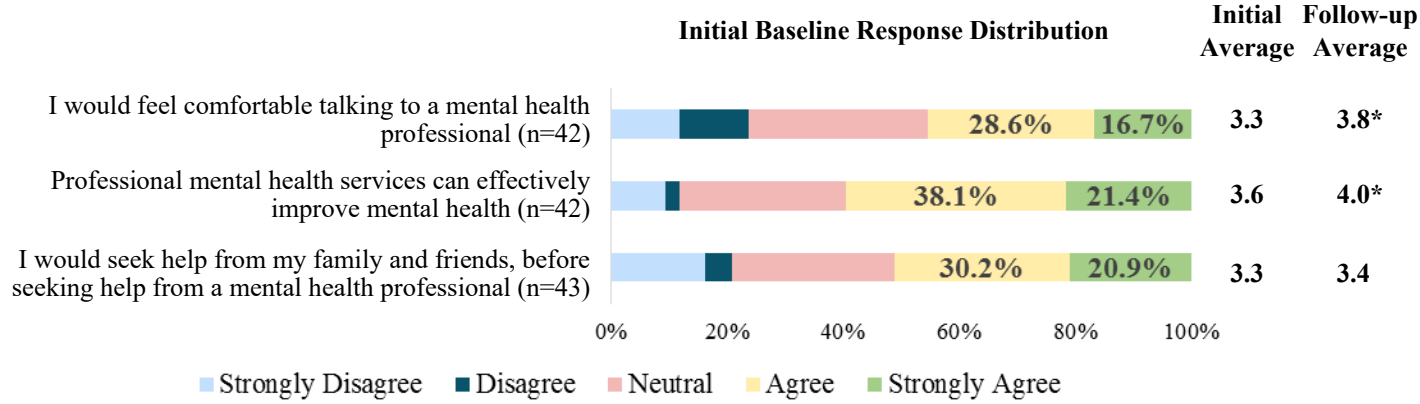
* Statistically significant change in mean rating scores, p<.05.

The Wellness Survey also inquired about the quality of health, mental health, and satisfaction with social activities/relationships. Many Urban Beats participants indicated they had health and mental health concerns, with 17.7% and 24.4%, respectively rating their overall health and mental health, as "Poor" or "Fair." These findings highlight the importance of focusing on physical and mental health within the Urban Beats program. The average ratings for these items did not change significantly at follow-up.

URBAN BEATS PARTICIPANT ATTITUDES ABOUT MENTAL HEALTH SERVICES

The Wellness Survey also included questions about participant attitudes towards mental health services. At baseline, 45.3% of the Urban Beats participants agreed or strongly agreed that they would "feel comfortable talking to a mental health professional." A majority (59.5%) agreed or strongly agreed that "professional mental health services can effectively improve mental health." These findings indicate that many Urban Beats participants had positive perceptions of professional mental health services in improving mental health, but at the same time may not feel entirely comfortable interacting with mental health professionals. The Urban Beats program sought to address these concerns through psychoeducation and promoting engagement with professional mental health services when needed. Likely as a result of these efforts, the average rating for whether "I would feel comfortable talking to a mental health professional" increased significantly from an average rating of 3.3 at baseline to 3.8 at most recent follow-up. These values correspond to an average response close to "Neutral" at baseline and "Agree" at follow-up.

FIGURE 2. URBAN BEATS PARTICIPANT ATTITUDES-BASELINE AND FOLLOW-UP COMPARISONS

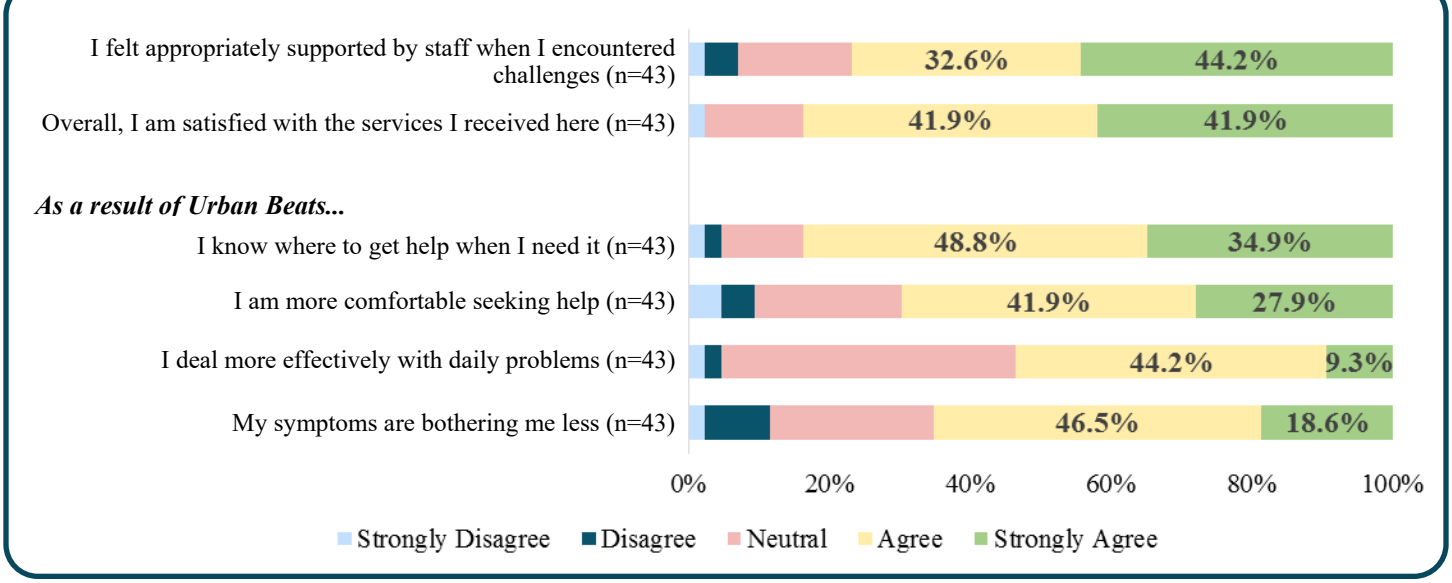


* Statistically significant change in mean rating scores, p<.05.

