COUNTY OF SAN DIEGO
HEALTH & HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES
COMMUNITY ENGAGEMENT REPORT 2016

HOFFMAN CLARK+ associates

2016 COMMUNITY ENGAGEMENT REPORT

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

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I. OVERVIEW: 2016 COMMUNITY ENGAGEMENT

Behavioral Health Services (BHS) of the County of San Diego Health & Human Services Agency (HHSA) is engaged in an ongoing Community Planning Process (CPP) that helps to inform decision-making, including how to best use Mental Health Services Act (MHSA) funding to achieve positive health outcomes. This process includes the participation of the San Diego County Behavioral Health Advisory Board and the System of Care Councils, as well as other community organizations, stakeholders, and individuals.

In 2016, Hoffman Clark + Associates (HCA) was contracted to design and conduct regional community forums and focus groups throughout the County of San Diego. The goal was to continue to gather input from community stakeholders including consumers and family members regarding services within the BHS System of Care. This report presents and analyzes community input data. It is anticipated that the results will be incorporated into the County's 10-year Roadmap, which is a strategic vision framework aligned with the mission, vision and values of the County of San Diego including Live *Well San Diego* and intended to guide BHS planning.

What are the deeper learnings from the community engagement process?

Meaningful engagement is valued and desired. An across-the-board message from participants in the 2016 community engagement process was that they valued the opportunity to have their voices heard. More than 650 stakeholders, including providers, consumers, and other individuals, came to the table to envision a bright future for Behavioral Health Services and to give their input on how to effect meaningful change. Many suggested deeper and sustained participation in the Community Planning Process as part of their vision, and made specific requests and suggestions for additional engagement activities.

Care coordination and a seamless continuum of care are both viewed as critical. When the community engagement data was decoded and analyzed, the topics of care coordination and continuum of care emerged as essential priorities. Greater connectivity within the provider community and with BHS, education and information sharing, and integration of services across systems were key components of an overall vision.

Access to services and education and awareness were the most pressing concerns in the area of children's behavioral health. The community expressed a need for home-based services and services embedded in schools, and for education programs and campaigns targeting parents, teachers, school staff, and students, with the goals of enhancing awareness of behavioral health issues, normalizing and destigmatizing these issues, and teaching skills for dealing with them.

Unserved and underserved populations warrant focused attention. The community engagement process surfaced many actionable solutions to how to best meet the needs of specific target populations. Some of these populations were the focus of the smaller groups or community conversations, while others such as refugees or individuals who are deaf or hard of hearing were discussed during community forums. Understandably, an increase in services was the top request. Across all regions, the need for culturally competent services was noted, along with suggestions for consumer-driven and peer-led services. Other requests were for stigma reduction, public education, and the establishment of mobile and one-stop centers of care.

Barriers relating to housing and transportation are of paramount concern. It is clear that issues of housing and transportation are closely connected to behavioral health, and that they cut across the areas of Care Coordination, Unserved and Underserved Populations, and Children's Behavioral Health. Participants offered solutions in these areas that range from simple suggestions to provide BHS consumers with greater access to bus passes, to innovative ideas to address problems of homelessness.

How do the results of the community engagement process inform BHS's 10-year Road Map? The stories that emerged from the community engagement process in 2016 show that the county's 10-year Roadmap is on track. However, feedback across regions and topics suggested that consumer and provider awareness of BHS programs, and ongoing co-leveraging collaboration across services is seen as a critical. These processes, although included in all areas of the Roadmap, may need to be elevated into a stand-alone service area to be more visible, intentional, and measurable. This is especially imperative for the disenfranchised and those communities often lacking a voice

Many of the solutions proposed do not require more funding or a dramatic change in policy or practice on the part of BHS. They are more a call to action: a call for authentic and ongoing community engagement in order to inform, communicate, and collaborate around a shared vision that entails both low and high tech innovative solutions to help the most vulnerable community members navigate through the behavioral health system.

How did we arrive at these results? The 2016 community engagement process is summarized below, with more detail of the methodology following in section II.

Who? More than 650 stakeholders, including providers, consumers, and other individuals, participated in the 2016 community engagement process: 553 stakeholders at twelve regional forums, and more than 100 representatives from target populations (Native American, Southeastern San Diego Community, Justice Partners, Male and Female incarcerated individuals, and Peer Workers) who attended six special focus groups. Demographics of forum attendees were collected.[1]

What? In conversation with the BHS team, HCA identified the World Café as a model for the community forums that would allow us to channel input into three identified priority areas: Children's Behavioral Health, Care Coordination, and Unserved/Underserved Populations. Our adaptation of this method, the Conversation Café, was scalable to community turnout and encouraged collaborative envisioning of future possibilities in the three priority areas and next steps for realizing those possibilities. They also allowed for community input on the desirability of four proposed Innovation Projects in line with MHSA requirements. The six special groups were selected based on feedback from the community planning process in previous years, and provided an opportunity to pay targeted attention to specific populations.

When? Late August through early November of 2016.

Where? Two forums, one in the day and one in the evening, were held in community centers or county facilities in each of the six HHSA regions. Special groups met at the San Diego County Hall of Justice, NAMI San Diego, the CARE Community Center, Las Colinas Detention and Reentry Facility, the George Bailey Detention Facility, and the Rincon offices of the Indian Health Council.

[1] Forum Feedback was reported previously; a copy of this report with demographics and participant feedback is included in Appendix A.

Why? Community engagement – gathering data from and providing feedback to the community – is a required component of MHSA funding, and is also part of both the Live Well vision and a guiding principle of BHS.

II. PROCESS METHODOLOGY

Community Forums. In meetings with Behavioral Health Services, several ideas and issues emerged that informed the forum process:

- The history of the community engagement process, data collected, and community response to the process
- Desire to encourage community members to delve deeper into specific topic areas
- Focusing on the topics of Underserved/Unserved Populations, Children's Behavioral Health, Care Coordination, and Innovation
- Aim to have participants give input on all of the focus areas
- Preference for the HCA team members to facilitate forums to avoid the potential bias of having county staff facilitate the process
- Need for a short infographic to provide historical context and to summarize how past community planning informed program funding
- Need to collect demographic data from forum participants
- Need to vet proposed Innovation projects
- Application of the World Café model to the forum process to engage the community through the lens of Appreciative Inquiry

Appreciative Inquiry is based on a social constructivist approach that asks questions aimed at strengthening system capacity by focusing on productive potential.[2] The process begins with an unconditionally positive question. The initial question posed to forum participants was, "What do we need for a Brighter Future for Behavioral Health Services?" The participants made progressive rounds amongst tables to participate in collective conversations about the future in each of the three topic areas. In most of the forums each table was hosted by a HCA facilitator. Participants were also asked to discuss concrete 'Next Steps' for moving toward the positive future they had collectively envisioned. Participants were directed to come to a consensus on key ideas before moving to the next topic. Consensus ideas were harvested and graphically recorded. The participants also spent a 15-minute round discussing the four proposed Innovation Programs. Finally, participants were asked to fill out a questionnaire about the forum process, which included demographic questions.

Special Groups. The protocols for the special group meetings were developed with input from BHS and/or stakeholder organizations connected to the participants. In each case an emphasis was placed upon developing questions that would facilitate meaningful participation and result in the identification of actionable solutions. Consideration was given to the size of the group and background of the attendees. Partners in these efforts included: Public Safety Planning Group (Justice Partners); NAMI and RI International (Peer Workers); Indian Health Council (Native American community); and Live Well Communities Task Force (Southeastern San Diego community). Details of group processes are included in the full reports in Appendices E through J. A summary of these groups is provided in section IV.

[2] JM Watkins & BJ Mohr. *Appreciative Inquiry: Change at the Speed of Imagination*. New York: Wiley, 2011.

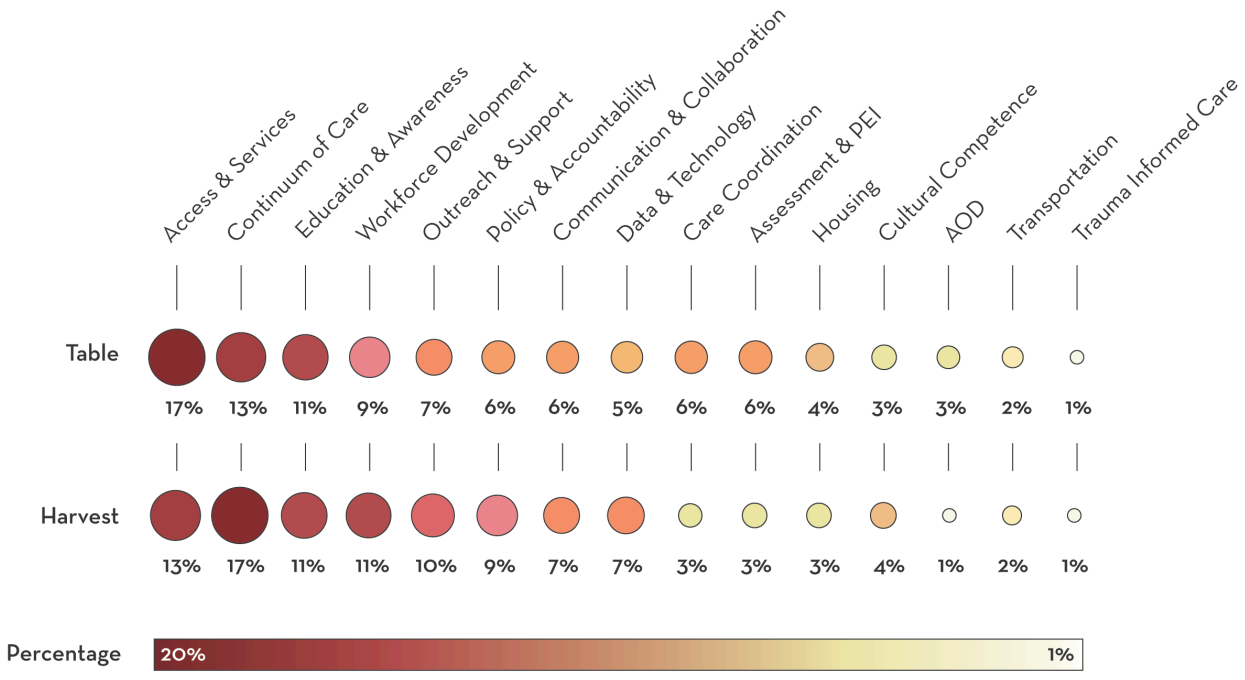
III. Community Forums

Data was collected at the Community Forums in four ways: 1) Participants and facilitators at each table noted ideas on tabletop papers; 2) Key ideas were 'harvested' from each table to capture central themes of each forum; 3) A 'parking lot' allowed participants to contribute ideas and concerns not covered in table conversations; and 4) A questionnaire was distributed at the end of each forum to gather demographics and feedback on the process. Questionnaire data can be found in Appendix A. Parking Lot data can be found in Appendix B, and is reported below in section F. Harvest and Table data are reported below in section A, and broken out by topic in sections B through E. Data was also graphically recorded and aggregated into a 3'x6' visual, and an interactive data story was published online and will be available to the public. See Appendix K.

A. Harvest & Table Data

Both Harvest and Table data were entered into NVivo and Kumu to analyze and visualize clustering of frequently recurring concepts. This yielded a set of 15 'Essential Themes' into which all data was coded.[3] Two members of the HCA team conducted coding, with 94% inter-rater reliability in a 10% sample. Coded Harvest and Table data were compared to validate the representativeness of the harvest. Across all six regions and three topic areas, there is significant proportional correlation (r = .876) between Harvest and Table data. See Figure 1.

Figure 1. Harvest & Table Data Across all Regions



However, when sliced by topic and region, disparities between Harvest and Table data are revealed even as correlation remains significant (r = .841 for topics; r = .733 for regions). Dominant categories such as Access & Services, Continuum of Care, Workforce Development, and Education & Awareness

[3] See Appendix C for an explanation of these categories.

continue to stand out, but notable differences in some areas emerge. For example, Outreach & Support registered at 23.2% in the Harvest from the Central Region but only 5.3% at the Tables. See Figures 2 and 3. This is likely due to the smaller sample size as the data is sliced thinner, but can also expose more granular distinctions at topical and regional levels between community concerns expressed at the tables and those captured in the harvest. For this reason, while the harvesting of data was useful for the overall graphic recording of community input across the county, we base our analysis primarily on data captured at the tables.

