COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY

Mental Health Services Act (MHSA) Fiscal Year 2024-25 Annual Update

Behavioral Health Services

June 4, 2024

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Contents

A LETTER FROM THE BEHAVIORAL HEALTH SERVICES DIRECTOR.....5

MHSA OVERVIEW.....6

Background.....6

Investments.....6

Live Well San Diego.....7

Advancing Diversity and Health equity.....7

Homelessness and Housing.....9

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION PARTNERS.....10

MHSA PRUDENT RESERVE.....10

THE JOURNEY AHEAD.....13

DEMOGRAPHICS.....14

COMMUNITY PROGRAM PLANNING (CPP) PROCESS.....15

MHSA Review and Public Comment Period.....16

MHSA FUNDED PROGRAMS.....17

COMMUNITY SERVICES AND SUPPORTS (CSS).....17

CSS PROGRAMS FOR CHILDREN, YOUTH, AND FAMILIES.....18

CSS PROGRAMS FOR TRANSITION AGE YOUTH, ADULTS, AND OLDER ADULTS.....22

CSS PROGRAMS FOR ALL AGES (ALL).....28

PREVENTION AND EARLY INTERVENTION (PEI).....31

INNOVATION (INN).....36

WORKFORCE EDUCATION AND TRAINING (WET).....38

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN).....40

MHSA DATA COLLECTION AND ANALYSIS.....41

APPENDICES.....42

Appendix A: MHSA Expenditure Plan.....43

Appendix B: Certifications and Minute Order.....52

Appendix C: MHSA Program Summaries.....60

Appendix D: MHSA Justice Involved Programs.....87

Appendix E: County of San Diego Demographics.....89

Appendix F: Community Engagement Report.....95

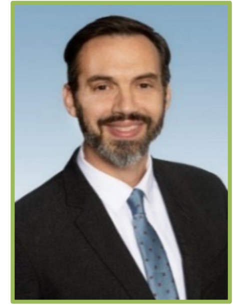
Appendix G: MHSA Issue Resolution Process.....190

Appendix H: Community Supports and Services (CSS) Annual Report FY 2022-23.....193

Appendix I: Full-Service Partnership (FSP) Outcomes Report FY 2022-23 – Children, Youth, and Families.....196

Appendix J: Annual System-wide Assertive Community Treatment (ACT) Report FY 2022-23– Adult 206
Appendix K: Housing Update Executive Summary 217
Appendix L: Prevention and Early Intervention (PEI) System-wide Summary 222
Appendix M: Prevention and Early Intervention (PEI) Components and Priorities... 285
Appendix N: Innovation Reports 287
Appendix O: Glossary of Acronyms.. 387
Appendix P: Glossary of Terms.. 390
Appendix Q: Stakeholder Comments 393

A LETTER FROM THE BEHAVIORAL HEALTH SERVICES DIRECTOR



The Mental Health Services Act (MHSA) Annual Update for Fiscal Year (FY) 2024-25 is an opportunity for the County of San Diego (County) Health and Human Services Agency (HHSA), Behavioral Health Services (BHS) department to inform stakeholders, partners, consumers, and community members of MHSA-funded programs, funding priorities, as well as highlighting key accomplishments from FY 2022-23.

California's behavioral health system of care will be experiencing a major transformation in the upcoming years through legislative and financial changes that are impacting our system of care. In March 2024, voters passed Proposition 1, the Behavioral Health Services Program and Bond Measure, also referred to as Behavioral Health Services Act (BHSA) Act. The BHSA transforms the MHSA by significantly shifting the scope of services to those with the most serious mental illness, with an emphasis on housing to support individuals experiencing homelessness or chronic homelessness. It also dedicates resources for full-service partnerships, early intervention services, and support programming for individuals with substance use disorders regardless of a co-occuring mental health disorder. Included in the BHSA is a bond measure, which allows counties to finance loans or grants for capital assets for permanent supportive housing for veterans and others who are homeless with behavioral health conditions. Efforts are underway to assess the impact of BHSA, including new opportunities.

In the midst of system transformation, BHS continues to support new and enhanced services and programs funded through MHSA funding, as follows:

- Transforming the Behavioral Health Continuum of Care (COC) by enhancing, expanding, and innovating the array of behavioral health services available through collaboration with justice partners, hospitals, community health centers, community-based providers, and residents through the Optimal Care Pathways (OCP).
- Bolstering the workforce through the new Behavioral Health Workforce Development and Retention program funded through MHSA Innovation funds, which is anticipated to begin FY 24-25.
- Enhancing the Screening to Care program to increase partnerships with school districts for behavioral health screenings of middle school students.
- Creating new pathways for services for clients referred through the civil court process for the Community Assistance, Recovery, and Empowerment (CARE) Act program, implemented in October 2023.
- Developing and constructing a new crisis stabilization unit in the East Region of San Diego County.

Despite the economic and legislative changes impacting our system of care, BHS remains committed to achieving the regional *Live Well San Diego* vision of achieving a healthy, safe, and thriving region by providing accessible, culturally aware community-based services throughout the region to support the long-term health and wellness of children, adults, and families.

Sincerely,

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

MHSA OVERVIEW

BACKGROUND

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

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

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

As required by the Welfare and Institutions Code, counties must complete a three-year plan and subsequent annual updates for MHSA-funded programs. The most recent MHSA Three-Year Plan for Fiscal Years (FY) 2023-24 through 2025-26 provided program and expenditure information for the five MHSA components: Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). This MHSA FY 2024-25 Annual Update provides an overview of the recent Community Planning Process (CPP), summarizes outcomes for FY 2022-23, and outlines adjustments to the Three-Year Plan.

INVESTMENTS

The proposed MHSA spending plan for FY 2024-25 is $299,681,937 as outlined in the following chart. The budget reflects an increase of $4,055,546 from the amended MHSA Three-Year Plan budget for FY 2024-25. By the end of FY 2025-26, it is estimated that the County will have invested over $3 billion in MHSA programs since its inception in 2005.

MHSA Component	Amended Three Year Plan FY 2024- 25	Annual Update FY 2024-25 Budget	Variance	Percent of MHSA Budget
Community Services and Supports (CSS)	$ 239,628,451	$ 214,479,530	$ (25,148,921)	71.6%
Prevention and Early Intervention (PEI)	$ 39,461,818	$ 51,167,156	$ 11,705,339	17.1%
Innovation (INN)	$ -	$ 17,401,800	$ 17,401,800	5.8%
Workforce Education and Training (WET)	$ 7,536,121	$ 7,633,450	$ 97,329	2.5%
Capital Facilities and Technological Needs (CFTN)	$ 9,000,000	$ 9,000,000	$ -	3.0%
Total	**$ 295,626,390**	**$ 299,681,937**	**$ 4,055,546**	***100%**

**Figures are rounded and total may not add up to 100%*

The MHSA budget is based on priorities identified during the CPP in conjunction with staff recommendations. A summary of the proposed expenditures by each MHSA component is available in Appendix A. Summaries of all programs funded with MHSA dollars are available in Appendix C.

LIVE WELL SAN DIEGO

Implementation of the MHSA demonstrates our ongoing commitment to the regional *Live Well San Diego* vision of achieving a healthy, safe, and thriving region. BHS is committed to providing accessible, community-based, and client-oriented services to all six Health and Human Services Agency (HHSA) service regions: North Coastal, North Inland, North Central, Central, East, and South. The MHSA enhances access to services, and encourages self-sufficiency, health, and well-being in children, adults, and families as demonstrated by the personal stories embedded throughout this report. By collaborating with individuals, community partners, local government, schools, and others, the County continues its goal of achieving healthy, safe, and thriving communities through collective impact. In FY 2022-23, MHSA-funded programs provided services to nearly 60,000 children, transition-age youth, adults, and older adults in the San Diego County, with an emphasis on individuals who were previously unserved or underserved.

ADVANCING DIVERSITY AND HEALTH EQUITY

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

To identify and address unmet behavioral health needs within the region, and the systemic and regional inequities that lead to these unmet needs, BHS partnered with the University of California, San Diego (UCSD) to develop the Community Experience Partnership (CEP). The CEP is a joint initiative to promote behavioral health equity and inform culturally responsive, data-informed behavioral health service planning. Accomplishments of the CEP over the past year include:

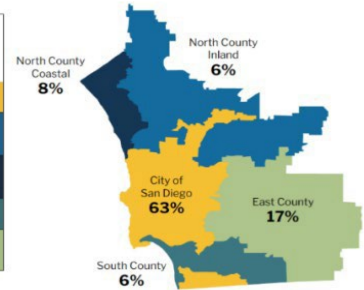
1. Constructed the **Behavioral Health Equity Index (BHEI),** a composite index designed to explore differences in the multifaceted and complex social determinants of behavioral health specific to San Diego County. The BHEI is a composite index which combines information from multiple sources into a single score. It is constructed from over 30 indicators, organized into eight domains that map to five social determinants of behavioral health. The BHEI is a valuable tool to summarize data is interpretable and can help build community consensus for equity work.
2. Created the CEP **Service Planning Tool (SPT),** a novel application designed for BHS service planners to help ensure service provision is informed by data, based in cultural and regional considerations, and directed toward communities that may be at greatest risk for unmet behavioral health need. The application uses data from diverse sources (e.g., U.S. Census and client health records) to help planners at BHS identify areas in San Diego County where at-risk populations are likely to be highly concentrated. Once areas are identified, users may explore community profiles and download custom reports that summarize the social, economic, and demographic profiles of the selected regions and at-risk populations.
3. Two customized **BHEI User Interfaces** are in development 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 SPT.

The CEP continues to refine and maintain key resources, including the CEP website and **Community Experience Dashboards** (CED). The CED allows 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. The dashboards have recently been updated with current data and enhanced features. The integration of inpatient and emergency department discharge data is currently in progress.

The CEP's efforts meet needs at the service, administrative, and community levels. This promotes a continuous feedback process by which issues can be identified, further informed by community engagement, and mediated by actionable plans that will aid in informing the design of BHS programs, including services funded through MHSA.

HOMELESSNESS AND HOUSING

	% of the Region	Total Homeless Persons
City of San Diego	63%	6,500
North County Inland	6%	653
North County Coastal	8%	783
South County	6%	625
East County	17%	1,703



Obtaining stable housing is critical in achieving health and wellness for individuals who are experiencing homelessness, or who are at risk of experiencing homelessness, and struggling with serious mental illness. The Point-in-Time Count is an annual effort to identify the number of persons experiencing homelessness that is conducted by hundreds of volunteers and outreach workers across San Diego County. The Regional Taskforce on Homelessness conducted its annual Point-in-Time Count of unsheltered persons in January 2023. There was a 22% increase in overall homelessness (sheltered and unsheltered) in 2023 with a total of 10,264 individuals compared to 8,427 the prior year.

The 2023 Report[1] shows the total estimated of persons experiencing homelessness into 5,093 sheltered (Emergency Shelter, Safe Haven, or Transitional Housing) and 5,171 unsheltered. Of those unsheltered, 44% were chronically homeless, 29% were 55 years and older, 9% were veterans, 6% were unsheltered youth, and 1% were families. MHSA programs continue to provide extensive outreach, engagement, treatment services, and permanent supportive housing to individuals with SMI who are experiencing homelessness. The map above outlines the homeless population, by region, identified in 2023.

The County of San Diego Behavioral Health Services developed a five-year (2022-2027) Strategic Housing Plan to set forth goals, strategies, and priorities for supportive housing that best supports BHS clients. It was developed through intensive outreach that included a wide variety of opportunities to gather input from people with lived experience/expertise and a broad range of stakeholders who care deeply about housing and behavioral health. Through this process, three key goals have been identified with 10 focus areas that call for purposeful action. These new housing and services resources are designed to support critical interventions that address the substantial need for new supportive/affordable housing resources, particularly for people experiencing homelessness with behavioral health concerns.

PROJECT ONE FOR ALL (POFA)

In 2016, the San Diego County Board of Supervisors (Board) implemented Project One for All (POFA) with a goal of connecting 1,250 individuals with SMI who are experiencing homelessness to housing and behavioral health services. POFA provides adults with SMI who are experiencing homelessness with fully integrated services, including outreach, case management, mental health treatment services, substance use disorder (SUD) services, referrals to primary health care, social services, and housing to ensure stability and live their best life. As of December 2023, a total of 2,582 individuals experiencing homelessness were housed and received BHS services through POFA.

LOCAL GOVERNMENT SPECIAL NEEDS HOUSING PROGRAM WITH MHSA PROGRAMS

The County has dedicated more than $53 million of MHSA CSS funds to the California Housing Finance Agency (CalHFA) for the Local Government Special Needs Housing Program (SNHP) and its predecessor, the MHSA Housing Program. Upon completion, these programs will result in approximately 407 permanent supportive housing units.

1 San Diego Regional Task Force on Homelessness, 2023 WeAllCount Report, retrieved on 2/4/2024 from <https://www.rtfhsd.org/reports-data/>

Of the 407 units, 397 units have been operationalized and 10 units are under construction or planned for development.

Status of Combined Housing (SNHP and MHSA) Units	# of Housing Units
Operationalized	397
Under Construction or Planned for Development	10
Total Housing Units	**407**

NO PLACE LIKE HOME

In 2018, Proposition 2 authorized the sale of up to $2 billion in revenue bonds and the use of a portion of Proposition 63 taxes for the MHSA No Place Like Home (NPLH) program. It provides funding for permanent supportive housing developments (PSH) to house clients who are experiencing homelessness and have a mental health condition. The San Diego County allocation was approximately $127.8 million. As of December 2023, there were six operational developments totaling 192 NPLH units. There are 13 new housing developments planned to add another 231 units, which will bring the total NPLH units to 423.

Status of NPLH Units	# of Projects	# of Housing Units
Operationalized	6	192
Under Construction or Planned for Development	13	231
Total Housing Units	**19**	**423**

COLLABORATION WITH JUSTICE, COURTS, AND PROBATION PARTNERS

Many MHSA programs provide access and support for individuals either entering or exiting juvenile detention, jails, or courts. Programs collaborate with the courts, the San Diego County Sheriff's Department, the County Probation Department, and other law enforcement agencies to support successful reintegration of clients into the community through prompt and appropriate identification and treatment of behavioral health issues.

Additionally, BHS continued collaboration with justice partners on the Board directed *Alternatives to Incarceration* efforts to divert individuals from justice involvement or repeated justice involvement by developing strategies to instead engage and connect individuals with behavioral health conditions to care and housing. In FY 2024-25, the total estimated investment in justice-related MHSA programs will be over $58 million. See Appendix D for a list of MHSA programs that serve justice-involved clients.

MHSA PRUDENT RESERVE

The County is required to establish and maintain a prudent reserve to ensure children, adults, and seniors can continue receiving services during years in which revenues for the Mental Health Services Fund are below recent averages adjusted by changes in the State population and the California Consumer Price index per WIC Code 5847(b)(7). A county can also include an allocation of funds from the Prudent Reserve in years in which the allocation of funds for services are not adequate to continue to serve the same number of individuals as in the prior fiscal year under section 5847(f). The funding for the County is at a minimum level of 5% and a maximum level of 33% of the average amount the County allocated to its CSS Account over the previous five fiscal years, pursuant to California Code of Regulations (CCR Title 9) section 3420.30(b).

Each county must electronically submit its calculation of the maximum prudent reserve level and submit a completed MHSA Prudent Reserve Assessment/Reassessment (DHCS 1819 (11/2022) (Enclosure 1) form to DHCS

by June 30, 2024, as part of the Three-Year Program and Expenditure Plan or annual update.

FY 2024-25 METHODOLOGY AND ASSESSMENT

The County reassessed its prudent reserve level in FY 19-20 at $33,478,186 based upon FY 2013-14 through FY 2017-18. As of FY 2023-24, the balance remains at $33,478,186. The next reassessment in FY 2024-25 is based upon FY 2018-19 through FY 2022-23.

Pursuant to CCR Title 9 section 3420.30(a), a county shall fund its prudent reserve with funds transferred from its CSS component. This funding is required at a minimum level of 5% and not to exceed 33% of the average CSS allocation received in the preceding five fiscal years per code. To determine the average amount allocated to the CSS component over the five fiscal years, each county must combine the MHSA distributions between July 1, 2018 and June 30, 2023, multiply that sum by 76% (9 CCR 3420(b)), add the revenue reallocations to the CSS component, and divide that total by five. Table 1 shows the current County prudent reserve balances by component, which remains within the required range described above. Table 2 depicts the actual minimum and maximum required amounts.

TABLE 1

FY 2023-24 MHSA Prudent Reserve Balance	
Component	*Prudent Reserve Balance*
Community Services and Supports (CSS)	$26,712,351
Prevention and Early Intervention (PEI)	$6,765,835
Total	**$33,478,186**

TABLE 2

Actual MHSA Revenue Received Through FY 2022-23		
Fiscal Year	*Total MHSA Revenue Received*	*76% CSS Allocation*
2018-19	$ 160,645,925	$ 122,090,903
2019-20	$ 149,864,074	$ 113,896,696
2020-21	$ 228,431,583	$ 173,608,003
2021-22	$ 257,809,991	$ 195,935,593
2022-23	$ 168,607,864	$ 128,141,977
Total	**$ 965,359,437**	**$ 733,673,172**
2019-20 Reallocated CSS		**$ 16,153**
2022-23 Reallocated CSS		**$ 26,218**
Total CSS Allocation 5 Years		**$ 733,715,543**
5-Year CSS Average		**$ 146,743,109**
5% Prudent Reserve (minimum)		**$ 7,337,155**
33% Prudent Reserve (maximum)		**$ 48,425,226**

REVERSION

Funds transferred from the prudent reserve to the CSS component and PEI component are subject to reversion if a County fails to spend such funds within three fiscal years. The applicable reversion period for these funds begins in the fiscal year when the county transferred the funds from the prudent reserve to the CSS component and PEI component. The funds shall revert to the Mental Health Services Fund for deposit into the Reversion Account.

FUTURE REASSESSMENT

The Prudent Reserve funding level must be reassessed every five years and include the reassessment in the applicable Three-Year Program and Expenditure Plan as per regulations. A county may reassess its Prudent Reserve funding levels more frequently and the reassessment shall include the minimum and maximum funding levels and the actual funding level of the County Prudent Reserve (9 CCR 3420.30(d)).

THE JOURNEY AHEAD

New large-scale policy shifts and economic uncertainty are predicted to have programmatic and financial impacts on the system of care this fiscal year and in upcoming years. In anticipation of these changes, BHS continues to identify strategies to mitigate any risks and impacts while remaining focused on improving the delivery of care through improved access and enhanced capacity, by bolstering the workforce and optimizing revenue streams to ensure adequate resourcing is available. The priority remains preserving the network of treatment, support services, and housing for individuals in need, despite any economic downturn.

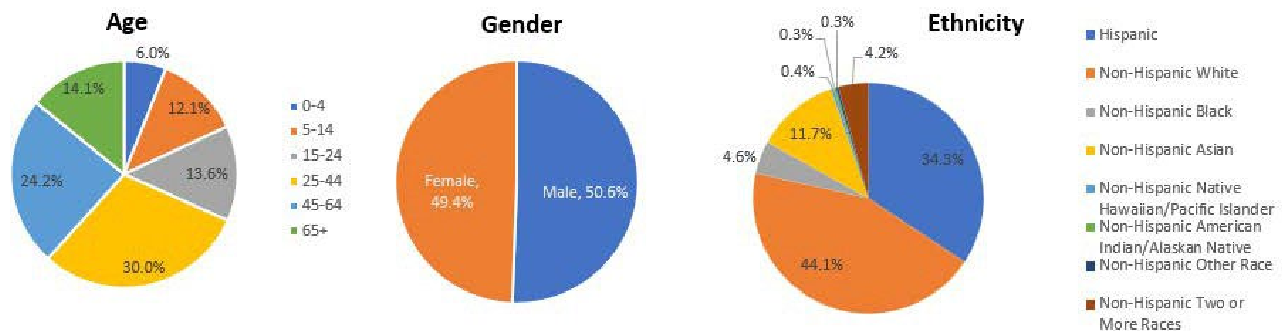
Changes that will have significant impacts locally to services and operations include:

- Implementing Proposition 1, the Behavioral Health Services Program and Bond Measure Act (BHSA). The BHSA implements a bond of over $6 billion for behavioral health infrastructure and restructures the MHSA funding to focus on individuals with the most serious mental illness, with a large emphasis on providing housing, and expansion to include substance use services.
- Continuing to implement Medi-Cal Transformation, a State initiative designed to improve the quality of life and health outcomes of Californians through delivery system, program, and behavioral health payment reform across Medi-Cal services, which began in July 2023. Medi-Cal Transformation is expected to modernize Medi-Cal by improving the quality of life and health outcomes of beneficiaries, including those with the most complex health and social needs.
- Implementing Senate Bill (SB) 525, Minimum Wage for Health Care Workers bill, which was signed by the Governor in October 2023. The new law establishes minimum wage schedules for health care employees, including employees working in public behavioral health settings and residential care facilities.
- Continuing to ramp up services for the Community Assistance, Recovery & Empowerment Act (CARE Act) program, implemented in October 2023.
- Identifying strategies to mitigate the State's budget deficit by shifting the array of services to optimize client care and revenue and pursing new funding opportunities to support long-term sustainability.
- Implementing SB 43 which significantly updates California's civil detention and conservatorship laws by establishing new diagnostic criteria and by broadening the definition of "grave disability."
- Supporting the clinical design process to improve services across the system to ensure they are meeting the needs of the communities being served.

DEMOGRAPHICS

San Diego County, California is located near the Pacific Ocean in the far southwestern part of the United States, has nearly 70 miles of coastline, and shares an 80-mile international border with Mexico. It is among the nation's most geographically varied regions with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. According to the United States Census Bureau, San Diego County has an area of 4,526 square miles, of which 4,210 square miles are land and 316 square miles are water[2]. San Diego County's population for 2021 was 3,296,317[3], making it the second-most populous county in California and the fifth-most populous county in the United States.

The culturally diverse region boasts robust technology and health industries, a business-friendly climate, green practices, and a high quality of life. It is home to world-class educational institutions and a large military presence. Over 200,573[4] veterans are estimated to reside in the region along with more than 115,000[5] active-duty military personnel and their families. The estimated demographics for San Diego County based on 2017-2021 U.S. Census data from the American Community Survey 5-year estimates[6] [7]:



The two most widely spoken languages at home are English and Spanish, with nearly 37 percent of county residents being bilingual[7]. The region has a steady increase in the Hispanic population and continuing growth in diverse ethnic backgrounds. The County's threshold languages are Somali, Arabic, Chinese (Mandarin), Korean, Persian (including Farsi and Dari), Spanish, Tagalog, and Vietnamese. Additional demographic data for San Diego County is in Appendix E.

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[2] U.S. Census Bureau, 2021 Gazetteer Files, Single State Counties Gazetteer File: California, retrieved on 11/28/2023 from <https://www2.census.gov/geo/docs/maps-data/data/gazetteer/2021_Gazetteer/2021_gaz_counties_06.txt>

[3] U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table B01001 retrieved on 11/28/2023 from <https://data.census.gov/table/ACSDT5Y2021.B01001?q=B01001&g=050XX00US06073&y=2021>

[4] U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table S2101 and B21002 retrieved on 3/22/2024 from <https://public.tableau.com/app/profile/chsu/viz/2021RegionandSRADemographicProfiles_16796719400160/HomePage?publish=yes>

[5] San Diego Military Advisory Council (n.d.) *Military in San Diego*. Retrieved on 3/22/2024 from <https://sdmac.org/military-in-san-diego/>

[6] U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table B03002 retrieved on 11/28/2023 from <https://data.census.gov/table/ACSDT5Y2021.B03002?q=B03002&g=050XX00US06073&y=2021>

[7] U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table C16001 retrieved on 11/28/2023 from <https://data.census.gov/table/ACSDT5Y2021.C16001?q=C16001&g=050XX00US06073&y=2021>

COMMUNITY PROGRAM PLANNING (CPP) PROCESS

The Community Program Planning (CPP) process emphasizes community involvement and participation in the planning of mental health services by providing community members and other stakeholders the opportunity to identify priorities, provide feedback, and make recommendations on how MHSA funds will be invested to best meet the needs of county residents. It is based on the principle of "nothing about us without us," ensuring individuals and communities directly impacted by mental health issues are actively involved in the decision-making process. Throughout the year, BHS engages in open dialogue with the Behavioral Health Advisory Board (BHAB), System of Care (SOC) Councils, various community-based and stakeholder-led councils and organizations, and individuals in various settings to determine priorities, solicit feedback, and make recommendations for the utilization of MHSA funds. BHS facilitates behavioral health community engagement sessions that are open for the public to inform the MHSA Three-Year Plan and subsequent Annual Updates.

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

BHS has created infrastructure to conduct ongoing community engagement as part of the MHSA CPP process. BHS solicits feedback from community stakeholders (inclusive of all stakeholder groups as identified in the MHSA) regarding behavioral health needs to gather input on how to better serve those residing in San Diego County and meet the requirements of the MHSA. Community members and other stakeholders are asked to discuss pressing behavioral health issues, suggest ways to better engage and serve the community, as well as brainstorm new programs and services. Input gathered from all stakeholders through various venues is used to inform program planning and help improve MHSA-funded services provided by the BHS system of care.

Stakeholder outreach and engagement through various mechanisms are implemented year-round including BHAB and SOC Council meetings. Six SOC Councils are explicitly designed to generate feedback from multiple stakeholder groups to inform the delivery of behavioral health services for specific target populations. The councils have cross-disciplinary membership and work with system partners to respond to gaps in access to care, to explore new opportunities for collaboration, and provide system and level of care recommendations to the BHS Director. For the FY 2023-24, in addition to year-round BHAB and SOC Council engagement, stakeholder engagement efforts, as part of the CPP process, were implemented through listening sessions, focus groups, and key informant interviews to identify priority and target populations.

There were three primary types of engagement activities that the UCSD Health Partnership team in collaboration with BHS facilitated as part of the FY 2023-24 community engagement process. Activities included: 1) Key informant interviews; 2) Focus Groups; and 3) Listening Sessions. Key informant interviews were conducted with identified key personnel in the San Diego community who have been working in the behavioral health field, along with target populations. UCSD in partnership with BHS identified the individuals for the key informant interviews.

Focus group participants were comprised of providers, community advocates, community groups, and consumers. Listening sessions were defined as instances where representatives of the UCSD Health Partnership developed and conducted structured feedback activities in all the regions at varying event locations (i.e., existing community meetings, libraries, County events, etc.) regarding behavioral health service needs, opportunities, and concerns as well as the preferred mechanisms for communication and engagement. These listening sessions took a variety of forms and reached a diverse range of audiences across all six HHSA regions, with an overarching goal of having the UCSD Health Partnership "go to" (either virtually or in-person) the places and spaces all around the county to facilitate their ability to provide essential input. Full details of the CPP can be found in the Community Engagement Report in Appendix F.

MHSA ANNUAL UPDATE REVIEW AND PUBLIC COMMENT PERIOD

A draft of the Annual Update for FY 2024-25 will be posted on the BHS website from April 2 through May 2, 2024, for public review and comments. The draft Annual Update will be sent to BHS stakeholders, including the San Diego Mental Health Coalition, Mental Health Contractors Association, and hospital partners for review and comment.

The County's Behavioral Health Advisory Board (BHAB) is comprised of consumers, family members, prevention specialists, and professionals from the mental health and substance use disorder fields who represent each of the five County Supervisorial districts. BHAB will hold a public hearing on May 2, 2024, at the conclusion of the 30-day public review and comment period for the MHSA Annual Update.

Stakeholder comments on the FY 2024-25 Annual Update will be available in Appendix Q. The MHSA Issue Resolution Process for filing and resolving stakeholder concerns related to the Community Program Planning and ensuring consistency between program implementation and approved plans, is available in Appendix G.

MHSA FUNDED PROGRAMS

The sections below summarize accomplishments in FY 2022-23 and budgetary changes from the MHSA Three-Year Plan for programs in FY 2023-24 through 2024-25. Changes are outlined for each of the five MHSA components, including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Needs (CFTN). A detailed budget by component can be found in Appendix A.

COMMUNITY SERVICES AND SUPPORTS (CSS)

CSS provides comprehensive services for children, youth, families, adults, and older adults experiencing SMI or SED. CSS programs enhance the mental health system of care resulting in the highest benefit to the client, family, and community, with a focus on unserved and underserved populations. In FY 2024-25, the estimated total budget for CSS programs is $214,479,530.

Up to $7 million of CSS funds annually will be transferred to the Workforce Education and Training (WET) component in FY 2024-25 and 2025-26 to continue funding programs identified in the WET section of this report.

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

As required by the California Code of Regulations (CCR), Title 9, Division 1, Chapter 14, Article 6, Section 3620 (c), each county "*shall direct the majority of its Community Services and Supports funds to the Full-Service Partnership Service Category.*" FSP programs account for a majority of the MHSA CSS budget in FY 2024-25.

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

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

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

CSS Programs for Children, Youth, and Families

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

Full- Service Partnerships (FSP) programs for children include school-based outpatient services, walk-in assessments, mobile assessment teams, medication support, intensive mental health services, case management, referrals and linkages, and assessments and interventions for people with co-occurring disorders. The Full- Service Partnerships FY 2022-23 outcome report for children and adolescents is available in Appendix I.

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

In FY 2024-25, the estimated total MHSA budget for CY-FSP programs is $64,091,906. In FY 2024-25, the estimated annual cost per client served in CY-FSP programs is $7,569 inclusive of all funding. The estimated number of clients to be served is 8,468.

HIGHLIGHTS FROM FY 2022-23:

Children's Full-Service Partnerships (FSP) (CY-FSP)

A countywide, community-based children's outpatient FSP mental health program is designed to serve youth and TAY who are experiencing homelessness. These comprehensive services are trauma-informed, data driven, integrated, and aimed to support the mental health needs of the youth while attending to their safety and housing needs. The program provides outreach services to locate and engage homeless and runaway youth within San Diego County. In FY 2022-23, the program served 199 youth and TAY who are experiencing homelessness.

Family Therapy (CY-FSP)

The family therapy participation engagement program is a component of selected outpatient mental health clinics which uses peer support specialists with lived experience to provide education and support to caregivers of children and youth with SED. The program educates caregivers on the benefits of being actively engaged in the treatment process and works collaboratively with the family to address and resolve barriers to participation. There were 511 clients who had family engaged through this process in FY 2022-23.

Incredible Years (CY-FSP)

Incredible Years provides a full range of family focused, strength based, comprehensive, and integrated mental health services to children up to age five and their families, using the Incredible Years evidence-based program. This evidence-based program is designed to teach positive interaction skills, social problem-solving strategies, anger management, and appropriate school behaviors to young children. The programs also strengthen parent-child relationships and help parents develop positive behavior guidance strategies. The program includes parent/teacher training and treatment services for children within a preschool setting. During FY 2022-23 the program screened over 13,000 students,

> ***Incredible Years***
> ***A Personal Story***
>
> *A caregiver from a family that just moved from El Salvador was referred to the School Based Incredible Year's Parent Program. Their son was displaying behaviors that were frustrating to both parents and teachers resulting from the unsettling move, transition of daily life, and family changes within the home. The caregiver reported that she has been implementing all of the things she has learned and has had great success. Their son was referred to school site-based counseling services for additional support, and he will be engaged in the Incredible Years small groups throughout the school year.*

engaged more than 3,500 students in small groups and provided parenting support to almost 2,000 caregivers.

Wraparound Services (Wrap) - Child Welfare Services (CWS) (CY-FSP)

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth who are involved with the County HHSA Child and Family Well-Being (CFWB) or Probation, and their families. The program provides team-based care planning and coordination of needs and services to facilitate the youth in returning home from a group-care setting or staying in their home. During FY 2022-23, the program served 339 clients.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

Wraparound Services (Wrap) - Child Welfare Services (CWS) (CY-FSP)

Wraparound programs provide highly individualized, strengths-based intensive case management services to youth who are involved with CFWB or Probation, and their families. The program provides team-based care planning and coordination of needs and services to facilitate the youth in returning home from a group-care setting or staying in their home. In FY 2024-25 the budget decreased by $310,997 due to cost savings from program redesign of services and a decrease in clients served.

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

As of FY 2024-25, no programs remain in CY-OE funding as programs have been transferred to other funding components.

HIGHLIGHTS FROM FY 2022-23:

Parent Partner Services (CY-OE)

Family & Youth Partnership Program (FYPP) provides supportive behavioral health services to residents in the Southeastern region of San Diego County which includes case management, support and education groups, community resource fairs, and focus groups to learn about the community needs. They also provide linkage to behavioral health treatment and education services. By providing linkage to services, the program can prevent clients from entering higher levels of care by engaging youth and their families before mental health issues arise. In FY 2022-23, 179 youth received case management services.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

Parent Partner Services (CY-OE)

Family & Youth Partnership Program (FYPP) provides supportive behavioral health services to residents in the Southeastern region of San Diego County which includes case management, support and education groups, community resource fairs, and focus groups to learn about the community needs. They also provide linkage to behavioral health treatment and education services. By providing linkage to services, the program can prevent clients from entering higher levels of care by engaging youth and their families before mental health issues arise. In FY 2024-25, the budget decreased by $349,812 due to restructuring the workplan from Outreach and Engagement (CY-OE) to School-based Prevention and Early Intervention Youth & Family Support Services (SA-03).

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

In FY 2024-25, the estimated total MHSA budget for CY-SD programs is $22,972,259; the estimated cost per client served in CY-SD programs is $6,831 inclusive of all funding; and the estimated number of clients is 3,363.

HIGHLIGHTS FROM FY 2022-23:

Commercially Sexually Exploited Children (CSEC) (CY-SD)

The CSEC program serves youth that are at risk for, or currently a victim of, commercial sexual exploitation and have mental health or co-occurring substance use recovery needs. Individuals have access to individual, group and/or family therapy with psychiatric medication management seven days a week. These drop-in centers offer supportive services such as caregiver support groups, internship programs, and peer support. The program provides a safe place for youth to receive behavioral health and supportive services. In FY 2022- 23, the program served 119 youth at risk for or currently a victim of being commercial sexual exploitation.

County Of San Diego - Juvenile Forensic Services (CY-SD)

The Juvenile Forensic Services Stabilization, Treatment and Transition (STAT) Team provides a full range of mental health services to SED youth currently on probation. The STAT Team services are designed to meet the individual need of the youth's family and cultural dynamics. The goals of the team, in addition to providing crisis mental health services, are to maximize successful transitions into the community, to reduce recidivism, and improve mental health outcomes. In FY 2022-23, the STAT team received a total of 7,472 referrals for clinical services for the youth at both the East Mesa and the Youth Transition Campus(es). The referrals resulted in a total of 14,223 clinical visits/sessions from the STAT clinicians either Licensed Mental Health Counselors, Sr. Clinical Psychologists, Clinical Psychologists and 2,536 services from the STAT team psychiatrists.

Juvenile Forensic Services - A Personal Story

An extraordinary transformation in a youth at Youth Transition Campus (YTC) who was initially resistant to therapy was made. The young individual's journey took a remarkable turn when dedicated STAT clinicians tirelessly pursued his engagement, leading to the development of a robust therapeutic bond. The youth decided to proactively reshape his life. Breaking ties with his gang, he earned his high school diploma and completed a successful furlough with his family. With newfound skills and experiences from the YTC, he made conscious, positive choices. Staying connected with his STAT clinicians, he proudly communicates his continued disassociation from the gang lifestyle. This success story stands as a testament to the transformative power of resilience, support, and the pursuit of positive change in the lives of the youth we serve.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

Acculturation Services (CY-SD)

Acculturation Services are provided to Middle-Eastern students to facilitate adjustment at school and in a new cultural environment. Outreach and welcoming groups are lead on school campuses with connection to behavioral health treatment when indicated. In FY 2024-25 the budget for this new program is $52,000.

Adolescent Day Rehabilitation (CY-SD)

Adolescent day rehabilitation provides a specialized curriculum within a congregate-care setting for foster youth that offers independent living skills. These services support the youths' transition into adulthood by increasing their knowledge of community resources, providing employment development services, teaching life skills, and encouraging self-sufficiency. In FY 2024-25, the budget decreased by $100,000 due to the program ending.

Crisis Action And Connection (CAC) (CY-SD)

The Crisis Action and Connection program provides children and youth who have had a recent acute psychiatric episode with intensive support and linkage to services and community resources. This program improves access to, and benefits of, mental health services to children, youth, and their families, which helps to divert or prevent use of acute services. The overall program was strengthened through two MHSA components known as Rapid Response and Intensive Respite. Rapid Response partners with PERT to expedite deployment of clinicians to support the youth and avoid escalation. Intensive respite supports the mental health needs of youth who are in a short-term respite setting. In FY 2024-25, the budget increased by $87,164

to include an online component via virtual communities to ensure accessibility for all members.

Incredible Families (CY-SD)

The Incredible Families program provides parenting support groups and outpatient mental health treatment services for children and families involved with CFWB and promotes the reunification of children with their families. The program enhances parenting skills and strengthens the bond between parent and child. Incredible Families receive all referrals from CFWB and collaborative efforts include treatment planning and outreach to support the child/youth and family goal of reunification. In FY 2024-25, the budget decreased by $83,293 due to a reduction of capacity and program redesign of services for alignment with the CFWB Family Visit Coaching model.

Peripartum Program (CY-SD)

The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program provides outpatient mental health treatment services for pregnant women and adolescents and new mothers experiencing peripartum depression or anxiety. Program services include individual, group, and family therapy, crisis intervention, case management/care coordination, medication services, peer support, and services (directly or by referral) for individuals with co-occurring mental health and substance use needs. ADAPT works closely with Public Health Nursing programs, such as the Maternal Child Health and Nurse Family Partnership, to provide comprehensive and supportive care for peripartum individuals at high risk, including offering consultations and case conferences for program participants with complex needs. ADAPT services are accessible for diverse populations, in person and by telehealth, and provided in the language of the participant and family, by bilingual staff or with professional interpreters. In FY 2024-25, the budget decreased by $505,162 due to restructuring the workplan from System Development (CY-SD) to All Ages System Development (ALL-SD).

Placement Stabilization Services (CY-SD)

Placement Stabilization Services provides case management and rehabilitation services, intensive care coordination, and crisis intervention services to foster youth with the goal of stabilizing their current placement and preventing placement in a higher level of care. The programs provide supportive services to stabilize the youth’s behavior in their current placement and support the transition back to their families. Within Placement Stabilization Services program, the Comprehensive Assessment Stabilization Services (CASS) contract provides a full array of specialty mental health services for children/youth placed at County level foster homes, also known as, Resource Family Homes. Program services aim to improve the child/caregiver relationship and stabilize the placement to reduce the impact and disruption that a change in placement would have on the child/youth. The A.B. and Jessie Polinsky Children’s Center (PCC) provides a full array of specialty mental health services to children/youth placed in the County’s temporary shelter. In FY 2024-25 the budget increased by $48,825 to align with the annual contract budget increases.

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

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

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

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

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

In FY 2024-25, the estimated total MHSA budget for TAOA-FSP programs is $101,316,210, with estimated cost per client served in TAOA-FSP programs at $11,725 inclusive of all funding and the estimated number of clients to be served is 8,641.

HIGHLIGHTS FROM FY 2022-23:

Behavioral Health Court (TAOA-FSP)

Behavioral Health Court provides FSP/ACT services to adults who have been incarcerated, are misdemeanor or felony offenders, and who have been referred by the Collaborative Behavioral Health Court of the San Diego County Superior Court. The program provides intensive and community-based treatment for mental health and/or substance-induced psychiatric disorders, clinical case management, and specialized treatment. The program goal is to improve the overall quality of life and prevent recidivism into the criminal justice system. In FY 2022-23, the program served 105 clients.

CARE Act Services (TAOA-FSP)

The Community Assistance, Recovery & Empowerment (CARE) Act provides mental health and substance use disorder services to the most severely impaired individuals who are facing homelessness or incarceration without treatment. CARE is aimed at these individuals who are suffering from untreated mental health and substance use disorders leading to homelessness and/or justice involvement with access to critical behavioral health services, housing, and support through providing a comprehensive CARE plan. This new program started October 1, 2023 and fiscal year data is not yet available.

CARE Act Services
A Personal Story

An order from the court on the first day of the new program was received to complete an investigation for a 35-year-old male who was experiencing homelessness, not engaged in treatment, and had been struggling for years with symptoms of psychosis and co-occurring substance use. Through repeated phone calls and outreach attempts, staff was able to build a rapport and explain the services that he could receive through the CARE Act. He agreed to participate and completed an intake for entry into a sober living facility the same day. He has been engaging with his ACT Team daily. He has expressed willingness to receive medication management and has expressed interest in education and employment services as well.

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

Institutional Case Management provides funding to support five case management positions to a variety of County-operated programs to provide stabilization and linkage to services for individuals with SMI or SED. In FY 2022-23, the program served 827 clients.

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

County Peer Support Services provides funding for the Medi-Cal Peer Support Specialist Certification Program to ensure that Peer Support Specialists meet state standards, qualifications, and core competencies required for certification. Peers use their lived experience to support engagement, education on recovery, advocacy, and assistance with navigating the service system and accessing needed services, and resources to behavioral health clients. In FY 2022-23, the Peer Support Specialists (PSS) provided supportive services to 1,524 clients.

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

FSP/ACT programs provide intensive community-based services for persons who are homeless or at risk of homelessness, have an SMI, and who may have a co-occurring substance use disorder to achieve success and independence. These programs employ a "whatever it takes" model to help clients avoid the need for emergency services such as crisis stabilization, crisis outpatient, crisis residential, and services provided at the psychiatric hospital. ACT teams provide medication management, mental health services, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community. In Fiscal Year 2022-23, approximately 4,822 clients received services, which included medication management, rehabilitation and recovery services, employment and education support, peer support, intensive case management, and connection to an array of supportive housing options.

North Coastal Mental Health Center and Vista Clinic (TAOA-SD, TAOA-FSP)

North Coastal Mental Health Center and Vista Clinic provide outpatient mental health rehabilitation and recovery, crisis services, peer support, homeless outreach, case management, and long-term vocational support. The goal is to increase mental health services for TAY while decreasing homelessness and increasing self-sufficiency through development of life skills. In FY 2022-23, the program served 1,505 clients.

Short-Term Mental Health Intensive Case Management - High Utilizers (TAOA-FSP)

The program provides short-term, intensive case management services utilizing the ACT treatment model. Teams work toward preventing unnecessary hospitalization, improving quality of life, and improving client function. The program uses evidence-based models of intervention, such as ACT and Strength Based Case Management (SBCM). Participation in the program results in reduced hospitalizations, reduced recidivism, and improved quality of life. In FY 2022-23, the program served 155 clients.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

Adult Residential Treatment (TAOA-FSP)

The adult residential treatment program provides a broad range of services in a residential environment to assist individuals improve their quality of life and work towards independent living. These services include physical health screening and referrals to primary care professionals, wellness groups, peer support services, mentoring, and employment and education assistance. In FY 2024-25 the budget increased by $66,716 to align with the annual contract budget increases.

Behavioral Health Court (TAOA-FSP)

Behavioral Health Court provides FSP/ACT services to adults who have been incarcerated, are misdemeanor or felony offenders, and who have been referred by the Collaborative Behavioral Health Court of the San Diego County Superior Court. The program provides intensive and community-based treatment for mental health and/or substance-induced psychiatric disorders, clinical case management, and specialized treatment. The program goal is to improve the overall quality of life and prevent recidivism into the criminal justice system. In FY 2024-25 the budget increased by $85,228 to align with the annual contract budget increases.

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

Strength Based Case Management (SBCM) is designed to provide continuity of care within County-operated behavioral health service to adults, living with serious and persistent mental health and co-occurring disorders. County case managers provide psychosocial rehabilitation intervention services along with resource management to assist individuals in obtaining optimum independence. Service plans might include assistance with accessing psychiatric treatment at the appropriate level, help with housing, educational and vocational planning, crisis management, life skills training, advocacy, and linkage and referral with other services such as physical health care, government assistance, legal services, and community based spiritual supports. In FY 2024-25 the budget increased by $500,000 to expand services to include a housing component for clients.

Crisis Residential Services - North Inland (TAOA-FSP)

The North Inland Crisis Residential program is a short-term crisis residential facility with 16 beds that serves adults with SMI and co-occurring disorders. It is open twenty-four hours a day, seven days a week and provides mental health outpatient services as an alternative to hospitalization or step down from acute care within a hospital. In FY 2024-25, the budget decreased by $1,754,825 due to restructuring the workplan from Transition, Age, Youth, Adults, and Older Adults (TAOA-FSP) to Adult Crisis Residential Treatment Program (TAOA-SD)

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

FSP/ACT housing programs provide housing and supports to persons experiencing SMI who are homelessness or at-risk of homelessness. Programs offer an array of short-term, transitional, and permanent supportive-housing resources, including housing subsidies provided through partnerships with local housing authorities. Homeless-dedicated ACT programs have MHSA housing funds for rental and non-rental housing assistance, as well as dedicated housing staff such as housing coordinators and housing specialists to provide housing navigation and ongoing tenancy support services. In FY 2024-25 the budget increased by $550,795 to expand ACT services.

North Coastal Mental Health Center and Vista Clinic (TAOA-SD, TAOA-FSP)

North Coastal Mental Health Center and Vista Clinic provide outpatient mental health rehabilitation and recovery, crisis services, peer support, homeless outreach, case management, and long-term vocational support. The goal is to increase mental health services for TAY while decreasing homelessness and increasing self-sufficiency through development of life skills. In FY 2024-25, the budget decreased by $335,202 due to restructuring the MHSA workplan from TAOA-FSP to TAOA-SD.

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

In FY 2024-25, the estimated total MHSA budget for TAOA-OE programs is $2,492,544; the estimated cost per client served in TAOA-OE programs is $1,906 inclusive of all funding; and the estimated number of clients to be served is 1,308.

HIGHLIGHTS FROM FY 2022-23:

COUNTYWIDE HOMELESS OUTREACH PROGRAM (CHO) (TAOA-OE)

The County Homeless Outreach Program conducts outreach and engages persons 18 and older with serious mental illness and/or substance use conditions who are unsheltered to provide a behavioral health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources. In FY 2022-23, the program served 1,308 unique clients.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25 for TAOA-OE.

There are no budgetary changes to report.

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

In FY 2024-25, the estimated total MHSA budget for TAOA-SD programs is $152,513,556; the estimated cost per client served in TAOA-SD programs is $4,713 inclusive of all funding; and the estimated number of clients to be served is 32,361.

HIGHLIGHTS FROM FY 2022-23:

CLUBHOUSE (TAOA-SD)

Clubhouses provide rehabilitative, recovery, vocational services, and support to adults throughout the county. The program assists members with improving social skills, reducing isolation, and achieving independent functioning. Clubhouses aim to increase client self-sufficiency through the development of life skills, creating and maintaining relationships, sustaining housing, and supporting employment and education. In FY 2022-23, the program served 3,395 clients.

> ***CLUBHOUSE***
> ***A PERSONAL STORY***
> *A member had been attending The Meeting Place Clubhouse for a year and developed a reputation as a reliable kitchen helper. Staff noticed his great energy and skill with washing dishes, chopping vegetables, and keeping the kitchen team in good spirits. They encouraged him to seek work to earn money and to put his mastery in the kitchen into good use. After further encouragement, staff helped him with drafting and collecting the necessary documents. The Clubhouse has no doubts that this special member will do great in his new role as an employee.*

CRISIS STABILIZATION UNIT (CSU) - NORTH COASTAL OCEANSIDE (TAOA-SD)

The CSU North Coastal Oceanside is a 24-hour community-based CSU located at the North Coastal Live Well Health Center that provides critical care services in a non-hospital setting for individuals experiencing a psychiatric crisis to stabilize and connect them with ongoing services that meet their individual needs. In addition, the CSU is co-located with the North Coastal Mental Health Clinic, the Mariposa Clubhouse, and the McAlister North Coastal Regional Recovery Center allowing the facilitation of a warm handoff to ongoing outpatient services when appropriate. In FY 2022-23, the program served 1,739 clients.

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

The North Inland CSU at Palomar Health provides critical treatment services in a hospital-based setting adjacent to the emergency or urgent care unit at Palomar Hospital in Escondido for individuals experiencing a psychiatric crisis to stabilize and connect them to ongoing services that meet their individual needs. The CSU provides 24-hour services to vulnerable patients in a safe setting under the direct and constant supervision of behavioral health staff to reduce risk of a psychiatric hospitalization. Patients have access to emergency department services if medical crises arise. In FY 2022-23, the program served 1,433 clients.

FAITH-BASED SERVICES (TAOA-SD)

The Faith-Based Services program provides community education, and faith-based behavioral health training

and education in the North, Central, and North Central Regions, along with faith-based wellness and a mental health ministry that provides services countywide. The program focuses on client-driven services to improve functioning, quality of life by decreasing isolation, and increasing values and self-sufficiency. Faith-Based In-Reach service is a collaboration with the San Diego County Sheriff's Department and local jails that pairs a mental health clinician with a member of the clergy to provide a "bridging service" between custody and community. In FY 2022-23, the program served 1,046 clients.

NORTH INLAND MENTAL HEALTH CENTER (TAOA-SD)

The North Inland Mental Health Centers provide outpatient mental health rehabilitation and recovery services, urgent walk-in appointments, peer support services, homeless outreach, case management, and long-term vocational support services to adults with SMI, including individuals with co-occurring SUD. The program is designed to increase access to mental health services and overcome barriers such as language, wait times, and lack of knowledge or awareness of available services. In FY 2022-23, the program served 1,357 clients.

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

The Short-Term Acute Residential Treatment program provides 24-7 crisis residential services as an alternative to hospitalization or to step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have co-occurring substance use conditions, and are residents of San Diego County. In FY 2022-23, the program served 1,609 clients.

> ***SHORT-TERM ACUTE RESIDENTIAL TREATMENT (START)***
> ***A PERSONAL STORY***
>
> *The Esperanza Crisis Residential Treatment Program supported a client who was chronically homeless who uses a wheelchair and is cognitively impaired from a stroke. The client suffered from significant learned helplessness and hopelessness- making it very difficult for him to get assistance. He had been turned away from various programs due to being non-ambulatory and unable to advocate for himself. Esperanza staff was able to find him supportive housing geared towards individuals with disabilities and enrolled him in an ACT program. He began asking for workbooks to challenge his mind post- stroke, believing that he now had a future worth trying to recover for. At his discharge, he told staff that he felt seen and valued by his community for the first time since needing a wheelchair several years ago.*

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

ACCULTURATION SERVICES (TAOA-SD)

The Acculturation Services program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle Eastern descent who are experiencing SMI or SED. This is a new program, and it is being implemented due to a restructuring within program and services without impact to services. The FY24- 25 budget is $264,281 and it is anticipated this program will be serving approximately 80 clients per fiscal year.

ADULT CRISIS RESIDENTIAL TREATMENT PROGRAM (TAOA-SD)

Adult Crisis Residential Treatment Programs provide short-term 24-7 crisis residential services to adults ages 18 and older as a diversion from psychiatric hospitalization or serves as a step down from in-patient care settings for acute and serious mental illness, including for those who may have co-occurring substance use disorders, and are residents of San Diego County. In FY 2024-25 the budget increased by $15,940,864 due to a funding shift from Short Term Acute Residential Treatment (START) and Crisis Residential Services – North Inland.

BIO-PSYCHOSOCIAL REHABILITATION (BPSR) (TAOA-SD)

Bio-Psychosocial Rehabilitation (BPSR) recovery centers provide a wide variety of outpatient mental health services such as rehabilitation medication management, care coordination, recovery services, and employment support at multiple locations throughout the county. BPSR program offers specific programs dedicated to TAY and older adult geriatric specialists who provide culturally and age-appropriate services.

These programs help improve the individual's level of functioning, quality of life, and housing status, as well as linkage to services, obtaining employment, and linkage to primary care services. In FY 2024-25 the budget increased by $1,399,919 for expansion of services and programs, as well as staffing increases to support BPSR.

CLUBHOUSE (TAOA-SD)

Clubhouses provide rehabilitative, recovery, vocational services, and support to adults throughout the county. The program assists members with improving social skills, reducing isolation, and achieving independent functioning. Clubhouses aim to increase client self-sufficiency through the development of life skills, creating and maintaining relationships, sustaining housing, and supporting employment and education. In FY 2024-25 the budget increased by $247,462 to include an online component for more participation from members.

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

North Coastal Mental Health Center and Vista Clinic provide outpatient mental health rehabilitation and recovery, crisis services, peer support, homeless outreach, case management, and long-term vocational support. The goal is to increase mental health services for TAY while decreasing homelessness and increasing self-sufficiency through development of life skills. In FY 2024-25 the budget increased by $501,189 to support staffing increases as well as restructuring the workplan from TAOA-FSP to TAOA-SD.

NORTH INLAND MENTAL HEALTH CENTER (TAOA-SD)

The North Inland Mental Health Centers provide outpatient mental health rehabilitation and recovery services, urgent walk-in appointments, peer support services, homeless outreach, case management, and long-term vocational support services to adults with SMI, including individuals with co-occurring SUD. The program is designed to increase access to mental health services and overcome barriers such as language, wait times, and lack of knowledge or awareness of available services. In FY 2024-25 the budget increased by $170,514 for an expansion of services as well as staffing increases.

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

The Short-Term Acute Residential Treatment program provides 24-7 crisis residential services as an alternative to hospitalization or to step down from acute in-patient care within a hospital for adults with acute and serious mental illness, including those who may have co-occurring substance use conditions, and are residents of San Diego County. In FY 2024-25 the budget decreased by $14,186,039 due to a shifting of funds to Adult Crisis Residential Treatment Program.

CSS Programs for All Ages (ALL)

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

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

In FY 2024-25, the estimated total MHSA budget for ALL-OE programs is $4,331,707; the estimated cost per client served in ALL-OE programs is $1,300, inclusive of all funding; and the estimated number of clients to be served is 3,332.

HIGHLIGHTS FROM FY 2022-23:

Behavioral Health Services - Victims of Trauma and Torture (ALL-OE)

This program improves access to mental health services for survivors of trauma and torture, and/or asylum seekers who are experiencing or at risk of SMI, including co-occurring substance use conditions or SED and are at risk of developing new or worsening behavioral symptoms. Through culturally specific outreach and education, the program goal is to increase access to, and use of, mental health services, outreach, and education to the specific population. The program is Medi-Cal Certified and provides services in 47 languages. In FY 2022-23, the program provided services to 130 unduplicated clients.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

Behavioral Health Services For Deaf & Hard Of Hearing (ALL-OE)

This program provides outpatient mental health services, case management, and integrated SUD treatment and rehabilitation services tailored to individuals with SMI who are deaf and/or hard of hearing, to achieve a more adaptive level of functioning. The program includes group or individual sessions, crisis intervention, and referrals to other community-based organizations. In FY 2024-25 the budget decreased by $365,000 as services are no longer eligible for MHSA funding.

Clubhouse - Deaf Or Hard Of Hearing (ALL-OE)

This member-operated clubhouse provides social skill development and rehabilitative, recovery, vocational, and peer support services for individuals who are experiencing SMI and are deaf or hard of hearing. In FY 2024-25 the budget increased by $31,350 to align with the annual contract budget increases.

ALL AGES - SYSTEM DEVELOPMENT (ALL-SD)

In FY 2024-25, the estimated total MHSA budget for ALL-SD programs is $20,555,169; the estimated cost per client served in ALL-SD programs is $1,957, inclusive of all funding; and the estimated number of clients to be served is 10,502.

HIGHLIGHTS FROM FY 2022-23:

Chaldean And Middle Eastern Social Services (ALL-SD)

The Chaldean and Middle Eastern Social Services program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle-Eastern descent who are experiencing SMI or SED. Children and youth with SED have access to outpatient clinical services and may be connected to acculturation groups. In FY 2022-23, the program outcomes included over 86% of clients showed clinical improvement or stabilization and 87% of clients showed functional improvement or stabilization over the previous six-month period and served 135 clients.

Psychiatric Emergency Response Team (PERT) (ALL-SD)

The PERT program partners clinicians with specially trained local police officers and deputies to ensure a more effective response to interactions involving law enforcement officers and individuals with mental illness. Teams are on-call and provide countywide services to individuals with a mental health crisis who have encounters with local law enforcement agencies and/or who need immediate mental health crisis intervention. In FY 2022-23, there were over 10,900 individuals who were experiencing a behavioral health crisis that were connected health care through PERT.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

Chaldean And Middle Eastern Social Services (ALL-SD)

The Chaldean and Middle Eastern Social Services program provides culturally competent mental health services, including outpatient clinics, case management, and linkages to services for individuals of Middle-Eastern descent who are experiencing SMI or SED. Children and youth with SED have access to outpatient clinical services and may be connected to acculturation groups. In FY 2024-25, the budget shifted $316,281 to Acculturation Services for Children and Youth – System Development (CY-SD) and TAY, Adults and Older Adults – System Development (TAOA-SD).

Peripartum Program (ALL-SD)

The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program provides outpatient mental health treatment services for pregnant women, adolescents and new mothers experiencing peripartum depression or anxiety. Program services include individual, group, and family therapy, crisis intervention, case management/care coordination, medication services, peer support, and services for individuals with co-occurring mental health and substance use needs. ADAPT works closely with Public Health Nursing programs such as Maternal Child Health and Nurse Family Partnership to provide comprehensive and supportive care for peripartum individuals at high risk, including offering consultations and case conferences for program participants with complex needs. ADAPT services are accessible for diverse populations, in person and by telehealth. The FY 24-25 budget is $711,555 and is anticipated to serve approximately 100 clients per fiscal year.

CSS Proposed Expenditure Plan and Estimated Cost Per Client

The table below represents the estimated cost per client for FY 2024-25, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA CSS Work Plan	FY 2024-25 Proposed Budget (All Funding)	FY 2024-25 Estimated Number of Clients Served					FY 2024-25 Estimated Cost Per Client
		Children	TAY	Adult	OA	Total	
CY-FSP	$ 66,073,409	7,405	1,091	-	-	8,496	$ 7,777
CY-SD	$ 25,871,787	2,425	1,088	-	-	3,513	$ 7,365
TAOA-FSP	$ 122,635,253	-	940	5,542	2,306	8,788	$ 13,955
TAOA-OE	$ 2,492,544	-	-	1,308	-	1,308	$ 1,906
TAOA-SD	$ 159,749,913	-	5,683	30,298	2,993	38,973	$ 4,099
ALL-OE	$ 4,331,707	1,628	543	1,132	29	3,332	$ 1,300
ALL-SD	$ 24,461,830	1,637	1,421	5,612	1,832	10,502	$ 2,329
Total CSS	**$ 405,616,443**	**13,095**	**10,766**	**43,892**	**7,160**	**74,912**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included.
- The FY 2024-25 estimated cost per client figures are based on the total proposed FY 2024-25 budget divided by the actual number of clients broken down by population served in FY 2022-23, plus the estimated new clients to be served in served in FY 2024-25. FY 2022-23 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figure will vary by service and contract base on the contracted rate, level of care, and number of clients.
- The annual projected unique clients for FY 2024-25 will vary from the number of unique clients served in Appendix H, I and J because some programs no longer exist, and new programs will be added in FY 2024-25. Additionally, clients may receive one or more different services, so there may be duplication of clients across work plans.

PREVENTION AND EARLY INTERVENTION (PEI)

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

In FY 2024-25, the estimated total budget for PEI programs is $51,167,156. As required by MHSA, a majority of funding for PEI programs must be directed to programs that serve persons less than 25 years of age. In FY 2024-25, this requirement will be met with nearly 60% percent of the budget for PEI programs budgeted for programs serving persons less than 25 years of age.

A detailed budget for PEI may be found in Appendix A. The FY 2022-23 PEI system-wide summary report can be found in Appendix L. A summary of the estimated cost per client is available at the end of the PEI section.

HIGHLIGHTS FROM FY 2022-23:

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

Check Your Mood is an annual event held the first Thursday in October in conjunction with National Depression Screening Day which engages and encourages San Diegans to monitor and assess their emotional well-being. Organizations across the San Diego region come together to provide free mental health resources, information, and Check Your Mood screenings to the community which helps to raise awareness and reduces the stigma related to mental health. BHS and other County staff partnered with local businesses, healthcare agencies, community partners, and volunteers to provide these services at 62 sites throughout the county.

COMMUNITY-BASED SERVICES - FOR OLDER ADULTS (OA-01)

The Elder Multicultural & Support Services (EMASS) program convenes Promotores, members of the community who are leaders in social circles and who are experienced working with people experiencing SMI in underserved communities, including Filipino, Latino, African refugee, African American, and Middle Eastern. The Promotores are trained by professionals to provide outreach and engagement to older adults, and engage them in group and individual activities, including recreation, exercise, mental health education, and counseling to prevent mental illness. EMASS provides referrals to multilingual mental health providers, transportation services, and translation services during medical and mental health appointments. In FY 22-23, EMASS served 1,988 seniors with PEI services. The program was selected as part of the California Master Plan for Aging webinar series.

MENTAL HEALTH FIRST AID (PS-01)

The Mental Health First Aid program provides individuals the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The program provides countywide, community-based education and training services. In FY 22-23, the program trained 3,807 community members.

Positive Parenting Program (Triple P) (EC-01)

The Positive Parenting Program is a training class which strengthens skills for parents with children in Head Start, Early Head Start and elementary school settings, who are exhibiting behavioral and/or emotional challenges. Families requiring specialty mental health services are linked directly to services and remain connected after completing the program and have the opportunity for individual consultations for up to six months. Through education and training, the program reduces child abuse, mental illness, behavioral and emotional problems, delinquency, and school failure. In FY 22-23, despite continued impacts of the pandemic and public health orders in place, the Positive Parenting Program provided services for over 5,514 parents and/or caregivers.

School-Based Prevention & Early Intervention (SA-01)

The School-Based PEI program utilizes a family-focused approach and evidenced-based curriculum to provide social-emotional support groups for children in preschool up to third grade who struggle with emotional and behavioral issues, and their parents. The services are provided in elementary schools in all six HHSA regions. Services include screening, child skill groups, parent skill groups, classroom skill lessons, community linkage and referrals, and outreach and engagement. During FY 22/23 the program screened over 13,000 students and provided small groups to more than 3,500 students, additionally providing parenting support to almost 2000 caregivers.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

ACEs Prevention Parenting Program for Fathers (PS-01)

The Adverse Childhood Experiences (ACEs) Prevention Parenting Program for Fathers (Father2Child) provides a best practice parenting program to unserved and underserved fathers that enhances fathering knowledge, skills, and positive attitudes while reducing mental health stigma. In FY 2024-25 the budget increased by $502,990 to increase services as well as staffing increases.

Alliance for Community Empowerment (DV-03)

Alliance for Community Empowerment (ACE) is a community response-team program that engages siblings of identified gang members to teach and encourage resiliency. The ACE team members engage children and youth in schools, recreational centers, and their homes. Parents are also engaged and supported with various activities which increase resilience, coping skills, and improve overall quality of life. In FY 2024-25 the budget increased by $90,000 to provide increase services and hiring of additional staff members.

County of San Diego-Community Health & Engagement (PS-01)

Staff responsible for community health and engagement efforts within HHSA Department of Homeless Solutions and Equitable Communities (HSEC) and Aging & Independence Services (AIS), in partnership with BHS staff, serve as community ambassadors for behavioral health PEI activities and initiatives. Staff collaborate with BHS to identify and address community priorities and programming gaps and, subsequently, develop and coordinate population-specific and/or region-specific community activities. Tailored activities promote resources to increase community awareness, literacy, and utilization of services that support mental health and wellness, suicide prevention, substance use prevention, harm reduction, and stigma reduction. Staff also conduct activities related to key observances such as Check Your Mood Day, May is Mental Health Matters Month, International Overdose Awareness Day, Recovery Happens, and Suicide Prevention Awareness Month among others. In FY 2024-25 the budget increased by $33,311 for continuity of services.

County of San Diego Youth Suicide Reporting and Crisis Response Pilot To Care (PS-01)

The Youth Suicide Reporting and Crisis Response Pilot program aims to develop and test models for rapidly reporting and responding to suicides and suicide attempts among youth under 25. San Diego County was selected due to having the second highest youth suicide count and rate in the state from 2018-2020. This program allows the County to enhance existing suicide prevention and crisis response efforts, such as improving data surveillance, implementing emergency department peer support programs, increasing outreach and behavioral health trainings, and enhancing coordination between partners. The budget for this new program for FY 2024-25 is $2,379,200.

Early Intervention for Prevention of Psychosis (FB-01)

The Kickstart program identifies and trains community leaders to identify the indicators of early psychosis. These leaders refer teens and young adults with potential behavioral health issues to clinicians who provide crisis intervention, treatment, individual and group therapy, and in-home services. Additionally, these youth can be transitioned to outpatient programs if needed. Early treatment of behavioral health issues results in increased well-being, school success, family involvement, improved functioning, and the reduction of hospitalizations. In FY 2024-25 the budget increased by $202,896 to align with the annual contract budget increases as well adding services to North and South regions. Additionally, a budget of $397,776 was shifted from INN and ARPA to MHSA-PEI.

Family Peer Support Program (PS-01)

The Family and Adult Peer Support programs, Friends in the Lobby and In Our Own Voice, provide outreach and awareness through training and the dissemination of education materials in primary care, senior centers, faith-based forums, and other venues. Individuals with lived experience promote social and emotional wellness for adults, older-adults, and their families who are visiting individuals that have been hospitalized in psychiatric units. The programs reduce stigma and discrimination, increase acceptance of mental illness and awareness of treatment choices, and increase access and use of available services, especially in unserved and underserved communities. Volunteers engage individuals, offer support, and answer questions in hospital lobbies throughout the County. In FY 2024-25 the budget increased by $11,512 for continuity of services.

Mental Health First Aid (PS-01)

The Mental Health First Aid program provides individuals the skills to help someone who is developing a mental health problem or experiencing a mental health crisis. The program provides countywide, community-based education and training services. In FY 2024-25 the budget increased by $177,810 for continuity of services and increased operational and staffing cost.

Native American Prevention and Early Intervention (Dream Weaver) (NA-01)

The Dream Weaver program is a partnership with three Native American health clinics that joins cultural practices with evidence-based practices. It operates on reservations and in urban areas and provides education and outreach at community events, cultural and social gatherings, and health clinics. The program provides information on available mental health services and behavioral health issues to prevent mental illness and promote wellness activities in American Indian/Alaska Native communities and increases involvement in child abuse prevention activities. In FY 2024-25 the budget increased by $454,337 to align with the annual contract budget increases.

Recuperative Services and Support Program for Transitional Age Youth (PS-01)

This program provides short-term recuperative services and supports (up to 120 days) for Transition

Age Youth ages 18-25 who have been diagnosed or are at risk of developing SMI, including those who may be experiencing their first episode of psychosis and may have a co-occurring substance use disorder. Program aids with Instrumental Activities of Daily Living (ADLs), coordination of transportation for appointments, connection to services including employment, education, psychiatric assessments, and reduction of stigma associated with mental health condition. In FY 2024-25 the budget increased by $1,398,678 for the addition of beds and increased operational and staffing costs.

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

The Rural Integrated Behavioral Health and Primary Care Services program provides prevention and early intervention services through mobile outreach. The program increases access to services by providing assessments and education to individuals with SMI or SED living in the rural areas of San Diego County. The Roaming Outpatient Access Mobile (ROAM) team has continued to provide medical, dental, and behavioral health services to Native Americans residing on reservations in rural San Diego County. In FY 2024-25 the budget increased by $410,679 for increased service costs as well as expansion of services.

SCREENING TO CARE (SA-01)

Screening to Care is a School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Early intervention is provided through group sessions on school campuses to strengthen student's social emotional wellness, with care coordination offered to students who need connection to behavioral health treatment. Promotores work to engage the parents to cultivate connections and foster a positive school environment. In FY 2024-25 this new program received a budget of $6,400,000 due to the shifting of funding from American Rescue Plan Act to MHSA.

SUPPORTED EMPLOYMENT TECHNICAL CONSULTANT SERVICES (PS-01)

The Supported Employment Technical Consultant services program provides technical expertise and consultation on countywide employment development, partnership, engagement, and funding opportunities for adults with SMI. Services are coordinated and integrated through BHS to develop new employment resources. In FY 2024-25 the budget increased by $148,310 to expand the Individual Placement and Support (IPS) model across the system of care and to include an IPS trainer to align with the program's learning community requirements.

VETERANS & FAMILY OUTREACH EDUCATION (VF-01)

The Courage to Call program provides confidential outreach, education, peer counseling, referrals, and support services to veterans and their families to increase awareness of mental illness and reduce mental health risk factors. Services are provided to veterans and their family members. In FY 2024-25 the budget increased by $174,669 to align with the annual contract budget increases.

