BEHAVIORAL HEALTH SERVICES
COMMUNITY ENGAGEMENT

Fiscal Year 2023-2024 Annual Update

COUNTY OF SAN DIEGO
Health and Human Services Agency

LIVE WELL SAN DIEGO

UC San Diego

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Executive Summary

An updated Executive Summary will be included in the final report.

Chapter 1 – The Mental Health Services Act & the Community Program Planning Process

Introduction

The Mental Health Services Act (MHSA) provides a substantial amount of funding for the San Diego County Behavioral Health Services (SDCBHS) Department. The fiscal support of the MHSA offers critical resources to support the SDC region's historically marginalized populations and serves all ages, including children, youth, transitional-aged youth (TAY), adults, older adults (OA), and families. MHSA funding supports prevention and early intervention, treatment services, and the development of critical infrastructure, technology, and training to support the public mental health system. The MHSA aims to increase access to unserved and underserved individuals and families by reducing disparities in the service delivery system for children, adults, and OAs with Serious Mental Illness (SMI). Integral to the MHSA is a required Community Program Planning (CPP) process, through which counties gather input from a diverse range of stakeholders as to the needs and priorities of community members.

The MHSA Stakeholder Engagement Activities and CPP process is led by a University of California, San Diego (UC San Diego) team, who was awarded a five-year community engagement contract in May 2022 by the SDCBHS. In efforts to effectively engage community stakeholders, UC San Diego is partnering with Community Health Improvement Partners (CHIP), and Global Action Research Center (Global ARC) to support the community engagement efforts connected to the contract. CHIP has been a leader in innovative, collaborative solutions to address critical community health issues in San Diego for nearly 30 years. CHIP is well-known for bringing together diverse partners to assess community health needs, educate and advocate to create policy, systems, and environmental change in efforts to reduce health disparities. Global ARC works to bring the community's voice into the public dialogue, focusing on marginalized communities. By using a place-based approach, Global ARC works with residents in San Diego to build on and strengthen their existing social networks to empower them to effectively engage in the decisions that shape their community and their lives.

This collective group, the UC San Diego Health Partnership, creates a strong team with complementary capacities that together facilitate the achievement of the CPP goals and the establishment of a sustainable community engagement process. The UC San Diego Health Partnership is committed to authentic community engagement efforts by having equity as the center of the engagement process, along with promoting community empowerment directly to the unserved, underserved, and hard-to-reach populations.

Advancing Diversity and Health Equity

The vision of the MHSA is to build a system in which mental health services are equitable, regionally distributed, and accessible to all individuals and families within the region who are in need. MHSA funding provides individuals who are experiencing a SMI or Social-Emotional Disturbance (SED) with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. These programs

serve individuals of all ages, providing support to the SDC's most vulnerable, unserved, and underserved populations.

The community's need for behavioral health services continues to increase, especially among the most vulnerable populations and in the wake of the COVID-19 pandemic. To guide clinical service design and placement, and to ensure effective outcomes are achieved, the SDCBHS continues to enhance data integration and health equity work through the establishment of the SDCBHS Data Sciences and Population Health units. Additionally, SDCBHS is partnering with UC San Diego to develop the Community Experience Partnership (CEP) with the purpose of identifying and addressing unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs. The SDCBHS further demonstrates its commitment to implementing health equity, diversity, and inclusion initiatives through procurements and contracting, specifically requiring outreach and engagement with unserved, underserved, and historically hard-to-reach communities.

An essential component of community engagement work is the direct acknowledgment of structural racism and historic inequity experienced by unserved and underserved populations. The UC San Diego Health Partnership is building a community engagement approach that intentionally de-centers the voice of the researcher and highlights the voices of those who have been historically silenced. The intent is to create an unduplicated community engagement process that is welcoming, inclusive, and aligned with other behavioral health-related engagement activities. The CPP process itself is an opportunity to build power for unserved and underserved communities. The UC San Diego Health Partnership works to incorporate a racial and ethnic equity perspective through several approaches. First, by developing capacity among racially marginalized communities by conducting listening sessions, focus groups, and interviews that focus on understanding and responding to priorities determined by the community members. Additionally, communities are considered partners in the community engagement process and are acknowledged for their contribution. The UC San Diego Health Partnership has been working with community stakeholders to participate in the development of communications, materials, review summaries and key findings to ensure accuracy in reflecting the communities' voices prior to dissemination. Community participation at this level helps to ensure languages, images, and content are culturally relevant, engaging, and inclusive.

The basis of the enacted community engagement process is that UC San Diego Health Partnership promotes community empowerment and equity, with local stakeholders co-leading the process, sharing in the development and interpretation of evaluation findings, as well as implementation and sustainability planning.

Background and Purpose

The MHSA is a California law passed in 2004, which aims to provide funding and resources for mental health services and programs for individuals with SMI, individuals experiencing homelessness, and those who have experienced trauma. The CPP process is an essential component of the MHSA, emphasizing community involvement and participation in the planning and implementation of mental health services. The CPP process is based on the principle of "nothing about us without us," ensuring that individuals and

communities that are directly affected by mental health issues are actively involved in the decision-making process.

The ongoing nature of the CPP process is critical, as it allows for continuous engagement with the community to gather feedback and input on their mental health needs. This feedback is then used to adapt and modify mental health and substance use services and programs to better serve the needs of the community. By engaging individuals and communities who have been historically marginalized and underserved in mental health care, the CPP process ensures that their needs and voices are heard. This helps promote equity and social justice in mental health services, ensuring that the needs of all individuals and communities are addressed.

The County of San Diego's Three-Year Plan currently covers 2023-2026, with Annual Updates published each year containing summaries of programs, outcomes, and funding updates. All components and aspects of the MHSA funding are driven by the MHSA Three-Year Plan. The CPP process helps inform the MHSA Three-Year Plan and subsequent Annual Updates. Engagement efforts conducted this fiscal year are utilized to inform the Annual Update to the current MHSA Three-Year Plan.

The current local community engagement efforts involve building trust, enlisting new resources and allies for facilitating better communication and improving health outcomes. The SDCBHS and UC San Diego Health Partnership collaborate to solicit feedback from the community, inclusive of all stakeholders, about behavioral health needs to inform program planning and development of the SDCBHS continuum of care. Regular contact with the public through interactive councils, advisory boards, and stakeholder engagement throughout the year is maintained to inform program planning and improve the services provided by SDCBHS system of care.

In summary, the CPP process is a vital part of the MHSA, emphasizing ongoing community engagement, feedback gathering, and collaboration to create a more inclusive and responsive mental health system in SDC. The CPP process reflects the importance of listening to and acting on the needs of individuals and communities that have historically been left out of mental health discussions and services. The CPP process helps inform the MHSA Three-Year Plan and subsequent Annual Updates, which drive all aspects of MHSA funding. Ongoing community engagement efforts in SDC are essential to improving the quality of life and achieving important life goals for individuals and groups subjected to marginalization and oppression.

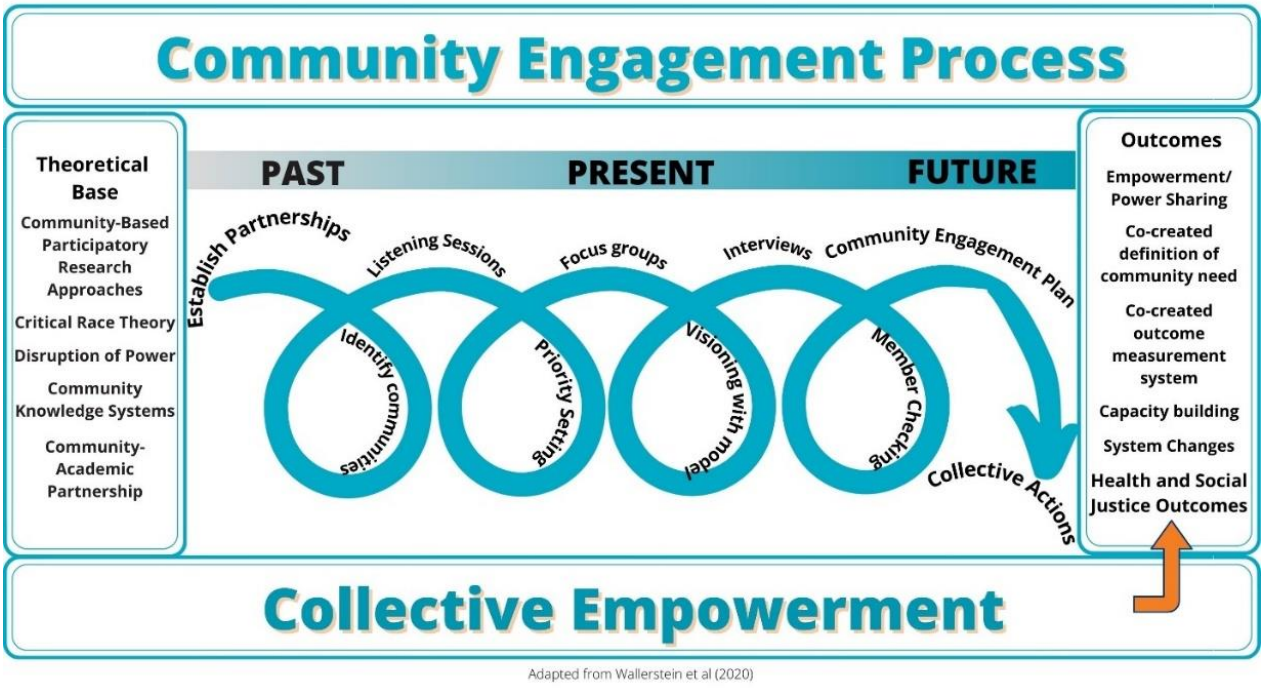
Best Practices

Relying on principles of community organizing and participatory research and evaluation, the UC San Diego Health Partnership’s community engagement process employs an outreach approach consistent with Community-Based Participatory Research (CBPR) methods used to integrate key constituencies in the development and implementation of comprehensive community engagement activities. CBPR is the most recognized form of health-focused, community-engaged research, integrating community partners throughout the process with the goal of promoting equity and reducing health disparities. As such, the UC San Diego Health Partnership provides a strong foundation for the community engagement process. However, to truly accomplish the CPP process, we must identify persons from a wide range of unserved and underserved communities throughout SDC and create safe, accessible, and supportive opportunities for sharing their behavioral health needs, experiences, and recommendations. This ultimately requires

the involvement of many different community members and representatives from large and small behavioral health and non-behavioral health services, advocacy, and faith-based organizations.

As depicted in Figure 1, the UC San Diego Health Partnership-led community engagement process is rooted in approaches that promote community empowerment, ultimately combining in a strategic plan that will improve service delivery for unserved, underserved, and hard-to-reach populations. The UC San Diego Health Partnership embraces the goals of community engagement – building trust, enlisting new resources and allies, creating better communication, and improving overall health outcomes – as fundamental to this endeavor. The community engagement approach utilizes a group-based participatory, developmental process through which individuals and groups subjected to marginalization and oppression gain and enhance necessary skills for their lives and environment, acquire valuable resources and basic rights, and achieve important life goals and reduce social marginalization. In this context, empowerment is both a process and an outcome of community engagement.

Figure 1. UC San Diego Health Partnership Community Engagement Process



Adapted from Wallerstein et al (2020)

The UC San Diego Health Partnership is committed to authentic community engagement efforts by having equity at the center of the engagement process along with promoting community empowerment directly to the unserved, underserved, and hard-to-reach populations.

To develop capacity in and for unserved and underserved communities, engagement activities should focus on understanding and responding to priorities as determined by the community members. Communities are considered partners in the Community Engagement Process and will be acknowledged for their contribution. Community stakeholders should participate in the development of communications, materials, and reports and review summaries and key findings to ensure accuracy in reflecting the communities' voice prior to dissemination. Community participation at this level helps to

ensure languages, images, and content are culturally relevant, engaging, and inclusive. The result will produce more useful information for SDCBHS. On the continuum of community engagement (see Figure 2), the UC San Diego Health Partnership's approach moves away from more traditional approaches like "Outreach" (on the left) and towards those that are more collaborative, centering active community involvement at all phases of the process such as shared leadership.