Figure 2. Harvest & Table Data by Topic

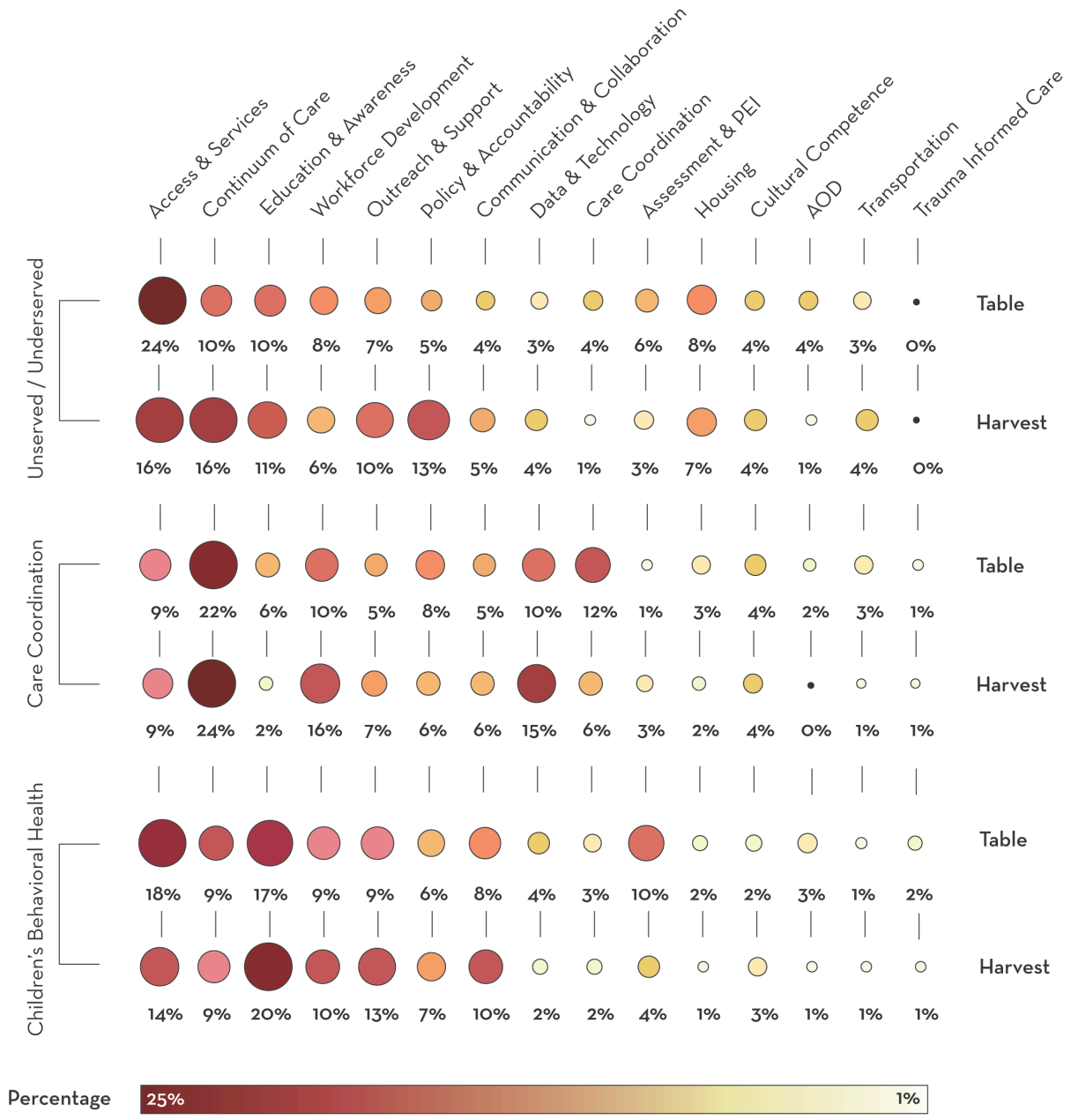


Figure 3. Harvest & Table Data by Region

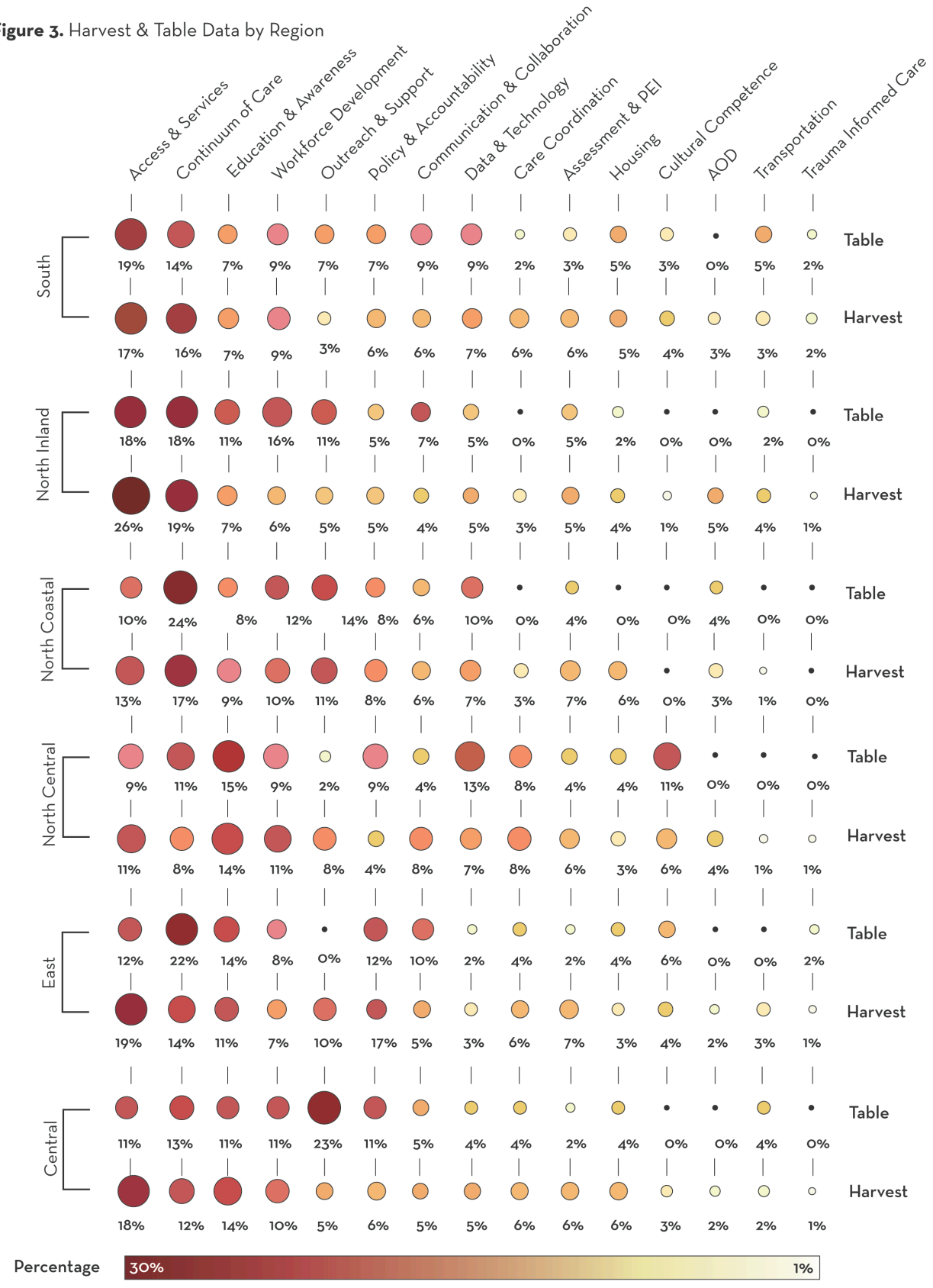
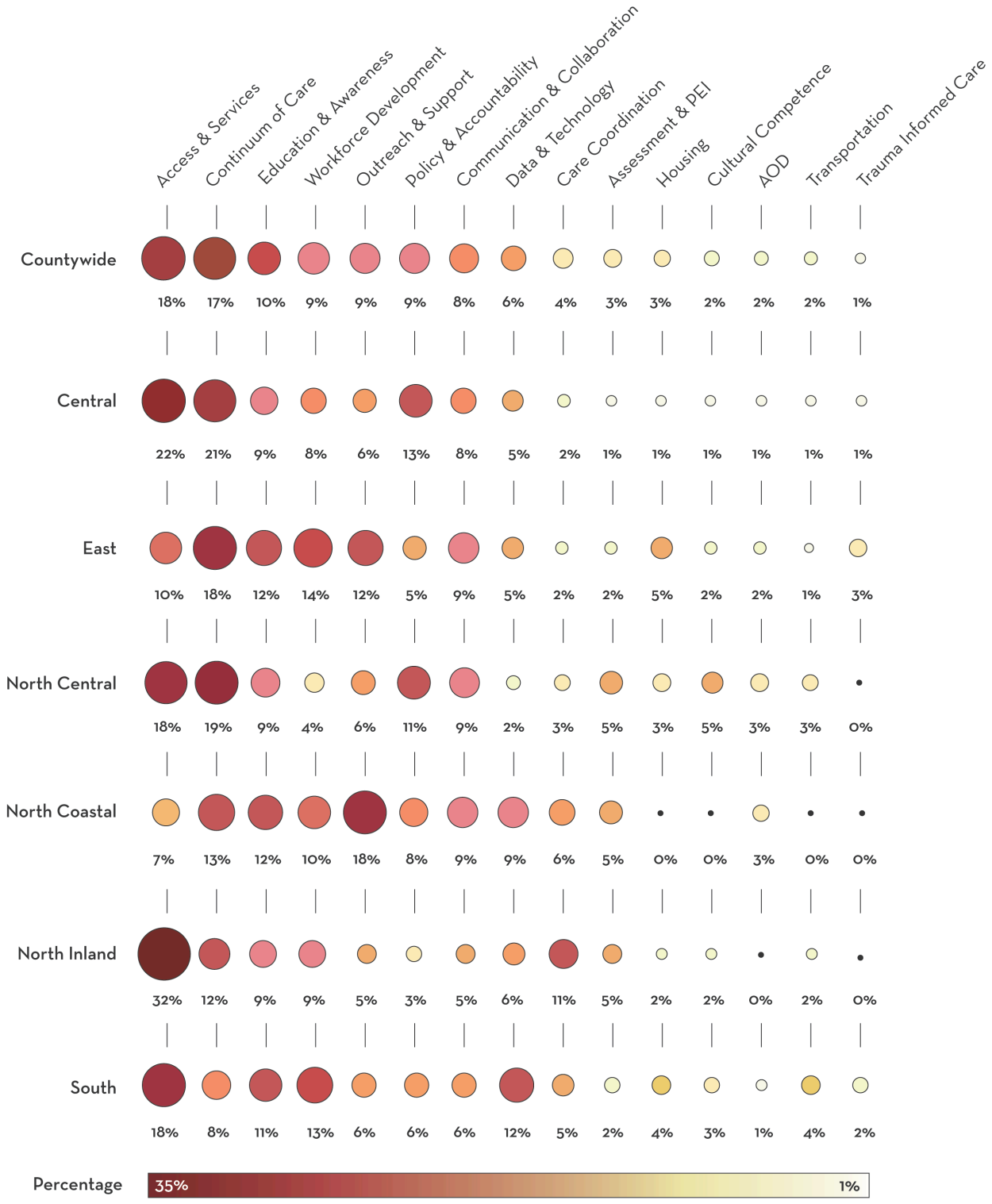


Table data is broken out by topic below, with regions visually indexed to a priority scaling of county 'Essential Themes' overall. Categorical weight as measured by percentage is shown in both size and tone, which reveals prominent priorities for each topic as well as some significant regional differences. See Appendix D for Table data broken out by region with topics indexed to the county overall.

B. Children's Behavioral Health

Figure 4 maps the 15 Essential Themes within the topic of Children's Behavioral Health across the six HHSA service regions of San Diego County and indexes them against the county overall, revealing regional differences in prioritization of concerns.

Figure 4. Children's Behavioral Health by Region



Access & Services and Education & Awareness are the predominant categories in this topic area at 17.8% and 16.6% of 851 comments countywide. In particular, the community expressed a need for home-based services and services embedded in schools, and for education programs and campaigns

targeting parents, teachers, school staff, and students, with the goals of enhancing awareness of behavioral health issues, normalizing and destigmatizing these issues, and teaching skills for dealing with them. Participants from the East and North Coastal regions put less emphasis on Access & Services at 9.8% and 7.1% respectively, while those in North Inland emphasized this strongly at 31.8%. North Coastal forum participants favored Outreach & Support (17.9%) over these categories, looking particularly for more peer support groups to empower parents, students, and families.

Assessment, Prevention & Early Intervention also figured prominently at about 10% countywide and across regions, with a particular emphasis on children in the 0-5 age range expressed in the comments, including prenatal and postpartum assessments of mothers as a form of prevention. This category intersects with Access & Services and Education & Awareness in that many comments call for home, family, or school based screening and PEI services, as well as education both for awareness of signs and symptoms and for expanded implementation of preventative strategies in homes and schools.

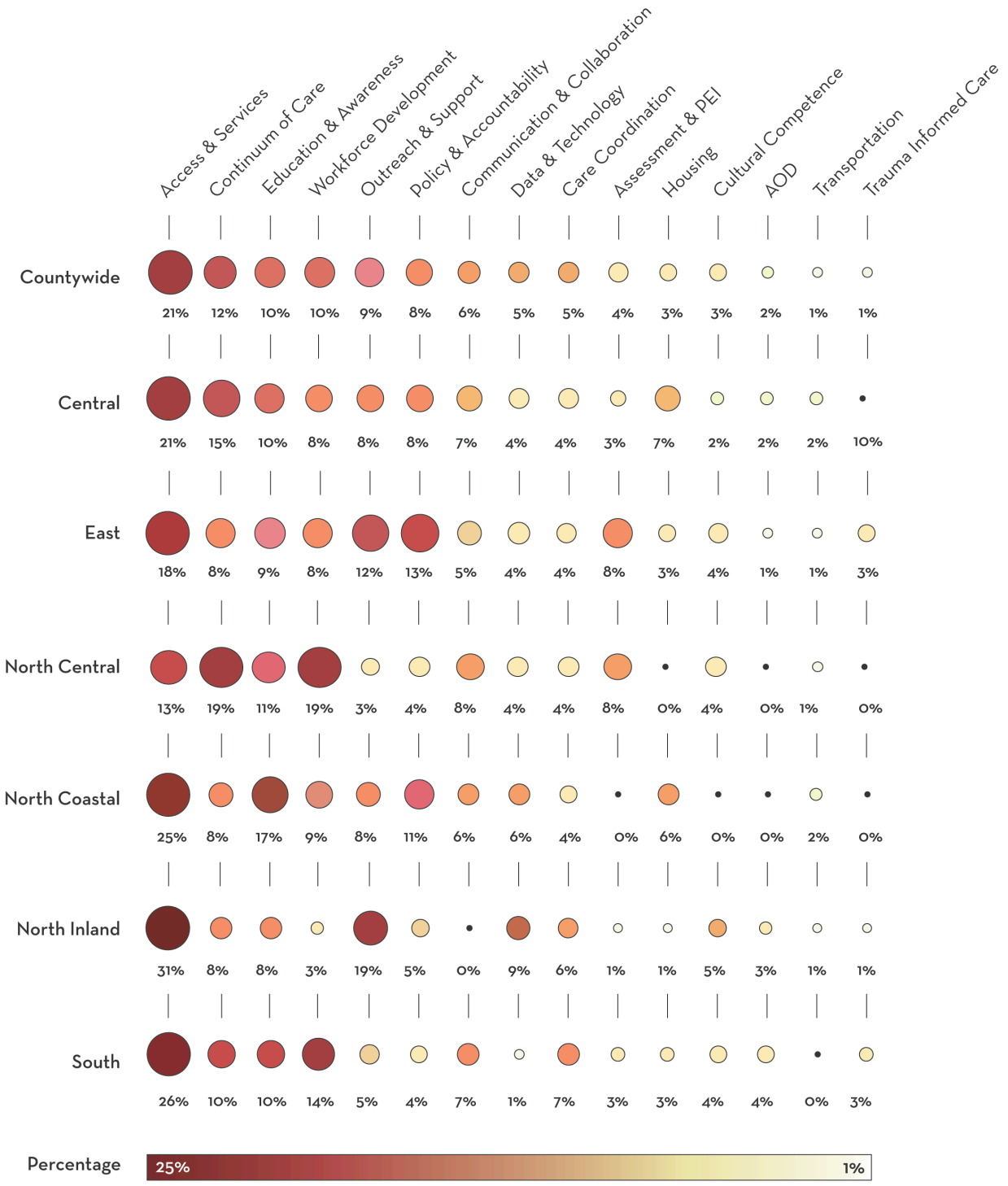
Comments across all categories focused on family-centered, community-based, peer-based, and intergenerational approaches to Children's Behavioral Health. Some notable steps suggested for optimizing Children's Behavioral Health include:

- Embedding behavioral health education into classroom curricula and school district trainings to increase awareness, decrease stigma, foster trauma-informed responses, and develop culturally competent skills
- Developing after school and extracurricular programs for education, awareness, support, and PEI with alternative approaches grounded in creative arts, music, gardens, fitness, and mindfulness
- Building community connections, collaborations, trust, and knowledge between parents, families, students, educators, and providers through conferences, forums, information and resource fairs, concerts, and other community events
- Developing a mobile technology toolbox for education, outreach, therapeutic services, and connecting clients to services, and also providing training to enhance the use of these tools by clients, case managers, and providers (mobile-technology toolbox?)