URBAN BEATS OUTCOMES

As shown in the chart below, the vast majority (83.8%) of Urban Beats participants with follow-up Wellness Survey data indicated they were satisfied with the Urban Beats program (41.9% strongly agreed). A similar percentage (76.8%) thought they were "appropriately supported by staff when [they] encountered challenges." The majority indicated that as a result of participating in the Urban Beats program, they knew "where to get help" (83.7%), felt "more comfortable seeking help" (69.8%), dealt "more effectively with daily problems" (53.5%), and were less bothered by symptoms (65.1%).

FIGURE 3. URBAN BEATS PARTICIPANT ASSESSMENT OF URBAN BEATS PROGRAM



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=227) who started the Urban Beats program at least 180 days prior to the end of the reporting period (6/30/2018).

As shown in Table 1, a little over one-quarter (26.4%) of the 227 Urban Beats 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 18.5% 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 (21.6%), while the participation rate and number of total visits for ACT had a modest increase (19.8%; 1793 vs 1879 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 11% had an inpatient psychiatric hospitalization in the 180 days before starting Urban Beats, only 4.4% (a 60% reduction in the hospitalization rate), had a hospitalization after starting Urban Beats (total admissions reduced from 52 to 18). There is also a substantial decrease in admission rate and total number of admissions to crisis residential treatment after starting Urban Beats (6.2% vs 1.3%; 19 vs 3 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.

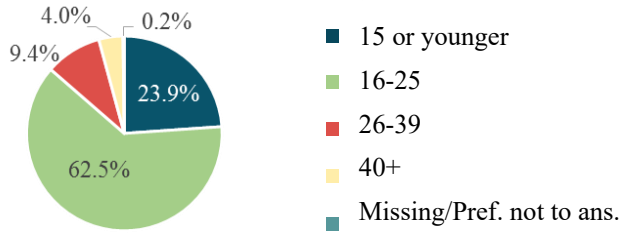
TABLE 1. BEHAVIORAL HEALTH SERVICE UTILIZATION BEFORE AND AFTER STARTING THE URBAN BEATS PROGRAM

	180 Days Before Start Urban Beats (n=227)			180 Days After Start Urban Beats (n=227)		
	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	60	26.4%	721	49	21.6%	539
Assertive Community Treatment (ACT)	42	18.5%	1,793	45	19.8%	1,879
Case Management	1	0.4%	20	1	0.4%	4
Urgent Outpatient	22	9.7%	40	11	4.8%	17
Crisis Stabilization	13	5.7%	17	1	0.4%	6
Psychiatric Emergency Response Team (PERT)	15	6.6%	20	6	2.6%	8
Justice-Related Mental Health Visit	13	5.7%	47	6	2.6%	25
	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	25	11%	52	10	4.4%	18
Crisis Residential Treatment	14	6.2%	19	3	1.3%	3

COMMUNITY PERFORMANCE ATTENDEE DEMOGRAPHICS

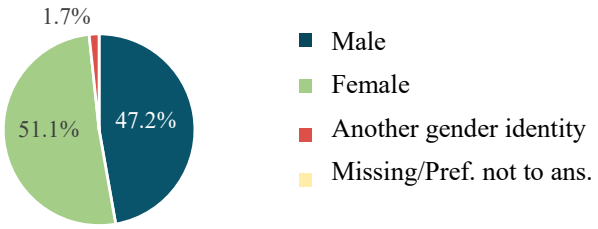
The following demographic data were collected from an audience self-report survey administered at the community performances.

AGE (N=180)



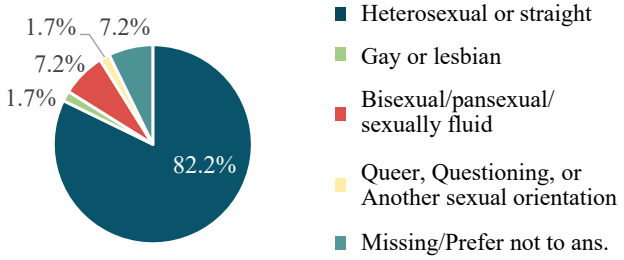
The majority (62.5%) of attendees were between the ages of 16 and 25, and about a quarter (23.9%) were under 15.

GENDER IDENTITY (N=180)



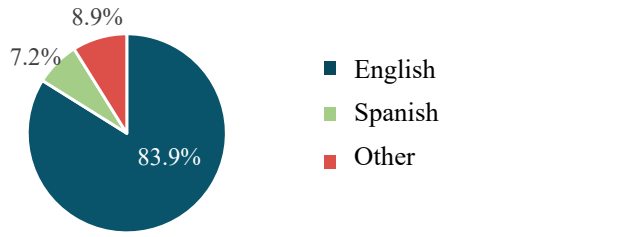
A slight majority (51.1%) of attendees were female.

SEXUAL ORIENTATION (N=180)



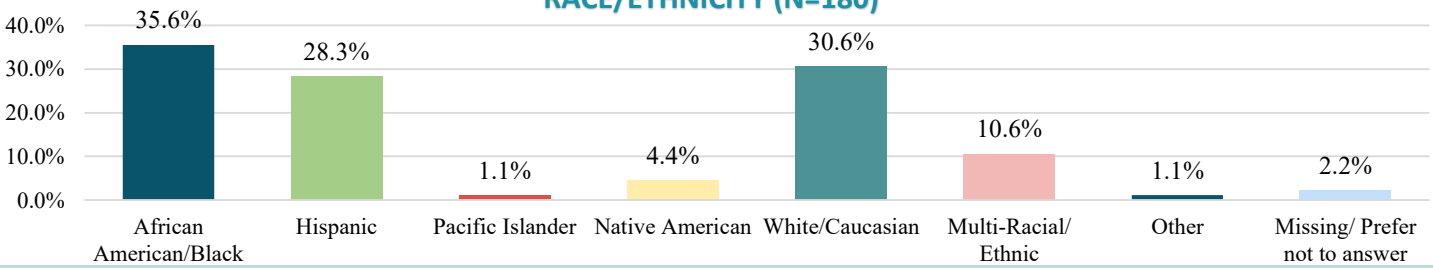
Eighty-two percent of participants were heterosexual or straight.