Figure 2. Continuum of Community Engagement

Increasing Level of Community Involvement, Impact, Trust, and Communication Flow

Outreach	Consult	Involve	Collaborate	Shared Leadership
Some community Involvement	*More community involvement*	*Better community involvement*	*Community involvement*	*Strong bidirectional relationship*
Communication flows from one to the other, to inform	*Communication flows to the community and then back, answer seeking*	*Communication flows both ways, participatory form of communication*	*Communication flow is bidirectional*	
Provides community with information	*Gets information or feedback from the community*	*Involves more participation with community on issues*	*Forms partnerships with community on each aspect of project from development to solution*	*Final decision making is at community level*
Entities coexist	*Entities share information*	*Entities cooperate with each other*	*Entities form bidirectional communication channels.*	*Entities have formed strong partnership structures*
Outcomes: Optimally, establishes communication channels and channels for outreach.	*Outcomes: Develops connections*	*Outcomes: Visibility of partnership established with increased cooperation*	*Outcomes: Partnership building, trust building*	*Outcomes: Broader health outcomes affecting broader community. Strong bidirectional trust built.*

Reference: modified by the authors from the International Association for Public Participation.

Chapter 2 – Community Engagement Efforts

Stakeholder Engagement Efforts

Background

In its inaugural year, the UC San Diego Health Partnership, in collaboration with the SDCBHS Contracting Officer's Representative (COR) and BHS representatives, developed a stakeholder outreach and engagement plan to facilitate a county-wide community engagement process that ensured commitment to priority population groups within SDC (see Figure 3 below). Outreach efforts were facilitated through the UC San Diego Health Partnership's extensive network of first- and second-order community connections and participation in a variety of community meetings occurring throughout SDC. The UC San Diego Health Partnership, in collaboration with SDCBHS, was the foundational structure used to capture and leverage community resident and stakeholder behavioral health input regarding challenges and prevention strategies to inform the SDCBHS continuum of care. The information collected as part of the

community engagement efforts (i.e., listening sessions, focus groups, and interviews, as well as active participation in community events via grassroots, faith-based, and other nonprofit organizations) was used to determine the community and regional behavioral health needs, assets, and recommendations for this annual report.

Stakeholder outreach and engagement efforts are implemented year-round. Behavioral Health Advisory Board (BHAB) and BHS System of Care (SOC) Council meetings are held as part of the CPP process. Other community engagement efforts included SDC listening sessions, focus groups, and key informant interviews to identify priority and target populations. The section below describes the methodology and framework for the recruitment, implementation, and analysis process for each of those stakeholder engagement efforts.

Identifying & Engaging Hard to Reach Populations

Outreach efforts conducted in this community engagement process worked to connect with unserved and underserved communities, including communities that are historically unreached, such as the Asian American and Pacific Islander community, the Black and African American community, the Deaf community, individuals experiencing housing instability, individuals experiencing SMI, LGBTQ+ populations, rural communities, TAY, veterans, and young children, among several others. To help establish trust with potential participants who may not be inherently comfortable engaging in available feedback opportunities, the UC San Diego Health Partnership collaborated closely with SDCBHS and existing community connections. Outreach with existing organizations and/or individual community members who have established relationships, predicated on a foundation of trust and respect, can encourage participants, and provide assurance for the supportive process we seek to develop.

Figure 3. The County of San Diego Priority Population Groups

Black/African American	➢ Nearly 5% of the population in San Diego County yet experience the highest rates of poor health outcomes compared to any other racial or ethnic group in the County
Deaf Community	➢ Deaf population in San Diego County is between 500,000 - 600,000 people ➢ Unemployment for the working deaf is about 65%
Individuals Experiencing Homelessness	➢ Despite the small percentage of residents experiencing homelessness in San Diego County, 15.5% of adults accessing County Mental Health Services and 30.9% accessing substance use disorder services reported experiencing homelessness.
Individuals with SMI	➢ It is estimated that 5% of San Diego County population may be living with SMI. Persons with untreated SMI often experience significant impairment which may make it difficult to maintain relationships, employment, and housing.
Justice-Involved	➢ More likely to engage in heavy or binge drinking, and experience depression when compared to individuals who had no criminal justice involvement

Latine/Hispanic	➢ More than one-third of San Diego County residents
Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ+)	➢ Represent 12.3% of adult SDCBHS clients in 2019-2020 ➢ Report unsatisfactory experiences with behavioral health providers due to prejudice, bias, or inability to comprehend the needs of LBGTQ+ clients ➢ LGBTQ+ individuals often experience higher rates of mental health needs due to depression, anxiety, and substance use.
Refugee Communities	➢ More than 23% of San Diego County's population is comprised of foreign-born individuals, naturalized U.S. citizens, immigrants, temporary migrants such as foreign students, humanitarian migrants such as refugees and asylees, and unauthorized migrants.
TAY aged 17 to 25	➢ Of particular concern for public service agencies, as they transition from youth-based or pediatric services into adult service agencies ➢ TAY with mental health concerns are less likely to finish high school/be employed ➢ Nearly 20% of TAY in San Diego County are living below 100% federal poverty level, which represents the largest percentage of any age group in San Diego
Veterans/Military	➢ Veterans/military make up 8.6% of San Diego County residents and face multiple housing, income, and mental health disparities

Currently, over 4 million people live in SDC. In October 2023, 1,057,375 SDC residents were enrolled in Medi-Cal. The six HHSA regions (see Figure 4) are highly diverse regarding demographic characteristics like race/ethnicity, education, single-parent households, unemployment, and income.

Figure 4. Map of the HHSA Regions

Existing Networks

The community engagement process led by the UC San Diego Health Partnership has been working to build upon existing networks and facilitate stakeholder engagement efforts to identify a wide range of potential community partners.

Behavioral Health Advisory Board

The BHAB serves as the primary oversight and engagement advisory board for the SDC behavioral health system and evaluates the community's behavioral health needs, services, programs, and procedures used to ensure citizen and professional involvement in the planning of behavioral health services. Additionally, BHAB assures that the MHSA Three-Year Plan and subsequent annual updates involve community and professional input. BHAB is committed to ensuring diverse community input in the planning of regional behavioral health programs and services. Community input is gathered at monthly BHAB meetings including ad-hoc subcommittees that offer community stakeholders an opportunity for collaborative knowledge building and action-oriented discussion to inform BHAB recommendations on the most pressing issues impacting the behavioral health system of care. The CPP process builds on this commitment and partnership with the community for the development of this Three-Year Plan and subsequent annual reports.

Live Well San Diego Community Regional Leadership Team Meetings

Live Well San Diego (LWSD) Community Regional Leadership Team (CRLT) Meetings are comprised of diverse partners, agencies, and advocates who are working together to identify the needs and priorities of each region. The LWSD CRLT Meetings provide a space for networking, identifying regional priorities, sharing tools and resources, and facilitating collaborative action. The LWSD CLRT meetings also provide opportunities to engage community members of San Diego by collecting stakeholder feedback regarding the strengths, needs, and priorities of each region. There are five regional LWSD CRLT monthly meetings: Central, South, East, North Central, and North County (comprised of North Inland and North Coastal).

SDCBHS System of Care Councils

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

SOC Councils promote the *Live Well San Diego* Vision and SDCBHS Framework for Our Future, recognizing the pandemic and racial justice context, as well as considering population health and social determinants of health. Councils evaluate the SOC and advocate for needed adjustments with recognition of the economic effects of the pandemic and its impacts to the community. Councils provide input for MHSA Community Engagement events and SDCBHS Forums.

See Figure 5 for a list of the six councils in the SDCBHS SOC.

Figure 5. SDCBHS SOC Councils

The Cultural Competence Resource Team (CCRT)

- Advisory board to the SDCBHS Director
- Provides framework to SOC Councils and their sub-committees to facilitate culturally competent activities
- Collaborates with all other SOC Councils to examine and address health care disparities and social determinants of health in unserved and underserved communities, particularly around access to care and workforce goals
- All SOC Councils' Vision, Mission, Principles and Framework include language of cultural competency

The Adult System of Care Council

- Oversees, plans and develops programs for the public Adult SOC for San Diego County

The Children, Youth, and Families (CYF) Behavioral Health System of Care Council

- Vision: wellness for children, youth, and families throughout their lifespan
- Mission: to advance systems and services to ensure that children and youth are healthy, safe, lawful, successful in school and in their transition to adulthood, while living in nurturing homes with families
- Relies on 10 principles, ranging from collaboration and integration to ensuring that services and programs are child-, youth-, and family-driven

The Housing Council

- Facilitates design, implementation, and evaluation of housing for individuals with serious mental illness by providing feedback and recommendations to the SDCBHS Director and Executive Team
- Created a 5-year Housing Plan for the COSD through extensive stakeholder engagement to address the behavioral health needs of individuals at risk of or experiencing homelessness or housing insecurity

The Older Adult (OA) Council

- Makes recommendations related to the development of the OA SOC
- Provides consultation and feedback to help understand what is and what is not working for OAs
- Facilitates the exchange of information across all sectors of the SOC
- Provides representation and input for the integrity and advancemenet of all services and aspects of the SOC
- Provides recommendations and feedback to the COSD BHS Director regarding the progress and future expansion of all OA Behavioral Health programs and services

The TAY Behavioral Health System of Care Council

- Provides feedback and recommendations regarding TAY (ages 16 to 25) services in the Children, Youth and Families (CYF) and the Adult and Older Adult (AOA) systems of care
- Provides community representation and input for the integrity of all TAY services and advancement of all TAY related aspects of the systems of care

Other Community Networks

In efforts to enlist new resources and allies, as well as reach and connect with the historically marginalized or oppressed individuals and groups of SDC, the UC San Diego Health Partnership and SDCBHS is collaborating with multiple existing networks. As will be discussed in more detail below, stakeholders consistently recommend aligning outreach and engagement efforts with existing platforms to best engage

communities, using the platforms and trusted community groups to create a foundation for establishing successful and meaningful engagement.

Suicide Prevention Council

The San Diego Suicide Prevention Council (SPC) is a collaborative community-wide effort focused on realizing a vision of zero suicides in SDC. The SPC mission is to prevent suicide and its devastating consequences in SDC. The SPC's core values encompass a public health approach to prevention, collaboration, non-competitive partnerships, evidence-based practices, and cultural and linguistic sensitivity. The primary strategy the SPC uses to work on its mission is enhancing collaborations to promote a suicide-free community. They conduct ongoing needs assessments to identify gaps in suicide prevention services and supports while providing resources to those affected by suicide, and work to advance policies and practices that contribute to the prevention of suicide.

San Diego Veterans Coalition

The San Diego Veterans Coalition (SDVC) was organized in 2009 and incorporated as a non-profit in May 2011. SDVC utilizes the Collective Impact Model, which is based on leveraging relationships with other Veteran and family serving organizations so that they may provide Veterans and their families with a complete array of services and other opportunities. The purpose of the SDVC is to serve the needs of San Diego regional Veterans, their families, and significant others. They intend to improve collaboration and coordination among community service providers in all sectors so that the delivery of services is more comprehensive and Veteran family-centric.

Chula Vista Community Collaborative

The Chula Vista Community Collaborative is a monthly in-person meeting in the South Bay region of Chula Vista designed to bring community leaders and advocates in the local region together to network and foster new relationships. The meetings are structured in a casual context where folx are invited to present about their organizations and initiatives, and time is built-in for building connections. This meeting has been instrumental in the outreach processes built into UC San Diego Health Partnership's community engagement plan to reach diverse communities.

Resident Leadership Academy

The Resident Leadership Academy (RLA) empowers residents in SDC communities with the knowledge, tools, strategies, and commitment to make positive changes at the neighborhood level. There are 800+ RLA graduates, aged high school to older adult, who have completed the in-depth CHIP training to empower them to be leaders and advocates in and for their personal communities. Additionally, there are 101 certified RLA trainers, 30% of whom speak a language other than English (i.e., Spanish, Vietnamese, Arabic). RLA has been a great partner, utilizing this network to disseminate information about our community engagement opportunities and thereby increasing our network building with community advocates and individuals.

Healthy San Diego Justice-Involved Workgroup

The Healthy San Diego Justice-Involved Workgroup is a monthly remote meeting focused on meeting goals to address issues raised by the criminal justice sector. In 2023, the workgroup discussed CalAIM initiatives, in addition to various reentry issues for current and previously incarcerated individuals. This meeting has been instrumental in the outreach processes built into UC San Diego Health Partnership's community engagement plan to reach justice-involved populations.