C. Care Coordination

Figure 5 maps the 15 Essential Themes within the topic of Care Coordination across the six HHSA service regions of San Diego County and indexes them against the county overall, revealing regional differences in prioritization of concerns.

Figure 5. Care Coordination by Region



Not surprisingly, Continuum of Care and Care Coordination are the top categories here, constituting about 1/3 of 711 comments across the County, with the exception of the East Region where they total only 25.7%. While the distinction between these categories might not have been fully observed by community participants, the prominent vision of a care continuum in this topic area suggests a need for

not only coordination of transitions between inpatient and outpatient services and behavioral and physical health resources, but also better coordination and integration of services within the Behavioral Health Systems of Care.

Workforce Development and Data & Technology also rank highly at about 10% each countywide, with variations from 7.5% North Inland to 17% North Coastal for the former and 2.5% North Inland to 18.9% North Central for the latter. These two categories combined weigh 30% among North Central participants. Despite variations in weight, comments across the county suggest the need for better training of providers, staff, and case managers to facilitate 'warm hand offs' and seamless integration across services, and also for the development of technologies for sharing data and streamlining paperwork. North Inland is a bit of an outlier here with participants putting more of an emphasis on Access & Services (18.8% compared to 9.3% countywide) than Workforce Development and Data & Technology combined (10% compared to 20.3% countywide), as is those in theEast Region, where the combined weight (25.7%) of Access & Services (12.4%) and Policy & Accountability (12.3%) equals the combined weight of Care Coordination (17.7%) and Continuum of Care (8.0%).

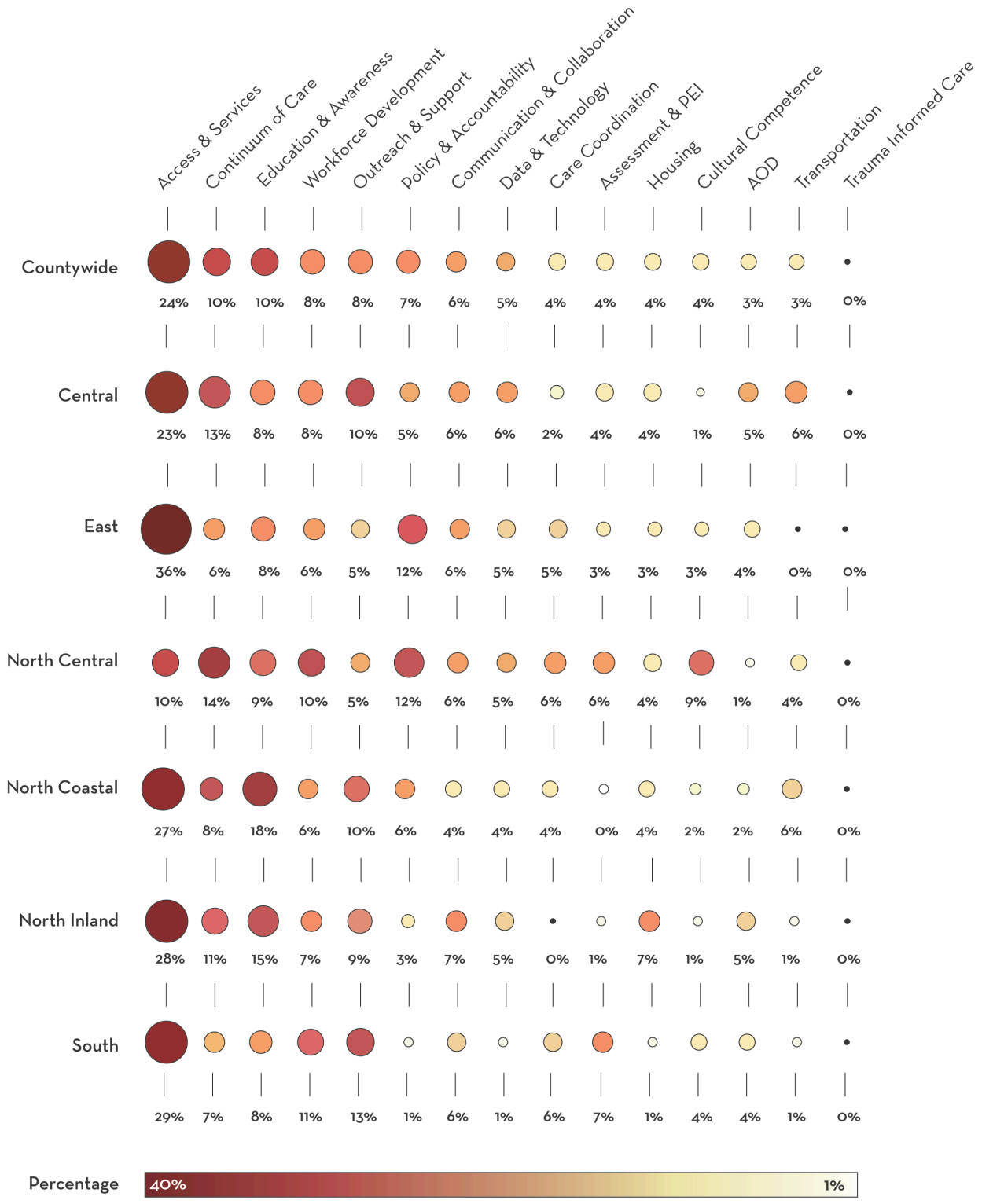
In particular, comments call for case managers to act as better advocates, liaisons, and system navigators for their clients, empowering them by connecting them to resources, assisting them with insurance claims and paperwork, and following up on referrals and transitions. They also call for the integration of information to facilitate consistency, communication, and tracking between clients, case managers, and medical and behavioral health providers, and for the centralization of services into regional hubs providing access to holistic care spanning behavioral and physical health needs. Generally, comments focus on client-driven, community-focused, team-based, and multidimensional approaches to Care Coordination. Some notable steps suggested for optimizing Care Coordination include:

- Establishing 'One Stop Shops' as a single point of entry and access, with triage coordinators, case management, and co-located behavioral health, physical health, and AOD services
- Creating an easily accessible central database to reduce duplication, streamline paperwork, and increase efficiency
- Increasing compensation, incentives, and recruitment, and decreasing caseloads to help maintain quality case management and improve staff retention
- Leveraging, expanding, and integrating existing services rather than creating new ones in order to avoid duplication and to improve efficiency

D. Unserved / Underserved Populations

Figure 6 maps the 15 Essential Themes within the topic of Unserved / Underserved Populations across the six HHSA service regions of San Diego County and indexes them against the county overall, revealing regional differences in prioritization of concerns.

Figure 6. Unserved/Underserved by Region



The community primarily envisioned increased access to culturally competent services for unserved and underserved populations (24% of 814 comments countywide), although in the North Central Region Education & Awareness took precedence at 13.5% of comments over 9.9% for Access & Services, and, in

East Region, Access & Services weighed in at 35.8%. Unserved and underserved populations identified by the community include: the homeless, undocumented immigrants, refugees, asylum-seekers, single parents, older adults, victims of domestic violence, torture survivors, justice-involved individuals, LGBTQI, TAY, foster youth, teen parents, Native Americans, and the deaf community. Across these populations, comments suggest not only a need for access to services, but also for increased education to expand awareness of behavioral health issues, indicators, and available services, and to promote tolerance and understanding. Teaching life skills and job training also stands out as an important educational task.

A vision of an improved Continuum of Care (10.1%), particularly prominent in the North Coastal (17.6%) and North Inland (14.7%) regions, emerges from numerous comments concerned with barriers, gaps, and waiting lists, jumping through hoops, wrong doors, and revolving doors. Workforce Development (8.2% countywide) focuses here on increasing staffing, training, and cultural competence to better serve the needs of those underserved populations identified. Housing ranks particularly high in this topic area at 8% countywide and 12.5% in the South. A significant need for Outreach & Support is expressed by participants at the East (11.9%) and North Central (12.1%) region forums, which reflects the needs of specific underserved population in those areas.

In general, comments focus on family-centered, community-based, and culturally appropriate approaches to better serving these populations. Some notable steps suggested for optimizing behavioral health for Unserved / Underserved Populations include:

- Developing mobile clinics that provide support, resources, and services for rural communities, families, the homeless, and homebound older adults
- Establishing regional 'One Stop Shops' that provide equal access to services by functioning as 'funnels' for unserved populations to enter into the behavioral health system
- Increasing temporary, transitional, emergency, and long-term housing by utilizing land in unincorporated areas, PODS, decommissioned ships, tiny homes, and multi-family housing, offering incentives to landlords, and partnering with Habitat for Humanity
- Increasing community outreach, education, and partnerships to create culturally embedded and knowledgeable behavioral health advocates, champions, and peer support groups

E. Innovation Projects

The Mental Health Services Act (MHSA) requires San Diego County to spend 5% of its MHSA funding on Innovation programs. Participants in the Conversation Cafés were given a handout to explain the requirements of MHSA Innovation project funding, and were presented four in-process BHS Innovation concepts. Participants discussed these proposed innovations in terms of similarity to existing programs and whether there was actually a need for what they would provide. A consensus was gathered from each table during the harvest. All of the projects were determined to be needed, although there were some exceptions and comments that were shared.

- ***Tele-Mental Health*.** 25% of the participants stated that the program was not a good use of funding and that similar programs already exist. 50% mentioned that the program would be more appropriate if offered in existing facilities or combined with the mobile ROAM project. Native American community members expressed this might be a good way to have culturally appropriate services in the rural areas of the southern reservations. Other participants felt that the Tele-Mental

Health program would be appropriate in rural and geographically isolated communities, e.g. Borrego, and refugee and Native American communities where culturally competent providers are scarce.

- ***Roaming Outpatient Assessment Mobile (ROAM).*** Participants expressed that ROAM services would need to be embedded with regular physical health services in order to reduce stigma attached to mental health services provided by a mobile unit. Many stated that ROAM would be best coupled with Tele-Mental Health to optimize services. They also mentioned BHS' In-home Outpatient Treatment (IHOT) program and suggested that community members with lived experience could help staff the unit to make services more acceptable, and also that appropriate marketing could help reduce the stigma.
- ***Postpartum Depression Prevention and Intervention.*** This was one area that everyone agreed was a priority, and many suggestions were given about how the services could be integrated. Public Health Nurses were seen as viable educators who were also able to do home visits. Incorporating prevention education during regular OB/GYN visits and prenatal WIC programs was suggested. Participants felt it was important that the services be billable and possibly offered in-home. They also expressed the program should focus not only on the whole family, but also on traditional care givers such as grandparents or neighbors.
- ***Recuperative Bridge Housing.*** Recuperative Bridge Housing was determined to be the most needed project. Similar programs might exist, but participants suggested that the idea could be more innovative if coupled with variations in the housing, extended family, and whole family services. Using tiny houses and decommissioned ships was also mentioned. Several examples of similar programs given were Second Chance, Veteran's Village, and Kinship Housing, but these programs do not contain all the services of the proposed innovation, and they do not have enough capacity to meet need. The most common comment was that the program needs to be extended to at least 6 months or longer.

F. Parking Lot

Due to the change in the format of the forums this year, a 'Parking Lot' was established where people could register issues or ideas not discussed in the context of the three forum topics or captured in the harvest. Most of these repeated comments were captured in Table or Harvest data, likely because participants felt that the more times the issue was mentioned, the more funding it would attract.

In addition, several groups submitted extensive minutes from meetings that were conducted as part of BHS other community engagement activities. These notes suggested ways of targeting the needs of particular populations. The refugee community, for example, expressed the need for specific mental health assessment for newly arrived refugees and children. Other community-based agencies held similar group meetings to which they invited clients to address their specific issues with mental health. This input was not included in the process but the material was reviewed and considered for this report.

IV. SPECIAL GROUPS

Special Groups were conducted to meet the needs of populations previously identified in the community engagement process or that surfaced in the interim as needing more targeted and focused attention.

A total of six special group meetings were held. This section summarizes of these meetings: Table A provides an overview of meeting logistics, and Table B provides suggested strategies and examples of actionable solutions. The full reports can be found in Appendices E through J.