PRIMARY LANGUAGE (N=180)



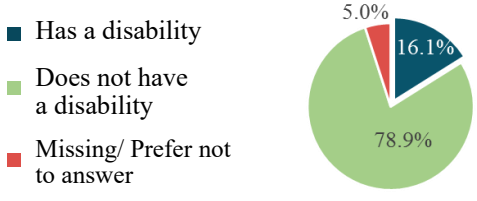
The vast majority (83.9%) of participants preferred English as their primary language.

RACE/ETHNICITY (N=180)



The performances reached a diverse audience. Approximately one-third (30.6%) identified as White, one-third (35.6%) as African American, and one-quarter as Hispanic (28.3%). Totals may exceed 100% as attendees could indicate more than one option.

DISABILITY[1] STATUS (N=180)



Sixteen percent of attendees had some type of non-SMI disability.

Most attendees (92.2%) indicated they had never served in the military.

TYPE OF DISABILITY (N=29)

Type	n	%
Communication	4	13.8
Mental (e.g., learning, developmental)	6	20.7
Physical	7	24.1
Other	13	44.9

The table above describes the types of disabilities these attendees reported. Totals may exceed 100% as attendees could indicate more than one type of disability.

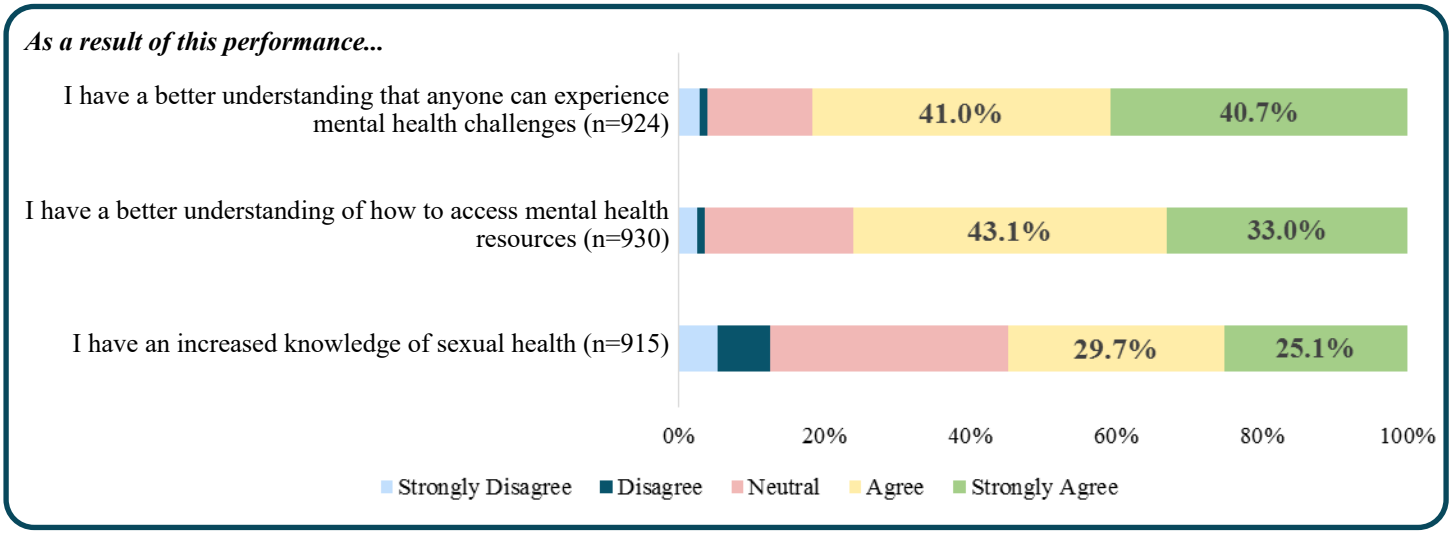
[1] *A disability was defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness (SMI).*

KEY EVALUATION FINDINGS: COMMUNITY PERFORMANCES

COMMUNITY PERFORMANCE OUTCOMES

During year 3, the Urban Beats program hosted or co-hosted 28 community performances and collected outcome surveys from 950 persons. By contrast, only four performances with 250 attendees occurred during the first year of the program. TAY audience members (ages 16-25) comprised 62.5% (n=180) of the demographics survey respondents. 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 4, a majority of respondents (81.7%) 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 (76.1%) 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 (54.8%).

FIGURE 4. ASSESSMENT OF COMMUNITY PERFOMANCE ATTENDEE LEARNING



The response patterns between TAY (n=594) and non-TAY (n=356) who attended the performances were fairly similar regarding the percent who agreed or strongly agreed that they "had a better understanding that anyone can experience mental health challenges" (83.2% compared to 79.1%) and "had a better understanding of how to access mental health resources" (77.4% compared to 73.8%). However, TAY audience had a much higher feedback that they "had increased knowledge of sexual health" (59.7% compared to 46.4%) as a result of the performance.

UTILIZATION OF TECHNOLOGY TO EXPAND REACH OF URBAN BEATS PROGRAM

URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTVITIES

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 2 lists the website (https://www.sdurbanbeats.org/) and other social media activities for the program.