YOUTH & FAMILY SUPPORT SERVICES (SA-03)

Youth & Family Support Services program offers early intervention services to residents in the Southeastern region of San Diego County which includes focus groups to learn about the community needs, case management, support and education groups, and community resource fairs. The program provides linkage to community resources and behavioral health treatment when indicated through an identified screening process. The services provided are structured to prevent clients from entering higher levels of care by engaging youth and their families through early intervention services. in FY 2024-25 the budget increased by $653,236 to align with the annual contract budget increases as well as expansion of staff and services and shifting of funds from CY-OE.

The table below represents the estimated cost per client for FY 2024-25, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

PEI Proposed Expenditure Plan and Estimated Cost Per Client

MHSA PEI Work Plan	Population Served	FY 2024-25 Proposed Budget (All Funding)	FY 2024-25 Estimated Number of Clients Served	FY 2024-25 Estimated Cost Per Client
CO-03 Integrated Peer & Family Engagement - Next Steps	ALL	$ 3,158,045	2,545	$ 1,241
DV-03 Community Violence Services - Alliance for Community Empowerment	Children, Youth	$ 998,712	735	$ 1,359
DV-04 Community Services for Families - Child Welfare Services	Children, Youth	$ 504,408	202	$ 2,497
EC-01 Positive Parenting Program (Triple P)	Children, Youth	$ 1,395,098	5,514	$ 253
FB-01 Early Intervention for Prevention of Psychosis	Children, TAY	$ 2,396,578	489	$ 4,898
NA-01 Native American Prevention and Early Intervention	ALL	$ 2,586,021	4,906	$ 527
OA-01 Elder Multicultural Access & Support Services (EMASS)	OA	$ 574,162	1,988	$ 289
OA-02 Home Based Services - For Older Adults	OA	$ 583,652	1,273	$ 458
OA-06 Caregiver Support for Alzheimer & Dementia Patients	Adults, OA	$ 1,090,271	75,000	$ 15
PS-01 Education and Support Lines	ALL	$ 16,555,419	27,027	$ 613
RC-01 Rural Integrated Behavioral Health and Primary Care Services	ALL	$ 2,137,434	915	$ 2,336
RE-01 Independent Living Association (ILA)	TAY, Adults, OA	$ 302,640	-	
SA-01 School Based Prevention and Early Intervention	Children, Youth	$ 13,173,195	19,415	$ 679
SA-02 School Based Suicide Prevention & Early Intervention	Children, Youth, TAY	$ 2,478,136	14,664	$ 169
SA-03 Youth & Family Support Services	Children, Youth	$ 658,984	199	$ 3,311
VF-01 Veterans & Family Outreach Education	ALL	$ 1,596,596	2,662	$ 600
Total PEI		**$ 50,189,351**	**157,534**	

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs and PEI assigned funds are not included.
- The following program does not have client count data
    - RE-01: Independent Living Association
- The FY 2024-25 estimated cost per client figures are based on the total proposed FY 2024-25 budget divided by the actual number of clients served in FY 2022-23, plus the estimated new clients to be served in FY 2024-25. FY 2022-23 is the most recent full year of data available.
- The estimated average cost per client is a summary of the work plan. The figure will vary by service and contract based on the contracted rate, level of care, and number of clients.
- The annual projected unique clients for FY 2024-25 will vary from the number of unique clients served in Appendix L.

INNOVATION (INN)

Innovation projects are short-term, novel, creative mental health practices or approaches that contribute to learning. INN programs require data analysis and evaluation services to assess client and system outcome measures. Budget funds are allocated for program evaluation and services are provided by UCSD Child and Adolescent Services Research Center and/or UCSD Health Services Research Center. In FY 2024-25, the estimated INN expenditures will be $17,401,800. A detailed budget for INN may be found in Appendix A. The Innovation Report can be found in Appendix N.

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

HIGHLIGHTS FROM FY 2022-23:

TELEMENTAL HEALTH (INN-19)

Telemental Health provides 24/7 mental health treatment via electronic devices for tele-therapy to children, youth and adults who frequently use psychiatric emergency services and are not connected to a mental health provider. The goal is to reduce re-hospitalization and psychiatric emergency services for individuals by connecting them to mental health services via tele-therapy. In FY 2022-23, these services were provided to 146 individuals, reducing the use of psychiatric emergency services. A total of 206 persons were served in FY 2022-23, including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23.

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

PERIPARTUM PROGRAM (INN-18)

The Peripartum Program provides outreach and engagement to new or expecting parents with mood and anxiety disorders to reduce and manage postpartum depression and anxiety. The Accessible Depression and Anxiety Peripartum Treatment (ADAPT) model identifies at-risk peripartum women for engagement and provides services for women and their partner. Referrals to ADAPT from public health nursing programs were substantially reduced as public health resources were largely diverted to address the COVID-19 emergency. ADAPT responded by expanding referral sources to include hospitals and birthing centers and transitioned to telehealth to maintain client access to services. In FY 2024-25, the budget decreased by $505,162 due to the project study ending.

TELEMENTAL HEALTH (INN-19)

Telemental Health provides 24/7 mental health treatment via electronic devices for tele-therapy to children, youth and adults who frequently use psychiatric emergency services and are not connected to a mental health provider. The goal is to reduce re-hospitalization and psychiatric emergency services for individuals by connecting them to mental health services via tele-therapy. In FY 2024-25, the budget decreased by $1,100,000 due to the Innovation funding ending. Services have been integrated into existing system of care for specialized peripartum services.

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

The Early Psychosis Evaluation and Learning Health Care Network program was an INN program approved by the Mental Health Services Oversight and Accountability Commission (MHSOAC) in FY 2018-19. It was a statewide collaborative led by the University of California, Davis, Behavioral Health Center of Excellence in partnership with other universities and multiple California counties. It provided clinicians the opportunity to

share and discuss outcomes with clients immediately upon completion, allowed programs to learn from each other through a training and technical assistance collaborative, and allowed the State to participate in the development of a national network to inform and improve care for individuals with early psychosis. In FY 2024-25, the project ended and the remaining budget of $199,867 was shifted to KickStart.

Public Behavioral Health Workforce Development and Retention Program (INN-25)

The Public Behavioral Health Workforce Development and Retention Program will implement strategies and incentives to address unmet needs within the region by recruiting, training, and retaining a diverse public behavioral health workforce. This program will distribute and monitor the use of funding to support individuals seeking a variety of training, tuition support, upskilling and incentive opportunities designed to attract and retain workers in the public behavioral health field. In FY 2024-25, the budget for this new program is $15,000,000.

INN Estimated Cost Per Client

The table below represents the estimated cost per individual for FY 2024-25, including all revenue sources. MHSA, Realignment, Federal Financial Participation (FFP) and other revenue sources are represented in the proposed budget since they are comingled within services.

MHSA INN Work Plan	Population Served	FY 2024-25 Proposed Budget (All Funding)	FY 2024-25 Estimated Number of Individuals	FY 2024-25 Estimated Cost Per Individual
INN-25 Public Behavioral Health Workforce Development and Retention Program	ALL	$ 15,132,000	570	$ 26,547
Total INN		**$ 15,132,000**	**570**	**$ 26,547**

Assumptions:

- Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.
- The proposed funding and cost per client estimates are inclusive of all direct funding within the programs. Figures may include MHSA, Realignment, Federal Financial Participation (FFP), and other funding. Administrative costs are not included.

WORKFORCE EDUCATION AND TRAINING (WET)

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

In FY 2024-25, the estimated WET expenditures will be $7,633,450. Annually, up to $7 million in CSS funds will be transferred to the WET component to continue funding programs. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually.

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

HIGHLIGHTS FROM FY 2022-23:

TRAINING AND TECHNICAL ASSISTANCE (WET-02)

The Regional Training Center (RTC) provides training to behavioral health and contracted behavioral health staff focused on emerging topics and specific populations. The goal of the RTC is to leverage expert trainers who provide knowledge, skill-based trainings, or subject matter expertise in short-term and responsive formats to meet staff and program needs. In FY 2022-23, the trainings and conferences facilitated through RTC were attended by over 1,000 individuals. Notable focuses of these trainings include Racial Equity, Early Childhood Mental Health, and Care Coordination.

PUBLIC MENTAL HEALTH ACADEMY (WET-03)

The Public Mental Health Academy (PMHA) at San Diego City College was established in 2010 with funds provided through the MHSA WET to address the shortage and lack of diversity in mental health service providers. The PMHA facilitates workforce development and career pathways in public mental health by offering coursework leading to a Mental Health Work Certificate of Achievement (MHWCA) as well as academic counseling services, conferences, and workshops. During the 2022-2023 academic year, 51 new students were enrolled in the PMHA/Mental Health Work Certificate program with 28 students completing the certificate, contributing to 412 total graduates since program inception. There are currently 502 students enrolled in the program. There were over 451 academic counseling appointments provided to individuals for ongoing support and guidance.

> ***PUBLIC MENTAL HEALTH ACADEMY***
> ***A PERSONAL STORY***
>
> *I cannot express enough gratitude for the exceptional support and care I received from the moment I arrived. Dawn made me feel heard, understood, and valued. She spent ample time addressing my concerns and articulating a blueprint for my academic success. She is an empathetic listener who offers insightful advice. Her dedication to the well-being of her students is truly apparent, and I am grateful to have the opportunity to work with her, and look forward to her keen assistance. Dawn is a true asset to our school community and a shining example of what a school counselor should be. Thank you for all that you do.*

ENHANCEMENTS AND CHANGES FOR FYS 2023-24 AND 2024-25:

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

The Behavioral Health Training Curriculum provides training and technical assistance to behavioral health and contracted behavioral health staff on trauma informed care, cultural competency, and mental health/substance use co-occurring disorders and primary care/behavioral health integration. Training is

provided in-person and virtually via eLearning and webinar. In FY 2024-25 the budget increased by $228,155 to align with the annual contract budget increases.

***Cultural Competency Academy* (WET-02)**

The Cultural Competency Academy (CCA) provides training to behavioral health and contracted behavioral health staff focused on multicultural populations. The goal of the CCA is to provide awareness, knowledge, and skill-based trainings, while ensuring the information provided is trauma informed. In FY 2024-25 the budget increased by $45,000 for continuity of services.

***Community Psychiatry Fellowship* (WET-04)**

The UCSD Community Psychiatry Program places psychiatric mental health nurse practitioner (PMHNP) trainees side-by-side with psychiatry residents throughout the entire program. This program was created to address the shortage of psychiatrists working in public behavioral health. The goal is to engage psychiatry residents to continue their fellowship within public behavioral health. In FY 2024-25 the budget increased by $474,400 for program enhancements to include workforce training and psychiatry residency programs.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

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

In FY 2024-25, the estimated CFTN expenditures will be $9,000,000 as reported in Appendix A.

HIGHLIGHT AND CHANGES FOR FYS 2023-24 AND 2024-25:

EAST REGION CRISIS STABILIZATION UNIT (CSU) (CF-6)

In May 2024, an Amendment to the MHSA Three-Year plan will be presented to the County of San Diego Board of Supervisors for approval. The Amendment allocates funding for CFTN in the amount of $10,000,000 for the construction and development of the East Region Crisis Stabilization Unit.

MHSA DATA COLLECTION AND ANALYSIS

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

OPTUM SAN DIEGO

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

UCSD CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

UCSD HEALTH SERVICES RESEARCH CENTER

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

CASRC and HSRC works in collaboration with BHS to evaluate and improve behavioral health outcomes for county residents. Aspects of the outcomes and service demographics are referenced throughout this MHSA Report with full reports in Appendices I, J, L and N.

APPENDICES

APPENDIX A

MHSA EXPENDITURE PLAN

FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan

Funding Summary

County: San Diego

	A	B	C	D	E	F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve	Totals
A. Estimated FY 2024/25 Funding							
1. Estimated Unspent Funds from Prior Fiscal Years	$ 29,119,715	$ 69,642,528	$ 52,055,114	$ 2,379,763	$ 9,000,000	$ 33,478,186	$ 195,675,307
2. Estimated New FY2024/25 Funding [1]	$ 161,164,907	$ 40,291,227	$ 10,602,954	$ -	$ -	$ -	$ 212,059,088
3. Transfers in FY2024/25 [2]	$ (7,000,000)	$ -	$ -	$ 7,000,000	$ -	$ -	$ -
4. Access Local Prudent Reserve in FY2024/25	$ -	$ -	$ -	$ -	$ -	$ -	$ -
5. Estimated Available Funding for FY2024/25	$ 183,284,622	$ 109,933,755	$ 62,658,069	$ 9,379,763	$ 9,000,000	$ 33,478,186	$ 407,734,395
B. Estimated FY2024/25 MHSA Expenditures	**$ 214,479,530**	**$ 51,167,156**	**$ 17,401,800**	**$ 7,633,450**	**$ 9,000,000**	**$ -**	**$ 299,681,937**
C. Estimated FY2024/25 Unspent Fund Balance *	**$ (31,194,908)**	**$ 58,766,599**	**$ 45,256,269**	**$ 1,746,313**	**$ -**	**$ 33,478,186**	**$ 108,052,458**

*Above figures reflect projected receipts and the proposed budget. Figures are not reflective of actual expenditures, which have historically resulted in savings due to maximized FFP drawdown.
Additional FFP revenue is anticipated to become available through the implementation of Medi-Cal Transformation, which began on 7/1/23. Though not reflected within FFP estimates above, it is likely that payment reform will generate additional revenue that is likely to offset use of MHSA CSS funding.
Expenditures and projected receipts will be monitored closely throughout the year and adjustments to spending will be made as needed.

		Prudent Reserve Detail	
D. Estimated Local Prudent Reserve Balance	**Total**	*CSS*	*PEI*
1. Estimated Local Prudent Reserve Balance on June 30, 2024	$ 33,478,186	$ 26,712,351	$ 6,765,835
2. Contributions to the Local Prudent Reserve in FY 2024/25	$ -	$ -	$ -
3. Distributions from the Local Prudent Reserve in FY 2024/25	$ -	$ -	$ -
4. Estimated Local Prudent Reserve Balance on June 30, 2025	$ 33,478,186	$ 26,712,351	$ 6,765,835

(1) Balances projected utilize State consultant revenue estimates as of January 2024.
(2) Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Note: Figures are rounded to the nearest whole number and therefore may not exactly add up to the total.

Highlights

• A reassessment of the Prudent Reserve is required every five years under Senate Bill (SB) 192, Chapter 328 of the Statutes of 2018, and the Department of Health Care Services (DHCS). A detailed methodology and assessment of Prudent Reserve for FY2024-25 can be found on page 10 & 11 of the MHSA Annual report.

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
CY-FSP Full Service Partnerships for Children & Youth						
Children's Full Service Partnership (FSP)	$ 3,232,630	$ 1,206,361	$ 1,741,549	$ -	$ 284,720	$ -
Children's School Based Full Service Partnership (FSP)	$ 47,220,949	$ 12,257,280	$ 30,627,136	$ -	$ 4,336,532	$ -
Family Therapy	$ 1,086,895	$ 661,180	$ 425,716	$ -	$ -	$ -
Incredible Years	$ 932,131	$ 355,664	$ 576,467	$ -	$ -	$ -
Therapeutic Behavioral Services (TBS)	$ 4,907,812	$ 2,825,703	$ 2,082,109	$ -	$ -	$ -
Wraparound Services (WRAP) - Child Welfare Services (CWS)	$ 6,711,489	$ 1,644,977	$ 3,174,065	$ -	$ 1,892,446	$ -
TAOA-FSP Full Service Partnerships for Children & Youth						
Adult Residential Treatment	$ 1,065,082	$ 1,065,082	$ -	$ -	$ -	$ -
Assisted Outpatient Treatment (AOT)	$ 1,441,696	$ 599,566	$ 842,130	$ -	$ -	$ -
Behavioral Health Court	$ 2,985,384	$ 454,931	$ 2,030,453	$ -	$ 500,000	$ -
CARE Court Services	$ 2,017,600	$ 2,017,600	$ -	$ -	$ -	$ -
County of San Diego - Institutional Case Management (ICM)	$ 692,787	$ 456,403	$ 40,385	$ -	$ 196,000	$ -
County of San Diego - Peer Support Services	$ 255,512	$ 255,512	$ -	$ -	$ -	$ -
County of San Diego - Probation	$ 605,280	$ 244,604	$ -	$ -	$ 360,676	$ -
County of San Diego - Strengths Based Case Management (SBCM)	$ 788,949	$ 788,949	$ -	$ -	$ -	$ -
County of San Diego - Strengths Based Case Management (SBCM) - Housing	$ 504,400	$ 129,400	$ 375,000	$ -	$ -	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	$ 63,363,126	$ 29,104,090	$ 29,155,355	$ -	$ 5,103,681	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	$ 17,332,268	$ 16,503,995	$ 385,556	$ -	$ 442,717	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	$ 2,030,706	$ 1,011,454	$ 1,019,253	$ -	$ -	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	$ 2,127,623	$ 359,198	$ 1,768,424	$ -	$ -	$ -
Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	$ 3,861,028	$ 2,701,668	$ 1,049,360	$ -	$ 110,000	$ -
Short-Term Mental Health Intensive Case Management - High Utilizers	$ 751,005	$ 367,827	$ 383,178	$ -	$ -	$ -
Strengths Based Case Management (SBCM)	$ 1,493,763	$ 1,000,043	$ 493,720	$ -	$ -	$ -
Total Full Service Partnership (FSP) Programs	**$ 165,408,116**	**$ 76,011,489**	**$ 76,169,855**	**$ -**	**$ 13,226,772**	**$ -**
Non-FSP Programs						
All-OE Outreach & Engagement for All Ages						
Behavioral Health Services - Victims of Trauma and Torture	$ 994,023	$ 910,100	$ 83,923	$ -	$ -	$ -
Behavioral Health Services and Primary Care Integration Services	$ 1,562,089	$ 1,562,089	$ -	$ -	$ -	$ -
Clubhouse - Deaf or Hard of Hearing	$ 471,600	$ 471,600	$ -	$ -	$ -	$ -
Psychiatric and Addiction Consultation and Family Support Services	$ 1,303,994	$ 1,303,994	$ -	$ -	$ -	$ -
All-SD System Development for All Ages						
Chaldean and Middle-Eastern Social Services	$ 306,270	$ 97,674	$ 208,596	$ -	$ -	$ -
Mobile Crisis Response Team (MCRT)	$ 8,776,721	$ 7,065,225	$ 36,456	$ -	$ 1,675,040	$ -
Peripartum Program	$ 717,816	$ 303,693	$ 414,123	$ -	$ -	$ -
Psychiatric Emergency Response Team (PERT)	$ 10,754,362	$ 7,006,627	$ -	$ -	$ 3,747,735	$ -
CY-OE Outreach & Engagement for Children & Youth	$ -	$ -	$ -	$ -	$ -	$ -
CY-SD System Development for Children & Youth						
Acculturation Services	$ 52,458	$ 52,458	$ -	$ -	$ -	$ -
Administrative Services Organization (ASO) - TERM	$ 2,853,200	$ 2,853,200	$ -	$ -	$ -	$ -

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
BridgeWays Program	$ 564,928	$ 218,975	$ 121,953	$ -	$ 224,000	$ -
Commercially Sexually Exploited Children (CSEC)	$ 1,250,912	$ 507,569	$ 243,343	$ -	$ 500,000	$ -
County of San Diego - Juvenile Forensic Services	$ 1,109,680	$ 1,109,680	$ -	$ -	$ -	$ -
Crisis Action and Connection	$ 2,552,647	$ 537,842	$ 1,500,942	$ -	$ 513,864	$ -
Emergency Screening Unit (ESU)	$ 5,897,179	$ 363,792	$ 3,616,940	$ -	$ 1,916,448	$ -
Incredible Families	$ 1,877,303	$ 674,040	$ 411,577	$ -	$ 791,686	$ -
Medication Clinic	$ 1,552,543	$ 947,309	$ 605,234	$ -	$ -	$ -
Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	$ 1,957,072	$ 1,103,102	$ 253,970	$ -	$ 600,000	$ -
Placement Stabilization Services	$ 2,838,587	$ 1,007,864	$ 1,830,723	$ -	$ -	$ -
Rural Integrated Behavioral Health and Primary Care Services	$ 141,810	$ 91,810	$ -	$ -	$ 50,000	$ -
Supplemental Security Income (SSI) Advocacy Services	$ 302,640	$ 182,640	$ -	$ -	$ 120,000	$ -
Telemedicine	$ 21,300	$ 21,300	$ -	$ -	$ -	$ -
TAOA-OE Outreach & Engagement for Ages 18-60+						
Countywide Homeless Outreach Program	$ 2,492,544	$ 1,998,384	$ -	$ -	$ 494,160	$ -
TAOA-SD System Development for Ages 18-60+						
Acculturation Services	$ 266,607	$ 266,607	$ -	$ -	$ -	$ -
Adult Crisis Residential Treatment Program	$ 16,081,144	$ 2,296,070	$ 10,390,526	$ -	$ 3,394,547	$ -
Augmented Services Program (ASP)	$ 12,802,322	$ 11,152,322	$ -	$ -	$ 1,650,000	$ -
Behavioral Health Assessors	$ 691,028	$ 387,028	$ -	$ -	$ 304,000	$ -
Bio-Psychosocial Rehabilitation (BPSR)	$ 48,273,518	$ 23,506,449	$ 17,403,802	$ -	$ 7,363,267	$ -
Clubhouse	$ 5,333,466	$ 5,119,707	$ 213,759	$ -	$ -	$ -
Consumer Advocacy	$ 1,266,704	$ 817,721	$ -	$ -	$ 448,984	$ -
Crisis Stabilization - North Coastal Oceanside	$ 7,666,880	$ 5,130,525	$ 2,536,355	$ -	$ -	$ -
Crisis Stabilization - North Coastal Vista	$ 7,631,363	$ 4,546,284	$ 3,085,080	$ -	$ -	$ -
Crisis Stabilization - North Inland	$ 10,245,258	$ 1,181,236	$ 7,829,880	$ -	$ 1,234,142	$ -
Crisis Stabilization - South	$ 7,628,401	$ 1,599,592	$ 4,591,137	$ -	$ 1,437,672	$ -
Faith Based Services	$ 1,464,037	$ 1,464,037	$ -	$ -	$ -	$ -
Family Education	$ 1,045,769	$ 1,045,769	$ -	$ -	$ -	$ -
In-Home Outreach Teams (IHOT)	$ 4,288,276	$ 4,288,276	$ -	$ -	$ -	$ -
Inpatient and Residential Advocacy Services	$ 723,541	$ 723,541	$ -	$ -	$ -	$ -
Institutional Case Management (ICM) - Older Adults	$ 1,118,526	$ 716,274	$ 201,044	$ -	$ 201,208	$ -
Justice System Discharge Planning	$ 1,149,403	$ 779,403	$ -	$ -	$ 370,000	$ -
Mental Health Advocacy Services	$ 446,644	$ 446,644	$ -	$ -	$ -	$ -
No Place Like Home BHS	$ 525,520	$ 317,146	$ -	$ -	$ 208,374	$ -
No Place Like Home Dept Pub Works Envir Svcs Unit	$ 27,742	$ 3,742	$ -	$ -	$ 24,000	$ -
No Place Like Home Housing & Community Dev Svcs	$ 1,209,708	$ 340,864	$ -	$ -	$ 868,844	$ -
North Coastal Mental Health Center and Vista Clinic	$ 6,692,959	$ 2,832,953	$ 3,860,006	$ -	$ -	$ -
North Inland Mental Health Center	$ 6,882,594	$ 2,826,920	$ 4,055,674	$ -	$ -	$ -
Peer Assisted Support Services	$ 900,853	$ 900,853	$ -	$ -	$ -	$ -
Public Defender - Behavioral Health Assessor	$ 242,112	$ 146,112	$ -	$ -	$ 96,000	$ -
San Diego Employment Solutions	$ 1,990,288	$ 1,535,119	$ -	$ -	$ 455,169	$ -
San Diego Housing Commission	$ 121,056	$ 109,056	$ -	$ -	$ 12,000	$ -
Short-Term Bridge Housing	$ 1,519,434	$ 1,519,434	$ -	$ -	$ -	$ -

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Supplemental Security Income (SSI) Advocacy Services	$ 504,400	$ 504,400	$ -	$ -	$ -	$ -
Telemedicine	$ 464,570	$ 439,570	$ -	$ -	$ 25,000	$ -
Tenant Peer Support Services	$ 3,309,433	$ 3,157,831	$ -	$ -	$ 151,602	$ -
Total Non-Full Service Partnership (FSP) Programs	**$ 202,865,236**	**$ 110,492,451**	**$ 63,495,044**	**$ -**	**$ 28,877,741**	**$ -**

	A	B	C	D	E	F
CSS Administration	$ 27,975,591	$ 27,975,591	$ -	$ -	$ -	$ -
CSS MHSA Housing Program Assigned Funds	$ -	$ -	$ -	$ -	$ -	$ -
Total CSS Program Estimated Expenditures	**$ 396,248,943**	**$ 214,479,530**	**$ 139,664,899**	**$ -**	**$ 42,104,514**	**$ -**
FSP Programs as Percent of Total	77.1%					

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego

	Fiscal Year 2024/25						
	A	B	C	D	E	F	
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding	PEI Category
PEI Programs							
1. CO-03 Integrated Peer & Family Engagement	$ 3,158,045	$ 2,908,045	$ -	$ -	$ 250,000	$ -	P
2. DV-03 Alliance for Community Empowerment	$ 998,712	$ 998,712	$ -	$ -	$ -	$ -	P
3. DV-04 Community Services for Families - Child Welfare Services	$ 504,408	$ 504,408	$ -	$ -	$ -	$ -	P
4. EC-01 Positive Parenting Program (Triple P)	$ 1,395,098	$ 955,098	$ -	$ -	$ 440,000	$ -	P
5. FB-01 Early Intervention for Prevention of Psychosis	$ 2,396,578	$ 701,877	$ 1,334,094	$ -	$ 360,607	$ -	EI
6. NA-01 Native American Prevention and Early Intervention	$ 2,586,021	$ 1,847,098	$ -	$ -	$ 738,922	$ -	P
7. OA-01 Community-Based Services for Older Adults	$ 574,162	$ 346,500	$ -	$ -	$ 227,661	$ -	P
8. OA-02 Home Based Services - For Older Adults	$ 583,652	$ 583,652	$ -	$ -	$ -	$ -	P
9. OA-06 Caregiver Support for Alzheimer & Dementia Patients	$ 1,090,271	$ 1,090,271	$ -	$ -	$ -	$ -	P
10. PS-01 Education and Support Lines							P / S&D / O
ACEs Prevention Parenting Program for Fathers	$ 2,113,930	$ 2,113,930	$ -	$ -	$ -	$ -	
Breaking Down Barriers	$ 441,653	$ 441,653	$ -	$ -	$ -	$ -	
Clubhouse Services Program	$ 504,400	$ 504,400	$ -	$ -	$ -	$ -	
Come Play Outside	$ 504,400	$ 504,400	$ -	$ -	$ -	$ -	
County of San Diego - Community Health & Engagement	$ 910,955	$ 910,955	$ -	$ -	$ -	$ -	
County of San Diego - Youth Suicide Reporting and Crisis Response Program	$ 2,400,137	$ 213,845	$ -	$ -	$ 2,186,292	$ -	
Family Peer Support Program	$ 211,920	$ 211,920	$ -	$ -	$ -	$ -	
Mental Health First Aid	$ 803,237	$ 752,470	$ -	$ -	$ 50,767	$ -	
Recuperative Services and Support Program for Transitional Age Youth	$ 2,257,921	$ 1,802,266	$ -	$ -	$ 455,655	$ -	
Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	$ 5,320,444	$ 5,320,444	$ -	$ -	$ -	$ -	
Suicide Prevention Action Plan	$ 717,663	$ 717,663	$ -	$ -	$ -	$ -	
Supported Employment Technical Consultant Services	$ 368,758	$ 368,758	$ -	$ -	$ -	$ -	
11. RC-01 Rural Integrated Behavioral Health and Primary Care Services	$ 2,137,434	$ 2,137,434	$ -	$ -	$ -	$ -	P / EI
12. RE-01 Independent Living Association (ILA)	$ 302,640	$ 302,640	$ -	$ -	$ -	$ -	O
13. SA-01 School Based Program							P / EI
School Based Prevention and Early Intervention	$ 6,716,875	$ 6,716,875	$ -	$ -	$ -	$ -	
Screening to Care	$ 6,456,320	$ 6,456,320	$ -	$ -	$ -	$ -	
14. SA-02 School Based Suicide Prevention & Early Intervention	$ 2,478,136	$ 2,478,136	$ -	$ -	$ -	$ -	SP
15. SA-03 Youth & Family Support Services	$ 658,984	$ 658,984	$ -	$ -	$ -	$ -	EI
16. VF-01 Veterans & Family Outreach Education	$ 1,596,596	$ 1,596,596	$ -	$ -	$ -	$ -	A
PEI Categories A - Access to Treatment EI - Early Intervention O - Outreach P - Prevention S&D - Stigma & Discrimination SP - Suicide Prevention Individual programs may serve more than one area							
PEI Administration	$ 6,621,803	$ 6,621,803	$ -	$ -	$ -	$ -	
PEI Assigned Funds	$ 400,000	$ 400,000	$ -	$ -	$ -	$ -	
Total PEI Program Estimated Expenditures	**$ 57,211,154**	**$ 51,167,156**	**$ 1,334,094**	**$ -**	**$ 4,709,904**	**$ -**	

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated INN Funding ***	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
INN Programs						
1. INN-18 Peripartum Services	$ -	$ -	$ -	$ -	$ -	$ -
2. INN-19 Telemental Health	$ -	$ -	$ -	$ -	$ -	$ -
3. INN-20 Roaming Outpatient Access Mobile (ROAM) Services	$ -	$ -	$ -	$ -	$ -	$ -
4. INN-21 Recuperative Services Treatment (ReST) Recuperative Housing	$ -	$ -	$ -	$ -	$ -	$ -
5. INN-22 Medication Clinic	$ -	$ -	$ -	$ -	$ -	$ -
6. INN-24 Early Psychosis and Learning Health Care Network	$ -	$ -	$ -	$ -	$ -	$ -
7. INN-25 Public Behavioral Health Workforce Development and Retention Program	$ 15,132,000	$ 15,132,000	$ -	$ -	$ -	$ -
* Up to 5% for evaluation is embedded in Estimated INN Funding						
INN Administration	$ 2,269,800	$ 2,269,800	$ -	$ -	$ -	$ -
Total INN Program Estimated Expenditures	**$ 17,401,800**	**$ 17,401,800**	**$ -**	**$ -**	**$ -**	**$ -**

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. WET-02 Training & Technical Assistance	$ 3,069,236	$ 3,069,236	$ -	$ -	$ -	$ -
2. WET-03 Mental Health Career Pathway Programs	$ 100,880	$ 100,880	$ -	$ -	$ -	$ -
3. WET-04 Residency and Internship Program	$ 4,463,335	$ 4,463,335	$ -	$ -	$ -	$ -
WET Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total WET Program Estimated Expenditures	**$ 7,633,450**	**$ 7,633,450**	**$ -**	**$ -**	**$ -**	**$ -**

Appendix A
FY 2024-25 Annual Update Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	**Estimated CFTN Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
CFTN Programs - Capital Facilities Projects						
1. CF-2 North County Mental Health Facility	$ -	$ -	$ -	$ -	$ -	$ -
2. CF-4 North Inland Crisis Residential Facility	$ -	$ -	$ -	$ -	$ -	$ -
3. CF-5 Emergency Screening Unit (ESU) Facility	$ -	$ -	$ -	$ -	$ -	$ -
4. CF-6 East Region Crisis Stabilization Unit (CSU)	$ 9,000,000	$ 9,000,000	$ -	$ -	$ -	$ -
CFTN Programs - Technological Needs Projects						
1. SD-3 Personal Health Record	$ -	$ -	$ -	$ -	$ -	$ -
2. SD-5 Telemedicine Expansion	$ -	$ -	$ -	$ -	$ -	$ -
CFTN Administration	$ -	$ -	$ -	$ -	$ -	$ -
Total CFTN Program Estimated Expenditures	**$ 9,000,000**	**$ 9,000,000**	**$ -**	**$ -**	**$ -**	**$ -**

APPENDIX B

CERTIFICATIONS AND MINUTE ORDER

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: San Diego

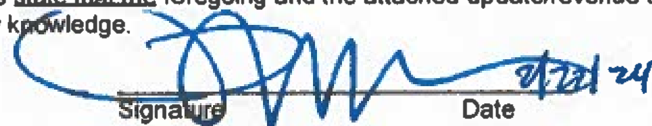
- ☐ Three-Year Program and Expenditure Plan
- ☑ Annual Update
- ☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Luke Bermann, Ph. D.	Name: Julie Bjerke, CPA
Telephone Number: 619-563-2766	Telephone Number: 858-694-2216
E-mail: Luke.Bergmann@sdcounty.ca.gov	E-mail: JulieL.Bjerke@sdcounty.ca.gov
Local Mental Health Mailing Address: 3255 Camino Del Rio South, San Diego, CA 92108	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Luke Bermann, Ph. D.
Local Mental Health Director (PRINT)

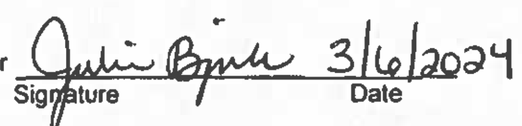


Signature Date 2/22/24

I hereby certify that for the fiscal year ended June 30, 2023, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 11/21/23 for the fiscal year ended June 30, 2023. I further certify that for the fiscal year ended June 30, 2023, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Julie Bjerke, CPA, Financial Accounting and Reporting Manager
County Auditor Controller / City Financial Officer (PRINT)



Signature Date 3/6/2024

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

MHSA COUNTY COMPLIANCE CERTIFICATION

County: San Diego

Local Mental Health Director	Program Lead
Name: Luke Bermann, Ph. D.	Name: Nadia Privara Brahms
Telephone Number: 619-563-2766	Telephone Number: 619-846-1032
E-mail: Luke.Bergmann@sdcounty.ca.gov	E-mail: Nadia.Privara@sdcounty.ca.gov
County Mental Health Mailing Address: 3255 Camino Del Rio South, San Diego, CA 92108	

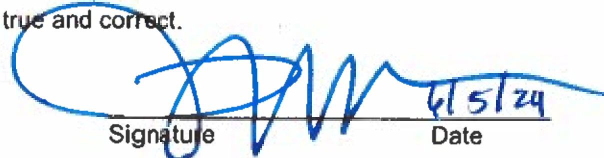
I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 4, 2024.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Luke Bergmann, Ph. D.
Local Mental Health Director/Designee (PRINT)



Signature — Date: 6/5/24

County: San Diego

Date: ____________________

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: County of San Diego

Fiscal Year: FY 2024-25

Local Mental Health Director

Name: Luke Bergmann, Ph.D.

Telephone: (619) 515-6923

Email: Luke.Bergmann@sdcounty.ca.gov

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

Luke Bergmann, Ph.D.	LUKE BERGMANN, Ph.D., Director — Digitally signed by LUKE BERGMANN, Ph.D., Director Date: 2024.03.08 11:12:58 -08'00'	
Local Mental Health Director (PRINT NAME)	Signature	Date

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

DHCS 1819 (02/19)

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, JUNE 04, 2024

MINUTE ORDER NO. 16

SUBJECT: RECEIVE AND APPROVE THE MENTAL HEALTH SERVICES ACT ANNUAL UPDATE FOR FISCAL YEAR 2024-25 (DISTRICTS: ALL)

OVERVIEW

The Mental Health Services Act (MHSA) provides ongoing dedicated funding to counties to address a broad continuum of mental health service needs, including prevention, early intervention, system development, technology, and training to effectively support the public mental health system. MHSA programs provide services for children and their families, transition age youth, adults, and older adults, with an emphasis on individuals who are unserved or underserved. MHSA is comprised of five components, including 1) Community Services and Supports; 2) Prevention and Early Intervention; 3) Innovation; 4) Workforce Education and Training; and 5) Capital Facilities and Technological Needs.

County of San Diego, Behavioral Health Services is in the second year of implementing the MHSA Three-Year Program and Expenditure Plan for Fiscal Years (FY) 2023-24 through 2025-26 (Three-Year Plan), previously approved by the San Diego County Board of Supervisors (Board) on June 13, 2023 (22). The MHSA FY 2024-25 Annual Update (Annual Update) includes budget and programmatic changes to the Three-Year Plan. The Annual Update includes MHSA funding of $299.7 million in FY 2024-25. It also includes $400,000, dedicated to the California Mental Health Services Authority, to continue participation in statewide prevention and early intervention campaigns and local initiatives. A majority of services outlined in the Annual Update are a continuation of programs previously approved by the Board in the Three-Year Plan. As mandated by the MHSA, the Three-Year Plan and Annual Update require Board approval prior to submission to the California Mental Health Services Oversight and Accountability Commission (MHSOAC) and the Department of Health Care Services (DHCS).

Today's action requests the Board receive and approve the Annual Update and to submit to the MHSOAC and the DHCS, if approved. Today's action also supports the County vision of a just, sustainable, and resilient future for all, specifically for communities and populations in San Diego County that have been historically left behind, as well as our ongoing commitment to the regional *Live Well San Diego* vision of healthy, safe, and thriving communities.

RECOMMENDATION(S)
CHIEF ADMINISTRATIVE OFFICER

Receive and approve the Mental Health Services Act Annual Update for Fiscal Year 2024-25 and authorize the Agency Director, Health and Human Services Agency, to submit the Annual Update to the California Mental Health Services Oversight and Accountability Commission and the Department of Health Care Services.

EQUITY IMPACT STATEMENT

The vision of the Mental Health Services Act (MHSA) is to build a system in which mental health services are equitable and accessible to all individuals and families within the region who are in need. According to 2021 data from the California Department of Healthcare Access and Information, Black or African American residents experienced higher emergency department rates of serious mental illness,

self-inflicted injury/suicide attempt, and substance related disorders, compared to others. Additionally, according to the California Health Interview Survey, conducted by University of California Los Angeles in 2022, nine percent of San Diegans reported experiencing serious psychological distress in the past month. However, higher percentages of serious psychological distress were reported by residents who live below 200% of the federal poverty level, had a history of incarceration, or identified as Black or African American, Hispanic/Latino, Asian, or multiracial, compared to others.

MHSA funding provides individuals, who are experiencing serious mental illness, serious emotional disturbance, or have co-occurring substance use disorders, including those with opioid use disorder, with timely access to quality behavioral health care that is responsive to their cultural and linguistic needs. County of San Diego (County), Behavioral Health Services (BHS) serves a diverse range of vulnerable, unserved, and underserved low-income populations who include, but are not limited to, all age groups, individuals experiencing homelessness, LGBTQ+, Black or African American, Indigenous, and People of Color. Behavioral health services offered through County-operated and contracted programs address the social determinants of health by being accessible, capable of meeting the needs of a diverse population, and with the intent to equitably distribute services to those most in need.

In support of these efforts, BHS utilizes a population health approach, along with evidence-based practices and robust data analysis to identify needs and design services that are impactful, equitable, and yield meaningful outcomes for clients. This includes facilitating community engagement forums to solicit input from the community, stakeholders, consumers, family members, community-based providers, and healthcare organizations through formal and informal convenings, along with cross-collaboration with other County departments and community partners.

SUSTAINABILITY IMPACT STATEMENT

Mental Health Services Act (MHSA) programs support the County of San Diego (County) Sustainability Goal #1 to engage the community in meaningful ways and seek stakeholder input to foster inclusive and sustainable communities. County, Behavioral Health Services engages the community through the Community Planning Process, advisory boards, and stakeholder engagements to collaborate and encourage community and diverse range of stakeholders to partner and participate in decisions that impact their lives and communities.

Additionally, MHSA programs support the County Sustainability Goal #2 to provide just and equitable access through the regional distribution of services by allowing chronically unserved and underserved communities and individuals with behavioral health conditions to receive care near where they live. Services are provided at County locations, as well as through community-based providers to ensure care is geographically dispersed throughout the region.

FISCAL IMPACT

Funds for this request are included in the Fiscal Year (FY) 2024-26 CAO Recommended Operational Plan for the Health and Human Services Agency. If approved, this request will result in estimated Mental Health Services Act (MHSA) costs and revenues of approximately $299.7 million in FY 2024-25, inclusive of $400,000 dedicated to the California Mental Health Services Authority, to continue participation in statewide prevention and early intervention campaigns and local initiatives. The funding source is MHSA. There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT
N/A

ACTION:
ON MOTION of Supervisor Vargas, seconded by Supervisor Anderson, the Board of Supervisors took action as recommended.

AYES: Vargas, Anderson, Lawson-Remer, Montgomery Steppe, Desmond

State of California)
County of San Diego) §

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

ANDREW POTTER
Clerk of the Board of Supervisors

Signed by Andrew Potter

APPENDIX C

MHSA
PROGRAM
SUMMARIES

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	ALL-OE	Behavioral Health Services - Victims of Trauma and Torture	Survivors of Torture International (SOTI) Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC)	An outpatient Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) that is a Short-Doyle Medi-Cal (SD/MC) certified Mental Health Clinic in the County of San Diego Health and Human Services Agency. Provides services countywide to residents of San Diego, age 18+, who experienced trauma and torture in their home countries and/or their journey to the United States, including refugees and/or asylum seekers, and have a serious mental illness (SMI), including those who may have a co-occurring substance use disorder.	Improve access to mental health services and provide culturally appropriate outreach and education to persons with a serious mental illness or emotional disturbance who have been victims of torture. Provide referrals for victims of trauma and torture who are indigent and do not meet medical necessity.	Transition Age Youth (TAY) aged 18-25, adults aged 26-59, and older adults aged 60+ of uninsured, unserved individuals with a Serious Emotional Disturbance (SED) and Serious Mental Illness (SMI) who are victims of trauma and torture.	• Bio-psychosocial rehabilitation services recovery • Urgent Walk-In • Culturally appropriate outreach, engagement, assessment, case management/brokerage, rehabilitation, crisis intervention, medication management, therapy, and mobile outreach	Survivors of Torture International PO Box 371104 San Diego, CA 92137 (619) 278-2400	All
CSS	ALL-OE	Behavioral Health Services and Primary Care Integration Services	Behavioral Health and Primary Care Integration Services	Provides enhanced screening, brief intervention and referral to treatment through a collaborative care model for adult patients identified with behavioral health needs based on screenings at primary care sites.	Provide brief, effective, evidence-based treatment and increase access to behavioral health care in a primary care setting.	Adults 18 years and older.	• Mental health assessment • Dual diagnosis screening information • Brief mental health services • Linkages to services as needed	Community Clinic Health Network dba Health Quality Partners 3710 Ruffin Rd San Diego, CA 92123 (619) 542-4300	All
CSS	ALL-OE	Clubhouse - Deaf or Hard of Hearing	Recovery and Skills for Deaf and Hard of Hearing/Clubhouse	Recovery and skill center/clubhouse for the deaf or hard of hearing.	Assist clients who are deaf and hard of hearing to achieve a more adaptive level of functioning.	Transition Age Youth (TAY), adults/older adults, who are deaf or hard of hearing who have or are at risk of a serious mental illness or co-occurring disorder.	• Member-operated recovery and skill development clubhouse program • Services include social skill development, rehabilitative, recovery, vocational and peer support. • Advocacy to the priority population in accessible language	Deaf Community Services of San Diego Inc. 1545 Hotel Circle S., Suite 300 San Diego, CA 92108 (619) 398-2437 2240 Cleveland Ave National City CA 91950 (619) 618-0501	4
CSS	ALL-OE	Psychiatric and Addiction Consultation and Family Support Services	Psychiatric and Addiction Consultation and Family Support Program	Provides psychiatric, addiction consultation, and family support services for primary care and pediatric providers who serve patients with Medi-Cal or who are uninsured, youth under the age of 21, and caregivers in San Diego County.	Enhance primary care and behavioral health providers' levels of competence, confidence, and capacity to assess and appropriately treat clients with behavioral health needs; improve identification and treatment of behavioral health issues in youth, including suicide and overdose risk; provide education, referrals, and linkages to support youth and families.	Children, Transition Age Youth.	• Psychiatric and addiction consultation • Client education, referral, and linkage to services	Vista Hill Foundation 8825 Aero Dr, #315 San Diego, CA 92123 (858) 956-5906	All
CSS	ALL-SD	Chaldean and Middle-Eastern Social Services	Chaldean and Middle-Eastern Social Services (Adult)	Outpatient mental health clinic provides treatment, rehabilitation, and recovery services to adults 18 years and older who have a serious mental illness, including those who may have a co-occurring substance use disorder.	Provide culturally competent treatment, services, and referrals for individuals who are Middle Eastern and who experience mental health issues or a serious mental illness.	Adults 18 years and older and eligible for Medi-Cal funded services.	• Outpatient mental health clinic which provides treatment, rehabilitation, and recovery services • Referrals and linkage support	Chaldean and Middle-Eastern Social Services 875 El Cajon Blvd. El Cajon, CA 92020 (619) 662-4100	2
CSS	ALL-SD	Mobile Crisis Response Team (MCRT)	Regional Mobile Crisis Response Team	The MCRT is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis.	The goal of the MCRTs is to respond to community (non-911calls) urgent/emergency calls, provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care. These services are performed by trained clinicians and peers in the field.	Services to individuals experiencing a behavioral health crisis in the community, including adults and older adults, children, youth, and families in the community.	Provide crisis intervention for individuals in a behavioral health crisis and connect them to the most appropriate level of care. The MCRTs are available 24 hours/7 days per week.	Telecare Corp 409 Camino Del Rio South, Suite 201, San Diego, CA 92108 619-346-8484	3, 5
CSS	ALL-SD	Psychiatric Emergency Response Team (PERT)	Psychiatric Emergency Response Team (PERT)	The Psychiatric Emergency Response Team (PERT) is made up of a licensed mental health clinician and a PERT trained law enforcement officer. Together, they seek to de-escalate a mental health emergency and, when possible, redirect the individual to mental health services instead of hospitalization or incarceration.	Improve collaboration between mental health providers and law enforcement officers with the goal of more humane and effective handling of incidents between law enforcement officers and those who are mentally ill and developmentally disabled.	Children, Transition Age Youth, Adults/Older Adults, with a focus on veterans, homeless populations.	• Case coordination • De-scalation and crisis intervention services • Training for law enforcement personnel	Community Research Foundation (CRF) 1202 Morena Blvd., Suite 300 San Diego, CA 92110 (619) 275-0892	All
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Connections Community Counseling	Engage homeless and runaway youth to increase access to mental health services and family reunification. Individual/group/family services provided at schools, community, or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to homeless children, youth, and their families.	Homeless children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	North County Lifeline Inc. Connections Community Counseling 4180 Ruffin Rd Ste 295 San Diego CA 92123 (760) 842-6202	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	CY-FSP	Children's Full Service Partnership (FSP)	Foster Family Agency Stabilization and Treatment (FFAST)	Outpatient diagnostic and treatment services for children and youth who require specialty mental health services and reside in the County of San Diego Foster Family Agency (FFA) homes. Services includes the oversight of Therapeutic Foster Care (TFC) services, including the provision of specific Specialty Mental Health Services.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21, involved in Child & Family Well-Being (formerly Child Welfare Services) and reside in Foster Family Agency homes, who meet medical necessity and serious emotional disturbance criteria.	• Individual/group/family treatment • Care coordination • Intensive Home-Based Services • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement • Therapeutic Foster Care	San Diego Center for Children - FFAST 2655 Camino Del Rio N Suite 450 San Diego, CA 92108 (858) 277-9550 North County 145 Vallecitos de Oro, Suite 210 San Marcos, CA 92069 (858) 633-4115	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Para Las Familias	Individual/group/family services provided at pre-schools, home, or office/clinic location. Utilizing a team approach and when indicated, offers case management, and peer support.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children up to age 5 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Outreach and engagement	Episcopal Community Services Para Las Familias 1424 30th St., Suite A San Diego, CA 92154 (619) 565-2650	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mi Escuelita South Region School Based	Individual/group/family services provided at schools, pre-schools, home, community or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Merit Academy (East Region)	Day School Services provides individual, group and family services at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Vista Hill Foundation 1600 N. Cuyamaca St. El Cajon, CA 92020 (619) 994-7860	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Youth Enhancement Services (YES) School Based	Individual/group/family services provided at schools, home, community or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	San Ysidro Health Center Youth Enhancement Services 1666 Precision Park Lane, San Diego, CA 92173 (619) 428-5533	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Crossroads	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Crossroads Family Center 700 N. Johnson Ave, Suite P El Cajon, CA 92020 (619) 441-1907	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Douglas Young	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach and when indicated, offer case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Douglas Young Youth and Family Services 7917 Ostrow St., Suite A San Diego, CA 92111 (858) 300-8282	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Housing Case Management/Monarch Supportive Housing	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment. Housing case management component for children and families in the Monarch program.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who may attend a Juvenile Court and Community School (JCCS) and meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Mobile Adolescent Services Team 1260 Morena Blvd., Suite 200 San Diego, CA 92110 (619) 398-3261	All
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Mobile Adolescent Services Team (MAST)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment. Housing case management component for children and families in the Monarch program	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who may attend a Juvenile Court and Community School (JCCS) and meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Mobile Adolescent Services Team 1260 Morena Blvd., Suite 200 San Diego, CA 92110 (619) 398-3261	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Nueva Vista	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client - and family - focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement	Community Research Foundation Nueva Vista Family Services 1161 Bay Blvd., Suite B Chula Vista, CA 91911 (619) 585-7686	1
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community Circle Central & East	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Family Health Centers - Logan Heights 2130 National Ave. San Diego, CA 92113 (619) 255-7859 3845 Spring Dr. Spring Valley, CA 91977 (619) 255-5444	1, 2, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Community and School Based Counseling Services (CSBCS)	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Mental Health Systems Inc. School Based Program 4660 Viewridge Ave. San Diego, CA 92123 (858) 278-3292	3, 4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Cornerstone	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Pathways Cornerstone School Based Outpatient Treatment 6244 El Cajon Blvd., Suite 14 San Diego, CA 92115 (619) 640-3269	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central Region Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-5832	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Children's Mental Health (CMH) School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Union of Pan Asian Communities (UPAC) Children's Mental Health 1031 25th St., Suite C San Diego, CA 92102 (619) 232-6454	4, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	TIDES	Individual/group/family services provided at schools, home, community or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	YMCA-TIDES 4394 30th St. San Diego, CA 92104 (619) 543-9850	4
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North County Outpatient School-Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	New Alternatives Inc 1529 Grand Ave. Suite A San Marcos CA 92078 (760) 798-0299	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Oceanside & Vista School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	North County Lifeline - Vista 200 Michigan Ave. Vista, CA 92084 (760) 726-4900 North County Lifeline - Oceanside 707 Oceanside Blvd. Oceanside, CA 92054 (760) 757-0118	3, 5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland/North Coastal & Fallbrook School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 120 West Hawthorne St. Fallbrook, CA 92028 (760) 731-3235 945 Vale Terrace Dr Vista CA 92084	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Coastal Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, peer support, and/or co- occurring substance treatment.	Provide a full range of client-and-family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Coastal 3605 Vista Way, Suite 258 Oceanside, CA 92056 (760) 758-1480	3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	North Inland Outpatient Psychiatry	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital North Inland 2125 W. Citacado Pkwy., Suite 200 Escondido, CA 92025 (760) 294-9270	2, 3, 5
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Family Wellness Center - East County Outpatient Program	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment. PCIT utilized when indicated.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Center for Children East Region Outpatient 6386 Alvarado Ct Suite 310 San Diego CA 92120 (619) 668-6200 2655 Camino del Rio South San Diego, CA 92108	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	East County Behavioral Health Clinic	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offer case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity...	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	San Diego Youth Services 1870 Cordell Ct., Suite 101 El Cajon, CA (619) 448-9700	2
CSS	CY-FSP	Children's School Based Full Service Partnership (FSP)	Central East South Region (CES) School Based	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Vista Hill Foundation - Escondido 1029 N. Broadway Ave. Escondido, CA 92026 (760) 489-4126 Vista Hill Foundation - North Inland Ramona 1012 Main St., Suite 101 Ramona, CA 92065 (760) 788-9724	1, 2, 4
CSS	CY-FSP	Family Therapy	Family Therapy Participation	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Rady Children's Hospital Central-East-South 3665 Kearny Villa Rd., Suite 101 San Diego, CA 92123 (858) 966-8471	2
CSS	CY-FSP	Family Therapy	Family Therapy Participation	Individual/group/family services provided at schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance treatment.	Provide a full range of client- and family-focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth and their families.	Children and youth up to age 21 who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Community Research Foundation Crossroads Family Center 700 N. Johnson Ave, Suite P El Cajon, CA 92020 (619) 441-1907	2
CSS	CY-FSP	Incredible Years	ChildNET Incredible Years North Costal & North Inland	Individual/group/family services provided at pre-schools, home, or office/clinic location. Utilizing a team approach that when indicated offers case management and peer support.	Provide a full range of client and family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children up to five years old and families, using the Incredible Years evidence-based curriculum.	Children up to age 5 who meet medical necessity and their families.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement	Palomar Family Counseling 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660 945 Vale Terrace Dr Vista CA 92084	2, 3, 5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	CY-FSP	Therapeutic Behavioral Services (TBS)	Therapeutic Behavioral Services (TBS)	Ancillary short term one-on-one behavioral coaching for children & youth, who are experiencing a current emotional or behavioral challenge, or experiencing a stressful life transition.	Support permanency and promote successful return of children/youth to their family or family-like setting.	Children up to age 21 who are eligible for Medi-Cal, receiving specialty mental health reimbursable services, and experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.	• One-on-one behavioral coaching	New Alternatives - TBS 8755 Aero Drive, Suite 230 San Diego, CA 92123 (858) 256-2180	All
CSS	CY-SD	BridgeWays Program	BridgeWays Program Services	Individual/group/family services provided at office/clinic, home, or other community locations. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use interventions.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health services to children, youth, and their families who are at risk of involvement or currently involved in the Juvenile Justice System.	Children and youth up to age 21, who are at risk of involvement or currently involved in the Juvenile Justice System, who meet medical necessity.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Home Based Services • Crisis intervention • Medication services • Outreach and engagement • Substance use services	North County Lifeline 4180 Ruffin Rd. Ste. 295 San Diego, CA 92123 (760) 726 -4900	All
CSS	CY-SD	Commercially Sexually Exploited Children (CSEC)	I CARE	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach that when indicated offers case management, peer support, and/or co-occurring substance use interventions. Supportive services at drop-in center.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children, youth and their families that are at risk for or are victims of commercial sexual exploitation.	Children and youth up to age 21 who are at risk for or are victims of commercial sexual exploitation and who meet medical necessity. Any at risk for or a victim of commercial sexual exploitation who would benefit from supportive services at the drop-in center.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and engagement • Assistance with housing • Job skill assessment • GED preparation • Support groups • Peer support • Mentors	San Diego Youth Services I CARE 3660 Fairmount Ave. San Diego, CA 92105 (619) 521-2550 x 3816	All
CSS	CY-SD	County of San Diego - Juvenile Forensic Services	County of San Diego - Juvenile Forensics	Provides behavioral health services to youth transitioning out of juvenile detention and rehabilitative institutions.	Prepare youth for transition back to the community and work with youth on probation who have been released and are living in the community.	Youth transitioning out of juvenile institutions.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services	Youth Transition Campus 2801 Meadow Lark Drive 1st Flr. San Diego, Ca 92123-2711 (858) 298-6070 East Mesa Detention Facility 446 Alta Road San Diego, CA 92158 (619) 671-6558	All
CSS	CY-SD	Crisis ACTION and Connection	Crisis ACTION and Connection	Provides intensive support and linkage to services and community resources for children/youth who had a recent psychiatric episode.	Improve the ability of children and youth and their families to access and benefit from mental health services in order to divert or prevent readmission to acute services.	Children and youth up to age 21 who meet medical necessity and meet set criteria.	• Intensive case management and treatment to stabilize high risk youth • Crisis intervention • Medication services • Case management	New Alternatives/CAC 730 Medical Center Chula Vista, CA 91911 (619) 421-6979	All
CSS	CY-SD	Emergency Screening Unit (ESU)	Emergency Screening Unit	Provides crisis stabilization to children and youth experiencing a psychiatric emergency.	Reduce the use of emergency and inpatient services, prevent escalation, and promote the management of mental illness.	Children and youth under age 18 who are experiencing a psychiatric emergency.	• Crisis stabilization services for high risk youth • Crisis intervention • Medication services	New Alternatives Inc. Emergency Screening Unit 4309 Third Ave. San Diego, CA 92103 (619) 876-4502	All
CSS	CY-SD	Medication Clinic	Center for Child & Youth Psychiatry Medication Clinic	Outpatient psychiatric evaluation and medication support services utilizing face-to- face and telepsychiatry/telehealth practices for children and youth with complex psychiatric pharmacological needs, including children and youth who may be involved in the juvenile justice system,child welfare systems, or have co-occurring needs.	Promote stabilization by providing psychotropic medication support to children and youth, who require complex medication management.	Children and youth, up to age 21, requiring on-going medication support , and who have successfully completed a comprehensive mental health treatment plan with a system of care provider.	• Medication management • Psychiatric consultation • Psycho-educational seminars and groups for families	Vista Hill Foundation 8910 Clairemont Mesa Blvd. San Diego, CA 92123 (858) 514-5100	All
CSS	CY-SD	Mental Health Services - For Lesbian, Gay, Bisexual, Transgender or Questioning (LGBTQ)	Our Safe Place	Individual/group/family services provided at home, drop-in center or office/clinic location. Utilizing a team approach and when indicated, offers case management, peer support, and/or co-occurring substance use interventions. Supportive services at 5 drop-in centers.	Provide a full range of family focused, culturally and linguistically competent, strength based, comprehensive, trauma informed, data driven, and integrated mental health and supportive services to children and youth who identify as LGBTQ+ and their families.	LGBTQ+ children and youth up to age 21 who meet medical necessity. Any LGBTQ+ youth who would benefit from supportive services at the drop-in centers.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Crisis intervention • Medication services • Outreach and Engagement • Assistance with housing • Job skill assessment • General Education Diploma (GED) preparation • Support groups • Peer support • Mentors	San Diego Youth Services Our Safe Place 3427 4th Ave. Second Floor San Diego, CA 92103 (619) 525-9903	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	CY-SD	Placement Stabilization Services	Comprehensive Assessment & Stabilization Services (CASS)	Outpatient mental health services, including a comprehensive behavioral health assessment, individual and family therapy, case management, individual rehab and psychiatric services/medical management for children and youth placed by Child & Family Well-Being in a resource family home and at risk of change of placement disruption.	Stabilize current placement, deter children and youth from placement in a higher level of care and support transition of children and youth back to their biological families.	Foster children and youth, up to age 21, who recently experience placement disruption and meet medical necessity.	• Assessment • Case management and rehabilitative services • Intensive Care Coordination • Intensive Home-Based Services • Crisis intervention • Medication management	New Alternatives, Inc. 3517 Camino del Rio South Suite 407 San Diego, CA 92108 (619) 955-8905	All
CSS	CY-SD	Placement Stabilization Services	Placement Stabilization Services Polinsky Children's Center	Short-term mental health supportive services for children and youth placed at the County of San Diego's 10- day assessment center, Polinsky Childrens Center (PCC).	Support emotional needs of children and youth while at PCC to promote stabilization.	Children and youth, up to age 18, who meet medical necessity brought to Polinsky Children's Center by Child and Family Well-Being for a short assessment period.	• Assessment • Case management and rehabilitative services • Intensive Care Coordination • Intensive Home-Based Services • Crisis intervention • Medication management	New Alternatives, Inc. 9400 Ruffin Ct. San Diego, CA 92123 (858) 357-6879	All
CSS	CY-SD	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	Provides Collaborative Care Model in rural community primary clinics, including routine screening, behavioral health consultation/education, prevention, early intervention, brief treatment, and assisting in accessing care.	Prevention, early identification, education and intervention, and treatment to prevent development of more serious mental health or substance use conditions, and increase access to care for children, transitional age youth and adults/older adults.	Children, Transition Age Youth, Adults/Older Adults.	• Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725	2, 5
CSS	CY-SD	Supplemental Security Income (SSI) Advocacy Services	Children SSI Advocacy	Individual/group/family services to children and youth in a residential setting. Provides Independent Living Skills services to youth involved with CFWByouth in placement. These services result in integrated treatment services for youth with co-occurring mental health substance use disorders.	Return children/youth to their family or family-like setting; deter children/youth from placement in a higher level of care; and stabilize current placement.	Children and youth, up to age 18, residing at San Diego Center for Children, who meet medical necessity and serious emotional disturbance criteria.	• Individual/group/family treatment • Care coordination • Case management • Rehabilitative services • Medication services • Independent Living Skills	San Diego Center for Children 3002 Armstrong St. San Diego, CA 92111 (858) 277-9550	All
CSS	TAOA-FSP	Adult Residential Treatment	Residential Dual Diagnosis Treatment Program - ARF	Residential facility for adults with serious mental illness.	Maximize each individual's recovery in the least restrictive environment through a comprehensive medical, psychological, and social approach to assist the client's recovery and return to independent living.	Adults, 18 years and older, with serious mental illness needing 24-hour care due to the inability to live independently.	• Psycho-educational and symptom/wellness groups • Employment and education screening/readiness • Skill development • Peer support, and mentoring • Physical health screening • Referrals	Changing Options Inc. 500 Third St. Ramona, CA 92065 (760) 789-7299	All
CSS	TAOA-FSP	Assisted Outpatient Treatment (AOT)	Assisted Outpatient Treatment (AOT)	A time-limited Assertive Community Treatment (ACT) Team services for persons who are assigned to court-ordered Assisted Outpatient Treatment (AOT), and for persons who otherwise meet AOT criteria and agree to participate in these services as an alternative to court-ordered AOT.	Integrate behavioral health, rehabilitation treatment, recovery services for adults with a serious mental illness, and identified as potential AOT candidates by the County- identified entity which serves potential AOT candidates In-Home Outreach Team, have agreed to an AOT court settlement, or have AOT status resulting from a contested court hearing.	Adults 18 years and older who meet Title 9 criteria, as established under Laura's Law.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare Corporation 1660 Hotel Circle N., Suite 101 San Diego, CA 92108 (619) 481-3840	All
CSS	TAOA-FSP	Behavioral Health Court	Collaborative Behavioral Health Court	Uses the Assertive Community Treatment model to enhance the lives of individuals who are experiencing a serious mental illness and co-occurring conditions through case management and mental health services.	Integrate mental health, substance-induced psychiatric disorder rehabilitation treatment, and recovery services for adults with serious mental illness to improve their mental health, quality of life in the community, and prevent recidivism in the criminal justice system.	Underserved adults,18 years and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and have misdemeanor or felony offenses.	• Team-based management • Peer support specialist • Medication management • Health care integration services • Linkage to services in the community • Housing subsidy • Providing education/vocational services and training	Telecare Corporation 4930 Naples St. San Diego, CA 92110 (619) 276-1176	4
CSS	TAOA-FSP	County of San Diego - Institutional Case Management (ICM)	County of San Diego - ICM	County Operated Direct Service Program: ICM provides case management services to LPS Conservatees, aged 18-59, in long-term locked placements. ICM is designed to improve the mental health and quality of life of adults as they prepare to transition to a lower level of care, which can include transitioning back to the community, if clinically appropriate. Long-term locked facilities include behavioral health units, jails, skilled nursing facilities, institutions for mental disease, and State hospitals.	Improve the mental health and quality of life of adults who are managing severe mental illness. Focus is stabilization and linkage to services while client is residing in a long-term locked treatment facility.	Adults, aged 18 -59, who reside in a State hospital or in out-of-county, in-county Institutions for Mental Disease (IMD), or Skilled Nursing Facilities. Can include jails and Behavioral Health Units.	Case management program offering Institutional Case Management (ICM) services to LPS conservatees who reside in long-term locked placements. Services consist primarily of linking, coordinating, and monitoring functions while in long-term locked settings, and assistance with transitioning to a lower level of care upon discharge.	County of San Diego - Institutional Case Management (ICM) 1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-FSP	County of San Diego - Probation	Probation Officers MOU, Annual COLA based on County Comp Ordinance	Probation Officer for Behavioral Health Court. Interventions, case management, and supervision of juveniles and adults who are at risk of entering the justice system or re- offending while placed on probation by the courts,	• Stabilize and link to services • Reduce incarceration and institutionalization, provide timely access to services, and reduce homelessness	• Transition Age Youth, adults/older adults • Transition Age Youth and adults who have a serious mental illness	• Transition services • Mental health assessments • Interventions • Case management • Outreach and engagement	County of San Diego Probation Administration 9444 Balboa Ave. San Diego, CA 92123 (858) 514-3148	All
CSS	TAOA-FSP	County of San Diego - Strengths Based Case Management (SBCM)	County of San Diego - SBCM(Central/North Central)	County Operated Direct Service Program: SBCM provides clinical case management and mental health services with a rehabilitation and recovery focus to adults, aged 18-59, managing severe mental illness. SBCM encourages recovery efforts in participants by identifying and coordinating a range of resources, both environmental and personal, to help people achieve their goals.	Improve the mental health and quality of life of adults who are managing severe mental illness. Increase access to needed mental health, medical, educational, social, prevocational, vocational, housing supports, rehabilitative and/or other community services.	Adults, aged 18 - 59, who have a serious mental illness, including those who may have a co-occurring substance use disorder residing in the Central, North Central or East County community. Services are for SSI/Medi-Cal, SSA/Medicare and/or indigent populations	• SBCM • Rehabilitation and recovery services • Care Coordination to needed services • Co-occurring services linkages • Access and linkage to Supportive Housing • Access to supportive employment/vocational and educational services	North Central 1250 Morena Blvd. 2nd Floor San Diego, CA 92110 (619) 692-8715 East County 1000 Broadway Suite 100 El Cajon, CA 92021 (619) 401-5424	2, 3, 4
CSS	TAOA-FSP	Crisis Residential Services - North Inland	Crisis Residential Treatment Programs (CRTP) Esperanza Crisis Center	Crisis Residential Treatment Programs are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home- like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit, or step-down from acute inpatient care	Adults, age 18 and older, who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non- hospital intervention but are able to be managed in a voluntary setting.	• Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Esperanza Crisis Center 490 North Grape Street Escondido, CA 92025 (760) 975-993	5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Catalyst	Provide ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk for homelessness.	Transition Age Youth, aged 16-25, who are homeless, at risk of homelessness, have a serious mental illness, or a co-occurring substance use disorder and need the highest level of care to maintain in the community.	Transition Age Youth, aged 16-25, who are homeless, at risk of homelessness, have a serious mental illness, or a co- occurring substance use disorder and need the highest level of care to maintain in the community.	Pathways Community Services 7986 Dagget St. San Diego, CA 92111 (858) 300-0460	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Catalyst Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT Justice Involved Svcs (Vida ACT)	FSP/ACT - Justice Involved.	Provides ACT services to persons with serious mental illness who are justice involved.	Adults, aged 18 and older, with serious mental and/or substance-induced psychiatric disorder illnesses, who have been incarcerated and have misdemeanor or felony offenses.	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Telecare Corporation 3491 Kurtz Street, Suite 150 San Diego, CA 92110 (619) 332-5830	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Justice Involved Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from Acute	ACT La Luz	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adults, aged 18 and older, who are homeless, at risk of homelessness, have serious mental illness, or co-occurring diagnosis of substance use, and are stepping down from a long-term care facility setting and need the highest level of care to maintain in the community.	• Clinical case management • Medication management • Individual and group counseling • Education and employment support • Peer support services • Housing support	Telecare La Luz 3489 Kurtz San Diego, CA 92110 619-320-2404	3
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT La Luz Housing						