Table A. Special Groups Overview

Focus Community or Population	Meeting Purpose or Focus Topic	Location of Meeting	Number and Description of Participants
Justice Partners	Justice involved clients who have behavioral health concerns	San Diego County Hall of Justice	38 individuals participated in the Justice Partners Solutions Forum: Cross-sector leaders and staff from juvenile and adult systems represented within the County Public Safety Planning Group
Peer Workers	Role of Peer Workforce in behavioral health services	San Diego NAMI office	12 individuals participated in the Peer Worker Focus Group who were Peer workers with lived experience that is the same or like those being served by County HHSA-funded programs (Child/youth and adult systems and mental health and AOD); Eight non-profit organizations were represented
Southeastern San Diego community	Children's Behavioral Health concerns	CARE Center	15 individuals participated in this community conversation: 11 residents and/or individuals providing community-based services within Southeastern San Diego and 4 representatives from County Behavioral Health Services
Native American community	Native American behavioral health concerns	Indian Health Council (Rincon office)	34 leaders and staff from community-based organizations working with children, youth, families, and individuals participated in this community conversation. The majority, if not all, were Native American
Male Inmates	Community re-entry	George H. Bailey Detention Facility	11 low-risk, non-violent male inmates. Most were repeat offenders. Participants were recruited from a GED class and diverse in age and ethnicity: low 20's to late 50's and representatives from all major ethnic/racial groups
Female Inmates	Community re-entry	Las Colinas Detention and Reentry Facility	6 female inmates, most were repeat offenders; participants represented diverse ethnic groups

Promising Practices and Approaches. The following best practices or approaches were proposed by one or more groups:

- Trauma-informed care
- One-stop shops/no wrong door
- Culturally competent programs
- Stigma reduction Recovery-oriented care
- "One Brain" approach
- Inter-generational approach
- Early intervention
- Peer navigators and/or cultural brokers
- Restorative justice
- Whole Person approach
- Care integration

Table B. Summary of Strategies and Examples of Suggested Actionable Solutions

Focus Community or Population	**Strategies**	**Examples of Suggested Actionable Solutions**
Justice Partners	• Build capacity of all those engaged in providing services • Support system and services integration and improvement • Provide improved access to needed behavioral health treatment and services • Address other barriers to success such as housing instability, employment, transportation etc.	• *Bridge the cultures of clinical and criminal justice* • *Develop screening and triage for high risk youth* • *Provide cross-sector training that more clearly defines and describes the target populations to ensure that service providers*
Peer Workforce	• Support and build capacity of this workforce • Address systemic challenges that impact the effectiveness of peer-led services • Explore innovative ways of reaching and serving people • Reduce barriers that prevent or make it difficult for people to access services • Enhance school-based PEI services	• *Allow for integration at the service delivery level – considerable frustration at how services are currently in siloes.* • *Develop materials that illustrate career pathways for Peer Workers*
Southeastern San Diego community	• Create a working framework for real change • Utilize a strength-based approach that builds upon existing community assets • Provide accessible youth-friendly services • Support parents and grandparents	• *Provide ongoing training on trauma and ACE – not one-time efforts* • *Support on campus suspensions –keep youth in school*
Native American community	• Connect, inform and address misconceptions • Think outside the box – be innovative and resourceful • Eliminate barriers to behavioral health services • Address the impact of intergenerational trauma with an array of services and supports	• *Be proactive in facilitating Native American engagement with BHS – "don't leave us out of the conversation"* • *Use Positive Indian Parenting as a culturally specific program*

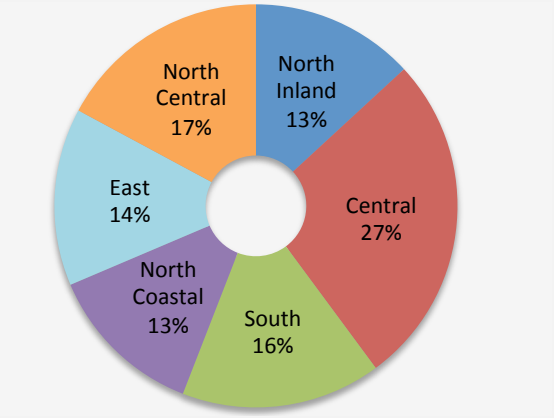
Male Inmates	• Provide services that support transition prior to release or immediately upon release • Help ex-offenders re-enter the job market • Advocate for system change that can reduce homelessness among ex-offenders • Provide access to drug treatment programs	• *Provide education on types of employment that are open to ex-offenders* • *Create ways for potential employers to come face to face with ex-offenders*
Female Inmates	• There is room to enhance pre-release and re-entry programs • Provide community services that address challenges to reentry and reduce the risk of recidivism. • Provide more support for the transition with the transition from jail to community, especially with those dealing with Mental Health and co-occurring disorders.	• *Provide InReach services earlier after re-entry* • *Reduce paperwork burden.* • *Address needs for women after release to the community and ongoing.*

APPENDIX A. FORUM FEEDBACK

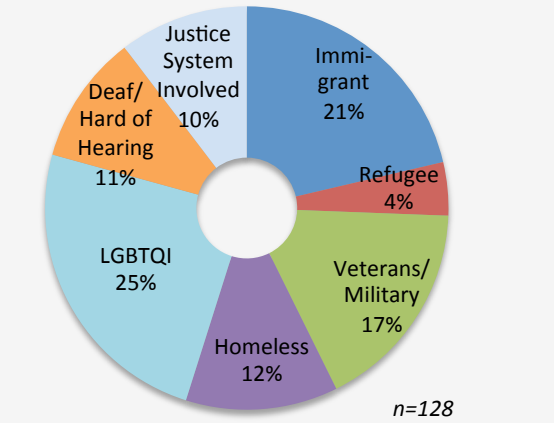
The County of San Diego division of Behavioral Health Services conducted 12 Conversation Cafés to engage the community in planning services to meet needs across age groups in the areas of Unserved and Underserved populations, Children's Behavioral Health, and Care Coordination. The process asked the community to envision a future for BHS, identify next steps, and explore proposed Innovation projects for the upcoming year. Forum feedback was gathered at all forums and is summarized below.

Feedback Responses by Region

553 Total Community Conversation Participants
449 Forum Feedback Forms *(80% response rate)*



Participants by Special Populations



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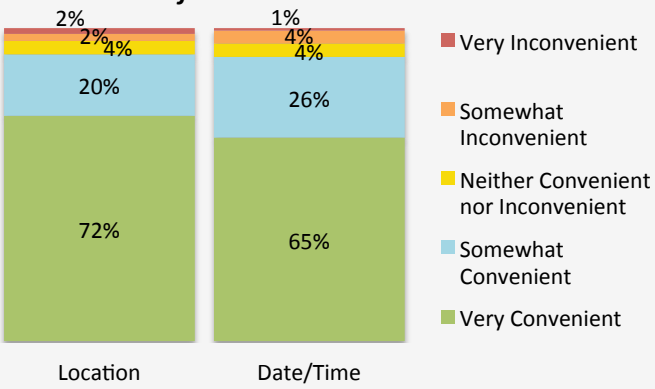
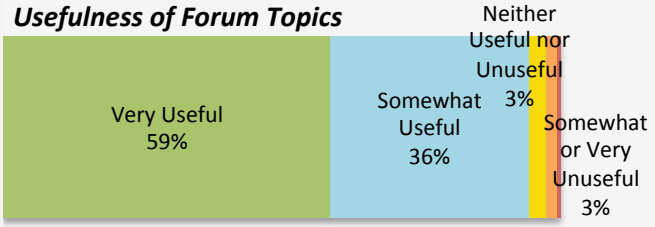
Convenience of Forum