TABLE 2. URBAN BEATS WEBSITE AND SOCIAL MEDIA ACTIVITIES

	Fiscal Year 2017-18		Fiscal Year 2017-18
New Instagram Followers	461 (751 Total)	**Facebook**	
New Twitter Followers	94 (134 Total)	• Page Likes	459
Website Visits	5,102	• Post Likes	3,358
SoundCloud Plays/Likes	359	• Reach (unique views)	21,032

URBAN BEATS PROGRAM ANNUAL STAFF FEEDBACK SURVEY

Urban Beats program administrative and provider staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the Urban Beats program. There were 12 respondents from the 15 persons invited to participate in the survey, a response rate of 80%. 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. *The major program goals identified by Urban Beats staff:*
   a. Mental health education and stigma reduction
   b. Provide opportunities for artistic expression
   c. Engagement of transitional age youth (TAY) in a positive, wellness-oriented program
   d. Community education and outreach related to mental health and stigma reduction
   e. Increase TAY service access and utilization
2. *Factors that helped the Urban Beats achieve program goals:*
   a. Collaborations and partnerships with other community organizations
   b. Intensive outreach and engagement efforts
   c. Offering art as a focus
   d. The unique resources available to participants through Urban Beats
   e. The structure of the program (i.e., social cohorts with individual mentoring)
   f. Providing linkages to resources in the community
   g. Increased staffing levels
   h. Conducting performances throughout community
   i. Providing psychoeducation to TAY
   j. Staff skills/support of participants
3. *Key program "innovations" or factors that make this program unique from other programs with similar goals:*
   a. Using art and music to engage youth in mental health
   b. Providing a safe space to discuss mental health
   c. Youth-led events/youth control over their own project/process
   d. Diversity of the staff
4. *Most effective ways to identify and recruit potential TAY participants for the Urban Beats program:*
   a. Community outreach/performances
   b. Actively recruit youth involved in other services
   c. Encourage referrals from other community partners/service providers
   d. Outreach to schools
   e. Youth word-of-mouth
   f. Social media outreach
   g. Recruitment at homeless shelters
5. *Primary barriers to linking Urban Beats TAY with mental health services:*
   a. Lack of information about mental health resources
   b. Challenges with participant motivation/follow-through
   c. Ongoing stigmas related to receiving services
   d. Transportation barriers
   e. Participants not meeting treatment program requirements
   f. Previous negative experiences/lack of trust in treatment
6. *Role of Urban Beats to help TAY reduce mental illness stigma among themselves and in the community:*
   a. It improved comfort levels with discussing mental health
   b. It facilitated youth growth & education
   c. It offered opportunities for youth expression
   d. It created opportunities for youth-to-youth support
   e. It increased TAY connections/engagement in their communities
   f. It provided a "safe space"
   g. It used social media presence to provide education and reduce stigma
   h. It facilitated linkages to providers

KEY YEAR 1 URBAN BEATS PROGRAM "LEARNINGS"

1. An arts-based curriculum was an effective approach to engage TAY in a behavioral health-oriented outreach and support program, particularly for racial/ethnic and sexual orientation minorities who may be underserved in more traditional service settings.
2. Including a public performance component of the Urban Beats program was vital for achieving program objectives.
3. Urban Beats' staff's with receiving mental health services facilitated connections with TAY and discussions about accessing needed services.
4. The length of the Urban Beats program (i.e., 20 weeks), created some difficulties retaining participants throughout program, but the extended amount of time that the TAY worked with each other and Urban Beats staff also encouraged the development of mentor- and peer-support relationships.
5. It was important to adapt the Urban Beats curriculum to accommodate and recruit a broader population of youth (e.g., initially focus on trauma rather than stigma for youth with less direct exposure to mental health issues and services).
6. Short-term Urban Beats outcomes, such as increased communication, leadership, and self-discovery skills, may be "stepping stones" to bigger, longer-term outcomes related to education, employment, and mental health and wellness management.
7. It is essential to recruit and retain creative, talented, and passionate Urban Beats staff.
8. Urban Beats "graduates" who assisted with subsequent classes took on more responsibilities for outreach and performance planning and functioned as peer mentors for incoming cohorts.

KEY YEAR 2 URBAN BEATS PROGRAM "LEARNINGS"

1. Having more community performances facilitated greater engagement of TAY throughout the program and increased opportunities for community education/stigma reduction, particularly among TAY audience members.
2. Establishing regularly scheduled community performances (e.g., every 3rd Friday), reduced planning burdens and helped with outreach/advertising since times and locations were known well in advance.
3. Challenges/barriers still exist with linking more TAY to appropriate mental health services. For example, older TAY (i.e., 21-25), were not always comfortable receiving services in traditional "adult" oriented mental health programs and may benefit from additional mental health services more targeted to their needs/experiences.
4. Continuing to expand the community partner network is important to allow for reaching diverse, and often under-served TAY populations (e.g., partnerships in Year 2 allowed for greater recruitment/engagement of justice-involved and LGBTQI youth).
5. Evidence is emerging that utilization of acute/crisis-oriented mental health care services diminishes after enrolling in the Urban Beats program.
6. Allowing youth to participate multiple times in Urban Beats is important for some youth since the positive, significant changes may not occur until 2nd or 3rd time through the program.

KEY YEAR 3 URBAN BEATS PROGRAM "LEARNINGS"

1. Access to a vehicle (i.e., Urban Beats van) facilitates TAY participation in performances and program events.
2. Substantial need and interest increased within other San Diego communities, prompting Urban Beats program expansion.

YEAR 3 PROGRAM CHANGES

During FY 2017-18 the INN-16 Urban Beats program implemented three substantial programmatic changes. First, they expanded into several communities in San Diego, including a partnership designed to increase engagement with TAY from East Africa. Second, the program added a clinical position to the Urban Beats team so that therapeutic care could be made available to TAY from someone within the Urban Beats program while still working to facilitate appropriate linkages to external treatment services as needed. Finally, the Urban Beats program acquired a van to facilitate transportation to Urban Beats classes and performances and other community services as needed.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

1. Increased access to technical resources/facilities (e.g., computers, recording studios, editing equipment).

   Status: During FY 2017-18, Urban Beats was able to increase TAY access to other resources, such as DJ equipment and smartphones. The DJ equipment provided an opportunity for TAY to learn an art medium, which is also a lucrative employment skill. The smartphone provided opportunities for TAY to create social media posts and engage in the platform in real time. Urban Beats also created a second studio (for North Central), which enabled TAY to create more artistic content and learn music production.