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Step Down from IMD	ACT Tesoro	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adults 18 years and older who are homeless, at risk of homelessness, have a serious mental illness, or co-occurring substance use disorder, and are stepping down from a behavioral health unit and need the highest level of care to maintain in the community.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Telecare Tesoro 489 Kurtz San Diego, CA 92110 619-320-2404	3
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Tesoro Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-In-reach to Long Term Care-Pathway to Recovery	ACT and In-Reach for adults in and discharged from long-term care.	Provide ACT Services to persons with serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff such as: counselors, social workers, peer specialist, vocational specialist, housing specialists, nurses, physician's assistants, medical doctors, and substance use disorder specialists.	Adults, aged 18-59, with serious mental illness and are, or recently have been, in a long-term care institutional setting.	• Provide Assertive Community Treatment Team • Multidisciplinary, wraparound treatment and rehabilitation services for adults discharged from long-term care facilities who have a serious mental illness and needs that cannot be adequately met through a lower level of care. • Includes an in-reach component for some persons served by the county institutional case management program. • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3100	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-In-reach to Long Term Care-Pathways to Recovery Member Housing II						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice	24-hour community -based treatment for individuals with a criminal justice background who have been diagnosed with a severe and persistent mental illness.	Provides ACT services to persons with very serious mental illness.	Adults, aged 25 to 59, who have a serious mental illness and adults, aged 18 and older, who may have been homeless.	• Clinical case management Mental health services with a rehabilitation and recovery focus • Supportive housing • Educational and employment development • Individual and group rehabilitation counseling • Psychiatric assessment	Mental Health Systems Inc. 4283 El Cajon Blvd., Suite 115 San Diego, CA 92105 (619) 521-1743	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Justice Integrated Services - Center Star - Justice Housing)						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Strength Based Case Management (SBCM) - North	Program uses strength based case management team approach to deliver comprehensive, community based services and support for adults who are transitioning from higher levels of care.	Recovery-oriented strengths-based clinical case management services to persons with serious mental illness.	Transitional Age Youth ages 18-25 and Adults 25 to 59 years old who have a serious mental illness, are homeless or at risk of homeless.	• Strengths based case management	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 103 Escondido, CA 92025 (760) 294-1281	3, 5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT ACTION Central	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adults, aged 18 and older who are homelessness, at risk of homelessness, with a serious mental illness or a co-occurring diagnosis of substance use and need the highest level of care to maintain in the community. (This program provides SUD services under the same contract).	• Clinical case management • Medication management • Individual and group counseling • Education and employment support • Peer support services • Housing support	Mental Health Systems Inc. (MHS) ACTION Central 6244 El Cajon Blvd., Suite 15-18 San Diego, CA 92115 (858) 380-4676	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT ACTION Central - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT ACTION East	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adults 18 years and older who are homeless, at risk of homelessness, have a serious mental illness, or a co-occurring diagnosis of substance use disorder and need the highest level of care to maintain in the community. (This program provides SUD services under the same contract).	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) ACTION East 10201 Mission Gorge Rd., Suite O Santee, CA 92071 (619) 383-6868	2
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT ACTION East - Housing						

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Persons with High Service Use	Provides an ACT, FSP program for person 18 years and older who have been very high users of Medi-Cal hospital psychiatric services and/or institutional care.	Provide ACT Services to persons with very serious mental illness who may also have a co-occurring use disorder.	Adults 18 years and older with very serious mental illness who have been high users of Medi-Cal psychiatric hospital services and/or institutional care, including those with co-occurring substance use disorder.	• ACT intensive, multidisciplinary treatment services for who have a very serious mental illness and needs that cannot be adequately met through a lower level of care • Includes housing component	Telecare Corporation 3132 Jefferson St. San Diego, CA 92110 (619) 683-3101	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Persons with High Service Use (Housing)						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT- City Star	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adult 18 years and older who are homeless, or at risk of homelessness, with a serious mental illness, or co-occurring diagnosis of substance use and need the highest level of care to maintain in the community.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) 8775 Aero Dr., Suite 132 San Diego, CA 92123 (858) 609-8742	3, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-City Star - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT North Coastal	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adult 18 years and older who are homeless, or at risk of homelessness, with a serious mental illness, or co-occurring diagnosis of substance use and need the highest level of care to maintain in the community.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) 2122 El Camino Real #102 Oceanside, CA 92054 (760) 290-8170	5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT North Coastal - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT North Star	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adults 25 to 59 years old who are homeless, at risk of homelessness with a serious mental illness, or co-occurring diagnosis of substance use and need the highest level of care to maintain in the community.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	Mental Health Systems Inc. (MHS) Escondido 474 W. Vermont Ave., Suite 104 Escondido, CA 92025 (760) 294-1281	3, 5
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT North Star - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT South Bay IMPACT	Provides ACT, FSP to persons with a serious mental illness who may also have a co-occurring use disorder. Services are provided by a multi-disciplinary team of professional and paraprofessional staff with a housing first approach.	Integrate behavioral health and rehabilitation treatment and recovery services for adults with serious mental illness who are homeless or at risk of homelessness.	Adults 18 and older who are homeless, at risk of homelessness, have serious mental illness or a co-occurring diagnoses of substance abuse and need the highest level of care to maintain in the community.	• Clinical Case Management • Medication Management • Individual and Group Counseling • Education and Employment support • Peer Support Services • Housing Support	South Bay IMPACT (CRF) 855 Third Ave., Suite 1110 Chula Vista, CA 91911 (619) 934-5770	1
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT South Bay Impact - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT Senior Impact (High Utilizer Integrated Services)	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders for older adults.	Increase timely access to services and supports to assist older adults and family/ caregivers in managing independent living, reducing isolation, improving mental health, and remaining safely in their homes.	Adults, aged 60and older who are homeless or at risk of homelessness and have serious mental illness.	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) 928 Broadway San Diego, CA 92102 (619) 977-3716	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT Senior Impact Supported - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Central IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders.	Improve the mental health and quality of life of adults in the community who have been or at-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults, aged 18-59, who are homeless or at risk of homelessness, have serious mental illness , and who may also have a co- occurring condition of substance use in the Central and North Central Regions of San Diego.	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) 1260 Morena Blvd., Suite 100 San Diego, CA 92110 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Central IMPACT - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	ACT-Downtown IMPACT	Fully integrated and wrap around services to clients diagnosed with a serious mental illness, as well as individuals with co-occurring, mental health and substance disorders.	Improve the mental health and quality of life of adults in the community who have been or at-risk of becoming homeless and have a serious mental illness by increasing clinical and functional stability through an array of mental health services, housing opportunities and educational and employment supports	Adults, aged 18-59, who are homeless or at risk of homelessness, have serious mental illness (SMI), and who may also have a co- occurring condition of substance use in the Central and North Central Regions of San Diego,	• Linkage to food, housing and/or physical health services • Medication management • Vocational services • Substance use disorder services • Includes housing component	Community Research Foundation (CRF) 995 Gateway Center Way, Suite 300 San Diego, CA 92102 (619) 398-2156	1, 4
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Housing	ACT-Downtown IMPACT - Housing						
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT)	Agewise	Strengths-Based Case Management, and Institutional Case Management for Older Adults.	Provide SBCM and ICM services to adults, aged 60 and over, who suffer from serious mentalillness and who may have a co-occurring substance use disorder. ICM population is on Public Conservatorship.	Older adults, who are aged 60 and older, and ICM population, who are 60 and older who have a public conservatorship.	• Strengths-Based Case Management and Institutional Case Management	Telecare Corporation 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Transitional Residential and Adult Residential Facility	FSP/ACT - Transitional Residential and Adult Residential Facility. Program provides transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co- occurring disorders.	Provide transitional residential beds and bio-psychosocial rehabilitative services to adults with a serious mental illness and co- occurring disorders.	Adults, aged18 and older, with primary serious mental illness diagnosis.	• Functional adaptation skills training; • Integrated co-occurring disorder services; • Wellness Recovery Action Plan; • Cognitive behavioral therapy and dialectical behavioral therapy; • Problem solving • Independent living skills	Crestwood Behavioral Health, Inc. 5550 University Ave, Suite A San Diego, Ca 92105 (619) 481-5447	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	FSP / ACT - Transitional Project-Based Subsidy Program for Homeless - Safe Haven AB2304 - C-HRT Safe Haven	Residential transitional housing program that provides supportive services for those who are experiencing homelessness and have a serious mental illness. The C-HRT services are for individuals experiencing homelessness and have a substance use condition.	Provide residential support, crisis intervention, and transitional housing services to clients experiencing homelessness who are enrolled in ACT services. C-HRT clients are to be serviced by the C-HRT program.	Adults/older adults with a serious mental illness or substance use conditions who are experiencing homelessness.	• Transitional housing for eligible individuals • Provide food • Case management	Uptown Safe Haven 2822 5th Ave. San Diego, CA 92103 (619) 294-7013 C-HRT Safe Haven 3690 Couts Street, San Diego, CA 92110 (619) 228-2800	All
CSS	TAOA-FSP	Full Service Partnership (FSP) / Assertive Community Treatment (ACT) - Transitional Residential Program	Casa Pacifica	Transitional residential services provide a full- range of bio-psychosocial rehabilitative services to seriously mentally ill adults who have Medi-Cal coverage and benefits in a residential setting within San Diego County. These services are an integral component of the long-term care system in which the program serves as both a step- down and diversion function from higher level and more costly services.	Provide an alternative to long-term care settings and support community reintegration after discharge from long-term care facility. Provide rehabilitative residential resource for residents who require FSP level of care to remain in a community setting to reduce need of being placed in a locked facility.	Adults, aged 18 and older with a primary diagnosis of serious mental illness that meets Medi-Cal criteria for psychosocial rehabilitative services and who will benefit from unlocked transitional residential rehabilitative services. Clients must have Medi-Cal coverage; benefits such as Supplemental Security Income; and be residents of San Diego County.	24-hour hour, seven days a week services in accordance with Title 9 and Behavioral Health Services policy, including medication support, case management/brokerage, crisis intervention, rehabilitation and other rehabilitative and recovery interventions, including peer supports.	Community Research Foundation 321 Cassidy Street Oceanside, CA 92054 (760) 721-2171	All
CSS	TAOA-FSP	Short-Term Mental Health Intensive Case Management - High Utilizers	Safe Connection Program	NHA Safe Connections delivers SC/MC certified Care Coordination/Short-term intensive case management services.	Provides Short-Doyle/Medi-Cal-certified care coordination and short-term intensive clinical case management services for clients with serious mental illness who have had high service use.	Adults, aged 18 and older, who are eligible for Medi-Cal funded services or are indigent, have a serious mental illness (including those with co-occurring substance use), and reside in San Diego County.	• Provide care coordination/short-term intensive clinical case management. • Connect clients with appropriate behavioral health services and short-term housing if the client is homeless.	Safe Connections Neighborhood House Association 286 Euclid Ave. Ste. 104 San Diego, CA 92114 (858) 285-0979	4
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	Maria Sardinas Wellness Recovery Center Biopsychosocial Rehabilitation (BPSR) - South Region	BPSR Wellness Recovery Center that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co- occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma-informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness, including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • SBCM • Care coordination • Peer support services • Mobile outreach • Supportive employment services • Transitional Age Youth services • Older adult services	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-FSP	Strengths Based Case Management (SBCM)	South Bay Guidance Wellness Recovery Center Biopsychosocial Rehabilitation (BPSR)- South Region	BPSR Wellness Recovery Center that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co- occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Strengths-based case management • Care coordination • Peer support services • Mobile outreach •Supportive employment services • Transitional Age Youth (TAY) services • Geriatric services	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661	1
CSS	TAOA-OE	Countywide Homeless Outreach Program	Countywide Homeless Outreach Program	The program conducts outreach and engages persons, aged 18 and older, with serious mental illness and/or substance use conditions who are unsheltered to provide a behavioral health screening and receive short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	Assist persons experiencing homelessness by connecting them with housing, improving health and quality of life, and connection to community resources.	Persons served will be adults/older adults, aged 18 or older, with serious mental illness and/or substance use conditions and are homeless.	• Provides behavioral health screening and short-term case management (up to 90 days) for persons who agree to engage and participate in the services to achieve outcomes connected to housing, quality of life, and community resources.	PATH San Diego's Connections Housing 1250 Sixth Ave., San Diego, CA 92101 (619) 810-8600	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Casa De Oro Residential Care ASP	ASP provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, aged 18 and older, who have a serious mental illness living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Anthem Compassionate Care LLC 3602 S. Cordoba Ave Spring Valley, CA, 91977 (619) 303-3717	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Carroll's Community CareASP	ASP provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, 18 and older, who have a serious mental illness living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Carroll's Community Care 523 Emerald Ave. El Cajon, CA, 92020 (619) 442-8893	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Carroll's Residential Care ASP	ASP provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, 18 and older, who have a serious mental illness living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Carroll's Residential Care 655 S. Mollison Street El Cajon, CA, 92020 (619) 444-3181	All
CSS	TAOA-SD	Augmented Services Program (ASP)	ASP	ASP provides additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults 18 years and older who have a serious mental illness living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Casa El Cajon 306 Shady Lane El Cajon, CA, 92021 (619) 440-1335	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Fancor Guest Home ASP	ASP to provide additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, aged 18 and older, who have a serious mental illness living in San Diego County	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Fancor Guest Home 631-651 Taft Ave El Cajon, CA, 92020 (619) 588-1761	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Augmented Services Program (ASP)	Orlando Residential Care ASP	ASP to provide additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults. aged 18 and older, who have a serious mental illness living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Orlando Guest Home 297-299 Orlando Street El Cajon, CA, 92021 (619) 444-9411	All
CSS	TAOA-SD	Augmented Services Program (ASP)	Rancho Digius - Enhanced Augmented Services Program (EASP)	Enhanced ASP to provide additional therapeutic and support services in licensed residential care facilities.	Maintain or improve client functioning in the community and to prevent or minimize institutionalization.	Adults, aged 18 and older who have a serious mental illness living in San Diego County.	• Provides additional services to people with serious and prolonged mental illness in licenses residential care facilities (also known as B&C facilities); Identified eligible persons will receive additional services from these B&C facilities beyond the basic B&C level of care.	Rancho Digius 2445 Broadway Ave San Diego, CA, 92102 (619) 468-5700	All
CSS	TAOA-SD	Behavioral Health Assessors	Pilot Project for Lemon Grove Family Resource Center (FRC) - 2 Clinicians (non-County Staff)	Bio-Psychosocial Rehabilitation Wellness Recovery provides outpatient mental health rehabilitation and recovery services, case management; and long-term vocational support.	Provide transitional services to support youth who are released from detention.	At-risk African American and Latino citizens who are incarcerated adults or Transition Age Youth at designated detention facilities and released in San Diego County.	• Advocacy, assessment, engagement, and resource connection	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 207 San Diego, CA 92114 (619) 766-5994	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Maria Sardinas Wellness Recovery Center (WRC) BPSR	BPSR WRC that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co-occurring substance use disorder. The program provides community- based, recovery- oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Strengths-based case management • Care coordination • Peer support services • Mobile outreach • Supportive employment services • Transitional Age Youth (TAY) services • Older adult services	Maria Sardinas Wellness & Recovery Center 1465 30th St., Suite K San Diego, CA 92154 (619) 428-1000	1
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	South Bay Guidance Center BPSR-South Region	BPSR Wellness Recovery Center that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co- occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Strengths-based case management • Care coordination • Peer support services • Mobile outreach •Supportive employment services • Transitional Age Youth (TAY) services • Geriatric services	South Bay Guidance Wellness and Recovery Center 1196 3rd Ave., Chula Vista, CA 91911 (619) 427-4661	1
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Alianza Wellness Recovery Center BPSR - Central/North Central for Latino & TAY	BPSR Wellness Recovery Center that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness) including those who may have a co- occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent. This includes enhancements for Transitional age youth (TAY), geriatric, and Latino populations.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transitional Age Youth (TAY) services • Geriatric services	Mental Health Systems, Inc. Alianza Wellness Center 5555 Reservoir Dr. Ste. #204-A San Diego, CA 92120 (619) 822-1800	4

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Counseling & Treatment Center (CTC - AOA & TA BPSR & Geriatric)	BPSR Wellness Recovery Center that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness, including those who may have a co- occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent. This includes enhancements for Transitional age youth (TAY) and geriatric populations.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transitional Age Youth (TAY) services • Geriatric services	CTC Mid-City 5348 University Avenue, Suite 101, San Diego, CA 92105 (619) 229-2999 CTC Serra Mesa 8745 Aero Drive, #330 San Diego, CA 92123 (858) 268-4933	3, 4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Jane Westin Urgent Walk-In Program Central Region	Urgent Walk-In Services for mental health outpatient services that are consistent with psychosocial rehabilitation and recovery principles with persistent and serious mental illness and,or co-occurring mental health and substance disorders. Program also provides crisis intervention as needed.	Provide eligible clients with same-day walk- in assessment, psychiatric consultation, and linkage to appropriate level of care for ongoing care once urgent services have been concluded on site.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in services • Behavioral health assessments • Psychiatric evaluation • Medication support • Case management/linkage • Crisis intervention	Jane Westin Center 1045 9th Ave San Diego, CA 92101 (619) 235-2600	All
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Healing Oaks Clinic BPSR Wellness Recovery Center (WRC)	BPSR WRC that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transitional Age Youth (TAY) services • Older adult services	Healing Oaks Clinic 286 Euclid Ave. Suites 101,102, and 304 San Diego, CA 92114 (619) 859-6270	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Central Region BPSR WRC-Areta Crowell (ACC) Housing	Biopsychosocial Rehabilitation BPSR Wellness Recovery Center that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co- occurring substance use disorder. The program provides community-based, recovery- oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive Housing • Supportive employment services • Transitional Age Youth (TAY) services • Older adult services	Areta Crowell Wellness Recovery Center 1963 4th Ave. San Diego, CA 92101 (619) 233-3432	4
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	North Central Region BPSR Wellness Recovery Center (WRC) (Douglas Young clinic)	BPSR WRC that provides outpatient mental health treatment, rehabilitation, and recovery services to adults, aged 18 and over, who have serious mental illness , including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, and specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults, aged 18 and older, who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive employment services • Transitional Age Youth (TAY) services • Older adult services	Community Research Foundation (CRF) - Douglas Young Clinic 10717 Camino Ruiz, Suite 207 San Diego, CA 92126 (858) 695-2211	3
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Promise Wellness Center	Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) provides outpatient mental health treatment, rehabilitation, and recovery services to adults age 18 and above who have serious mental illness (SMI). This includes those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Supportive Employment services • Transitional Age Youth (TAY) services • Older Adult (OA) services	Union of Pan Asian Communities (UPAC) Main site 995 Gateway Center San Diego, CA 92102 Satellite Site: 3280 Main Street Suite 7C San Diego, CA 92113 (619) 232-6454	4

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Bio-Psychosocial Rehabilitation (BPSR)	Bio-Psychosocial Rehabilitation (BPSR) (East - Heartland)	Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) provides outpatient mental health treatment, rehabilitation, and recovery services to adults age 18 and above who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation, and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Supportive Employment services • Transitional Age Youth (TAY) services • Geriatric services • AB 109 enhanced services • Services are provided in English, Arabic, and Chaldean for individuals who identify as members of the Middle Eastern community	Community Research Foundation (CRF) East Region Heartland Center 460 North Magnolia Ave., Suite 110 El Cajon, CA 92020 (619) 440-5133	2
CSS	TAOA-SD	Clubhouse	Mariposa Clubhouse	Mariposa Clubhouse provides mental health-related recovery group counseling, social support services and employment development to members.	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills.	Adults 18 years and older who have a serious mental illness living in San Diego County.	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems (MHS), Inc. 1701 Mission Ave, Suite 120 Oceanside, CA 92058 (760) 439-2769	5
CSS	TAOA-SD	Clubhouse	PCS Clubhouse Oasis Program	PCS Clubhouse Oasis Program provides mental health-related recovery group counseling, social support services and employment development to transition age youth members.	Member-driven center that assists to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services.	Transition Age Youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder.	• Provides clubhouse services to transition age youth 16 to 25 years old diagnosed with a serious mental illness who may have a co-occurring substance use disorder	Pathways Community Services 3330 Market St. #A San Diego, CA 92102 (858) 300-0470	All
CSS	TAOA-SD	Clubhouse	Adult Peer Support Line (Warm Line)	Peer Support Line provides a non-crisis telephone and live chat service operated by and for adults 18 and older who are in recovery from a mental illness.	Promote stability and reduce problematic situations that may lead to a crisis. The support line will be an essential peer support service for persons recovering from mental illness by providing support, information, and referrals. The support line will operate as a non-crisis telephone and live chat service program and will achieve the following: • Promote stability and reduce problematic situations that may lead to a crisis. • Provide information and referrals to appropriate community resources. • Prevent escalation of symptoms or problematic situations that may lead to a crisis. • Provide non-crisis intervention and referral to the appropriate services. • Provide training and employment opportunities for adults recovering from a mental illness who will provide the services listed above.	Adults 18 and older who are in recovery from a mental illness and who are low income, indigent, Medi-Cal beneficiaries, or Medi-Cal eligible.	• A telephone and live chat service to provide peer support, information, resources, referrals, and non-crisis intervention	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6590	All
CSS	TAOA-SD	Clubhouse	NAMI San Diego - Mental Health Clubhouse in Central Region	The Central Region Clubhouse is for adults who have a serious mental illness, including those who may have a co-occurring substance use disorder.	Member access to socialization and rehabilitation supports, reduce social isolation, identify areas of interest (personal, cultural, vocational, intellectual, and recreational), improve functioning, increase employment and education, improve health and quality of life.	Adults/Older Adults 18 years and older located in the Central Region with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi- Cal beneficiaries, or are indigent, including those with co-occurring substance use. The persons may have been previously unable to work, and are interested in improving their social, healthy living and vocational skill sets.	• Provides rehabilitation services • Assist clients to achieve goals in areas such as: employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	Casa del Centro Clubhouse - NAMI San Diego 2754 Imperial Ave San Diego, CA 92102 (619) 951-9007	1

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Clubhouse	The Plaza Clubhouse	South Region Clubhouse is for adults who have a serious mental illness, including those who may have a co-occurring substance use disorder.	Member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Adults/Older Adults 18 years and older located in the Central Region with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi- Cal beneficiaries, or are indigent, including those with co-occurring substance use. The persons may have been previously unable to work, and are interested in improving their social, healthy living and vocational skill sets.	• Provides rehabilitation services • Assist clients to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services	NAMI San Diego 535 Broadway Chula Vista, CA 91910 (619) 605-9706	1
CSS	TAOA-SD	Clubhouse	East Wind Clubhouse	East Wind Club provides mental health-related recovery group counseling, social support services and employment development to Clubhouse for monolingual and/or limited English proficient Asian/Pacific Islander Adult members who have a serious mental illness, including those who may have a co- occurring substance use disorder.	• Provide member-driven clubhouse services to individuals experiencing and/or recovering from serious mental illness. • Increase countywide social and community rehabilitation activities and employment services. • Increase client's self-sufficiency through development of life skills	Monolingual and/or limited English proficient Asian/Pacific Islander adults who have a serious mental illness.	• Helps clients achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services • Group counseling • Social support • Employment and education services • Mobile outreach • Peer support	UPAC East Wind Clubhouse 8745 Aero Dr., Suite 330 San Diego, CA 92123 5348 University Avenue Suite 108 San Diego CA92105 (858) 268-4933	4
CSS	TAOA-SD	Clubhouse	Connection 2 Community Clubhouse	This clubhouse will serve adults/older adults with a serious mental illness (SMI) age 18 and older including those who may have a co- occurring substance use condition. The clubhouse will assist individuals with serious mental illness to achieve social, financial, health/wellness, educational, and vocational goals and shall follow Clubhouse International Standards located at: https://clubhouse-intl.org/resources/quality-standards/	This program shall provide member-driven Clubhouse International accredited clubhouse services to the priority population of adults aged 18 years and above, with serious mental illness, including co-occurring substance use. Overall goals of this program include member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual, and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Homeless Adults/Older Adults who have a serious mental illness; Services are in Central Region with an emphasis in downtown San Diego.	Clubhouse services including recovery education and support, supported employment, assistance with SSI application Additional contract components include shower and laundry support, and street outreach services.	National Alliance on Mental Illness (NAMI) San Diego C2C Clubhouse 101 16th Street San Diego, CA 92101 (619) 776-8605	4
CSS	TAOA-SD	Clubhouse	Escondido Clubhouse (North Inland)	Escondido Clubhouse (North Inland) provides mental health-related recovery group counseling, social support services and employment development to members.	Increase countywide social and community rehabilitation activities and employment services. Increase client's self-sufficiency through development of life skills.	Adults 18 years and older who have a serious mental illness living in San Diego County.	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Mental Health Systems, Inc. (MHS) 474 W. Vermont Ave., Suite 105 Escondido, CA 92025 (760) 737-7125	3
CSS	TAOA-SD	Clubhouse	Adult/Older Adult Mental Health Clubhouse/SSI Advocate Services	Clubhouse International Accredited Clubhouse is a member-operated program in the Central Region for adults/older adults ages 18 and older with a serious mental illness (SMI) including those who may have a co-occurring substance use disorder. The program provides rehabilitative, recovery, health and vocational services and support to the target population. The Warm Line is an essential peer support service for persons recovering from mental illness who are living in the community by providing support, understanding, information, and referrals.	Overall goals of this program include: member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Underserved adults/older adults located in the Central-Downtown Region with a serious mental health illness and who are eligible for Medi-Cal funded services, Medi- Cal beneficiaries, or are indigent, including those with co-occurring substance use. The persons may have been previously unable to work, and are interested in improving their social, healthy living and vocational skill sets.	• Provides rehabilitative, recovery, health and vocational services and supports • Supplemental Security Income (SSI) application and advocacy services	The Meeting Place 2553 State St. Ste 101 San Diego, CA 92101 (619) 294-9582	4
CSS	TAOA-SD	Clubhouse	Central Region Member-Operated Clubhouse	This program provides mental health-related recovery group counseling, social support services and employment development to members.	Increase countywide social and community rehabilitation activities and employment service as well as increase client's self- sufficiency through development or life skills.	Adults/Older Adults 18 years and older who have a serious mental illness including those with co-occurring substance use disorders.	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	Corner Clubhouse 2864 University Ave. San Diego, CA 92104 (619) 683-7423	4
CSS	TAOA-SD	Clubhouse	East Corner Clubhouse	The East Corner Clubhouse provides mental health-related recovery group counseling, social support services and employment development to members.	This program will be continuously monitored and assessed for adherence to the Clubhouse International Accreditation process.	Adults 18 years and older who have a serious mental illness living in San Diego County.	• Group counseling • Social support • Employment and education services • Support access to medical, psychiatric, and other services	East Corner Clubhouse 1060 Estes St., #104 El Cajon, CA 92020 (619) 631-0441	2

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Consumer Advocacy	Consumer Advocacy	Consumer Advocacy provides recovery-oriented services to all BHS service recipients and their families, who have experience with their own behavioral health conditions and recovery process, and/or who are seeking to or are already working or volunteering within the County's Behavioral Health System of Care. In addition, collective consumer voice obtains consumer feedback and elevates to the BHS continuum of care.	Create a Trauma Informed System of Care and minimize re-traumatization of consumers who continue to receive services in San Diego's Behavioral Health System.	All BHS service recipients and their families, including Transition Age Youth (TAY), Adult, and Older Adults.	• Recovery-oriented services which include advocacy training and peer support for persons and family members	National Alliance on Mental Illness (NAMI) San Diego 5095 Murphy Canyon Rd. San Diego, CA 92123 (858) 634-6590	4
CSS	TAOA-SD	Crisis Stabilization - East Region	Crisis Stabilization and Expanded Recovery Bridge Center – East Region	The East Region Crisis Stabilization Unit (CSU) and Expanded Recovery Bridge Center (ERBC) offers services 24-hours, seven days a week for adult and older adults, including individuals who are Medi-Cal beneficiaries, indigent and/or underserved, and who are residents of San Diego County, who have serious mental illness and who are experiencing a psychiatric emergency. This may also include co- morbid alcohol and other drug-induced conditions. The Expanded Recovery Bridge Center is a safe space for public inebriates or intoxicated individuals. Individuals may be dropped off by health, safety, and law enforcement agencies and are kept a minimum of four hours for sobering purposes in lieu of incarceration.	CSU: Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting. ERBC: To provide safe, alcohol and other drug-free sobering services to adults identified as intoxicated by law enforcement and/or adults with symptoms of intoxication referred by health, safety and law enforcement agencies.	Transition Aged Youth 18-25 years, 25-59 years and older adults 60 years and up who have SMI including those with co- occurring substance use, eligible for Medi- Cal funded services or who are indigent. Voluntary clients and those on WI 5150 hold who are experiencing a psychiatric crisis referred by health, safety, and law enforcement agencies in the East County region.	• Rapid access to mental health evaluation and assessment, crisis intervention, medication, collateral, care coordination and disposition planning	Exodus Recovery, Inc. East Region CSU and RBC 367 N. Magnolia El Cajon, CA 92020 (619) 528-1752	2
CSS	TAOA-SD	Crisis Stabilization - North Coastal Oceanside	Crisis Stabilization Unit North Region	The North Region Crisis Stabilization Unit operates 24-hours/7 days a week for adult and older adults, are Medi-Cal beneficiaries, indigent and/or underserved, and those who are residents of San Diego County, who have serious mental illness and are experiencing a psychiatric emergency, which may also include co-morbid alcohol and other drug-induced problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting. CSU services shall last less than 24 hours (23.59 hours).	Services provided to transition aged youth (TAY) 18-25 years, 25-59 years and older adults aged 60 years and up, who have a serious mental illness including those with co-occurring substance use and who are eligible for Medi-Cal funded services or who are indigent. This includes voluntary clients and those on WI 5150 hold who are experiencing a psychiatric crisis of such magnitude that it would place the health or safety of the individual or others.	• Psychiatric assessment • Transfer to inpatient services • Physical health assessment • Crisis intervention • Medication management • Linkage and care coordination • Transportation to short-term housing • Flex funds	Exodus Recovery, Inc. 1701 Mission Ave, Ste 130 Oceanside, CA 92058 Main: (760) 305-4848 Fax: (760) 305-4845	5
CSS	TAOA-SD	Crisis Stabilization - North Coastal Vista	Crisis Stabilization Unit North Coastal Vista	The North Coastal Vista Crisis Stabilization Unit provides telepsych prescriber services on an on-demand basis. They also provide 24/7 crisis stabilization services to individual experiencing a psychiatric emergency.	Outpatient psychiatric prescriber services for children, and adult mental health consumers utilizing Telehealth practices and technology. Reducing the severity of a person's level of distress and/or need for a higher level of care.	WIAC and CSU: Transition Age Youth, Adults/Older Adults who have serious mental illness, including those who may have a co-occurring substance use disorder. Telehealth: all ages.	• Telehealth prescriber services • Crisis stabilization services	Vista Walk In Assessment Center 524 W. Vista Way Vista, CA 92083 (760) 758-1150	3, 5
CSS	TAOA-SD	Crisis Stabilization - North Inland	Crisis Stabilization Unit North Region	The Crisis Stabilization Unit in the North Inland Region is for San Diego County residents who are experiencing a psychiatric emergency, which may also include co-morbid substance use disorder problems.	Provide crisis stabilization services that assist with reducing the severity of a person's level of distress and/or need for a higher level of care associated with a serious mental illness or co-occurring condition, while promoting care in a recovery-oriented treatment setting.	Voluntary and involuntary adults with a serious mental illness.	• Provide a 24-hour, seven days a week hospital-based CSU for adult and older adult Medi-Cal beneficiaries	Palomar Health 2185 Citracado Parkway Escondido, CA 92029 (760) 480-7901	3, 5
CSS	TAOA-SD	Crisis Stabilization - South	Crisis Stabilization South Paradise Valley	The South Region Crisis Stabilization Unit provides 24-hour hospital-based crisis unit for Adults who are experiencing a psychiatric emergency.	Impact unnecessary and lengthy involuntary inpatient treatment, as well as promote care in voluntary recovery-oriented treatment settings.	Voluntary and involuntary adults and older adults with a serious mental illness.	• 24-hour, seven days a week, hospital- based crisis stabilization as an alternative to emergency room services. • Behavioral Health Assessments • Medication management • Case management • Linkage to community services	Prime Health Paradise Valley Bayview Crisis Stabilization Unit 330 Moss Street Chula Vista, Ca. 91911 (619) 426-6310	1

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Faith Based Services	Faith-Based Behavioral Health Training and Education Academy (FBBHEA) & Community Education	Provides training and education to FBBHEA participants using the developed curriculum for both faith leaders and behavioral health providers. The program outreaches, engages, and provides educational opportunities for faith-based leaders and behavioral health providers to participate in FBBHEA combined trainings. This includes creating educational materials to address faith/spirituality principles and values, wellness, behavioral health conditions, and resource information to the African-American and Latino communities in designated regions.	Increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health. The FBBHEA and its community education trainings will facilitate behavioral health awareness and connection to resources within their community. Identify Faith- Based and Behavioral Health Champions (faith leaders and behavioral health professionals who have successfully completed FBBHEA), who together provide Community Educational Presentations. These champions form a Cadre of Facilitator Trainers within the HHSA North Coastal and North Inland Regions.	Faith-based leaders and behavioral health providers provide resource information to African American and Latino communities in North Coastal and North Inland Regions. Faith-based organizations, churches, synagogue, temples, mosques and other places of worship, to support them and establish a ministry or group, designed and created by its members, to assist their membership in the area of behavioral health.	• Provide Community Education Presentations (CEPs) to the faith-based community. • Provide FBBHEA to faith leaders and behavioral health professionals. • Identify champions from FBBHEA sessions to create Cadre of Facilitator Trainers (FT) within the designated region	Interfaith Community Services, Inc. 613 W. Valley Parkway Escondido, CA 92025 (760) 204-2025	3, 5
CSS	TAOA-SD	Faith Based Services	Faith-Based Behavioral Health Training and Education Academy (FBBHEA) & Community Education	Provides training and education to FBBHEA participants using the developed curriculum for both faith leaders and behavioral health providers. The program outreaches, engages, and provides educational opportunities for faith-based leaders and behavioral health providers to participate in FBBHEA combined trainings. This includes creating educational materials to address faith/spirituality principles and values, wellness, behavioral health conditions, and resource information to the African-American and Latino communities in designated regions.	Increase awareness and understanding of behavioral health issues and faith-based approaches to behavioral health. The FBBHEA and its community education trainings will facilitate behavioral health awareness and connection to resources within their community. Identify Faith- Based and Behavioral Health Champions (faith leaders and behavioral health professionals who have successfully completed FBBHEA), who together provide Community Educational Presentations. These champions form a Cadre of Facilitator Trainers within the HHSA Central Region.	Faith-based leaders, behavioral health providers, provide resource information to African American and Latino communities in North Coastal and North Inland Regions. Faith-based organizations, churches, synagogue, temples, mosques and other places of worship, to support them and establish a ministry or group, designed and created by its members, to assist their membership in the area of behavioral health.	• Provide Community Education Presentations (CEPs) to the faith-based community. • Provide FBBHEA to faith leaders and behavioral health professionals. • Identify champions from FBBHEA sessions to create Cadre of Facilitator Trainers (FT) within the designated region	Stepping Higher, Inc. 7373 University Ave. Ste 201 La Mesa, CA 91942 (619) 577-6187	4
CSS	TAOA-SD	Faith Based Services	Project In-Reach Ministry	Provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life. The Faith-Based Wellness and Mental Health In-Reach Ministry will provide support services consistent with pastoral counseling and the individual's faith in addition to information, linkage and education about community-based resources.	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults.	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness.	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 286 Euclid Ave., Suite 209 San Diego, CA 92114 (619) 737-2639	All
CSS	TAOA-SD	Family Education	Family Mental Health Education & Services	Culturally appropriate outreach and engagement for the purpose of increasing access to mental health services.	Provide education and support that is built around goals and tools to help family members and friends understand, cope with, and respond to issues that arise due to mental illness, and shall promote the natural supports of family and friends' encouragement on recovery and resiliency.	Family members and friends of persons with behavioral health conditions.	• A series of educational classes presented by staff and/or family members using an established family education curriculum to provide education and support for persons who have relatives or close friends with behavioral health issues	Central Region St. Timothy's Lutheran Church 2602 Reo Drive San Diego, CA 92139 New Creation Church 3115 Altadena Ave. San Diego, CA 92105 North Central La Jolla Presbyterian Church 7715 Draper Ave. La Jolla, CA 92037 The Rock Church at Liberty Station 2277 Rosecrans St. San Diego, CA 92106 St. Gregory the Great Catholic Church 11451 Blue Cypress Drive San Diego, CA 92131 North Coastal: North Coast Calvary Church 1130 Poinsettia Lane Carlsbad, CA 92011	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	In-Home Outreach Teams (IHOT)	In-Home Outreach Team (IHOT)	IHOT provides mobile in-home outreach teams and engagement services to individuals with Serious Mental Illness (SMI) who are reluctant to seek outpatient mental health services and to their family members or caretakers.	The goal of IHOT is to reduce the effects of untreated mental illness in individuals with Serious Mental Illness (SMI), increase family member satisfaction with the mental health system of care while protecting public safety.	Adults/Older Adults 18 years of age and older reluctant to seek outpatient mental health services and to their family members.	• IHOT shall provide in-home assessment, crisis intervention, short term case management and peer and family/care-taker support services, psycho-education, linkage to outpatient mental health care, rehabilitation, recovery and other services to individuals with SMI, and their family or caretakers, as necessary. • IHOT outreach and engagement program shall facilitate follow up services that may include outpatient specialty mental health services, crisis intervention, acute care, alternatives to psychiatric hospitalization, conservatorship and case management services	Telecare Corporation - IHOT 1080 Marina Village Pkwy,. Suite 100 Alameda, CA 94501 (619) 961-2120	All
CSS	TAOA-SD	Inpatient and Residential Advocacy Services	Patient Advocacy Service	Patient Advocacy Services for mental health clients will be expanded to County-Identified Skilled Nursing Facilities.	Provide on-going support/advocacy services and training to staff and residents at County-identified Board and Care facilities. Expands services for County- Appointed Patient Advocate.	Children, Transition Age Youth, Adults/Older Adults.	• Provides inpatient advocacy services for adults and children/adolescents receiving mental health services in any covered 24-hour facility • Provides client representation at legal proceedings where denial of client rights are concerned • Handles client complaints and grievances for clients in these facilities	Jewish Family Service 8788 Balboa Ave. San Diego, CA 92123 (619) 282-1134	All
CSS	TAOA-SD	Institutional Case Management (ICM) - Older Adults	Agewise Supported Housing	Agewise Supported Housing is a Strengths-Based Case Management, and Institutional Case Management for Older Adults.	Provide SBCM and ICM services to adults over age 60 who suffer from serious mental illness and who may have a co-occurring substance use disorder. ICM population is on Public Conservatorship.	Older Adults (60+ y/o). ICM population is 60+ y/o and on Public Conservatorship.	• Strengths-Based Case Management and Institutional Case Management	Telecare Corporation 6160 Mission Gorge Road, Suite 108 San Diego, CA 92120 (619) 481-5200	All
CSS	TAOA-SD	Justice System Discharge Planning	Jail Discharge Planning	Jail Discharge Planning provides in-reach, engagement; education; peer support; follow- up after release from detention facilities and linkages to services that improve participant's quality of life.	Reduce recidivism, diminish impact of untreated health, mental health and/or substance use issues, prepare for re-entry into the community, and ensure successful linkage between in-jail programs and the community aftercare program that support former incarcerated youth and adults.	At-risk African-American and Latino adults (1170/re-alignment population) or Transition Age Youth incarcerated at designated facilities, with an additional focus on inmates with serious mental illness.	• Program provides discharge planning and short-term transition services for clients who are incarcerated and identified to have a serious mental illness to assist in connecting clients with community-based treatment once released	Neighborhood House Association Project In-Reach 5473 Kearny Villa Rd, Suite 300 San Diego, CA 92123 (619) 766-5994	All
CSS	TAOA-SD	Mental Health Advocacy Services	Adult SSI Advocacy	This program is responsible for the submission of applications to the Social Security Administration and further follow-up as needed.	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs.	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of BHS.	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid Society of San Diego Inc. 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	Bio-Psychosocial Rehabilitation (BPSR) and Wellness Recovery Center (WRC) (Vista)	The Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) provides outpatient mental health treatment, rehabilitation, and recovery services to adults age 18 and above who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi- Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Supportive Employment services • Transitional Age Youth (TAY) services • Older Adult (OA) services • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues • Weekend capability	Mental Health Systems, Inc. (MHS)/TURN BHS 550 West Vista Way Ste. 407 Vista, CA 92083 760-758-1092 Mental Health Systems, Inc. (MHS)/TURN BHS 1701 Mission Avenue Ste. 230 Oceanside, CA 92058 760-227-1490	5
CSS	TAOA-SD	North Coastal Mental Health Center and Vista Clinic	North Coastal Mental Health Center (N. Coastal MHC)						

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	North Inland Mental Health Center	North Inland Mental Health Clinic BPSR - N. Inland Region	The Biopsychosocial Rehabilitation (BPSR) Wellness Recovery Center (WRC) provides outpatient mental health treatment, rehabilitation, and recovery services to adults age 18 and above who have serious mental illness (SMI), including those who may have a co-occurring substance use disorder. The program provides community-based, recovery- oriented, specialty behavioral health services that are integrated, strength-based, culturally competent, and trauma informed.	Provide client access to integrated mental health, rehabilitation and recovery services in a timely manner to improve mental health and quality of life in the community.	Adults 18 years and older who have serious mental illness including those who may have a co-occurring substance use disorder and who are eligible for Medi-Cal funded services or are indigent.	• Urgent walk-in/screening services • Behavioral health assessments • Psychiatric evaluations and medication management • Group and individual counseling • Crisis intervention • Case management/care coordination • Peer support services • Mobile outreach • Homeless Outreach Services (including Programs to Assist Transition from Homelessness (PATH)) • Supportive Employment services • Transitional Age Youth (TAY) services • Older Adult (OA) services • Older Adult Outreach Services (OAOS) component, providing short-term clinical outreach for persons age 60 and over who may be at risk due to mental health issues • Weekend capability	Mental Health Systems, Inc. (MHS) North Inland Mental Health Clinic 125 W. Mission, Suite 103 Escondido, CA 92025 (760) 747-3424 MHS Kinesis North WRC 474 W. Vermont Escondido, CA 92025 (760) 480-2255 Kinesis North WRC--Ramona 1521 Main St. Ramona, CA 92065 (760) 736-2429 Kinesis North WRC - Fallbrook 591 East Elder St, Suite C Fallbrook, CA 92028 (760) 480-2255	3
CSS	TAOA-SD	North Inland Mental Health Center	Kinesis BPSR North Wellness Recovery Center						
CSS	TAOA-SD	Peer Assisted Support Services	Peer Assisted Support Services (Formerly INN-15 Peer Assisted Transitions)	Peer Assisted Support Services is a culturally competent program for adults with serious mental illness who are not connected to County operated or Contracted Behavioral Health Services (BHS) and present at Behavioral Health Units or Crisis Residential programs in the Central region. The Peer Assisted Support Services program engages with individuals in inpatient or crisis residential programs and continues engagement with these individuals after discharge from these programs to ensure they are connected to BHS. The program provides linkages and a warm handoff to needed mental health, substance use, and social services with the goal of decreasing hospitalization and crisis residential acute care by increasing connections to ongoing behavioral health services.	The goal of the Peer Assisted Support Services project is to increase the depth and breadth of services to persons diagnosed with serious mental illness who use acute, crisis-oriented mental health services but are unconnected with Mental Health services, substance use disorder services or community resources through the provision of peer specialist coaching incorporating shared decision-making and active social supports.	Transition Age Youth, Adults/Older Adults with serious mental illness. Adults diagnosed with a serious mental illness, including co-occurring substance use disorder and are not currently connected to County Operated Outpatient Clinics or contracted mental health or substance use programs and who are present at the designated 24/7 programs in the Central Region: Scripps Mercy and University of California San Diego (UCSD) Behavioral Health Units, and in their Emergency Departments (ED), as well as County designated Crisis Residential facilities.	• Peer specialist coaching • Connecting participants to relevant services	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 634-6586	4
CSS	TAOA-SD	Public Defender - Behavioral Health Assessor	Public Defender - Mental Health Assessor (Case Management) COLA increase based on County Comp Ordinance)	This program is comprised of licensed mental health clinicians who will provide discharge planning, care coordination, referral and linkage, and short-term case management to persons with a serious mental illness who have been referred by the Court for services.	Public Defender Treatment Unit will reduce untreated mental illness by ensuring persons are connected to system of care.	Adults 18 years and older with a serious mental illness who are incarcerated or Transition Age Youth at designated detention facilities who will be released in San Diego County.	• Discharge planning • Care coordination • Referral and linkage • Short term case management	Public Defender 450 B St., Ste 1100 San Diego, CA 92101 (619) 338-4700	All
CSS	TAOA-SD	San Diego Employment Solutions	Continuum of Supported Employment	The Continuum of Supported Employment offers services and opportunities for Transition Age Youth, Adults and Older Adults with serious mental illness.	Increase competitive employment of adults 18 and older who have a serious mental illness and who want to become competitively employed.	Adults 18 years and older who have a serious mental illness and need assistance with employment.	• Supportive employment program that provides an array of job opportunities to help adults with serious mental illness obtain competitive employment • Use a comprehensive approach that is community-based, client and family- driven, and culturally competent	Mental Health Systems, Inc. Employment Solutions 10981 San Diego Mission Rd. # 110 San Diego, CA 92108 (619) 521-9569	All
CSS	TAOA-SD	San Diego Housing Commission	SDHC Admin Home Finder Program	The SDHC Admin Home Finder Program provides support for 180 San Diego Housing Commission subsidies.	Provide support for housing.	Adults 18 years and older who have a serious mental illness and are experiencing homelessness in the city of San Diego.	• Housing vouchers/subsidies	San Diego Housing Commission 1122 Broadway San Diego, CA 92101 (619) 231-9400	1, 2, 3, 4
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	CRTP Del Sur Crisis Center	CRTP are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults (age 18 and older) who are seriously mentally ill and who may have a co-occurring substance use condition. Clients shall be voluntary clients who are experiencing a mental health crisis of such magnitude that they are unable to function without this type of intensive non- hospital intervention but are able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Del Sur Center 892 27th Street San Diego, CA 92154 (619) 575-4687	1

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	CRTP Halycon	CRTP are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness and who may have a co-occurring substance use condition. Services are on a volunteer basis for clients experiencing a mental health crisis and unable to function without this type of intensive non- hospital intervention, but able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Halcyon Crisis Center 1664 Broadway El Cajon, CA 92021 (619) 579-8685	2
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	CRTP Jary Barretto	CRTP are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness and who may have a co-occurring substance use condition. Services are on a volunteer basis for clients experiencing a mental health crisis and unable to function without this type of intensive non- hospital intervention, but able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Jary Barreto Crisis Center 2865 Logan Avenue San Diego, CA 92113 (619) 232-4357	1
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	CRTP New Nueva Vista	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness and who may have a co-occurring substance use condition. Services are on a volunteer basis for clients experiencing a mental health crisis and unable to function without this type of intensive non- hospital intervention, but able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF New Vistas Crisis Center 734 10th Avenue San Diego, CA 92101 (619) 239-4663	1
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	CRTP Turning Point	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness and who may have a co-occurring substance use condition. Services are on a volunteer basis for clients experiencing a mental health crisis and unable to function without this type of intensive non- hospital intervention, but able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Turning Point Crisis Center 1738 South Tremont Street Oceanside, CA 92054 (760) 439-2800	5
CSS	TAOA-SD	Short Term Acute Residential Treatment (START)	CRTP Vista Balboa	Crisis Residential Treatment Programs (CRTP) are short-term, intensive residential programs that provide recovery-oriented, intensive and supportive services to individuals 18 years of age and older, in a safe and therapeutic, home-like setting.	Provide an alternative to acute psychiatric hospital admission for clients who are voluntary. Accept clients appropriate for hospital diversion, including Crisis Stabilization Unit (CSU), or step-down from acute inpatient care.	Adults aged 18 and older who have a serious mental illness and who may have a co-occurring substance use condition. Services are on a volunteer basis for clients experiencing a mental health crisis and unable to function without this type of intensive non- hospital intervention, but able to be managed in a voluntary setting.	Twenty-Four hour, seven days a week crisis residential service as an alternative to hospitalization or step down from acute in-patient care within a hospital	Community Research Foundation CRF Vista Balboa Crisis Center 545 Laurel Street San Diego, CA 92101 (619) 233-4399	4
CSS	TAOA-SD	Short Term Bridge Housing	Short Term & Bridge Housing	Short-term & Bridge Housing is a program for adults with serious mental illness who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Rick's Independent Living 1021 South 37th Street San Diego, CA 92113 (619) 944-5795	4
CSS	TAOA-SD	Short Term Bridge Housing	Short Term & Bridge Housing	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Starts & Stripes 8064 Allison Ave #125 La Mesa, CA 91942 (619) 786-3486	4, 5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-Term & Bridge Housing is a program for adults with serious mental illness who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-Term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	Interfaith Community Services 550 W. Washington St., Suite B Escondido, CA 92025 (760) 489-6380	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	Short-term & Bridge Housing for adults with serious mental illness who are experiencing homelessness.	Provide housing and support services to adults with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients. Increase client-driven services to empower people with serious mental illness by decreasing isolation and increasing self-identified valued roles and self-sufficiency.	Adults, aged 18 and above, who have a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Shelter and food in a residential setting that has staff available during all operating hours • Safe and sanitary quarters on a nightly basis • Coordinate Peer Support Services	United Homes 515 North Horne St. Oceanside, CA 92054 (760) 612-5980	3, 5
CSS	TAOA-SD	Short-Term Bridge Housing	Emergency Shelter Beds/Short Term Bridge Housing	The Short-term & Bridge Housing for Transitional Age Youth (TAY) is for those with serious mental illness or serious emotional disturbance who are experiencing homelessness.	Provide housing and support services to TAY with serious mental illness or serious emotional disturbance, by providing accessible Short-term and Bridge Housing beds for identified clients.	TAY, 18 to 24 years of age, who have a serious emotional disturbance or a serious mental illness, and who may have a co-occurring substance use disorder, who are experiencing homelessness.	• Emergency shelter and transitional beds • Case management	Urban Street Angels, Inc. 1404 Fifth Ave San Diego, CA 92101 (619) 415-6616	4
CSS	TAOA-SD	Supplemental Security Income (SSI) Advocacy Services	Adult SSI Advocacy	Supplemental Security Income Advocacy Services is responsible for the submission of applications to the Social Security Administration and further follow-up as needed.	Expedite awards, provide training and consultation to designated Clubhouse advocates, and provide outreach and education to child focused programs.	Consumers who are recipients of General Relief, Cash Assistance Program for Indigents, County Medical Services and mental health consumers (children and adults) of Behavioral Health Services.	• Supplemental Security Income Advocacy • Collaborative advocacy with designated Clubhouse staff • Outreach, education, consultations • Application processing	Legal Aid Society of San Diego, Inc. 110 South Euclid Ave. San Diego, CA 92114 (877) 734-3528	All
CSS	TAOA-SD	Tenant Peer Support Services	Tenant Peer Support Services (TPSS)	TPSS is a program that provides housing navigation and support for persons with serious mental illness who are experiencing homelessness.	On-going support for clients experiencing homelessness who are connected to permanent supportive housing resources. Services include housing navigation and tenant support services. Includes nonclinical services for MHSA developed units, such as No Place Like Home (NPLH) units.	Adults 18 years and older with serious mental illness who are experiencing homelessness. Small number of families who are accessing family MHSA units will also be served.	• Support identifying and securing safe and affordable housing • Provides flex funds to support resident retention • Housing resources and education to clients, staff, and landlords regarding affordable housing for people with serious mental illness	Alpha Project 3808 El Cajon Boulevard Suite 102 San Diego, CA 92105 (619) 542-1877	All
PEI	DV-03	Alliance for Community Empowerment	Community Violence Services (ACE)-Central	This program provides trauma informed, community centered, family driven and evidenced-based Community Violence Response services, support, referrals, and linkages to care countywide.	Increase in resilience; increased knowledge of services; increased problem- solving and coping skills; reduces stigma and suicidal risk factors; reduces psycho- social impact of trauma.	Community members including middle-school age youth boys and girls affected by community violence.	• Immediate support and assistance, referrals and linkages to care after an incidence of community violence • Grief counseling, individual, and group interventions • Outreach, engagement, community education	Union of Pan Asian Communities (UPAC) 5348 University Ave., Suites 101 and 102 San Diego, CA 92105 (619) 232-6454	All
PEI	DV-04	Community Services for Families - Child Welfare Services (CWS)	Point of Engagement (CWS Contract)	This program provides family preservation, family support, and family reunification services to children and families in the CWS system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children 0 to 17 years old and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Home Start 5005 Texas St., Suite 203 San Diego, CA 92108 (619) 629-0727	2
PEI	DV-04	Community Services for Families - Child Welfare Services (CWS)	Point of Engagement (CWS Contract)	This program provides family preservation, family support, and family reunification services to children and families in the CWS system.	Provide family preservation, family support, and family reunification services to children and families in the CWS system.	Children 0 to 17 years old and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	North County Lifeline 707 Oceanside Blvd. Oceanside, CA 92054 (760) 842-6250	3, 5
PEI	DV-04	Community Services for Families - Child Welfare Services (CWS)	Point of Engagement (CWS Contract)	This program provides family preservation, family support, and family reunification services to children and families in the CWS system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children 0 to 17 years old and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	Social Advocates for Youth 8755 Aero Dr., Suite 100 San Diego, CA 92123 (858) 565-4148	4

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
PEI	DV-04	Community Services for Families - Child Welfare Services (CWS)	Point of Engagement (CWS Contract)	The Point of Engagement program provides family preservation, family support, and family reunification services to children and families in the CWS system.	Establish a community safety net to ensure the safety and well-being of children and their families.	Children 0 to 17 years old and their families at a high risk of child abuse and neglect.	• Case management • In-home parent education • Safe Care • Systematic Training for Effective Parenting • Parent Partners	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	EC-01	Positive Parenting Program (Triple P)	Positive Parenting Program	The Positive Parenting Program provides mental health prevention and early intervention services for parents using the Positive Parenting Program (Triple P) education curriculum.	Specialized culturally and developmentally appropriate mental health Prevention and Early Intervention (PEI) services to promote social and emotional wellness for children and their families.	Countywide parents and caregivers of children and adolescents, and child care staff who care for children in Head Start, Early Start and Education Enrichment Services centers.	• Free parenting workshops • Early intervention services • Referrals and linkage	Jewish Family Service 8804 Balboa Ave. San Diego, CA 92123 (858) 637-3000 ext. 3006	All
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	The Native American Prevention and Early Intervention (PEI) provides substance use disorder prevention and treatment services for Native Americans.	Increase community involvement and education through services designed and delivered by Native American communities.	American Indians; Alaska Natives; tribal members of North Region tribes; and qualified family members residing on reservations; All age groups; North Regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services	Indian Health Council 50100 Golsh Rd. Valley Center, CA 92082 (760) 749-1410	5
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides Prevention and Early Intervention (PEI) services for Native American Indian/Alaska Native urban youth.	Increase community involvement and education through services designed and delivered by Native American communities.	At risk and high risk urban American Indian and Alaska Native children and Transitional Age Youth.	• Specialized culturally appropriate prevention and early intervention services to Native American Indian/Alaska Native urban youth and their families who are participants at the Youth Center	San Diego American Indian Health Center 2602 1st Ave., Ste. 105 San Diego, CA 92103 (619) 234-1525	4
PEI	NA-01	Native American Prevention and Early Intervention	Native American Prevention and Early Intervention	Provides Prevention and Early Intervention (PEI) and substance use disorder prevention and treatment services for Native Americans.	Increase community involvement and education through services designed and delivered by Native American communities.	American Indians; Alaska Natives; tribal members of South and East Region tribes; and qualified family members residing on reservations; All age groups; South and East regions of San Diego County.	• Prevention and early intervention and substance use disorder treatment services	Southern Indian Health Council, Inc. 4058 Willows Rd. Alpine, CA 91901 (619) 445-1188	2
PEI	OA-01	Community-Based Services for Older Adults	Older Adult Prevention and Early Intervention (PEI) Community-Based Program	Community-Based Services for Older Adults provides outreach and support to older adults, especially to those who are non-Caucasian/non- English speaking.	Reduce ethnic disparities in service access and use. Increases access to care.	Multicultural Seniors, refugees, 60 years and older who are at risk of developing mental health problems.	• Outreach and education • Referral and linkage • Benefits advocacy • Peer counseling • Transportation services • Home and community-based services	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	All
PEI	OA-02	Home Based Services - For Older Adults	Older Adult Prevention and Early Intervention (PEI) - Caregiver Support Services	The Older Adult Prevention and Early Intervention (PEI) – Caregiver Support Services provides outreach, and prevention and early intervention services for homebound and socially isolated older adults by using Program to Encourage Active and Rewarding Lives (PEARLS) model.	Increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults. Reduces stigma associated with mental health concerns and disparities in access to services.	Homebound older adults 60 years and older who are at risk for depression or suicide.	• Screening • Assessment • Brief intervention (PEARLS and/or Psycho-education) • Referral and linkage • Follow-up care	Union of Pan Asian Communities (UPAC) 1031 25th St. San Diego, CA 92102 (619) 238-1783 ext. 30	1, 4, 5
PEI	OA-06	Caregiver Support for Alzheimer & Dementia Patients	Older Adult Prevention and Early Intervention (PEI) Services Homebound Program	The Caregiver Support for Alzheimer & Dementia Patients provides caregiver education, training, and early intervention services to prevent or decrease symptoms of depression and other mental health issues among caregivers.	Reduce incidence of mental health concerns in caregivers of patients that have Alzheimer's and other types of dementia. Improve the quality of well-being for caregivers and families. Provides services to an underserved/unserved population.	Adult Caregivers 18 years and older.	• Outreach • Information dissemination • Early intervention • Prevention education	Southern Caregiver Resource Center 891 Kuhn Drive, Suite 200 Chula Vista, CA 91914 (800) 827-1008	All
PEI	PS-01	Breaking Down Barriers	Breaking Down Barriers	The Breaking Down Barriers program provides outreach, engagement and community organizing to reduce the stigma associated with mental illness and improve mental health well-being.	Reduce mental health stigma to culturally diverse, unserved and underserved populations.	Unserved and underserved populations; Latino; Native American; African; Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ); African-American.	• Outreach and education to reduce mental health stigma to culturally diverse, unserved and underserved populations • Collaboration with community-based organizations to identify and utilize "cultural brokers" in community of color and non-ethnic groups	Jewish Family Services of San Diego 8804 Balboa Ave San Diego., CA 92123 (858) 637-3000	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
PEI	PS-01	Clubhouse Services Program	Clubhouse Homeless	This clubhouse will serve adults/older adults with a serious mental illness ages 18 and older including those who may have a co- occurring substance use condition. The clubhouse will assist individuals with serious mental illness to achieve social, financial, health/wellness, educational, and vocational goals and shall follow Clubhouse International Standards located at: https://clubhouse-intl.org/resources/quality-standards/.	Provide services to adults aged 18 years and older, with serious mental illness, including co-occurring substance use. Overall goals of this program include member access to socialization and rehabilitation supports, reducing social isolation, identifying areas of interest (personal, cultural, vocational, intellectual, and recreational), improve functioning, increasing employment and education, improving health and quality of life.	Homeless Adults/Older Adults who have a serious mental illness; Services are in Central Region with an emphasis in downtown San Diego.	• Clubhouse services including recovery education and support, employment assistance with SSI application • Additional Clubhouse components include shower and laundry support, and street outreach services	National Alliance on Mental Illness (NAMI) San Diego C2C Clubhouse 101 16th Street San Diego, CA 92101 (619) 776-8605	4
PEI	PS-01	Come Play Outside	Come Play Outside	The Come Play Outside program offers community-based programming inclusive of Parks After Dark curriculum to support the health and wellness of children, youth, and families.	Connect participants with outdoor activities within their community to increase pro-social interactions, promoting wellness, positive self-image while emphasizing confidence, respect, and a sense of responsibility.	Children, youth and their families.	• Outreach and engagement • Socialization, pro-social and wellness activities	City of San Diego Parks & Recreation Department 202 C W St. San Diego, Ca 92101 (619) 525.8211	All
PEI	PS-01	Family Peer Support Program	Family Adult Peer Support	The Family Peer Support Program provides an educational series, where community speakers share their personal stories about living with mental illness and achieving recovery. Written information on mental health and resources will be provided to families and friends whose loved one is hospitalized with a mental health issue.	Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	Family members and friends of psychiatric inpatients.	• Resources and support to family and friends visiting loved ones in psychiatric inpatient units in San Diego area • Public education	National Alliance on Mental Illness (NAMI), San Diego 5095 Murphy Canyon Rd., Suite 320 San Diego, CA 92123 (858) 643-6580	All
PEI	PS-01	Mental Health First Aid	Mental Health First Aid (MHFA)	MHFA is a public education program designed to give residents the skills to help someone who is developing a mental health problem or experiencing a mental health crisis.	Provide county-wide community- based mental health literacy education and training services.	Adults/Older Adults who work with youth.	• Interactive class that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders	Mental Health America of San Diego County 4069 30th St. San Diego, CA 92104 (619) 543-0412	All
PEI	PS-01	Suicide Prevention & Stigma Reduction Media Campaign - It's Up To Us	Primary/Secondary Prevention - Suicide Prevention ACTION Plan (Up 2 Us Media Campaign)	This program is a countywide media campaign geared towards suicide prevention and stigma discrimination, a suicide prevention action council to increase public awareness.	Prevent suicide and reduce stigma and discrimination experienced by individuals with mental illness and their families. Increases awareness of available mental health services.	Countywide individuals with mental illness; families of individuals with mental illness; general public.	• Public media campaign to education and promote mental health awareness • Print, radio, and TV ads • Printed materials	Rescue Agency Public Benefit, LLC 2437 Morena Blvd San Diego, CA 92110 (619) 231-7555	All
PEI	PS-01	Suicide Prevention ACTION Plan	Suicide Prevention ACTION Plan	The Suicide Prevention ACTION Plan provides facilitation of the San Diego Suicide Prevention Council to increase public awareness and understanding of suicide prevention strategies.	Reduce the number of suicides in San Diego County. Provide support and increase knowledge of mental illness and related issues. Reduces stigma and harmful outcomes.	General population, mental health service consumers, local planners, and mental health organizations.	• Suicide prevention action plan for understanding and awareness • Implement prevention initiatives • Facilitate Suicide Prevention Council and workgroups.	Community Health Improvement Partners 5095 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	PS-01	Supported Employment Technical Consultant Services	Supported Employment Technical Consultant Services	The Supported Employment Technical Consultant Services provides technical expertise and consultation on county-wide employment development, partnership, engagement, and funding opportunities for adults with serious mental illness. Behavioral Health Services coordinates and integrates services to develop new employment	Develop 5-Year Strategic Plan and implement strategies within BHS programs that include Supported Employment. Additionally, will operate as sub-committee of the BHS Adult Council.	Service providers, employers, agencies, government organizations, and other stakeholders.	• Promote employment opportunities for adults with serious mental illness.	San Diego Workforce Partnership, Inc. 9246 Lightwave Ave. #210 San Diego, CA 92123 (619) 228-2900	All
PEI	RC-01	Rural Integrated Behavioral Health and Primary Care Services	Rural Integrated Behavioral Health and Primary Care Services	This program provides prevention and early intervention services. The program works in partnerships with various primary care clinics in rural areas and utilizes a Screening, Brief Intervention and Referral to Treatment model to identify persons at risk for behavioral health issues. Treatment services are strengths-based, time limited and embrace the concepts of resilience and recovery for adults and children with severe emotional disturbance (SED), and their families.	Program staff provide health education and community engagement events, brief behavioral health interventions, psychiatric consultations, case management services, wellness screenings and referrals to treatment.	Children, Transition Age Youth, Adults/Older Adults.	• Assessment • Brief intervention • Education • Mobile outreach	Vista Hill Foundation 1012 Main Street, #101 Ramona, CA 92065 (760) 788-9725	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
PEI	RE-01	Independent Living Association (ILA)	Independent Living Association (ILA) & Care Court Program	This program provides and manages an ILA and Recovery Residence Association, which are a resource to identify, promote, and develop independent living, build their capacity, and direct those individuals in need of such services to available resources in the community.	Promote the highest quality home environments for adults with severe mental illness and other disabling health conditions. Serve residents that do not need medication oversight, are able to function without supervision, and live independently.	Member operators, individuals, families, discharge planners and care coordination who are seeking quality housing resources countywide.	• Education and training to member operators and residents. • Website listings • Resources to support clients • Resources to develop their business • Marketing tools • Advocacy support	Community Health Improvement Partners 5059 Murphy Canyon Rd., Suite 105 San Diego, CA 92123 (858) 609-7974	All
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-North Coastal	The School Based Prevention and Early Intervention provides services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Palomar Family Counseling Services 1002 East Grand Ave. Escondido, CA 92025 (760) 741-2660	3
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-Central & North Central	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	3, 4
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-Central Southeastern	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	4
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-East	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	San Diego Youth Services 3845 Spring Dr. Spring Valley, CA 91977 (619) 258-6877	2
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-South	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	South Bay Community Services 430 F St. Chula Vista, CA 91910 (619) 420-3620	1
PEI	SA-01	School Based Prevention and Early Intervention	School Based Prevention & Early Intervention-North Inland	Early intervention services utilizing the Incredible Years curriculum to provide school based social-emotional groups to parents and children in designated elementary schools.	Improve children's school success, reduce parental stress, reduce family isolation and stigma associated with seeking behavioral health services.	Pre-school through 3rd grade at risk children who struggle emotionally and behaviorally at designated elementary schools.	• Screening • Child skill groups • Parent skill groups • Classroom skill lessons • Community linkage/referrals • Outreach and engagement	Vista Hill Foundation 1029 N. Broadway Escondido, CA 92026 (760) 489-4126	5
PEI	SA-01	Screening to Care	Screening to Care North Coastal	Screening to Care is a school-based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Early intervention is provided through group sessions on school campuses to strengthen student's social emotional wellness, with care coordination offered to students who need connection to behavioral health treatment. Promotoras work to engage the parents to cultivate connections and foster a positive school environment.	Screen to identify students that could benefit from social emotional support and offer early intervention services.	Students with an emphasis on middle schools.	• Student Social Emotional Screening • All-campus social emotional activity recommendations based on screening results • Student small groups • Student individual check-ins • Student referrals to higher level of care • Parent groups • Parent outreach	Palomar Family Counseling Services Inc. 945 Vale Terra Drive Vista, CA 92084 (760) 741.2660	5

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
PEI	SA-01	Screening to Care	Screening to Care Central	School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Early intervention is provided through group sessions on school campuses to strengthen student's social emotional wellness, with care coordination offered to students who need connection to behavioral health treatment. Promotoras work to engage the parents to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from social emotional support and offer early intervention services.	Students with an emphasis on middle schools.	• Student SEL Screening • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check ins • Student referrals to higher level of care • Parent Groups • Parent Outreach	San Diego Unified School District 4487 Oregon St. San Diego, CA 92116 (619) 362-4330	4
PEI	SA-01	Screening to Care	Screening To Care East	School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Early intervention is provided through group sessions on school campuses to strengthen student's social emotional wellness, with care coordination offered to students who need connection to behavioral health treatment. Promotoras work to engage the parents to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from social emotional support and offer early intervention services.	Students with an emphasis on middle schools.	• Student SEL Screening • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check ins • Student referrals to higher level of care • Parent Groups • Parent Outreach	Fred Finch Youth Center 3845 Spring Drive Spring Valley, CA 91977 (619) 797-1090 ext 1045	2
PEI	SA-01	Screening to Care	Screening to Care South	School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Early intervention is provided through group sessions on school campuses to strengthen student's social emotional wellness, with care coordination offered to students who need connection to behavioral health treatment. Promotoras work to engage the parents to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from social emotional support and offer early intervention services.	Students with an emphasis on middle schools.	• Student SEL Screening • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check ins • Student referrals to higher level of care • Parent Groups • Parent Outreach	SBCS Corporation 430 F Street Chula Vista, CA 91910 (619) 952-6308	1
PEI	SA-01	Screening to Care	Screening to Care North Inland & Poway	School-Based behavioral health program which utilizes social-emotional screening to determine the level of support students may need. Early intervention is provided through group sessions on school campuses to strengthen student's social emotional wellness, with care coordination offered to students who need connection to behavioral health treatment. Promotoras work to engage the parents to promote connections and a sense of a positive school environment.	Screen to identify students that could benefit from social emotional support and offer early intervention services.	Students with an emphasis on middle schools.	• Student SEL Screening • All-campus SEL activity recommendations based on screening results • Student Small Groups • Student Individual check ins • Student referrals to higher level of care • Parent Groups • Parent Outreach	Vista Hill Foundation 1029 N Broadway Escondido, CA 92026 1012 Main St. Ste 101 Ramona, CA 92065 (760) 214-5207	2, 5
PEI	SA-02	School Based Suicide Prevention & Early Intervention	School Based Suicide Prevention & Early Intervention	This program provides school-based suicide prevention education and intervention services to middle school, high school, and Transition Age Youth.	Reduces suicide ideation, suicides, bullying and the negative impact of suicide in schools. Increases education of community and families.	Middle school, high school, and Transition Age Youth.	• Education and outreach • Screening • Crisis response training • Short-term early intervention • Referrals	San Diego Youth Services 3255 Wing St. San Diego, CA 92110 (619) 221-8600	All
PEI	VF-01	Veterans & Family Outreach Education	Veterans & Family Outreach Education (Courage to Call)	The Veterans & Family Outreach Education program provides confidential, peer- staffed outreach, education, referral and support services to the Veteran community & families and its service providers.	Increase awareness of the prevalence of mental illness in this community. Reduces mental health risk factors and/or stressors. Improves access to mental health and PEI services, information, and support.	• Education and outreach • Peer counseling/support groups • Linkages to mental health services and other resource • Support hotline	• Education • Peer counseling • Linkage to mental health services • Mental health information • 7/24/365 support hotline	Mental Health Systems, Inc. (MHS) 9465 Farnham St., Suite 100 San Diego, CA 92123 (858) 573-2600	All
WET	WET-02	Cultural Competency Academy	Specialized Training Modules (Cultural Competency)	The Cultural Competency Academy (CCA) provides training to Behavioral Health Services (BHS) and BHS contracted staff with trainings focused on clinical and recovery interventions for multicultural populations. The goal of CCA is to provide awareness, knowledge and skill-based trainings, while ensuring continued focus on being trauma informed from environmental to clinical applications.				San Diego State University Research Foundation 5250 Campanile Dr. San Diego, CA 92182 (619) 594-1900	All