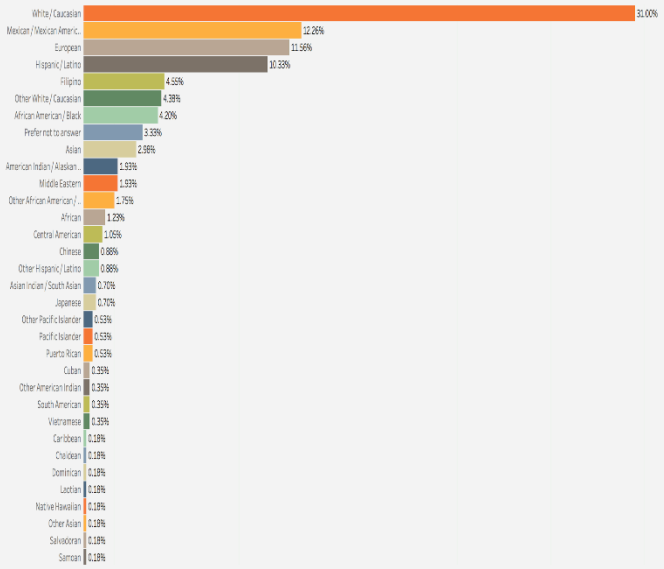


Usefulness of Forum Topics



Overall Quality of Forum

Ethnicity



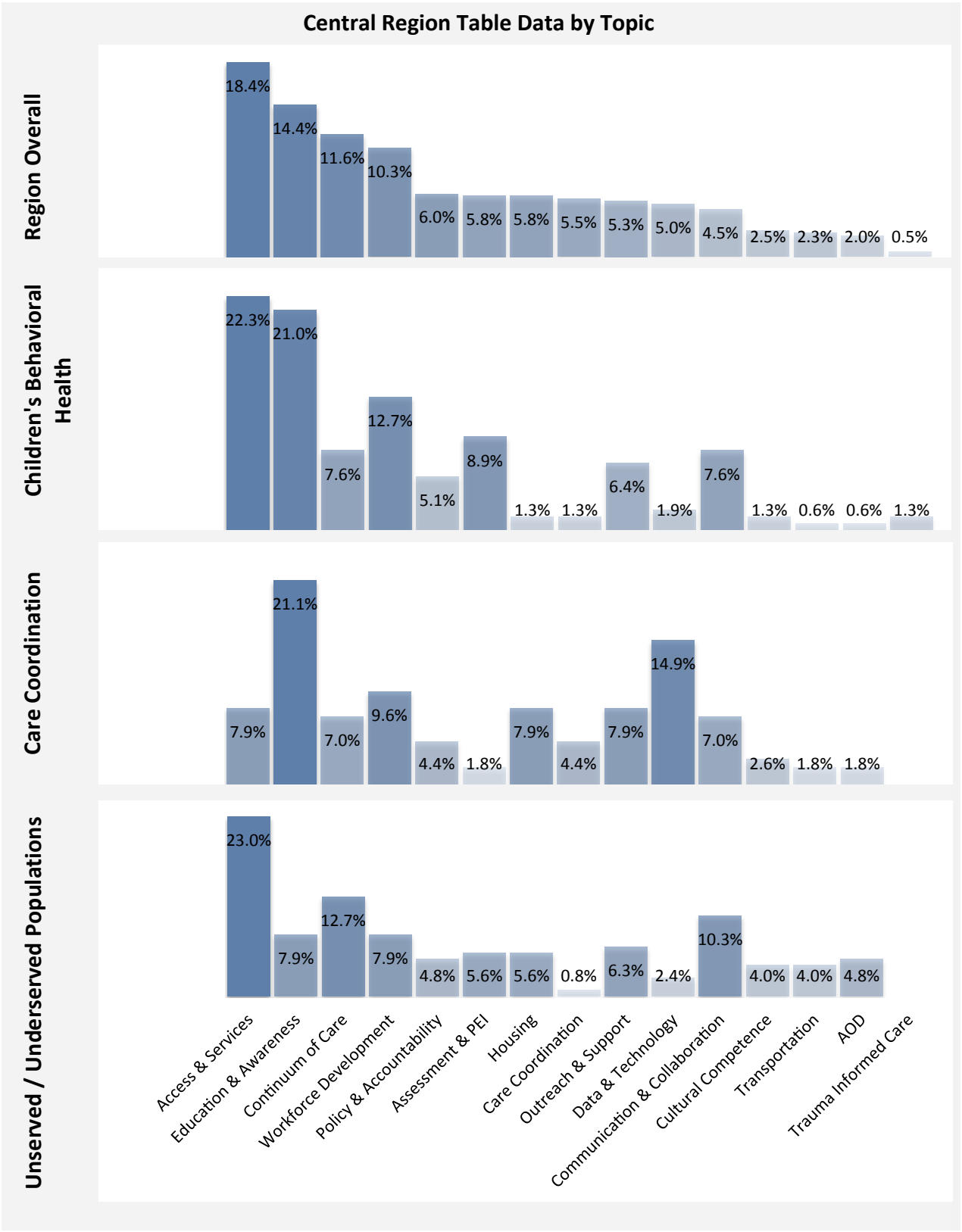
APPENDIX B. PARKING LOT DATA

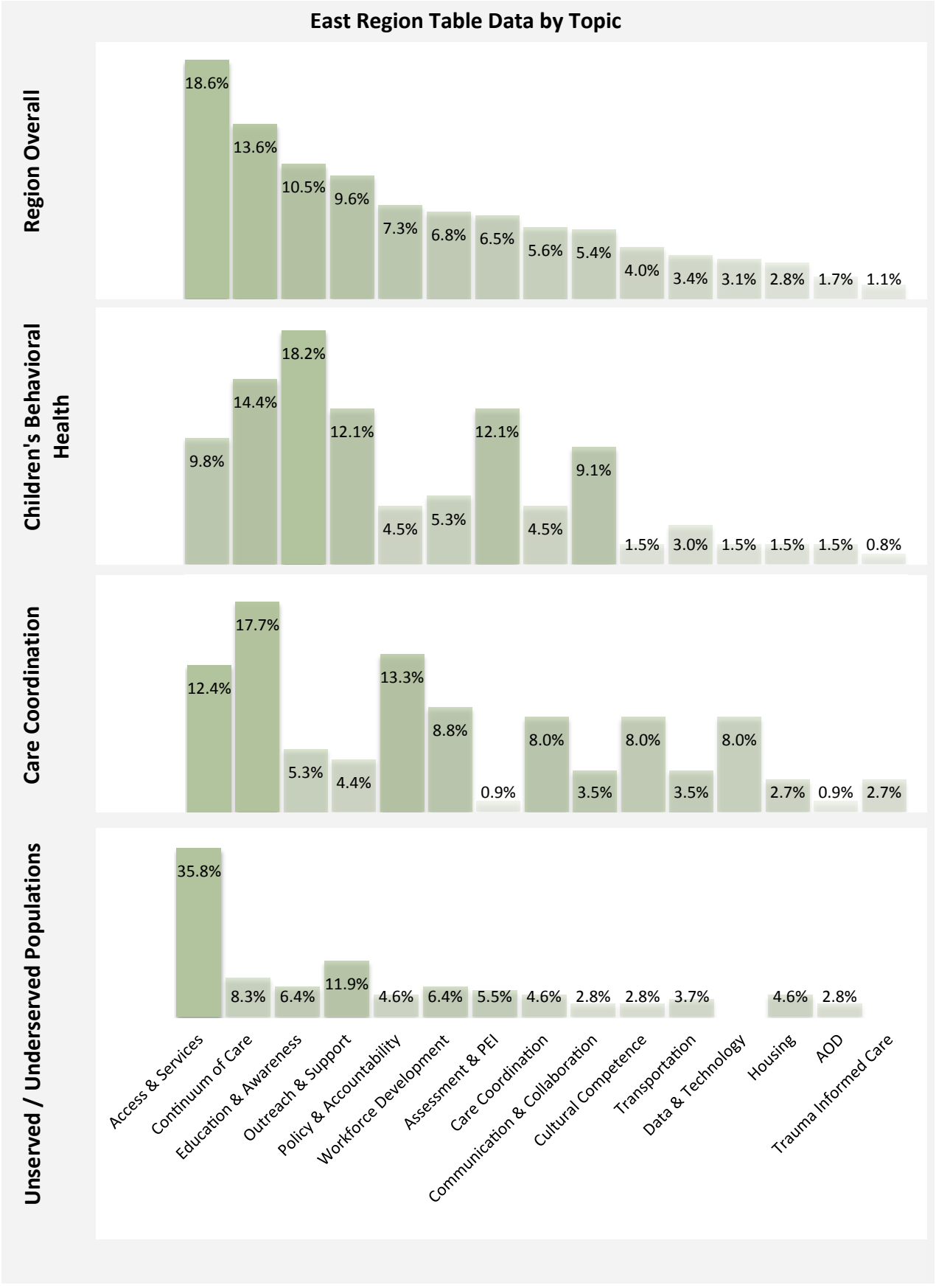
- Stop overmedicating, treat the whole person, practitioners are drug oriented
- Increase staff salaries
- Homeless people need housing not meds
- Incentives for psychiatrists
- Prevention and early intervention for veterans prior to discharge and support for families during transition
- Collaboration with existing organizations that serve specific populations to reach individuals whose culture makes accessing BHS difficult
- Partnering/augmenting home visiting adding early childhood mental health programs
- Culturally competent continuum of care for East African communities
- Residential services for men with children
- Caregiver mental health services in same place as children's behavioral health services
- Increased/improved senior behavioral health services
- Caregiver mental health services in same place as children's behavioral health services
- Increased/improved senior behavioral health services
- Provide similar forum farther into East County
- Post-partum longer-term support "nurse partnership program"
- Separate AOD from BHS
- Project evaluation instead of just data collection
- More opportunities to hire professional consultants not just employees
- Allow applicants to bid on RFP, not just regions
- Fund non-traditional MH programs like art and cultural therapy
- More clubhouses in South Bay & increase funding for existing clubhouses in SB
- More services for deaf and hard of hearing
- Incentive program for college students to pursue BHS careers
- More publicity around forums like this to demonstrate to community the care and thought that goes into decision making
- Substance abuse detox services provided immediately upon request
- Long term live-in facility for teens with addiction issues with school and counseling included
- WRAP program works
- Increase aftercare services
- Rideshare incentives to transport people with MH disabilities
- Rideshare tax used to fund programs for adults and children
- Engage bars and restaurants to donate as a PR opportunity
- Income support and work training woven through all programs
- Eliminate time restrictions for treatment
- Better integration of physical and mental health
- Multidisciplinary team approach
- Better electronic health record sharing

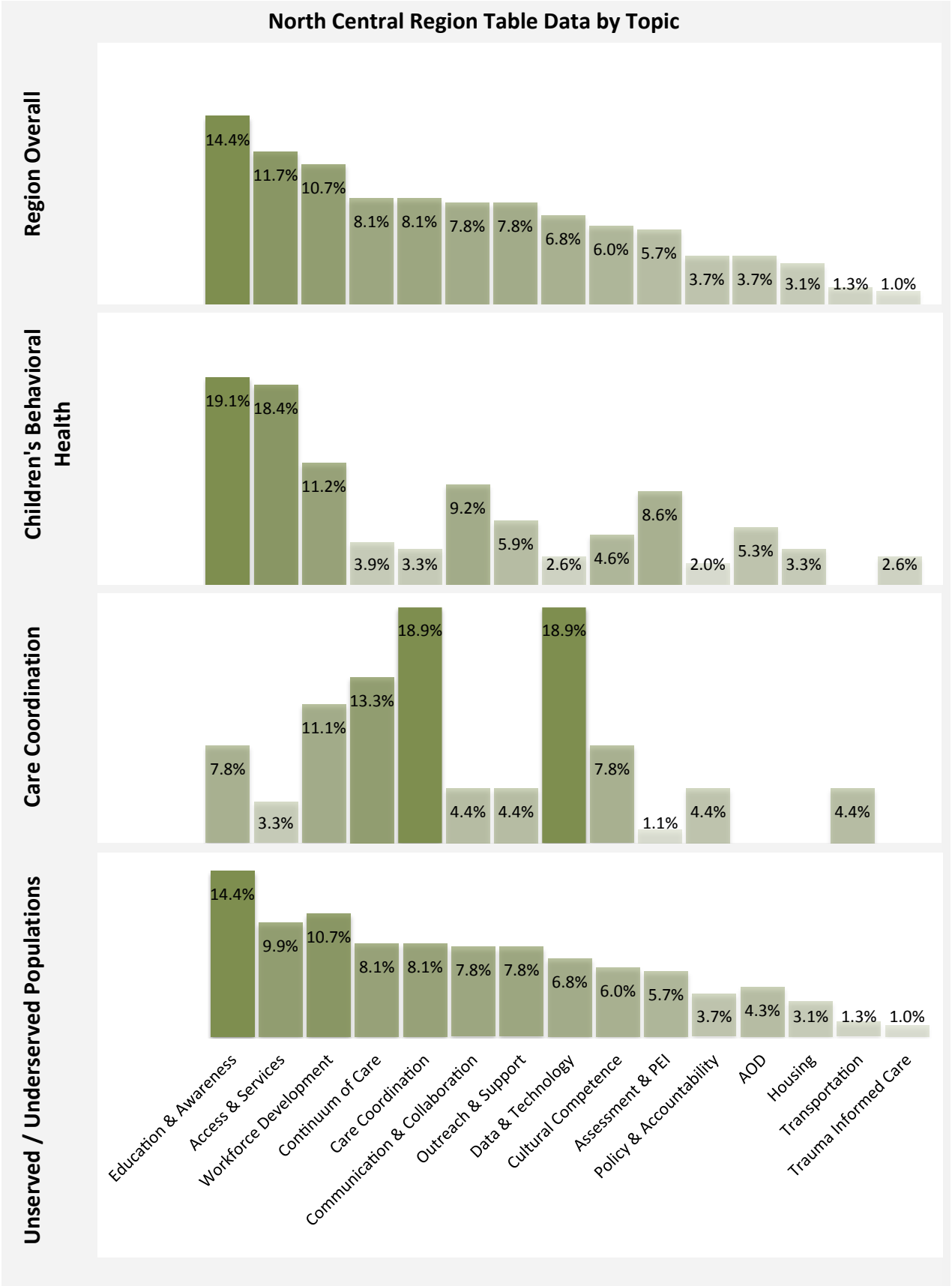
APPENDIX C. ESSENTIAL THEMES

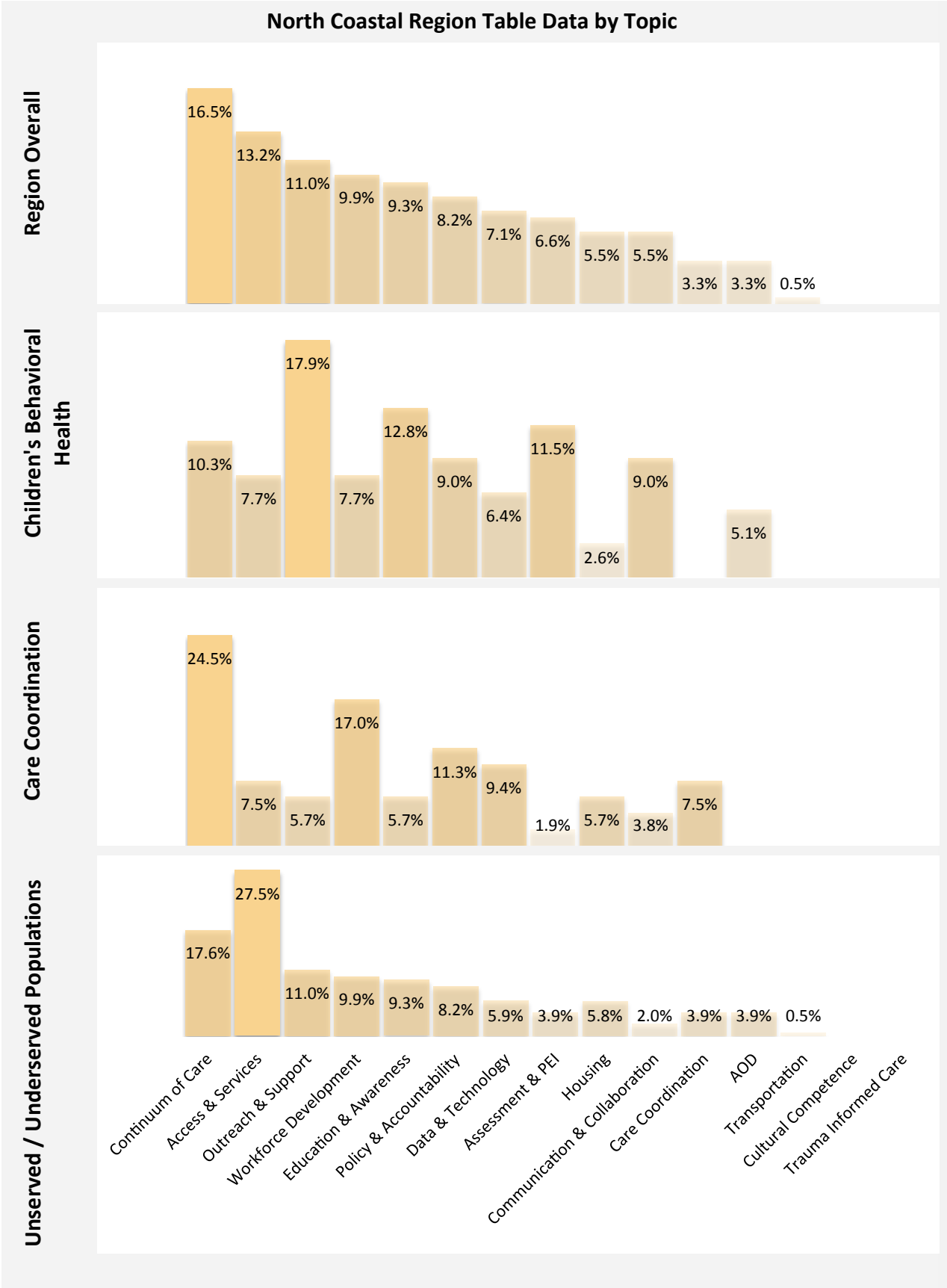
- **Access & Services:** Comments envisioning improved access to, and expansion of programs and services, as well as suggestions such as more mobile, in-home, and school-based services.
- **AOD:** Specifically, comments pertaining to alcohol and drug treatment programs and services, AOD education and awareness, and the integration of AOD and Mental Health services.
- **Assessment, Prevention & Early Intervention:** Comments calling for earlier assessment and the development and expansion of preventative education and intervention programs.
- **Care Coordination:** Specifically, comments pertaining to the coordination of mental and physical health, transitions between inpatient and outpatient care, and re-entry from the justice system.
- **Communication & Collaboration:** Comments calling for better communication and collaboration between clinics, providers, schools, parents, the county, law enforcement, and community organizations.
- **Continuum of Care:** Comments suggesting better coordination and integration of services and improved case management to close gaps and to help clients navigate the system.
- **Cultural Competence:** Comments calling for more cultural awareness, education, training, and language proficiency to help serve diverse populations.
- **Data & Technology:** Both comments expressing a need for a centralized, integrated, and accessible database to facilitate communication and coordination, and comments suggesting the use of technologies for education, outreach, and service provision.
- **Housing:** Comments envisioning more temporary, transitional, emergency, long-term, and full service housing, and also suggestions for alternative housing solutions.
- **Outreach & Support:** Comments calling either for community outreach campaigns and events to meet people where they are, expand awareness, and build trust, or for the development of more peer support groups, programs, and services.
- **Policy & Accountability:** Specific to comments about changing requirements, laws, or policies to make access easier, or comments calling for better assessment of programs and providers.
- **Education & Awareness:** Comments suggesting better education for teachers, families, students, and communities to increase awareness of behavioral health issues and indicators, to destigmatize these issues, and to teach skills for dealing with them.
- **Transportation:** Mostly comments calling for transportation services to help clients access services.
- **Trauma Informed Care:** Comments that specifically mention the need for treatment to be sensitive to traumatized clients, or call for education and training in this area.
- **Workforce Development:** Comments envisioning an improved and expanded behavioral health workforce and suggesting increased recruitment, salaries, incentives, and training, and reduced caseloads, to facilitate staff retention, better service provision, and improved case management.