2. More strategic use of social media to advance program goals (e.g., TAY recruitment, retention, education, and community outreach).

   Status: Program staff created a Social Media Branding Guide, which was used to train all staff and TAY to create their own social media. This process led the program to rely less on a social media consultant. The social media component of the program included an increased use of social media marketing strategies (e.g., use of popular uniform hashtags, timed posts, intentional content geared towards the mental health community, and disclaimers for mental health resources). Based on these strategies, the program has seen a dramatic increase in online followings, mostly on Instagram and Twitter.

3. Explore potential for providing on-site or direct, dedicated access to mental health counseling for Urban Beats participants.

   Status: During FY 2017-18 the Urban Beats program added a clinician who can provide therapeutic services directly to Urban Beats participants prior to any linkages to external treatment services.

4. Improve data collection approach to facilitate completion of greater numbers of Urban Beats participant follow-up surveys.

   Status: Consistently collecting follow-up surveys from Urban Beats participants continues to be a challenge. One reason to develop a shorter version of Urban Beats (i.e., still 20 hours, but during less than 20 weeks) is to increase retention and therefore have increased opportunities to collect the follow-up survey data to assess impact of Urban Beats participation.

CURRENT YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the Urban Beats program and support the achievement of program objectives include the following:

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.
2. Establish a location for the North Central office in order to better serve the target population (e.g., having the ability to host classes).

For additional information about the INN–16 Urban Beats program and/or annual report, send your inquiry to:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

COGNITIVE REHABILITATION AND EXPOSURE/ SORTING TREATMENT (CREST) PROGRAM (INNOVATIONS-17)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY BEHAVIORAL HEALTH SERVICES ANNUAL REPORT: YEAR 2 (1/1/17 - 12/31/17)

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. CREST is designed to reduce hoarding behaviors among older 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 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 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; INN-17) is a 26-session "in-home" program designed to reduce hoarding behaviors among older 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.

- During 2017, 36 persons participated in CREST (including 12 new enrollees). Of the 77 persons screened during 2017 almost all met criteria for hoarding disorder (94.8%), but the majority (71.4%) were unable to enroll due to insurance status (e.g., had Medicare) or zip code restrictions.
- Of the 12 new enrollees, the average age was 66 (range = 60 to 76) and nearly 60% were female. The majority identified as "white" (58.3%), all reported English as their primary language, and half (50.0%) had a post-secondary degree.
- Over 80% reported having at least one disability unrelated to mental health (e.g., physical disability or pain) and many had at least one comorbid psychiatric diagnosis in addition to hoarding disorder, such as major depression (58.3%).
- During 2017, key outcomes included preventing evictions (n = 7), substantially reducing clutter (measured by the Clutter Image Rating scale), and substantially reducing functional impairment (measured by the Hoarding Rating Scale).
- While demonstrating improvements, 54.5% of the persons who completed the 26-sessions during 2017 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) having a mobile team to provide in-home visits, 3) having coordinated, full-service care provided by a multi-disciplinary team, 4) focusing on factors affecting home safety, 5) having funds to purchase services (e.g., home repairs/dumpster rentals), and 6) having supportive and collaborative community partners.

RECOMMENDATIONS

Primary recommendations include: 1) expand services by modifying eligibility criteria (e.g., allowing Medicare enrollees), 2) improve media outreach/community engagement for recruitment and establishing community partnerships, 3) improve home repair and clutter removal processes, 4) incorporate family groups into treatment model, 5) increase flexibility regarding length of stay in the CREST program, and 6) add yearly income to screening tool to identify persons who may have incomes higher than Medi-Cal thresholds, but still have limited resources.

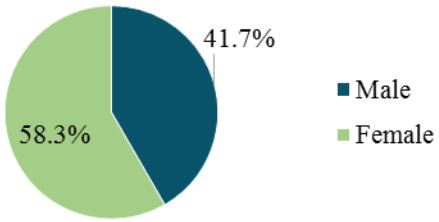
CREST PROGRAM PARTICIPANT CHARACTERISTICS

The following data elements were collected via a participant self-report survey administered at the start of the CREST program.

- During 2017, 77 new persons were screened for CREST program eligibility, 73 (94.8%) met criteria for hoarding disorder, 18 (23.4%) met all eligibility requirements (i.e., region and insurance status), and 12 (15.6%) decided to enroll into CREST.
- During 2017, a total of 36 clients participated in the CREST program (24 were enrolled during 2016).
- Many referrals earned more than Medi-Cal income thresholds, but were too impoverished to afford services.

- New participants ranged in age from 60 to 76, with an average age of 66.
- All new participants reported English as their primary language.
- All new participants identified as heterosexual.
- One (8.3%) new participant previously served in the military.
- Seven (58.3%) participants identified as White and five (41.2%) participants identified as another race/ethnicity.

GENDER IDENTITY (N=12)

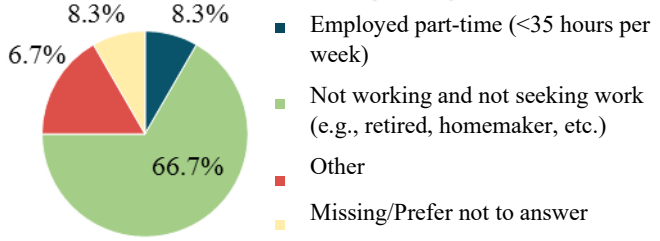


Over half (58.3%) of participants identified as female.

HOMELESSNESS RISK FACTORS (N=12)

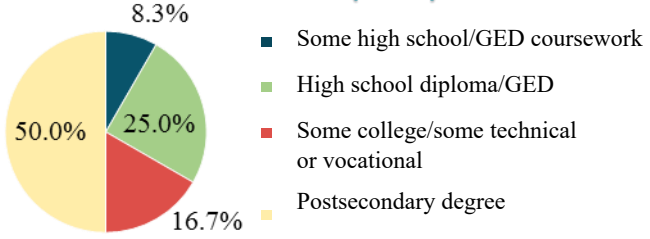
41.7%	Have a poor credit history
41.7%	Ever homeless/not have a home of own
41.7%	Without somewhere to stay/without plan for housing if lost current housing
66.7%	Have at least one barrier to getting or keeping their home, including: lack of employment (25%), lack of transportation (50%), and lack of financial assistance (50%).