MHSA COMPONENT	WORKPLAN	RER REVISED PROGRAM NAME	PROGRAM NAME	PROGRAM DESCRIPTION	PROGRAM GOAL	POPULATION FOCUS	SERVICES OFFERED	CONTACT INFORMATION	DISTRICTS
WET	WET-02	Interfaith Behavioral Health Workforce Centers Of Excellence (COE)	Interfaith Grant Agreement	The Interfaith Behavioral Health Workforce Centers of Excellence is a regional training center of excellence that provides training, education, and licensure to the workforce to advance career opportunities and fill behavioral health positions. The regional training center will provide opportunities for diverse populations to enter the behavioral health workforce and provide connected care to historically underserved communities.				Interfaith Community Services, Inc. 550 W. Washington Ave. Escondido, CA 92025 (760) 489-6380	All
WET	WET-02	Training and Technical Assistance	Big Why Conference	The Training and Technical Assistance program provides administrative and fiscal training support services to County of San Diego Health and Human Services Agency, Behavioral Health Services (BHS) in the provision of training, conferences and consultants. RTC shall contact trainers/consultants, develop, and execute training contracts between RTC and trainers/consultants, coordinate with BHS staff, facilitate payments to trainers/consultants and all approved ancillary training costs.				Regional Training Center 6155 Cornerstone Ct., Suite 130 San Diego, CA 92121 (858) 550-0040	All
WET	WET-02	Training and Technical Assistance	Training and Technical Assistance (TTA)						
WET	WET-02	Training and Technical Assistance	We Can't Wait Annual Conference (Early Childhood)						
WET	WET-03	Public Mental Health Academy	Public MH Academy – Academic Counselor	The Public Mental Health Academy provides an academic counselor to support student success in the community-based public mental health certificate program. This certificate program assists individuals in obtaining educational qualifications for current and future behavioral health employment opportunities. The certificate program provides options for individuals to be matriculated into an Associates and/or Bachelor Degree program to assist in the career pathway continuum.				San Diego Community College District 3375 Camino Del Rio South San Diego, CA 92108 (619) 388-6555	All
WET	WET-04	Community Psychiatry Fellowship	Residency Internship Programs Community Psychiatry Fellowship	The Community Psychiatry Fellowship programs are for physicians and public mental health nurse practitioners. One program i s for adult psychiatry residents and fellows and another program is for child and adolescent psychiatry residents and fellows. There are up to seven public mental health nurse practitioners who are studying at local universities. These programs foster the development of leaders in community psychiatry and provide exposure to the unique challenges and opportunities, and targeted approaches to ethnically and linguistically diverse populations.				Regents of the University of California, UCSD 200 West Arbor Dr. San Diego, CA 92103 (619) 471-9396	All

APPENDIX D

MHSA JUSTICE INVOLVED PROGRAMS

Population Served	*Program Name and Description*	*FY 2024-25 MHSA Three Year Plan Funding**	*MHSA Component*
All Ages	The **Mobile Crisis Response Team (MCRT)** is a field-based program utilizing teams that consist of a clinician, case manager, and a peer, that respond to emergency (non-911) calls to provide crisis intervention for individuals in a behavioral health crisis, and to connect them to the most appropriate level of care.	$ 8,700,159	CSS
All Ages	The **Psychiatric Emergency Response Team (PERT)** provides mental health consultation, case coordination, linkage to services and limited crisis intervention services for individuals with mental illness who come in contact with law enforcement officers.	$ 10,660,549	CSS
Youth	The **Bridgeways** program is a newly redesigned juvenile justice program that provides comprehensive services to address the behavioral health needs of justice involved youth or youth at risk of justice involvement. The program provides outpatient clinical services, field supportive services, and institutional services with the primary goal of establishing a unified continuum of care that allows for coordination of services within and outside the detention facilities.	$ 560,000	CSS
Youth	The **County of San Diego Juvenile Forensics** team provides mental health and case management services to children and youth in juvenile detention facilities to ensure they are able to successfully reintegrate into the community and to reduce recidivism.	$ 1,100,000	CSS
Youth	**Mobile Adolescent Service Team (MAST)** is an outpatient treatment program that serves children and youth in the community who are involved with the justice system. The program enhancement allows for increased psychiatry coverage.	$ 2,165,000	CSS
Transitional Age Youth	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) program for Transition Age Youth (TAY)** provides services to TAY who are homeless, may have been referred by jail services, are experiencing serious mental illness (SMI), and who may also have a co-occurring substance use disorder.	$ 5,999,968	CSS
Adults	The **Faith Based Wellness and Mental Health Inreach Ministry** program focuses on adults diagnosed with serious mental illness (SMI) while in jail and also engages individuals with schizophrenia or bipolar disorders to provide spiritual support, wellness education for physical and mental health, and linkages to community- based resources for reintegration into the community.	$ 926,485	CSS
Adults	The **Justice Integrated Full Service Partnership (FSP) Assertive Community Treatment (ACT)** program provides services to homeless adults experiencing serious mental illness (SMI) who may also have a co-occurring substance use disorder. Clients served are system involved and have received mental health services while in detention. An array of housing options is provided to enrolled clients. Includes new program rows added to Center Star.	$ 6,268,167	CSS
Adults	The **Full Service Partnership (FSP) Assertive Community Treatment (ACT) for Persons with High Service Usage and Persons on Probation** program provides multidisciplinary, wraparound treatment and rehabilitation services, along with housing.	$ 5,233,693	CSS
Adults	The **Collaborative Behavioral Health Court and Assertive Community Treatment (ACT)** program focuses on adults in the Central Region who are referred by the Court for services as an alternative to custody.	$ 2,959,342	CSS
Adults	The **Public Defender Discharge and Short Term Case Management Service** adds two licensed mental health clinicians to provide discharge planning, care coordination, referral and linkage to services, and short term case management for persons with SMI who have been referred by the Court for services.	$ 240,000	CSS
Adults	**Justice System Discharge Planning**, or Project Enable, provides in-reach services to assist with discharge planning and short-term transition services for clients who are in jail and identified to have SMI, to assist in connecting clients with community- based treatment once released.	$ 1,139,376	CSS
Adults	**Probation Officers for Behavioral Health Court and Full Service Partnerships (FSPs)** are dedicated to specific Assertive Community Treatment (ACT) teams to provide support and case management of individuals with SMI who are on probation.	$ 600,000	CSS
Adults	The **Behavior Health Assessor** is a program within the Lemon Grove Family Resource Center that provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 250,000	CSS
Adults	The **Behavior Health Assessor** is a program for Courts in South and Central Regions the provides screening, assessment and linkage for mental health and/or drug and alcohol issues for offenders prior to and/or following release to determine need and level of care.	$ 435,000	CSS
Adults	The **Veterans & Family Outreach Education** program, or Courage to Call, is a veteran peer-to-peer support program staffed by veteran peers. The program provides countywide outreach and education to address the mental health conditions that impact veterans, active duty military, reservists, National Guard, and their families (VMRGF), and provides training to service providers of the VMRGF community. This program includes navigator assistance in Veterans' Court for those involved with the justice system	$ 1,582,669	PEI
Grand Total		**$ 48,820,409**	

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

APPENDIX E

COUNTY OF SAN DIEGO DEMOGRAPHICS

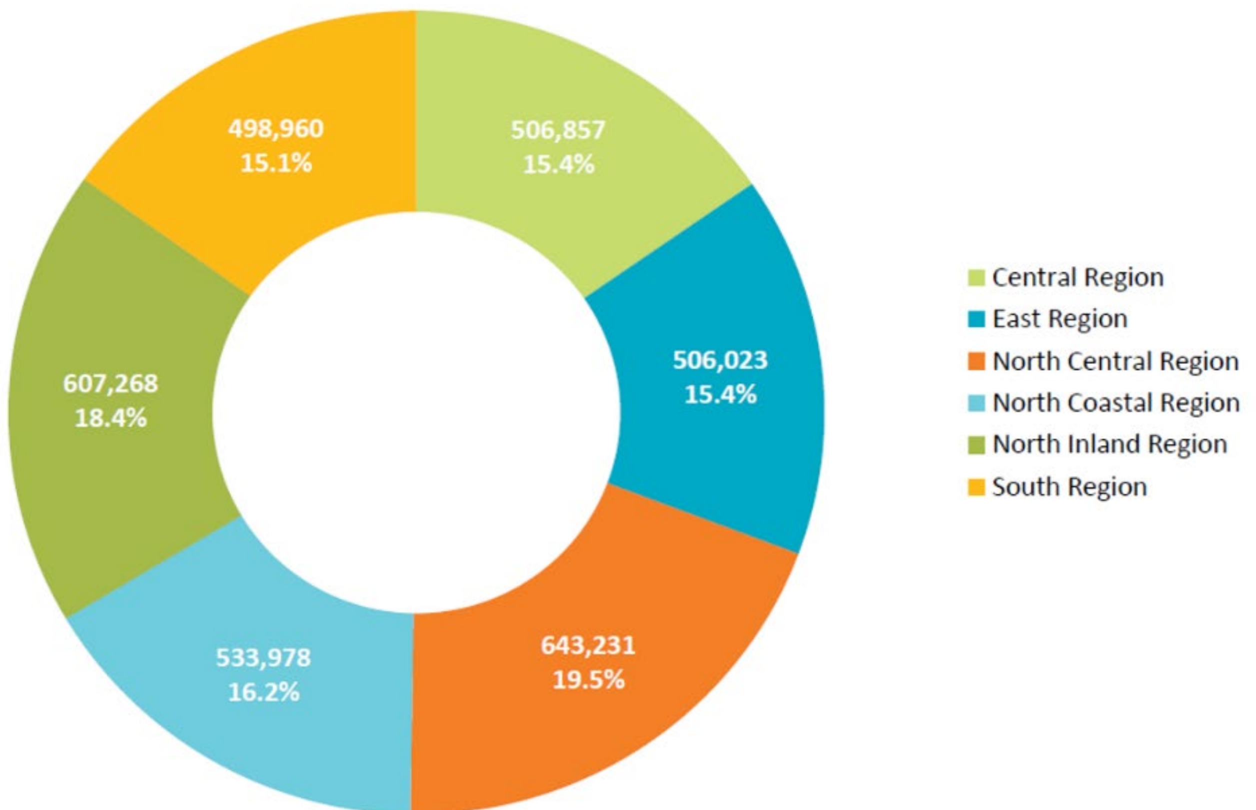
TOTAL POPULATION

San Diego County Population Distribution by HHSA Regions, 2021

HHSA Region	Population	%
Central Region	506,857	15.4%
East Region	506,023	15.4%
North Central Region	643,231	19.5%
North Coastal Region	533,978	16.2%
North Inland Region	607,268	18.4%
South Region	498,960	15.1%
San Diego County Total	**3,296,317**	**100.0%**

Source: U.S. Census Bureau; 2017-2021 American Community Survey 5-Year Estimates, Table B01001.
Note that percentages may not add up to 100% due to rounding.

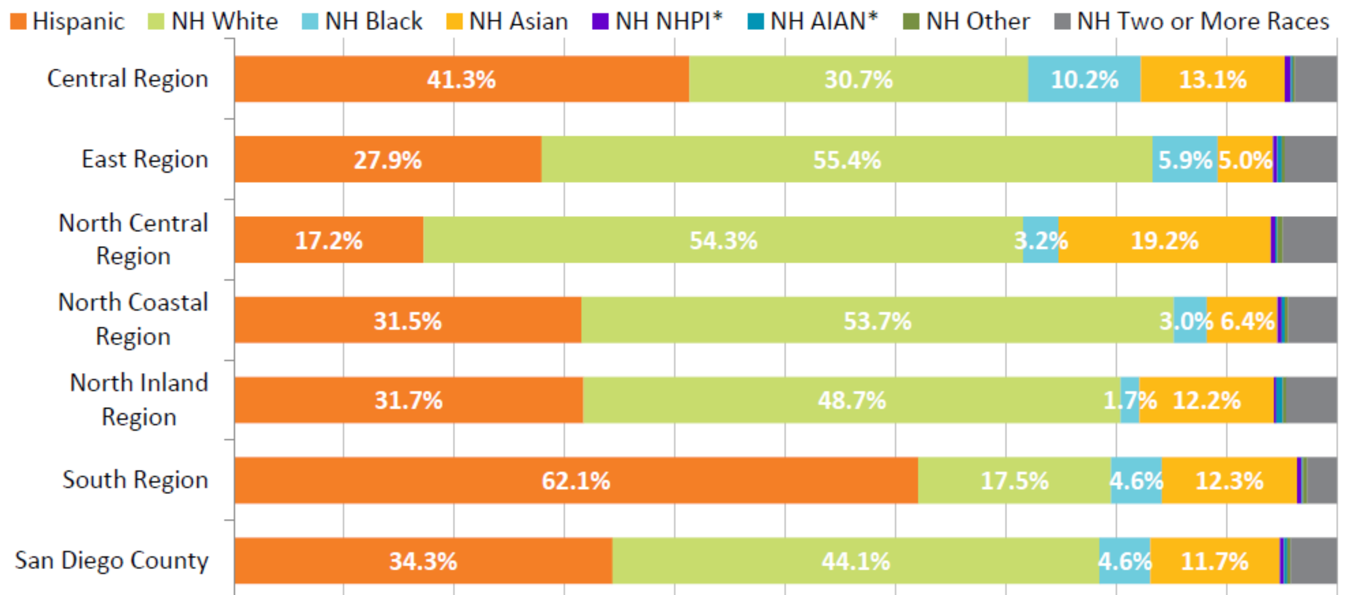
Figures above show the number of persons living at each Health and Human Services (HHSA) Region. In 2021, San Diego had a population of nearly 3.3 million.



RACE/ETHNICITY BY HHSA REGIONS

HHSA Region	Hispanic	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Native Hawaiian/ Pacific Islander	American Indian/ Alaskan Native	Other Race Alone	Two or More Races
Central Region	209,376	155,483	51,894	66,251	2,577	1,016	1,183	19,077
East Region	141,187	280,379	30,048	25,468	1,814	2,139	1,412	23,576
North Central Region	110,890	349,381	20,487	123,740	2,504	1,436	3,428	31,365
North Coastal Region	168,141	286,680	15,806	34,280	2,323	1,528	1,516	23,704
North Inland Region	192,254	295,820	10,299	73,904	1,322	3,846	1,924	27,899
South Region	309,607	87,429	22,744	61,601	1,993	471	1,782	13,333
San Diego County Total	**1,131,455**	**1,455,172**	**151,278**	**385,244**	**12,533**	**10,436**	**11,245**	**138,954**

Source: U.S. Census Bureau; 2017-2021 American Community Survey 5-Year Estimates, Table B03002.

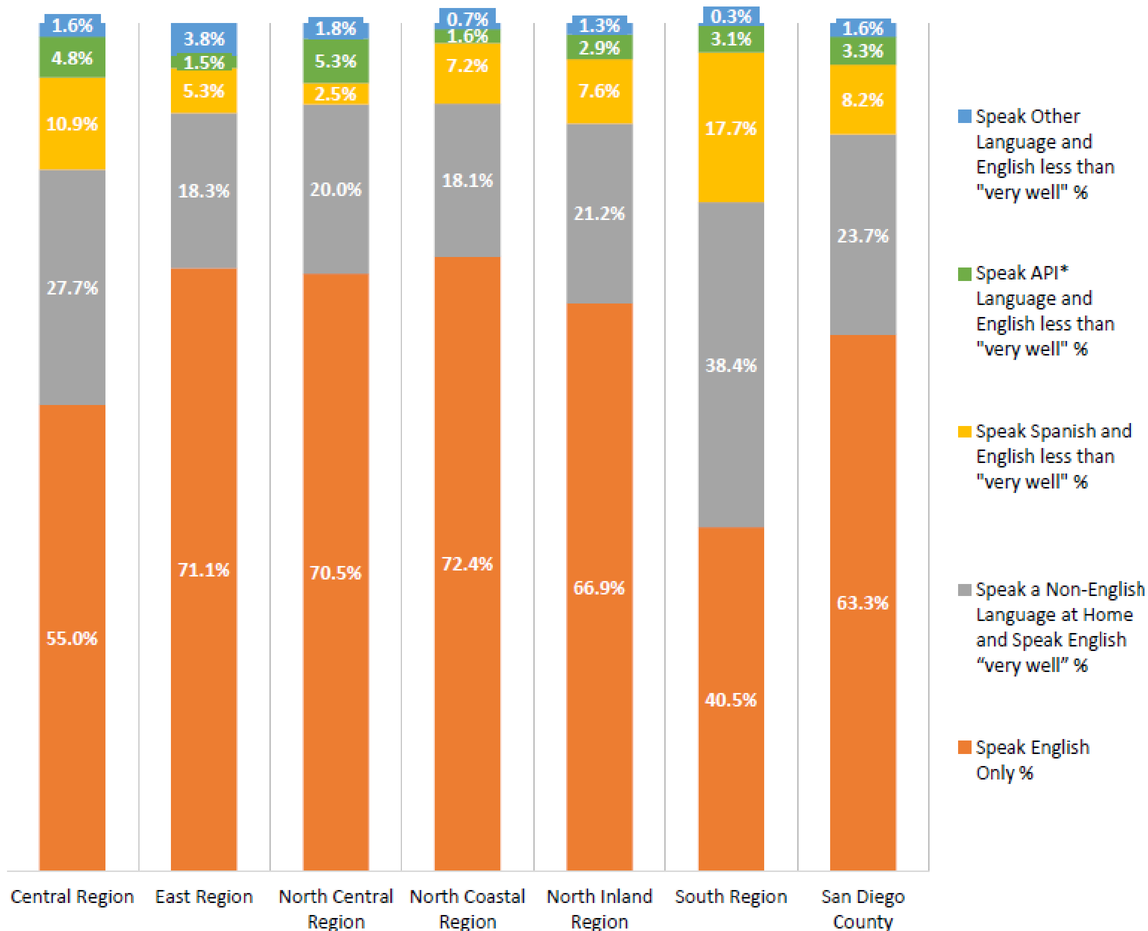


*NH refers to Non-Hispanic or Latino; NHPI refers to Native Hawaiian or Pacific Islander; AIAN refers to American Indian/ Alaska Native. Source: U.S. Census Bureau; 2017-2021 American Community Survey 5-Year Estimates, Table B03002.

LANGUAGE SPOKEN AT HOME AND ABILITY TO SPEAK ENGLISH (5 YEARS AND OLDER)

HHSA Region	Population Age 5+	Speak English only	Speak a non-English language at home and English "Very Well"	Speak Spanish and Speak English less than "Very Well"	Speak Asian and Pacific Islander languages and English less than "Very Well"	Speak Other Language and English less than "Very Well"
Central Region	480,485	55.0%	27.7%	10.9%	4.8%	1.6%
East Region	472,241	71.1%	18.3%	5.3%	1.5%	3.8%
North Central Region	606,908	70.5%	20.0%	2.5%	5.3%	1.8%
North Coastal Region	501,432	72.4%	18.1%	7.2%	1.6%	0.7%
North Inland Region	567,430	66.9%	21.2%	7.6%	2.9%	1.3%
South Region	469,444	40.5%	38.4%	17.7%	3.1%	0.3%
San Diego County	**3,097,940**	**63.3%**	**23.7%**	**8.2%**	**3.3%**	**1.6%**

Source: U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.

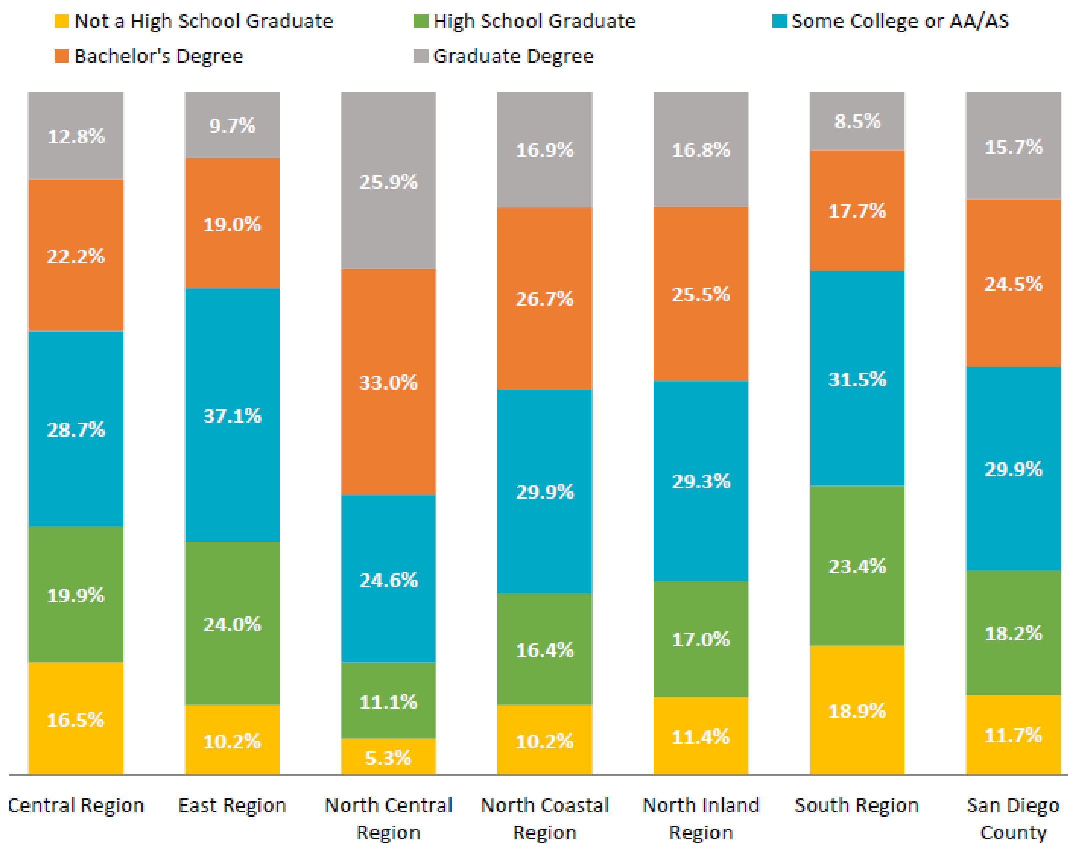


*API refers to Asian/Pacific Islander. Source: U.S. Census Bureau, 2017-2021American Community Survey 5-Year Estimates, Table DP02.

EDUCATIONAL ATTAINMENT AMONG POPULATION 25 YEARS AND OLDER

HHSA Region	Population Age 25+	Not a High School Graduate	High School Graduate	Some College or AA/AS	Bachelor's Degree	Graduate Degree
Central Region	354,336	16.5%	19.9%	28.7%	22.2%	12.8%
East Region	343,873	10.2%	24.0%	37.1%	19.0%	9.7%
North Central Region	453,663	5.3%	11.1%	24.6%	33.0%	25.9%
North Coastal Region	354,091	10.2%	16.4%	29.9%	26.7%	16.9%
North Inland Region	413,627	11.4%	17.0%	29.3%	25.5%	16.8%
South Region	331,731	18.9%	23.4%	31.5%	17.7%	8.5%
San Diego County	**2,251,321**	**11.7%**	**18.2%**	**29.9%**	**24.5%**	**15.7%**

Source: U.S. Census Bureau; 2017-2021 American Community Survey 5-Year Estimates, Table DP02.
Note that percentages may not add up to 100% due to rounding.

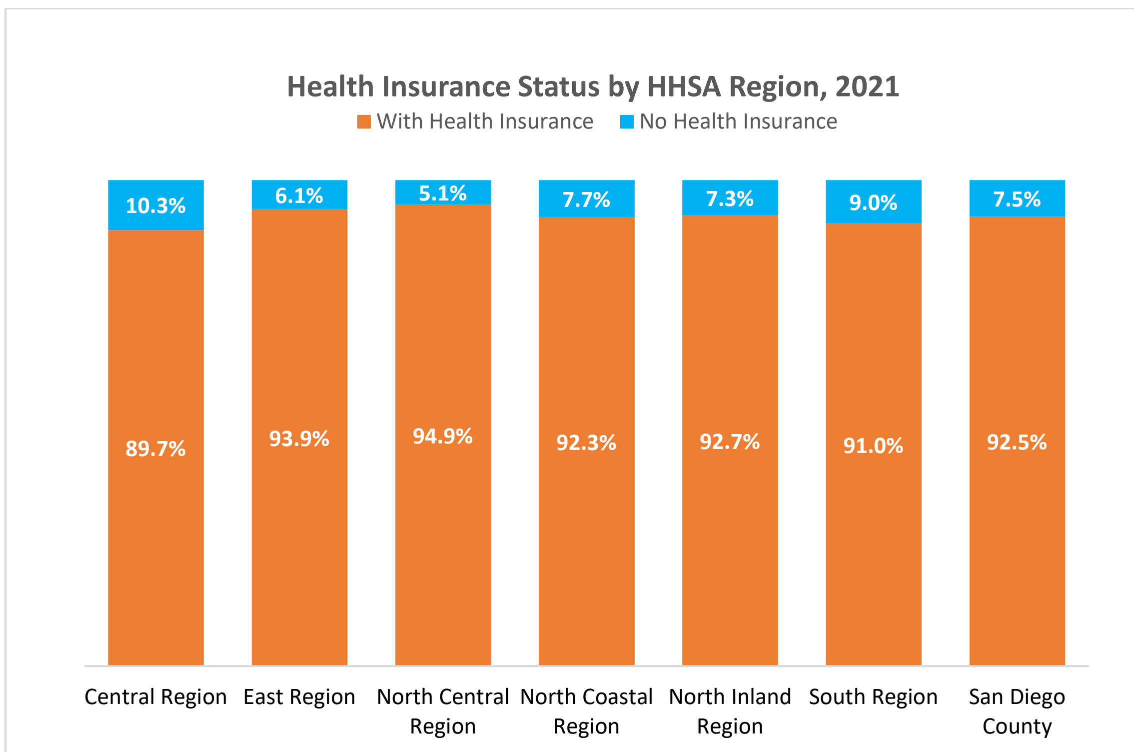


Source: U.S. Census Bureau, 2017-2021American Community Survey 5-Year Estimates, Table DP02

HEALTH INSURANCE STATUS

HHSA Region	With Health Insurance	No Health Insurance	0-18 with Health Insurance	19-25 with Health Insurance	26-44 with Health Insurance	45-64 with Health Insurance	65+ with Health Insurance
Central Region	89.7%	10.3%	94.8%	86.6%	85.5%	88.1%	98.7%
East Region	93.9%	6.1%	96.4%	90.3%	90.8%	92.9%	98.9%
North Central Region	94.9%	5.1%	97.7%	92.1%	92.3%	94.6%	99.2%
North Coastal Region	92.3%	7.7%	96.5%	87.0%	86.7%	91.5%	99.1%
North Inland Region	92.7%	7.3%	96.1%	86.0%	88.2%	91.8%	98.8%
South Region	91.0%	9.0%	94.7%	85.2%	86.5%	90.2%	98.4%
San Diego County	**92.5%**	**7.5%**	**96.1%**	**88.1%**	**88.5%**	**91.7%**	**98.9%**

Source: U.S. Census Bureau; 2017-2021 American Community Survey 5-Year Estimates, Table B27001.
Note that percentages may not add up to 100% due to rounding.



Source: U.S. Census Bureau, 2017-2021 American Community Survey 5-Year Estimates, Table DP02.

APPENDIX F

COMMUNITY ENGAGEMENT REPORT

BEHAVIORAL HEALTH SERVICES
COMMUNITY ENGAGEMENT

Fiscal Year 2023-2024 Annual Update

COMMUNITY HEALTH IMPROVEMENT PARTNERS
making a difference together

UC San Diego

Contents

Executive Summary 98
Chapter 1 – The Mental Health Services Act & the Community Program Planning Process 101
Introduction 101
Advancing Diversity and Health Equity 102
Background and Purpose 103
Best Practices 104
Chapter 2 – Community Engagement Efforts 106
Stakeholder Engagement Efforts 106
Existing Networks 109
Other Community Networks 110
Outreach Events 114
Chapter 3 – Community Engagement: Methodology 117
Key Informant Interviews 117
Focus Groups 117
Listening Sessions 118
Chapter 4 – Community Engagement: Analysis & Results 120
Qualitative Analysis 120
Community Engagement Efforts: Participants 121
Community Engagement Efforts: Findings 127
Listening Sessions 128
Overall Themes from Interviews and Focus Groups 135
Chapter 5 – Recommendations for Behavioral Health Services 141
Chapter 6 – Future Directions 145
Promote Inclusivity, Accessibility, and Stakeholder Representation 147
Next Steps 148
Appendix List 149
Appendix A: Satisfaction & Demographic Survey 149
Appendix B: UC San Diego Focus Group Flyer 149
Appendix C: UC San Diego Focus Group Interview Guide 149
Appendix D: UC San Diego Listening Session Presentation 149
Appendix E: UC San Diego Listening Session Flyer 149
Appendix F: Community Specific Findings 149

Executive Summary

Background

In 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The primary aims of the MHSA are to increase access to unserved and underserved individuals and families by reducing disparities in the service delivery system for children, adults, and older adults (OAs), with Serious Mental Illness (SMI). To facilitate these efforts, the MHSA incorporates a 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. During Fiscal Year (FY) 2023-24, CPP engagement activities were designed to inform the MHSA Annual Update to the current County's MHSA Three-Year Plan for 2023-2026 which describes Behavioral Health Services' (BHS) 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 as well as guides the provision of behavioral health services throughout San Diego County.

In San Diego County, the community engagement activities were led by the University of California San Diego (UC San Diego) Health Partnership, in partnership with Community Health Improvement Partners (CHIP), and the Global Action Research Center (Global ARC), in collaboration with BHS. This collective partnership facilitated the establishment of community engagement efforts focused on engaging vulnerable, unserved, and underserved populations with a commitment to equity, diversity, and inclusion to promote community empowerment.

Engagement Efforts

The UC San Diego Partnership is committed to authentic community engagement efforts, focusing on equity, and promoting community empowerment of unserved, underserved, and hard-to-reach populations. Stakeholders are considered partners throughout the community engagement process. To fully realize the potential of the community engagement process, the UC San Diego Health Partnership must be inclusive of stakeholders representing diverse communities, large and small behavioral health and non-behavioral health services, advocacy, faith-based, and other nonprofit organizations. With this intention, UC San Diego Health Partnership approached the community engagement process relying on the principles of Community-Based Participatory Research (CBPR) methods to integrate key constituencies in the development and implementation of community engagement activities.

In FY 2023-24, the UC San Diego Health Partnership, in collaboration with BHS, developed a stakeholder outreach and engagement plan to facilitate a county-wide community engagement effort ensuring commitment to priority population groups, such as Black/African American, deaf and hard of hearing community, individuals experiencing homelessness, individuals with SMI, justice-involved, Latine/Hispanic, lesbian, gay, bisexual, transgender, queer (LGBTQ+), refugee communities, Transitional Aged Youth (TAY, aged 17 to 25), and Veterans/military. Outreach was facilitated through UC San Diego Health Partnership's extensive network of community partners and individuals who have a specific understanding of each priority population to aid recruitment and participation in a variety of existing community meetings occurring throughout the county. Outreach efforts conducted in this community engagement process connected with unserved and underserved communities, including those historically

unreached. Three primary types of community engagement activities were facilitated by the UC San Diego Health Partnership team to gather information from community stakeholders throughout the county: 1) Key Informant Interviews; 2) Focus Groups; and 3) Listening Sessions. Additional outreach included regular contact with the public and building on existing networks through interactive councils, advisory boards, and stakeholder engagement.

Key informant interviews and focus groups gathered insight into the existing community strengths, resources, and needs of program services for specialized populations, and input from community leaders and advocates regarding essential steps needed for community engagement efforts within the San Diego community. Interview and focus group participants included a combination of providers, community advocates and leaders, community groups, and consumers of the following identified specialized populations: Adult Residential Facilities, Black communities, Clubhouses, the deaf and hard of hearing community, individuals experiencing homelessness, individuals with SMI, justice-involved, Latine/Hispanic communities, LGBTQ+, Native Americans, peer support specialists, OAs, refugee communities, rural communities, TAY, Veterans, and youth.

Listening sessions were developed and conducted by the UC San Diego Health Partnership as structured feedback activities in all the regions at varying event locations (i.e., existing community meetings, libraries, Live Well San Diego spaces, etc.). 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 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 BHS and the UC San Diego Health Partnership and providing background to the MHSA community engagement efforts. Participants were then guided through a community engagement activity addressing a series of questions related to behavioral health needs, challenges in accessing resources, strategies to address specific community needs and ideas of how to effectively share behavioral health resources. Each session included a facilitated discussion of individual responses. Both the discussion notes and the structured feedback were documented and incorporated into the analyses discussed in this report.

Community engagement efforts also included outreach to existing networks for input gathering and to build a wide range of community partners and allies. These networks include the Behavioral Health Advisory Board (BHAB), BHS System of Care Councils, and community stakeholder groups. The UC San Diego Health Partnership also attended various community outreach events throughout the year for intentional networking, to connect with the community and organizational leaders. Events included the National Recovery Month Celebration, Live Well 5k, Meeting of the Minds, Out of the Darkness, and the Live Well Advance.

The information collected as part of the community engagement process was used to determine the community and regional behavioral health needs, assets, and recommendations for this Annual Update to the current MHSA Three-Year Plan for 2023-2026.

Findings

Collectively, the FY 2023-24 community engagement activities included 20 key informant interviews, 20 focus groups, and 14 listening sessions, engaging over 400 people. Learnings from all the engagement

activities were robust, resulting in key findings and themes that were persistent among participants across engagement activities. The five major findings that were salient across all engagement activities are highlighted below:

- Lack of healthcare access and support systems.
- Lack of housing and behavioral health beds.
- The value of culturally competent services.
- The need for continued community engagement.
- The importance of valuing community input on behavioral health services.

Participants emphasized the strength and resilience within San Diego's diverse communities throughout all engagement activities. The importance of community input on behavioral health services was highlighted, with emphasis on the need for BHS to not only collect but to act on the provided input. Community members also value the community engagement efforts led by UC San Diego Health Partnership and in collaboration with BHS. Providing participation incentives was a theme for ensuring authentic reach and value for unserved or underserved key populations. 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 shared in the Appendix F - Community Specific Findings. 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.

Consistent with the efforts to realign system priorities, as detailed in the County's MHSA Three-Year Plan for 2023-2026, emergent recommendations from the community engagement activities centered primarily around the varying community needs. Results include innovative suggestions about behavioral health prevention, early intervention, and treatment services. In addition, BHS should work to enhance community members' awareness of and cultivate a positive understanding of behavioral health needs and services that would allow people to benefit from such a system. Furthermore, if there are existing BHS services that address the recommendations, those should be effectively promoted to reach a wide range of diverse communities. The findings formed the basis for the set of 16 primary behavioral health service change recommendations listed in Table 9 (see page 141). In addition to specifying the recommendations that emerged from the community feedback findings, Table 9 includes potential strategies that could be utilized, with community input and participation, to make progress toward achieving each recommendation.

The community input and recommendations are 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." The "right service" includes recommendations centered on the wide range of services needed and to ensure these services are high quality and effective. A few examples of this include "warm handoffs" and follow-through from providers, along with an increased variety of services for specific populations or geographical needs. Those characterized as "right time" include services that address waitlist issues, hours of care facilities, and timely care. Services needed 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 preferable community spaces. Lastly, services by the "right people" speaks to ensuring culturally relevant services, improving language diversity, and diversifying the workforce.

Future Directions

Through this formative effort, a substantial amount of feedback was collected and the findings in this report highlight a wide range of community needs, suggestions for resources, and recommendations for how best to continue this work in the future. Strengthening the feedback process with the community, ensuring the final MHSA annual report reflects the experiences and ideas of those who participated in the community engagement activities is important for establishing and maintaining community trust. Additional steps that may be taken to further community trust and engagement include:

- Following up with the community to communicate how feedback has been utilized to inform MHSA program planning.
- Encourage participation by providing information about the feedback process and establishing a regular, structured process.
- Ensuring transparency by ensuring community input is inclusively and truthfully included in the final MHSA Annual Report.

Next Steps

Taken together, the feedback obtained through the FY2023-24 community engagement process led by the UC San Diego Health Partnership illuminated key ingredients for realizing the full benefits and potential of this process, including engaging diverse communities with authenticity, inclusion, transparency, and trust. Both the UC San Diego Health Partnership and BHS will continue to expand outreach efforts to ensure the representation of unreached populations and communities in ongoing engagement endeavors. Community members emphasize a key foundation for this goal requires providing substantial advance notice of input opportunities, creating multiple modes of obtaining input, and ensuring that engagement activities are available in multiple languages, in settings where stakeholders are most at ease. Flexibility to community needs and preferences remains essential to the UC San Diego Health Partnership's meaningful, authentic, and responsive community engagement process. The Partnership will continue fostering a community engagement approach that is welcoming, inclusive, and aligned with other behavioral health-related engagement activities, with a particular emphasis on connecting with individuals from historically unserved and underserved communities.

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 County of San Diego County Behavioral Health Services (BHS) Department. The fiscal support of the MHSA offers critical resources to support the County'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 BHS. 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 and 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 collaborates 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 County'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, BHS continues to enhance data integration and health equity work through the establishment of the BHS Data Sciences and Population Health units. Additionally, BHS 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. BHS 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 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, that 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's MHSA 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 this Plan. The CPP process helps inform the County's MHSA Three-Year Plan for 2023-2026 and subsequent annual updates. Engagement efforts conducted this fiscal year are utilized to inform the annual update.

The current local community engagement efforts involve building trust and enlisting new resources and allies for facilitating better communication and improving health outcomes. The BHS 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 BHS 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 the BHS system of care.

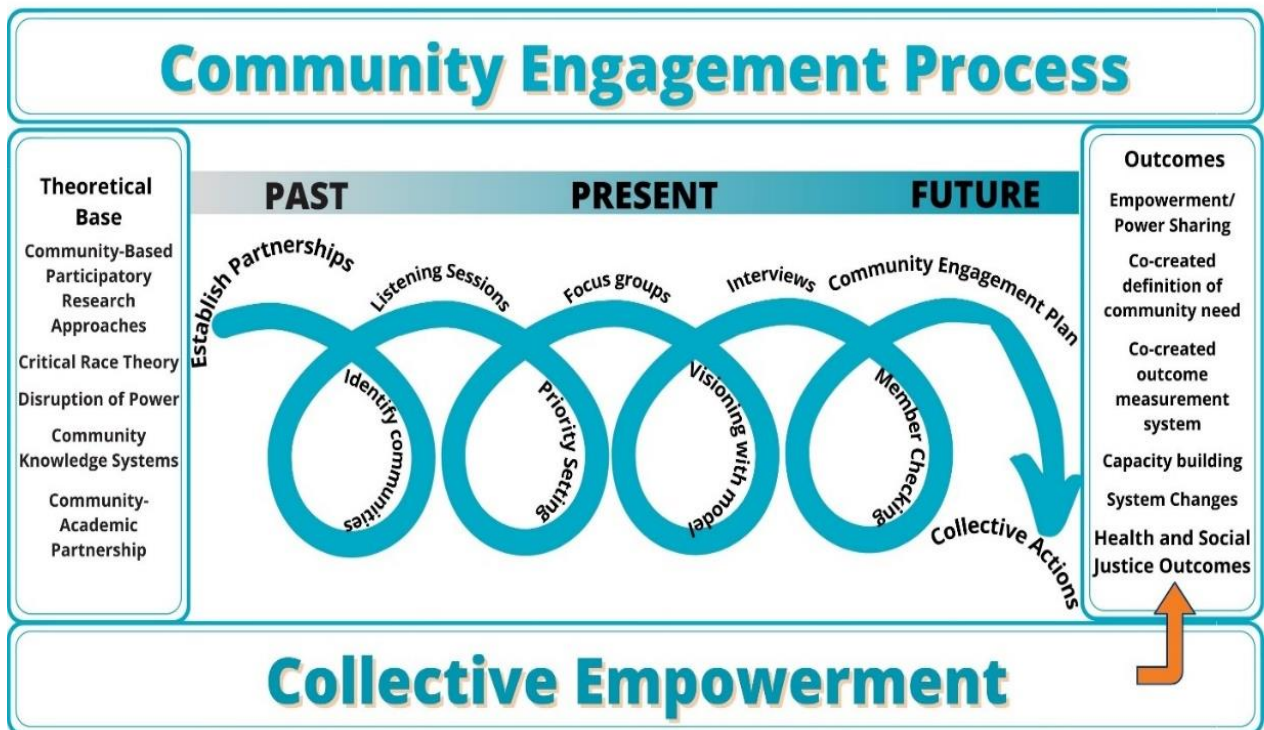
In summary, the CPP process is a vital part of the MHSA, emphasizing ongoing community engagement, feedback gathering, and collaboration to create a more inclusive and responsive mental health system in the County. The CPP process reflects the importance of listening to and acting on the needs of individuals and communities that have historically been left out of mental health discussions and services. The CPP process helps inform the County's MHSA Three-Year Plan for 2023-2026 and subsequent Annual Updates, which drive all aspects of MHSA funding. Ongoing community engagement efforts in the County 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 the County 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



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 BHS. 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 BHS 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 the county. 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 the county. UC San Diego Health Partnership, in collaboration with BHS, was the foundational structure used to capture and leverage community resident and stakeholder behavioral health input regarding challenges and prevention strategies to inform the BHS 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 the County 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 Black and African American community, the Deaf community, individuals experiencing homelessness, individuals experiencing SMI, justice-involved, Latine/Hispanic, LGBTQ+ populations, refugee 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 BHS 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 BHS seeks to develop.

Figure 3. The County of San Diego Priority Population Groups

Population	Description
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 6% of adult BHS clients in 2022-2023 ➢ 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 ➢ 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 the County. In October 2023, 1,057,375 County 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 Behavioral Health Advisory Board (BHAB) serves as the primary oversight and engagement advisory board for the County's 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 County's MHSA Three-Year Plan for 2023-2026 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 the County's MHSA Three-Year Plan for 2023-2026 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 San Diego County community members 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).

BHS System of Care Councils

Six BHS 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, explore new opportunities for collaboration, and provide recommendations to the BHS Director. All SOC Councils work directly with the BHS, system partners, and other BHS Councils to address social determinants of health, including the technology needs of consumers.

SOC 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 BHS Forums.

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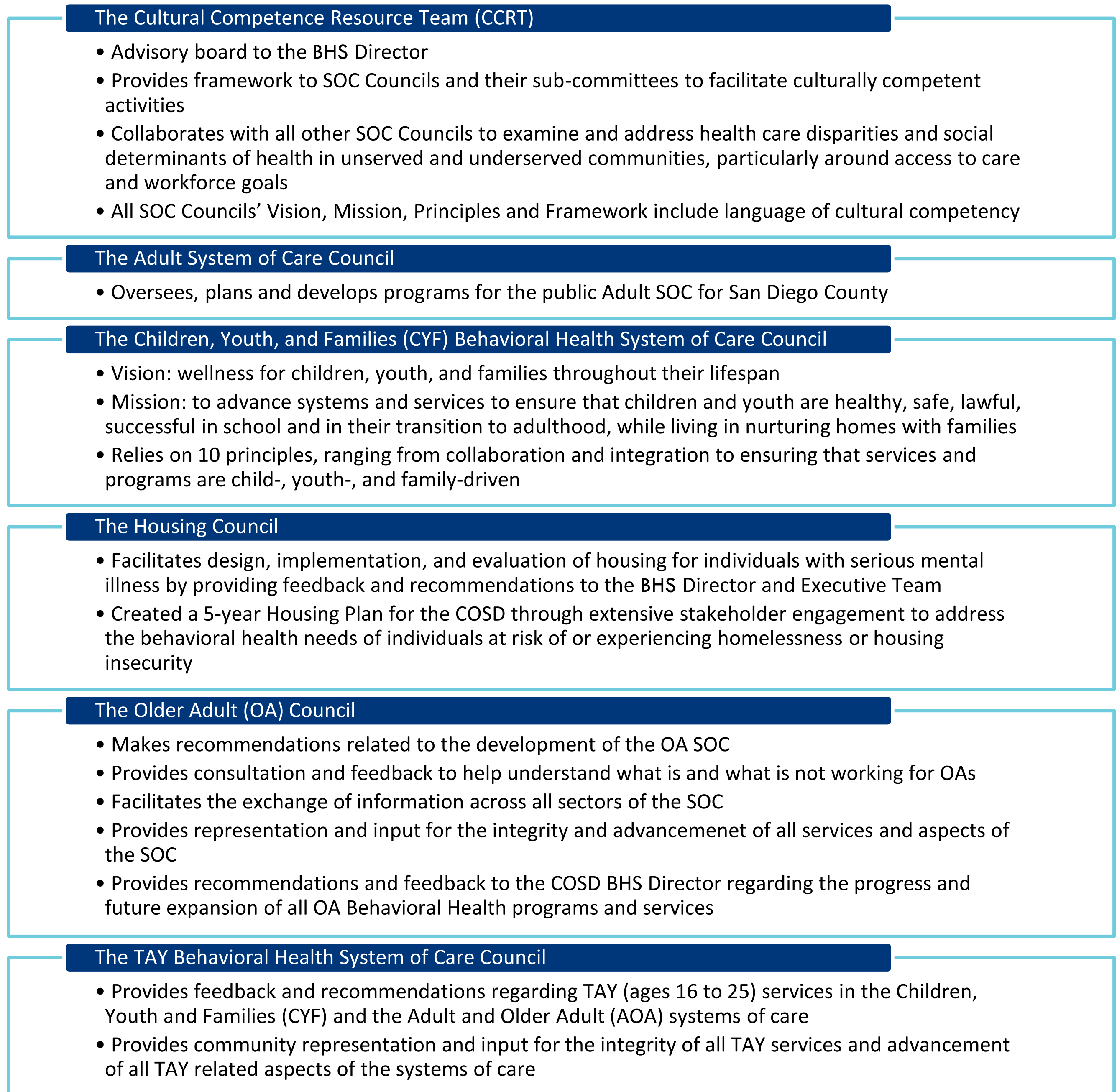
See Figure 5 for a list of the six councils in the BHS SOC.

Figure 5. BHS SOC Councils



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 the County, the UC San Diego Health Partnership and BHS 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 the County. The SPC's mission is to prevent suicide and its devastating consequences in the County. 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 facilitate the implementation of a countywide Suicide Prevention Action Plan that is informed by the community and implemented by the SPC membership. In addition, 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 folks 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 the County’s communities with the knowledge, tools, strategies, and commitment to make positive changes at the neighborhood level. There are over 1,000 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 communities. Additionally, there are 178 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 healthcare 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 BHS 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 BHS 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 the County, and the systemic and regional inequities that lead to these unmet needs. The project promotes a continuous feedback process in 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 BHS, 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 the County 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 BHS 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, the County 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 the 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 addresses 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 Union of Pan Asian Communities (UPAC).

Live Well 5K

In partnership with 2-1-1 San Diego, the County 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 including the importance of pronouns, empowering parent engagement in K-12 education, tenant peer support, elevating the voices of Black women, and more. 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 with the UC San Diego Health Partnership team so that they could bring that information forward to BHS 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 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 CHIP's SPC to host a resource booth and engage with attendees in conversation about their perspectives on 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 County was held on November 1, 2023, to bridge connections and promote the County'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 a 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 and 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 the 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 throughout the County. Activities included: 1) Key Informant Interviews; 2) Focus Groups; and 3) Listening Sessions.

Key Informant Interviews

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 BHS 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 of 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 group 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, 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 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 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

Participants of each listening session 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 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 2023-24 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 the County.

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 (N=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 about 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%.*

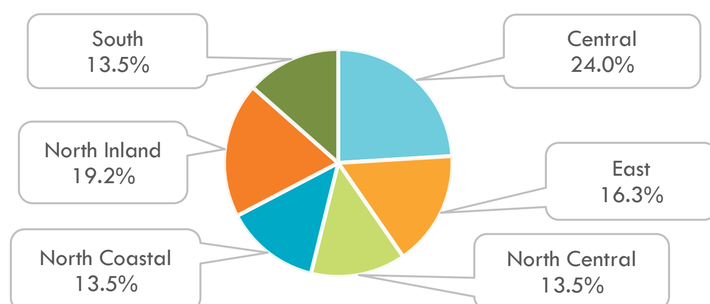
Participants were also asked about their sex assigned at birth, gender identity, and sexual orientation. Most of the participants identified as female at birth (69.9%), female gender (65.8%), and heterosexual (74.1%). Across all questions, nearly 5% of responding participants preferred not to answer.

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%).

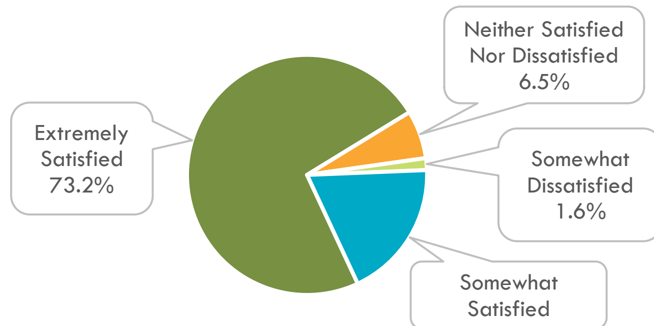
Figure 7. The County of San Diego HHSA Regions of Respondents



Overall Satisfaction

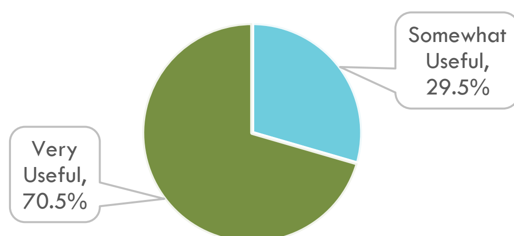
One survey item asked participants to share their overall satisfaction with the activity in which they participated.

Figure 8. Participant's Satisfaction with Activity



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.

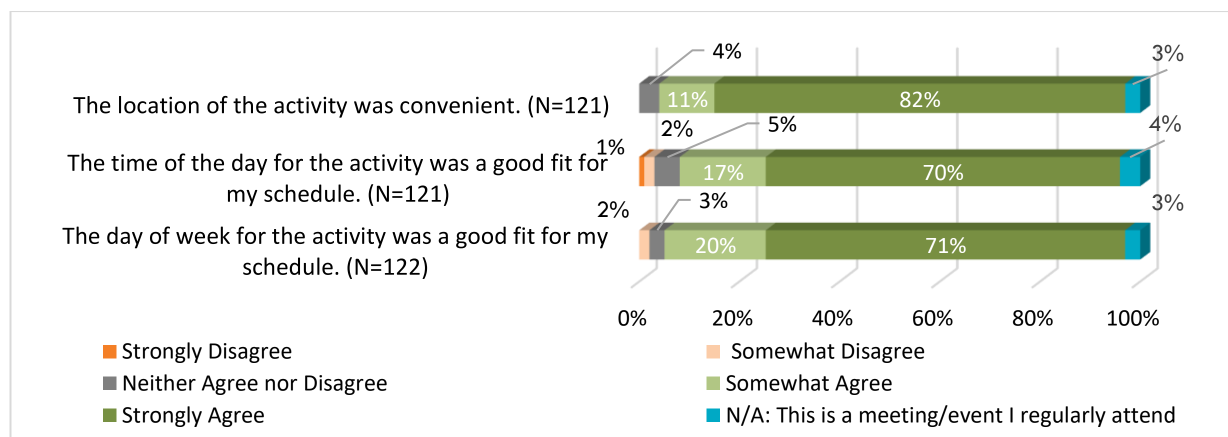
Figure 9. The Usefulness of the Information Covered in Activity



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.

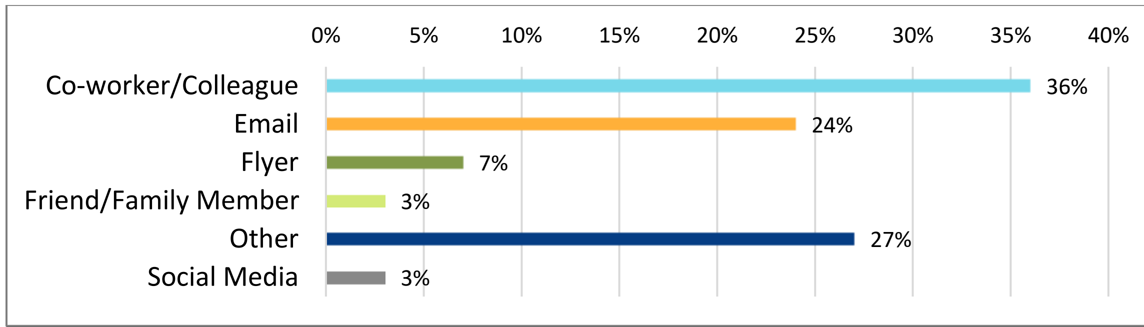
The survey then asked respondents to rate their level of satisfaction with the engagement activity details (i.e., location, time, and day of the week). Over 90% of the respondents either somewhat or strongly agreed that the location of the activity was convenient, and the day of the week was a good fit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

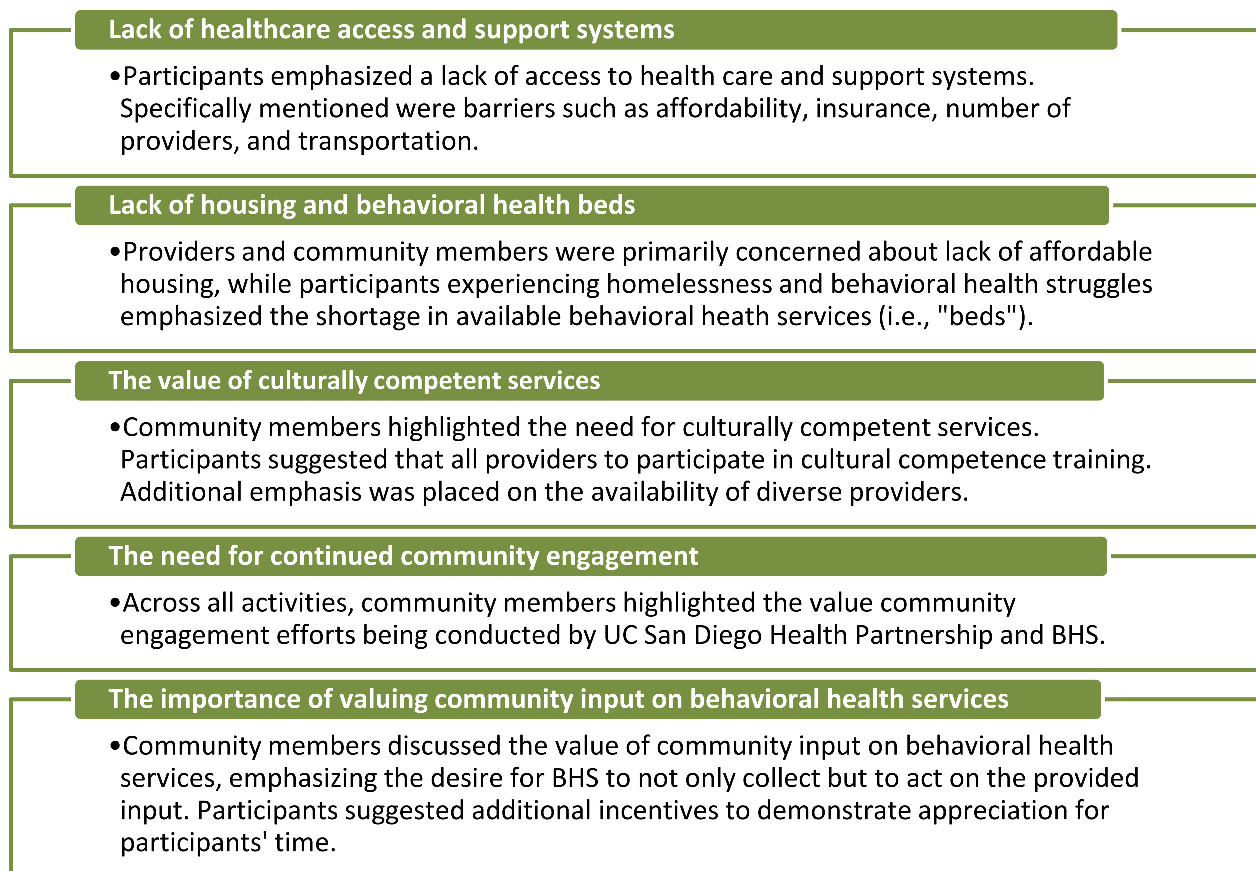


Community Engagement Efforts: Findings

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. Highlighted below are 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



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 the County 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 BHS, 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 regions in the County 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 the county as planning sessions were highly dependent on the 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, the UC San Diego Health Partnership 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 along with this year. The 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 the County 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 the County 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 region, **healthcare access and support systems** were 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 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 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, elevated 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 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 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 the County. Many 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 region, the most prominent theme was **stigma** with receiving mental health and substance use services. In the East region, **language** and **culturally aligned services** were among the most salient. In the North region, **affordability** and **lack of awareness/knowledge of resources** were among the most salient among community members. In the North Central region, **stigma** was also the most prominent among community members. In the South region, **lack of awareness/knowledge of resources** was among the most salient across community members. Lastly, in the unspecified 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 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 County 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 the County. 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 County 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 the County. Among the recommendations were increased funding for housing support, homeless solutions, 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**.

BHS-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. The 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 by 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 a **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 TikTok and Instagram.

Overall Themes from Interviews and Focus Groups

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."*
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. *"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."*

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 the 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."*

**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 BHS programming and outreach from the interviews and focus groups.

Table 8. Specific Themes for BHS 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.”*
Peer Support Services	Participants across communities shared the importance and value of peer support specialists in the County. 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."*
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. The community suggested increasing 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 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.’"*

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 throughout the County. 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."*
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."*
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 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."*

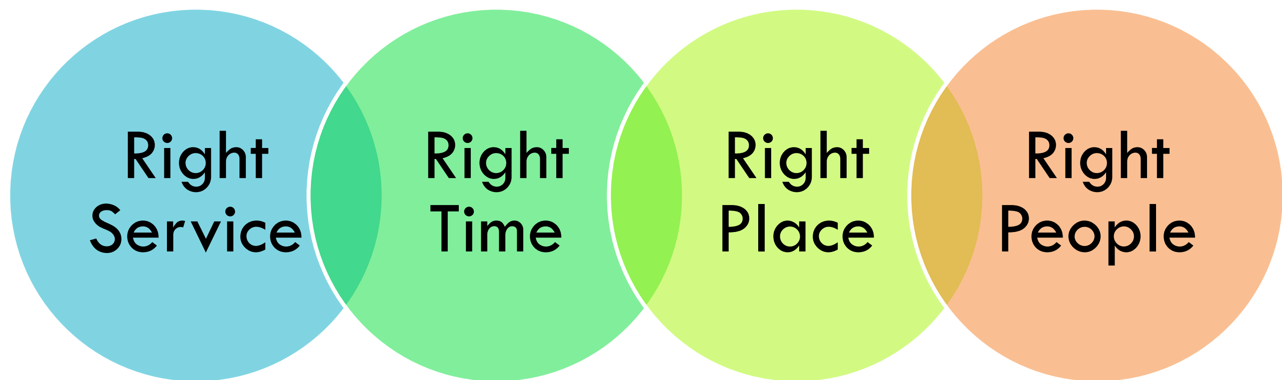
**Note – For each of the themes quotes in blue are from interviews and quotes in green are from focus group participants.*

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

The County needs a comprehensive behavioral health system that can address any emergent crisis and acute care needs while centering around prevention and early intervention. Consistent with the efforts to realign system priorities (as detailed in the County's MHSA Three-Year Plan for 2023-2026 describing BHS' goal to create a rebalanced continuum of care. emergent recommendations from the community engagement activities centered primarily around the varying community needs.

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

The community input and recommendations are 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." The "right service" includes recommendations centered on the wide range of services needed and to ensure these services are high quality and effective. A few examples of this include "warm handoffs" and follow-through from providers, along with an increased variety of services to attend to specific population or geographical needs. Those characterized as "right time" include services that address waitlist issues, hours of care facilities, and timely care. Services needed 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.

The findings formed the basis for the set of 16 primary behavioral health service change recommendations listed in Table 9. In addition to specifying the recommendations that emerged from the community

feedback findings, Table 9 includes potential strategies that could be utilized, with community input and participation, to make progress toward achieving each recommendation.

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 address 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)**
	(4) Increase availability of basic needs/non-behavioral health) services	➢ Address basic needs concerns across the County, 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)**

	Recommendations*	Potential Community-Driven Strategies to Act on Recommendation
Domain 2: Right Time	**(1) Increase staffing/decrease waitlists at behavioral health treatment programs***	➢ Expand the behavioral health workforce funding in the County 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)**
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)**

	Recommendations*	Potential Community-Driven Strategies to Act on Recommendation
Domain 4: Right People	**(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 BHS 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 BHS contracts to allow local community organizations to hire providers outside the county to better fit the needs of their community **(6.1c)**

	Recommendations*	Potential Community-Driven Strategies to Act on Recommendation
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 – 10 of 16 recommendations are listed in the County's MHSA Three Year Plan for 2023-2026 Report and emerged again in the current year.*

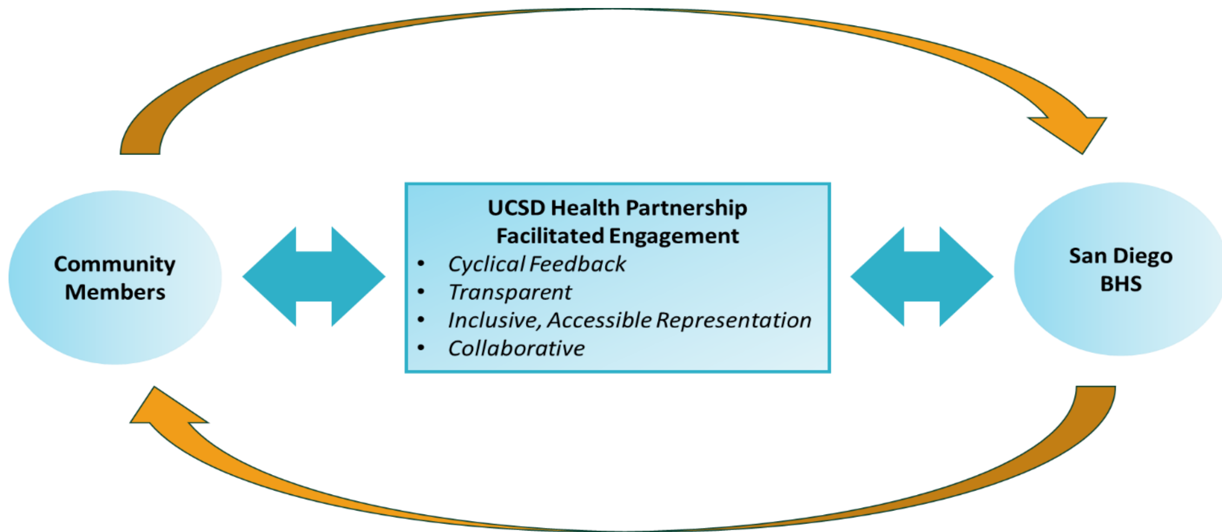
Chapter 6 – Future Directions

In FY 2023-24, the UC San Diego Health Partnership held community engagement activities in multiple formats and with a diverse set of community members, reaching over 400 people countywide. Through this formative effort, a substantial amount of feedback was collected, and the findings summarized in this report highlighted a wide range of essential community needs, suggestions for resources, and recommendations for how to best continue this work into the future.

The feedback obtained this year from the community engagement process led by the UC San Diego Health Partnership illuminated key ingredients needed to realize the full benefits and potential of this process, including engaging diverse communities with an authentic, inclusive, transparent, and trustworthy process.

One of the UC San Diego Health Partnership's engagement process priorities is elevating engagement in a cyclical feedback approach that utilizes a collaborative follow-up process with the community. As shown in Figure 13, effective communication and feedback processes between government organizations and the community ensure transparency, accountability, and responsive governance. Incorporating feedback loops into the engagement process ensures the findings in the final annual report to BHS authentically reflect the experiences and ideas of those who participated in the community engagement activities. Importantly, participants emphasized that the feedback process is important for establishing and maintaining trust.

Figure 13. Conceptualization of UC San Diego Health Partnership Facilitated Community Engagement



Some steps that may be taken to facilitate the community engagement feedback process include:

BHS response to community feedback: Upon receiving feedback from the community, respond promptly and provide updates on the steps being taken to address the issues raised. This would be a combined effort of the UC San Diego Health Partnership and BHS, initiated by regular communication (e.g., quarterly meetings) during which BHS would share with the UC San Diego Health Partnership how the input from the community represented in the BHS Community Engagement report was integrated into MHSA programming and funding allocations.

"I'm so glad that [the County is] even doing this. This [interview] in and of itself is progress... that they're trying to get in touch with the communities that need it the most."

1. **Follow up with the community:** Communicate how the community's feedback has been utilized to inform MHSA program planning. This could be attained through social media, an MHSA/Community engagement website, and attending community meetings. It will be essential to follow up with individuals who participated in interviews and focus groups and continue nurturing the relationships established through regular communications. The follow-up should also include a mechanism to evaluate the effectiveness of the community engagement process (e.g., satisfaction questionnaires, email/phone line for suggestions/complaints, etc.) to make improvements.

   During our FY 2023-24 engagement activities, the UC San Diego Health Partnership team received numerous requests for an online and social media presence that could serve as a resource for upcoming engagement opportunities, such as listening sessions and learning more about how to get more involved with our efforts. The UC San Diego Health Partnership is developing and implementing a social media presence for FY 2024-25.

2. **Encourage participation:** Efforts will continue to encourage ongoing community participation by providing information about the feedback process and how it works, thereby setting expectations for a regular, structured feedback process, and establishing the importance of community participation. Additionally, community members should be given adequate time and resources to provide feedback on the pre-published report to encourage transparency. This can be done through outreach campaigns, public meetings, and other forms of communication.

3. **Ensure Transparency:** A central theme that emerged from the community engagement activities was the importance of the facilitating agencies to analyze and report community input inclusively and truthfully. The UC San Diego Health Partnership is expected to conduct the community engagement process with authenticity and accountability to community stakeholders and BHS.

"There's a lot of community programs that are already there, that if they were given funding, they would have the trust of the community to start things… a lot of programs that get started, they come in, they get their information, and they leave, and so the community does not want to work with outsiders anymore."

To this end, the UC San Diego Health Partnership has summarized all findings in this report based exclusively on the input of the community engagement activities participants. Further, the UC San Diego Health Partnership will: 1) encourage feedback on this report from those who have been involved in the process through the 30-day feedback period happening in late Spring 2024, and 2) condense report findings into brief reports that are accessible, to be disseminated through multiple venues, and accurately reflect the recommendations of the community stakeholders.

Promote Inclusivity, Accessibility, and Stakeholder Representation

The UC San Diego Health Partnership recognizes substantial community outreach and interaction are essential for developing the relationships needed for leading and facilitating engagement about behavioral health needs, experiences, and innovations. Consistent with findings from this report, a cornerstone of the UC San Diego Health Partnership approach is the utilization of existing community spaces for outreach, engagement efforts, and data collection that are essential to informing BHS program planning.

Both the UC San Diego Health Partnership and BHS will continue to expand outreach efforts to ensure the representation of unreached populations and communities in ongoing engagement endeavors. Community members emphasize a key foundation for this goal requires providing substantial advance notice of input opportunities, creating multiple modes of obtaining input, and ensuring that engagement activities are available in multiple languages, in settings where stakeholders are most at ease.

Ideas to ensure inclusivity in stakeholder representation that were identified by our engagement activities this year include:

1. **Identify community leaders to engage**: Participants shared that collaboration between BHS and historically unserved/underserved communities could be prompted by collaboration with 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.