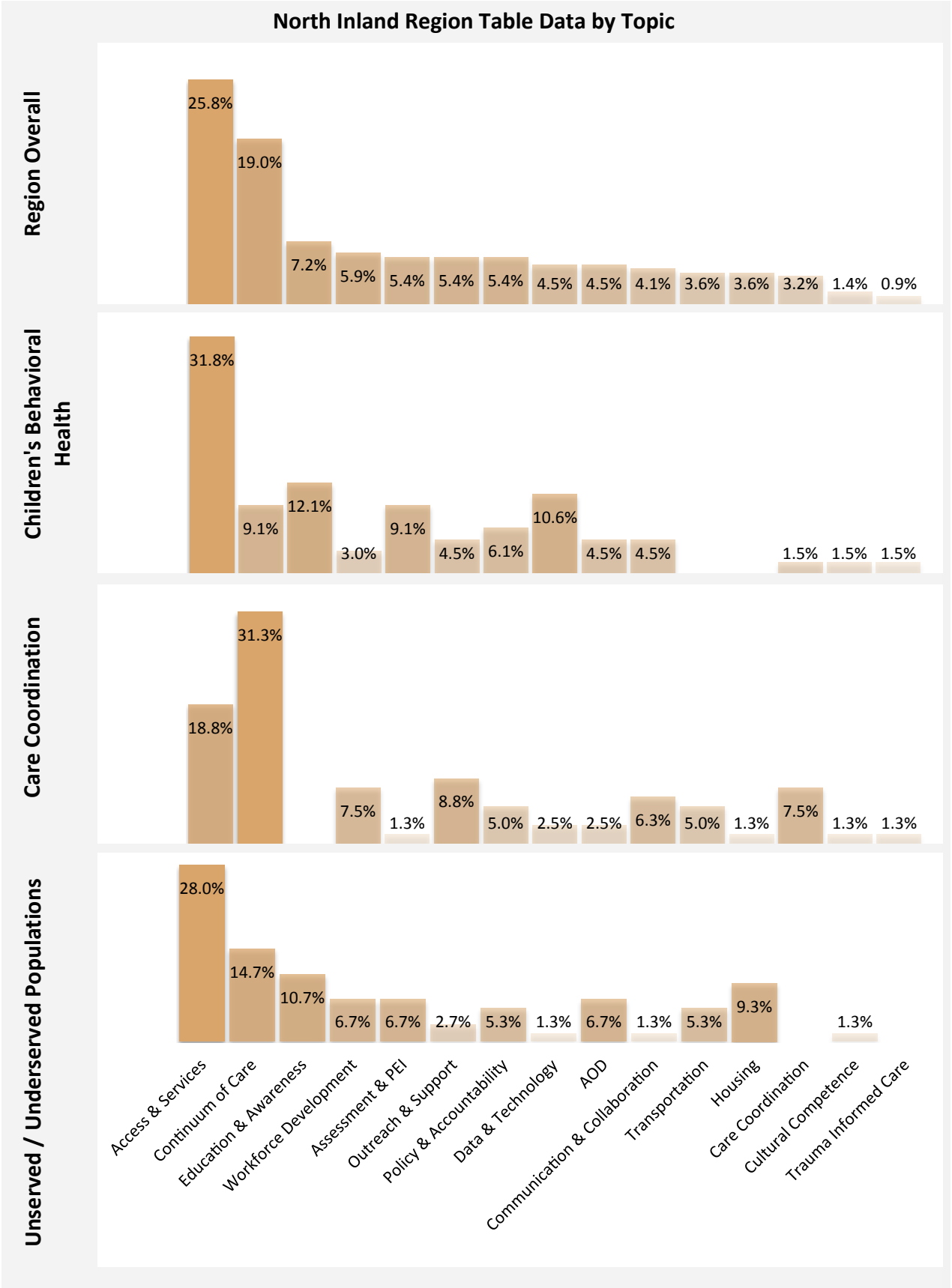
APPENDIX D. TABLE DATA BY REGION




East Region Table Data by Topic
Region Overall
18.6%
13.6%
10.5%
9.6%
7.3%
6.8%
6.5%
5.6%
5.4%
4.0%
3.4%
3.1%
2.8%
1.7%
1.1%
Children's Behavioral Health
9.8%
14.4%
18.2%
12.1%
4.5%
5.3%
12.1%
4.5%
9.1%
1.5%
3.0%
1.5%
1.5%
1.5%
0.8%
Care Coordination
12.4%
17.7%
5.3%
4.4%
13.3%
8.8%
0.9%
8.0%
3.5%
8.0%
3.5%
8.0%
2.7%
0.9%
2.7%
Unserved / Underserved Populations
35.8%
8.3%
6.4%
11.9%
4.6%
6.4%
5.5%
4.6%
2.8%
2.8%
3.7%
4.6%
2.8%
Access & Services
Continuum of Care
Education & Awareness
Outreach & Support
Policy & Accountability
Workforce Development
Assessment & PEI
Care Coordination
Communication & Collaboration
Cultural Competence
Transportation
Data & Technology
Housing
AOD
Trauma Informed Care


North Central Region Table Data by Topic
Region Overall
14.4%
11.7%
10.7%
8.1%
8.1%
7.8%
7.8%
6.8%
6.0%
5.7%
3.7%
3.7%
3.1%
1.3%
1.0%
Children's Behavioral Health
19.1%
18.4%
11.2%
3.9%
3.3%
9.2%
5.9%
2.6%
4.6%
8.6%
2.0%
5.3%
3.3%
2.6%
Care Coordination
7.8%
3.3%
11.1%
13.3%
18.9%
4.4%
4.4%
18.9%
7.8%
1.1%
4.4%
4.4%
Unserved / Underserved Populations
14.4%
9.9%
10.7%
8.1%
8.1%
7.8%
7.8%
6.8%
6.0%
5.7%
3.7%
4.3%
3.1%
1.3%
1.0%
Education & Awareness
Access & Services
Workforce Development
Continuum of Care
Care Coordination
Communication & Collaboration
Outreach & Support
Data & Technology
Cultural Competence
Assessment & PEI
Policy & Accountability
AOD
Housing
Transportation
Trauma Informed Care


North Coastal Region Table Data by Topic
Region Overall
16.5%
13.2%
11.0%
9.9%
9.3%
8.2%
7.1%
6.6%
5.5%
5.5%
3.3%
3.3%
0.5%
Children's Behavioral Health
10.3%
7.7%
17.9%
7.7%
12.8%
9.0%
6.4%
11.5%
2.6%
9.0%
5.1%
Care Coordination
24.5%
7.5%
5.7%
17.0%
5.7%
11.3%
9.4%
1.9%
5.7%
3.8%
7.5%
Unserved / Underserved Populations
17.6%
27.5%
11.0%
9.9%
9.3%
8.2%
5.9%
3.9%
5.8%
2.0%
3.9%
3.9%
0.5%
Continuum of Care
Access & Services
Outreach & Support
Workforce Development
Education & Awareness
Policy & Accountability
Data & Technology
Assessment & PEI
Housing
Communication & Collaboration
Care Coordination
AOD
Transportation
Cultural Competence
Trauma Informed Care


North Inland Region Table Data by Topic
Region Overall
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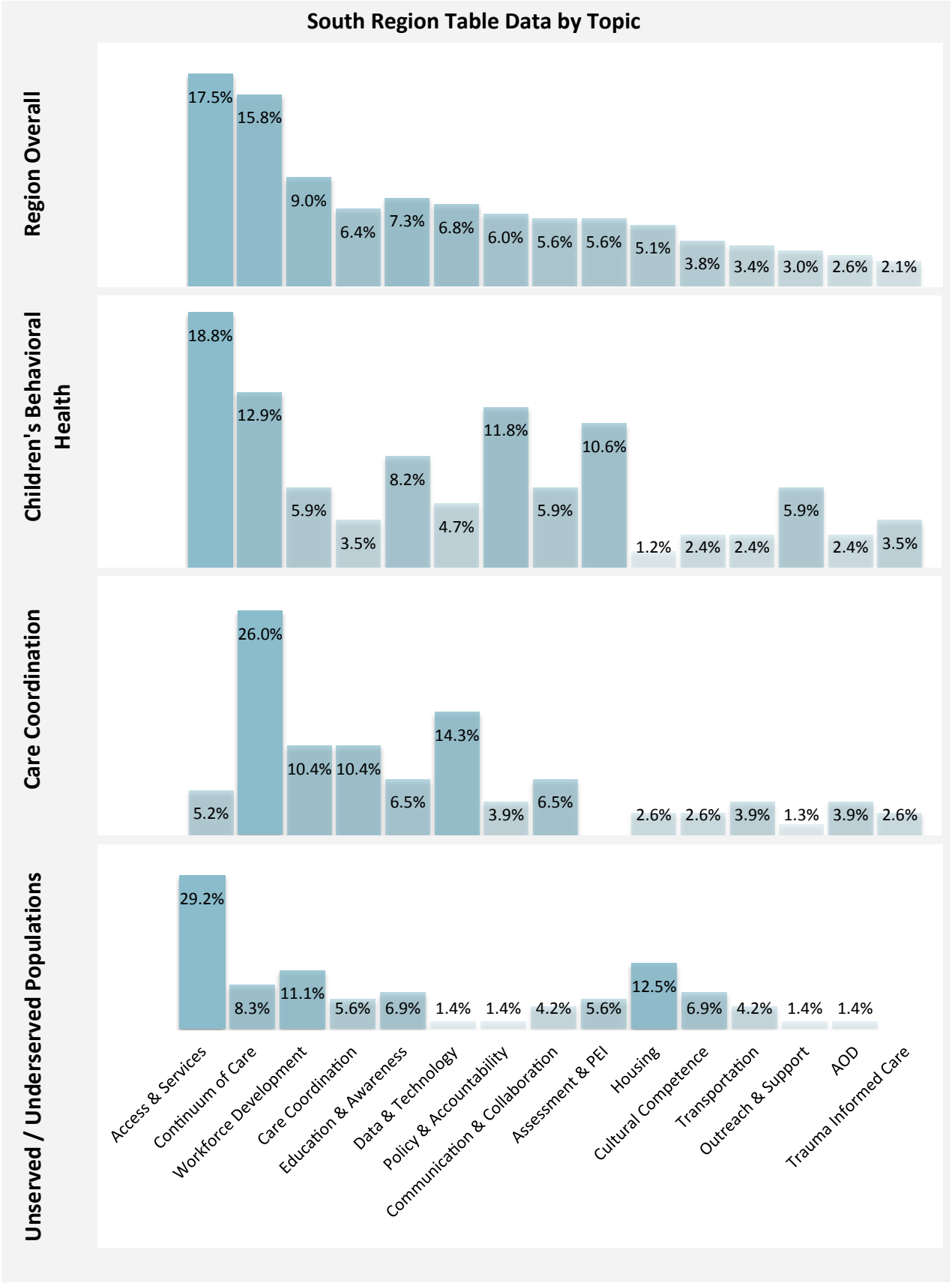
19.0%
7.2%
5.9%
5.4%
5.4%
5.4%
4.5%
4.5%
4.1%
3.6%
3.6%
3.2%
1.4%
0.9%
Children's Behavioral Health
31.8%
9.1%
12.1%
3.0%
9.1%
4.5%
6.1%
10.6%
4.5%
4.5%
1.5%
1.5%
1.5%
Care Coordination
18.8%
31.3%
7.5%
1.3%
8.8%
5.0%
2.5%
2.5%
6.3%
5.0%
1.3%
7.5%
1.3%
1.3%
Unserved / Underserved Populations
28.0%
14.7%
10.7%
6.7%
6.7%
2.7%
5.3%
1.3%
6.7%
1.3%
5.3%
9.3%
1.3%
Access & Services
Continuum of Care
Education & Awareness
Workforce Development
Assessment & PEI
Outreach & Support
Policy & Accountability
Data & Technology
AOD
Communication & Collaboration
Transportation
Housing
Care Coordination
Cultural Competence
Trauma Informed Care


South Region Table Data by Topic
Region Overall
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15.8%
9.0%
6.4%
7.3%
6.8%
6.0%
5.6%
5.6%
5.1%
3.8%
3.4%
3.0%
2.6%
2.1%
Children's Behavioral Health
18.8%
12.9%
5.9%
3.5%
8.2%
4.7%
11.8%
5.9%
10.6%
1.2%
2.4%
2.4%
5.9%
2.4%
3.5%
Care Coordination
5.2%
26.0%
10.4%
10.4%
6.5%
14.3%
3.9%
6.5%
2.6%
2.6%
3.9%
1.3%
3.9%
2.6%
Unserved / Underserved Populations
29.2%
8.3%
11.1%
5.6%
6.9%
1.4%
1.4%
4.2%
5.6%
12.5%
6.9%
4.2%
1.4%
1.4%
Access & Services
Continuum of Care
Workforce Development
Care Coordination
Education & Awareness
Data & Technology
Policy & Accountability
Communication & Collaboration
Assessment & PEI
Housing
Cultural Competence
Transportation
Outreach & Support
AOD
Trauma Informed Care

APPENDIX E. JUSTICE PARTNERS FORUM REPORT

Overview. Attendees at the Justice Partners Solutions Forum were cross sector leaders and staff from juvenile and adult systems (n=38) represented within the County Public Safety Planning Group. This special focus group was held at the Hall of Justice.

Process. The process used was a planning forum format in which attendees were separated into four groups: one juvenile and three adult focused. Each group was tasked with: a) reviewing outcomes; b) identifying needs and gaps; c) agreeing upon actionable solutions and strategies that meet the goal "We are more fully meeting the needs of justice involved clients who have behavioral health concerns".

General Themes: The overarching call for action that emerged from this planning session is for services across the spectrum of care to: prevent engagement of children with behavioral health needs in the criminal justice system; reduce recidivism among both juveniles and adults; and support community re-entry and family unity.

Findings. The following gaps and unmet needs in services or provider capacity were identified:

Within Juvenile Justice Partners groups:

1. **Ability to meet the demand for services.** Participants discussed gaps in capacity from the perspective of a lack of programs or services to meet the need, as well as problems recruiting staff to fill vacant positions. One of the suggested causes for unfilled vacancies was the pay structure (understood to mean that the compensation offered may not be competitive enough). Gaps in ability to provide bilingual services were also referenced. Specific service gaps identified by the juvenile group were:
    - prevention and early intervention services
    - gender-specific and age-specific treatment
    - dual-diagnosis treatment services
    - placement beds (i.e. for youth with mental health and/or AOD diagnosis)
    - transportation
    - insufficient insurance
2. **Awareness, knowledge and skill of those tasked with providing services.** Participants called out a need for training that would raise overall mental health awareness among law enforcement to ensure cultural competency and to improve understanding of acute mental health symptoms among younger children (i.e. 4th and 5th grade). The group also suggested a need for more comprehensive assessment of treatment providers.