St. Paul's Program of All-Inclusive Care for the Elderly

St. Paul's Program of All-Inclusive Care for the Elderly (PACE) is a managed health care plan exclusively for seniors. St. Paul's PACE services include (but are not limited to) primary medical care, medication management, physical therapy, specialty services, in-home care, social work assistance, and transportation to and from the medical center. The care program is specifically designed for seniors 55 years and older who have chronic medical conditions and are struggling to live at home independently. UC San Diego Health Partnership worked in collaboration with St. Paul's PACE in Fall 2023 to facilitate a fully remote listening session.

Interfaith Community Services

Interfaith Community Services is a non-profit organization started in 1979 that partners with diverse faith communities and people of compassion to provide food, housing, employment, treatment, and other emergency resources for local people in crisis. UC San Diego Health Partnership worked in collaboration with Interfaith Community Services to host a Spanish-led listening session in Escondido, CA.

Jireh Providers

Jireh Providers is a mobile community health clinic based in San Diego. They strive to bring equitable health and healing to communities of color, through initiatives such as maternal and infant health, COVID-19 awareness, health equity, and advocacy to end violence against the Black community. UC San Diego Health Partnership and SDCBHS collaborated with Founder and Executive Director, Samantha Williams, to host a listening session in the central region at the new Southeast LWSD community resource center.

Community Experience Partnership

The Community Experience Partnership (CEP) is a joint initiative between SDCBHS and the UC San Diego Child & Adolescent Services Research Center (CASRC) and Health Services Research Center (HSRC). The CEP is designed to identify and address unmet behavioral health needs in SDC, and the systemic and regional inequities that lead to these unmet needs. The project promotes a continuous feedback process which issues can be identified, further informed by community engagement, and mediated by actionable plans. Outlined below are the CEP accomplishments for FY 2022-23 and plans for FY 2023-24 enhancements.

Behavioral Health Equity Index

In FY 2022-23, the CEP finalized the Behavioral Health Equity Index (BHEI), an index designed to explore differences in the social determinants of behavioral health specific to San Diego County. Because the

determinants of behavioral health are multifaceted and complex, the BHEI is a composite index that combines information from multiple sources into a single score. The index is constructed from over 30 indicators, organized into 8 domains that map to 5 social determinants of behavioral health. Areas with higher BHEI scores may not have access to the resources and services that promote behavioral health and may serve as priority zones for equity work and service enhancements. The BHEI is a valuable tool to summarize data in a way that is interpretable and can help build community consensus for equity work.

In FY 2021-22, indicators and domains were selected in partnership with the Community Experience Committee, a workgroup composed of subject matter experts including community experts, representatives from SDCBHS, and UC San Diego researchers. In March 2023, a focus group consisting of diverse community stakeholders, including program managers and directors representing local behavioral health agencies and advocacy groups, was held to finalize the domain weights that would be used to construct the BHEI.

Once the weighting methodology was determined, UC San Diego researchers finalized the technical methodology and calculated the index using 2020 census geographies at four geographic resolutions: HHSA regions, subregional areas, zip code tabulation areas (ZCTAs), and census tracts. Detailed methods outlining construction and preliminary results for the BHEI are presented in the Behavioral Health Equity Index: Technical Report.

Two customized BHEI User Interfaces have been drafted to allow distinct user groups access to the BHEI. A public-facing version, designed for behavioral health advocates, policymakers, providers, consumers, and other stakeholders, will be hosted on the public CEP website. The second application, designed specifically for internal use by BHS service planners, will be integrated into the Service Planning Tool (SPT; see below). Relative to the public-facing version, the internal BHEI application offers more advanced options to explore, filter, and visualize BHEI scores but requires more training to use.

Drafts of the public-facing application were presented for feedback at the CCRT meeting on September 1st, 2023, and the Adult Council Meeting on November 13th, 2023. Specifically, the councils were invited to provide feedback to help optimize the tool's usability, cultural competency, data components, and interpretability. The CEP team will continue to seek feedback from community representatives, subject matter experts, and stakeholders to revise and improve the tool prior to the official launch of the public facing BHEI application in FY 2023-24.

Service Planning Tool

In FY 2022-23, the CEP team also developed the SPT, a custom application designed by UC San Diego in close collaboration with BHS representatives overseeing data-informed service planning enhancements at BHS. The goals of the tool are to help ensure service provision is informed by data, based on cultural and regional considerations, and focused on communities that may be at greatest risk for unmet behavioral health needs. The application uses data from diverse sources, including the U.S. Census Bureau's American Community Survey and client service records from Cerner Community Behavioral Health to help planners at BHS identify areas in SDC where at-risk populations are likely to be highly concentrated.

Once areas are identified, users may explore community and client profiles and download custom reports that summarize the social, economic, and demographic conditions of the selected regions and at-risk populations. The tool also highlights the BHEI internal user interface. An advanced version of the tool will

also be available to UC San Diego and SDCBHS researchers interested in conducting more complicated analytics (e.g., the ability to identify areas based on more than one condition, etc.).

A draft of the SPT was presented at the BHS Unit Management Meeting on October 23rd, 2023. The SPT training is currently under development and is slated to be presented to County CORs in February 2024. The tool will be launched for internal BHS use at that time. In FY 2023-24, we will continue to revise and refine the tool based on user feedback and requests. We plan to expand the tool's capabilities by adding additional features, such as service provider locations, network adequacy indicators, and penetration rate estimates.

Community Experience Dashboards

The CEP website and Community Experience Dashboards (CED) allow users to explore, monitor, and visualize behavioral health equity data through a series of interactive dashboards. Users can evaluate indicators of equity over time, across neighborhoods, and for numerous subpopulations, including by race/ethnicity, gender, sexual orientation, age, justice involvement, and more.

In FY 2022-23, all dashboards were updated with the most current data and enhanced features were added. Specifically, the Social Determinants of Health Dashboard was expanded to present data not just at census tract levels but for HHSA regions, subregional areas, and zip code tabulation areas (ZCTAs). Additionally, a feedback survey was embedded in the CEP website inviting users to provide input about the site's usability and to offer suggestions for improvements. Finally, the CED was presented at the BHS COR Meeting on December 8th, 2023, as a tool to monitor program-level cultural competency.

The CEP will continue to refine and maintain the CEP website in FY 2023-24. Planned enhancements include the inclusion of recently released FY 2022-23 BHS client data and U.S. Census Data from 2018-2022. The UC San Diego team is working with BHS epidemiologists to integrate inpatient and emergency department discharge data from the California Department of Health Care Access and Information. As previously noted, the BHEI will be integrated into the newest version of the CED dashboard. Trainings will be provided upon request.

Outreach Events

National Recovery Month Celebration

On August 26, 2023, SDC held the "National Recovery Month Celebration." The event featured dozens of organizations and attracted hundreds of participants at Waterfront Park in Downtown San Diego. The event brought together organizations, motivational speakers, information on prevention and treatment of substance use, and outlets for creative expression intended to promote the overall behavioral health of San Diego residents.

Numerous organizations hosted resource booths, using the event as an opportunity to spread awareness of their respective goals. The UC San Diego Health Partnership booth was designed to gather perspectives regarding behavioral health services within the community. Interested individuals could utilize a tablet to respond to a set of questions or scan a QR code and interest form link to provide feedback or contact information. Individuals could share their email address for future opportunities. All resources were provided in English and Spanish languages. The UC San Diego Health Partnership outreach team also engaged in intentional networking at the event, connecting with organizational leaders including Oasis Clubhouse and UPAC.

Live Well 5K

In partnership with 2-1-1, SDC hosted the annual Live Well San Diego 5K and 1-Mile Fun Run on September 17, 2023. This family-friendly event brought together thousands of San Diegans (i.e., 5,500 people in attendance in 2022), local businesses, and community-based organizations in an effort to connect them and share resources to support a healthy, safe, and thriving San Diego County.

The UC San Diego Health Partnership hosted a booth for the duration of the event, engaging with attendees regarding perceptions of behavioral health needs and services. In addition, a brief community survey and an interest form to be contacted for future outreach and education opportunities were provided via QR code. All resources were provided in English and Spanish languages. The UC San Diego Health Partnership outreach team also engaged in intentional networking at the event and connected with organizational leaders including the African American Association of County Employees.

Meeting of the Minds

The Meeting of the Minds is an annual behavioral health services-related conference held in San Diego to share the latest research, programs, resources, and policies relevant to promoting the behavioral health of County residents. The 2023 conference, "Being Heard – Connecting with Our Wellbeing" was held on October 11th. Presentations offered covered a wide range of behavioral health topics (e.g., the importance of pronouns, empowering parent engagement in K-12 education, tenant peer support, elevating the voices of Black women). In addition, program resource booths provided information and networking opportunities.

UC San Diego Health Partnership hosted a booth to provide space for community members and providers to ask questions about the community engagement efforts as well as share their thoughts and insight to the UC San Diego Health Partnership team so that they could bring that information forward to SDCBHS decision-makers. Participants could complete a tablet-based survey about community mental health and substance use needs and resources, and/or utilize a QR code to access more resources or provide their contact information for future information. All information was provided in English and Spanish languages. The UC San Diego Health Partnership outreach team also engaged in intentional networking at the event and connected with various organizational leaders.

Out of the Darkness

The American Foundation for Suicide Prevention hosted its annual Out of the Darkness Walk on October 21, 2023, at NTC Liberty Station to bring together community members, organizations, and providers that have been affected by suicide, to raise awareness and funding, and to continue to promote the message that suicide can be preventable and that no one is alone. Friends, family members, neighbors, and co-workers walk in memory of those they have lost. The event aims to provide a safe space for discussion about mental health and foster a culture that safeguards mental health and prevents suicide.

The UC San Diego Health Partnership partnered with the Community Health Improvement Partner's Suicide Prevention Council to host a resource booth and engage with attendees in conversation about their perspectives of the behavioral health services within the community. All resources were in English and Spanish. The flyer included a QR code link to a survey and interest form where participants could submit their contact information. Also, the UC San Diego Health Partnership team promoted the upcoming community engagement listening sessions to increase attendance and participation.

Live Well Advance

The annual Live Well Advance conference hosted by the SDC was held on November 1, 2023, to bridge connections and promote the SDC's vision of a healthy, safe, and thriving region. Over 2,100 people registered from various programs: researchers, providers, community members, and professionals all dedicated to sharing resources with others to improve the health of the community by increasing knowledge of and access to organizations, opportunities, and resources.

The UC San Diego Health Partnership team hosted a resource booth within the Connection Hub at the conference. Participants were encouraged to provide feedback regarding the behavioral health resources within their community through a survey accessed via QR code. The booth also included a 2-page brief document on the 2022-2023 community engagement efforts and findings. Additionally, individuals could share their information to be contacted in the future regarding upcoming engagement opportunities the overall efforts of the UC San Diego Health Partnership. The Partnership outreach team also engaged in intentional networking at the event and connected with numerous organizational leaders including Walk with Me Impact organization. All resources were provided in English and Spanish languages.

San Diego High School

The San Diego High School Wellness Fair occurred on November 15, 2023, with approximately 2,000 students, 200 staff members, and community organizations in attendance. The goal of the event was to connect students and staff to organizations and resources related to job training, mentorship, and mental health to promote overall wellness: emotional, occupational, physical, social, intellectual, and spiritual.

A resource booth was hosted by the UC San Diego Health Partnership team during the lunch period portion of the Wellness Fair to engage with students on their perceptions of behavioral health services in the community. School-based youth and staff could participate in an active engagement activity where they provided feedback on sticky notes regarding two posed community engagement questions. The booth provided a 2-page brief document on the 2022-2023 community engagement efforts, findings, and recommendations. Additionally, a flyer was provided with the QR code and interest form link to allow any interested individuals to provide feedback or contact information. Like all the other events listed above, resources were provided in English and Spanish languages.

Chapter 3 – Community Engagement: Methodology

The UC San Diego Health Partnership team facilitated three primary types of activities as part of the FY 2023-24 community engagement process to gather information from stakeholders through SDC. Activities included: 1) Key Informant Interviews; 2) Focus Groups; and 3) Listening Sessions.

Key Informant Interviews

In order to gather stakeholder input from community leaders and advocates regarding the essential understanding and vital steps needed for community engagement efforts within the San Diego community, key informant interviews were conducted with identified personnel in the San Diego community who have been working in the behavioral health field along with target populations. UC San Diego in partnership with SDCBHS identified the individuals for the key informant interviews. UC San Diego

researchers contacted the identified individuals to explain the community engagement process and determine a conducive time to schedule an interview via a video conferencing platform (i.e., Zoom).