EMPLOYMENT (N=12)



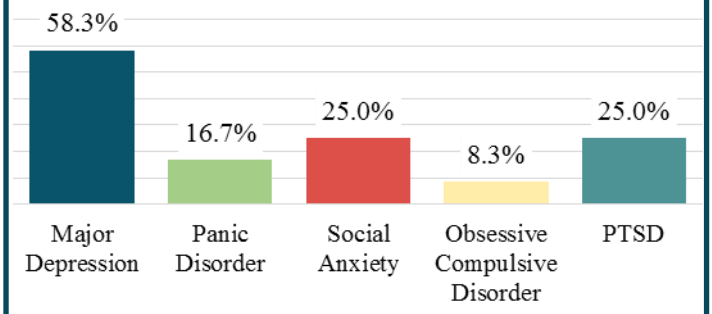
Two-thirds (66.7%) of participants were not employed and were not seeking employment.

EDUCATION (N=12)



Half (50.0%) of participants had completed a postsecondary degree.

COMORBID DIAGNOSES (N=12)



Over half (58.3%) of the participants were diagnosed with comorbid major depression.

DISABILITY STATUS[1] (N=12)

Type	n	%
Physical	6	50.0
Chronic health/pain	5	41.7
Learning disability	1	8.3
Communication (hearing/speaking)	3	25.0
Difficulty seeing	1	8.3
Dementia	1	8.3
Other	4	33.3
Missing/Prefer not to answer	2	16.7

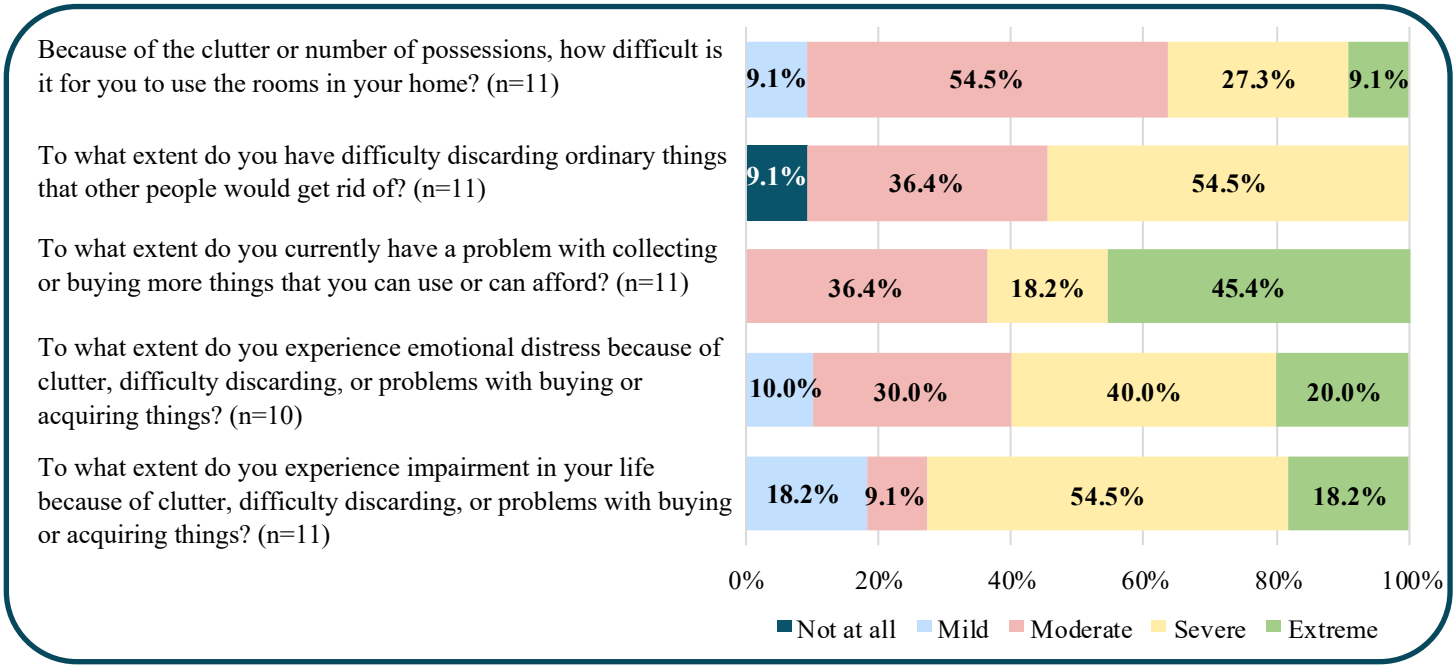
Totals exceed 100% as participants could indicate more than one type of disability.

[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.*

KEY EVALUATION FINDINGS—BASELINE HOARDING RATING SCALE

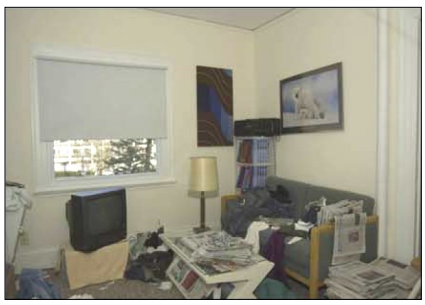
The chart below presents baseline responses to Hoarding Rating Scale (HRS) questions for participants enrolled during 2017. Overall, results indicated substantial negative effects on the lives of CREST participants due to clutter in their home, with 91% reporting moderate to extreme difficulty using rooms in their house, 90% reporting moderate to extreme emotional distress, and 82% reporting moderate to extreme impairment in their life.