2. **Develop incentives for community participation**: Although in FY 2023-24, refreshments and snacks were provided, other forms of financial incentives were requested by members of various

communities such as offering gift cards, providing childcare, a stipend for an organization, and recognition for participation (awards, certifications, or public acknowledgement). Incentives can serve as a tool to promote equity and fairness, particularly when asking people to contribute personal time and expertise to the CPP on a volunteer basis.

3. **Meeting community in their spaces:** To better engage communities, SDCBHS should "meet people where they are at." This includes asking community leaders and/or members where they would like to meet and what is accessible for data collection.
4. **Respecting communities' culture:** To learn and engage with other cultures, participants shared the need to understand the history of different 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.

Next Steps

The UC San Diego Health Partnership is continuing to build a community engagement approach that is intentionally committed to authentic community engagement efforts, focusing on equity, and promoting community empowerment of unserved, underserved, and hard-to-reach populations. This community engagement approach is welcoming, inclusive, and aligned with other behavioral health-related engagement activities. While the UC San Diego Health Partnership infuses its approach with these core principles, the Partnership also acknowledges its capacity and need for further improvements in future years to ensure that priority populations are included throughout the community engagement process and that engagement activities exist in culturally relevant ways for diverse communities. The UC San Diego Health Partnership will continue to work towards providing a comprehensive outreach and engagement effort, in partnership with BHS, for individuals in historically unserved and underserved communities.

"Making a relationship with the community, with each individual patient too, to get your foot in the door, and then let them know that you're there for them, you're there to help them. And let them know that you're willing to come out there to see them in their homes or provide resources for them. Once you establish that kind of relationship, I think that's when you can start introducing more talks about mental health, mental health services with them."

The UC San Diego Health Partnership is primarily responsible for ensuring accountability to the two phases of community engagement identified by stakeholders: ensuring stakeholders have the information and understanding to contribute to the community engagement process, and actively involving communities in the decision-making process. Indeed, stakeholders expressed a strong desire to be engaged in this work from a leadership perspective, as having a "seat at the table" would enable them to advocate on behalf of their communities. While BHS and the UC San Diego Health Partnership ensure that accountability and cyclical communication are part of the process (as shown in Figure 13 above), our community engagement process seeks to integrate each community in ways that each community prefers, as well as empower historically unserved and underserved groups by co-creating meaningful information for program policy planning and funding. Collectively, what this Partnership will strive to accomplish as this work continues to move forward is being invited to all possible tables in the very diverse San Diego communities.

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

Appendix A: Satisfaction & Demographic Survey

Satisfaction & Demographic SurveyBHS Community Engagement Sign-In and Demographics

The following satisfaction and demographic information will be used to generate reports about the community engagement efforts led by the County of San Diego HHSA Behavioral Health Services and UC San Diego. This survey is completely anonymous, and you have the option to provide your name and email address if you would like to receive updates about this work.

Overall, how satisfied were you with this activity?

- ○ Extremely satisfied
- ○ Somewhat satisfied
- ○ Neither satisfied nor dissatisfied
- ○ Somewhat dissatisfied
- ○ Extremely dissatisfied

Overall, how useful was the information covered in this activity?

- ○ Very useful
- ○ Somewhat useful
- ○ Barely useful
- ○ Not at all useful

To what extent do you agree or disagree with the following statements:

	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree	N/A; This is a meeting/event that I regularly attend
The day of week for the activity was a good fit for my schedule.	O	O	O	O	O	O
The time of day for the activity was a good fit for my schedule.	O	O	O	O	O	O
The location of the activity was convenient.	O	O	O	O	O	O

How did you learn about this activity?

- O Flyer
- O Friend/Family Member
- O Co-worker/Colleague
- O Social Media
- O Email From: (please specify) ____
- O Other: (please specify) ____

Demographics

What is your age group? *(Please select one)*

- ○ 0-15 years old
- ○ 16-25 years old
- ○ 26-59 years old
- ○ 60 years old and over
- ○ Prefer not to answer

Please select your racial and ethnic identity. *(Select all that apply)*

- ☐ Hispanic, Latino/a, or Spanish origin: Mexican, Mexican American, or Chicano
- ☐ Another Hispanic, Latino/a, or Spanish origin (please specify): ___________________________
- ☐ Alaska Native
- ☐ Native or Indigenous American
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian or Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ My race or ethnic identity was not captured above. I identify as: ___________________________
- ☐ Prefer not to answer

What is the primary language you use at home?

- English
- Spanish
- Arabic
- Farsi
- Tagalog
- Vietnamese
- Other (please specify): ____

What is your sexual orientation? *(Select the option that best describes you)*

- Heterosexual or straight
- Gay or lesbian
- Bisexual/pansexual/sexually fluid
- Queer
- Questioning/unsure of sexual orientation
- Another sexual orientation (please specify): ____
- Prefer not to answer

Do you have a disability?

If yes, please select all that apply. (A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.)

- ☐ No, I do not have any of these disabilities
- ☐ Difficulty seeing
- ☐ Difficulty hearing or having speech understood
- ☐ Other communication disability (please specify) ____
- ☐ Learning disability
- ☐ Developmental disability
- ☐ Dementia
- ☐ Other mental disability not related to mental illness (please specify) ________________________
- ☐ Physical/mobility disability
- ☐ Chronic health condition/chronic pain
- ☐ Other (please specify): ____
- ☐ Prefer not to answer

Are you a Veteran?

- ○ No
- ○ Yes
- ○ Other (please specify): ____
- ○ Prefer not to answer

Do you identify with any of these additional groups? *(Select all that apply)*

- ☐ Immigrant
- ☐ Refugee/Newcomer
- ☐ Asylee
- ☐ Veterans/Military
- ☐ Homeless
- ☐ African
- ☐ Chaldean
- ☐ LGTBQIA+
- ☐ Prefer not to answer
- ☐ Do not identify as any of these additional groups
- ☐ Other (please specify): ____

What is your gender identity? *(Select one that best describes you)*

- ○ Male
- ○ Female
- ○ Transgender male/trans man
- ○ Transgender female/trans woman
- ○ Genderqueer/gender non-conforming
- ○ Questioning/unsure of gender identity
- ○ Another gender identity (please specify): ____________________________________
- ○ Prefer not to answer

What sex were you assigned on your original birth certificate?

- ○ Male
- ○ Female
- ○ Prefer not to answer
- ○ Other (please specify): ______________________________

What is your home address ZIP Code?

ZIP Code: ______________________________

If you'd like to receive updates about this work, please enter your personal information below. This information will not be linked to the data you provided today and will be carefully stored.

Name: ______________________________

Email Address: ______________________________

Do you have any other comments to share with us?

____

____

Appendix B: UC San Diego Focus Group Flyer

LET'S TALK ABOUT...

COMMUNITY MENTAL HEALTH NEEDS

FRIDAY, DECEMBER 8, 2023 10:00-11:30AM

UCSD will be holding a remote focus group with Southern Caregiver Resource Center

JOIN US TO SHARE:

- The most important issues for you and your community when it comes to mental health or substance use
- Programs, services, or activities to provide support and help address challenges for your community

WHERE?

Zoom Meeting

Meeting ID: 872 1238 2871

Password: 293426

https://uchealth.zoom.us/j/87212832871

Your recommendations will be shared to the County of San Diego Behavioral Health Services to better address mental health and substance use challenges faced by the community members throughout the County

CAN'T MAKE IT? SCAN HERE TO SHARE YOUR THOUGHTS WITH US!

HAVE ANY QUESTIONS?

Please email Krystal Lira at **amlira@health.ucsd.edu**

UC San Diego Health

Appendix C: UC San Diego Focus Group Interview Guide

Focus Group Interview Guide

Goals:

1. *Understand priority mental health and substance use needs of stakeholders/priority populations*
2. *Perceptions of what resources and community strengths exist and challenges to accessing those resources.*
3. *Identify community strengths – areas of opportunity to meet behavioral health needs in innovative ways.*
4. *Understand successful community engagement for this group, including expectations around participation, feedback mechanisms, responsibility of BHS to the community?*

Introduction
Thank you for taking the time to talk with us. We are very excited to be continuing this process of intentional community engagement to inform the ways in which Behavioral Health Services designs and implements mental health and substance use programming to meet the needs of our very diverse San Diego community. We acknowledge that there have been previous efforts toward engagement. Our commitment is entirely to authenticity and accountability in including community this process. And, to do that, we need to hear from those with experience in this field.

Our approach includes a community engagement process that is welcoming, inclusive, and aligned with other behavioral health related engagement activities. Today, we are here to specifically focus on the (*insert population*) community. We will ask some questions focused on helping us understand what you see as the strengths of your *(insert population*) community, some priority areas for mental health and substance use and resources, and how best to do ensure community voice can be successfully included in the ways in which San Diego BHS creates and implements its programs. The information collected as part of these groups will be shared with BHS as a summary blueprint that includes *(insert population*) behavioral health needs, assets, and recommendations.

Guidelines

1. We are encouraging verbal dialogue for this engagement session. To make sure everyone is heard we encourage you to use the hand raise option, so that each person is heard. Explain where this is.
2. Secondary, you can use the chat if you prefer. A team member will be monitoring the chat and we may very likely review the chat feedback and possibly ask for further follow up on responses in the chat.
3. We will be recording this session today so that notes can be used to inform the behavioral health community planning process.
4. Please try to remain on mute while you are not speaking to decrease background sounds.
5. Any questions before we begin?

<u>Reminders</u>
o Participation in the focus group is voluntary.
o It's all right to abstain from discussing specific topics if you are not comfortable.

o All responses are valid—there are no right or wrong answers.
o Please respect the opinions of others even if you don't agree.
o Try to stay on topic; we may need to interrupt so that we can cover all the material.
o Speak as openly as you feel comfortable.
o Avoid revealing very detailed information about your personal health.
o Help protect others' privacy by not discussing details outside the group.

As mentioned, so that we can be sure to capture everything that is shared, we will be recording this discussion. None of the information you share will be attached to your name in any way and the data will be anonymized before being used for research purposes The recording is to ensure that we are able to thoroughly listen and review later. We will start the recording now.

Ensure okay to start recording and GO!

INTRODUCTION: Let's take a minute to introduce ourselves to one another. Share your name, in what area of San Diego you live, and what brings you to this event today. If you are representing a community organization or group, what is the name of that group? (*Facilitator starts, then passes to F2, then F3, the just goes around the virtual room*.)

SECTION ONE: Priority mental health & substance use needs

1. We want to start with talking about the mental health and substance use needs of the (*insert population*) community before we ask you questions about your community's strengths. What would you say are the most pressing mental health concerns, right now, for your community?

   Probes if needed:
   a. How have you become aware of these concerns in your community?
   b. To what degree are concerns being met?
   c. What actions have been taken to address these concerns?
   d. What actions should still be taken to address these concerns?
   e. What discussions has your community had about addressing housing for people with behavioral health issues?
   f. What discussions has your community had about how to best provide mental health services to people with serious mental illness and who are resistant or hesitant to enter treatment?

2. Similarly, what are the most pressing substance use concerns, right now, for your community?

   Probes if needed:
   a. How have you become aware of these concerns in your community?

   b. To what degree are concerns being met?
   c. What actions have been taken to address these concerns?
   d. What actions should still be taken to address these concerns?
   e. What discussions has your community had about addressing substance overdose in San Diego County?

SECTION TWO: Community Strengths

3. What would you say are the strengths (*and/or assets*) of the (*insert population*) community that are important to hear when thinking about mental health and substance use needs?

   a. *Probe if needed:* Could you think back to a time when the community utilized its strengths in collaboration with the County to attend to mental health and substance use needs?

4. What unique aspects of your community should the behavioral health system consider when thinking of the development of new programs and services for mental health and substance use?

SECTION THREE: Resources/Opportunities for Innovation

5. Reflecting on the past year, could you provide an example of mental health or substance use related services or resources that have been useful to you or people you know?

   Probes if needed:
   a. Was this service or resource provided by the County?
   b. Are there other behavioral health services or resources in your community that we should know about?

6. What would you say are the biggest challenges for your community when it comes to accessing behavioral health resources and services?

   Probes if needed:
   a. are there examples of specific barriers in place for you or your community to access resources?
   b. How have you or community members overcome, or adapted to, these barriers?

7. What kind of mental health and/or substance use services do you need to make sure you, your family, and the community are cared for?

   Probe if needed:

   a. Do you have any recommendations for a specific mental health or substance use program or service that your community could benefit from? Perhaps you have envisioned an ideal program or have learned about a program offered in another community that you would want to be integrated into your program.

8. (*Skip if participants have not worked with BHS before*): Could you provide an example of behavioral health services that were culturally appropriate for your community or an example where behavioral health services were not culturally appropriate for your community?

SECTION FOUR: Outreach, Engagement, Expectations, & Accountability

9. What are some ways you think work best to successfully engage with your (*insert population*) communities?

   Probes if needed:
   a. Where, in your experience, has this fallen short to date?
   b. Are there specifics that would be helpful to know when engaging with this community in a culturally appropriate way?

10. What types of communications and messages should be used to gather your input for behavioral health?

   Probe if needed:
   a. How would you like to learn about Behavioral Health Services initiatives, including programming and funding, and their responses to your community's needs?

SECTION FIVE: Wrap-Up

11. As we are wrapping up, were you able to share enough about your community behavioral health needs and recommendations?

12. Did the language we used about mental health and substance use make sense?

13. Is there anything else that is important for us to know related to your behavioral health and substance use concerns that we did not ask about today?

SHAPING THE BEHAVIORAL HEALTH SERVICES LANDSCAPE IN SAN DIEGO: SHARE YOUR COMMUNITY'S PRIORITIES

Live Well San Diego Advance

November 1, 2023

Facilitated by: Danielle Fettes, PhD & Krystal Lira, PhD

UC San Diego Health

UCSD Health Partnership & Authentic Engagement

Goals of community engagement:

building trust, enlisting new resources and allies, creating better communication, and improving health outcomes

Equity is centered

recognize and appreciate that all who are involved in engaging a community must be responsive to the needs of that community, *as defined by the community itself*

Commitment to ongoing feedback & communication

Community Members

UCSD Health Partnership Facilitated Engagement

- *Cyclical Feedback*
- *Transparent*
- *Inclusive, Accessible Representation*
- *Collaborative*

SDBHS

What are the most pressing issues related to mental health or substance use your community?

Conversation #2

COUNTY OF SAN DIEGO Health and Human Services Agency

LIVE WELL SAN DIEGO

What are the biggest challenges to accessing resources for mental health or substance use in your community?

Conversation #3

COUNTY OF SAN DIEGO Health and Human Services Agency

LIVE WELL SAN DIEGO

What activities or programs do you think would help address behavioral health issues & challenges by those living in your community?

Conversation #4

COUNTY OF SAN DIEGO Health and Human Services Agency

LIVE WELL SAN DIEGO

How would you like to see behavioral health resources shared with this community?

Where do we go from here?

The Partnership synthesizes the information → Recommendations to BHS based entirely on community input

BHS shares report for additional community input: Did we hear you?

Behavioral Health Advisory Board reviews report

Learnings → BHS program & planning

And, the conversation is continuous – we welcome all who will engage in this important space with us

https://ucsd.co1.qualtrics.com/jfe/form/SV_9QVFtSXnMeYgnIO

LET'S TALK ABOUT... **Appendix E: UC San Diego Listening Session Flyer**

COMMUNITY MENTAL HEALTH NEEDS

THURSDAY, NOVEMBER 9, 2023 5:30 - 7:00 PM

SCAN HERE TO REGISTER!

JOIN US TO SHARE:

- The most important issues for you and your community when it comes to mental health or substance use
- Programs, services, or activities to provide support and help address challenges for your community

SNACKS AND REFRESHMENTS WILL BE PROVIDED!

HAVE ANY QUESTIONS?

Please email Katie Wan at klrule@health.ucsd.edu

WHERE?

Rancho San Diego Library
11555 Via Rancho San Diego, El Cajon, CA 92019

CAN'T MAKE IT? SCAN HERE TO SHARE YOUR THOUGHTS WITH US!

What you share will be included in a set of recommendations developed for the County of San Diego Behavioral Health Services to better address mental health and substance use challenges faced by the community members throughout the County.

UC San Diego Health

COMMUNITY HEALTH IMPROVEMENT PARTNERS
making a difference together

"Let's Talk About..." Community Events encourage people to talk openly about behavioral health topics, challenges, and needs, promote local organizations and related resources, and aim to reduce stigma through community conversation.

Communities Section

This section presents community-specific findings, as requested by participants to ensure a thorough representation of each of the communities involved in the engagement activities. Presenting community-level themes and ideas provides the opportunity to uplift community voices and highlight emergent concerns about mental health and substance use issues and services in their respective communities, beyond the list of global themes across all communities. It is important to iterate that **the themes in this section are not intended to be representative of an entire community or San Diego County**, but instead are the concerns of local neighborhoods, community leaders, consumers, family members, community health, and social service workers gained through lived experience.

We thank each of the interview and focus group participants for their time and candid responses to our questions. This report would not have been possible without their generosity. We have done our best to report their concerns and recommendations accurately and fairly. While this report does not fully capture the richness of each community, nor the enormous multicultural nature of San Diego County, we hope it provides an important and unique contribution to community engagement.

Adult Residential Facilities

One focus group was conducted with six individuals, all working in an adult residential facility (ARF) in San Diego County. ARFs provide treatment and housing for psychiatric clients.

Participants expressed many concerns for their residents and staff at the residential facility. They reported an increase in violence within the facilities and a lack of support from the police and surrounding hospitals. One participant shared the following: *"The residents are aggressive against each other, one was bleeding from the face, the police come, they don't do anything. And a lot of things to have the police put somebody on a hold on a 5150."* If staff feel unsafe and request that a resident does not return, the facilities can potentially get penalized by the State for "refusing to take someone back." Also, ARF staff noted that fentanyl and methamphetamines were the most common substances used among residents and that this substance use *"increases the behaviors"* and *"leads to more incidents."*

Throughout the focus group, participants discussed the need for more staffing within their facility as a lack of staffing leads to larger issues for the residents. One participant stated, *"We can't have eyes on everyone, but it seems like we have to… so we can reduce the number of incident reports, reduce drug use… because it only takes a few seconds or a few minutes for them to overdose."* In addition to increasing staffing, one participant emphasized the importance of *"getting different trainings, different perspectives, different professionals that could help out in our day-to-day operations, even if it's repetitive, but at least, we know that they're coming to help us out."*

Participants also highlighted the need for funding increases:

"*I think just more funding for staffing, more benefits, like higher salary… I just feel like we're not getting any help from anybody anymore.*" Participants believe funding and staffing increases could "*help reduce a lot of relapses; it can reduce a lot of [residents] going to hospitals*" as the increase in staffing provides residents more supervision and support while at the ARF.

Black/African American Community

Three interviews and one focus group with seven participants (for a total of 10 participants) were conducted with members of the Black community and people who work closely with the Black community. Participants shared prevalent behavioral health concerns while providing recommendations for how the County can best support their community.

Participants discussed many community strengths, including strong leadership and resiliency. One participant explained the community members themselves are a strength because *"You have to be resilient despite the system misusing [them]."* Another highlighted the *"organizations that are going really strong, as far as supporting mental health in the African American community"* as well as the community leadership: *"Despite the challenges that arise, [one leader] in particular, continues to pick themselves back up and continues to fight because they understand that the work that they are doing for the community is really important."*

Trauma is a prevalent issue community members face. One participant shared, *"Trauma is probably the most present distinguishing characteristic of the community that I represent"* and an experience where *"there was no intervention, there was nothing to help them heal from that trauma. And [the participant] doesn't think that the war on certain segments of the population has stopped. So, we are dealing with continual trauma in some spaces."*

Participants highlighted the issues of systemic and internalized racism that impact their community. One participant expressed that for their community there is a *"need to identify that we all, as products of American culture, hold racist ideas… understanding that we are working in trauma and in racism is the heart and soul of Behavioral Health Services in the communities that I come from."* Another participant touched on the issue of exclusion: *"Because I am an African American woman, my expertise is diminished. It's dismissed. That happens repeatedly in various spaces because of the systemic racism that exists, because of people's own insecurities…and that happens time and time again, not only with me but with other people of color with expertise. If we've done our work to earn our seat at the table, why don't we have a seat at the table?"*

Participants discussed the issues that stem from a lack of Black providers. One participant asserted, *"There's almost no Black therapists, there's almost no Black female therapists."* The importance of providers of color was highlighted: *"There's definitely things I wouldn't tell… to a white doctor as opposed to a Black doctor… I'm much more likely to be more like myself around someone that looks like me."*

Participants expressed the importance of including members of the Black community in County discussions and decisions: *"When those mobile units were initiated, there weren't any Black or Brown agencies that were included in that discussion. And those were deployed in the Northern part of the*

County. So, we are still kind of left to support our own. And that's the ongoing tragedy throughout the many years that I've been doing this…" One participant acknowledged the County *"has done some stuff related to cultural diversity"* but believes *"it would be awesome if [cultural diversity classes] were offered by the African Americans who are doing this work and functioning in these spaces… because then there's lived experience, there's real examples, it expands the network, and gives some real application."*

Deaf/Hard of Hearing Community

We had the opportunity to host one focus group with nine staff members working in social and health services for the deaf community. Six out of the nine participants identified themselves as deaf and/or hard of hearing. Two American Sign Language (ASL) interpreters were in attendance to facilitate discussion between the English-speaking facilitator and the participants who communicate with ASL. Emergent themes follow.

According to the participants, *"the two big topics"* were *"therapy access and interpreter permission."* Participants mentioned the difficulty in finding deaf therapists or counselors: *"As far as we know, there's two deaf certified drug and alcohol counselors in the state of California, and one is someone that works here."* The participants also shared that it has been difficult hiring deaf counselors due to County contract restrictions: *"We lost the behavioral health program because they couldn't hire clinicians; the County contract requires that people live within the County boundaries. There are accessible mental health clinicians out there, but they live outside of San Diego, some that are across the country, wonderful clinicians, but they won't allow us to have that access."*

Participants asserted that therapists must understand the deaf community in order to treat deaf individuals with mental illness. One participant stated, *"Our biggest struggle is really to have a therapist who understands the struggles that a deaf person experiences in their lives, and has the cultural knowledge"* while another added, *"Most hearing therapists come from a medical perspective, and they lacked the cultural background and awareness to really understand what a deaf person goes through in their lives."* In general, the focus group participants agreed that *"the entire community has been oppressed from the hearing world throughout history."*

Participants noted the lack of interpreters as a barrier to accessing mental health and substance use services: *"The Recovery Center, mental health centers, they don't have the funding to provide interpreters, at least that's what they say."* Further, *"There should be a line item for a budget for that [interpreters], because it's set for other languages."*

According to participants, the lack of interpreters is particularly problematic in sober living spaces. As one case manager shared, *"In these hearing sober houses, if one of our Deaf clients moves there, they refuse to provide interpreters. They refuse to provide access, sometimes they have to fight to have a TV or a video phone in their room for better communication."*

While online interpreter service platforms are available, they have their own challenges: *"Some clients, for example, are Deaf-blind and struggle to actually see the interpreter on the screen."* Participants shared that they *"have explained to the County repeatedly their system of using Microsoft Teams is ineffective in a deaf space. It doesn't work because the interpreter ends up on a small box and then the closed captioning goes across their face, so they can't read the captioning or the interpreter."*

The deaf community has tried to assuage some of these issues by connecting with more organizations and institutions, but those connections have proven to be a challenge on their own. As one participant shared, *"The system is not designed to support deaf people quickly. We're not a priority, not in education, we're not a priority in employment, we're not a priority anywhere really, that's it. That's why we're doing the job because we're trying to provide culturally sensitive services. We are trying to educate and network with the police, the sheriff's department, the fire department, to become familiar, but that's not enough. That's really not enough. We need more...the question is, when we're providing deaf cultural sensitivity training, are those people really taking it in and remembering the training when they're meeting deaf clients? I don't think so. I think they're attending the training, fine in one ear, out the other."*

Participants shared a few clear recommendations for BHS to better collaborate with and support the deaf community. These recommendations include changing contract regulations so that they could refer deaf clients to deaf therapists outside of San Diego County. In addition, participants asserted that all County services should hire more ASL interpreters: *"It shouldn't be up for debate, ever."*

One participant stated the need for a specific County position to improve services for the deaf community: *"I really do believe that if we had one advocate, one, in the County system, working in the behavioral health department, advocating for these marginalized communities. One salaried position, somebody that we can connect with, somebody that we can communicate with, somebody that can intermingle with their own crowd, we can ask question after question after question."*

Individuals Experiencing Homelessness

We conducted three focus groups and two interviews with individuals who work with people experiencing homelessness. All focus groups were composed of people with lived experience of homelessness, who currently provide services to individuals experiencing homelessness. The first focus group included fifteen people, the second and third focus groups included five people each for a total of 25 participants. The following themes were evident in the discussions.

All of the participants in these focus groups and interviews identified lack of housing as a central driver of mental health and substance use issues in San Diego. One person highlighted the interconnectedness of all these factors, stating that *"Mental health and substance abuse is like hand in glove, but then you also get families who like as we return back to normalcy from COVID, somebody's new normal is they're homeless now."*

The rising rate of homelessness among elderly and disabled folks in San Diego County was a high concern for the participants, who highlighted the lack of services for these populations. As one participant shared, *"We have seen such a huge explosion of elderly. Elderly homeless. Elderly who are severely disabled, and we have no resources for them."* One participant approximated that most ("85%") housing placement issues would be solved if San Diego County would more consistently implement Americans with Disabilities Act (ADA) requirements. Relatedly, participants shared that many physically disabled people are turned away from shelters if they cannot climb up to the top bunk of remaining shelter beds. Besides offering more accessible beds, participants suggested that more of the BHS budget be allotted to disability awareness and accommodation.

Participants shared the belief that people with lived experience should play a key role in guiding homelessness and behavioral health services. One participant stated, *"A whole lot of decisions made by people who have never spent one hour working with the homeless. And there's a lot of things that sound like a really great theory, but are so impractical, and in practice, it just doesn't work."*

Lack of affordable housing in San Diego is an additional problem faced by peer support specialists working with individuals experiencing homelessness who also have a mental illness: *"It's very hard to keep people in the mental health field, in the behavioral health field, in San Diego, [because] we can hardly afford to live here."* Another participant suggested, *"One of the ways that we could potentially incentivize that is if we were to offer down payment assistance for workers in the mental health field."*

Participants were supportive of expanding housing options through a Housing First policy, a model of addressing homelessness by providing individuals experiencing homelessness with housing as quickly as possible with supportive services as needed. However, more than one participant emphasized the need for accessible behavioral health treatment along with housing. As one participant shared, *"The City of San Diego is doing, Housing First, but you put a client in without the infrastructure, the help, the support that they need, and in this case, a mental health support. They don't have the tools to maintain their housing. So we're not doing them any favors, we are actually perpetuating the cycle. And they give up."*

Justice-Involved

Through an individual interview, we gained insight into the justice-involved perspective from a participant with lived experience. This participant was formerly incarcerated in early adulthood and currently works with the County's criminal justice system in several capacities, including the District Attorney's office. This participant has a broad range of collaborations with multiple organizations, both nonprofit and for-profit, advocating for justice-involved individuals. While this participant's input was highly informative, we plan on additional interviews and focus groups with people

who have lived experience of justice involvement and their family members for next year's community engagement report.

The participant discussed the importance of including individuals with lived experience in the planning and decision-making process of the County and other organizations, as that experience can offer a unique perspective while others may be comparatively *"naïve to the justice system."* The participant elaborated on the potential benefit of collaboration between those with and without lived experience, asserting *"there's a divide right now, and that divide is growing, as the so-called peer movement is growing. There's this big clash between my 20 years of lived experience in prison, versus the 20 years it took for you to get a PhD, or 18 years it took to get your Masters…there's a clash coming. And I don't think there should be a clash; I still think there's so many lessons to learn from each other."*

Additionally, the participant highlighted the importance of acknowledging traumas and lifetime harm incarceration causes individuals: *"We don't address carceral traumas in any form or fashion. And that's easily indicated when you watch a juvenile repeat a crime that was committed against him."* The participant noted the correlated issues of substance use, mental health problems, and homelessness. It has become more evident across the country that individuals involved in the criminal justice system often have mental health problems, the participant asserted that *"whatever the problem is, you can't treat one [mental health problems or legal problems] and then go treat the other, they need to be treated simultaneously."*

The participant recommended that BHS take a closer look at the County operations to identify potential areas of improvement, such as *"...more self-investment in the [grassroots] organizations that are here, that are doing the work."* Overall, the participant asserted that *"it's [mental health] a bigger problem… unless we start again, investing in making healthy people, healthy kids at all costs."*

Latino

We conducted three interviews with individuals who identified as Latine (or Latino/Latina/Latinx) and who work in the Latine community in the County. Each participant has experience with mental health and/or substance use outreach in the community. Interview participants shared their behavioral health concerns and recommendations for effective and culturally appropriate behavioral health services for the Latine communities in the County. The following themes were evident in the discussions.

Like many other communities we reached, participants discussed fentanyl as a primary substance use concern for the Latine community. Additionally, the interview participants mentioned the impact of substance use stigma and incarceration for BIPOC (Black, Indigenous, People of Color) individuals, including Latine folks. One individual shared how substances and incarceration have affected their family: *"...I've seen this the most in my Black family and my Mexican family. The trauma keeps them completely uncomfortable with any cannabis conversation. They saw their sons get locked away for 10 years, they don't want to talk about cannabis business."*

Participants asserted the need for effective behavioral health services in the County, including more translation services and language (Spanish) accessibility, training for additional Latino therapists, and

more providers for senior Latina women with shorter wait times. For instance, one participant stated, *"There's a lot of bilingual therapists...they don't even understand where you're coming from. So I think that's one of the things you know, we need to train more Latinos in this field."* This participant also shared that *"in La Mesa, there's free therapy for senior women. But they only have one therapist, and she's the volunteer, so she doesn't get paid. And so she's booked, like the classes booked for years."*

Participants suggested that, to improve the relationship between behavioral health services and historically marginalized communities, outreach should consider the community's *"cultural perspective and history before creating more harm."* Adding that the history of the land is especially important for considering mental health issues, *"We talk about any issue, mental health, social, environment, it all goes back to that injustice here on this land."*

Finally, participants shared the need for transparency from BHS regarding the effectiveness of BHS programs and to include testimonials when reporting program effectiveness. For example, one participant stated, *"The County gives a lot of money to a lot of agencies. Millions, millions, okay, not hundreds, millions… and sometimes they are not that effective."* The participant added, *"You know, Latinos, we love testimonials...so when I talk about drugs or alcohol, I have three or four people who come and share their testimony."*

LGBTQ+

Two interviews and two focus groups, one with six participants and the other with seven participants , were conducted with LGBTQ+ (Lesbian, Gay, Bisexual, Transgender, Queer) community members and people working with the LGBTQ+ community. Participants shared their behavioral health concerns and challenges surrounding the LGBTQ+ community in San Diego County, while also providing recommendations for what would be most beneficial for this population.

The participants highlighted a variety of strengths within the LGBTQ+ community, especially *"taking things into their own hands," adding, "if nobody else is going to do it, we're going to do it for ourselves."* However, the County could further support this community: *"It would be amazing if we had people who aren't part of this community help us get our foot in the door, amplify our voices, help us attend these classes, get certified [to] be able to help each other."*

One participant we interviewed discussed the high prevalence of mental health issues among the LGBTQ+ community and their difficulty accessing services: *"Most often if a client is coming in who identifies as transgender, just because of the experiences that they have experienced in life, their mental health, typically is on the higher side. Yet I struggle with referring them to any other place because there is no other place that really services LGBTQ, especially transgender population. So there's a gap, there's a hole of high mental health co-occurring LGBTQ services. I can state my life on that sentence, that's a fact."* One interview participant discussed the connection between homelessness and mental health in the LGBTQ+ community: *"We have a huge homeless crisis going on, but unless the mental health is really supported and there are services…we're going to continue to have homeless people."*

Additionally, participants asserted that if LGBTQ+ community members are able to access mental health services, it is difficult to find a provider with shared experience: *“I've been in and out of therapy kind of my whole life… and seeing no one that looks like me, that I can actually talk to, and has had my experience… like there's next to no transgender therapists.”* An LGBTQ+ outreach coordinator also mentioned, *“A lot of people are struggling to find therapists, specifically QT-BIPOC [Queer, Transgender, Black, Indigenous, and other People of Color] therapists that are affordable.”*

When discussing services for the LGBTQ+ community, participants discussed the importance of understanding sexual health. One participant explained the positive impact of having a space for *“discovering sexual health and recovery. I don't know if any other programs have a sex group, but when we're talking about addiction and how it affects multiple areas of one's life, relationships, and sexual relationships.”* Additionally, a prevention and harm-reduction approach is important. One participant explained, *“Not focusing on ‘don't do these things at all,’ because it's not realistic and just giving education on how bad [substances] are. It's more so the trauma-informed stuff... checking in on like, why are you doing these? Is there some underlying trauma, is there some coping going on?”*

To successfully engage with the LGBTQ+ community, participants recommended utilizing social media as it is the *“easiest and fastest way to get communication…especially younger age groups.”* Additionally, when physically meeting with this community, it is important to be mindful of the venue: *“Venues [with] accessibility, good parking… good transportation, being near a bus line…venues that are BIPOC, queer owned… so you're supporting the community that you're trying to reach out to.”*

Lived Experience

We conducted four “Lived Experience” focus groups, two at a clubhouse (i.e. a community-based resource for individuals suffering from mental illness), one with peer support specialists, and one other with mental health advocates.

Clubhouses

A clubhouse serves as a community-based resource for individuals suffering from mental illness. Generally speaking, a clubhouse provides a cooperative and healing atmosphere with possibilities for work, learning, skill building, housing, and better health. The clubhouse focus groups included 11 participants who experience mental illness and another group with five clubhouse staff. The following themes emerged.

Participants expressed the feeling of being surveilled and *“treated like criminals”* in mental health spaces: *“And because of all the metal detectors, it was triggering my anxiety and depression, a little bit of PTSD…all these buzzings don't always help everyone. They need to find another way to be able to help more people, but not making us feel like we're criminals coming in.”* Clubhouse members also expressed concerns with mental health treatment aftercare: *“…When they go into like psych wards, and then they come back to society, they're not exactly sure how to deal with themselves and heal themselves.”* Another member of the clubhouse shared his experience with stigma from a medical provider: *“I had a couple of times when*

I've been to the hospital before, and I've had doctors be rude to me because of my mental illness. And I feel that needs to be addressed as well..."

Clubhouse members also shared experiences with substance use prevalence in downtown San Diego, notably near residences of clubhouse members: *"Meth, crystal meth, fentanyl any other hard drug is as bad, it's making our communities go bad and having too many overdoses."* The high prevalence of illicit substances in the area means that clubhouse members being treated with a substance use disorder may be particularly vulnerable to relapse and overdose. Another participant added, *"Yes, alcohol can be killing everyone. But the drugs that do the most killing and we should be more concerned about the drugs that are on the street than people drinking alcohol."*

Both clubhouse members and staff recommended that BHS create additional mobile clinics for mental and physical health issues among individuals experiencing homelessness and people with mental illness: *"Get more mobile units… even if it's not the therapist, but the psychiatrists that might come to like our clubhouse. So people that don't like to travel that far to go all the way to Grossmont, or wherever to go see the psychiatrist."*

Clubhouse staff highlighted the need for better pay for people providing behavioral health services, stating, *"I think the biggest part that I would say is that behavioral health direct staff are severely underpaid. Like very severely underpaid and our contract cannot sustain it, like we are pinching pennies. To have the funds to buy enough food and to do anything like that, where it's like if somebody gets a $1 raise, it's like, okay, all of a sudden we have no recreation budgets and the inflation, and it's going to be much easier for staff in general to do well at their jobs if they are not struggling with the same problems that their members are financially. And also, just like with retention, and with attracting good staff too…"*

Lastly, clubhouse staff and members discussed the potential benefit of a universal basic income plan: *"I know they actually did the Seattle one [guaranteed income pilot program] with 12 people who were actually struggling with addictions. So nine of them, after two years, found a job and they were investing the money on education, on having a house, instead of like, they were not buying drugs or things like that."*

Mental Health Advocates & Peer Support Specialists

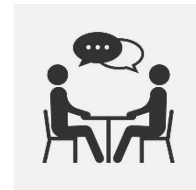
We conducted two additional "Lived Experience" focus groups, one with peer support specialists and the other with mental health advocates with self-identified lived experience of mental illness in San Diego County. A total of 8 individuals participated in these groups.

Participants shared a number of concerns around mental health that they see in their community; however, barriers to services were their most common concern. Participants discussed the lack of mental health resources for children: *"It's even hard for me to find youth tailored resources to put on that application for parents to get help for their children because a lot of the resources out for mental health and substance use disorder are just for 18 and over."*

Participants are wary about the changes to the clubhouse model in San Diego being more structured around obtaining employment and job readiness skills: *"we used to be artistic and creative and musical"* but the shift *"towards a working model, where now they're going to program us to get jobs"* includes

changes made with *"little to no input"* from people with lived experience: *"Where was our voice in taking this new clubhouse model? In shifting everything away? Like I've heard from quite a few people that they are really disheartened. And now they've left the clubhouse, and that was their little safe place."*

Participants also shared the need to not only focus on the biomedical model of diagnosis when it comes to mental health. As one participant shared, *"I don't believe that the biomedical model completely answers what these things are…maybe let's stop medicalizing [the mind]…I don't think forced treatment is the way to go. I think it's a very temporary Band Aid fix."*



All of the participants from each of the focus groups highlighted the importance of peer support specialists in behavioral health programs. As one participant shared, *"A strength about the peer model that doesn't get talked about as much, but it's really learning from one another how to adapt and accommodate within the system."* Another participant shared the need for BHS administration to respect the expertise of peer support specialists, stating, *"The point is that they expect us to respect their education [BHS administration] and trust that their plan is accurate and successful. But then when we try to use our education, which is street, and drugs, and trauma, they somehow go blind and don't respect our education."*

Participants recommended more peer-led models of care, as well as more pay for peer support specialists. For instance, one participant stated, *"I would love to see like a Soteria house sort of model where there's this peer community where peers look after each other. And it's this larger sort of ecosystem…imagine if that was funded by the County of San Diego."* Another participant highlighted the rigorous training for peer support partners and asserted the pay should reflect the work involved: *"This is pretty simple and sounds kind of terse but pay the peer support partners more. Just pay them more. The amount of studying and testing is huge."* Participants further suggested more active peer specialist recruitment by BHS. One participant added that there should be more recruitment of peers from different ethnicities and cultures: *"BHS should have that active peer recruiting entity that is filling spots that are speaking different languages, that are from different cultures, that are from war torn countries where we're getting the most immigrants."*

Native American

Three participants were members of the Native American community or people who work with the Native American community. Participants shared behavioral health barriers and concerns unique to this community and highlighted how the County can successfully work with them.

Participants reported alcohol consumption as the most prevalent form of substance use in the Native American community. One participant stated, *"[Alcohol] would be at the top of the list because it's socially acceptable to self-medicate with alcohol."* The participant later discussed steps the community is taking to help reduce substance use, for instance, *"There are a lot of efforts by the tribes. Many of the tribes are 'dry,' where they don't allow alcohol consumption."* Additionally, they discussed a sober living program

for Native Americans: *“It's called Well-briety, and it's a sober living program that they offer to the community. They follow native a structure that's been built over the years...”*

The Native American community faces a variety of barriers to services. One participant explained, *“A lot of the communities are very frugal and the only access to care are clinics where you get basic needs met… then therapists that work at these Indian Health Services are only there for a short period of time…people get trusted relationships with these therapists, and then they leave... so it's hard to get people to trust in anything.”* Additionally, a focus group participant discussed additional barriers, like privacy and the lack of clinics: *“There’s only three Native clinics in San Diego County for all Native people here. So, everybody knows everybody that goes to the clinics.”* Further, there exists a hesitance to seek help due to past trauma: *“The number one concern is the results of trauma…you see a lot of pathology that is unsociable in people who have trauma, and they want to stick to themselves, or be in groups that feel safe.”* Participants also discussed the war on drugs and how specific groups, including Native Americans, were targeted. One participant stated, *“How do we rectify harms caused by the war on drugs? … highlight those that are directly impacted, which according to the County assessment, is Black, Brown, and Indigenous peoples.”*

For BHS to best engage with the Native American community, a participant recommended the County hold *“little community events, to have a group of people to talk to them and hear them”* and involve the larger community through *“Facebook pages that [Native Americans] get all [their] information from for events that are happening, or funding, or jobs that are out there…all of us just clock on constantly to give each other information, and we trust it, because it's coming from other natives.”* Participants recommended BHS allow the community to lead the efforts. One participant explained, *“There's a lot of community programs that are already there, that if they were given funding, they would have the trust of the community to start things… a lot of programs that get started, they come in, they get their information, and they leave, and so the community does not want to work with outsiders anymore.”*

Older Adults and Caregivers

One focus group was held with six staff with varying roles from a resource center for caregivers of older adults across San Diego County. The participants discussed behavioral health concerns of both caregivers and the older adult population and shared recommendations on how best to support these communities.

For the older adult population, a common problem is the lack of housing options and the associated cost: “*The conversation around housing is a lot around placement and how expensive it is when [clients] have dementia or significant cognitive decline and our caregivers can't take care of them...finding access to affordable or manageable memory care facilities or assisted living facilities, it's so hard.*” Additionally, when discussing barriers for these populations, the participants stated, “*Accessibility in general… some of the systems that these caregivers are working with, multiple doctors, multiple different hospitals, the VA, lots of big entities that may or may not be as helpful.*”

Family consultants highlighted isolation as a primary concern for their clients: *"[There's] still some taboo around mental health in general…a client that I worked with, not only is he experiencing isolation, but then feeling hesitant to even reach out and utilize the supports being offered to him."* Another consultant added insight: *"With the depression piece of loneliness and isolation, there is a lack of support for them with other family members or outside support."*

The participants reported alcohol as the most commonly used substance in the caregiver and older adult populations: *"I think if [substance use] presents, it's if a caregiver's using a harmful coping mechanism to deal with stress."* While an additional family consultant added, *"They report drinking in the evenings, or that type of substance, but I would just say that would be the most common [substance] that is reported to me."*

To further support the caregiver and older adult populations, a participant recommended that BHS creates a system where *"someone can call 211, or call Medi-Cal, or County, or whatever nonprofit, and describe their symptoms and their depression and things, and that person can help them connect to a program."* Further, Spanish-speaking support is needed: *"Somebody actually helping them fill out the application… whether it's applications of Medi-Cal, things like that can be very intimidating, and overwhelming, and time consuming."*

To engage with the caregiver and older adult populations, it was recommended sending *"something like a newsletter, both email and physical options are good for this community."* Family consultants mentioned that caregivers range in age and they believe *"mail would be the most effective if you're trying to reach all generations."* A participant specified, the older generation will likely engage if the information is sent to *"any type of community, whether that's senior living or a senior center, where it's a trusted space."*

Refugee Communities

Two interviews and one focus group, for a total of 11 individuals, included refugees and/or those who work in various refugee communities in San Diego. Each participant had experience with mental health and/or substance use outreach in the community. Interview participants shared their behavioral health concerns and recommendations for effective and culturally appropriate behavioral health services for the refugee communities in the County. The following themes emerged.

Participants identified a number of mental health concerns among people in the refugee community, including depression, anxiety, dual diagnosis with gambling addiction, and substance use problems. Participants described the stigma around mental health from inside and outside refugee communities as a considerable concern and barrier for care. Providers have found that the term "brain health" can help work avoid the stigma around mental health. As one participant shared, *"You can't say directly the mental issues, we have to do something like anxiety or depression or something like symptoms, we talk about the symptoms."*

Access to housing and cost of living were additional concerns: *"It always comes up. Housing is one of the main issues that we are dealing with, especially with refugees who are ending their five-year support, and they need to start finding resources for them in terms of how they're going to pay their rent. Rents are increasing, and it's always a challenge."* Another participant added, *"There is a limit on how much they can work to get cash or health insurance, or food stamps. If the County increased this amount, because when the people say, if I work like $2000, my food stamps and my cash will be cut because I have more than limited."* Participants stated that accessing basic needs is a considerable barrier to addressing behavioral health issues in refugee communities.

Participants highlighted the need for improved interpretation services: *"Please hire the people with the native language, not the second language."* They further added that interpreters should slow down with communicating to older adult refugee clients. As one participant shared, *"When the interpreters are interpreting, they're doing it so fast, that the older adult doesn't hear or doesn't have a chance to express."*

Finally, participants shared the need for more services for refugees with substance use disorders and for those with mild to moderate mental health issues: *"There's some restrictions on certain programs, because the criteria is still so strict that some of the older adults don't, can't even get near there, or the waiting list is too big. So perhaps some of these contractual entities can enhance or loosen up their criteria a little bit, or they can be giving more money to enhance these programs that are excellent. And what we are finding is that there's not enough services. There's a lot of services for chronically ill, mentally ill, chronic patients, but not for mild and moderate."*

Rural Communities

The following themes emerged from two interviews and one focus group (i.e., a total of four participants) with local medical and emergency service providers in a rural community in East San Diego County. All participants were staff members working in rural community health services.

It was thoroughly noted by the participants that due to the remoteness of this region, there is a general lack of behavioral health services available to community members due to a low number of providers and transportation issues. For instance, one participant stated that rural community members *"either can't drive to the store because they don't have transportation, or they don't have money for gas, to get to the store and the doctor's office and things like that."* Another participant noted the impact of isolation on mental health of the rural community: *"We know people who have suicidal ideation… we definitely have seen that. Anxiety and depression, especially in our teens. And older communities, sometimes it's hard to tell because they're very isolated…and some of the ones that we do know are dealing with dementia and Alzheimer's."*

Participants discussed the wide use of alcohol, marijuana, and methamphetamines in the region, and the perceived differences in substance use between the rural East region compared to other parts of the County. For instance, one participant stated, *"there's probably some fentanyl, but nothing. I don't think it's really kind of hit up here as much as it has down the hill."*

One participant noted the benefits of collaborating with outside organizations to provide additional behavioral health services: *"We just met with the high school, because we just helped get a contract with [another local CBO], who will come in and do therapy and do some, for the students, which will be great. But just in talking to them, the need is so big. Yeah, that I mean, that's not even going to maybe cover all of the students that actually need services."*

Participants also shared recommendations for BHS to expand services in the County such as a mobile behavioral health clinic. As one participant suggested: *"[How about] bringing the resources to them [the community] when they go to these visits because they're already there for medical care, so why not include more talk about mental health there?"*

Another participant noted the importance of pets for providing support and the need to include pets as part of behavioral health services, *"A lot of our patients have pets, and their pets are their families. For example, if there are services that could involve animals or include their pets, something like that, I think would also be beneficial for them."*

To further engage with rural communities in the County, participants recommended maintaining regular contact: *"It's just important to make those services available out there on a recurring basis. Not once a year, not bi-annually. It's got to be more often because maybe these people are at work, or they're not available that day, so they need to have other options on times to go visit and see what's available."* Additionally, an interview participant recommended *"making presentations to the Woman's Club [and] going to the chamber meetings."*

Another focus group participant shared the following details for engaging the rural community: *"Making a relationship with the community, with each individual patient too, to get your foot in the door, and then let them know that you're there for them, you're there to help them. And let them know that you're willing to come out there to see them in their homes or provide resources for them. Once you establish that kind of relationship, I think that's when you can start introducing more talks about mental health, mental health services with them."*

Transitional Aged Youth (TAY)

We conducted three focus groups to gain insight into the TAY (16–25-year-olds) community in San Diego. One focus group with four participants was conducted with TAY, while two focus groups, each with three participants, were held with staff who work with TAY in a TAY-oriented clubhouse and/or a non-profit organization. The participants shared the behavioral health concerns and recommendations surrounding the TAY community, based on what they have experienced and witnessed. The following themes emerged.

According to TAY, there are a variety of mental health issues affecting their population: *"I have to be blunt... a lot of suicide rates are going up, a lot of people are turning to drugs because they can't get the*

help. A lot of people are abandoning these people and the government is not giving people enough SSI [Supplemental Security Income] or giving them the proper home they need... we need to have more housing for people with disabilities, the independent living homes are just not it."

When expressing concerns surrounding the mental health of TAY, participants identified a lack of services and providers. One staff member stated, *"Over the last five, seven years, youth are not really considered [San Diego's] priority in mental health because they're not considered high-risk... it's hard to get them seen quick... [and] get services in a rapid manner... we've been told they're just not considered the highest need."* Turnover is another issue: *"Unfortunately, there's turnover of staff where these therapists will leave after six months to a year of working with this youth. And it really devastates the youth."* Income is a factor in turnover: *"People want to be in this field, but they are not having enough money to support their families and not having enough money to live right now, especially with inflation."* Additionally, one staff member discussed the lack of housing services: *"[Housing] is one of the biggest challenges, especially when [Transitional Aged Youth] come in and they want resources, and we don't have resources to give them because all the resources are exhausted."* Similarly, the participants of the TAY focus group expressed concern around Supplemental Security Income amounts while living in San Diego. One participant stated, *"I just had a call from SSI because I'm only getting $59 a month."* Another participant expressed, *"Rent is so high and if they can't lower the rent, they need to up our SSI to at least $2,000."*

Peer support has had a positive effect, according to staff: *"I'm such a big advocate for the peer support role just because both personally and professionally, I have interacted with mental health, I've seen the barriers, personally, with getting access to mental health, because of either cultural stigma, or even class backgrounds that can make it hard for someone to want to engage with services."*

An additional staff participant acknowledged the positives of working with the County and identified an area for improvement. They stated, *"Over the last 11 years, our greatest partner who understands this demographic, more than any year, has been the County. And I just wish that the County would get into helping support the long-term housing piece of youth."*

Participants recommended BHS increase services solely for the TAY to benefit their community. The participant explained, *"The big change was they're starting to become more specific young adult services, and that's helpful, but it's very few of them... if all the resources out there have one worker designed just to work with the TAY, that's helpful, because then the coordination becomes so much more easy. You get a provider who actually understands TAY, and not just a provider who's just providing resources maybe the old school way."* Another participant highlighted the need for BHS flexibility in services for this population: *"They don't adjust to the needs of what our youth are."*

Veterans

We conducted three interviews with Veterans with lived experience who also work with the Veteran community and one focus group with 20 participants from an organization composed of Veterans. These participants shared the most pressing behavioral health concerns and recommendations for the Veteran community. The following themes emerged.

The main mental health concern was the high suicide rates in the Veteran community. One interview participant explained their organization's prevention efforts, *"We're trying to just really enhance suicide prevention networks, increase engagement within Veterans, improve community climate outcomes, reducing gaps, and really improving and increasing adoption of community-based interventions for suicide prevention."* However, participants noted the need for additional suicide prevention efforts and funding for Veteran behavioral health services in the County.

Participants also expressed challenges accessing services for the Veteran community. One Veteran explained, *"I did acupuncture, and it really helped me. Well, there's a waiting list for that. Okay, I'd like to do art therapy. Well, you're not depressed enough to do it at the VA... you can't do this class because you're not in a wheelchair… I wasn't blind enough. I wasn't crippled enough."* If the Veteran is eligible for a service, they explained the additional challenge of waitlists: *"Talk therapies, normally three to six months… the colon clinic, the first time, I waited a month, for the second time anywhere between eight to twelve weeks on average to get started, but you have to do your intake. And then it'll probably be another four to eight weeks afterwards… stuff through the VA, you just kind of have to get in line."* Another Veteran expressed frustration around being in a time-restricted program: "*Everything was numbers… once they've hit 90 days, they've graduated… I get it sometimes facilities are hamstrung by budget or by constrictions…and that's really tough because you got somebody who needs more care."*

Within the focus group, the Veterans expressed continual appreciation for their art programs, and they believe it is a great way for the County to reach the Veteran community. One of the Veterans stated, *"I think [the County] supporting us financially to do more pop-up cafes in our community [is best]. Because actually seeing the average Veteran, creating artwork, and showing it to the community is huge for us. And that's someone actually getting eyes on that's therapy.*"

The Veteran community recommended BHS involve more people with lived experience. One focus group participant stated, *"... our staff in the County… I feel that they're committed to help solving problems, but yet, there's not that experience base of living in your car for a while, or hitting bottom as a substance abuser, or losing a child, or getting beat up on the streets, or having domestic violence issues… you get a lot less metrics from those people."* Another interview participant discussed the issue with the County utilizing metrics when trying to reach and educate the general population: "*I see a lot of metrics at the County. And in my opinion, [there is] too much metrics…[it's better to use] anecdotal data. I don't think the vast majority of people are really interested.*"

Youth (Age 16 and under)

Two interviews and two focus groups, for a total of 10 participants, with adults who work closely with youth provided insight into the behavioral health challenges, concerns, and recommendations for the youth. Participants ranged in specialty, expertise, and education: from working within different departments in San Diego County school districts, to a behavioral health program, to working with youth in more specialized care.

When discussing the strengths of the youth population, one participant expressed, *"They're amazing, they're so strong. I always would joke that the adults wouldn't be able to come to work with the things that they're going through."* Additionally, a focus group touched on how the youth themselves have difficulty identifying their own strengths, so their program works with the youth for them to recognize their strengths.

The participants discussed various mental health concerns for the youth. Participants listed factors impacting the youth's mental health including income, lack of basic needs, poverty, immigration, refugee status, and the price of gas. One participant expressed, *"Trauma is the number one thing... and it's hard to learn [in school] when you're in it."* The participant also discussed what is reported in their school district: *"Primarily it is a lot of anxiety, depression... students are reporting a higher array of eating disorders... we are seeing a lot of suicidality."* One participant touched on the importance of educating parents as *"kids will identify that they have anxiety, or depression and things like that, but their parents... need further education on mental health for it to help their kids."*

Participants touched on the difficulties and restrictions that come from the County's available mental health services. One focus group participant explained, *"A lot of the County programs outpatient level are short term, six months. So what happens, they can get approved for an additional six months? But with a high turnover rate, where's the continuity?"* Another focus group participant discussed an additional dilemma: *"Thinking in terms of County outpatient programs, because it's Medi-Cal and to meet criteria eligibility for those programs, typically you need to have a severe mental illness diagnosis. What if you have some sort of milder diagnosis? What if you have a personality disorder and would need more than a short-term service?"*

Regarding substance use, vaping was frequently mentioned as a problem with the youth. One participant explained, *"They bring it to school, they're smoking it in the bathrooms... I think they have that misconception that it's healthier than smoking a cigarette."* Another participant discussed the impact of substances on the youth, explaining, *"I also have the opportunity to see, this student was tested three years ago prior to substance use, and now being evaluated three years later, seeing what that decline really looks like in their cognitive functioning, in their memory, and then ultimately, in their academic functioning."*

One focus group discussed cultural barriers the parents and students experience. A participant stated, *"The school district's incredible because they have social workers... however, they're not necessarily Hispanic, or speak the language..."* Another participant discussed the cultural challenge around mental health stigma: *"When I do help, some parents know that their children may need more support. But it takes a process for them to culturally accept."*

A participant who works in a school district explained the benefit of collaborating with the County. They explained, *"Probably the biggest support we receive from County Behavioral Health is their school-link program, where they provide us with an agency that provides counseling support, and that's for Medi-Cal eligible families. And that is through a Youth Enhancement Services Program, and that is extremely helpful..."* Another participant recommended the County continue certain services for the youth, as they have shown to be impactful: *"I would really continue having a school-based mental health provider at*

every single one of our schools. It makes such a difference to the students, it changes their lives... connection, with a safe adult, is a huge indicator of resiliency."

APPENDIX G

MHSA ISSUE RESOLUTION PROCESS

Mental Health Services Act Issue Resolution Process
Updated January 2024

Purpose:

This procedure supplements the Department of Health Care Services (DHCS) Beneficiary Problem Resolution Process and local policies which provide detailed guidelines for the BHS contracted Patient Advocacy program in addressing grievances and appeals regarding services, treatment, and care provided by the Mental Health Plan and Drug Medi-Cal Organized Delivery System in alignment with DHCS contracts. In addition, this procedure provides a process for addressing issues, complaints, and grievances about Mental Health Services Act (MHSA) program planning process and implementation as required per DHCS Performance Contract Exhibit A.

DHCS requires the counties' local MHSA issue resolution process be exhausted before accessing State venues, which include the Mental Health Services Oversight and Accountability Commission (MHSOAC) or the California Mental Health Planning Council (CMHPC) in addition to DHCS .

The County of San Diego (County) Health and Human Services Agency, Behavioral Health Services (BHS) has adopted an issue resolution process for clients, family members, providers, and/or community members in San Diego to file and resolve issues that are related to the MHSA Community Program Planning process, and ensure consistency between program implementation and approved plans.

BHS is committed to:

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

Types of MHSA issues to be resolved in this process include:

- Appropriate use of MHSA funds
- Allegations of fraud, waste, and abuse of funds are excluded from this process. Allegations of this type will be referred directly to the County Business Assurance and Compliance Office for investigation.
- Inconsistency between the approved MHSA Plan and its implementation
- The San Diego County Community Program Planning Process pursuant to Welfare and Institutions Code (WIC) Section 5848 (a).

Process:

- An individual may file an issue related to the MHSA planning process or MHSA Plan and/or its implementation, as well as a complaint or grievance related to any aspect of the Mental Health Plan and Drug Medi-Cal Organized Delivery System at any point and through any avenue within these systems of care. These avenues include, but are not limited to, the BHS Director, BHS Assistant Directors, BHS Deputy Directors, BHS Councils, County Business Assurance and Compliance Office, MHSA Issue Resolution Contact, Patient Advocacy Program, and BHS providers. Issues may be filed via letter, email or phone.
- The MHSA issue shall be forwarded to the MHSA Issue Resolution Contact (IRC) listed

below for review within three (3) business days of receipt.

- The IRC shall provide the Issue Filer a written acknowledgement confirming receipt of the issue, complaint, or grievance within two (2) business days.
- The IRC shall notify the BHS MHSA Coordinator of an issue received while maintaining anonymity of the Issue Filer within two (2) business days if BHS not already in receipt of issue, complaint, or grievance.
- If issue does not fall within the scope of the MHSA Issue Resolution Process, the issue will be referred to other resources such as Patient Advocacy, Medi-Cal and other State/Local resources appropriate to the issue and relevant timelines will then be followed.
- If the issue is within scope of the MHSA Issue Resolution Process, the IRC will investigate the issue.
    - IRC may convene an MHSA Issue Resolution Committee (MIRC) whose membership includes unbiased, impartial individuals who are not employed by the County.
    - IRC will communicate with the Issue Filer every seven (7) days while the issue is being investigated and resolved.
- Upon completion of the investigation, IRC shall issue a committee report to the BHS Director within 15 days for awareness.
    - Report shall include a description of the issue, brief explanation of the investigation, IRC/MIRC recommendation and the County resolution to the issue.
    - IRC shall notify the Issue Filer of the resolution in writing within sixty (60) calendar days of original receipt of the issue and provide information regarding the appeal process and State-level opportunities for additional resolution.
- If the filer does not agree with the local resolution, the filer may file an appeal with the following agencies at any time:

  Mental Health Services Oversight and Accountability Commission (MHSOAC)
  1325 J Street, Suite 1700
  Sacramento, CA 95814
  Phone: (916) 445-8696 Fax: (916) 445-4927 Email: MHSOAC@mhsoac.ca.gov

  California Mental Health Planning Council (CMHPC) MS 2706
  PO Box 997413
  Sacramento, CA 95899-7413
  Phone: (916) 701-8211 Fax: (916) 319-8030

  California Department of Health Care Services (DHCS) Department of Health Care Services Mental Health Services Division Attention: MHSA Issue Resolution Process
  1500 Capitol Avenue, MS 2702
  P.O. Box 997413
  Sacramento, CA 95899-7413
  Email: mhsa@dhcs.ca.gov

- The BHS Director will provide a quarterly MHSA Issue Resolution Report to the Behavioral Health Advisory Board.

Issue Resolution Contact (IRC):
Consumer Center for Health Education & Advocacy – CCHEA
Carol Neidenberg
110 S Euclid Avenue
San Diego, CA 92114
(877) 534-2524
caroln@cchea.org

APPENDIX H

COMMUNITY SUPPORTS AND SERVICES (CSS) ANNUAL REPORT

FY 2022-23 Community Services and Supports (CSS)

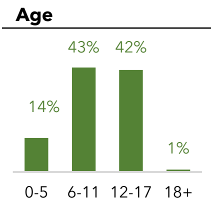
County of San Diego Behavioral Health Services — MHSA CSS Programs

Children & Youth – Full-Service Partnership (CY-FSP; n=7,675)

Living Situation	%
Children's Shelter	1%
Correctional Facility	1%
Foster Home	4%
Homeless	1%
House/Apartment	87%
Institutional	0%
Other/Unknown	7%

Race/Ethnicity (excludes missing)	%
African American	7%
Asian/Pacific Islander	3%
Hispanic	67%
Native American	1%
Other	1%
White	17%

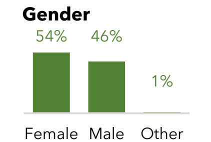
Age



Language	%
Arabic	0%
English	87%
Farsi	0%
Other/Unknown	1%
Spanish	12%
Tagalog	0%
Vietnamese	0%

Diagnosis (excludes missing/invalid)	%
ADHD	6%
Anxiety disorders	8%
Bipolar disorders	5%
Depressive disorders	9%
Oppositional/Conduct	11%
Other/Excluded	15%
Schizophrenic	0%
Stressor/Ajustment	41%

Gender



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

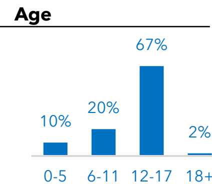
Total CSS Clients (unduplicated) N = 33,720

Children & Youth – System Development (CY-SD; n=2,908)

Living Situation	%
Children's Shelter	3%
Correctional Facility	13%
Foster Home	9%
Group Home	2%
Homeless	1%
House/Apartment	65%
Other/Unknown	9%

Race/Ethnicity (excludes missing)	%
African American	16%
Asian/Pacific Islander	2%
Hispanic	55%
Native American	0%
White	22%
Other	2%

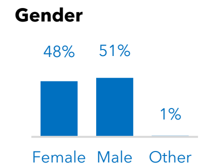
Age



Language	%
Arabic	0%
English	91%
Farsi	0%
Other/Unknown	1%
Spanish	7%
Tagalog	0%
Vietnamese	0%

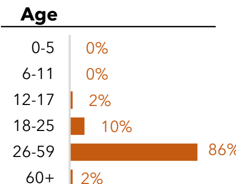
Diagnosis (excludes missing/invalid)	%
ADHD	7%
Anxiety disorders	5%
Bipolar disorders	7%
Depressive disorders	11%
Oppositional/Conduct	10%
Schizophrenic	1%
Stressor/Ajustment	43%
Other/Excluded	13%

Gender



All CSS – Outreach and Engagement † (ALL-OE; n=129)

Age



Gender	%
Female	53%
Male	47%
Other	0%

Race/Ethnicity (excludes missing)	%
African American	6%
Hispanic	28%
Native American	0%
Other	38%
White	24%
Unknown	4%

Diagnosis (excludes missing/invalid)	%
ADHD	0%
Anxiety disorders	4%
Bipolar disorders	11%
Depressive disorders	29%
Oppositional/Conduct	0%
Other/Excluded	1%
Schizophrenic	14%
Stressor/Ajustment	41%

Living Situation	%
Board & Care	7%
Correctional Facility	1%
Group Home	0%
Homeless	11%
House/Apartment	74%
Institutional	0%
Other/Unknown	6%

Language	%
Arabic	14%
English	37%
Farsi	4%
Other/Unknown	27%
Spanish	19%
Tagalog	0%
Vietnamese	0%

† Clients may be duplicate

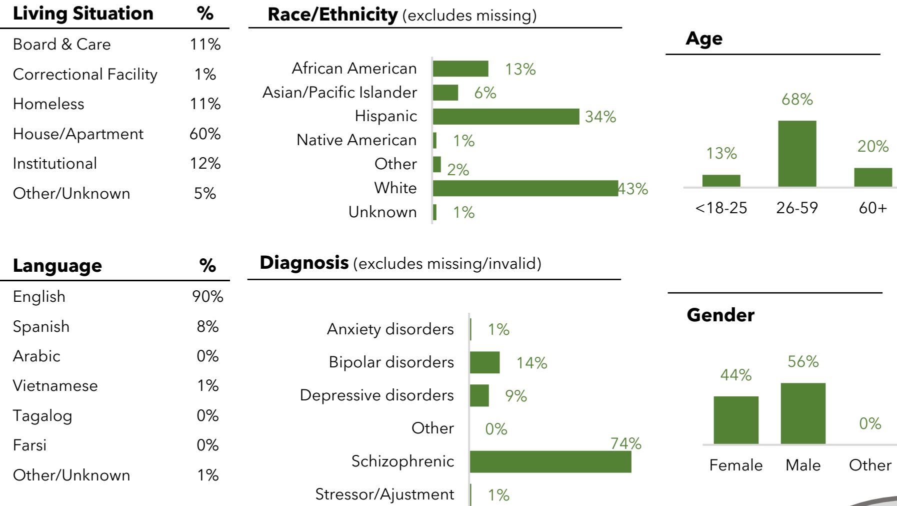
CSS Report | Source: Optum | Data Source: Optum Monthly data extracts.
Note: Clients may have received services from more than 1 CSS category within the fiscal year. Only CSS programs that enter data into CCBH are included in this report. Some CSS programs that are excluded: Clubhouses, Emergency Transition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

Report Date: 10/06/2023

FY 2022-23 Community Services and Supports (CSS)

County of San Diego Behavioral Health Services — MHSA CSS Programs

TAY, Adult, Older Adult – Full-Service Partnership (TAOA-FSP; n=7,321)



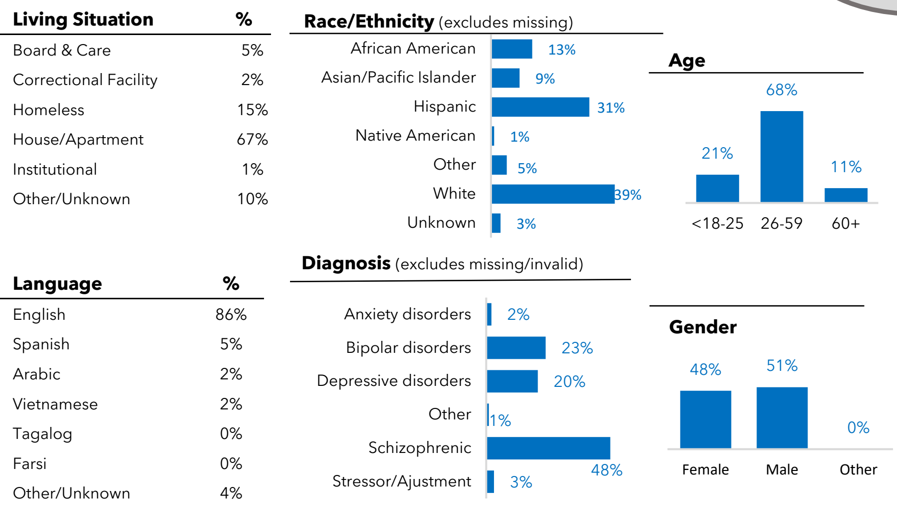
Living Situation	%
Board & Care	11%
Correctional Facility	1%
Homeless	11%
House/Apartment	60%
Institutional	12%
Other/Unknown	5%

Language	%
English	90%
Spanish	8%
Arabic	0%
Vietnamese	1%
Tagalog	0%
Farsi	0%
Other/Unknown	1%

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

Total CSS Clients (unduplicated) N = 33,720

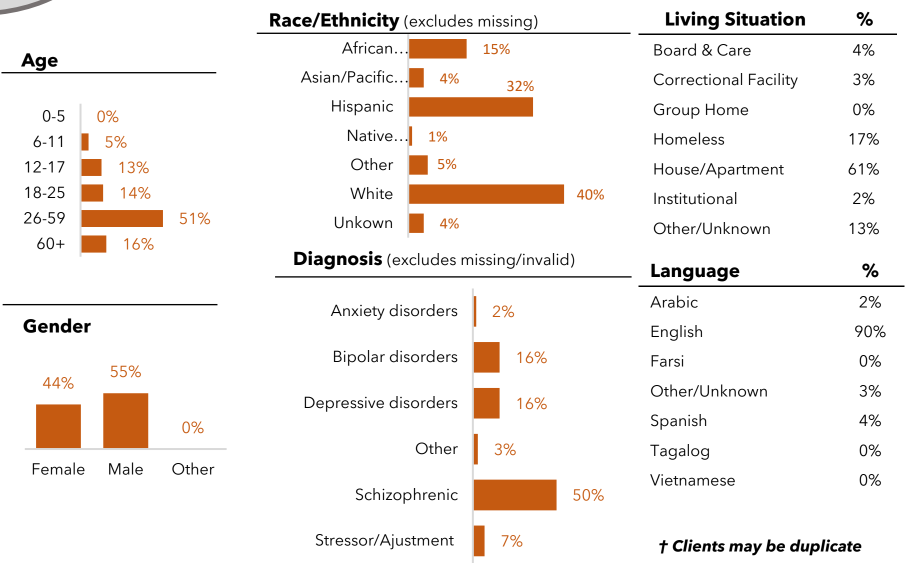
TAY, Adult, Older Adult – System Development (TAOA-SD; n=12,302)



Living Situation	%
Board & Care	5%
Correctional Facility	2%
Homeless	15%
House/Apartment	67%
Institutional	1%
Other/Unknown	10%

Language	%
English	86%
Spanish	5%
Arabic	2%
Vietnamese	2%
Tagalog	0%
Farsi	0%
Other/Unknown	4%

All CSS – System Development † (ALL-SD; n=9,373)



Living Situation	%
Board & Care	4%
Correctional Facility	3%
Group Home	0%
Homeless	17%
House/Apartment	61%
Institutional	2%
Other/Unknown	13%

Language	%
Arabic	2%
English	90%
Farsi	0%
Other/Unknown	3%
Spanish	4%
Tagalog	0%
Vietnamese	0%

† Clients may be duplicate

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

Report Date: 10/06/2023

APPENDIX I

FULL-SERVICE PARTNERSHIP (FSP) OUTCOMES REPORT

Full Service Partnerships
OUTCOMES REPORT

Children, Youth & Families FSP Summary ***FY 2022-23***

What Is This?