Within the Adult Justice Partners groups:

1. **Insufficient availability of services.** Participants suggested that there are not enough services, including:
    - treatment beds
    - AOD and/or mental health treatment programs
    - therapeutic services
    - housing support
    - transportation services

- case management, care-coordination or system navigation (with those who don't qualify for ACT services specifically called out)

2. **Capacity of providers to meet the needs of the target population.** This was presented as a training and professional development gap. Service providers need an understanding of the target population and criminogenic needs and the law enforcement/justice community needs an understanding of behavioral health challenges and the impact of trauma.
3. **Quality of assessment process.** All three groups referenced a need to improve assessment or screening practices and for tools or approaches that target the right services to the right people at the right time.
4. **Integration across systems.** Gaps and needs in this area included the need to have a shared language and the ability to coordinate between the justice and service systems at different points and times.

Summary of promising practices or approaches that were suggested by one or more group:

- Trauma informed care
- Recovery-oriented
- Export best-practices (i.e. from cities of Los Angeles and Miami)
- Coordinated regional approach
- Innovate
- "Anything other than jail"
- Integration of custody/supervision and clinical services (criminal justice and behavioral health systems)

Strategies and Suggested Actionable Solutions. The suggested solutions and strategies were clustered under broad strategic directions. Items with a * are those that were also suggested by inmates who participated in focus groups at either George Bailey (men) or Los Colinas (women) Detention Facility along with other ideas (see companion report).

Strategy	Suggested Actionable Solutions
1. Build capacity of all those engaged in providing services	• *Provide cross-sector training that more clearly defines and describes the target populations to ensure that service providers understand criminogenic needs and characteristics and justice/law enforcement understand impact of trauma, mental health and co-occurring disorders* • *Train teachers and counselors about behavioral health needs with a focus on 4th to 8th grade* • *Breakdown the distinction between misdemeanor and felony*

2. Support system and services integration and improvement	• *Bridge the cultures of clinical and criminal justice practices* • *Assess why there are underutilized programs ("not willing to fill space or do the work")* • *Implement an anti-stigma campaign aimed to support reintegration of individuals with criminal justice history into community** • *Maintain an updated menu of available treatment options aligned with risk factors – provide to judges and prison counselors** • *Sustain collaborative approaches (BH Court, drug court)* • *Expand 211 contract to include tracking of resources for mental health beds/placement* • *Use waiting time to be processed into jail to complete a checklist of other needs to ID clients*
3. Provide improved access to needed behavioral health treatment and services	• *Develop a way to screen, triage, so highest risk youth are frontloaded for diversion services* • *Establish geographically-based coordination and assessment centers** • *Create a Multi-Disciplinary Team for high users in other HHSA programs (as a diversion/prevention approach)* • *Understand increased risk for criminal behavior among individuals with co-occurring disorders i.e. increases rates of resisting arrest* • *Develop PAARI/SMART/LEAD type programs that are holistic (treatment, housing and wrap services)* • *Expand dual diagnosis services* • *Work with Community Care Licensing for juvenile placement strategies* • *Use LPS facilities for hospitalizations for those with insurance* • *Under Prop 47, clients will voluntarily identify services that they need – need to determine how to incentivize them to accessing treatment*
4. Address other barriers to success such as housing instability, employment, transportation etc.	• *Expand the Cool Bed program for youth, offer incentives to landlords* • *Expand juvenile diversion and mentoring services* • *Provide care coordination and housing navigation services for all populations - youth, families, and adults* • *Establish in-custody assessment team to support transition planning and linkage to community services prior to release (treatment services, SSI benefits)* • *Design employment programs specifically for justice involved populations** • *Create a central coordination system and incentivize inmates to go directly to this service upon release** • *Address transportation needs** • *Expand ACT Program capacity* • *Provide more re-entry housing** • *Encourage peer engagement and volunteerism through clubhouses* • *Support mentoring and peer-based services for adults**

APPENDIX F. NATIVE AMERICAN COMMUNITY CONVERSATION REPORT

Overview. Attendees at this community conversation were representatives from Native American communities within San Diego County (n=34). The majority of participants were leaders or staff from community-based organizations and programs that are working with children, youth, families, and individuals. Several Native American consumers who reside on represented reservations were also present. This special focus meeting was conducted at the Rincon offices of the Indian Health Council, which also assisted with community outreach.

Process. A guided two-way conversation structured around four key questions:

- What would be good for people to know about Native American communities?
- What is currently working for Native American families around behavioral health?
- What are the most pressing needs of Native American communities when it comes to behavioral health?
- What ideas or suggestions do you have for approaches or practices that could make the best and biggest difference in improving behavioral health outcomes for Native American communities?

Attendees then broke into smaller groups to create graphic depictions of their responses to questions 2, 3 and 4.

General Themes. In addition to discussing strategies to improve behavioral health outcomes, participants also discussed factors that need to be considered when providing behavioral health services to Native American communities. These factors include: culture, history, geography (with many communities located in remote regions), and socio-economics such as poverty, unemployment and poor housing quality.

Findings. Things to be considered and acknowledged when working with Native American communities:

1. **There is a perception within this community that Native Americans are marginalized and that their needs and strengths are not fully understood.** It was noted that Native America communities experience the same types of behavioral health issues as other communities, but there are unique factors that need to be considered when developing services:
    - Geographic isolation makes it difficult to access services that are not provided within the community; many members live on unpaved roads and some tribes are located miles away from any kind of service.
    - The tight knit structure of Native American communities and families means that problems are less hidden and can impact a greater number of people (beyond immediate family members). This makes it important to have services that address the needs of family and community, not just the individual with the presenting mental illness or substance abuse problem.
    - There are 18 different tribes in San Diego County, and they are each unique with regards to history, cultural practices and access to resources. The “Casino Money Myth” is especially problematic: casinos are not funding tribal programs and there is not an excess of money.

- Historical and intergeneration trauma due to the legacy of Indian Boarding Schools, loss of land, breakdown of families, and erosion of culture are considered root causes of behavioral health issues. Providers who are working with Native American communities (including Native American and non-Native American staff) need access to training in trauma informed care that is culturally specific.

2. **Culture is important and needs to be woven into all efforts.** The group discussed how cultural values can both hinder and aid in the establishment of good mental health and sobriety. Also consider how some of these values are complex, contradictory, and not always uniform. Values that were referenced were: desire for privacy especially with regards to problems; tolerance; connection to family and community (makes it difficult to leave); respect for elders.
3. **There is a stated desire for greater engagement and connection to strengthen native-nonnative bonds.** Participants would like greater access to BHS staff, fewer restrictions on use of funding, consistency in accountability, and opportunities to work more closely with non-American Native providers. Also, for there to be efforts to have greater representation of Native Americans as staff, on committees, at training events.
4. **Unserved/underserved groups were identified.** The following groups with mental illness, substance abuse or dual diagnosis were called out as having unmet needs: individuals with disabilities; families with children with special needs; foster children and foster families (including grandparents); transition age youth including teen parents; individuals released from incarceration or placed on community supervision, and their families.

Summary of promising practices or approaches that were suggested by the group:

- "One Brain" approach
- No wrong door
- One stop shop
- Tele Health
- Alternative response teams
- Inter-generational
- Culture as prevention
- Arts for wellness
- Positive Indian Parenting

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Connect, inform and address misconceptions	• *Be proactive in facilitating Native American engagement and representation with BHS – "don't leave us out of the conversation"* • *Involve the community in service design, including elders and youth* • *Allow Native American organizations to provide training to non-Native Americans on culture, history, and needs to support stronger relationships and cultural competency* • *Recruit Native Americans for careers in BHS* • *Explore how trauma is affecting the community*
2. Think outside the box – be innovative and resourceful	• *Incorporate Native American culture into prevention and treatment – arts, cultural initiatives and rites of passage, social events, youth/elder groups, "stitch to Wellness"* • *Train first responders in mental health (fire fighters and ambulance) so they can serve as alternative response teams* • *Use technology, i.e. telehealth program for follow-up to appointments* • *Community events and celebrations that promote sobriety, including ones focused on youth (such as Friday Night Live)* • *Create one-stop-shops for BHS and other resources including domestic violence services, family strengthening programs, and support for foster families* • *Confidential substance abuse/mental health info line or hotline for Native Americans* • *Establish a tribal foster facility to keep children within the community*
3. Eliminate barriers to behavioral health services	• *Adopt a "no wrong door" approach – people don't come in for BHS but that is what they need; have to be flexible* • *Wraparound services to address basic needs, i.e. for housing, transportation, and employment (culturally competent vocational education)* • *Provide specific education and outreach to address stigma and promote the "beauty of recovery" from a cultural perspective*
4. Address the impact of intergenerational trauma with an array of services and supports	• *Develop a re-entry program for formerly incarcerated individuals – include transitional housing and family therapy* • *Use treatment approaches that address family dynamics and strengthen family capacity to support recover, break cycles* • *Provide peer support/navigation, education, and classes to parents, partners, and families of individuals who are struggling with AOD and/or mental health and parents with children with special needs* • *Use Positive Indian Parenting as a culturally specific program* • *More funding for services that address co-occurring AOD and mental health in inpatient settings for youth and adults* • *Provide services for parents of children with special needs* • *Safety net services for Native American foster parents or grand parents*

APPENDIX G. PEER WORKER FOCUS GROUP REPORT

Overview. Attendees at this focus group were individuals (n=12) employed as peer workers, i.e. those with lived experience that is the same, or similar, to those being served within County HHSA- funded programs. Individuals from child/youth and adult systems as well as mental health and AOD programs were represented. A total of 8 non-profit organizations were represented. The group was held at the San Diego NAMI offices, and outreach assistance was provided by County BHS Contracting Officer Representatives (CORs).

Process. A traditional focus group format was used that centered around the following questions:

- Tell us about your work: what services or strategies do you use in in helping peers/families on the path to recovery that are especially successful?
- BHS has identified the following priority goals:
  - Reaching underserved/unserved populations
  - Improving children's behavioral health services
  - Improving care coordination

  What ideas do you have of ways to reach these goals? What do you think is already working? What challenges or gaps do you see – and how might you address them?
- What innovations or ideas do you have of things that could help make you even more effective in improving outcomes for peers/families?

General Themes. Participants shared their perspective as front-line workers who are serving as a bridge between underserved populations and the complex system of care. There was also discussion about what could be done to make the peer-based workforce more effective.

Findings. The following are general observations and highlights from the focus group.

- **Peer workers are providing highly valuable services and play a unique role in the BHS workforce**. All but two of the participants work directly with consumers (the other two work with NAMI and are coordinating trainings and building capacity) and were very passionate, informed and articulate. Peer workers are especially useful in facilitating access and maintaining engagement of difficult-to-reach and underserved populations who are often most in need of BHS services, such as homeless youth. This workforce has insights and experience that could be useful when designing programs and services.
- **There is a general sense of frustration with their working conditions**. There was agreement that the current reporting requirements are burdensome and attendees questioned whether the value is proportionate to the time spent. There is also concern that stresses associated with documentation are causing staff who are highly skilled in engaging with consumers to leave the workforce, e.g. "people aren't attracted to this type of work because they like paperwork." Other concerns related to the need for more training, mentoring, peer support, and opportunities for networking.
- **Many of the ideas put forward were actionable and pragmatic in nature**. Participants in this group wanted to spend less time on identifying needs and more time on problem solving. They were quick in coming up with ideas and building upon suggestions that ranged from big

visionary concepts of how to address homelessness, to requests for more accessible and consumer-friendly information on available services.

Summary of promising practices or approaches that were suggested by the group:

- Whole person approach
- Trauma informed
- Stigma reduction
- Early intervention
- One stop shops
- Care integration
- No wrong door

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Support and build capacity of this workforce	• *Encourage HHSA contractors to provide meaningful self-care opportunities (pass to a gym or yoga class) to peer workers* • *Provide incentives or scholarships to attend trainings or certification courses* • *Develop materials that illustrate career pathways for peer workers* • *Allocate time for collaboration and networking with other organizations* • *Want peer support and mentoring opportunities*
2. Address systemic challenges that impact the effectiveness of peer-led services	• *Allow for integration at the service delivery level – there is considerable frustration at how services are currently siloed (i.e. a peer worker within a mental health program can't work with an individual who is receiving AOD services)* • *Make the process for completing progress notes more streamlined/easier - it takes at least 30 minutes to write progress notes after each contact (seen as a poor use of their time)* • *Create a Documentation Specialist position, and allow use of voice recognition software or simplify forms* • *Involve peer workers (users of data management systems) in the design so they can let you know if something is feasible and reasonable*
3. Explore innovative ways of reaching and serving people	• *Create kiosks/screens at trolley stations (e.g. 12th and Imperial) with interactive display of BHS services and videos* • *Establish one-stop-shops for mental health, AOD and public health – especially for populations like TAY and homeless (i.e. WELLNESS DEPOTS)* • *Establish a policy or procedure to make it possible for providers to create informational or educational videos featuring clients* • *Develop more consumer-friendly information on available services and programs and make available on County website and at places where target populations feel safe (e.g. libraries, community organizations, schools, clinics)*
4. Reduce barriers that prevent or make it difficult for people to access services	• *Keep the amount of bureaucracy, paperwork, and assessments to a minimum– try low barrier approaches (fewer eligibility requirements)* • *Allow for drop-in services, with a "no wrong-door" approach* • *Address the issue of transportation – provide more bus passes or have one-stop-shop (so people aren't going all over the place)*
5. Enhance school-based PEI services	• *Start reach-in programs before 4th grade* • *Support school-based programs that teach mindfulness* • *Provide more behavioral health specialists in schools to aid in prevention* • *Use a whole-person approach to wellness with children as well as with adults*

APPENDIX H. MALE INMATES FOCUS GROUP REPORT

Overview. The Male Inmates focus group was conducted with low risk, non-violent offenders (n=9) within the George Bailey Detention Facility operated by the County of San Diego Sherriff Department. Most participants were repeat offenders. Five participants were white, one was African American, and three were mixed race or Hispanic. Ages ranged from early 20's to late 50's. Participants had come from a GED class, so we can assume that none had graduated from high school. The meeting was observed by a counselor who also engaged in some trouble shooting around individual issues at the end of the session. The level of participation and engagement was very high.