Figure 1. Participant Hoarding Rating Scale Responses at Baseline



KEY EVALUATION FINDINGS—CLUTTER IMAGE RATING SCALE SCORES

CIR Living Room Rating #2

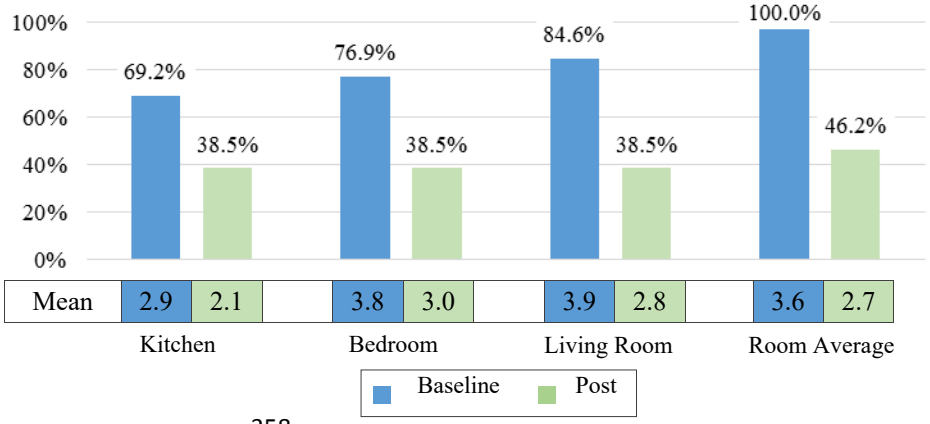


CIR Living Room Rating #4



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 to the left). 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 = 13), substantially fewer had CIR values greater than 2 after receiving CREST treatment services (mean CIR scores decreased as well). These findings of decreased clutter are consistent with improved symptom management due to CREST program participation.

Figure 2. Percent of Participants with a Clutter Inventory Rating Score Greater than 2



ADDITIONAL CREST PROGRAM OUTCOMES

- As measured by the Hoarding Rating Scale, participant's level of self-rated functional impairment due to clutter reduced from an average of 5.5 (moderate/severe) to 3.4 (mild/moderate) after CREST program treatment.
- While many participants experienced functional and behavioral improvements, 6 participants who completed the CREST program during 2017 (54.5% of the 11 CREST program completers in 2017) still met criteria for medical necessity at the end of the 26-session program.
- In 2017, the CREST program helped 7 participants avoid evictions.

COMMON CREST PROGRAM PARTICIPANT PROFILES

Profile 1: Clutter Reduction Takes Time—Importance of Participant Commitment/Re-Commitment to Goals

Untreated mental health needs (e.g., depression) for some CREST program participants can worsen with various emotional triggers (e.g., holidays, death anniversaries) and result in increased acquisition of items. CREST program therapists responded to these events by providing motivational enhance-ment sessions and facilitating connections to relevant ex-ternal supports (e.g., physicians and psychiatrists). Fur-thermore, additional exposure therapy sessions provided through the CREST program often led to positive out-comes such as increased independent sorting/discarding practices. By establishing trust and maintaining relation-ships throughout the duration of a longer-term treatment strategy, CREST program team members identified poten-tial challenges and intervened to transform the situations into ones of reinvigorated sorting/discarding practices and greater commitment to achieving overall goals.

Profile 2: Eviction Prevention and Improved Housing and Financial Situations

Participants often entered the CREST program on the verge of being evicted from their home and many exhibited health issues related to the unsafe home environment. Their living spaces may be nearly uninhabitable due to pest infestations, hazardous materials, and clutter that prevents the use of rooms and walkways. In addition, clients frequently also had external storage units whose monthly payments represented significant financial burdens. The CREST team worked with property managers and participants to improve the safety of their current living situation and/or identified and facilitated moving to a new living situation that better fit the needs of the participant. The CREST program then helped participants establish routines to keep their housing safe and functional. Additionally, some CREST participants have improved their finances by eliminating/reducing the number of external storage units utilized.

EXAMPLE OF CLUTTER REDUCTION DUE TO CREST PROGRAM PARTICIPATION



Before CREST program participation



After CREST program participation

ADDITIONAL CREST PROGRAM ACTIVITIES

- In 2017, the CREST program held 105 outreach and engagement presentations and educated 405 individuals about the CREST program and issues related to hoarding behaviors.
- The CREST manual was extensively revised by the team based on clinician and participant feedback.
- The CREST manual was translated into Spanish for future use with clients.
- The team continued to revise a County-wide resource guide specifically for clients with hoarding disorder symptoms. As of 12/31/2017 there were over 2,800 community resources listed.
- The team organized Program Advisory Group (PAG) meetings with community stakeholders to inform program actions.
- Per the recommendation of the PAG, a library of shareable hoarding-related reading materials was established for use by CREST program participants.

CREST PROGRAM ANNUAL STAFF FEEDBACK SURVEY

At the end of the second 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=8) responded to the survey for a response rate of 100%.

1. ***Major program goals as identified by CREST program personnel***
    a. Reduce hoarding behaviors by providing comprehensive evidence-based treatment and care management.
    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 outreach and education to communities to improve knowledge of hoarding.

2. ***Factors that helped the CREST program achieve these goals (Helping Factors)***
    a. Using evidence-based treatment practices for hoarding disorder.
    b. Flexibility of mobile treatment staff to provide services in patients' homes.
    c. Coordinated care provided by a multi-disciplinary team targets specific issues, increases awareness of community resources, and helps maintain long-term improvements (e.g., individual therapy, case management, aftercare group activities).
    d. Prioritization of safety improvements and increased functionality of participants' homes helped to reduce evictions, fines and code enforcements, and negative impact on relationships.
    e. Having funds to hire services that can address clients' physical and financial limitations (e.g., unable to move large objects or afford removal services/dumpsters).
    f. Support and collaboration from stakeholders, volunteers, and community partners to allow the CREST program to expand and improve its services.

3. ***Specific challenges to reaching program goals (Inhibiting Factors)***
    a. Limitations to serving potential participants due to eligibility and exclusion criteria (e.g., insurance status and region within county).
    b. Some clients with comorbid psychiatric conditions may have difficulty adhering to program objectives.
    c. Eviction notices require increased urgency in the treatment and case management timeline.