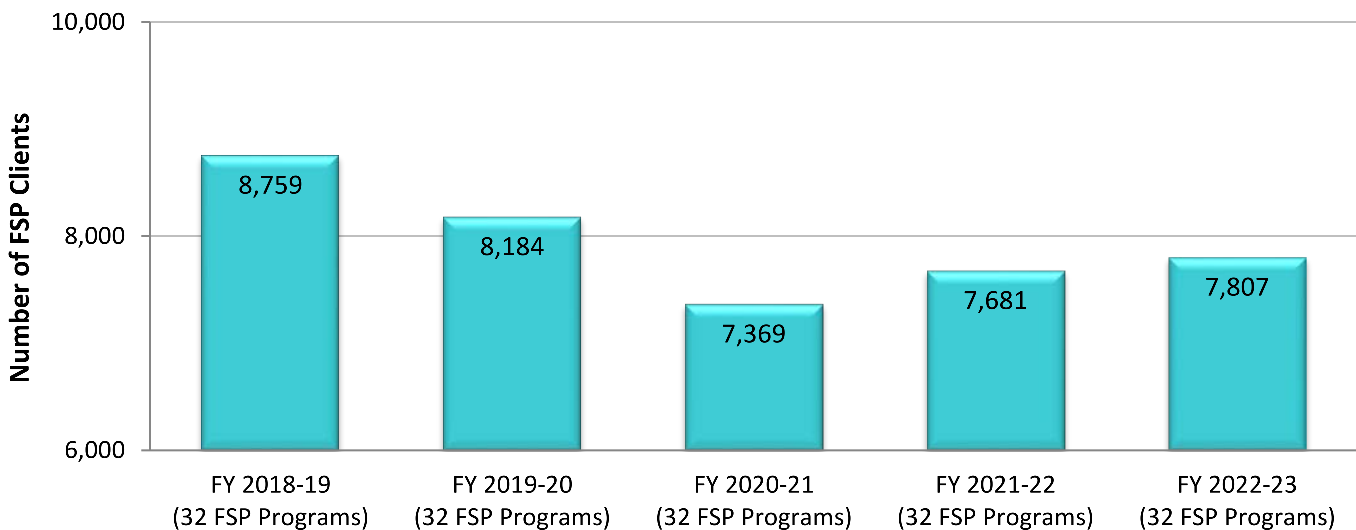
The Full Service Partnership (FSP) model offers integrated services with an emphasis on whole person wellness and promotes access to medical, social, rehabilitative, and other community services and supports as needed. An FSP provides all necessary services and supports to help clients achieve their behavioral health goals. Clients can access designated staff 24 hours a day, 7 days a week. FSP services address client and family needs through intensive services, supports, and strong connections to community resources with a focus on resilience and recovery. An FSP offers ancillary support(s), when indicated, provided by case managers, substance use disorder (SUD) counselors or certified peer specialists. Services are trauma-informed, with a recognition that a whole person approach is critical to promoting overall wellbeing. Emphasis on partnership with the family, natural supports, primary care, education, and other systems working with the family is a recognized core value.

Why Is This Important?

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

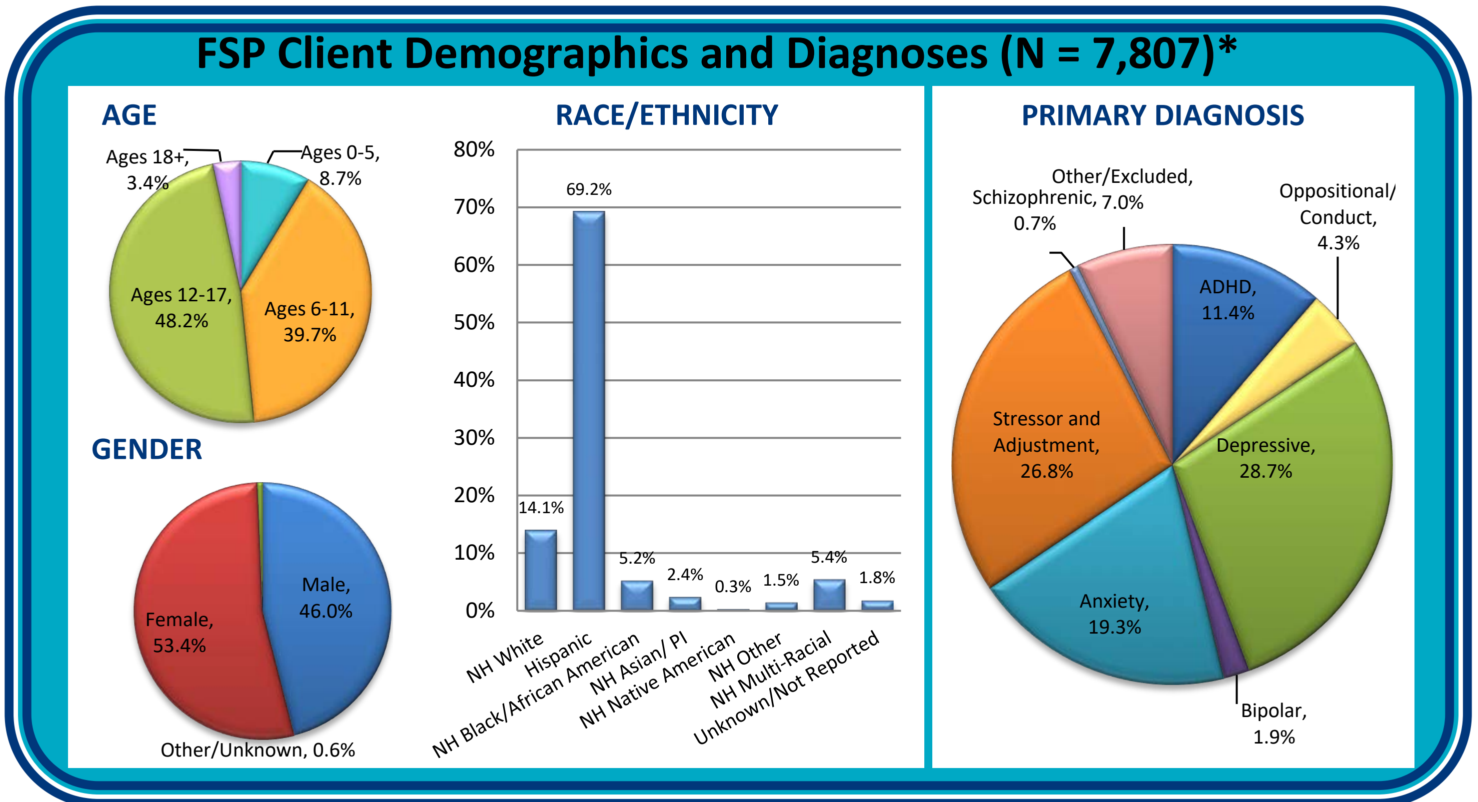
Who Are We Serving?

In Fiscal Year (FY) 2022-23, a total of 7,807 unduplicated clients received services at 32 Children, Youth & Families (CYF) FSP programs, a 2% increase from 7,681 FSP clients served in 32 CYF FSP programs in FY 2021-22.



Who Are We Serving?

In FY 2022-23, FSP clients were more likely to be female (53.4%), Hispanic (69.2%), and between the ages of 12 and 17 (48.2%). Depressive disorders were the most common diagnosis, affecting 28.7% of FSP clients.



**Data may differ from those reported elsewhere due to differences in download dates, recoding rules, and exclusion criteria.*

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

Data Collection and Reporting System (DCR)

FSP providers collected client and outcomes data using the California Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR). Referral sources were entered for new clients to FSP programs in FY 2022-23.

Referral Sources (N = 4,339)

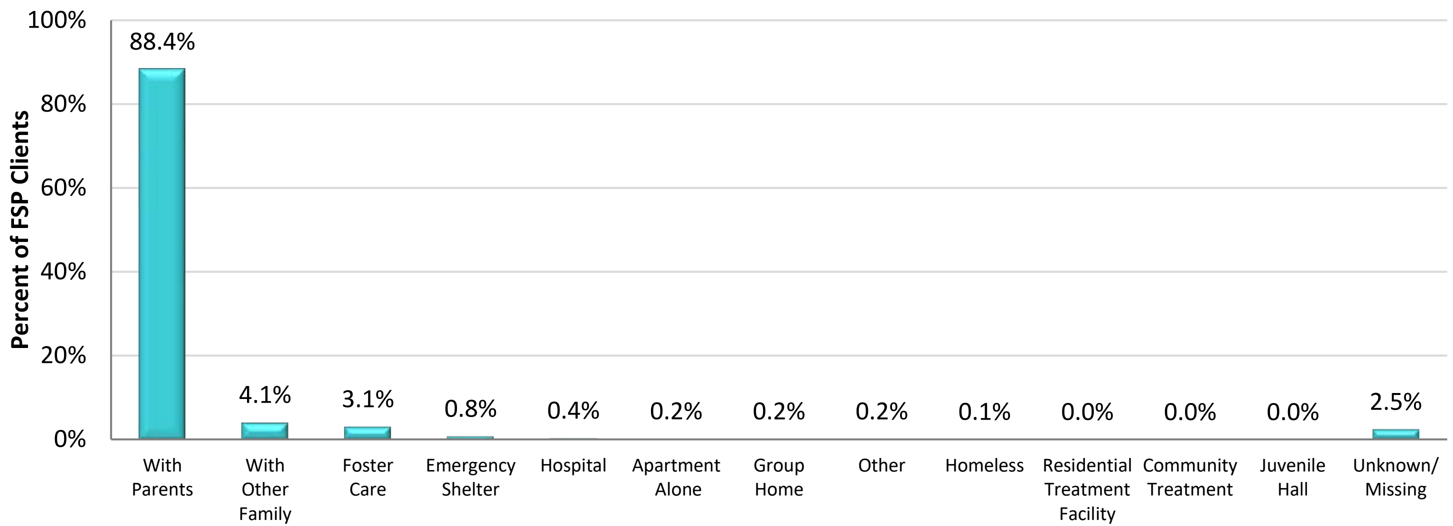
FSP referrals for clients with an intake assessment in FY 2022-23 were as follows (in order of frequency): school system (43%), family member (22%), primary care physician (11%), self-referral (7%), mental health facility (7%), social service agency (4%), other county agency (1%), Juvenile Hall (1%), acute psychiatric facility (1%), emergency room (1%), friend (1%), homeless shelter (<1%), and street outreach (<1%). The remaining 1% were referred by an unknown or unspecified source.

Who Are We Serving? (continued)

Living arrangement and risk factors were entered in the DCR for new clients to FSP programs in FY 2022-23.

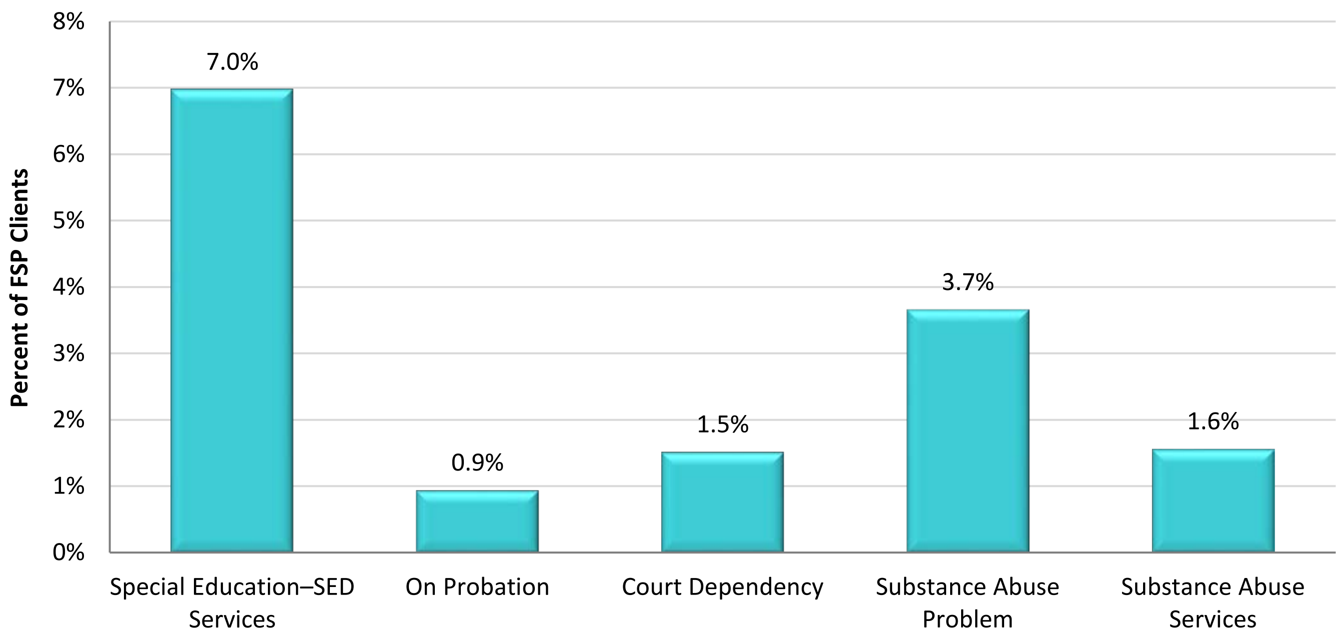
Living Arrangement at Intake (N = 4,339)*

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



Risk Factors at Intake (N = 4,339)*

The most prevalent risk factor for more intensive service utilization among youth entering FSP programs was related to Special Education—Serious Emotional Disturbance (SED) Services. A total of 3,557 (82%) of new clients did not have a risk factor identified on the intake form. Clients with identified risk factors may have had more than one risk factor endorsed.



**Clients with intake assessment in the DCR within FY 2022-23.*
NOTE: Percentages may not add up to 100% due to rounding.

Who Are We Serving? (continued)

Client involvement in the juvenile justice sector and emergency service provision was tracked by FSP providers.

Forensic Services

In FY 2022-23, a total of 7 FSP clients had an arrest recorded in the DCR.

Inpatient and Emergency Services

Of 7,807 unduplicated clients who received services from an FSP program in FY 2022-23, 277 (3.6%) had at least one inpatient (IP) episode and 465 (6.0%) had at least one Emergency Screening Unit (ESU) visit during the treatment episode.

Are Children Getting Better?

FSP providers collected outcomes data with the Pediatric Symptom Checklist (PSC), the Pediatric Symptom Checklist-Youth (PSC-Y), the Child and Adolescent Needs and Strengths (CANS), and the Child and Adolescent Needs and Strengths-Early Childhood (CANS-EC). Scores were analyzed for youth discharged from FSP services in FY 2022-23 who were in services at least 60 days, and who had both initial assessment and discharge scores completed. Additionally, Personal Experience Screening Questionnaire (PESQ) scores were analyzed for youth discharged from FSP programs augmented with a SUD component in FY 2022-23, who were in services for at least one month.

FSP PSC Scores

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

Amount of Improvement

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

Reliable Improvement

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

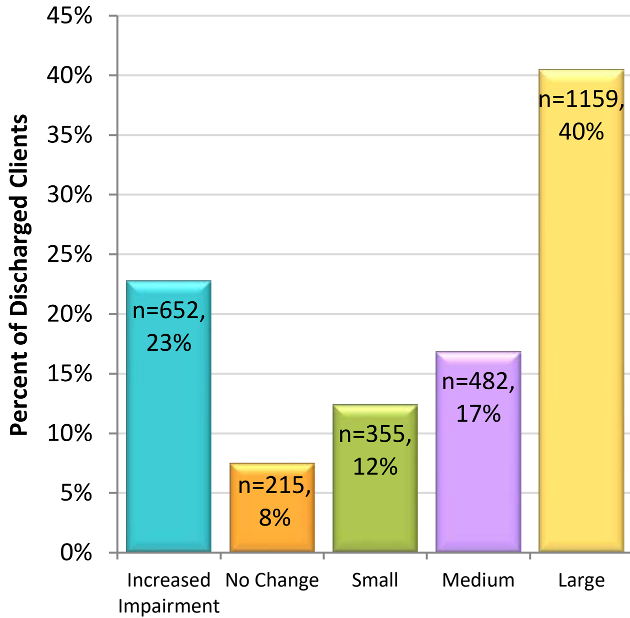
Clinically Significant Improvement

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

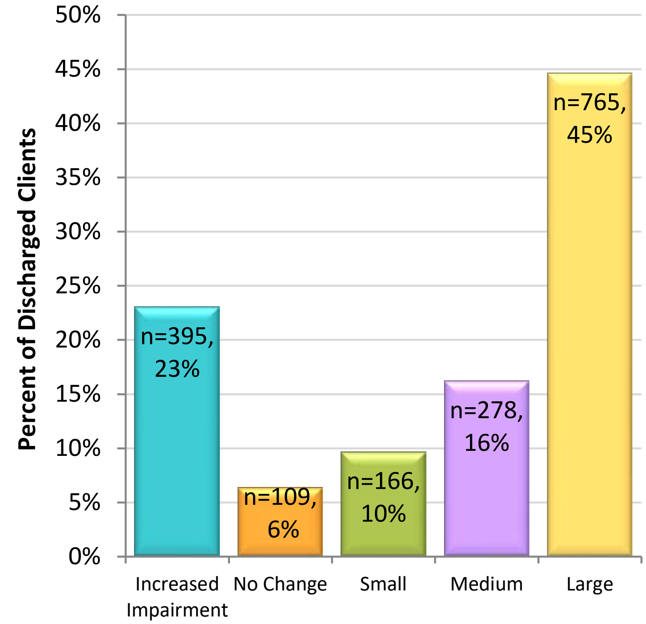
Are Children Getting Better? (continued)

PSC Amount of Improvement from Intake to Discharge

FSP Parent/Caregiver (N = 2,863)

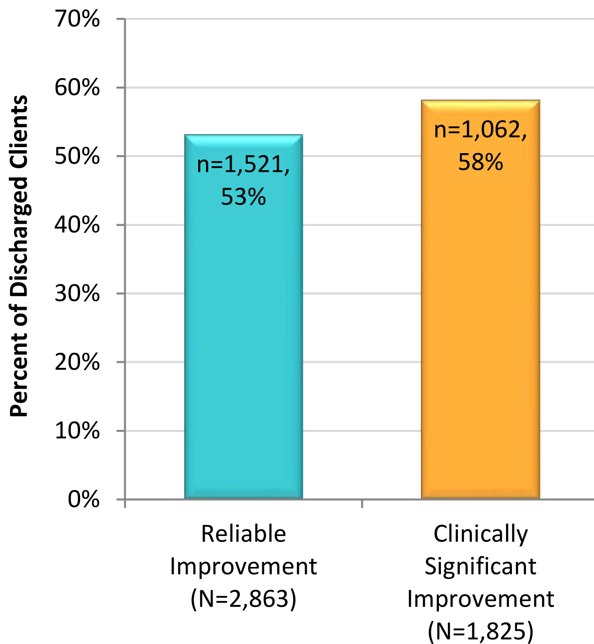


FSP Youth (N = 1,713)

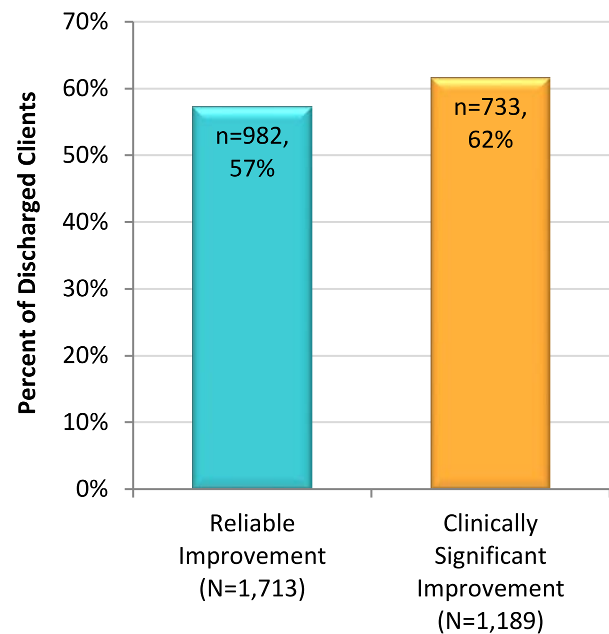


PSC Reliable and Clinically Significant Improvement from Intake to Discharge

FSP Parent/Caregiver



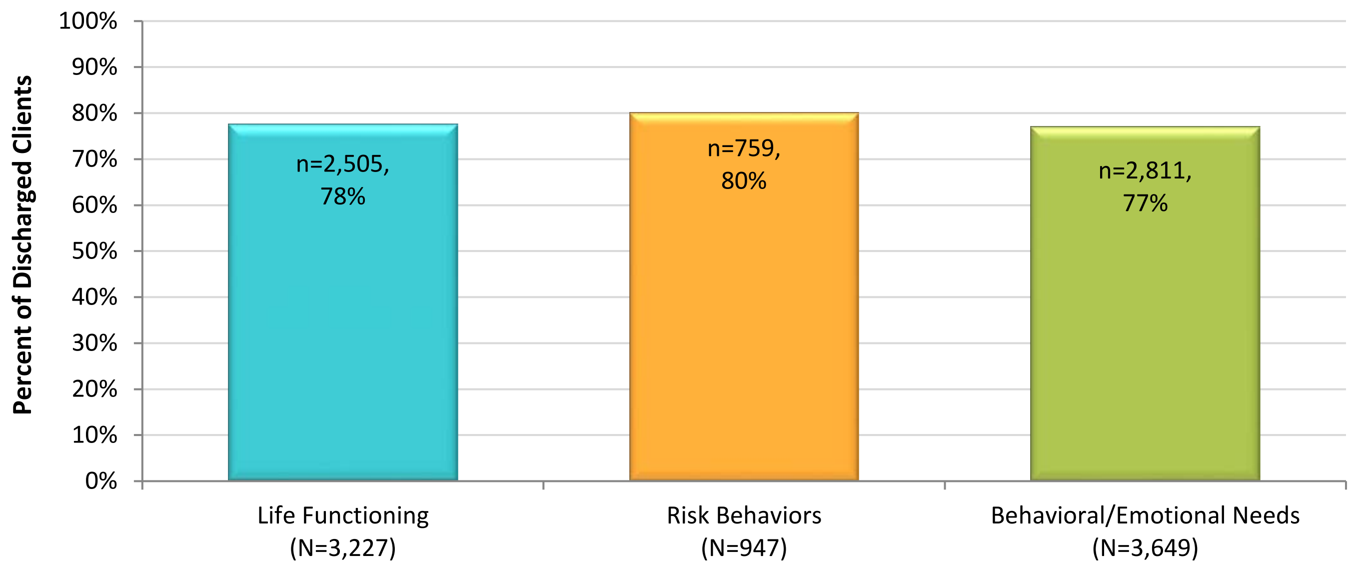
FSP Youth



Are Children Getting Better? (continued)

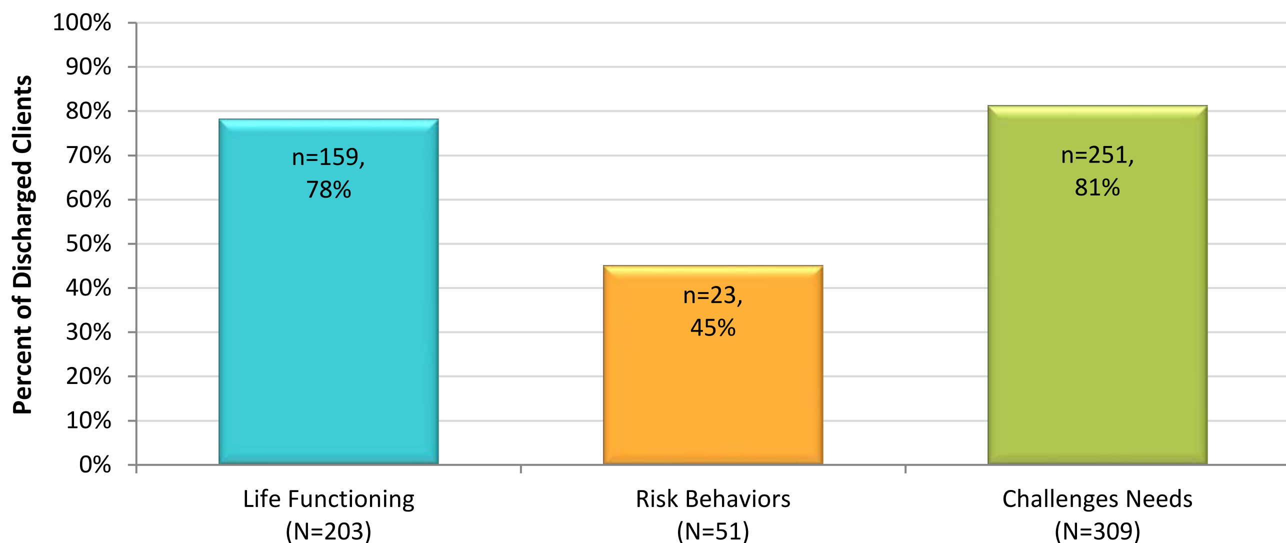
FSP CANS Scores

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



FSP CANS-EC Scores

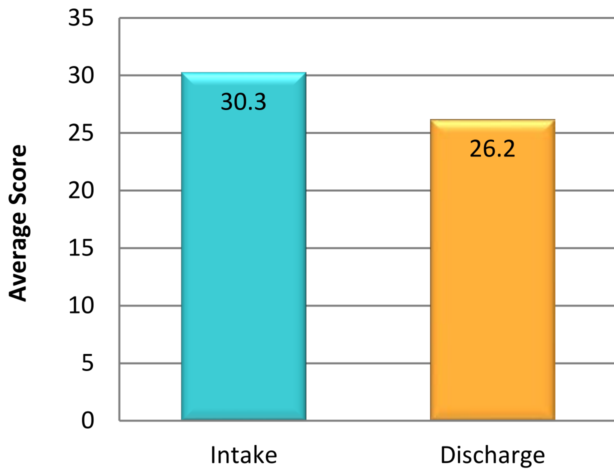
The CANS-EC is a structured assessment to identify youth and family strengths and needs completed by clinicians for clients ages 0 through 5. Progress on the CANS is defined as a reduction of at least one need from initial assessment to discharge on the CANS domains: Life Functioning, Risk Behaviors,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



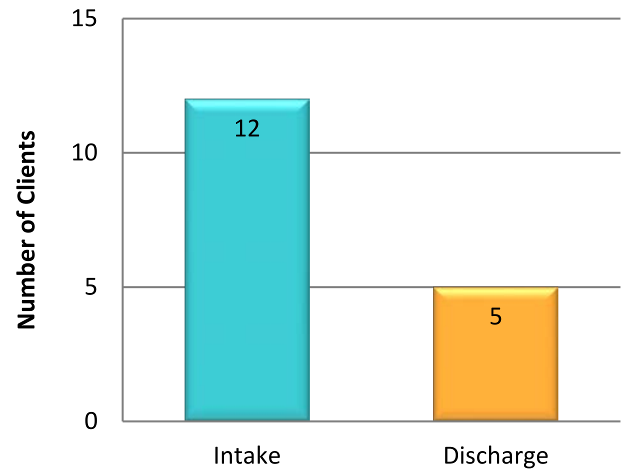
FSP PESQ Scores

The PESQ screens adolescents for substance abuse and is administered to youth ages 12 to 18 by their SUD counselor; the PESQ is only administered at FSP programs which are augmented with a dedicated SUD counselor. Scores are measured in two ways: 1) the Problem Severity scale, and 2) the total number of clients above the clinical cutpoint. For clients, a *decrease* on the Problem Severity scale is considered an improvement. For programs, a *decrease* in the number of clients scoring above the clinical cutpoint at discharge is considered an improvement. PESQ data were available for 31 discharged clients in FY 2022-23.

PESQ Severity Scale (N = 31)



PESQ Clinical Cutpoint

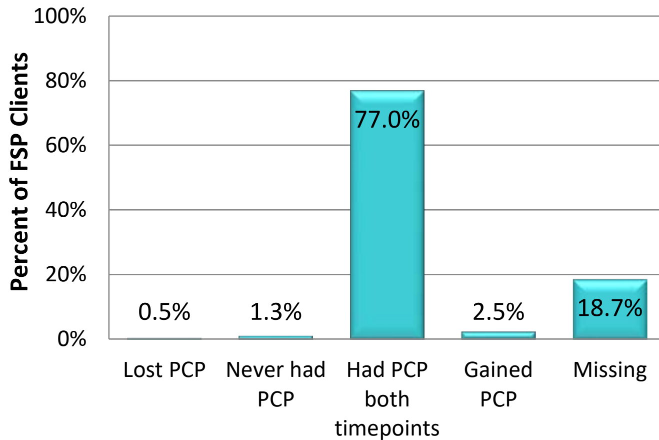


Are Children Getting Better? (continued)

FSP providers collected client and outcomes data on primary care physician (PCP) status, school attendance, and academic performance. These were recorded in the DCR for continuing clients with multiple assessments. Outcomes are calculated for clients who meet the following eligibility criteria: (a) Discharged within the current fiscal year; (b) In services for at least 120 days; (c) Between the ages of 5 and 18; (d) Served by a primary program (i.e., ancillary programs were excluded); (e) Eligible to receive a Partnership Assessment Form (PAF) assessment at intake. The most recent assessment was compared to intake.

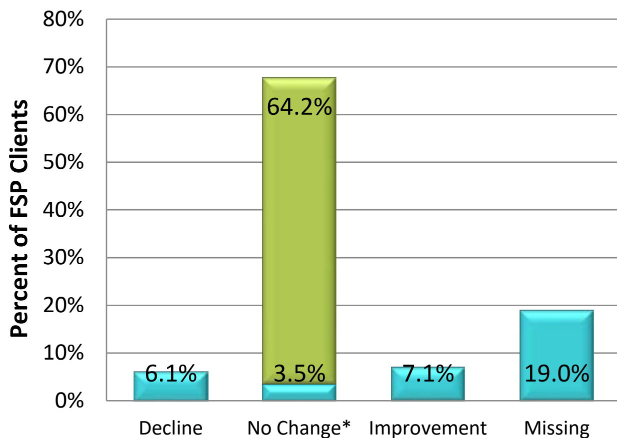
Primary Care Physician (PCP) Status (N = 2,914)

80% of FSP clients gained or maintained a PCP.



School Attendance (N = 2,914)

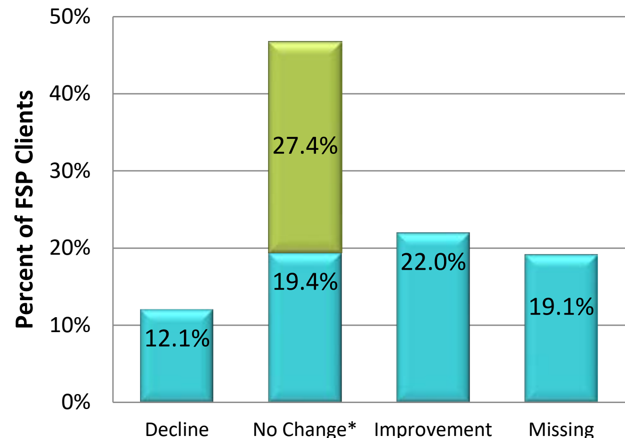
71% of FSP clients either improved (7%) or sustained high (64%) school attendance at follow-up assessment as compared to intake.



**Of the 68% of clients for whom no change was noted, 64% (green portion of bar) had "High" School Attendance Sustained (Clients who had ratings of "Always attends school (never truant)" or "Attends school most of the time" at both the initial assessment and the last quarterly (3M) assessment).*

Academic Performance (N = 2,914)

49% of FSP clients either improved (22%) or sustained high (27%) grades at follow-up assessment as compared to intake.



**Of the 47% of clients for whom no change was noted, 27% (green portion of bar) had "High" Academic Performance Sustained (Clients who had academic ratings of "Very Good" or "Good" at both the initial assessment and the last quarterly (3M) assessment.).*

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

What Does This Mean?

- Children and youth who receive treatment in FSP programs showed improvement in their mental health symptoms and reductions in needs, according to client, parent, and clinician reports. The CANS-EC data showed that a majority of clients 5 and under showed reductions in the Life Functioning and Challenges domains between intake and discharge.
- On average, children and youth who received treatment by SUD counselors showed improvement in their risk for substance abuse.
- The majority of FSP youth clients maintained a PCP during their participation in FSP programs.
- Nearly half of FSP youth clients also improved or maintained excellent school attendance during their participation in FSP programs and just over 70% either improved or sustained high school attendance.

Next Steps

- There should be continued collaboration between FSP programs and schools to improve or maintain FSP clients' academic performance and school attendance.

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

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

APPENDIX J

ANNUAL SYSTEM-WIDE ASSERTIVE COMMUNITY TREATMENT (ACT) REPORT

Annual Systemwide ACT Report

Fiscal Year 2022-23

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

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

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

Drawing from multiple data sources, this report presents a system-level overview of service use and recovery-oriented treatment outcomes for those who received FSP services from the 18 ACT programs* in San Diego County during fiscal year (FY) 2022-23.

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

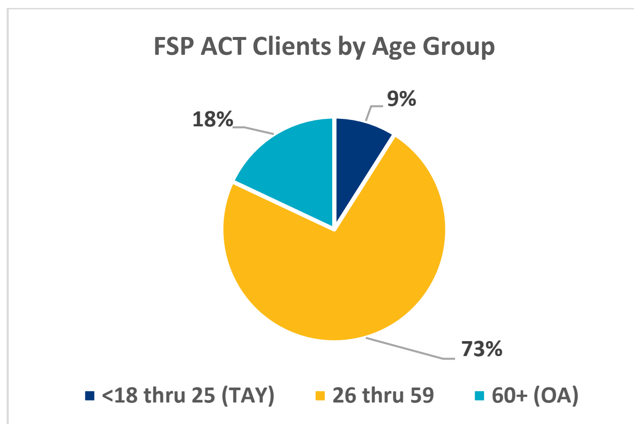
  were retrieved from the Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) system used by FSP programs across the State of California.
- Recovery outcomes and progress toward recovery were obtained from the County of San Diego's Mental Health Outcomes Management System (mHOMS).

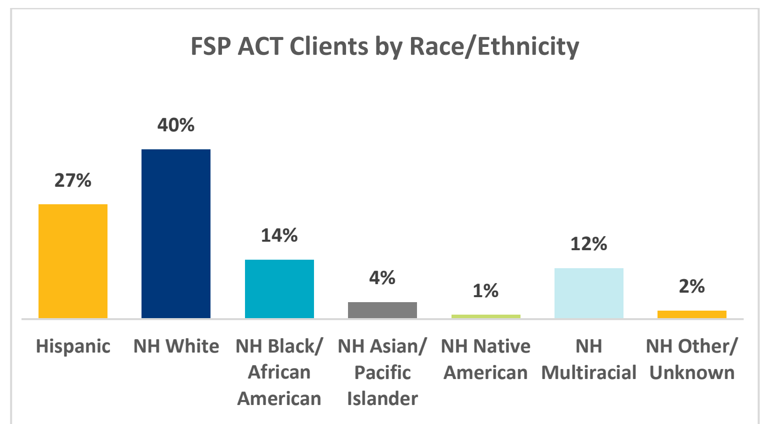
*Data from the following programs are included in this report (program name and sub-unit): CRF Downtown IMPACT (3241, 3246), Telecare Gateway to Recovery (3312, 3318), Telecare LTC (3331, 3332), MHS North Star (3361), CRF IMPACT (3401, 3405), MHS Center Star (3411, 3417), CRF Senior IMPACT (3481, 3483, 3484), Telecare MH Collaborative Court (4201, 4205), Telecare Assisted Outpatient Treatment (4211), MHS City Star (4221), MHS Action Central (4242), MHS Action East (4251), Pathways Catalyst (4261), CRF Adelante (4341,4344), MHS North Coastal (4351), Telecare Vida (4401), Telecare La Luz (4421) and Telecare Tesoro (4411).

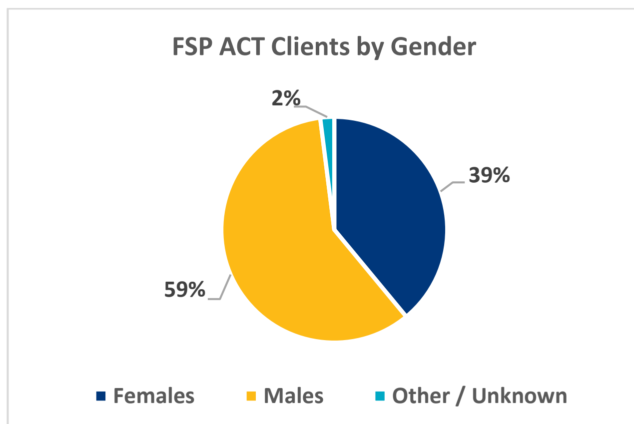
Note: Due to rounding, percentages in this report may not sum to 100%.

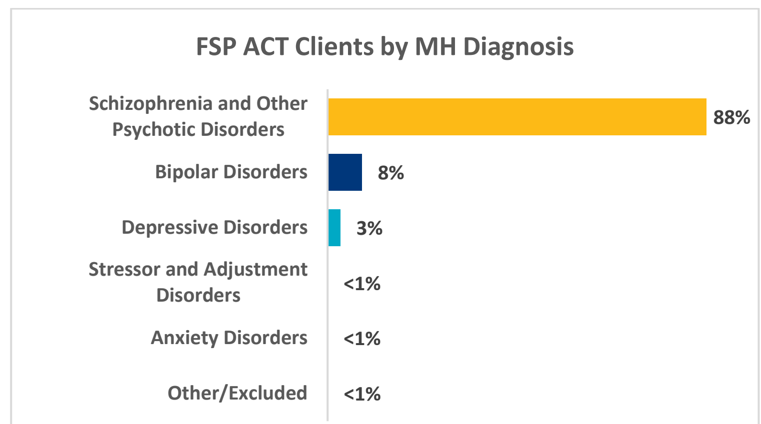
Demographics and Diagnoses

During FY 2022-23, 3,298 FSP clients received services from ACT programs in San Diego County. Of these, most clients were between the ages of 26 and 59 years (73%), a majority were male (59%), and the vast majority had a primary mental health diagnosis of schizophrenia or another psychotic disorder (88%). The next most common primary mental health diagnosis among FSP ACT clients served during the fiscal year was bipolar disorder (8%). In addition to their primary mental health diagnosis, 82% of FSP ACT clients served during FY 2022-23 had a history of substance use disorder. Two-fifths of FSP clients who received services from ACT programs during this period were Non-Hispanic (NH) White (40%), over one-fourth were Hispanic (27%) and nearly one-fifth were NH African American (14%).

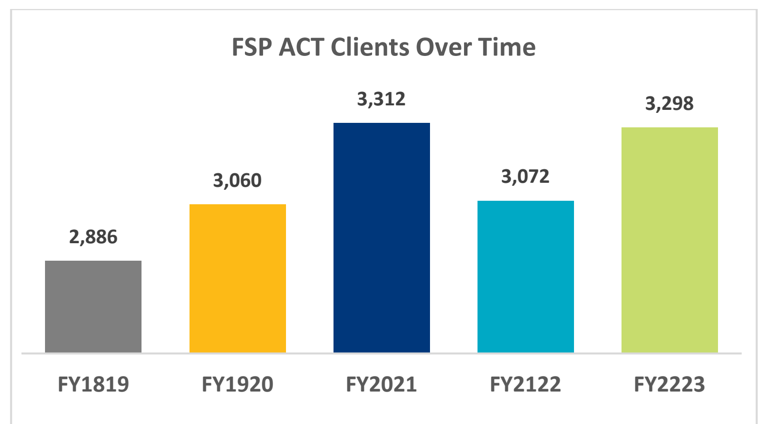








In FY 2020-21, there was an 8% increase in FSP clients served by ACT teams each year compared to the number of FSP clients served by ACT programs in FY 2019-20. In FY 2022-23, there was increase (7%) in the number of FSP clients served by ACT teams compared to FY 2021-22. Overall, the distribution of the key demographics highlighted above among FSP ACT clients served during FY 2022-23 is similar to the demographics of the clients served by these programs during the previous two fiscal years.



Meeting FSP ACT Clients' Basic Needs*

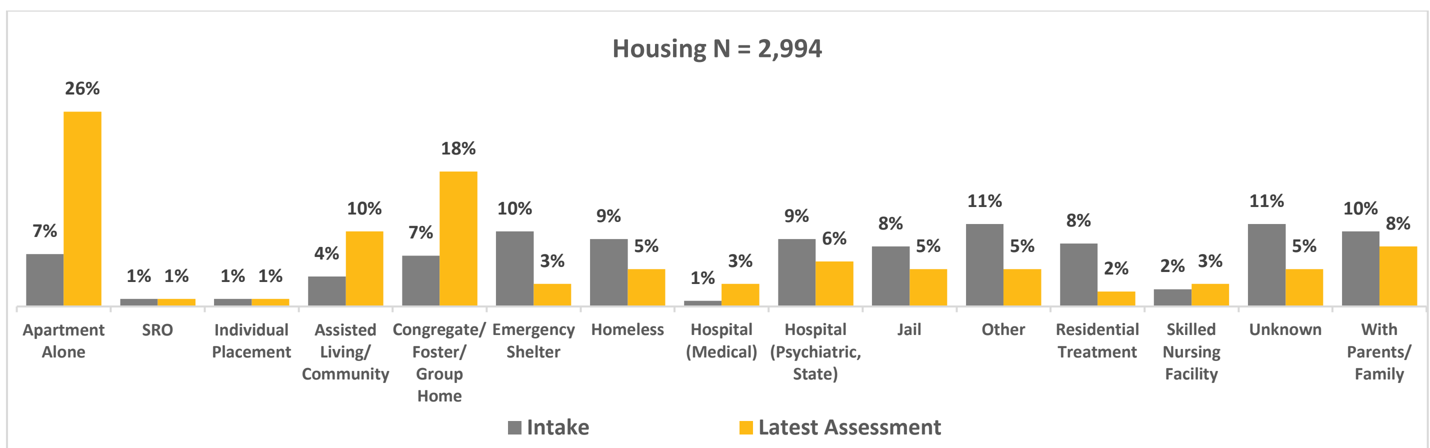
Housing

During FY 2022-23, FSP clients served by ACT programs showed progress in several areas of basic needs. Compared to intake, nearly four times as many clients were living in an apartment alone setting at the time of their latest assessment (7% at intake versus 26% at the latest assessment). Similarly, the proportion of clients living in a congregate, foster, or group home setting almost tripled from intake (7%) to the latest assessment (18%), and the proportion of clients living in an assisted living or community setting more than doubled from intake (4%) to the latest assessment (10%).

Notable decreases in the proportion of clients living in specific housing settings were also observed from intake to latest assessment. The proportion of clients housed in an emergency shelter decreased from 10% to 3%, the proportion of clients reporting a psychiatric hospital as their current living situation decreased from 9% to 6%, and the proportion of homeless clients decreased by nearly half from intake (9%) to latest assessment (5%).

Key Findings: Housing

- The proportion of FSP ACT **clients living in an apartment alone** setting nearly **quadrupled** from intake (7%) to latest assessment (26%).
- The proportion of **clients** housed in an **emergency shelter decreased** from 10% at intake to 3% at the latest assessment.
- The proportion of **homeless clients decreased** by nearly **one-half** from intake (9%) to latest assessment (5%).



Employment

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

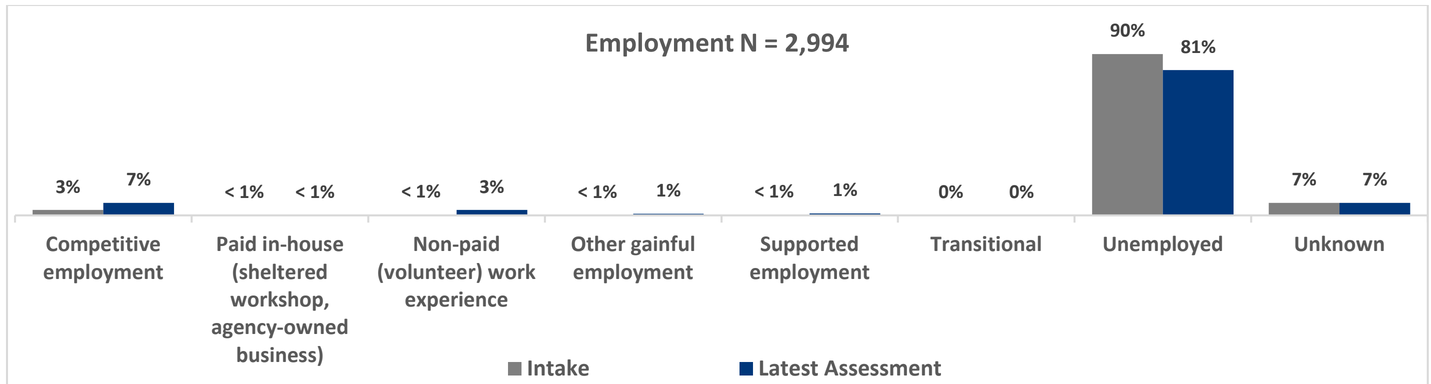
While most clients remained unemployed at the time of the latest assessment (81%), there was a 10% reduction in the number of clients that were unemployed at the latest assessment (2,426 clients) compared to intake (2,682 clients). A notable increase in employment status from intake to latest assessment was observed among those working in non-paid (volunteer) settings (3 clients at intake compared to 99 clients at the latest assessment). Additionally, there were nearly three times as many FSP ACT clients employed in competitive settings at the time of the latest assessment (217 clients) compared to the number employed at intake (75 clients). Similarly, there were over three times as many FSP ACT clients working in supported employment settings at the time of the latest assessment (19 clients) compared to intake (6 clients).

*Basic needs data (housing, employment, education, and report of a primary care physician) were compiled from all FSP ACT clients active at any time during FY 2022-23, as of the 10/2023 DHCS DCR download.

Lastly, while only five clients were employed in another gainful employment setting at intake, 19 clients were employed in this setting at the time of the latest assessment.

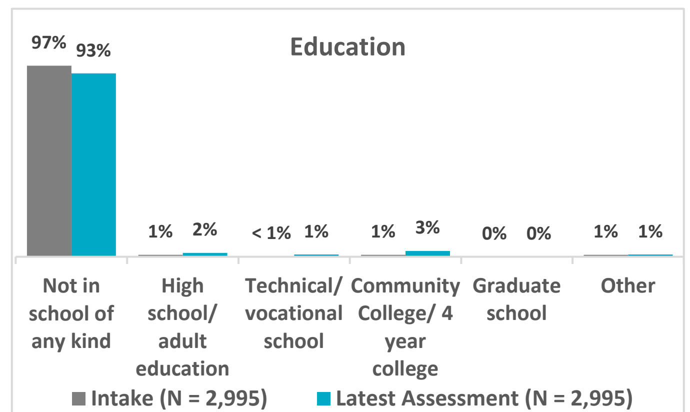
Key Findings: Employment

- There was a 10% **reduction** in the number of clients that were **unemployed** at the latest assessment compared to intake.
- Compared to intake, there were notable **increases** in the number of clients employed in **non-paid** (volunteer), **competitive**, **supported,** and **other gainful** employment settings.



Education

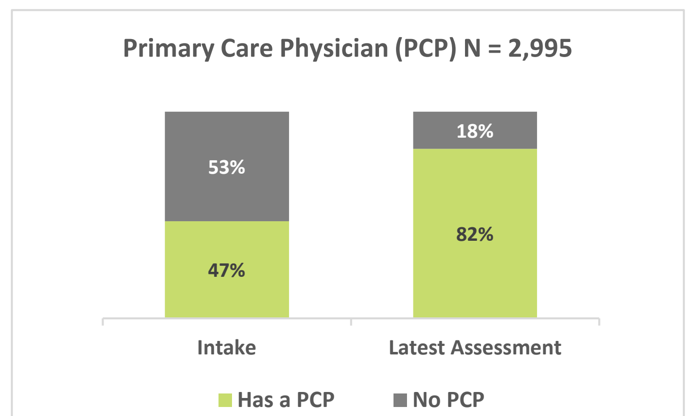
Education is a goal for some FSP clients who receive ACT services, but not all. Of the 2,995 FSP ACT clients with education information available at intake†, 82 (3%) were enrolled in an educational setting. At the time of the latest assessment, 189 of the 2,995 FSP ACT clients with educational information available (6%) were enrolled in an educational setting†. The largest increases from intake to latest assessment were observed in the proportion of clients enrolled in a community or four-year college (1% at intake versus 3% at the latest assessment for both settings) compared to other types of educational settings.



Primary Care Physician

Among FSP ACT clients served during FY 2022-23, there was a large increase in the number and proportion of clients who had a primary care physician at the time of the latest assessment compared to intake. Slightly less than half (47%; 1,413 clients) had a primary care physician at intake, while a majority (82%; 2,461 clients) had a primary care physician at the time of their latest assessment.

Overall, changes in basic needs from intake to latest assessment during FY 2022-23 were similar to those observed during previous fiscal years.



†Education information was missing for 468 clients at intake, and 410 clients at the time of the latest assessment.

Changes in Service Use and Setting

Use of Inpatient and Emergency Services (Pre/Post)‡

These programs employ a “whatever it takes” model to help clients avoid the need for emergency services such as Crisis Stabilization (CS), Urgent Outpatient (UO), Psychiatric Emergency Response Team (PERT) services, Mobile Crisis Response Team (MCRT), Crisis Residential (CR), and services provided at the psychiatric hospital. Overall, utilization of these types of services decreased by more than half (51%) from pre to post assessment during FY 2022-23. While utilization of all types of emergency services decreased from pre to post assessment, there was a greater reduction in the number of CR and psychiatric hospital services compared to the other types of emergency services.

Similar to the reduction in overall emergency service utilization, there was a 48% reduction in the number of unique FSP ACT clients who used emergency services from pre to post assessment with the largest reductions observed among clients receiving CR services (79%) and services at the psychiatric hospital (58%). The number of clients who received a PERT service decreased by 47%, the number of clients who received a CS service decreased by 32%, and the number of clients who received a UO service decreased by 54%, respectively, from pre to post assessment.

A reduction in the overall mean number of emergency services per client was also observed from pre to post assessment (6%). The most notable reduction observed among those receiving services from the psychiatric hospital (17%).

Reductions in utilization of PERT, CR, and psychiatric hospitalization services among FSP ACT clients during FY 2022-23 were similar to reductions in utilization observed among this population during FY 2020-21 and FY 2021-22. MCRT began services right before the beginning of FY 2021-22 resulting in 15 clients being served at pre assessment and 130 clients at post assessment and 30 services being provided at pre assessment and 225 services at post assessment.

Key Findings: Use of Inpatient and Emergency Services

- Utilization of **all emergency services, except MCRT decreased** among FSP ACT clients from pre to post assessment.
- The **greatest reductions** in emergency service utilization were observed in the **CR** and **psychiatric hospital** LOCs.
- A **reduction** in the overall **mean number of emergency services per client** was observed from pre to post assessment.

	# OF SERVICES			# OF CLIENTS*			MEAN # OF SERVICES PER CLIENT		
Type of Emergency Service	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change**	**Pre**	**Post**	**% Change****
CS	939	911	-3%	418	283	-32%	2.25	3.22	43%
UO†	1,082	446	-59%	493	226	-54%	2.19	1.97	-10%
PERT	904	450	-50%	502	265	-47%	1.80	1.70	-6%
MCRT	30	225	650%	15	130	767%	2.00	1.73	-13%
Crisis Residential	912	171	-81%	499	103	-79%	1.83	1.66	-9%
Psychiatric Hospital	2,071	711	-66%	767	319	-58%	2.70	2.23	-17%
Overall	**5,938**	**2,914**	**-51%**	**1,076**	**560**	**-48%**	**5.52**	**5.20**	**-6%**

**The overall number of clients at Pre (n=1,076) and Post (n=560) represent unique clients, many of whom used multiple, various services, while some clients did not use any emergency services.*
***Percent change is calculated using the pre and post means.*
Note: Clients in this analysis (n=1,606) had an enrollment date ≤ 7/1/2022 and discontinued date (if inactive) > 7/1/2022. Data may include individuals discharged from FSP during the fiscal year but who continued to receive services from a different entity.
†Formerly Crisis Outpatient (CO)

‡Pre-period data encompasses the 12-months prior to each client’s FSP enrollment and are sourced from the 10/2023 CCBH download. The 10/2023 DHCS DCR download was used to identify active clients, and for Post period data.

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

Similar to previous fiscal years, there were overall decreases from pre to post assessment in the number of days spent (65% reduction), and number of FSP ACT clients (58% reduction) residing in the following restrictive settings: jail/prison, state psychiatric hospital, and long-term care. The largest reductions observed from pre to post assessment were in the number of days clients spent in a state psychiatric hospital (89% reduction) and the number of clients who resided in a state psychiatric hospital (81% reduction). Notable reductions were also observed in the number of days (67% reduction) and the number of clients (56% reduction) residing in long-term care settings from pre to post assessment.

The residential status of individuals receiving FSP services is changed to "Acute Medical Hospital" when admission to a medical hospital setting occurs for a physical health reason such as surgery, pregnancy/birth, cancer, or another illness requiring hospital-based medical care. Data pertaining to placements in acute medical care settings are reported separately in the table below. Compared to pre assessment, there was an increase over five times (412%) in the number of days FSP ACT clients spent in an acute medical hospital setting, and a 49% increase in the number of FSP ACT clients in an acute medical hospital setting at post assessment. It is possible that this increase may be partly facilitated by the ACT programs as FSP ACT clients may have delayed seeking necessary medical care during crises prior to enrollment in an ACT program.

In general, during FY 2022-23 the rates of change between pre and post assessment for each type of restrictive setting mirrored the rates observed for these settings during the previous fiscal year. One change from last fiscal year is that the mean number of days per FSP ACT client in a jail or prison setting increased by only 1% from pre to post during FY 2022-23 but increased by 21% during FY 2021-22 (not shown). Also, to note, is the observed 43% decrease in the mean number of days per client spent in a state psychiatric hospital setting, a trend consistent with the increase observed during FY 2021-22.

Key Findings: Placements in Restrictive and Acute Medical Settings

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

	# OF DAYS			# OF CLIENTS*			MEAN # OF DAYS PER CLIENT		
Type of setting	Pre	Post	% Change	Pre	Post	% Change	Pre	Post	% Change**
Jail/Prison	46,658	21,016	-55%	410	182	-56%	113.80	115.47	1%
State Hospital	12,248	1,330	-89%	74	14	-81%	165.51	95.00	-43%
Long-Term Care	100,099	32,867	-67%	335	149	-56%	298.80	220.58	-26%
Overall	**159,005**	**55,213**	**-65%**	**819**	**345**	**-58%**	**194.15**	**160.04**	**-18%**
Acute Medical Hospital	4,466	22,881	412%	208	310	49%	21.47	73.81	244%

**The overall number of clients at Pre (n=819) and Post (n=345) represent unique clients who may have been placed in multiple and/or various types of settings.*
***Percent change is calculated using the pre and post means.*

[§]Data source: DHCS DCR 10/2022 download; 12-month pre-enrollment DCR data rely on client self-report.

Measuring Progress Towards Recovery**

Overall Assessment Means for Assessments 1 and 2

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

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

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

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

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

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

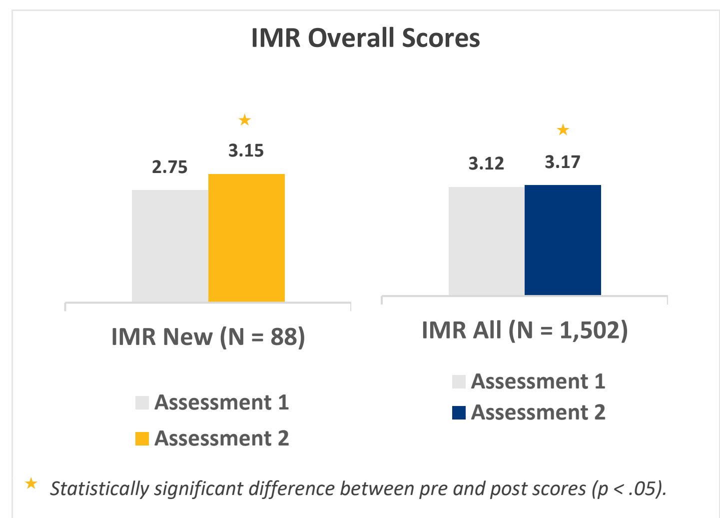
- **New** clients are defined as those who:
  1. began receiving ACT services in 2022 or later,
  2. had two IMR or RMQ assessments during FY 2022-23 (assessments 1 and 2), and
  3. had a first service date within 30 days of their first IMR assessment.
- **All** clients include every FSP ACT client with at least two IMR or RMQ assessments during FY 2022-23 (assessments 1 and 2), regardless of the length of FSP services from ACT programs.

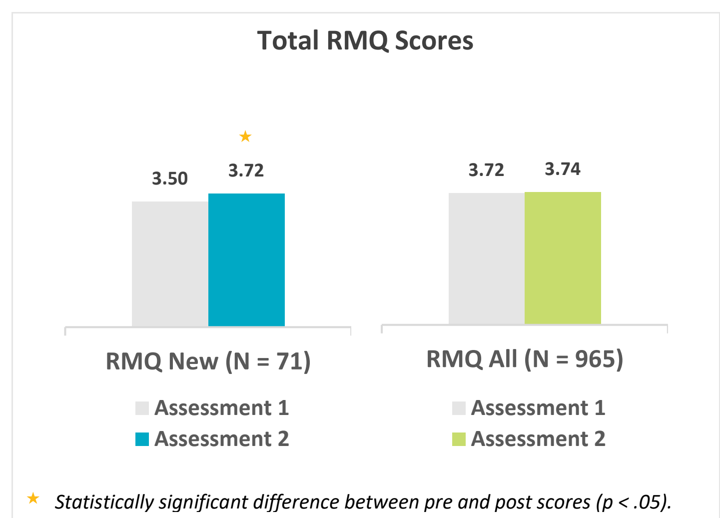
Clients receiving FSP services from ACT programs are generally reassessed on these IMR and RMQ measures every six months to measure progress towards recovery. In general, assessment scores for New clients tend to more directly demonstrate the effect of FSP ACT services on client outcomes because All clients include individuals who may have received services for many years.

As expected, overall IMR and RMQ assessment 1 mean scores for New clients were lower than assessment 1 mean scores for All clients. For both groups overall IMR assessment 2 mean scores were significantly higher than overall IMR assessment 1 mean scores ($p < .05$).

The mean assessment 1 score from All clients was relatively high compared to mean scores among New clients, suggesting that clients enrolled in ACT services for a longer period of time may reach the maintenance phase in their recovery where improvement is no longer expected.

Overall RMQ mean scores were slightly higher at assessment 2, compared to assessment 1 for both New and All clients, but this increase was statistically significant for only New clients. RMQ assessment scores for New and All clients were higher than their IMR scores indicating that both groups of clients rated their progress higher than clinicians.





**Outcomes data are sourced from mHOMS FY 2022-23; Data include all mHOMS entries as of 11/21/2023 for clients who received services in FSP ACT programs, completed an IMR or RMQ assessment 2 during FY 2022-23, and who had paired IMR or RMQ assessments 4 to 8 months apart.

IMR Subscale Means for Assessments 1 and 2

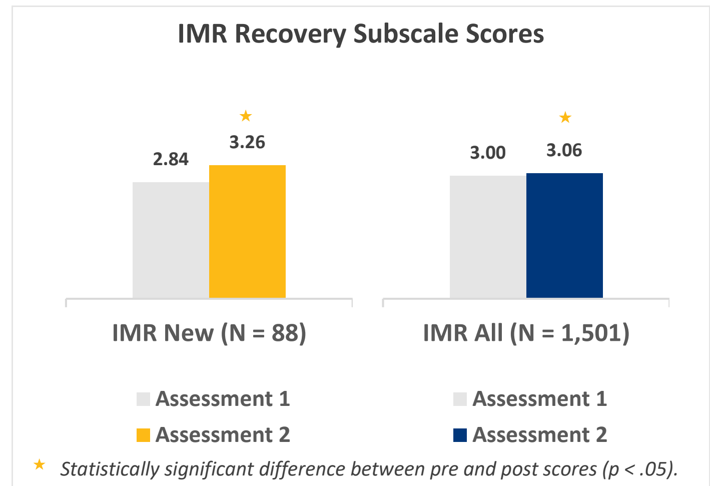
Changes in mean scores on each of the three IMR subscales from assessment 1 to assessment 2 were also analyzed for each group of clients (New and All). On average, both New and All FSP ACT clients had significantly higher mean Recovery and Management subscale scores ($p < .05$) at assessment 2 than they did at assessment 1. These data suggest that New and All clients made significant progress towards recovery from assessment 1 to assessment 2.

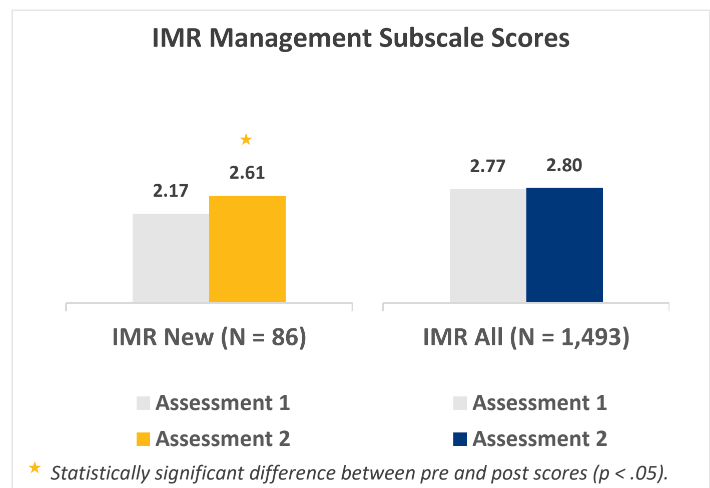
Two questions on the IMR assessment asked clinicians to rate the degree in which alcohol and/or drug use impaired the functioning of their client. Substance Use subscale scores at assessment 1 were high for both New and All clients, suggesting that the majority of FSP ACT clients may experience low or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

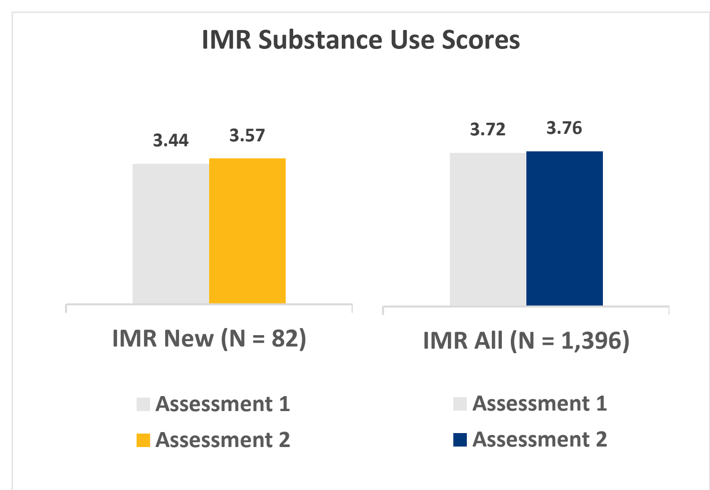
New and All FSP ACT clients had slightly higher mean Substance Use scores at assessment 2 compared to assessment 1; however, this difference in mean scores was not statistically significant. These findings suggest that drug and alcohol use may be a factor in impairment of functioning among new FSP clients but may not be a primary focus of early treatment and may be an area addressed when clients are in services for a while.

Key Findings: Assessment Outcomes

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

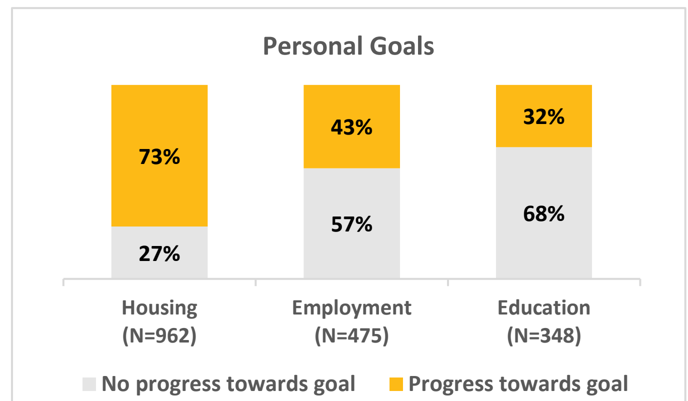






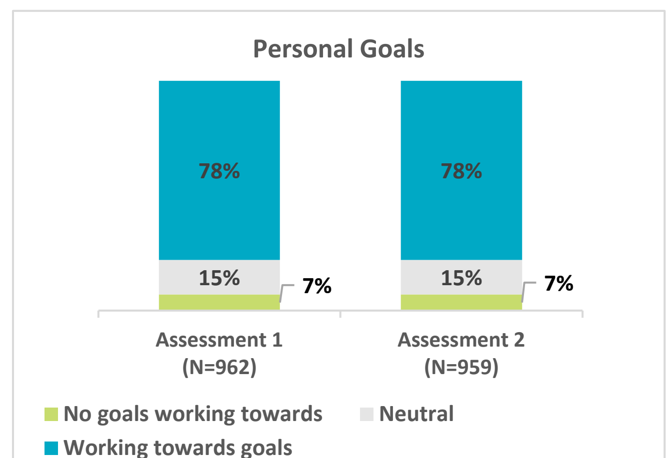
Progress Towards Key Treatment Goals

At the time of their follow-up IMR assessments, clinicians also noted client progress towards goals related to housing, education, and employment. Similar to trends observed during FY 2021-22, most FSP ACT clients served during FY 2022-23 with a completed Goal assessment had a goal related to housing (962 clients; 80%) on their treatment plan. Of these clients, clinicians reported that 73% made progress towards their individual housing goal at the time of the latest assessment. Fewer FSP ACT clients had goals related to employment (475 clients; 39%) or education (348 clients; 29%) on their treatment plan, compared to the number with housing related goals. Additionally, over two-fifths of clients with treatment goals related to employment (43%) and less than one-third of clients with goals related to education (32%) made progress towards their goals at the time of the most recent assessment. These results may reflect a "housing first" approach in that obtainment of stable housing may be a primary focus for most FSP ACT clients, while goals related to employment and education may be secondary and an area of focus after stable housing is obtained.



Personal Goals

One of the items in the RMQ assessment asks clients if they have goals which they are working towards achieving. More than three-quarters of FSP ACT clients at assessment 1 and assessment 2 (78%) agreed or strongly agreed that they had a goal (or goals) they were working towards. At assessment 1 and assessment 2, 15% of clients reported they were "neutral" about working towards goals. There were 63 FSP ACT clients (7%) disagreed or strongly disagreed with the statement that they were working towards achieving goals at the time of the latest assessment. Responses to this RMQ item were unavailable for three clients at assessments 1 and six clients at assessment 2 and the chart to the right exclude these clients from percentage calculations.