Process. A structured but conversational format was used, using the following agenda:

1. Overview of meeting purpose - to gather information about what is needed to support successfully re-entry into community.
2. Brainstorm of major services and supports needed
3. Deeper discussions about specifically what types of services are needed, where the gaps and challenges are, and their ideas for how these gaps and challenges could be addressed.
4. Closing – which included a brief discussion with the Counselor of available services.

General Themes. The overarching theme for this group was how to prevent recidivism. Inmates were asked to discuss the challenges they face when trying to re-enter successfully into community once they are released.

Findings. The following are general reflections and highlights from the deeper discussions:

1. **Housing is a source of major concern.** The topic of housing provoked the greatest participation and vocal frustration. One of the younger inmates said that housing was more important than getting a job, he spoke about how without shelter you couldn't easily keep clean and you were at constant risk of being picked up by police. They all agreed that the first 72 hours after being released are make or break time. I asked if people typically knew where they were going to spend their first night after they were released and the response was "*no... many people have no idea.".*
2. **The task of reentry can be overwhelming and there is a fear of failure.** One of the inmates said that he was much more likely to get depressed and frustrated when he was out of jail than when he was inside. "*I spend a lot of time in here making plans about what I'm going to do when I'm released. I have all these ideas. But when you get out it's frustrating because you can't do it, there's too much in the way, so you just give up and go back to doing what you were doing that got you in here*". *"In here you have food and somewhere to sleep. Outside you have to take care of those things yourself and it's not easy*". In response to this last comment other inmates agreed and added *"If you are hungry, cold or tired you are going to make bad decisions."*
3. **Jobs are viewed as a key to success, but this an area that is fraught with barriers.** This was the topic that the inmates wanted to talk about first and where they had the most suggestions. They see employment as critical to successful re-entry, they need a way to make money and to be productive.
4. **Further exploration of behavioral health services is warranted.** The discussions of mental health and substance abuse needs were the most challenging and had the least participation. A general comment was made that "*most of us are in here for drug offenses*" and there was discussion of depression, feelings of anxiety, and inadequacies of treatment approaches: "*I went*

to a 52-week anger management program, for DV, all they talked about was Red Flags and how to deal with being angry. No one ever asked why I was angry". Inmates were more comfortable talking about the need for drug treatment as opposed to need for mental health services. This topic suffered by being the last one to be discussed and from limited time.

Brainstorm of areas were support is needed, as suggested by the group:

- Money/jobs
- Resources/basis needs
- Support/Family
- Shelter/housing
- Transportation
- Counseling/mental health
- Drug treatment
- Education

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Provide services that support transition prior to release or immediately upon release	• *Provide education on types of employment that are open to ex-offenders* • *Provide information on housing programs, shelters and resources.* • *Provide clear guidelines and education on what constitutes a parole violation with regards to shared housing or shelter (they were confused about this).* • *Make sure the first 72 hours are covered – this is make or break time for many people, don't let people leave without a plan of where they are spending their first few nights especially if they have behavioral health needs.* • *Provide a place or person that they can go to for support and help (care coordination) upon release. Preferably a peer, someone with lived experience.* • *If on medication, connect them to a clinic (they are released with 10-day supply of meds, it is hard to get an appointment within that timeframe).* • *Provide more than 1 bus token. One token gets them to one place, in the first week they need to travel all over, to get medication, housing, etc. If they travel without a ticket it is a parole violation and they can be sent back inside.*
2. Help ex-offenders re-enter the job market	• *Create ways for potential employers to come face to face with ex-offenders – inmates feel that online applications are a waste of time.* • *Ensure that employers understand tax breaks available for hiring ex-offenders.* • *Subsidize cost of training programs (one attendee got into an occupational training course but couldn't afford the $80 materials fee).* • *Set up employment training programs or temporary job opportunities that are just for ex-offenders, help them learn useful skills and prove themselves.*
3. Advocate for system change that can reduce homelessness among ex-offenders	• *Create housing solutions for different people – halfway houses are not open to all populations (i.e. only for those released from State penitentiary), shelters often full, families cannot afford to accommodate them, cannot afford market rent.* • *Establish a protocol that would allow parole or probation officers to make exceptions to the rules that parolees/probationers cannot associate with other parolees/probationers. Inmates understand why there are restrictions but think there needs to be some flexibility – especially given the housing situation. For example, they may know someone who is living with family or have their own place, who might rent a room or provide accommodation for a few nights but can't do this because it would risk (i.e. violate their own parole).*

4. Provide access to drug treatment programs	• *Provide greater access to AOD treatment, both in jail and upon release, and more than just self-help programs.* • *Don't make drug treatment a punishment. Make it available to inmates who want it (a privilege and a choice). Don't waste it on people who don't want it.*

APPENDIX I. SOUTHEASTERN COMMUNITY CONVERSATION REPORT

Overview. Attendees at this community conversation were residents and/or individuals who are providing community based services within Southeastern San Diego (n=11) plus representatives from County Behavioral Health Services (n=4). This special focus group was held at the CARE Center on 10-22-2016. Community outreach was conducted by members of the Live Well Communities Task Force.

Process. A guided conversation structured around four key questions:

1. What would it be good for people to know about Southeastern San Diego to truly help children and families who are dealing with behavioral health issues?
2. What is currently working for families and children who live in Southeastern San Diego around behavioral health?
3. What are the most pressing needs of the Southeastern San Diego community when it comes to children's behavioral health?
4. What ideas or suggestions do you have of approaches or practices that could make the best and biggest difference in improving behavioral health outcomes for children in Southeastern San Diego?

General Themes. The conversation surfaced themes around needs to: a) build trust with this community; b) identify and address discrimination and institutional racism; c) provide services that deal effectively with the impact of trauma and victimization; d) ensure that services are culturally competent; e) create opportunity for enhanced connections and collaborations – especially for new or smaller organizations; f) meet the needs of underserved populations which include youth, refugees, and parents of children with behavioral health concerns.

Findings. Things to be considered and acknowledged when working with Southeastern community:

1. **Impact of Adverse Childhood Experiences and Trauma.** There are factors that impact the behavioral health of residents and contribute to adverse childhood experiences, including: systemic and ongoing racial discrimination; intergenerational history of struggles, substance abuse, incarceration; poverty; lack of educational or employment opportunity for families; homelessness or housing insecurity. There is a perception that institutional neglect and well-intentioned (but misguided) public policies have contributed to struggles both for the community and within individual families.
2. **Barriers to Access.** Barriers to addressing mental health needs include: stigma associated with mental illness; lack of trust of mainstream providers; prevalence of other needs such as shelter, food insecurity, and fears for safety; transportation.
3. **Community Strengths.** The Southeastern community has many strengths and assets that too often get overlooked: rich diversity; family values; faith-based and smaller grassroots organizations doing great work. There are existing efforts that are working that can be built upon and points of entry into the community such as schools, clinics, non-profit organizations. There is a prevailing sense that the Southeastern community is poorly represented (i.e. within the media and among systems), youth especially are misunderstood, and unfairly judged.

4. **One-size fits all approach won't work.** There are shifting demographics within Southeastern community, influx of newcomers including immigrants and refugees. Different cultural communities have different understandings of behavioral health.
5. **Desire for Connection, Respect and Responsibility.** This community would welcome opportunities for greater engagement with County BHS with the following requests: don't over promise; don't just listen – hear; make room for youth and new leaders to be part of the conversation. There is also a willingness for a "call to action" within the community, requesting individuals to step up and be part of the solution.

Summary of promising practices:

- Restorative justice
- Trauma informed care
- Culturally competent parenting programs
- Peer navigators and/or cultural brokers
- Mental health first aid
- Stigma reduction
- Home-based services
- Rapid response with warm-hand off
- Wraparound

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
1. Create a working framework for real change	• *Continue to have dialogue with this community and find ways to connect with different sectors and groups.* • *Include innovative approaches that break down stigma, build resiliency and address trauma – look at the It's Up to Us Campaign.* • *Provide ongoing training on trauma and ACE – not one-time efforts.* • *Use "Big Data" to inform changes.* • *Plan for an integrated and coordinated approach to BHS (mental health and substance use.)* • *Provide a way for smaller and emerging non-profit organizations to be able to provide county funded services. Encourage larger nonprofits to partner with smaller ones.* • *Address issues of misdiagnosis (PTSD not ADHD) and "Hood Disease".* • *Make room for research-based approaches not just evidence-based.*
2. Utilize a strength-based approach that builds upon existing community assets	• *Involve young people in decision making and planning and build on youth leadership.* • *Use points of entry that are already in place – schools (Lincoln and King Chavez), family resource centers, community-based clinics and health centers, grassroots and home-based providers.* • *Understand the value of faith-based leaders (example of United Women of Africa using faith leaders to address intergenerational divide).* • *Recognize the importance of family unity.*
3. Provide accessible youth-friendly services	• *Embed life skills, restorative justice opportunities, mentoring and other services in schools. Occupy space in schools to make services visible.* • *Talk about youth issues (suicide, drugs) and use language like wellness and student services (not mental health and treatment or counseling).* • *Provide services for out of school youth as part of CSOC.* • *Support on campus suspensions – keep youth in school.* • *Work with school based Family Resource Centers.*

4. Support parents and grandparents	• *Supplement parenting skills in a culturally competent way.* • *Support or expand existing prevention and early intervention programs and services that are working* • *Provide care-coordination and support in navigating services – use peer workers or cultural brokers. Use a "warm hand-off" approach not just paper referrals.* • *Provide services for very young children, include a focus on early childhood education in training programs.*

APPENDIX J. FEMALE INMATES FOCUS GROUP REPORT

Overview. This focus group was conducted with a group of six female inmates who reside in fair housing facilities within the Las Colinas Detention and Reentry Facility (LCDRF). The group was diverse with three individuals who identified as Hispanic, one as African American, one as White and one as Middle Eastern. This facility serves as the primary point of intake for women offenders in San Diego County and is operated by the County of San Diego Sherriff's Department. It is a 'heavily programmed' facility offering many drug and alcohol intervention and job training programs and the InReach transition program. Most but not all of attendees were repeat offenders and several has been in the facility for over 12 months.

Process. A structured but conversational format was used, using the following agenda:

1. Overview of meeting purpose - to gather information about what is needed to support successfully re-entry into community.
2. Discussion about specifically what types of services are needed, where the gaps and challenges are, and their ideas for how these gaps and challenges could be addressed, also on how Los Colinas programs were helping them to not return to detention.
3. Closing consisted of some troubleshooting with the counselor around some of the issues that were raised for individual inmates

General Themes. Attendees provided insight into some of the barriers and challenges to reentry. Due to LCDRF's focus on reentry, and the fact that the women present were engaged in a number of in-jail rehabilitative services, much of the conversation focused upon how the facilities' programs were supportive of re-entry and what could be done to make them even better.

Findings. The following are general reflections and highlights from the discussion.

1. **There are numerous services and programs available at this facility which set the women up for success upon release.** services on site include AOD programs, vocational and general education, self-improvement and wellness services including mental health providers. Some inmates qualify for supervised re-entry and early release services that includes monitored supervision. There is general appreciation for the quality of services and support and recognition that they are making a difference. Participants who had had the chance to take advantage of Los Colinas programs felt that their lives were changed in a very positive way; several specifically stated said they would have never been able to change without the program.
2. **There is room to enhance pre-release re-entry/rehabilitative services.** While there was consensus among the participants that this facility is superior to others (i.e. has a lot more services and supports) there is still room for improvement in areas such as early assessment, earlier access to programs, cultural competency, and ability to tailor services to individual needs. The women made a strong connection between availability and quality of pre-release services and their ability to succeed in the community and avoid re-entry.
3. **Pre and Post-release care coordination and support is seen as a priority need.** Inmates recognize that in order to succeed upon release they need a) help establishing a plan and for this to start as soon as possible (i.e. allow InReach to begin sooner by increasing InReach staff); b) once released they need ongoing assistance accessing and navigating needed services including AOD treatment

and counseling; c) want continued opportunity for peer support either one-on-one or via groups provided by community agencies once they are released.

4. **Other re-entry needs focused upon wellness and self-sufficiency.** Gaps in community services were those that meet the needs of women who are not eligible for transitional living or treatment but who still need ongoing support in order to sustain the gains they made while in jail.

Strategies and Suggested Actionable Solutions

Strategy	Suggested Actionable Solutions
Provide community services that address barriers and challenges to reentry and reduce risk for recidivism	• *Offer diverse types of Residential Drug Treatment Programs upon release* • *Offer support for job placement and additional job training* • *Provide job training that leads to jobs that pay more than minimum wage* • *Provide transitional housing and re-entry support for inmates not needing rehab* • *Several participants had mandated supervision upon their release, which was seen as a benefit that provided ongoing services and a place in a sober living facility; one participant did not have this or parole, and felt that after all the services provided in jail she might have trouble and reoffend without support* • *Participants who did not fit into either a sober living home or Monitored Supervision clearly felt they were at risk of reoffending – suggest that community-based case management, care coordination services are needed* • *Provide access to peer-led support groups focused upon helping women sustain motivation and encourage each other's success once they are released.*
Provide support with the transition from jail to community	• *Provide care coordination services - "Not knowing where I can get services when I leave makes me contact people I should not hang out with"* • *Assure quality of medication transition for inmates (warm hand-off between providers)*
Increase or improve facility programs that contribute to transition success	• *Provide InReach services upon entry and ongoing rather than just prior to release; Project InReach was cited as very successful, and all wanted to participate in it, but due to demand the program services were only offered when clients were nearing release and many felt this was too late; all participants mentioned the need to expand this program and to continue it beyond release* • *Reduce paperwork burden for inmates to apply for programs while in Los Colinas that would serve to support reentry*

Appendix K. Interactive Data Story and Forum Graphic Recording

Graphic Recording of the Aggregated Community Conversations

Interactive Data Results