4. ***Factors for successful recruitment and retention of participants***
    a. Media outreach and development of community partners to identify and recruit program participants.
    b. Easing the restrictions caused by existing eligibility criteria (e.g., insurance status and location).
    c. Maintain progress using motivational interviewing throughout treatment and forming aftercare groups.
    d. Using the Program Advisory Group to identify effective ways to recruit participants.

KEY YEAR 1 CREST PROGRAM "LEARNINGS"

1. Providing "in-home" services is essential.
2. Peer Support Specialists appear to provide important emotional and practical supports to participants in their efforts to change hoarding behaviors.
3. Comprehensive, "whole person" services are needed to address multiple factors contributing to hoarding behaviors.
4. Good communication and coordination is required to facilitate work of multi-disciplinary treatment and support team.
5. Usage of manualized, evidence-based practices helps provide structure to intervention delivery and is expected to promote achievement of desired outcomes.
6. External pressures such as threats of evictions or failed health inspections can provide initial motivation for hoarding behavior change.
7. Participants typically recognize that their hoarding behaviors have negative effects on their lives.
8. Hoarding behaviors have often been evident for long periods of time (i.e., more than several decades).
9. Change of hoarding behaviors is often not easy or comfortable for participants.
10. Involvement of other non-CREST team personnel such as landlords/property managers and other community connections can help support desired behavioral changes.
11. Initial results suggest that participation in CREST services can lead directly to positive outcomes such as evictions avoided, increased social connectedness, and improved sense of well-being.

KEY YEAR 2 PROGRAM "LEARNINGS"

1. Results suggest that participants who completed the CREST program demonstrate measurable reductions in household clutter and functional impairment.
2. Individuals with hoarding disorder are often socially isolated and poorly connected to community resources, which highlights importance of the mobile/in-home outreach and case management approach of the CREST program.
3. Reduction of symptoms and impairments can be difficult for participants to maintain after treatment completion and require continued support in the form of booster sessions, aftercare group, and referrals to community resources.
4. Family members and loved ones can be invaluable resources (e.g., referrals for treatment, emotional support, and help with maintenance) and it is important to prepare and support them through education and family groups.
5. The Program Advisory Group is an important resource in learning about effective ways to recruit participants.
6. Results suggest improvement in functional impairment and psychiatric symptom severity among participants.
7. Some participants may need more than the current 26 sessions of the CREST program to achieve desired results.
8. The CREST treatment manual needs to be applied with flexibility to accommodate specific needs and circumstances of individual participants.
9. Outreach engagement revealed that many potential participants are just above the income level for Medi-Cal, but still too impoverished to access the services they need.
10. Persons who need services for treating hoarding disorder are found throughout the County.
11. Having ample funds available for assistance with removal of items is a key element, particularly for participants who are under the threat of eviction.
12. Motivational interviewing is a good supplement to treatment.

YEAR 2 PROGRAM CHANGES

There were no changes to the INN-17 CREST Program during the second year of service provision (1/1/2017 to 12/31/2017) that differed substantially from the initial design of the program. However, some modifications to practices and procedures occurred throughout the year to improve operations and the fit between CREST and the service delivery context. For example, Drs. Ayers and Twamley have continued to refine the CREST treatment manual based upon clinician and participant feedback. An aftercare group was implemented to support maintenance of results following program completion. Additionally, the treatment team adopted a more flexible approach to applying the manual. Approvals received for CREST program expansions (i.e., increased eligibility and countywide service provision) will be implemented during Year 3.

STATUS OF PRIOR YEAR PROGRAM RECOMMENDATIONS

Recommendations for how to improve the CREST Program during Year 2 and further increase caregiver access to needed behavioral health and other support services and resources include the following:

1. Expand services by reducing/eliminating insurance status restrictions (i.e., not required to be uninsured) and providing services in additional zip codes.

   Status: The CREST program received approval during Year 2 to provide services to Medicare only patients if justified and approved (previously required to be uninsured or participating in Medicaid). Additionally, the CREST program expansion allows for treatment of participants throughout all of San Diego County. These changes will take effect during Year 3.

2. Add a bilingual (Spanish-speaking) therapist to the treatment team.

   Status: The CREST program will be adding a Spanish-speaking therapist during Year 3.

3. Improve communication options between participants and CREST team members.

   Status: Staff now have cell phones to use when they are in the community providing care. Participants are given staff members' cell phone numbers.

4. Explore opportunities for program sustainment.

   Status: In addition to the approved CREST program expansions discussed above, the CREST program was extended for an additional 18 months (total project time now = 4.5 years), which will provide additional time to establish program effectiveness and community partnerships. The program was also approved to start using the BHS electronic health record system and is exploring options for billing insurance for services provided.

YEAR 2 PROGRAM RECOMMENDATIONS

Recommendations for how to improve the CREST program and further increase caregiver access to needed behavioral health and other support services and resources:

1. Modify eligibility and inclusion criteria to allow interested persons to participate, particularly those enrolled in Medicare.
2. Improve media outreach and community engagement to recruit more participants and strengthen relationships with mental health providers and local partners.
3. Address need for home repairs or removal services by allocating funding or partnering with local business or organizations.
4. Incorporate family groups into treatment model.
5. Increase flexibility regarding length of stay in the CREST program.
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.

For additional information about the INN–17 CREST Program and/or this annual report, please contact:
David Sommerfeld, Ph.D., at dsommerfeld@ucsd.edu

Appendix P
Glossary of Acronyms

Glossary of Acronyms

ACE – Alliance for Community Empowerment
ACL – Access and Crisis Line
ACT – Assertive Community Treatment
ASP – Augmented Services Program
ASO – Administrative Services Organization
API – Asian/Pacific Islander
AOA – Adults and Older Adults
B&C – Board & Care
BHAB – Behavioral Health Advisory Board
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

Appendix Q
Glossary of Terms

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.

Appendix R

Stakeholder Comments

Will be added following 30 day public posting