Key informant interviews were scheduled to last between 45 to 60 minutes and were audio and video recorded. The audio files were transcribed, and the transcripts were used in data analysis (described in more detail in Chapter 4). A consistent key informant interview guide was used with minor tailored questions, when relevant for a specific individual. The discussion guide served as a blueprint for each interview, however, it is acknowledged and embraced that the conversation, at times, strayed from the guide when insightful and interesting discussions emerged naturally. Participants of each key informant interview were asked to complete a Qualtrics survey to collect satisfaction questions and demographic information to summarize and include in the analysis and results (detailed in Chapter 4). A sample satisfaction and demographic survey is located in Appendix A. Key informants were not incentivized for their participation and their participation was completely voluntary.

Focus Groups

To gather insight into the existing strengths, resources, and needs of program services for specialized populations, focus groups were held throughout FY 2023-24. The goal of each focus group was to understand the strengths and resources currently available to each target population, along with the needs and challenges to accessing behavioral health resources for each target population. Focus groups also aimed to identify best practices for communicating with community members and creating effective feedback loops for the community engagement process.

Focus groups participants were comprised of a mix of providers, community advocates, community groups, and consumers of the following identified target specialized populations: Adult Residential Facilities, the Deaf community, individuals experiencing homelessness, individuals with SMI, LGBTQ+, older adults, refugee communities, rural communities, TAY, veterans, and youth.

Recruitment for focus groups involved reaching out to community partners and individuals who expressed interest verbally during outreach and engagement efforts, via email to the “mhsavoices” email, and/or submitted contact information through the developed Qualtrics survey (shared at the aforementioned outreach events) regarding interest in future engagement efforts. The UC San Diego Health Partnership also relied on first and second order contacts (via UC San Diego Health Partnership), community partners and individuals who may have specific insight into each priority population to help with recruitment. When appropriate and accessible, flyers were also created for specific population focus groups to be shared via social media platforms. A sample flyer is provided in Appendix B.

Varied approaches to conduct focus groups were utilized for each special population to meet the needs of each community. These focus groups took a variety of forms, with an overarching goal of having the UC San Diego Health Partnership “go to” (either virtually or in-person) the places and spaces where people were already gathering in order to facilitate their ability to provide essential input. Also, to help build trust with certain populations, the UC San Diego Health Partnership team would attend community and membership meetings held by the organizations of a key informants (mentioned above) to connect and gather interest for a focus group. Focus groups typically were 60-90 minutes in duration. The focus group discussions were recorded, and the transcripts were used in data analysis (described in more detail in Chapter 4). A consistent focus group guide was used with minor tailored questions, when relevant for a specific specialized population. The discussion guide served as a blueprint for each focus group session,

however as in key informant interviews, when insightful and interesting topics emerged naturally the tangent was acknowledged and embraced. Participants of each focus group were asked to complete a Qualtrics survey to collect satisfaction and demographic information to summarize and include in the analysis and results (detailed in Chapter 4). A focus group interview guide sample is in Appendix C.

Listening Sessions

For this reporting period, "Listening Sessions" were defined as instances where representatives of the UC San Diego Health Partnership developed and conducted structured feedback activities in all the regions at varying event locations (i.e., existing community meetings, libraries, Live Well San Diego spaces, etc.) regarding behavioral health service needs, opportunities, and concerns as well as the preferred mechanisms for communication and community engagement. These listening sessions took a variety of forms and reached a wide range of audiences, as was the case with focus groups, the UC San Diego Health Partnership "went to" (either virtually or in-person) places and spaces all around the County in order to facilitate participant's ability to provide essential input.

While some tailoring for time and group orientation occurred across the listening sessions, the general format included a PowerPoint presentation introducing the UC San Diego Health Partnership and providing background to the MHSA community engagement efforts. Participants were then led through a community engagement activity where they provided input via sticky notes (for in-person listening sessions) or virtual whiteboard (i.e., Mentimeter Digital Platform) for each of the following four questions:

- What are the most pressing issues related to mental health and substance use in your community?
- What are some of the biggest challenges to accessing resources for mental health or substance use in your community?
- What activities or programs do you think would help address behavioral health issues & challenges by those living in your community?
- How would you like to see behavioral health resources shared with this community?

After each question, there were opportunities for participants to discuss and engage individual responses. Detailed notes of the conversation were taken and where feasible, the discussion was recorded to be transcribed and utilized in analyses. The ideas listed on the sticky notes/virtual whiteboard were also documented and incorporated into the analysis. The following are examples of listening session events conducted by the UC San Diego Health Partnership team.

Figure 6. Listening Sessions

LiveWell Advance Conference	➢ An opportunity to convene stakeholders from throughout the San Diego community, for the purpose of gathering input from underserved and unserved communities
Regional Community Engagement Forums	➢ Led in partnership with the Live Well San Diego Community Regional Leadership Teams ➢ Community engagement forum activities were implemented in within Live Well San Diego Community Regional Leadership Team meetings in four of the six HHSA regions of San Diego

Regional Community Engagement Listening Session	➢ To foster engagement among members of the San Diego community even further at a regional level, community engagement forum activities were held in the following libraries or community spaces across SDC: Imperial Beach, Encinitas, Fallbrook, Southeast Live Well Center
Spanish-speaking Engagement Session	➢ To engage the Spanish-speaking community two sessions were held in Spanish. One at One Safe Place in the North County of San Diego and one was held at Vallecitos school for held with parents/families and staff
Virtual Engagement Listening Session	➢ A virtual session to engage any individuals County-wide to try to accommodate individuals with barriers in accessing any of the in-person listening sessions
County-Led Engagement Listening Session	➢ A virtual session led by County of San Diego representatives for youth and young adults in partnership with Mind Out Loud organization

Participants of each listening session were asked to complete a Qualtrics survey to collect satisfaction and demographic information to summarize and include in analysis and results detailed in Chapter 4. A sample presentation is provided in Appendix D. A sample flyer is provided in Appendix E.

Chapter 4 – Community Engagement: Analysis & Results

As described in prior chapters, multiple types of engagement activities occurred during the FY 2022-23 community engagement process. In this chapter, the satisfaction and demographic data are reported and a description of the analytical strategies and findings from the wide range of other community engagement and data collection activities. While most findings pertain to perceptions about behavioral health service needs and priorities, the engagement efforts also provides input on what activities or programs could help address behavioral health issues and challenges as well as recommendations how to best share resources within the priority populations and communities of SDC.

Qualitative Analysis

Data collection included individual interviews with community stakeholders, focus groups, and community listening sessions. Interview and focus group data was collected via audio and/or video files and transcribed verbatim in Otter.ai (https://otter.ai/) and then uploaded into Atlas.ti qualitative coding software using version 23 (https://atlasti.com/). Data were collected in the listening session format using Mentimeter (https://www.mentimeter.com/) and Post-it Notes, or both depending on the session. Data collected through community listening sessions were downloaded via Mentimeter into a Microsoft Excel file and later uploaded into Atlas.ti version 23 for analyses. An internal quality assurance process was conducted on all data, with a minimum of two members of the UC San Diego Health Partnership providing to ensure reliability and consistency.

The interview and focus group data were analyzed first using deductive and inductive content analysis (Krippendorff, 2018). Deductive content analysis is an approach to qualitative analysis that starts with an existing theory or framework and applies conceptual categories to the data using a category application process to extend understanding of the research question (Hsieh & Shannon, 2005; Mayring, 2004). When content emerged in the transcripts that expanded upon the existing conceptual categories, an inductive content analysis approach was used to generate new codes within the conceptual framework (Hsieh & Shannon, 2005). After the initial content analysis was conducted, thematic analysis (Braun & Clarke, 2006) was used to distinguish salient themes across the engagement activities related to how community members viewed community behavioral health needs, recommendations, and concerns, along with strengths.

Community listening session data was analyzed separately from the interview and focus group data, using quantitative content analysis (Krippendorff, 2018). These data were analyzed using thematic analysis (Braun & Clarke, 2006) to identify how community members identified the strengths and challenges in their communities relative to substance use and mental health, and to identify community feedback related to addressing priority behavioral health concerns. Data from multiple sources was analyzed, including Mentimeter data, Post-it Notes, transcribed audio recordings, and detailed notes taken during the session by a member of the UC San Diego Health Partnership team.

Community Engagement Efforts: Participants

Table 1 lists the key information for each community engagement effort conducted regarding the focal audience, the process of engagement activity, and how data were collected as well as the number of participants.

Table 1. Summary of Community Engagement Efforts

Listening Sessions	Format	Community Engagement Effort Conducted	N
North Central Region (LWSD North Central Meeting)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	26
South Region (LWSD South – Mental Health Workgroup)	Virtual (Recorded)	Presentation & Community Engagement Activity utilizing Mentimeter Digital Platform	35
East Region (LWSD East Meeting)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	41
Central Region (LWSD Central Meeting)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	23

South Region (Imperial Beach Library)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	4
Countywide (Live Well Advance Conference)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	30
North Inland Region (Fallbrook)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	11
North Coastal Region (Encinitas)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes and Mentimeter Digital Platform	13
Central Region (Southeastern San Diego Live Well Center)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes	8
North Region (Spanish)	In-person (Recorded)	Presentation & Community Engagement Activity utilizing colored Sticky Notes	7
Countywide (Virtual)	Virtual (Recorded)	Presentation & Community Engagement Activity utilizing Mentimeter Digital Platform	32
North Rural Region (Spanish)	In-person	Presentation & Community Engagement Activity utilizing verbal sharing of responses	7
Central Region (Youth Spanish)	In-person	Presentation & Community Engagement Activity utilizing colored Sticky Notes	8
Countywide (County-led Youth Virtual)	Virtual	Presentation & Community Engagement Activity utilizing virtual whiteboards	25
Focus Groups	**Format**	**Community Engagement Effort Conducted**	**N**
Adult Residential Facilities	Virtual (Recorded)	Focus Group	7
Deaf Community	In-person (Recorded)	Focus Group	9
Individuals Experiencing Homelessness	In-person and Virtual (Recorded)	Focus Groups	25

LGBTQ+	In-person and Virtual (Recorded)	Focus Groups	13
Lived Experience Mental Health/Behavioral Health Consumers	In-person and Virtual (Recorded)	Focus Groups	26
Older Adults	Virtual (Recorded)	Focus Group	6
Refugee Community	In-person (Recorded)	Focus Group	9
Rural Community	Virtual (Recorded)	Focus Group	4
TAY	In-person and Virtual (Recorded)	Focus Groups	10
Veterans	In-person (Recorded)	Focus Group	18
Youth	In-person (Recorded)	Focus Groups	10
Interviews	**Format**	**Community Engagement Effort Conducted**	**N**
Black Community	Virtual (Recorded)	Individual Interviews	2
Individuals Experiencing Homelessness	Virtual (Recorded)	Individual Interviews	2
Individuals with Substance Use Disorders	Virtual (Recorded)	Individual Interview	1
Justice-Involved	Virtual (Recorded)	Individual Interview	1
Latine/Hispanic	Virtual (Recorded)	Individual Interviews	3
LGBTQ+	Virtual (Recorded)	Individual Interviews	2
Native American	Virtual (Recorded)	Individual Interview	1
Refugee Community	Virtual (Recorded)	Individual Interviews	2
Rural Community	Virtual (Recorded)	Small Group Interview	2
Veterans	Virtual (Recorded)	Individual Interviews	3
Youth	Virtual (Recorded)	Individual Interview	1

Demographics

Table 2 lists the characteristics of the people who participated in one of the community engagement efforts and completed the satisfaction and demographic survey. As shown in Table 2, most participants (72.6%) were between the ages of 25 and 59 years old, and 15% were between 16 and 25 years old. The largest group of respondents identified as White (42.5%) with the next largest group identifying as Hispanic/Latine (31.9%) and 15% identifying as Black or African American. Most participants (88.5%) reported English as their primary language. Approximately 8% of participants indicated their veteran status.