Level of Care

Completed by clinicians, the Level of Care Utilization System (LOCUS) is a short assessment of a client's current level of care needs and provides a system for assessment of service need for adults. The LOCUS is based on the following six evaluation parameters:

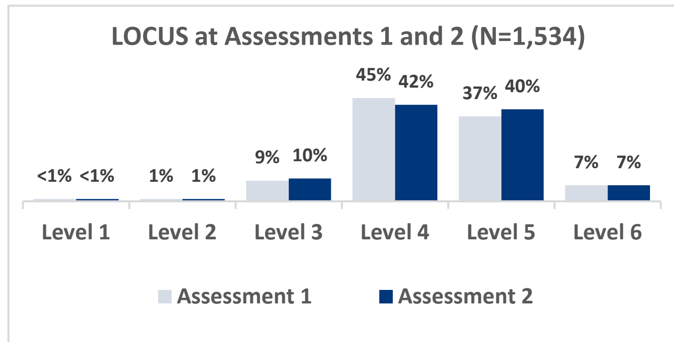
1. risk of harm,
2. functional status,
3. medical, addictive, and psychiatric co-morbidity,
4. recovery environment,
5. treatment and recovery history, and
6. engagement and recovery status.

In the LOCUS, levels of care are viewed as levels of resource intensity. Lower numbered levels correspond with lower intensity resources and services.

LOCUS Resource Levels

	Level of Care Description
Level 1	Recovery maintenance and health maintenance
Level 2	Low intensity community-based services
Level 3	High intensity community-based services
Level 4	Medically monitored non-residential services
Level 5	Medically monitored residential services
Level 6	Medically managed residential services

Similar to LOCUS results from previous fiscal years, the greatest proportion of FSP ACT clients were recommended for medically monitored non-residential services (Level 4) and medically monitored residential services (Level 5) by clinicians at both assessments. A reduction in the proportion of clients recommended for medically monitored non-residential services (Level 4) was observed from assessment 1 to assessment 2, and an increase in proportion of clients recommended for medically monitored residential services (Level 5) was observed between assessments.



Note: Percentages are rounded.

Key Findings: Goals and LOCUS

- **Majority** of FSP ACT clients (80%) had a **housing related goal** on their treatment plan.
- Of the clients with a housing goal on their treatment plan, a **majority** (73%) **made progress** towards that goal by assessment 2.
- **Most** clients (78%) agreed or strongly agreed that they were **working towards a treatment goal** at assessment 2.
- Clients were most likely to be recommended for a **Level 4** or **Level 5** treatment setting at both times points.
- **A reduction** in the proportion of clients recommended for medically monitored non-residential services **(Level 4)** was observed from assessment 1 to assessment 2, and **an increase** in proportion of clients recommended for medically monitored residential services **(Level 5)** was observed between assessments.

Conclusion

With the addition of several new FSP ACT programs within the San Diego County Behavioral Health System of Care during the past few years, there has been increased interest in learning more about the impact of these programs on clients' service use and outcomes. The FSP ACT model aims to serve homeless clients with severe mental illness, as evidenced by the vast majority of clients served during FY 2022-23 with 1) a housing-related goal (80%), 2) a diagnosis of schizophrenia or psychotic disorder (88%), or 3) a recommendation for medically monitored or managed treatment services (LOCUS Levels 4 through 6; 89% at intake).

Similar to trends reported from previous fiscal years, FSP ACT clients served during FY 2022-23 showed progress in the following areas of basic needs: housing, employment, and having a primary care physician. Notably, the proportion of clients living in an apartment only setting nearly quadrupled from intake (7%) to latest assessment (24%), the proportion housed in an emergency shelter decreased from 10% at intake to 3% at the latest assessment, and the proportion of homeless clients decreased from 9% at intake to 5% at the latest assessment. There was also an 8% reduction in the number of clients unemployed at the latest assessment compared to intake and an 35% increase in the number of clients with a primary care physician at the time of the latest assessment, compared to intake.

Additional success of the FSP ACT model is evident from reductions observed in 1) utilization of inpatient and emergency services and 2) placements in restrictive settings among clients. For example, overall, utilization of inpatient and emergency services decreased by 51% compared to utilization rates prior to receipt of services from ACT programs. Similarly, placements in restrictive settings, such as jail/prison, state psychiatric hospital, and long-term care settings, were also reduced from intake to latest assessment, as measured by the number of days FSP ACT clients spent in these settings (65% reduction), and the number of clients housed in these types of settings (58% reduction). Progress towards recovery among FSP ACT clients was also exhibited by 1) significant improvements in clinician-rated IMR scores for New FSP ACT clients and 2) progress towards treatment plan goals for All ACT clients between two assessment time points.

Overall, improvements were observed in several key areas among FSP clients served by ACT programs during FY 2022-23, mirroring improvements observed among this population during previous fiscal years and demonstrating a positive effect of services on the lives of clients served by the ACT programs.

APPENDIX K

HOUSING UPDATE
EXECUTIVE SUMMARY

County of San Diego Behavioral Health Services
Five Year (2022-2027) Strategic Housing Plan
Implementation Plan FY 2023-24 (Year 2)

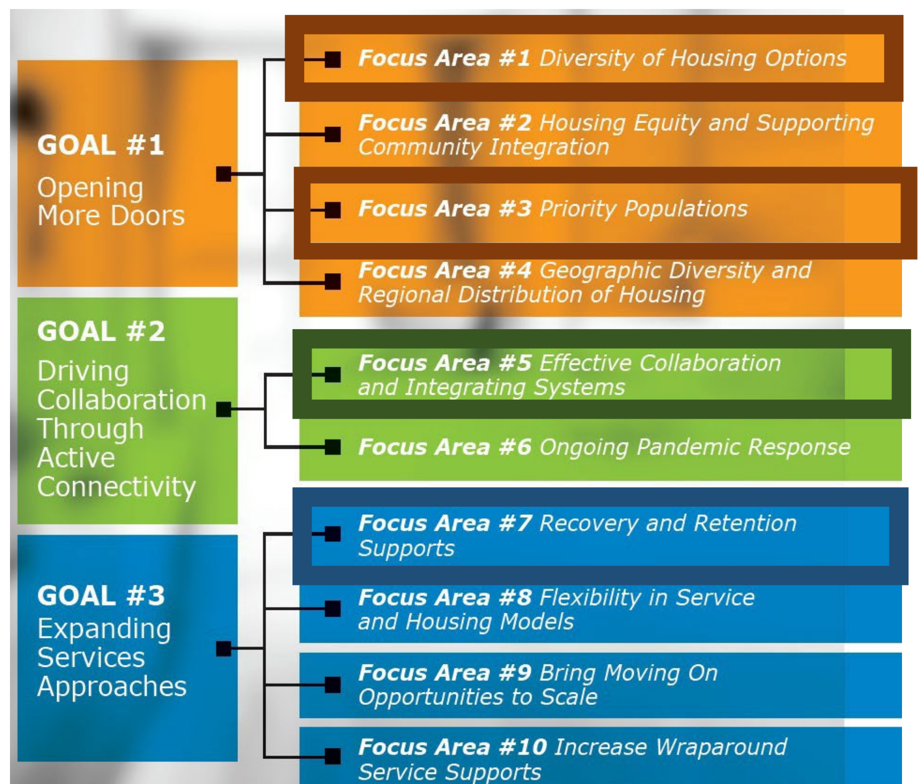
Strategic Housing Plan – Implementation Plan Overview

The Five-Year Strategic Housing Plan envisions *Creating Homes with Intention, Purpose and Collaboration*. It outlines guiding principles and targeted responses that maximize a range of housing options for people with behavioral health issues (people with serious mental illness/serious emotional disorders and/or substance use disorder) and limited resources through policy decisions, funding commitments, and programmatic initiatives. The Plan's approach is rooted in principles of equity and inclusion and the goals are driven by the voices of people with lived expertise. The Plan aims to maximize opportunities for community integration as well as choice in housing and services options that best meet individual needs and recovery goals. The plan includes three key goals: Opening More Doors; Driving Collaboration through Active Connectivity; and Expanding Service Approaches. Each goal area has focus areas with strategies or action steps for implementation. There will be a one-year implementation plan developed for each year of the five-year Plan based on the priorities identified by the Housing Council for the strategies to be acted upon in each fiscal year. This one-year implementation plan will be for fiscal year 2023-24 and represents year two implementation of the BHS Strategic Housing Plan. It describes the specific priorities identified by the housing council at their retreat in May, 2023. This plan is intended to be used as a management tool for monitoring progress in implementing the strategies set forth within the five-year plan and accomplishing its goals. It shall be updated on a quarterly basis for review by the Housing Council and indicate progress made in meeting the priorities of the housing council. Housing Council leads are assigned to each priority area to monitor activity/action steps within the noted priority area and report out to Housing Council on opportunities for advocacy, input and/or progress.

Implementation Plan

The FY 2023-24 implementation Plan is organized according to the BHS Housing Strategic Plan Goals and Focus Areas. Actions were prioritized for this fiscal year at the Housing Council planning retreat in May, 2023. Four Focus Areas were identified as priorities in this 2023-24 fiscal year:

- #1 Diversity of Housing Options
- #3 Priority Populations
- #5 Effective Collaboration and Integrating Systems Priorities
- #7 Recovery & Retention Supports



Goal #1 OPENING MORE DOORS

At their annual retreat, the Housing Council identified the following priorities within the focus areas of ***diversity of housing and priority populations*** for action steps in this FY 2023/24 (year two) implementation plan:

Housing Council Priorities FY 2023-24	Action Steps	Update	Timeline for Completion
Recapitalize MHSA Housing Program or similar funding programs for capital for development. HC Lead: Lisa Huff	Advocate for increased investment/re-investment in capital funding for BHS client housing and similar programs to produce more permanent supportive housing in San Diego County.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:	Ongoing throughout the year
Development of more Permanent Supportive Housing for Persons experiencing homelessness with special needs (disabled, seniors, youth, families, CARE court participants) HC Lead: Debbie Fountain	Encourage partnerships between the County Health and Human Services Department (specifically BHS & HCDS) along with other entities that fund housing development, and Permanent Supportive Housing Developers to increase the supply of housing for persons experiencing homelessness with special needs throughout San Diego County, including CARE court participants.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:	Ongoing throughout the year
Production of more tiny homes/villages (as defined by the housing council in the BHS Strategic Housing Plan) HC Lead: Angela Rowe	Advocate for the development of more tiny homes in the county, and for legislative/administrative changes and/or an incentive program(s) to support the development of tiny homes/villages throughout San Diego County. Create FAQ to assist tiny homes to pass housing quality inspections.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:	Ongoing throughout the year
Increase in supply of Recovery Residence homes for families involved in child welfare services HC Lead: Angela Rowe (co-lead to assist)	Research and advocate for increased development/provision of Recovery Residence homes throughout San Diego County with a specific focus on families involved in child welfare services. Pay for adult only.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:	Q3

GOAL #2 Driving Collaboration Through Active Connectivity

At their annual retreat, the Housing Council identified the following priorities within the focus area of ***effective collaboration*** for action steps in this FY 2023/24 (year two) implementation plan:

Housing Council Priorities FY 2023-24	Action Step	Update	Timeline for Completion
Enhanced training for on-site housing staff in permanent supportive housing HC Lead: Jeff Najarian	Advocate for an increase in all annual required trainings for on-site staff at permanent supportive housing and related housing sites (e.g., property managers, facility managers); training requirements to be set forth within regulatory agreements.	Q1 Update:	Q4
		Q2 Update:	
		Q3 Update:	
		Q4 Update:	

GOAL #3 Expanding Service Approaches

At their annual retreat, the Housing Council identified the following priorities within the focus area of ***Recovery & Retention Supports*** for action steps in this FY 2023/24 (year two) implementation plan:

Housing Council Priorities FY2023-24	Action Step	Update	Timeline for Completion
Continue to provide Supportive Case Management for BHS residents in permanent supportive housing HC Lead:	Advocate for continued and increased funding and on-site/more frequent supportive case management services for BHS clients residing in permanent supportive housing throughout San Diego County.	Q1 Update: Q2 Update: Q3 Update: Q4 Update:	Ongoing throughout the year
Supporting newly housed MHSA eligible residents with skills development to successfully retain housing over the long term. HC Lead: Debbie Fountain	Create a "housing onboarding" program for implementation by peer specialists/property management teams within each development; skills development program and support for newly housed MHSA eligible residents (by service providers).	Q1 Update: Q2 Update: Q3 Update: Q4 Update:	Q3

APPENDIX L

PREVENTION AND EARLY INTERVENTION (PEI) SYSTEM-WIDE SUMMARY

ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2022-23 ANNUAL REPORT

LIVE WELL SAN DIEGO

REPORT CONTENTS

03 Background

04 Participant Demographics

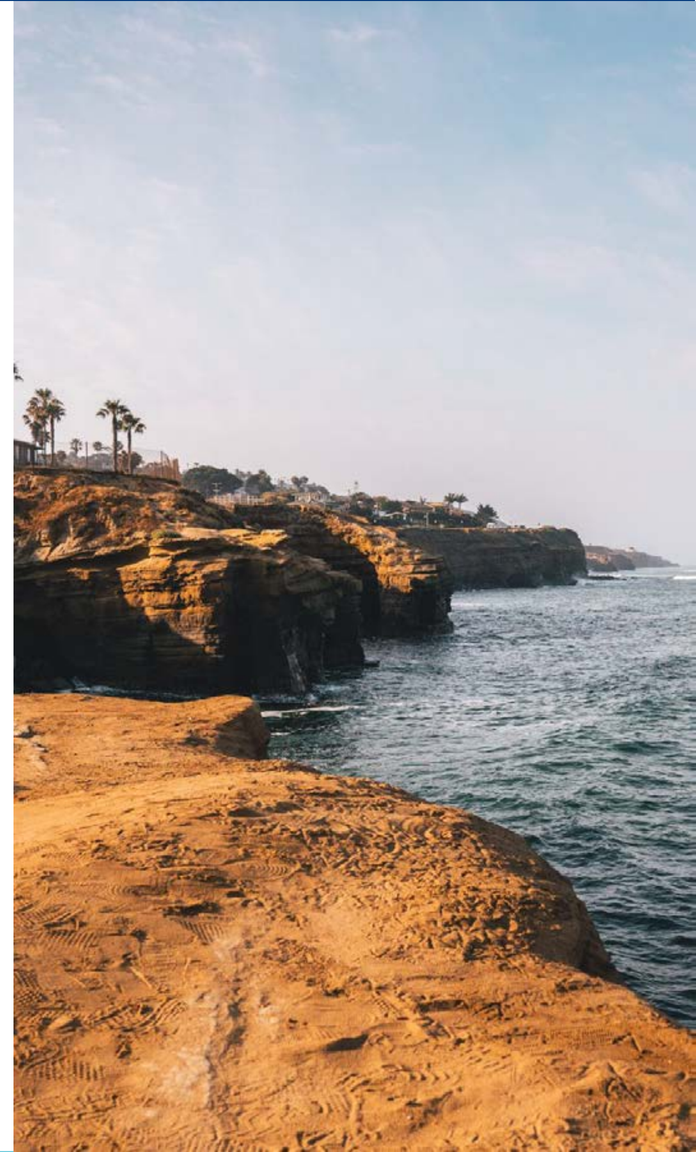
12 Participant Outcomes and Referrals

13 About the Health Services Research Center

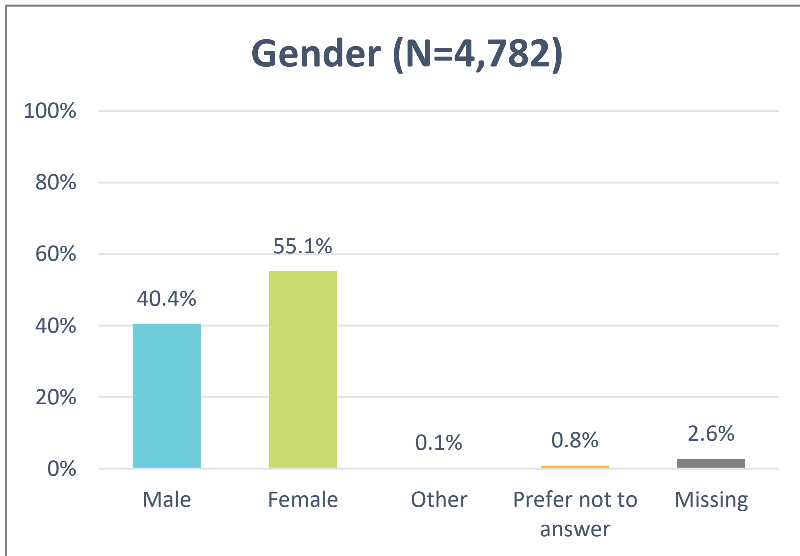
ADULT PEI PROGRAMS: BACKGROUND

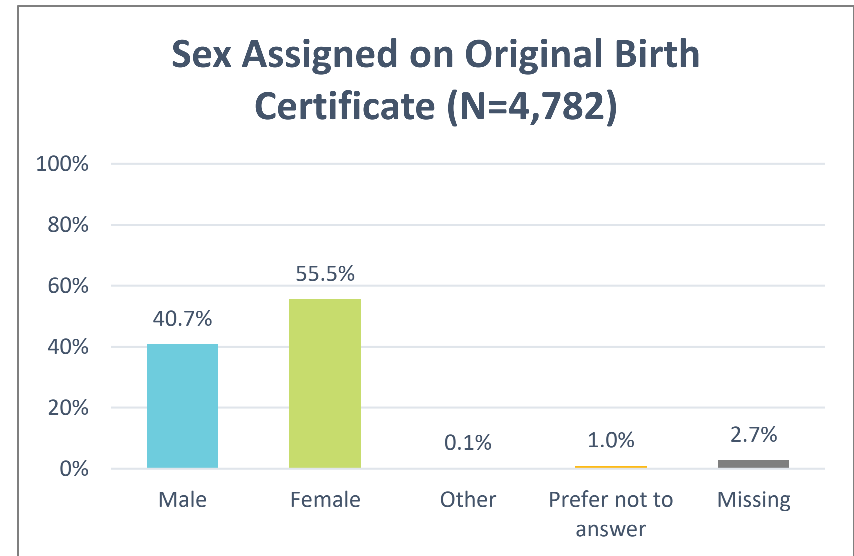
The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. The County of San Diego has funded contractors to provide PEI for adults. The focus of these programs varies widely, from reducing the stigma associated with mental illness to preventing depression in Hispanic caregivers of individuals with Alzheimer's disease. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided.

DATA: Adult PEI Programs
REPORT PERIOD: 7/1/2022 - 6/30/2023
NUMBER OF PARTICIPANTS WITH DATA IN FY 2022-23: 4,782 Unduplicated



PARTICIPANT DEMOGRAPHICS



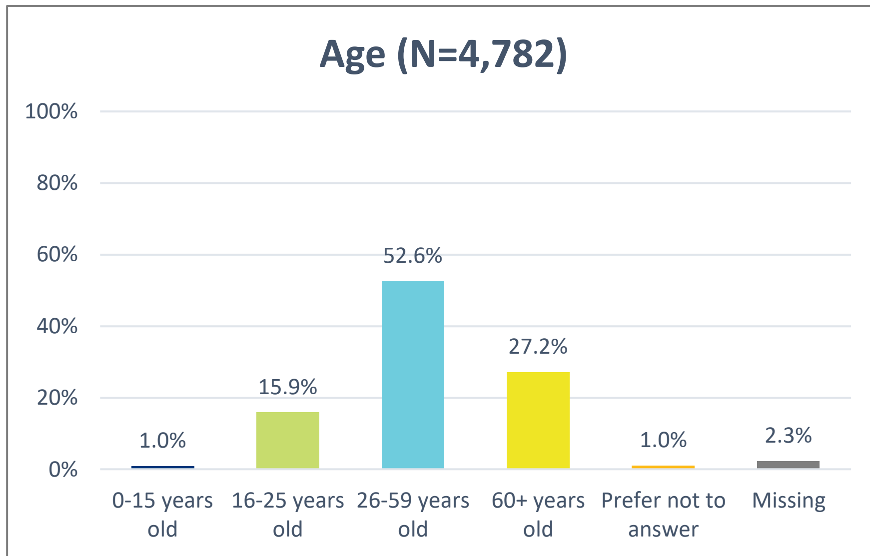


Just over 55% of participants identified as female. Less than 1% of participants endorsed some other gender identity. Nearly 1% of participants preferred not to answer this question.

Approximately 56% of participants reported that the sex they were assigned on their original birth certificate was female.

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

PARTICIPANT DEMOGRAPHICS continued



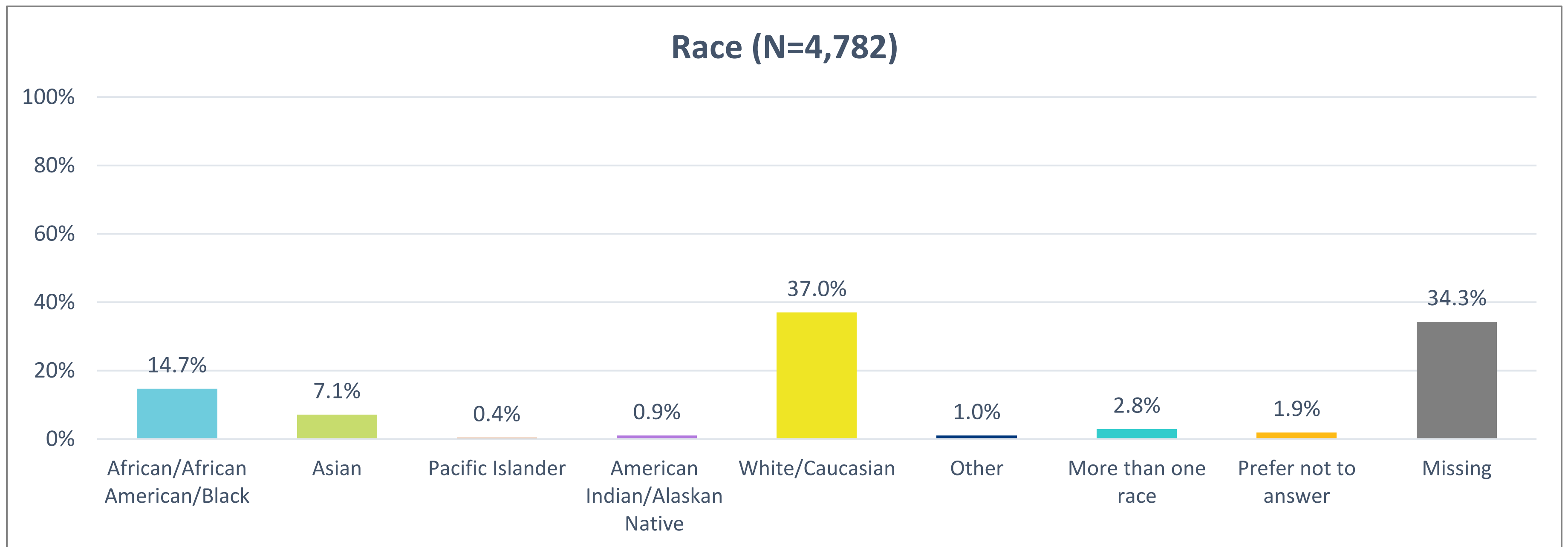
Primary Language (N=4,782)	Count	%
Arabic	93	1.9%
English	3,294	68.9%
Farsi	7	0.1%
Spanish	583	12.2%
Tagalog	31	0.6%
Vietnamese	18	0.4%
Other	534	11.2%
Prefer not to answer	43	0.9%
Missing	113	2.4%

The greatest proportion (53%) of participants were 26-59 years old.

Approximately 12% of participants identified their primary language as Spanish. Sixty-nine percent of participants identified their primary language as English.

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

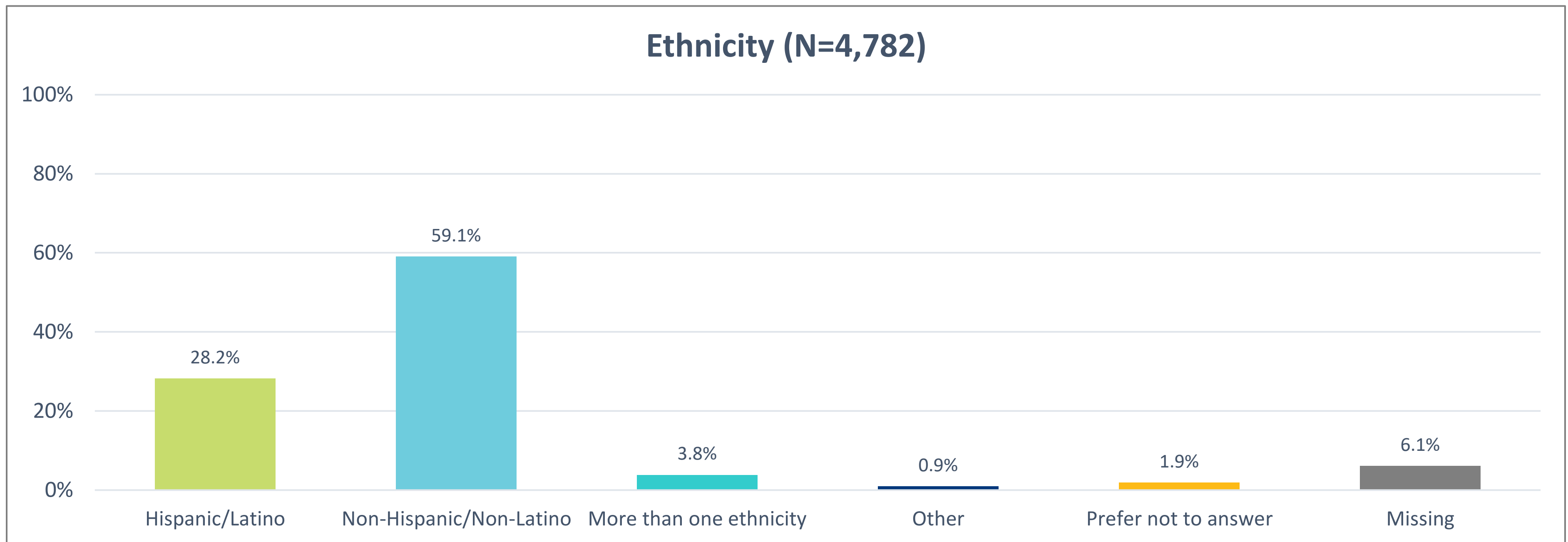
PARTICIPANT DEMOGRAPHICS continued



Thirty-seven percent of participants identified their race as White/Caucasian. Nearly 15% identified as African, African American or Black and 7% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

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

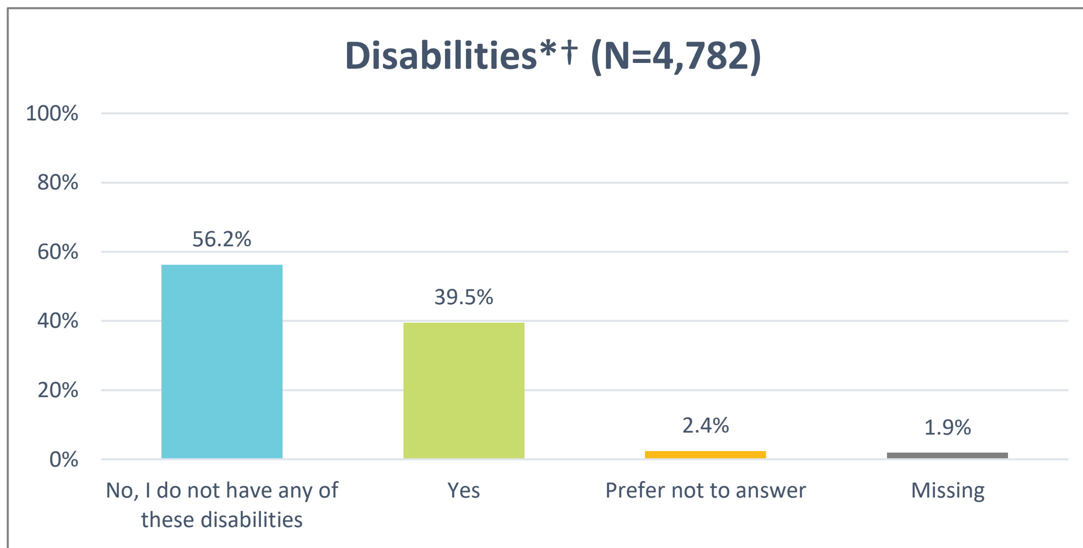
PARTICIPANT DEMOGRAPHICS continued



Twenty-eight percent of participants identified their ethnicity as Hispanic/Latino. Nearly 4% of participants identified as more than one ethnicity.

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

PARTICIPANT DEMOGRAPHICS continued

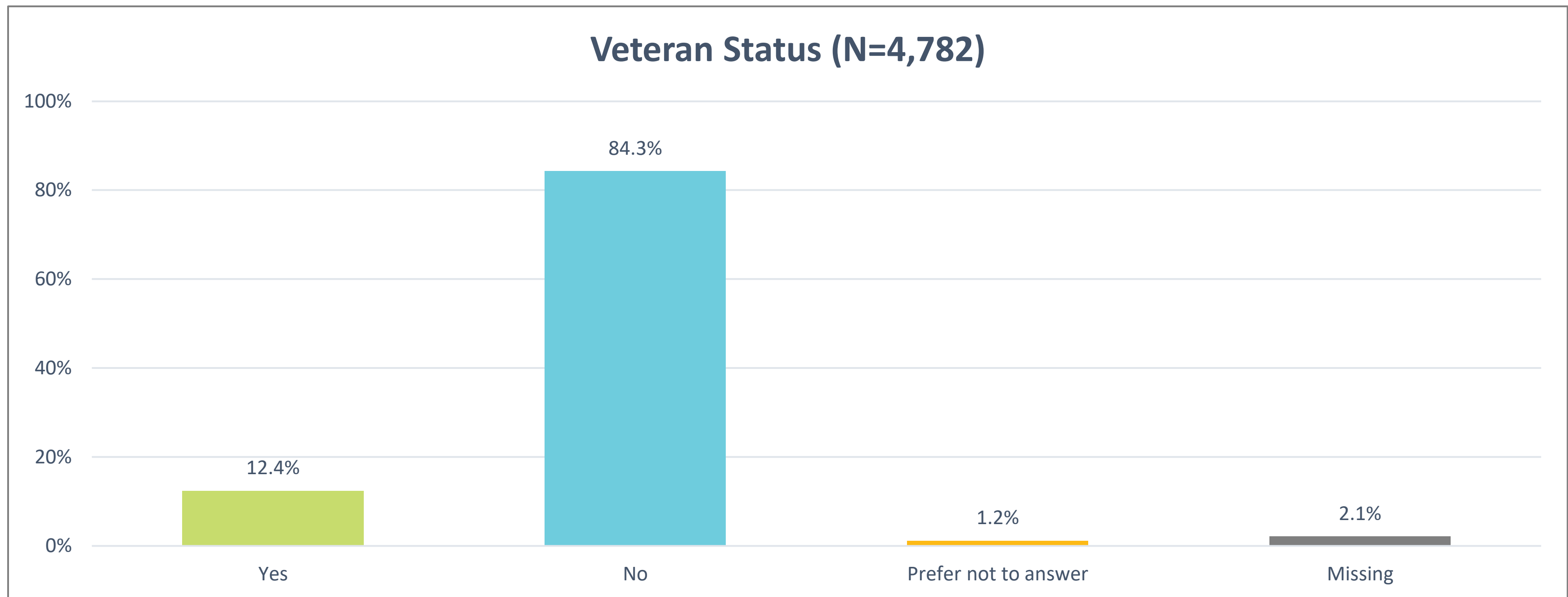


Nearly 40% of participants reported having a disability. Approximately 23% of participants indicated that they had a chronic health condition or chronic pain. Approximately 2% of participants preferred not to answer this question.

Disabilities*† (N=4,782)	Count	%
Difficulty seeing	201	4.2%
Difficulty hearing or having speech understood	72	1.5%
Other communication disability	9	0.2%
Mental disability not including a mental illness	255	5.3%
Learning disability	109	2.3%
Developmental disability	31	0.6%
Dementia	8	0.2%
Other mental disability not related to mental illness	107	2.2%
Physical/mobility disability	452	9.5%
Chronic health condition/chronic pain	1,113	23.3%
Other	335	7.0%
Prefer not to answer	116	2.4%
Missing	89	1.9%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability.
Note: Percentages may not add up to 100% due to rounding.

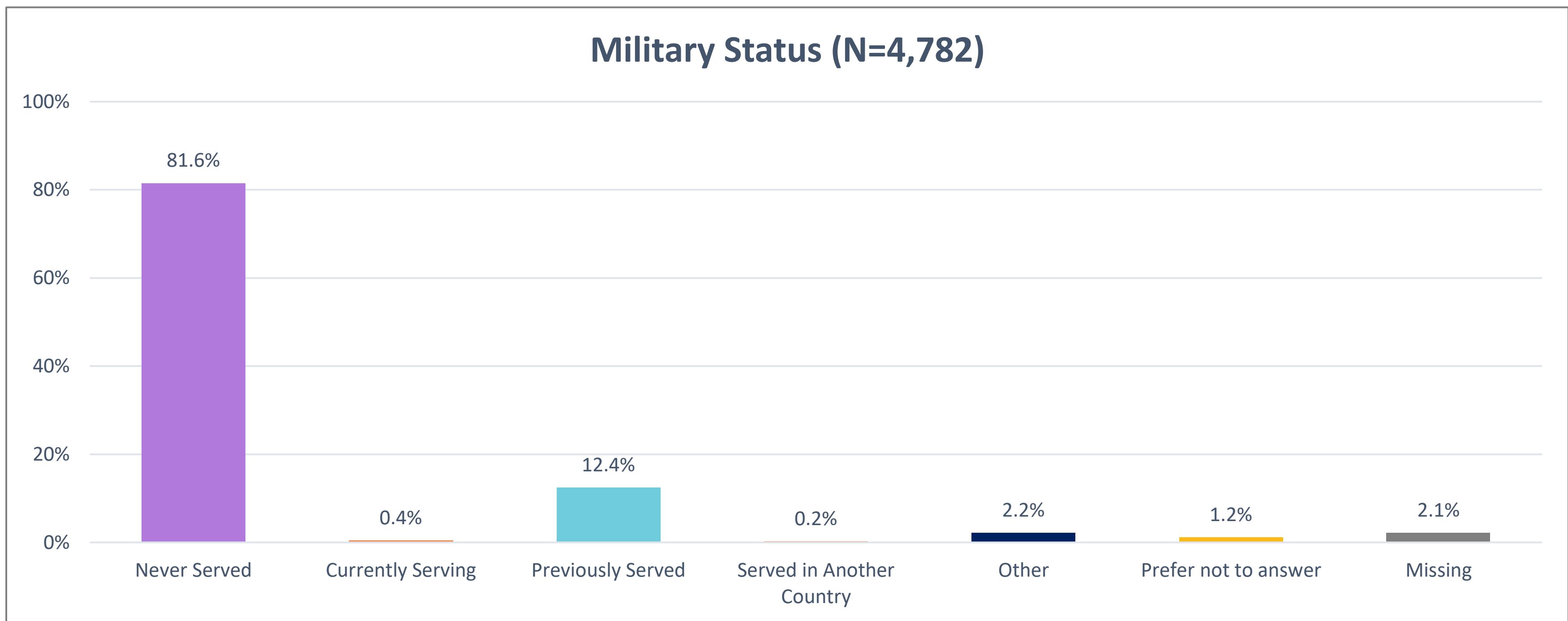
PARTICIPANT DEMOGRAPHICS continued



Just over 12% of participants had served in the military. Additionally, less than 1% of participants reported currently serving in the military (data not shown).

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

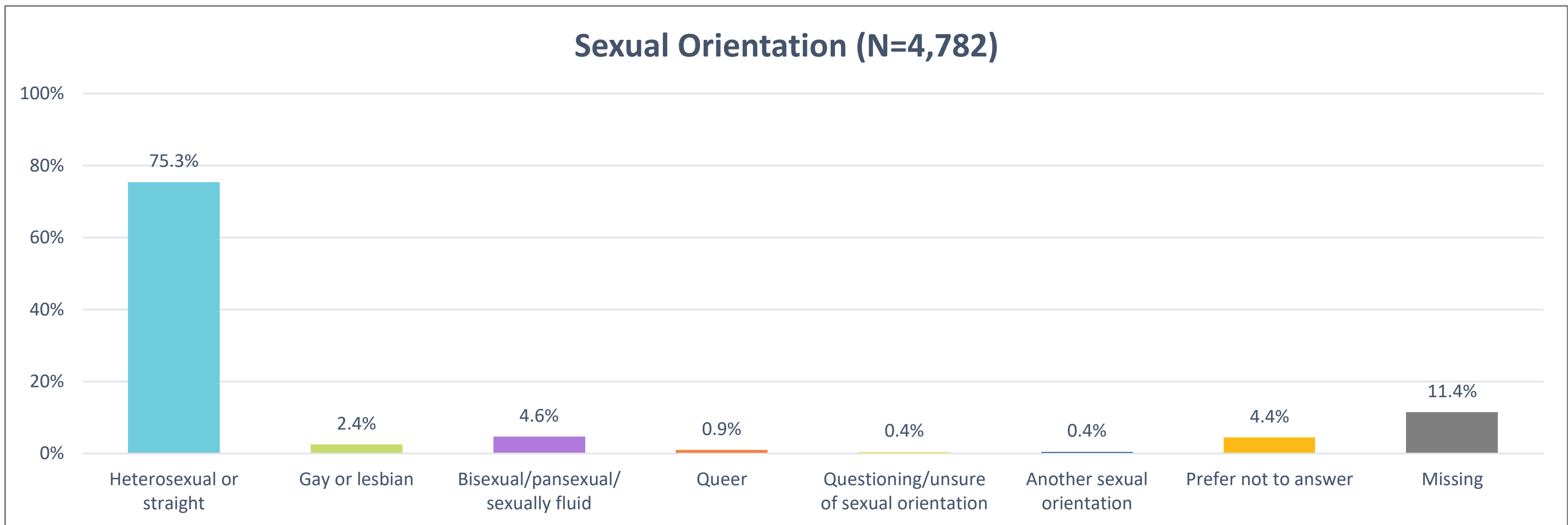
PARTICIPANT DEMOGRAPHICS continued



Nearly 82% percent of participants had never served in the military. Less than 1% of participants were currently serving in the military and just over 12% reported that they had previously served in the military.

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

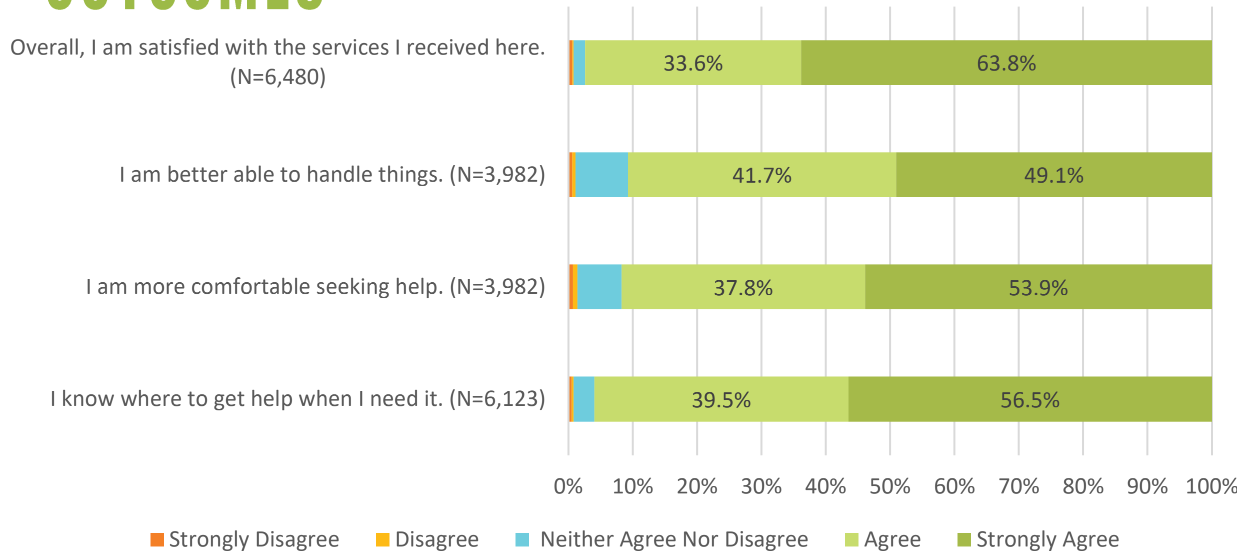
PARTICIPANT DEMOGRAPHICS continued



Approximately 75% of participants identified their sexual orientation as heterosexual or straight. Nearly 5% of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Approximately 4% of participants preferred not to answer this question.

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

PARTICIPANT SATISFACTION AND OUTCOMES*



**Satisfaction and outcome data are not available for all participants.*

Just over 97% of participants agreed or strongly agreed that they were satisfied with the services they received. Approximately 91% of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Approximately 92% of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. Ninety-six percent of the participants agreed or strongly agreed that they knew where to get needed help as a result of the program.

REFERRAL TRACKING SUMMARY*

- In FY 2017-18, the County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2022-23, a total of 314 participants received a mental health referral, and 100 of these participants received a mental health service as a result of the referral (Linkage Rate = 31.8%)
- A total of 406 participants received a substance use referral, and 274 of these participants received a substance use service as a result of the referral (Linkage Rate = 67.5%)
- The average time between referral and linkage to services was four days.

** Not all PEI programs make referrals.*

HEALTH SERVICES RESEARCH CENTER

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

CHILD & ADULT PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2022-23 ANNUAL REPORT

REPORT CONTENTS

03 Background

04 Systemwide Demographics

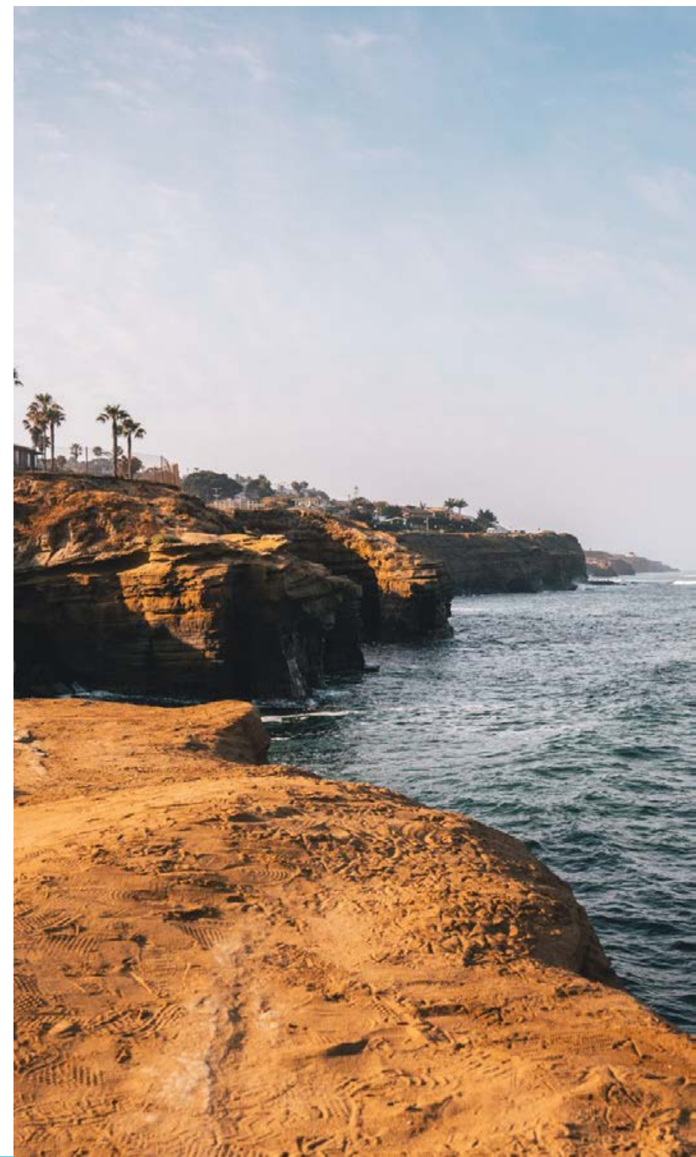
12 Systemwide Outcomes and Referrals

13 About the Research Centers

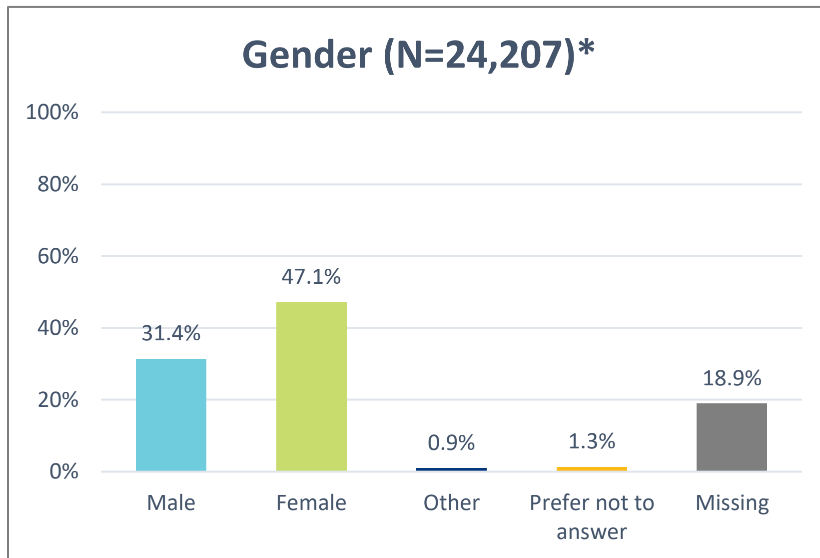
CHILD & ADULT PEI PROGRAMS: BACKGROUND

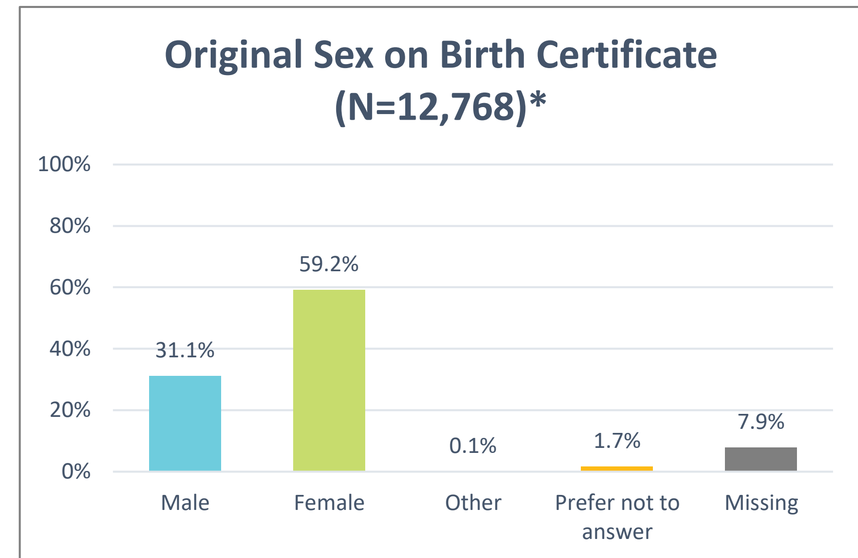
The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. With this funding source, the County of San Diego contracted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

DATA: Child and Adult PEI Programs
REPORT PERIOD: 7/1/2022-6/30/2023
NUMBER OF PARTICIPANTS WITH DATA IN FY 2022-23: 24,207 Unduplicated*†
*Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators referenced in this report (N=24,207 vs. N=12,768). †All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.



SYSTEMWIDE DEMOGRAPHICS





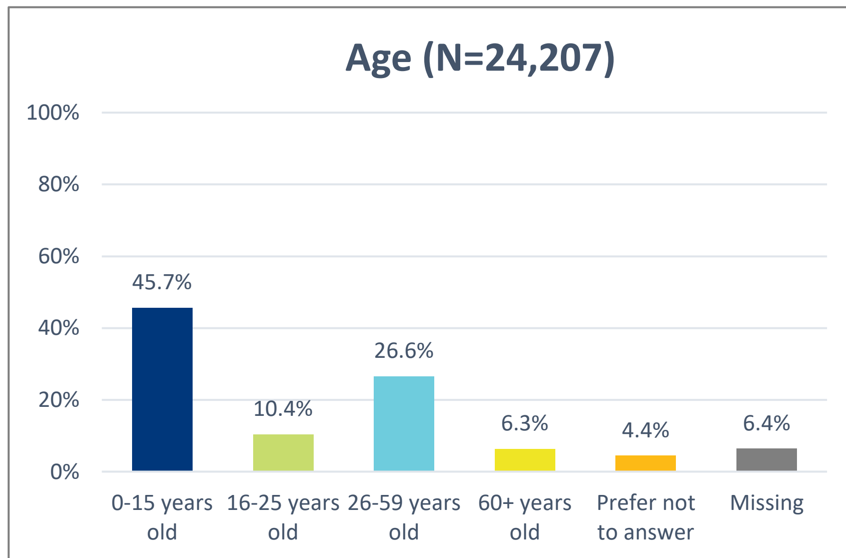
Forty-seven percent of participants identified as female. Nearly 1% of participants endorsed some other gender identity. Approximately 1% of participants preferred not to answer this question.

**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

Approximately 59% of participants reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =12,768 vs. N=24,207).*
Note: Percentages may not add up to 100% due to rounding.

SYSTEMWIDE DEMOGRAPHICS continued



Forty-six percent of participants were 15 or younger. Approximately 27% of participants were between the ages of 26 and 59.

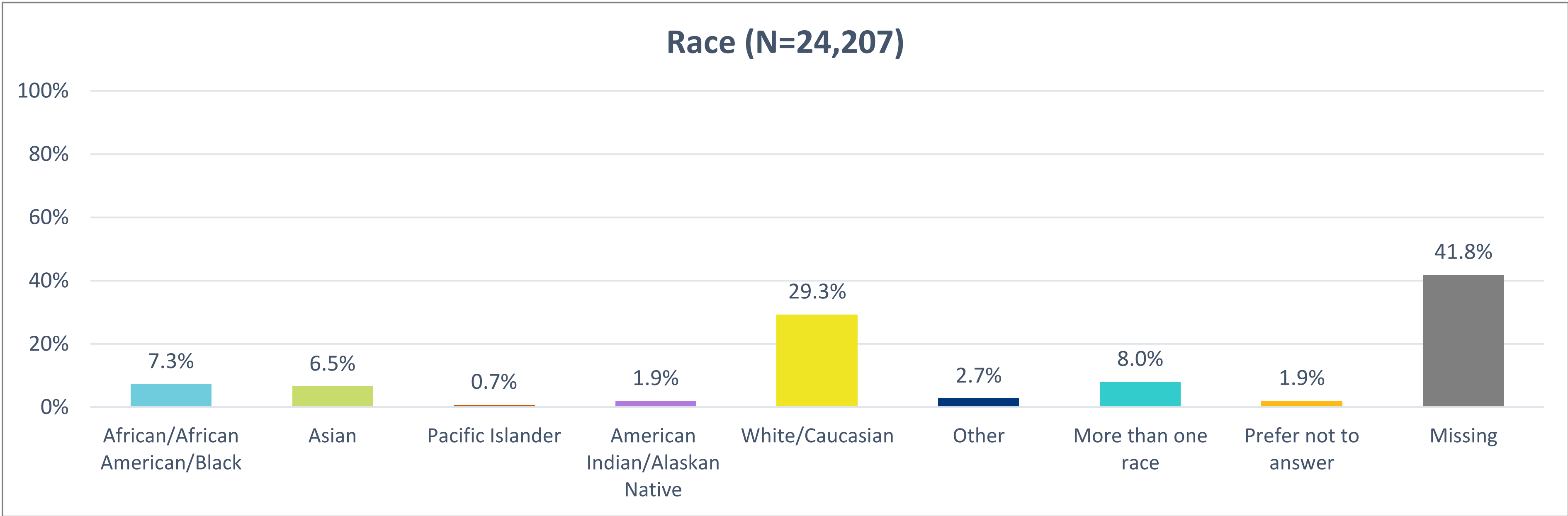
Note: Percentages may not add up to 100% due to rounding.

Primary Language (N=12,768)*	Count	%
Arabic	346	2.7%
English	6,333	49.6%
Farsi	72	0.6%
Spanish	3,824	29.9%
Tagalog	45	0.4%
Vietnamese	37	0.3%
Other	657	5.1%
Prefer not to answer	108	0.8%
Missing	1,096	8.6%

Thirty percent of participants identified their primary language as Spanish. Fifty percent of participants identified their primary language as English.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =12,768 vs. N=24,207).*
Note: Percentages may not add up to 100% due to rounding.

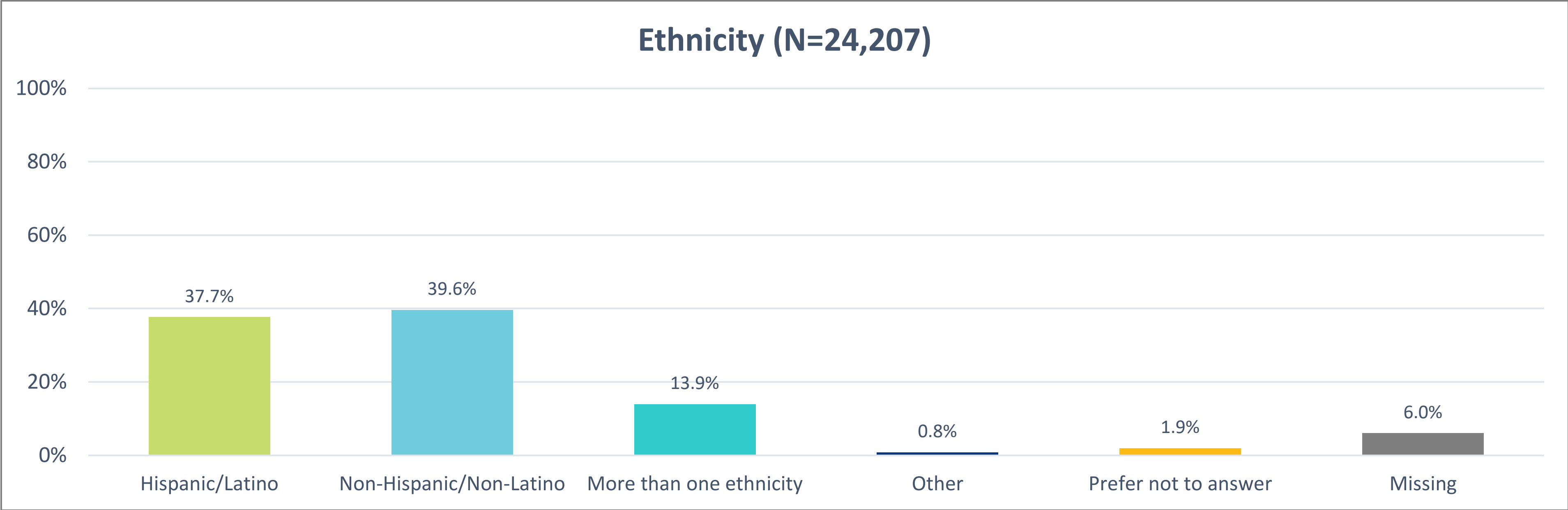
SYSTEMWIDE DEMOGRAPHICS continued



Just over 29% of participants identified their race as White/Caucasian. About 7% identified as African, African American or Black and approximately 7% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

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

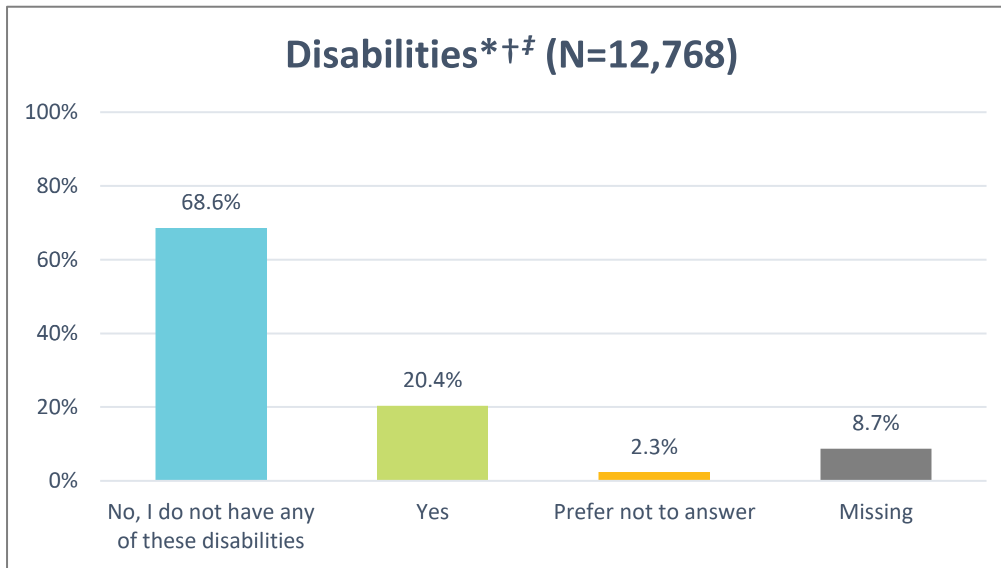
SYSTEMWIDE DEMOGRAPHICS continued



Approximately 38% of participants identified their ethnicity as Hispanic/Latino. Approximately 14% of participants identified as more than one ethnicity.

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

SYSTEMWIDE DEMOGRAPHICS continued

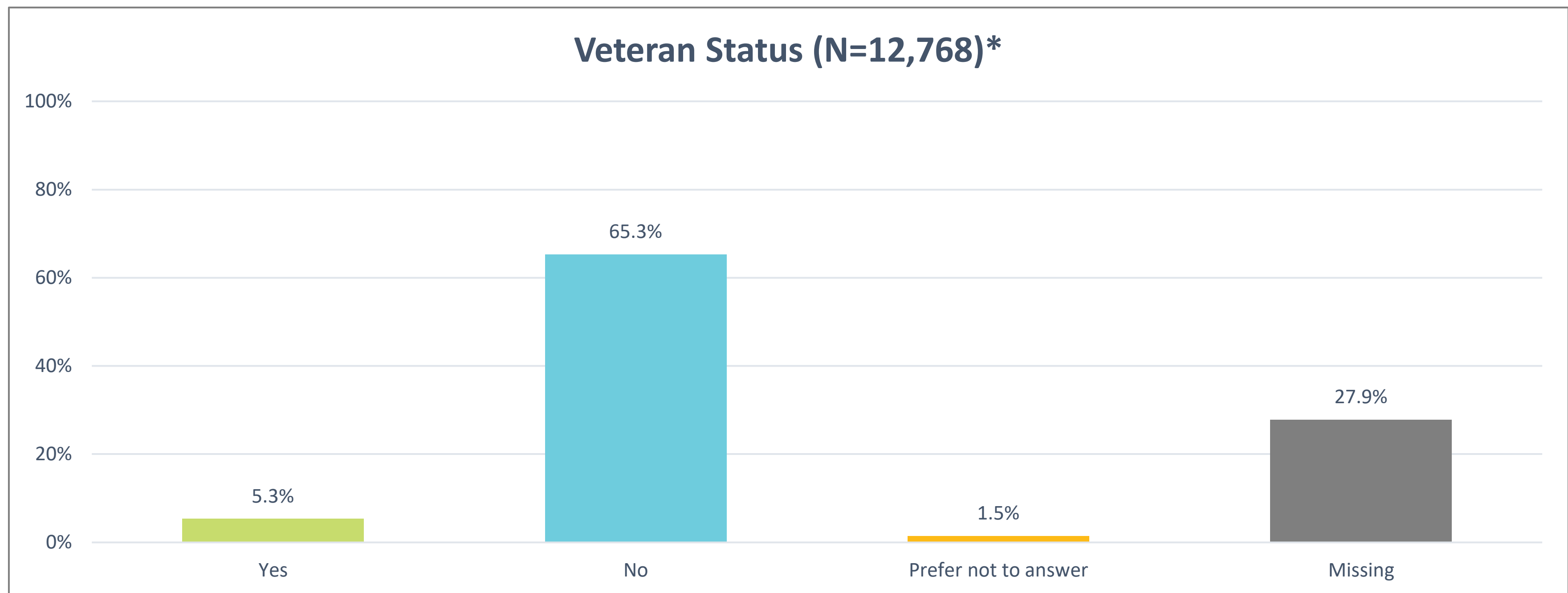


Disabilities*†‡ (N=12,768)	Count	%
Difficulty seeing	383	3.0%
Difficulty hearing or having speech understood	187	1.5%
Other communication disability	66	0.5%
Mental disability not including a mental illness	440	3.4%
Learning disability	204	1.6%
Developmental disability	76	0.6%
Dementia	13	0.1%
Other mental disability not related to mental illness	147	1.2%
Physical/mobility disability	529	4.1%
Chronic health condition/chronic pain	1,191	9.3%
Other	505	4.0%
Prefer not to answer	295	2.3%
Missing	1,112	8.7%

Approximately 20% of participants reported having a disability. Approximately 9% of participants indicated that they had a chronic health condition or chronic pain. About 2% of participants preferred not to answer this question.

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability.
‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =12,768 vs. N=24,207).
Note: Percentages may not add up to 100% due to rounding.

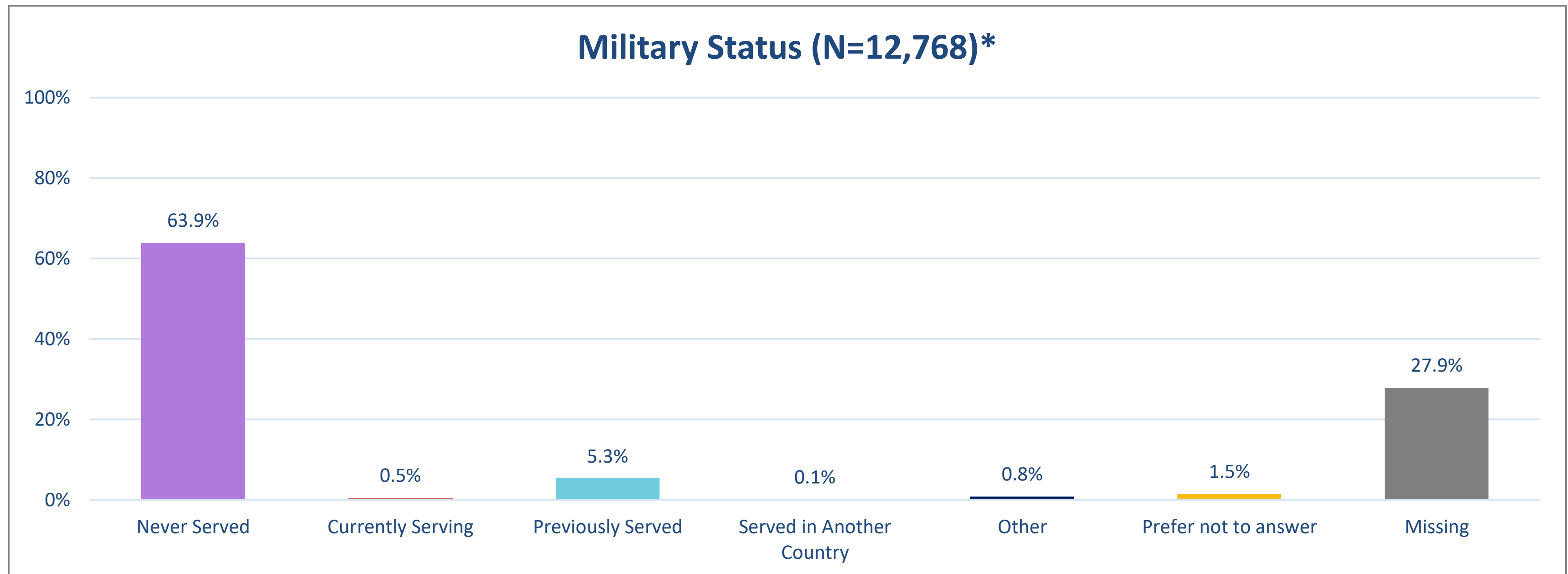
SYSTEMWIDE DEMOGRAPHICS continued



Information on veteran status indicated that about 5% of participants had served in the military. Less than 1% of participants reported that they are currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =12,768 vs. N=24,207).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

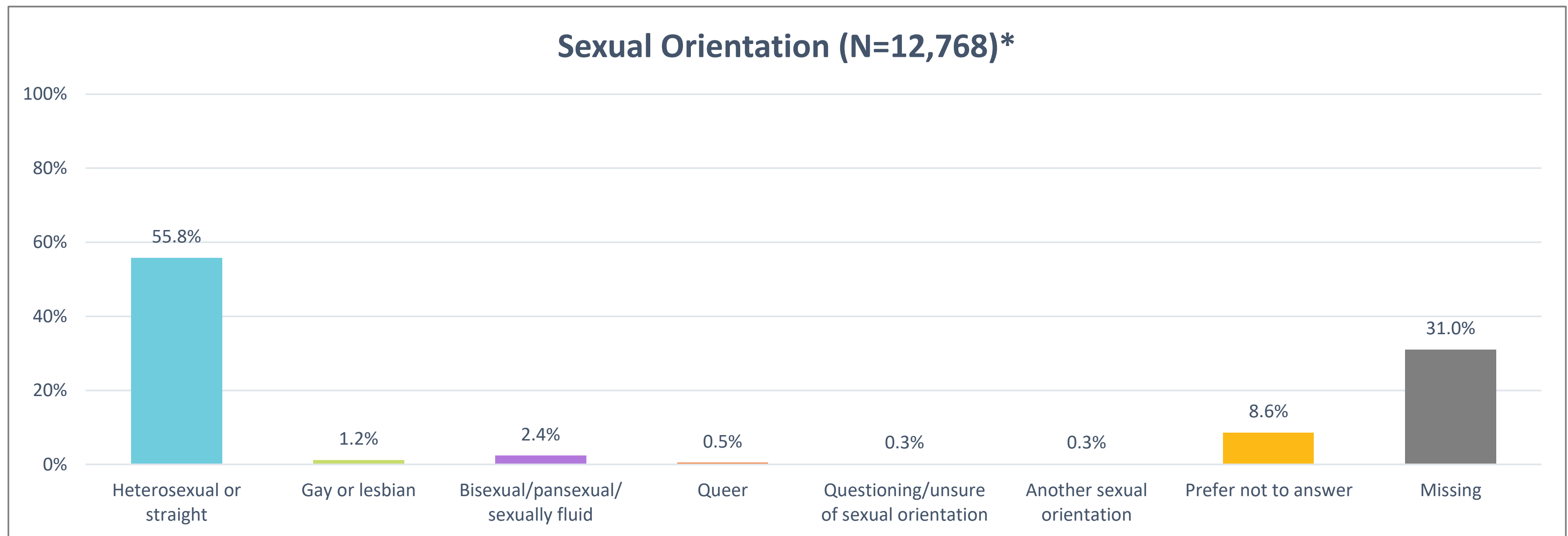
SYSTEMWIDE DEMOGRAPHICS continued



Nearly 64% of participants had never served in the military. Less than 1% of participants indicated that they are currently serving in the military and approximately 5% indicated that they had previously served in the military.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =12,768 vs. N=24,207).*
†Military status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

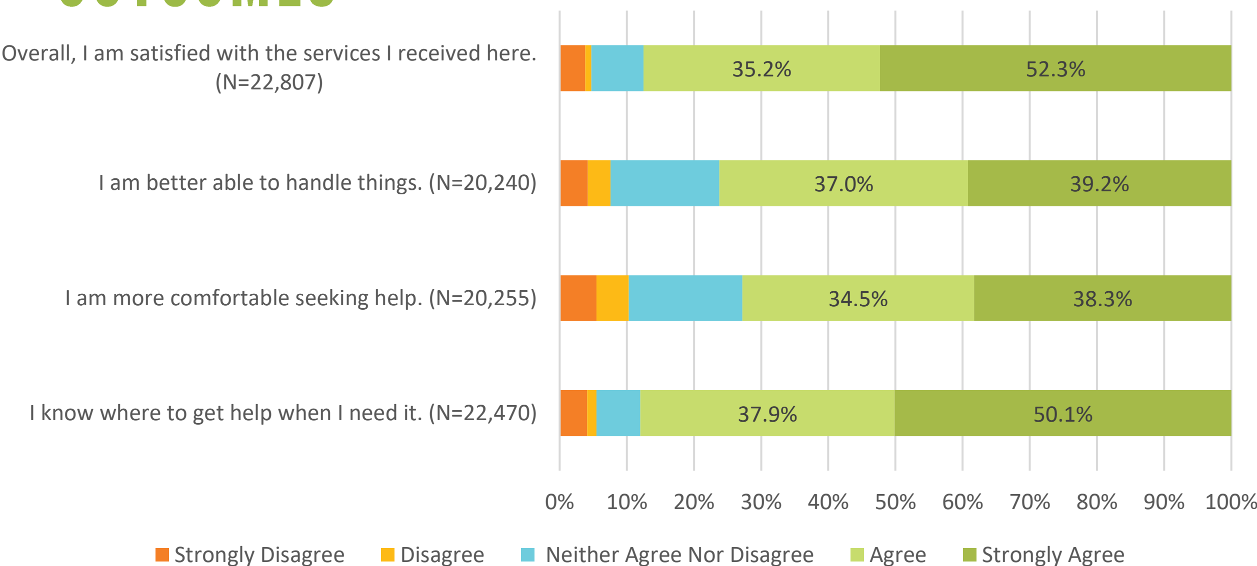
SYSTEMWIDE DEMOGRAPHICS continued



Nearly 56% of participants identified their sexual orientation as heterosexual or straight. Approximately 2% of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Approximately 9% of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =12,768 vs. N=24,207).*
†*Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

SYSTEMWIDE SATISFACTION AND OUTCOMES* †



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

Nearly 88% of participants agreed or strongly agreed that they were satisfied with the services they received and 88% of participants agreed or strongly agreed that they knew where to get needed help as a result of the program. Seventy-six percent of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Nearly 73% of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program.