Table 2. Characteristics of Persons Participating in Engagement Activities

Age Group	N=113	%
0-15 years old	1	0.9%
16-25 years old	16	14.2%
25-59 years old	82	72.6%
60 years old and over	13	11.5%
Prefer not to answer	1	0.9%
Race/Ethnicity[1]	**N=113**	**%**
Another Hispanic, Latino/a, or Spanish origin	7	6.2%
Asian Indian	3	2.7%
Black or African American	17	15.0%
Chinese	2	1.8%
Filipino	3	2.7%
Hispanic, Latino/a, or Spanish origin: Mexican, Mexican American, or Chicano	36	31.9%
Japanese	1	0.9%
Native or Indigenous American	2	1.8%
Native Hawaiian	1	0.9%
White	48	42.5%
Race or Ethnic Identity not Captured Above	3	2.7%
Prefer not to answer	1	0.9%
Primary Language	**N=113**	**%**
Arabic	1	0.9%
English	100	88.5%
Spanish	1	0.9%
Other	11	9.7%
Veteran Status	**N=112**	**%**
Yes	9	8.0%
No	103	92.0%
Sex Assigned at Birth	**N=113**	**%**
Female	79	69.9%
Male	33	29.2%
Prefer not to answer	1	0.9%
Gender	**N=114**	**%**
Female	75	65.8%
Male	33	28.9%

Another Gender Identity	6	5.3%
Sexual Orientation	**N=112**	**%**
Bisexual/pansexual/sexually fluid	10	8.9%
Gay or Lesbian	8	7.1%
Queer	7	6.3%
Heterosexual or straight	83	74.1%
Prefer not to answer	4	3.6%
Disability[1]	**N=111**	**%**
Does not have a disability	84	75.7%
Has some form of disability	21	18.9%
Prefer not to answer	6	5.4%
Additional Groups With Whom Participants Identify	**N=97**	**%**
African	5	5.2%
Asylee	2	2.1%
Homeless	7	7.2%
Immigrant	11	11.3%
LGBTQ+	23	23.7%
Refugee/Newcomer	2	2.1%
Veterans/Military	8	8.2%
Other groups not mentioned above	4	4.1%
Do not identify as any of these additional groups	52	53.6%
Prefer not to answer	4	4.1%

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

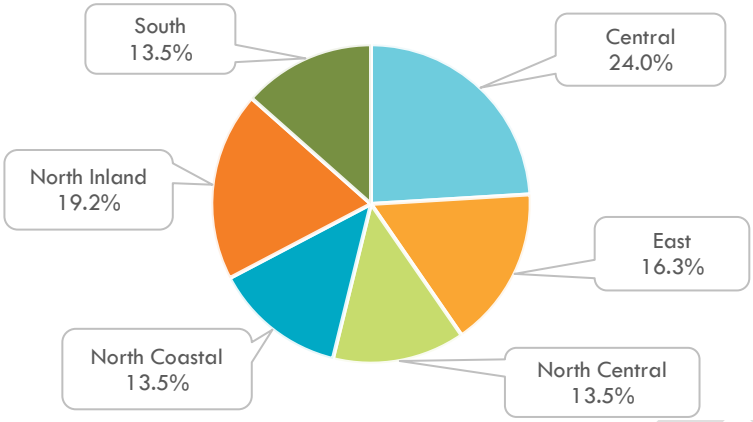
Participants were also asked about their sex assigned at birth, gender identity, and sexual orientation. Most of the participants identified as female at birth (69.9%), female gender (65.8%) and heterosexual (74.1%). Across all questions, nearly 5% of responding participants preferred not to answer.

To better understand the needs of respondents, they were asked to self-identify specific disabilities they were facing. The question covered a range of physical and mental impairments (other than mental illness), such as difficulty seeing or hearing, learning disability, developmental disability, and more. Participants also had the option to indicate other specific conditions. About 19% of survey respondents indicated that they had at least one type of disability.

Another survey item allowed participants to share which, if any, of the following additional groups they identify with immigrant, refugee/newcomer, asylee, Veterans/military, homeless, African, Chaldean, LGBTQ+, and any other group they identified with that was not listed. They were also able to select 'Prefer not to Answer.' Of note, 23.7% self-identified as LGBTQ+. Other groups endorsed were Immigrant (11.3%), Veterans/military (8.2%), homeless/unhoused (7.2%), African (5.2%), Asylee (2.1%), and refugee/newcomer (2.1%). Notably, 53.6% of participants reported that they identify with a group not listed in the survey options.

Participants voluntarily entered zip code information, which helped determine which HHSA regions of San Diego were represented in the survey. Overall, the representation of participants was spread fairly evenly in the six HHSA regions. Of the 104 participants that responded, the most representation of respondents lived in the Central region (24.0%). North Central, South, and North Coastal all had the fewest number of respondents living in those regions (13.5%).

Figure 7. The County of San Diego HHSA Regions of Respondents



Overall Satisfaction

One survey item asked participants to share their overall satisfaction with the activity in which they participated. Of the 123 participants who responded to this question, over 91% of participants reported that they were "somewhat or extremely satisfied" with their activity. Less than two percent of respondents reported being "somewhat dissatisfied" with the engagement activity and no respondent endorsed being extremely dissatisfied with the activity.

Figure 8. Participant's Satisfaction with Activity

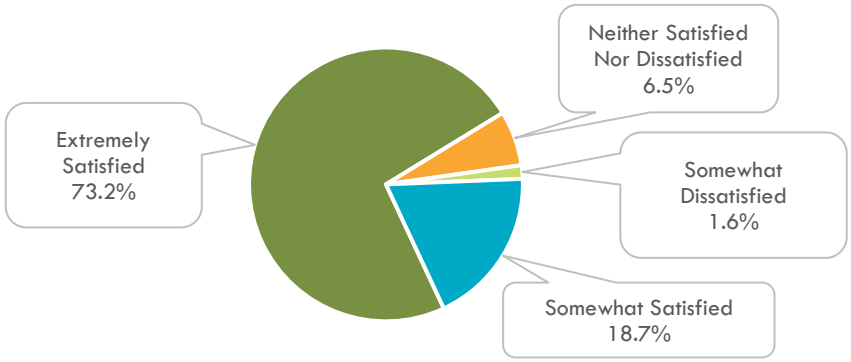
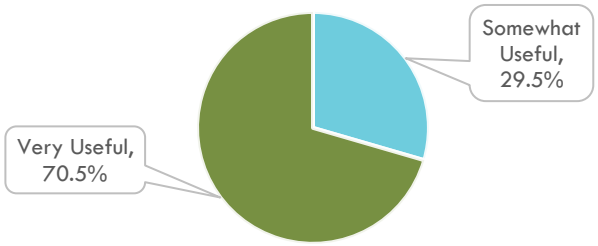


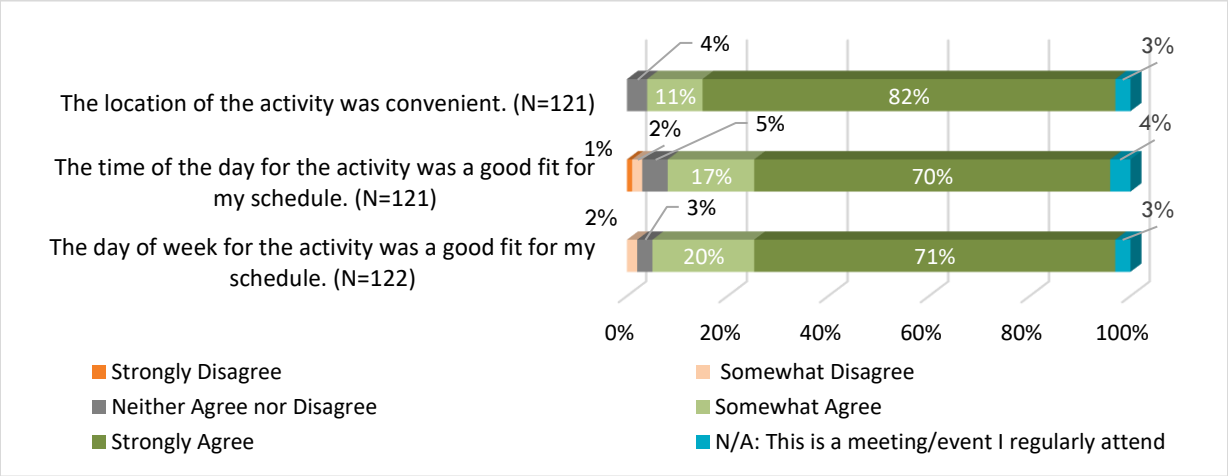
Figure 9. The Usefulness of the Information Covered in Activity



Another survey item asked participants to share how useful overall they found the information covered in their respective activity. Of the 122 participants who responded to this question, 100% found the activity at least somewhat useful. No respondents endorsed the information covered in the activity to be barely useful or not useful at all.

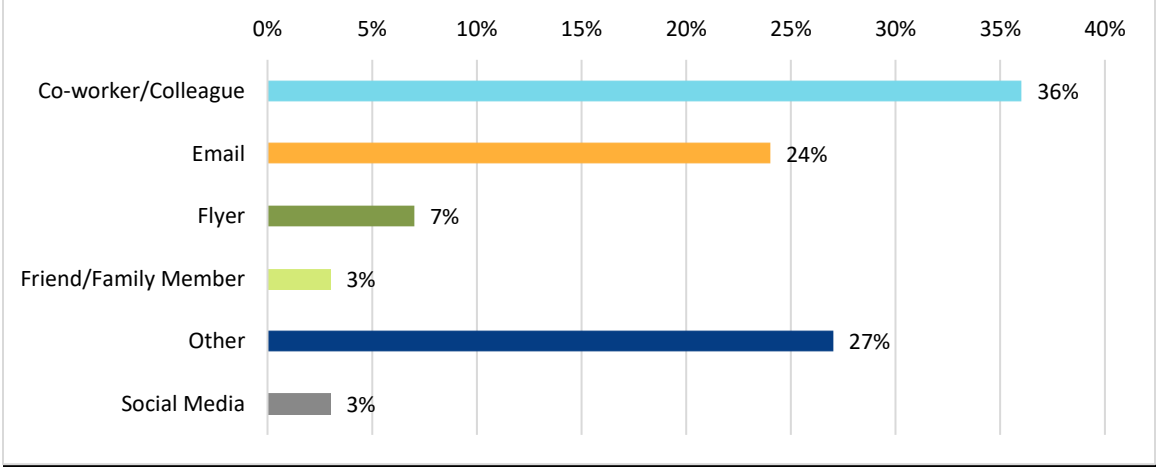
The survey then asked respondents to rate their level of satisfaction with the engagement activity details (i.e., location, time, and day of the week). Over 90% of the respondents either somewhat or strongly agreed that the location of the activity was convenient, and the day of the week was a good fit for their schedule. 87% of the respondents somewhat or strongly agreed that the time of day was a good fit with their schedule.

Figure 10. Satisfaction with Engagement Activity Details



Survey respondents were asked how they learned about the engagement activity. The most commonly reported means was a co-worker or colleague (36%), followed by another method (27%) or email (24%).

Figure 11. Ways Respondents Learned About the Engagement Activity



Community Engagement Efforts: Findings

Major Findings Across All Engagement Activities

The learnings across all engagement activities were robust, with many community-specific and regional highlights, as well as themes and ideas that were persistent throughout. In this section, we will detail emergent themes from each of the respective activities, as well as those specific to particular community populations. Below, we highlight the five major fundings that were repeated by participants across all

engagement activities: listening sessions, interviews, and focus groups. These key takeaways provide a succinct overview of the findings that will be shared throughout the remaining sections of the report.

Figure 12. Major Findings Across All Engagement Activities

Lack of healthcare access and support systems

- Participants emphasized lack of access to health care and support systems. Specifically mentioned were barriers such as affordability, insurance, number of providers, and transportation.

Lack of housing and behavioral health beds

- Providers and community members were primarily concerned about lack of affordable housing, while participants experiencing homelessness and behavioral health struggles emphasized the shortage in available behavioral heath services (i.e., "beds").

The value of culturally competent services

- Community members highlighted the need for culturally competent services. Participants suggested that all providers to participate in cultural competence training. Additional emphasis was placed on the availability of diverse providers throughout the system of care.

The need for continued community engagement

- Across all activities, community members highlighted the value community engagement efforts being conducted by UC San Diego Health Partnership and SDCBHS.

The importance of valuing community input on behavioral health services

- Community members discussed the value of community input on behavioral health services, emphasizing the desire for SDCBHS to not only collect but to act on the provided input. Participants suggested additional incentives to demonstrate appreciation for participants' time.

Participants Define Best Practices for Community Engagement

A foundational element of community engagement is stakeholder participation. As part of this year's engagement efforts, participants were asked to describe the best ways for behavioral health services to engage with their community. The overarching theme of their responses was **culturally relevant services that are inclusive of diverse communities**. Serving communities that are diverse and have unique needs is the cornerstone for supporting authentic community engagement, and this was a theme that was apparent at all levels of the community engagement data analysis in 2023-2024.

According to community stakeholders, engaging SDC communities in a culturally relevant and appropriate way requires a commitment to inclusion. The definition of "inclusion" is multifaceted, but in essence it means involving all community members regardless of race, ethnicity, age, sex at birth, gender identity, gender expression, disability, socio-economic status, sexual orientation, national origin, religion, marital status, or political affiliation. The inclusion process requires:

- Making intentional, ongoing efforts to reach out to all community members to invite participation

- Ensuring that events are scheduled with advance notice
- Arranging locations/modalities that are convenient for participants
- Making the community sessions fully accessible, including people with disabilities and those who may face language or cultural barriers
- Offering gratitude and adequate compensation for participation

Participants shared the importance of "meeting community members where they are," in other words tailoring care and support to each respective community with the understanding that not all members have the same access to resources and/or opportunities. For more information, see the "Community-Specific Needs" section of the focus group assessment. One recommendation was to engage community leaders in engagement efforts. Doing so invites informed knowledge about how to best support behavioral health in their community from the living experts in those spaces. Additionally, local organizations should be consulted as they already serve their respective communities and provide culturally relevant care and support.

Listening Sessions

UC San Diego Health Partnership, in collaboration with SDCBHS, held thirteen listening sessions between September 2023 and December 2023 to obtain community input. The goal was to host at least one in-person session in each region and a virtual countywide session to accommodate those who weren't able to attend in person. The input sessions were also held in collaboration with community partners throughout the SDC regions and within the Live Well San Diego meeting spaces (i.e., the annual Live Well Advance Conference). During these listening sessions, participants could share short responses through a virtual board (i.e., Mentimeter) or via Post-It Notes (for in-person sessions). The following regions were represented in these listening sessions.

Table 3. Listening Session by Region

Region	Number of Sessions
Central	**2**
Countywide	**3**
East	**1**
North Central	**1**
North	**4**
South	**2**
Total	**13**

**Note: The number of sessions was not equitable across the regions of SDC as planning sessions were highly dependent on availability of community centers (e.g., libraries) and on the ability to collaborate and coordinate with our featured session partners. In some communities, like the North region, we connected with more than one network which allotted the opportunity to have four unique listening sessions in that region.*

Question 1: Behavioral Health Needs

Thematic analysis was used to provide a broad understanding of reoccurring themes and ideas in the brainstorming sessions, the findings of which are included below. For question one, *"What are the most pressing issues related to mental health or substance use in your community?,"* we identified eight key themes speaking to the various issues and challenges related to mental health and substance use across

San Diego County. These eight themes are described in detail below.

Lack of healthcare access and support systems

For the question of behavioral health needs, lack of health care access and support systems was the most prominent theme identified in 2022-2023. SDC community members described barriers including affordable healthcare and detox facilities, health insurance, service providers, and transportation. Participants felt as if there is a lack of programming and accessible services in SDC that address behavioral health and overall health needs.

"Mental health care is difficult to afford, especially for low-income folx."

Increasing prevalence of mental health challenges

"Adding mental health and substance use disorder resources and programs onto utility bills, public spaces, libraries, etc."

The most pressing issues related to mental health were anxiety, depression, and suicidal ideation. These challenges were noted to be faced by individuals of all age ranges, including youth and seniors who face depression and isolation. Community members spoke to a need for more resources and programming to combat mental illness.

Stigma

Participants highlighted stigma (i.e., the negative perceptions or treatment of those affected by mental illness or substance misuse) as a pressing issue. Stigma has the potential to impact one's willingness and ability to seek care and benefits. Participants expressed experiencing stigma about their mental health and substance use challenges in cultural/familial, personal, and societal forms.

'"The stigma associated with receiving mental health support/treatment... Often it is seen as being "crazy" or "unstable" as opposed to "healing" & a "medical necessity".'

Youth mental health and substance use

"Substance disorder is now more commonly showing up in youth."

Youth-specific challenges were voiced across the County, including vaping and anxiety/depression, bullying, and social media influence and/or peer pressure. Also noted was the rise of suicide among LGBTQ+ youth.

Increasing prevalence of substance misuse and addiction

The theme of substance misuse, particularly addiction to alcohol, cocaine, vaping, and marijuana was vocalized by multiple community members during the listening sessions. Additionally, examples of the fentanyl and opioid crises impacting adults and homeless populations were emphasized. Participants highlighted the need for substance misuse education to increase awareness and education about how to prevent substance use and overdoses.

"Substance addiction is a complicated issue to address with one or two treatments. Drug & alcohol rehabilitation programs should be a key link in the chain."

Behavioral health staffing/workforce shortages

"Not enough staff for community needs because of high turnover rates due to working conditions and County expectations."

Participants shared frustration regarding a lack of service providers (i.e., staff, clinicians, therapists) in the behavioral health sector. Long wait times and impacted quality of care were attributed to these staffing challenges. Many individuals described the workforce as being underpaid, overworked, and experiencing high turnover.

Housing, homelessness, and isolation

Participants discussed the lack of affordable housing and high rates of homelessness in SDC in various listening sessions. Also, often homelessness was discussed in combination with mental health and substance use challenges, where immediate care is needed.

"A lack of safe, affordable transitional housing for people living with mental health and substance use issues."

Childhood trauma, abuse, neglect

"Strategic efforts to identify and address adverse childhood experiences and toxic stress that are community-based."

Community members shared their histories of childhood trauma, abuse, and neglect, and how those experiences impacted their mental wellbeing and, for some, led to substance misuse.

Behavioral Health Needs by Region

A content analysis of the data was conducted to understand broad regional differences across the themes identified and discussed above. The counts are based on the number of times the theme was mentioned. The heat maps below indicate the themes based on the frequency of response, such that the darker the green color in the table, the more frequently the response was mentioned. This heat map helps to quickly distinguish differences in responses per region represented, compared to all regions. Some regional differences are noted which may help make geographical decisions when planning the MHSA programs.

Table 4. Most Pressing Behavioral Health Issues By Region

Theme	All Regions	Central n = 2	East n = 1	North n = 4	North Central n = 1	South n = 2	Countywide n = 3
Healthcare access and support systems	121	23	16	18	17	8	39
Mental health challenges (anxiety, depression, suicidal ideation)	111	16	11	22	18	15	29
Stigma	63	8	7	4	24	5	15
Youth mental health and substance use	57	7	9	21	5	7	8
Substance misuse and addiction	53	11	2	13	4	12	11
Behavioral health staffing/workforce shortages	49	4	9	10	9	4	13
Housing, homelessness, and isolation	36	3	7	4	2	2	18
Childhood trauma, abuse, neglect	18	4	2	2	2	4	4

In the Central SDC region, **healthcare access and support systems** was the most salient theme. This speaks to the challenges around accessibility to services, like detox facilities, insurance, affordable housing, and resources in their native language. The second most prominent theme was **mental health challenges**, such as anxiety, depression, and thoughts of suicide. Similarly, substance misuse and addiction were identified as salient concerns in the central region.

Specific Concerns for Central:

- Integrating central region community members and leaders in community care planning
- Integrating health and wrap-around services that include prevention and trauma-informed care

Specific Concerns for East:

- Issues accessing transportation to receive care
- Not having therapists and clinicians that speak other languages like Arabic and Farsi

In the East SDC region, **healthcare access and support systems** was also the most salient theme. Some examples included timely access to services and the need for access to knowledge about how to support children and youth struggling with their behavioral health.

In the North SDC region, both **mental health challenges**, such as anxiety and depression, and **youth mental health and substance use** were among the high priorities. Among the youth-based concerns were youth engaging in drug use, high levels of social media engagement, and disconnects between youth and parents when understanding behavioral health concerns.

Specific Concerns for North:

- Unique challenges faced by seniors like mobility, access, and isolation

Specific Concerns for North Central:

- Finding diverse and multilingual providers

In the North Central SDC region, **stigma** was identified as one of the primary behavioral health challenges. Participants reported experiencing multigenerational stigma among family members, cultural stigma such as mental illness being a form of taboo in specific cultures, and stigma against substance use disorders.

In the South SDC region, the primary salient theme was **mental health challenges** such as anxiety, depression, and suicidal ideation.

Specific Concerns for South:

- Concerns for the opioid/fentanyl crisis

Specific Concerns Countywide:

- Community's experience with the prison and jail pipeline
- Lacking trust or being fearful about the government.

The Countywide listening sessions included a fully virtual session, sessions hosted at the annual Live Well San Diego Conference, and one specific young mothers' education and care center. Among the main findings were **healthcare access and support systems** like cost-effective resources and transportation. Following this was the prominence of **mental health challenges**, such as bipolar disorder, suicide, and depression.

Question 2: Challenges in Accessing Resources

For question two, *"What are the biggest challenges to accessing resources for mental health or substance use in your community?"*, we identified eight key themes speaking to the various issues and challenges related to mental health and substance use across San Diego County.

The first theme, and most prominent among the findings for question two, was ***stigma***. Many community members discussed how stigma against mental health and substance use exists in certain cultures, affects access and quality of care, negatively impacts Veterans, and transcends through community spaces.

Among other key themes were ***affordability/financial barriers*** *and* ***lack of awareness/knowledge of resources.*** Affordability was discussed at length, with most mentions related to the high cost of services, insurance, Medi-Cal challenges, impacts on low-income communities, and cost of living/affordable housing in SDC. Many SDC community members expressed a lack of knowledge of the current services, programs, and how to access that care for themselves and their families.

"Transportation for low-income TAY aged youth. Too old for free county youth bus pass too young to have the stability needed for money for transport."

Challenges Accessing Resources by Region

Region-specific analyses were conducted to identify trends. In the Central SDC region, the most prominent theme was **stigma** with receiving mental health and substance use services. In the East SDC region, **language** and **culturally aligned services** were among the most salient. In the North SDC region, **affordability** and **lack of awareness/knowledge of resources** was among the most salient across community members. In the North Central SDC region, **stigma** was also the most prominent among community members. In the South SDC region, **lack of awareness/knowledge of resources** was among the most salient across community members. Lastly, in the unspecified SDC region, **long wait times** were among the most prominent, though other access challenges like stigma and affordability were comparable.

"Having providers from different cultures who understand."

Table 5. Challenges Accessing Resources by Region

Theme	All Regions	Central	East	North	North Central	South	Unspecified SDC Region
Stigma	63	8	7	4	24	5	15
Affordability/financial barriers	59	1	8	17	13	5	15
Lack of awareness/knowledge of resources	54	6	3	16	9	7	13
Language and culturally aligned services	51	7	10	4	13	5	12
Shortage of providers	49	4	9	10	9	4	13
Long wait times	48	5	5	4	13	4	17
Transportation	33	2	5	7	6	3	10
Insurance access	29	4	8	2	6	2	4

Question 3: Ideas for Addressing Behavioral Health Needs

The listening sessions also engaged community members across two additional questions. For the question, *"What activities or programs do you think would help address behavioral health issues & challenges by those living in your community?"* community members brainstormed several activities and/or programs they want to see address behavioral health. First, suggestions for more **youth-specific and school-based mental health support** such as extracurricular activities (i.e., sports, clubs, art) and creative therapy such as drawing, music, and poetry. Similarly, proposals for **peer support and group therapy**, and working towards engaging families to support their youth. Other themes included more **substance use prevention programs** and **increased education/awareness about mental health services** (via fairs, pop-ups, family activities, etc.). Additionally, participants discussed the need for **increased funding for communities** (e.g., youth programming, community-based organizations/non-profits) and more **affordable housing** for SDC communities. Lastly, additional **support for homeless populations** was identified.

Youth-Based Support

Among recommendations for youth mental health and substance use were ideas of integrating additional support into school-based activities and increasing overall systems of support in schools. Participants acknowledged the need for increased funding to support in-house behavioral health providers, therapists, counselors, and programming. Programming examples included incorporating creative forms of therapy (i.e., art and music therapy) and mental health and life skills education into the curriculum. Other youth-based recommendations included bullying support, youth town halls, transportation for TAY, childhood trauma support, and increased parent involvement in youth-based experiences.

Substance Use Prevention Programs

Participants discussed the importance of prevention programs that target substance use before it begins, particularly in youth. Prevention programs may be useful for targeting cycles of addiction and using drugs and alcohol as a coping mechanism. Examples of prevention programs and activities include peer-to-peer programs and mentorship, prevention services in multiple languages, mental health education and emotional awareness training in schools, and holistic care/wellness approaches.

Mental Health Awareness and Education

Many participants shared that they were knowledgeable about the behavioral health services and programs offered in SDC. A lack of awareness of available services deters people from seeking the help they need for themselves or their loved ones. This is particularly challenging for diverse SDC communities that speak other languages and cannot access resources in their native language. Participants shared a desire to learn about existing resources through mental health fairs, pop-ups, and online or physical communications like mail and newspapers.

Affordable Housing and Support the Homeless Population

Participants highlighted the need for increased housing support due to the lack of affordable housing and the high rates of homelessness in SDC. Among the recommendations were increased funding for housing support, homeless solutions and increased shelters, equitable opportunities for housing, and housing vouchers.

Question 4: Ideas for Sharing Behavioral Health Resources

Lastly, community members were asked the following question: *"How would you like to see behavioral health resources shared with this community?"* Community members brainstormed the following ideas: 1) **provide resources and services in multiple languages**, 2) **reach people who do not have reliable technology** (e.g., via mail, newspaper), 3) **meet people where they are** in their community, 4) have **culturally-informed and trauma-informed providers and resources** available, 5) use **print materials** such as pamphlets and flyers, 6) and utilize **social media for communication and outreach**.

SDCBHS-Led Youth Community Listening Session

SDBHS led a virtual, youth-based community input session in collaboration with Mind Out Loud, a mental health movement that amplifies student voices to improve student mental health awareness, and Bring Change to Mind, an evidence-based campaign to harness education and empathy for students. Data were analyzed separately from the thirteen core listening sessions given the difference in methodological approaches. Youth were divided into two breakout sessions and asked to reflect on the following four questions:

- What do you feel are the most significant mental health or substance use challenges among youth and young adults?
- What obstacles do you think youth and young adults face when trying to get support for mental health or substance use issues?
- What types of activities or programs would help address mental health or substance use issues for you and your peers?
- In what ways would you prefer information about mental health and substance use resources to be shared with you and your peers?

Themes were identified across the four questions. For the first question, two key themes were found including **peer pressure** and **stigma** from peers and family**.** Youth discussed they feel pressure to misuse substances and/or abide to certain body standards. They spoke of the negative stigma associated with their behavioral health by their family and communities, for example peers not feeling comfortable disclosing their mental illness to family due to fear of judgement and negative consequences. This also emerged as a prominent theme in responses to the second question along with **lack of awareness of** and **barriers to accessing resources** including financial challenges.

In response to Question 3, the primary themes that emerged were **school-based support programs** and **mental health training/education in schools**. For instance, youth recommended integrating a mental health curriculum into their general education, as well as allowances for self-care such as later start times and mental health days (comparable to sick days).

For the fourth question, emergent themes included **mental health education and promotion in schools**, and **promotion on social media** through applications like Tik Tok and Instagram.

Overall Themes from Interviews and Focus Groups

An updated introduction is to be included in the final report.

Table 6 describes themes across both interviews and focus groups of the barriers and challenges to behavioral health services.

Table 6. Barriers to Behavioral Health Services*

Lack of Housing	Among the most common barriers to services that participants noted was the lack of housing options. Participants shared that the lack of affordable housing exacerbates mental health and substance use issues. Some participants also mentioned the lack of behavioral health beds and adult residential facilities for people receiving, or in need of, treatment in the County. Providers also shared the lack of affordable housing for themselves in San Diego County, which may entice them to seek employment elsewhere. Participants also highlighted the need for treatment alongside affordable housing as homelessness is sometimes co-occurring with mental illness, substance use disorder, and/or criminal justice-involvement. *"… I would say housing. It's one of the biggest challenges."*
Lack of Funding	One key barrier to services is the lack of funding for behavioral health programming among community partner organizations. Participants noted the lack of funding may shut down local community organizations and possibly restrict the kinds of services (such as housing, job assistance, etc.) that community organizations can offer. In addition, waitlists for underfunded programs, staff turnover, inadequate number of staff members, and lack of resources for quality training of staff, were frequent comments shared by interview and focus group participants. *"The issue is that from what I've heard from a lot of people, they're [community organizations] just not funded. Like they're not funded enough to [work], they're not funded enough."*
Barriers to Qualify for Services	Participants noted the barriers faced by individuals trying to access services but who may not qualify for them. Reasons for this could include a lack of medical insurance, lack of documentation of insurance, or other forms of identification. Some people may not be able to afford insurance or make too much money to receive social security benefits. Moreover, some people who are experiencing homelessness may no longer have an official form of identification, making it difficult for them to receive the necessary services they need. Participants also noted that some services have a limited length of time before a client is no longer eligible for services. *"It's really difficult in my role, because services that I do have, resources that I do have, there's [still] so many barriers put up for the community, whether it's not enough income, if they're seniors, and they just don't make enough on SSI. So, they don't qualify in that way for, permanent housing, to just the qualifications to get into programs is just not there. That's not easy, or accessible. There's just not enough of them."*
Need for Diverse Clinicians	While participants noted the overall lack of accessible behavioral health providers, some participants across different communities shared that more clinicians from diverse backgrounds are sorely needed. In particular, participants noted the lack of Black and LGBTQ+ providers in San Diego County. *"It's interesting because I feel like there's so many people that do look like me [i.e., Black], but I can't seem to find them in these behavioral health spaces and so I kind of wonder what's causing that divide?"*

Stigma	A common barrier to receiving treatment for either mental health or substance use is stigma. For participants, stigma is associated with negative stereotypes of people with mental illness or people with substance use disorder, as well as prejudice and discrimination (including from providers). Stigmatized individuals are at more risk for violence as highlighted by members working at an adult residential facility. *"I think with my mental health struggles, I think that's the worst pain of all, not what I went through in my childhood but the pain I'm going through now, because... you know how people go on horses, and they kick up their leg, and they just go on the horse? Well, people who are mentally challenged or mentally disabled, they have to go on steps, and I don't want to go on the steps. It's embarrassing to go on the steps, I want to jump on the horse like everybody else."* *"...[some people] see it [mental illness] as a personal deficit, rather than something that someone is struggling with, and it's not an option. Because nobody wants to have a mental illness. But people act like it's their choice."*
Lack of Employment Opportunities	Participants shared the lack of employment opportunities for disabled individuals, including people who experience mental illness. Some participants connected this issue to a lack of behavioral health providers and suggested a more streamlined way for people with lived experience to become peer support specialists. *"There needs to be more flexible jobs [in the County]. Bosses that can hire people with disabilities."*
Need for more Services for Disabled Communities	Participants from different communities shared that there is a need for more services for disabled people in the County. These services include the lack of beds and shelters for individuals experiencing homelessness, disabled populations, accessible transportation, sign language translators (in BHS meetings, appointments with providers, and at sober living spaces), and other accessibility accommodations. In addition, some barriers exist for disabled people trying to access housing. *"Housing Navigation will maybe find somebody... a place but it's not accessible for whatever disability they have, and they will count that as a refusal."* *"I'm not exaggerating, in every instance, somebody has reached out for my help with disability advocacy, it's always a disability discrimination issue at hand that's not being viewed through a disability accommodation lens."*

**Note – For each of the themes quotes in blue are from interviews and quotes in green are from focus group participants.*

Table 7 describes participants' perspectives on effective community engagement from interviews and focus groups.

Table 7. Participants' Perspectives on Effective Community Engagement*

Engage Community Leaders	Participants from various communities shared that to improve collaboration between BHS and marginalized communities, BHS should first reach out and connect with trusted community leaders. By developing trust with community leaders, BHS will be in a better position to collaborate on behavioral health programming more relevant for different communities.

	"...engaging them in their language, you are going to be discussing different issues, and engage trusted ambassadors. No one can just go into a community and say, hey, guess what, I want to talk to you about this problem. And they are going to say, 'Who are you?'. Right? So, engaging, who are these known leaders in the community, and involve them in the process, and then they can be able to share that information with the community and invite them to the focus group or however you are going to gather the information."
Provide Incentives	Participants shared that to increase community participation in focus groups, additional incentives should be included. While food and beverages are welcomed by most participants, cash, and gift cards, as well as other forms of incentives, could be helpful with community engagement in the future. *"It's all about that human connection, and it's all about not pushing the agenda...maybe even giving a gift card, buying them some food, or whatever, building that rapport. I think it goes a long way."*
Meet Communities in Their Spaces	To better engage communities, BHS should "meet people where they are at." This includes asking community leaders and/or members where it would be best for community events and data collection such as listening sessions, focus groups, and interviews. The location should also be accessible to everyone in the community. *"Picking venues that are going to have accessibility, good parking, that's important for our community, good transportation, being near a bus line or something is really important."*
Respect Communities' Culture	Beyond providing incentives and meeting communities where they are, BHS should learn about the various cultures in the County to better engage members of that culture. To learn and engage with other cultures, participants shared the need to understand the history of diverse cultures, to understand the stigma attached to mental health and substance use in certain cultures, and to make sure that BHS events and educational materials are translated into different languages. *"...for example, Somalis, they love tea, and that's how they do their business. So, if you have someone prepare a tea from a Somali flavor of tea, you'll [get] more information."*

**Note – For each of the themes quotes in blue are from interviews and quotes in green are from focus group participants.*

Table 8 describes specific themes for SDCBHS programming and outreach from the interviews and focus groups.

Table 8. Specific Themes for SDCBHS Programming & Outreach*

Navigating Services	An important change that BHS could make is increasing assistance in navigating behavioral health services in the County. Some participants suggest that this may be a problem with a lack of promotion of behavioral health services available to people. One consistent suggestion was for the County to train community leaders in navigating services so that these leaders could pass on their knowledge of services to the rest of the community.

	"...helping people understand, not only how to access resources, not only how to access care, but help them understand that once they have access to that type of care, these are the different avenues that you can take after that."
Understand Substance Use as a Coping	Some participants across communities shared that engagement with people who use drugs should not feel stigmatized due to their drug use. To better engage with people who use drugs, participants suggest that BHS understands that substance use is often a coping mechanism for dealing with other issues, including lack of access to services or affordable housing. *"Listen, from the scenario of being on the streets, please understand it this way, the drugs are the relief for the [redacted] that we're all going through."*
Peer Support Services	Participants across communities shared the importance and value of peer support specialists in SDC. Many participants shared the need to increase peer support services and to increase the wages of hired peer support specialists. According to many of the participants we spoke to, peer support is of the utmost value when it comes to treatment and recovery. *"You [need to] put somebody that has lived experience [into BHS programs]. Because I've been there...The one who's struggling with mental health or depression or trauma that are in the pit...The person in recovery jumps in the hole with them. 'Hey, I've been here. Come on, I know how to get out,' that's lived experience..."* *"I think one of the things that helps us with that as well, is that I think all of us, or almost all of us have our own lived experience with some sort of mental illness or other things that our members struggle with. So, we come from a place where it's a lot easier to relate and I think that helps."*
Translated Services and Materials	As previously mentioned, participants shared the need to have all BHS programs and educational materials translated for each of the languages spoken in SDC. Translated printed materials should also have bold and large ink to be accessible to older adults. Also, services and materials need to be accessible to disabled and deaf individuals. *"[Having] translated materials, also translated material and for older adults, they need 14-point font so that they can read their material"* *"The priority should be... interpreters are required immediately. It shouldn't be up for debate, ever."*
Prevention Services	Participants shared the need to increase prevention services for mental health and substance use, including screening youth for mental health concerns. Other prevention services could include Housing First and community models of care (such as clubhouses). Some participants shared the idea that expanding services for individuals with mild to moderate mental health issues could prevent their mental health from becoming severe (i.e., shift from a crisis response to prevention models). *"I wish there was just a priority of prevention. And that's another concern with this new bill, right, is that does that mean that now because a lot of it will be spent in the carceral system a lot of what's going to be cut is all the holistic stuff, the programs of prevention that are kind of looked at as fluff, but it's not. We really need more invested in our community, and wellness, and incentivizing healthy behaviors."*

Trauma-Informed Services	A particular challenge, specifically for BIPOC and LGBTQ+ communities, is the amount of individual trauma they experience, such as incarceration-based trauma and generational trauma. Community suggested to increase trauma-informed services across the County (e.g., trauma-informed group therapy). In addition, all providers contracted through BHS should receive trauma-informed training. Participants also shared that it is essential that there be continuity in care with providers in order to maintain the trust that is necessary for trauma-informed treatment. *"...It's more so the trauma-informed stuff. So making sure people know how to have healthier boundaries and relationships with these substances and checking in on like, why are you doing these? Is there some underlying trauma, is there some coping going on? Is there connection problems that you're having with community that you need these substances to feel that intimacy with other people? So we kind of focused more on that side of things.'"*

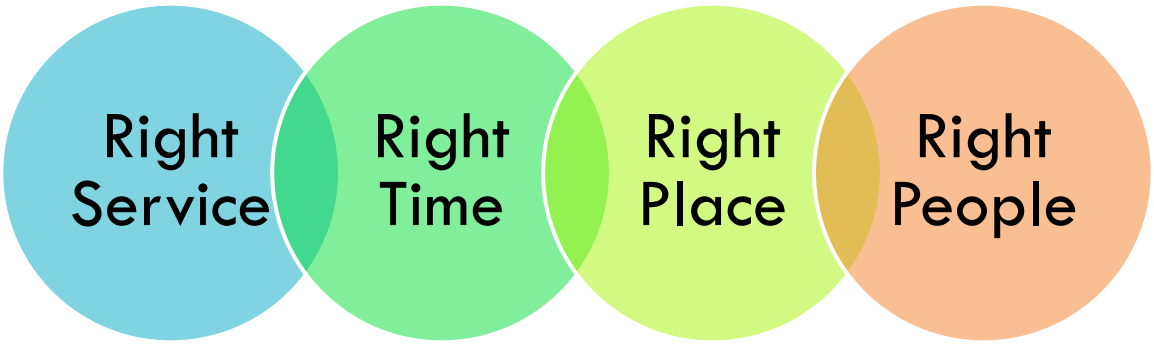
**Note – For each of the themes quotes in blue are from interviews and quotes in green are from focus group participants.*

In response to feedback received by participants and to ensure a thorough representation of each of the communities involved in the engagement activities, community-specific findings were also summarized and are shared in Appendix F. The summary highlights community-level themes and ideas, creating a space to elevate emergent concerns about mental health and substance use issues and services in the respective participants' communities, beyond the list of global themes across all communities. It is important to iterate that the themes in Appendix F are not intended to be representative of an entire community, but each theme acknowledges concerns from lived experience expertise of the specific community, elevating voices of community leaders, consumers and family members, and community health and social service workers.

Chapter 5 – Recommendations for Behavioral Health Services

SDC needs a comprehensive behavioral health system that can address any emergent crisis and acute care need while centering prevention and early intervention. Consistent with the efforts to realign system priorities detailed in the MHSA Three-Year Plan for 2023-2026 describing the SDCBHS goal to create a rebalanced continuum that removes barriers for individuals trying to access care, reduces cost, and promptly connects people to the care and housing they need, emergent recommendations from the community engagement activities centered primarily around the varying communities needs and provided innovative suggestions, about behavioral health prevention, early intervention, and treatment services.

The community input and recommendations can be summed up as the desire for a behavioral health system that provides the "right service, at the right time, in the right place, and by the right people."



In addition to this, SDCBHS should work to enhance community members' awareness of and cultivate a positive understanding about behavioral health needs and services that would allow people to benefit from such a system. Further, if there are existing SDCBHS services that address the recommendations, those should be effectively promoted to reach a wide range of diverse communities.

For services needing to be the "right service" we draw from recommendations centered on the wide range of services needed and to ensure that the wide range of services that are provided are of high quality and effective. A few examples of this include warm-handoffs and follow-through from providers, along with offering a more variety of services to attend to specific population or geographical needs in the community. Those characterized as "right time" include services that address waitlist issues, hours of care facilities, and timely care. Those services needing to be in the "right place" speaks to the accessibility of services such as mobile clinics, ease of access for rural communities, and meeting communities where they are and utilizing their venues or preferable community spaces. Lastly, services by the "right people" speaks to ensuring culturally relevant services, improving language diversity, and diversifying the workforce of providers.

Table 9. Recommendations for Behavioral Health Services

	Recommendations*	Potential Community-Driven Strategies to Act on Recommendation
Domain 1: Right Service	(1) **Increase opportunities for prevention and early intervention (PEI) programs***	➢ Expand treatment options/approaches to facilitate engagement (e.g., art/creative therapy, group therapy, family therapy) **(1.1a)** ➢ Prioritize prevention services (e.g., trauma-informed care and wraparound services) that combat the need for crisis response/stabilization **(1.1b)** ➢ Increase SUD treatment and facilities, including detox, rehab, and residential care centers **(1.1c)**
	(2) **Provide high-quality services that result in improved health and well-being***	➢ Attend to quality and effectiveness of care provided to clients, by focusing on warm hand-offs, culturally competent services, and wrap-around services that attend to overall health and well-being **(1.2a)** ➢ Emphasize personalized care that attends to individual needs and is continuous from entry into services to discharge. **(1.2b)** ➢ Expand evidence-based harm reduction services, such as syringe exchanges, naloxone distribution, and drug testing equipment, to reduce overdose incidence **(1.2c)** ➢ Provide competitive pay for behavioral health staff to allow for high-quality services to be delivered **(1.2d)**
	(3) **Increase care coordination across behavioral health and related services***	➢ Increase availability of integrative treatment models and programs that target both mental health and substance use challenges **(1.3a)** ➢ Improve communication across behavioral health silos that foster the ability to provide warm hand-offs for clients **(1.3b)**

	Recommendations*	Potential Community-Driven Strategies to Act on Recommendation
Domain 1: Right Service	(4) **Increase availability of basic needs/non-behavioral health) services**	➢ Address basic needs concerns across SDC, including food, shelter, and clothing **(1.4a)** ➢ Increase job and workforce opportunities for community members (e.g., JobCore) **(1.4b)** ➢ Provide additional supportive housing options (including Housing First programs) for individuals with behavioral health needs, such as those experiencing homelessness or at risk of becoming homeless **(1.4c)**
	(5) **Communicate service improvements to the community**	➢ Provide accessible and translated materials (e.g., pamphlets and infographics) explaining results of behavioral health services **(1.5a)** ➢ Timely sharing of BHS outcomes with community leaders to allow for impactful service improvements in their community **(1.5b)** ➢ Host forums with a wide range of communities to communicate behavioral health service results **(1.5c)**
Domain 2: Right Time	(1) **Increase staffing/decrease waitlists at behavioral health treatment programs***	➢ Expand the behavioral health workforce funding in SDC to meet the demand for services, as well as alleviate the long wait times to access care **(2.1a)**
	(2) **Reduce barriers to accessing behavioral health services***	➢ Invest in an integrative system that allows community members to access information about available services and programs "in one place" **(2.2a)** ➢ Develop a community care plan that provides flexible clinic hours of operation and appointment times to meet the needs of the community **(2.2b)** ➢ To help reduce administrative barriers, develop a more streamlined referral process that is accessible and user-friendly **(2.2c)**
Domain 3: Right Place	(1) **Ensure that services are accessible to all community members**	➢ Increase access to transportation to and from services, particularly for low-income communities and those in rural communities (e.g., Julian, Alpine) **(3.1a)** ➢ Expand telehealth and remote care options (including mobile behavioral health clinics) to facilitate access to care **(3.1b)**
	(2) **Create additional opportunities to provide services in locations already utilized by community members**	➢ To avoid overburdening communities and enhance accessibility, it is essential to meet community members where they are (e.g., in popular community spaces) and come to them to meet their needs **(3.2a)** ➢ Address community needs by bringing the resources (e.g., mobile behavioral health clinics, naloxone, etc.) to them and their local community spaces for efficient accessibility and trust building **(3.2b)**

	Recommendations*	Potential Community-Driven Strategies to Act on Recommendation
Domain 4: Right People	(1) **Create culturally appropriate services and programs for diverse communities**	➢ Expand the use of culturally appropriate resources and services to ensure the availability of materials and assistance in languages other than English **(4.1a)** ➢ Hire more translators (including for ASL) and bilingual staff, provide translated materials, and utilize cultural liaisons to ensure effective communication and understanding of cultural differences **(4.1b)** ➢ Increase representation of diverse providers in the behavioral health workforce, including BIPOC, LGBTQ+, and providers from diverse backgrounds **(4.1c)** ➢ Include additional cultural competency and structural competency training for BHS staff **(4.1d)**
	(2) **Utilize behavioral health-oriented peer supports, promotoras, and community health workers for co-production of services***	➢ Utilize peers, promotoras, and community health workers (CHWs) to provide a diverse and reliable workforce and promote continuity of care for and engagement with patients **(4.2a)** ➢ Hire and train peers, promotoras, and CHWs to provide health education, disease prevention, and support for patients in their communities **(4.2b)** ➢ Expand community listening sessions and BHS subcommittees to incorporate additional community leaders in service planning, programming, and promotion **(4.2c)**
Domain 5: Awareness and Attitudes about SDCBHS Services and Needs	(1) **Improve knowledge of existing behavioral health services***	➢ Develop and implement a comprehensive education and outreach campaign to increase awareness and knowledge of available resources for behavioral healthcare **(5.1a)** ➢ Increase awareness of existing programs and services through outreach, promotion, and authentic community engagement **(5.1b)** ➢ Work to make navigation across county-specific resources more accessible for community members **(5.1c)** ➢ Engage the community through a series of consistent events with follow-through (e.g., mental health fairs, substance use prevention events) **(5.1d)** ➢ Utilize a variety of channels for dissemination, such as social media, print and digital advertising, and in-person outreach events **(5.1e)**
	(2) **Increase community education regarding stigma reduction and suicide prevention***	➢ Combat stigma by working to normalize mental illness among youth and families (e.g., discussions, group therapy, peer-to-peer mentorship) **(5.2a)** ➢ Increase cultural and historical knowledge of impacted communities to better understand the link between conflict and oppression (e.g., colonialism) to disparities in mental illness and substance use disorder diagnoses **(5.2b)**

Domain 6: Investing in Existing Community Organizations	**(1) Create additional opportunities to provide resources to community organizations already interacting with underserved/focal populations**	➢ Allocate appropriate funds to community-based organizations (CBOs) and other non-profits that are already doing "the work" in their respective communities and have built trust and rapport with community members **(6.1a)** ➢ Given that local CBOs and non-profits must compete with larger organizations for the same grants, create a separate grant that is geared towards smaller organizations and can create equity in the funds allocated to programs **(6.1b)** ➢ Expand SDCBHS contracts to allow local community organizations to hire providers outside the county to better fit the needs of their community **(6.1c)**
Domain 7: Community-Specific Needs	**(1) Increase availability of services TAY aged 18-25***	➢ Expand the availability to programming and services for reducing vaping and marijuana use among youth **(7.1a)** ➢ Increase availability of youth-based behavioral health services integrated within schools, such as increased counselors and therapists, mental health curriculum, and promoting parent involvement **(7.1b)** ➢ Increase availability of trauma-informed TAY behavioral health treatment services **(7.1c)**
	(2) Continue engagement with a diverse range of community groups to identify populations with unique outreach and treatment needs*	➢ Explore the utilization of alternative and non-traditional models of healing, such as peer-driven Soteria house for persons living with psychosis **(7.2a)** ➢ Increase training on the cultural and historical knowledge of marginalized communities, including in the context of colonialism and racism **(7.2b)** ➢ Provide more focus group opportunities with various communities to continue to identify unique outreach and treatment needs **(7.2c)**

**Note – 6 of 18 recommendations are listed in the MHSA Three Year Plan Report and emerged again in the current year.*

Chapter 6 – Future Directions

An updated Future Directions section will be included in the final report.

Appendix List

Appendix A: Satisfaction & Demographic Survey
Appendix B: UC San Diego Focus Group Flyer
Appendix C: UC San Diego Focus Group Interview Guide
Appendix D: UC San Diego Listening Session Presentation
Appendix E: UC San Diego Listening Session Flyer
Appendix F: Community Specific Findings