SYSTEMWIDE REFERRAL TRACKING SUMMARY*

- In FY 2017-18, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2022-23, a total of 612 participants received a mental health referral, and 297 of these participants received a mental health service as a result of the referral (Linkage Rate = 48.5%)
- A total of 482 participants received a substance use referral, and 325 of these participants received a substance use service as a result of the referral (Linkage Rate = 67.4%)
- The average time between referral and linkage to services was six days.

**Not all PEI programs make referrals.*

HEALTH SERVICES RESEARCH CENTER

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

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

CHILD & FAMILY PEI PROGRAMS: SYSTEMWIDE SUMMARY

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

FISCAL YEAR 2022-23 ANNUAL REPORT

REPORT CONTENTS

03 Background

04 Participant Demographics

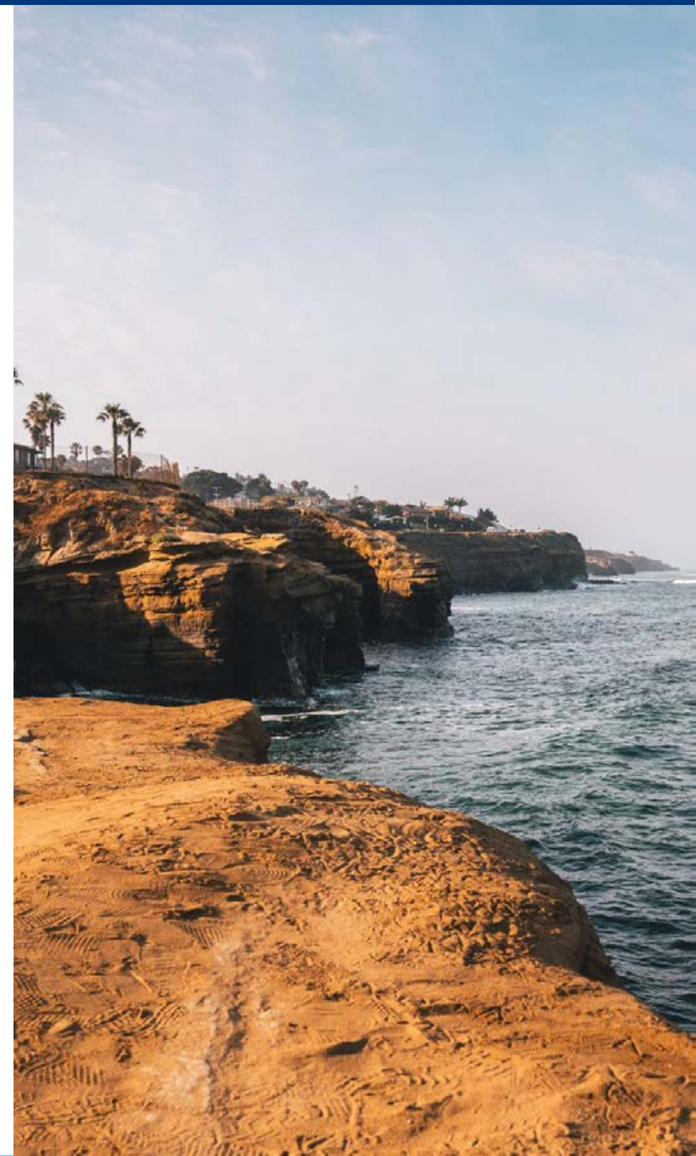
11 Participant Outcomes and Referrals

12 About the Child and Adolescent Services Research Center

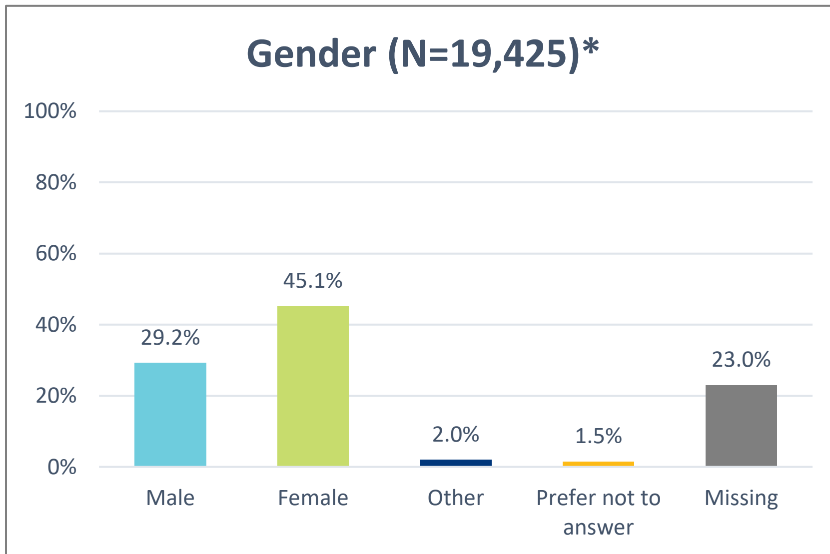
CHILD & FAMILY PEI PROGRAMS: BACKGROUND

The Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. The County of San Diego has funded contractors to provide PEI programs for youth and their families. The focus of these programs varies widely, from teaching caregivers how to cope with behavior problems in young children to preventing youth suicide. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided for both active and outreach participants. Active participants include people who are enrolled in a PEI program and/or are receiving services at a PEI program. Outreach participants include people who are touched by a PEI program via outreach efforts, including but not limited to: presentations, community events, and fairs.

DATA: Child and Adolescent PEI Programs
REPORT PERIOD: 7/1/2022-6/30/2023
NUMBER OF PARTICIPANTS WITH DATA IN FY 2022-23: 19,425 Unduplicated*†
*Data collection requirements vary by program type. Not all programs are required to collect data for every indicator, which accounts for the two different denominators referenced in this report (N=19,425 vs. N=7,986). †All known duplicates are excluded from this count; however, unduplicated status cannot be verified among programs that do not issue client identification numbers.



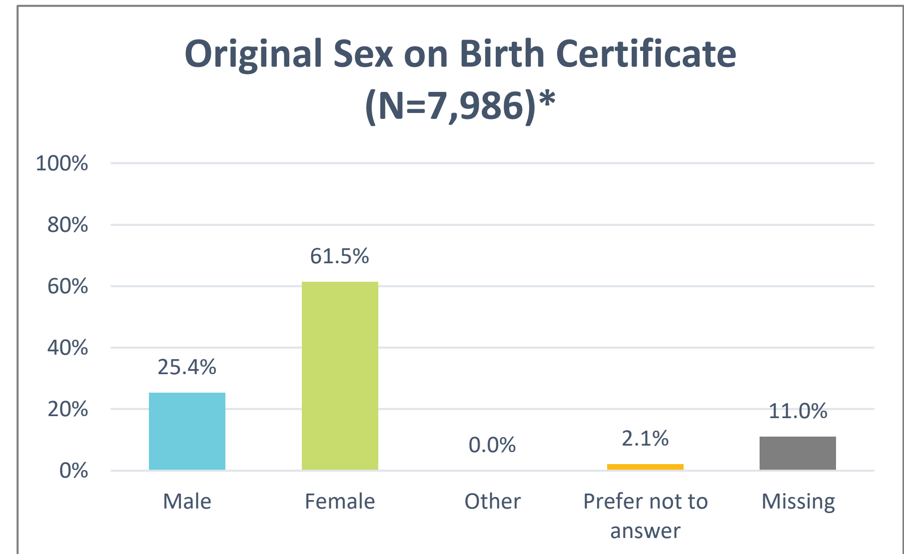
PARTICIPANT DEMOGRAPHICS



Forty-five percent of participants identified as female. Approximately 2% of participants preferred not to answer this question.

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

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

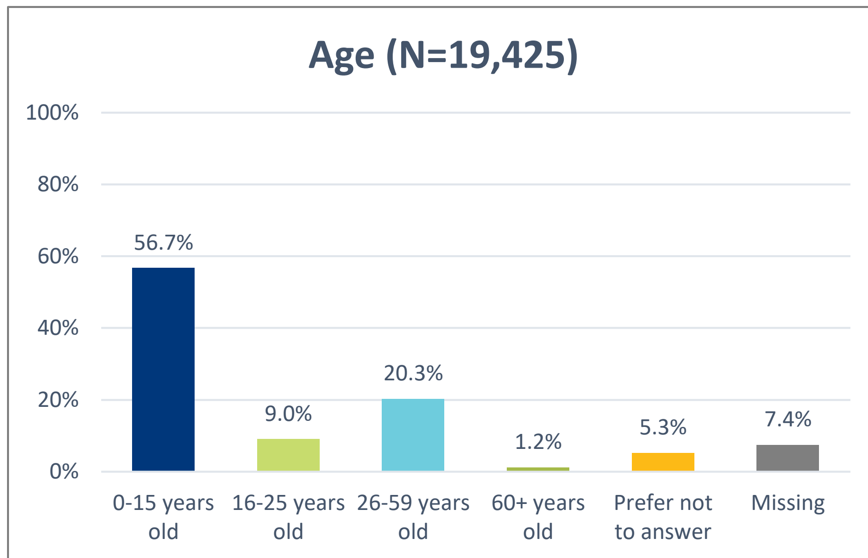


Nearly sixty-two percent of respondents reported that the sex they were assigned on their original birth certificate was female.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N =7,986 vs. N= 19,425).*

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

PARTICIPANT DEMOGRAPHICS continued



The majority (57%) of participants were 15 years old or younger. Many participants were older than 18 because several Child & Family PEI programs target caregivers, community members and Transitional Age Youth (TAY).

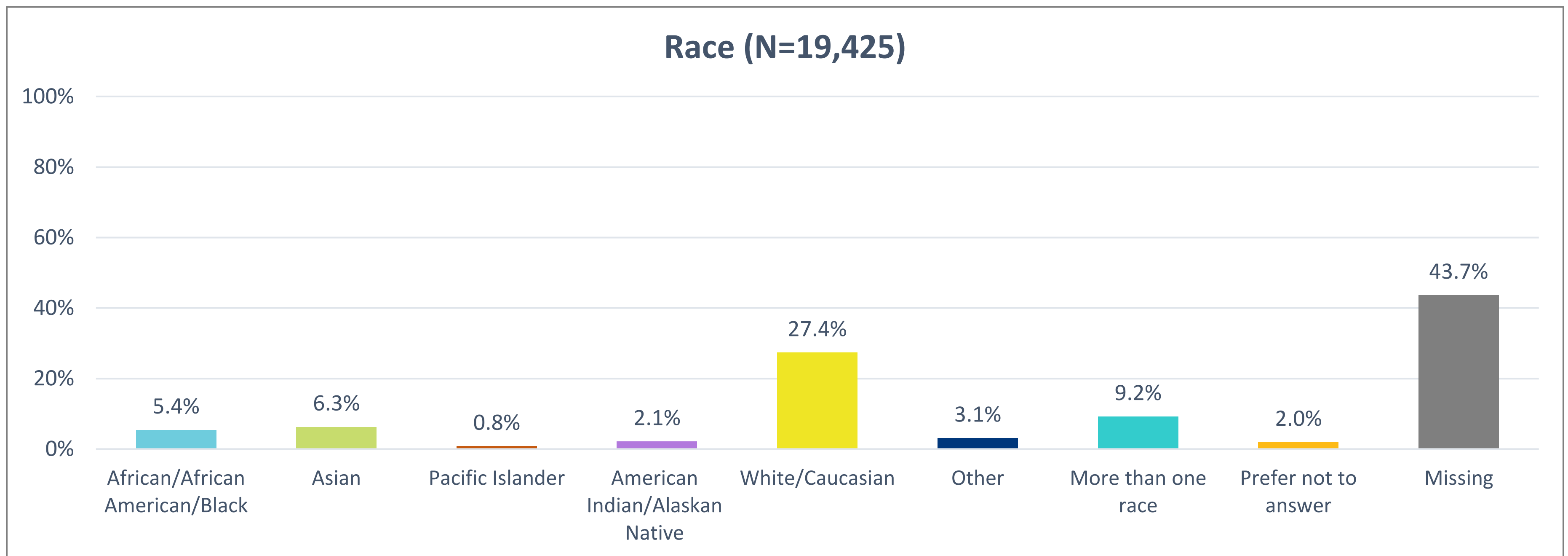
Note: Percentages may not add up to 100% due to rounding.

Primary Language (N=7,986)*	Count	%
Arabic	253	3.2%
English	3,039	38.1%
Farsi	65	0.8%
Spanish	3,241	40.6%
Tagalog	14	0.2%
Vietnamese	19	0.2%
Other	307	3.8%
Prefer not to answer	65	0.8%
Missing	983	12.3%

Almost 41% of participants identified their primary language as Spanish. About 38% of participants identified their primary language as English.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N=7,986 vs N=19,425).*
Note: Percentages may not add up to 100% due to rounding.

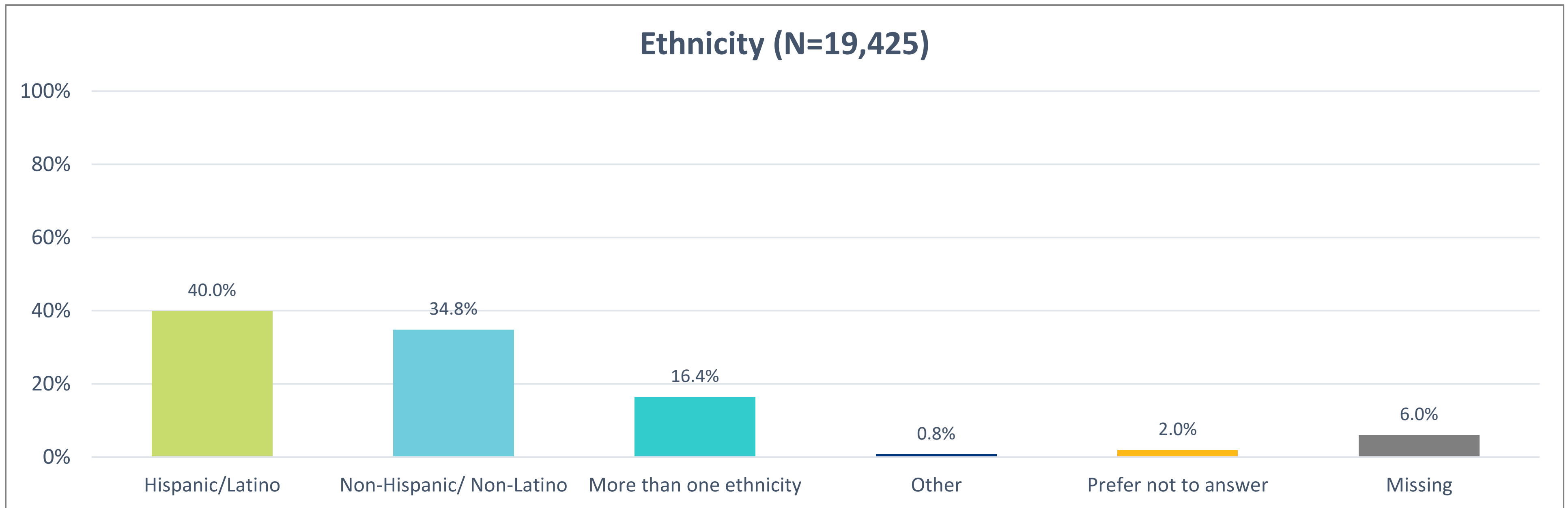
PARTICIPANT DEMOGRAPHICS continued



Twenty-seven percent of participants identified their race as White/Caucasian. Over 5% identified as African, African American or Black and over 6% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

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

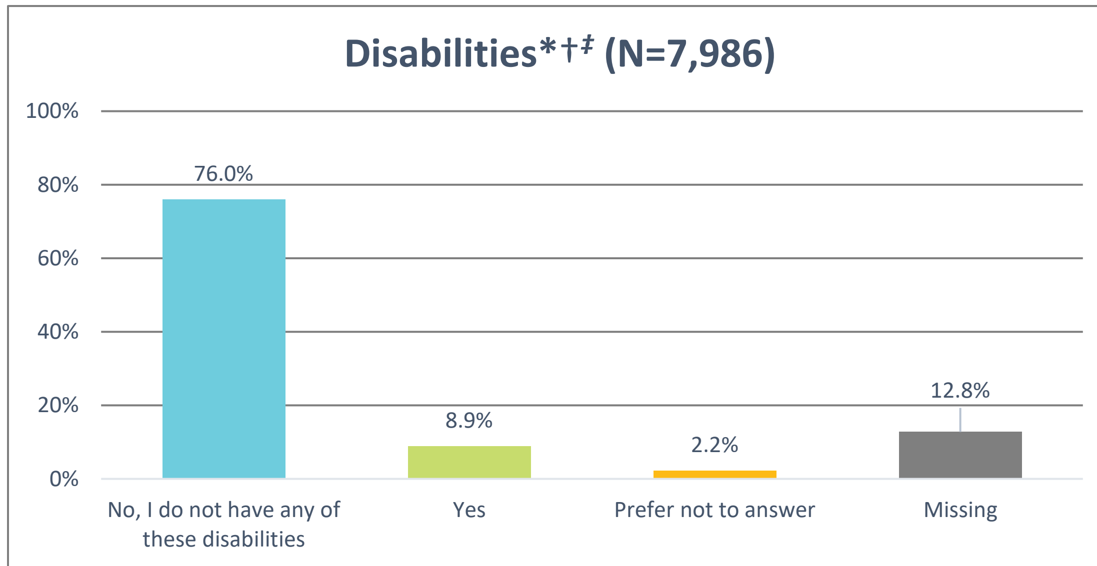
PARTICIPANT DEMOGRAPHICS continued



Forty percent of participants identified their ethnicity as Hispanic/Latino. Over 16% of participants identified as more than one ethnicity.

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

PARTICIPANT DEMOGRAPHICS continued

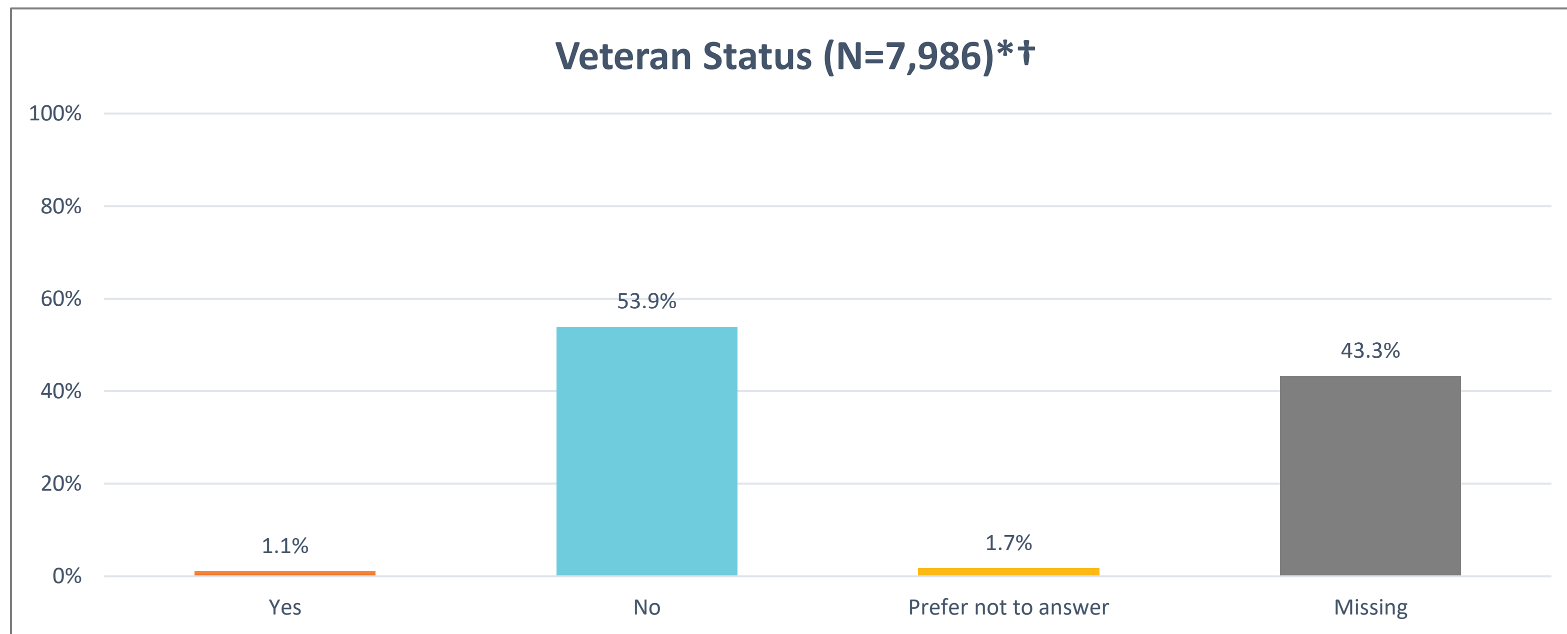


Approximately 9% of participants reported having a disability. Approximately 2% reported having a mental disability (not including a mental illness) and 2% reported having difficulty seeing. Just over 2% preferred not to answer this question.

Disabilities*†‡ (N=7,986)	Count	%
Difficulty seeing	182	2.3%
Difficulty hearing or having speech understood	115	1.4%
Other communication disability	57	0.7%
Mental disability not including a mental illness	185	2.3%
Learning disability	95	1.2%
Developmental disability	45	0.6%
Dementia	<5	<1.0%
Other mental disability not related to mental illness	40	0.5%
Physical/mobility disability	77	1.0%
Chronic health condition/chronic pain	78	1.0%
Other	170	2.1%
Prefer not to answer	179	2.2%
Missing	1,023	12.8%

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
†Participants can select more than one type of disability.
‡Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 7,986 vs N=19,425).
Note: Percentages may not add up to 100% due to rounding.

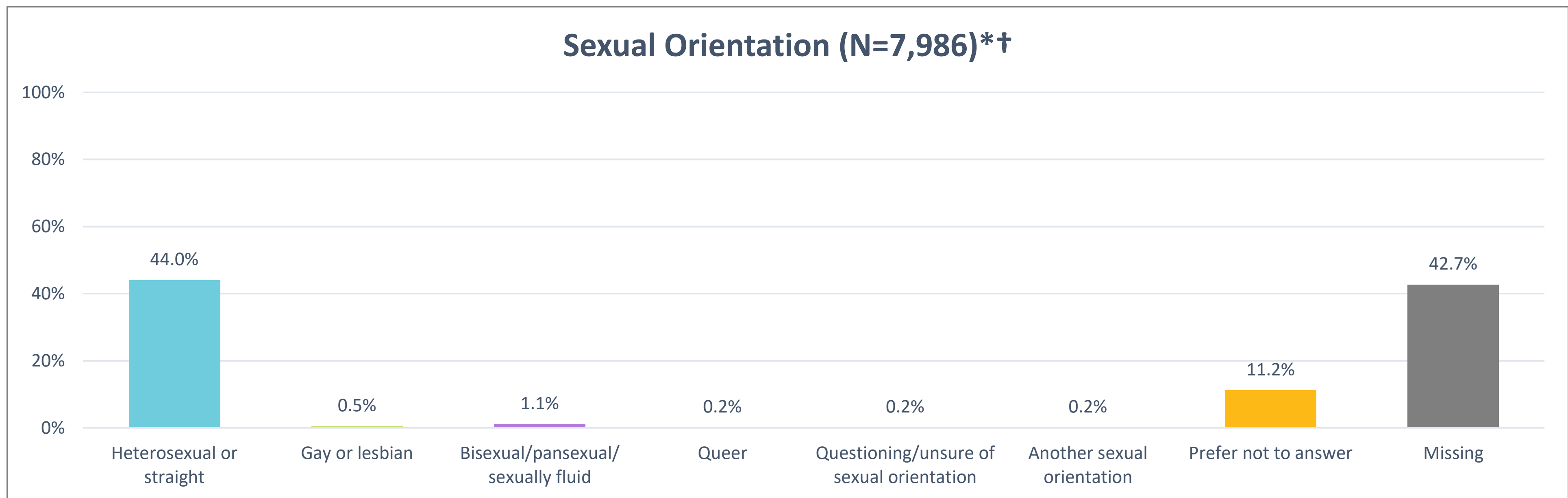
PARTICIPANT DEMOGRAPHICS continued



Approximately 1% of participants reported that they had served in the military. Less than 1% of participants reported currently serving in the military (data not shown).

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 7,986 vs N=19,425).*
† Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

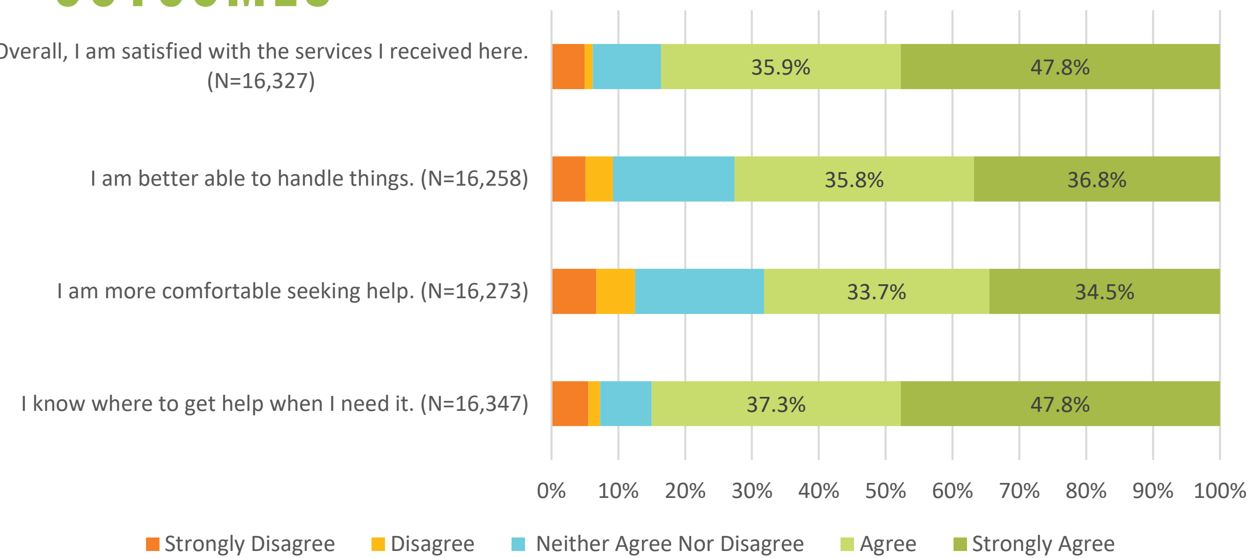
PARTICIPANT DEMOGRAPHICS continued



Forty-four percent of the participants identified their sexual orientation as heterosexual or straight. Approximately 1% of participants identified their sexual orientation as bisexual/pansexual/sexually fluid. Roughly 11% of participants preferred not to answer this question.

**Not all programs are required to collect data for every indicator, which accounts for the lower denominator for this indicator (N= 7,986 vs N=19,425).*
† Sexual orientation is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT SATISFACTION AND OUTCOMES* †



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

Nearly 84% of participants agreed or strongly agreed that they were satisfied with the services they received. Almost 73% of participants agreed or strongly agreed that they were better able to handle things and solve problems as a result of the program. Sixty-eight percent of participants agreed or strongly agreed that they were more comfortable seeking help as a result of the program. Nearly 85% of participants agreed or strongly agreed that they knew where to get needed help as a result of the program.

REFERRAL TRACKING SUMMARY*

- In FY 2017-18, County of San Diego Behavioral Health Services implemented a referral tracking procedure in order to collect data on referrals to mental health or substance use services and links to those services.
- In FY 2022-23, a total of 298 participants received a mental health referral, and 197 of these participants received a mental health service as a result of the referral (Linkage Rate = 66.1%)
- A total of 76 participants received a substance use referral, and 51 of these participants received a substance use service as a result of the referral (Linkage Rate = 67.1%)
- The average time between referral and linkage to services was eleven days.

**Not all programs are required to collect referral data.*

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

KICKSTART (FB01) PATHWAYS COMMUNITY SERVICES

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

FISCAL YEAR 2022-23 ANNUAL REPORT

REGION: Central & North Central – District 4

LIVE WELL
SAN DIEGO

REPORT CONTENTS

03 Background

04 Major Data Points

05 Participant Demographics

12 Intake: Phone Screens

13 Youth Outcomes

19 Outcomes for Youth Over 18

20 Family Member Increases in Knowledge

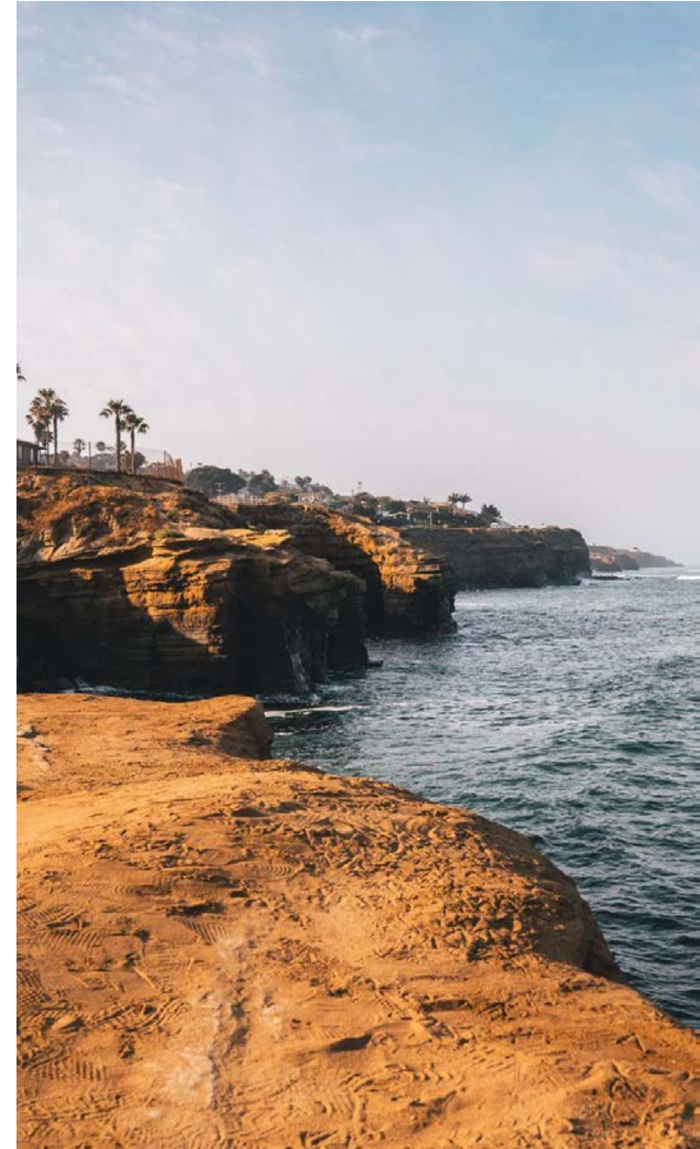
21 Community Outreach Psychoeducation Group

22 Satisfaction and Outcomes

24 About the Child and Adolescent Services Research Center

BACKGROUND

The purpose of this program is to provide prevention and early intervention services to youth and young adults ages 10-25 who may have clinical high risk (CHR) symptoms of psychosis or have had their first episode of psychosis (FEP). The prevention component of the program focuses on providing psychoeducation and outreach to the community, including other behavioral health providers, school staff, hospital staff, faith-based leaders, and others who may have contact with youth in general community settings. These community leaders are provided education and information on early detection of behaviors and symptoms that are risk factors for the development of psychosis. The early intervention component of the program includes a comprehensive assessment (the Structured Interview for Psychosis-Risk Syndromes) to determine the risk for or the presence of severe mental illness. This instrument also assesses for emotional dysregulation, physical health needs, stress tolerance, cognitive functioning, substance use issues, and potential safety concerns. Based upon results of the assessment, youth and their families maybe referred and linked to outside community resources to best meet their needs. Youth who screen positive for CHR or FEP symptoms receive an intake into this program and participate in a variety of services: psychoeducation workshops, multi-family groups, and support services including medication/nursing services, occupational therapy, peer support services, and education/employment support. Treatment interventions include individual, family, and group therapy. These services may be provided via telehealth. This report focuses on youth and community demographics and youth outcomes.



MAJOR DATA POINTS

CONTRACTOR: Pathways Community Services	
CONTRACT START DATE: 12/01/2009	DATA COLLECTION START DATE: 05/2010
PROGRAM SERVICES START DATE: 4/1/2010	**REPORT PERIOD: 7/1/2022-6/30/2023**

679

CLIENTS WITH DEMOGRAPHIC DATA IN FY 2022-23 (UNDUPLICATED)

174

COMMUNITY CLIENTS WITH DATA IN FY 2022-23 (UNDUPLICATED)

6,708

COMMUNITY MEMBERS WHO RECEIVED TRAININGS SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE PARTICIPANTS)

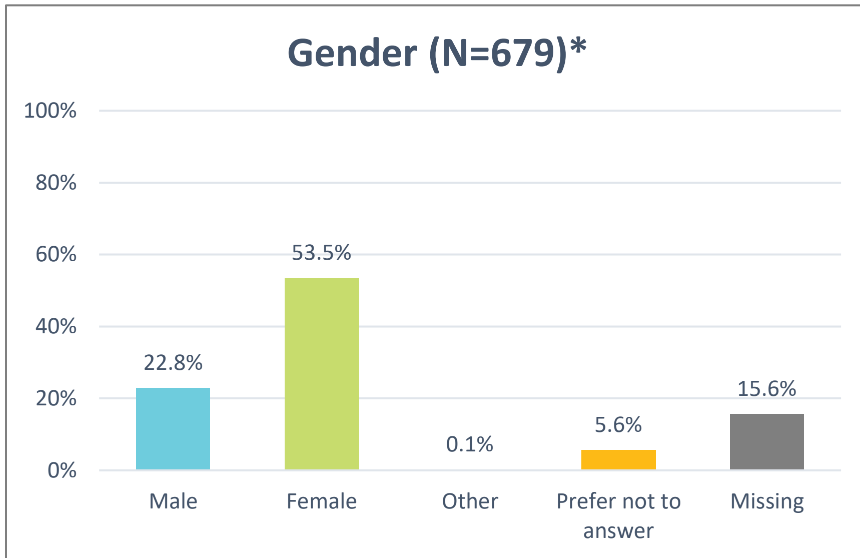
1,953

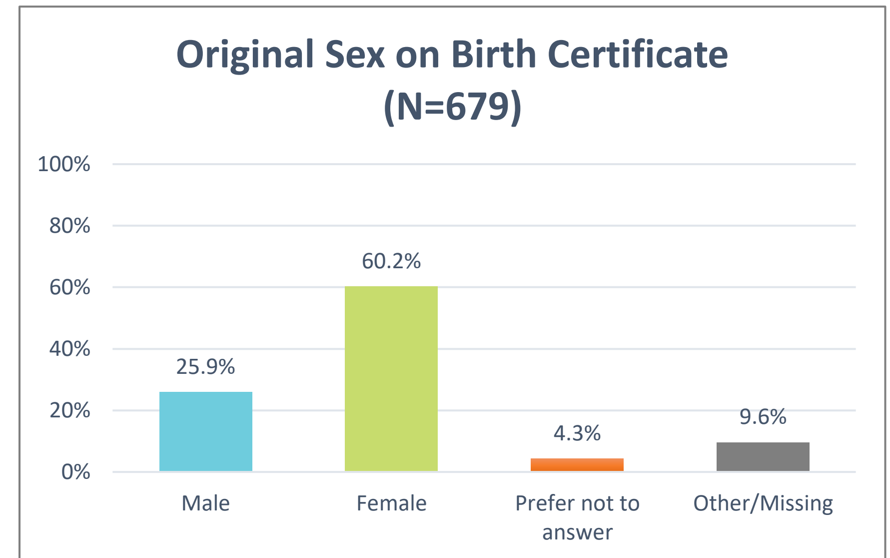
YOUTH SCREENED SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE YOUTH)

1,189

YOUTH ENROLLED SINCE PROGRAM INCEPTION (MAY INCLUDE DUPLICATE YOUTH)

PARTICIPANT DEMOGRAPHICS



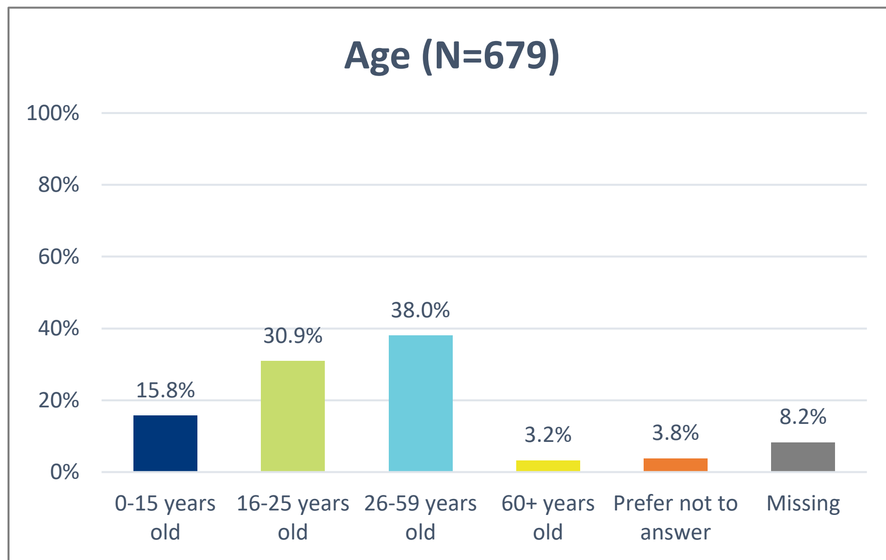


Almost 54% of participants identified as female. Fewer than 1% of participants endorsed some other gender identity. Six percent of participants preferred not to answer this question.

Sixty percent of participants reported that the sex they were assigned on their original birth certificate was female.

**Gender identity is not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



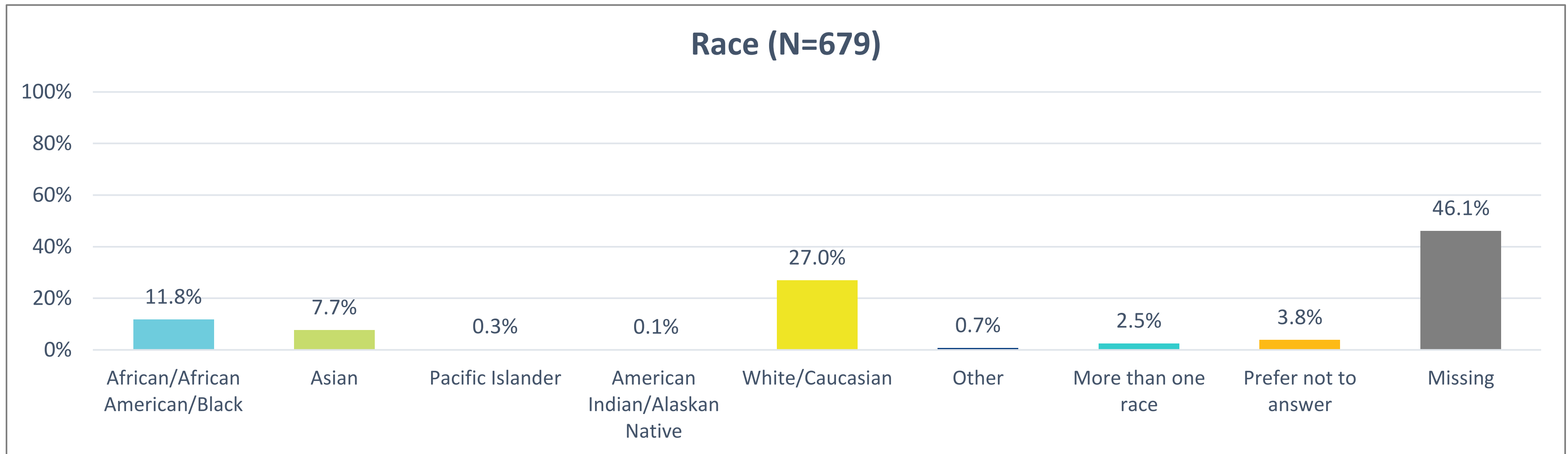
Nearly 31% percent of participants were 16 to 25 years old.

Primary Language (N=679)	Count	%
English	561	82.6%
Spanish	37	5.4%
Other	16	2.4%
Prefer not to answer	7	1.0%
Missing	58	8.5%

Just over 5% of participants identified their primary language as Spanish. Almost 83% of participants identified their primary language as English.

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

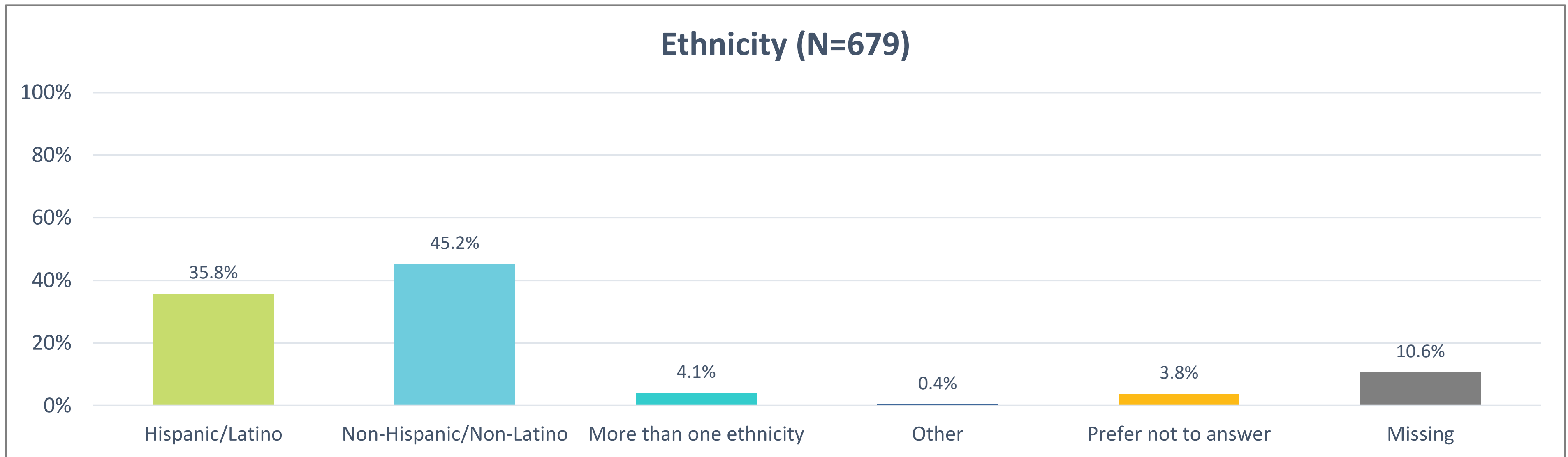
PARTICIPANT DEMOGRAPHICS continued



Twenty-seven percent of participants identified their race as White/Caucasian. Nearly 12% identified as African, African American or Black and close to 8% identified as Asian. The missing category includes participants who only endorsed being Hispanic/Latino and did not indicate a race. Data on ethnicity are presented in a separate table.

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

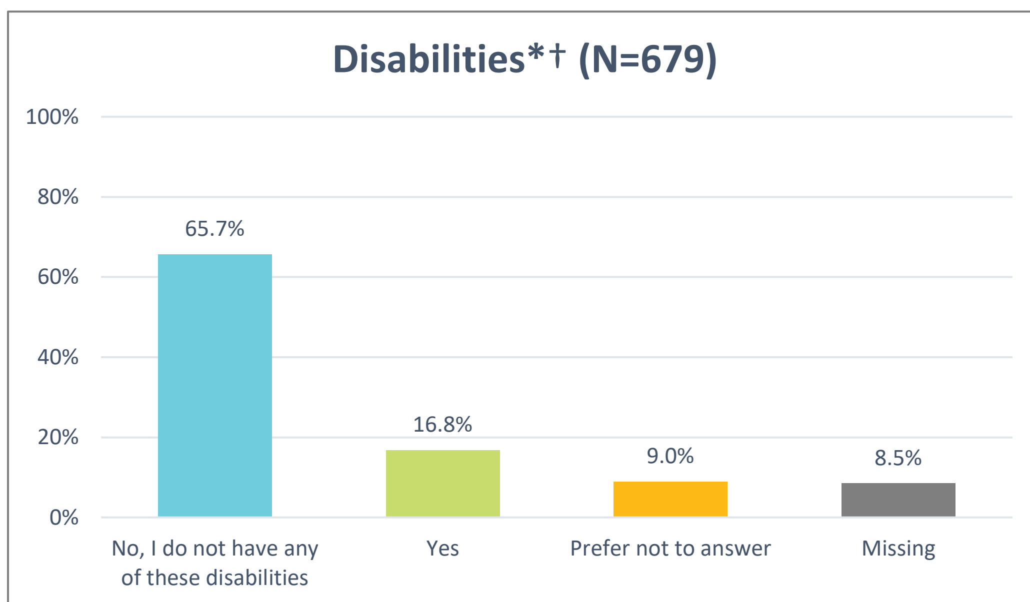
PARTICIPANT DEMOGRAPHICS continued



Just over 45% of participants identified their ethnicity as Hispanic/Latino.

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

PARTICIPANT DEMOGRAPHICS continued

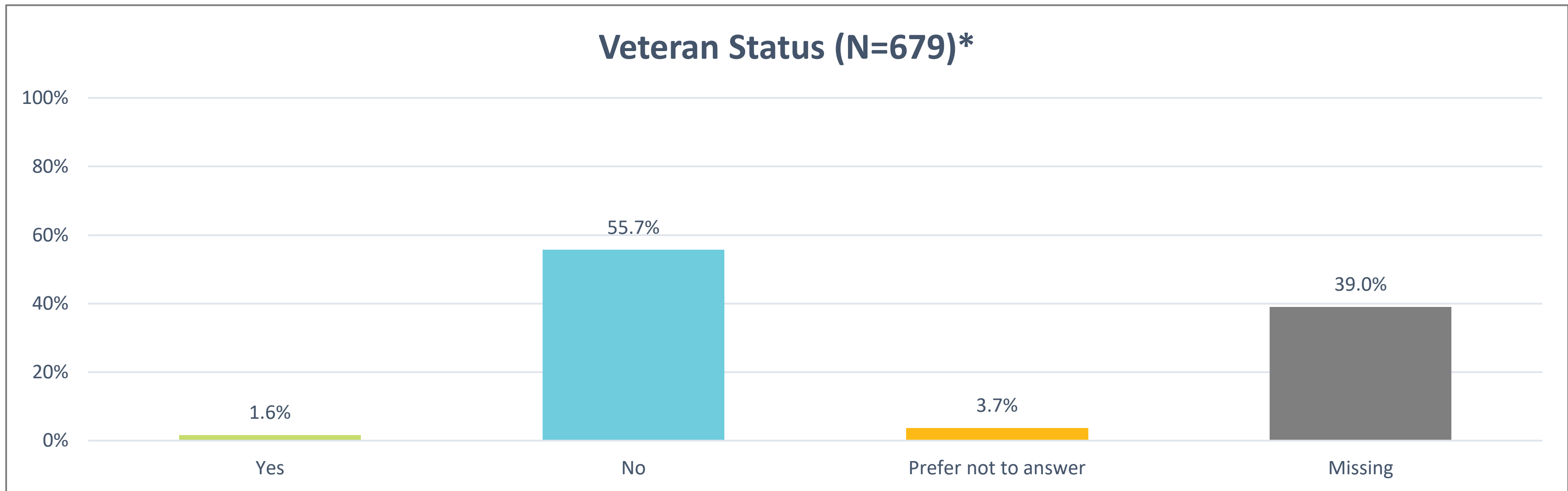


Disabilities*† (N=679)	Count	%
Difficulty seeing	9	1.3%
Difficulty hearing or having speech understood	<5	<1.0%
Other communication disability	<5	<1.0%
Mental disability not including a mental illness	42	6.2%
Learning disability	28	4.1%
Developmental disability	7	1.0%
Dementia	<5	<1.0%
Other mental disability not related to mental illness	7	1.0%
Physical/mobility disability	6	0.9%
Chronic health condition/chronic pain	13	1.9%
Other	56	8.2%
Prefer not to answer	61	9.0%
Missing	58	8.5%

Seventeen percent of participants reported having a disability. Approximately 6% of participants indicated having a mental disability (not including a mental illness). Nine percent preferred not to answer this question.

**A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a serious mental illness.*
† The sum of the percentages may exceed 100% because participants can select more than one type of disability.
Note: Percentages may not add up to 100% due to rounding.

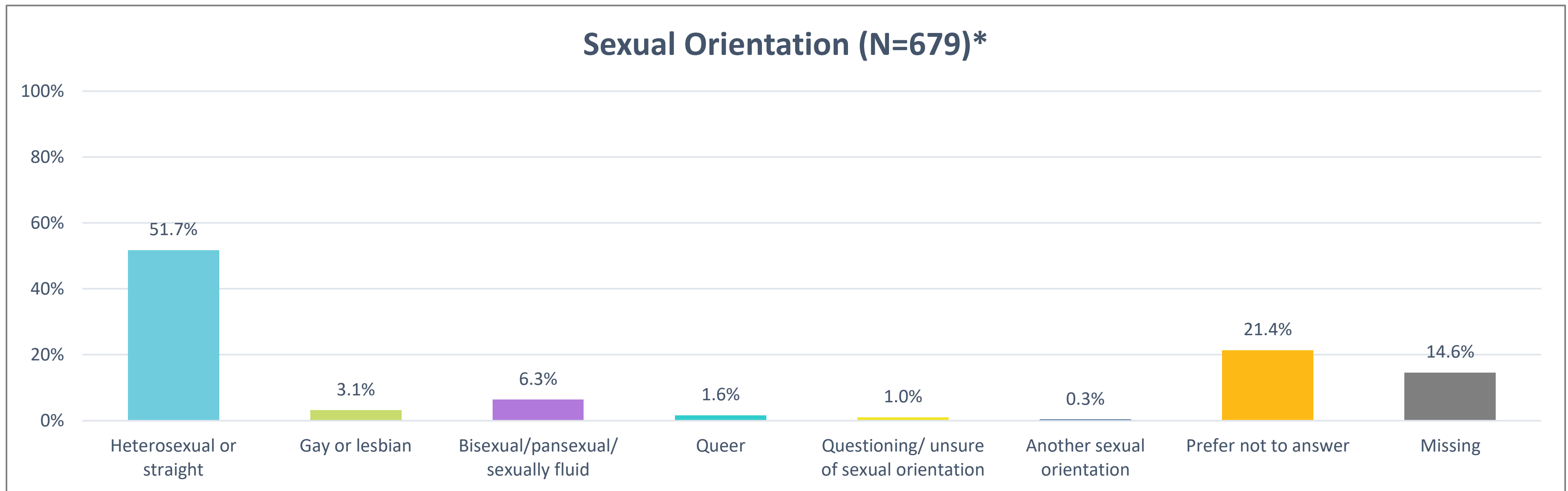
PARTICIPANT DEMOGRAPHICS continued



Fewer than 2% of participants had served in the military.

**Veteran status is not collected for Child & Family PEI participants younger than 18; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

PARTICIPANT DEMOGRAPHICS continued



Approximately 52% of the participants identified their sexual orientation as heterosexual or straight. Six percent identified their sexual orientation as bisexual/pansexual/sexually fluid and 3% identified as gay or lesbian. Approximately 21% of participants preferred not to answer this question.

**Sexual orientation not collected for Child & Family PEI participants younger than 12; these data are reported as "Missing."*
Note: Percentages may not add up to 100% due to rounding.

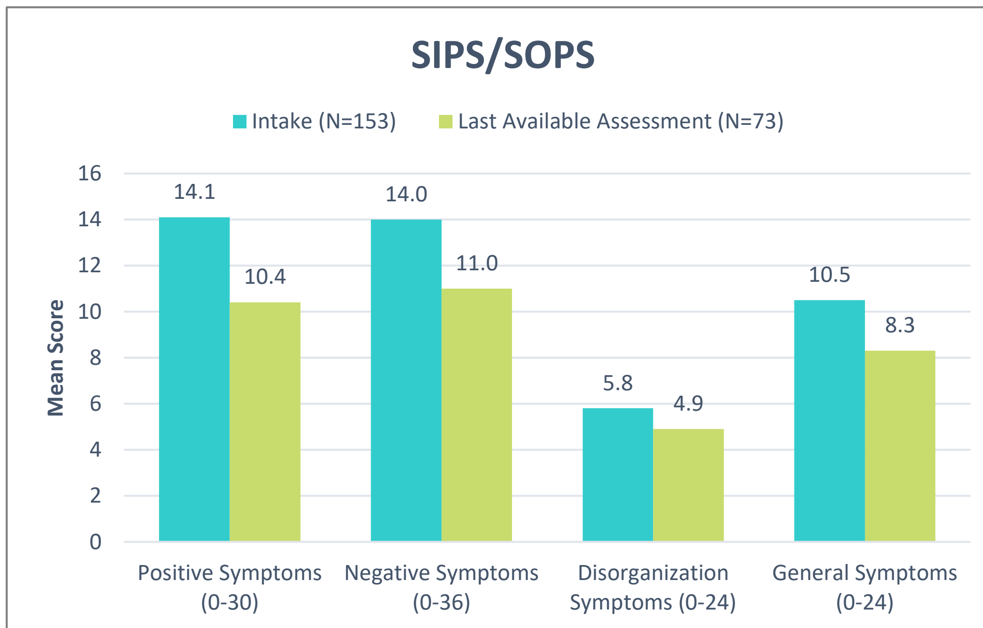
INTAKE: PHONE SCREENS

SYMPTOMS REPORTED AT INITIAL SCREENING	N	%
Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty concentrating), N=219	200	91.3
Changes in perception (auditory, visual, tactile, olfactory abnormalities), N=215	181	84.2
Changes in speech (disorganized communication, tangential speech), N=204	159	77.9
Changes in view (of self, others, or the world in general), N=185	136	73.5
Changes in emotions (depression, mood swings, irritability, flat affect), N=215	197	91.6
Vegetative symptoms (sleep problems, changes in appetite, social isolation), N=220	198	90.0
Family history of mental illness (schizophrenia, bipolar disorder, schizoaffective disorder, psychosis), N=195	135	69.2
Dramatic reduction of overall functioning), N=205	168	82.0

In FY 2022-23, 235 youth were screened for admission into the Kickstart program. The majority of phone screen participants experienced changes in thinking, emotions, and vegetative symptoms. Additionally, 82% of phone screen participants reported experiencing a dramatic reduction in overall functioning.

Not all youth had complete data for every item on the screener.

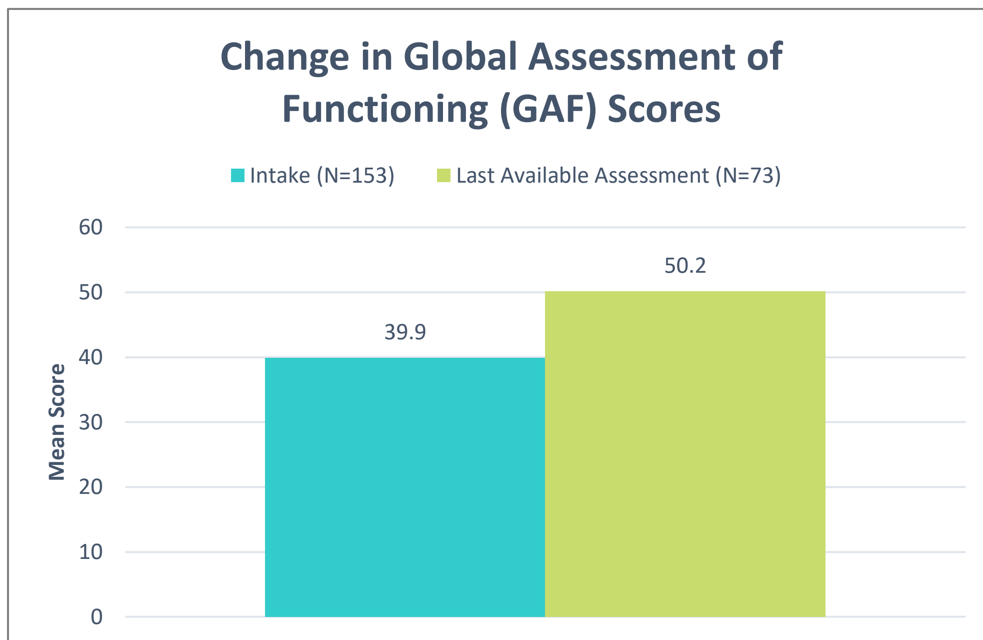
YOUTH OUTCOMES



A higher score on any Structured Interview for Psychosis-Risk Syndromes/Scale of Prodromal Symptoms (SIPS/SOPS) domain indicates higher symptom severity. On average, by the last available assessment, the severity of prodromal symptoms decreased compared to intake. Additional analyses were conducted with participants who had both an intake assessment and at least one other assessment. Participants included in these analyses showed statistically significant improvements ($p<.001$) on the Positive Symptoms, Negative Symptoms and General Symptoms Subscales.

*Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

YOUTH OUTCOMES continued

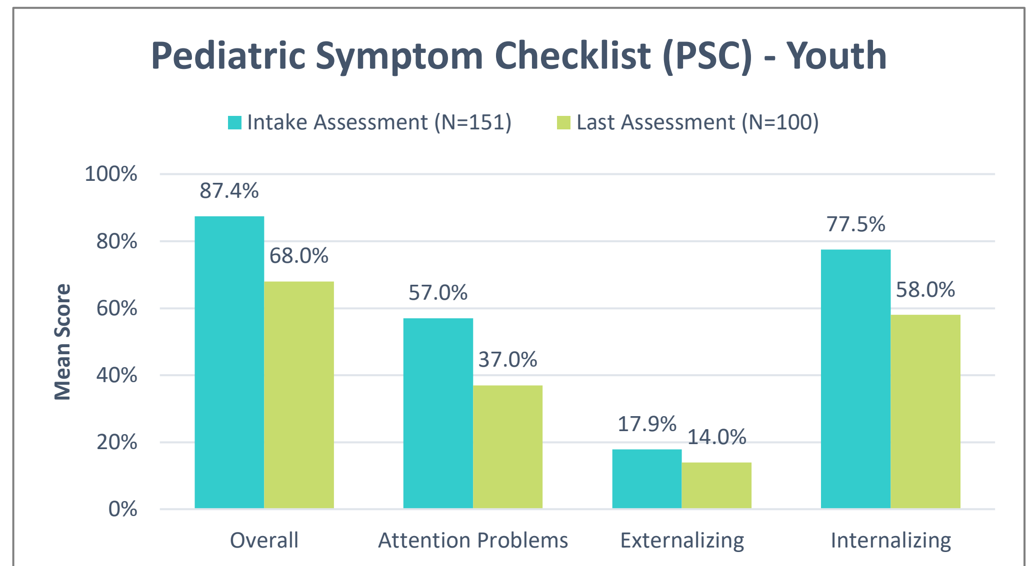


The Global Assessment of Functioning (GAF) is scored on a scale of 0-100; a higher score indicates better social and psychological functioning. On average, participants' functioning improved between the intake and the last available assessment. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvements on their GAF Score ($p<.001$).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

YOUTH OUTCOMES continued

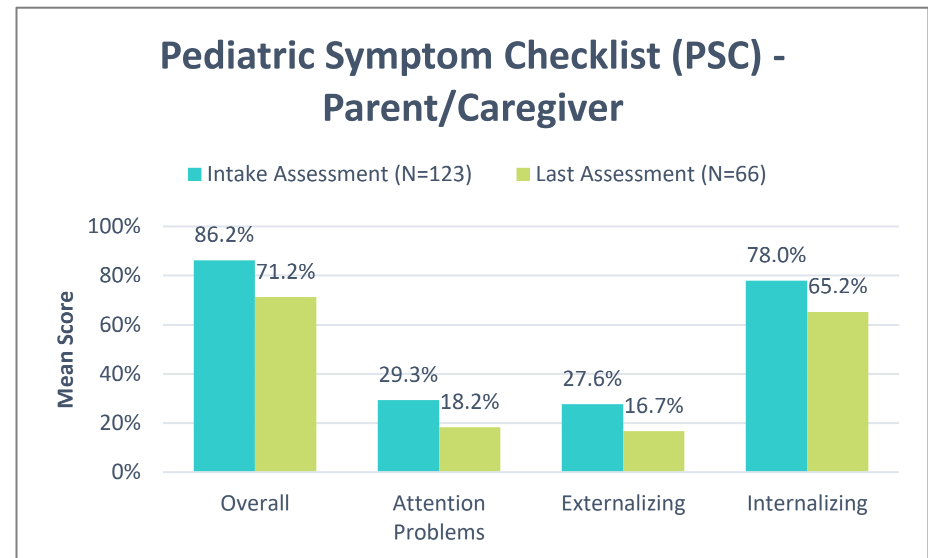
The Pediatric Symptoms Checklist (PSC) is completed by youth participants ages 11 to 18. At intake, just over 87% percent of youth met the criteria for psychosocial impairment. Seventy-eight percent of youth met the criteria for internalizing problems. On average, between the intake and the last assessment, the percent of youth whose scores indicated that they experienced impairment decreased for the total impairment score and all three subscales. For youth who completed both an initial assessment and at least one other assessment, there was a statistically significant ($p<.05$) decrease in overall impairment and impairment related to internalizing problems and attention problem.



Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

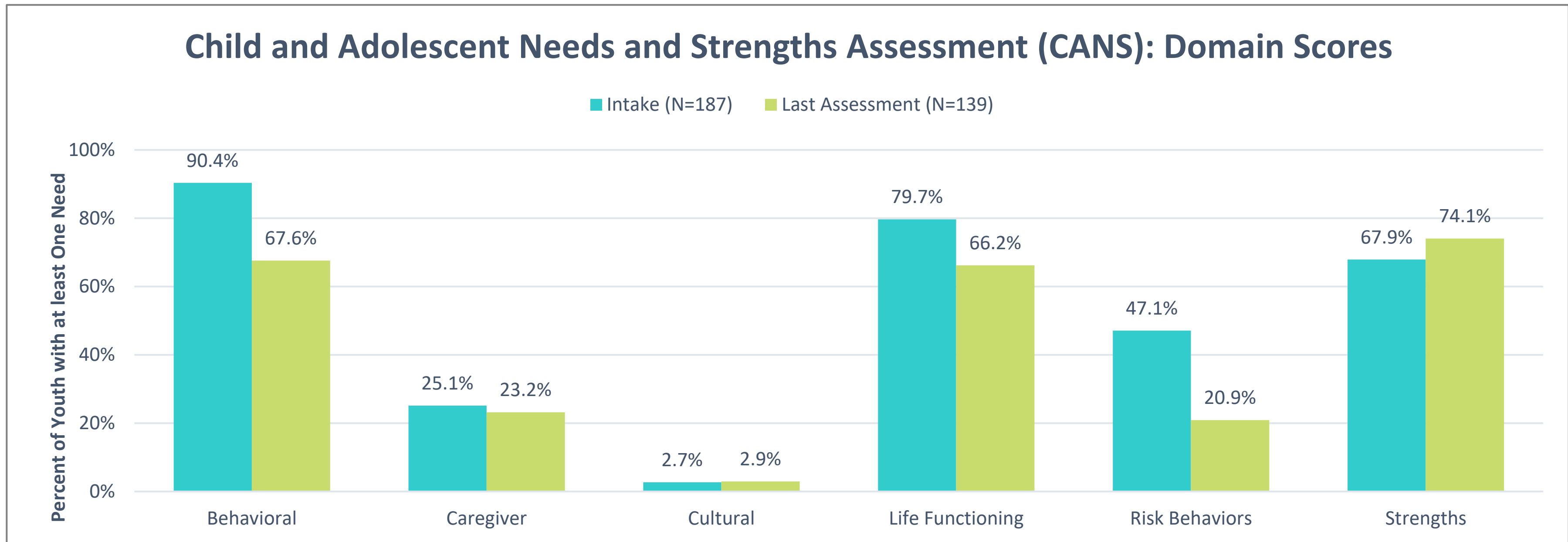
YOUTH OUTCOMES continued

The Pediatric Symptoms Checklist (PSC) is also completed by the parent/caregiver of youth participants ages 18 and younger. At intake, 86% of parents/caregivers indicated that their child met the criteria for experiencing overall psychosocial impairment. Nearly 78% of parents/caregivers reported that their child met the criteria for experiencing internalizing symptoms. On average, between the intake and the last assessment, the percent of parents/caregivers that reported that their child experienced impairment decreased for all subscales. For parents/caregivers who completed both an intake assessment and one additional assessment, there were statistically significant ($p<.05$) decreases in reports of impairment on the internalizing and attention subscales and on the overall impairment score.



Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

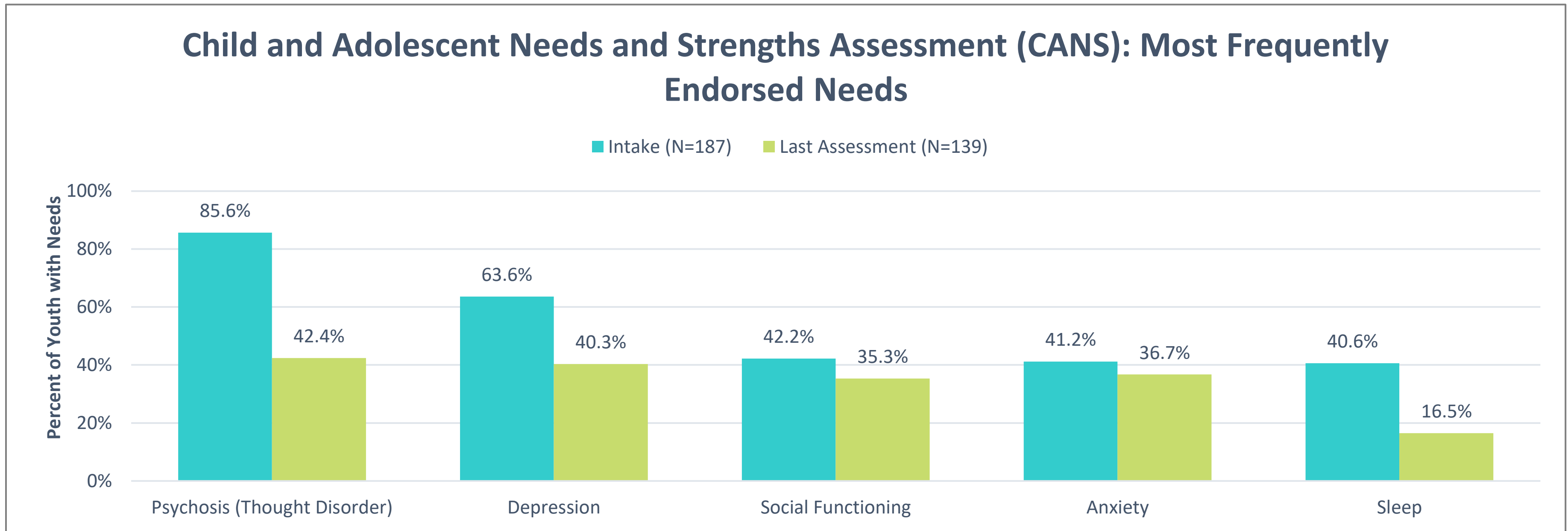
YOUTH OUTCOMES continued



The CANS is a 50-item measure completed by clinicians of youth ages 21 and younger. An analysis of the CANS subscales indicated that at intake 90% of youth participants had at least one behavioral or emotional need and 80% had at least one area of impaired life functioning. Nearly 68% of youth were identified as having at least one strength. With the exception of the strengths subscale, a decrease in the percent of respondents with need indicates improvement. Between intake and the last assessment, there were significant decreases in the behavioral, life functioning and risk behaviors subscales ($p<.05$).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

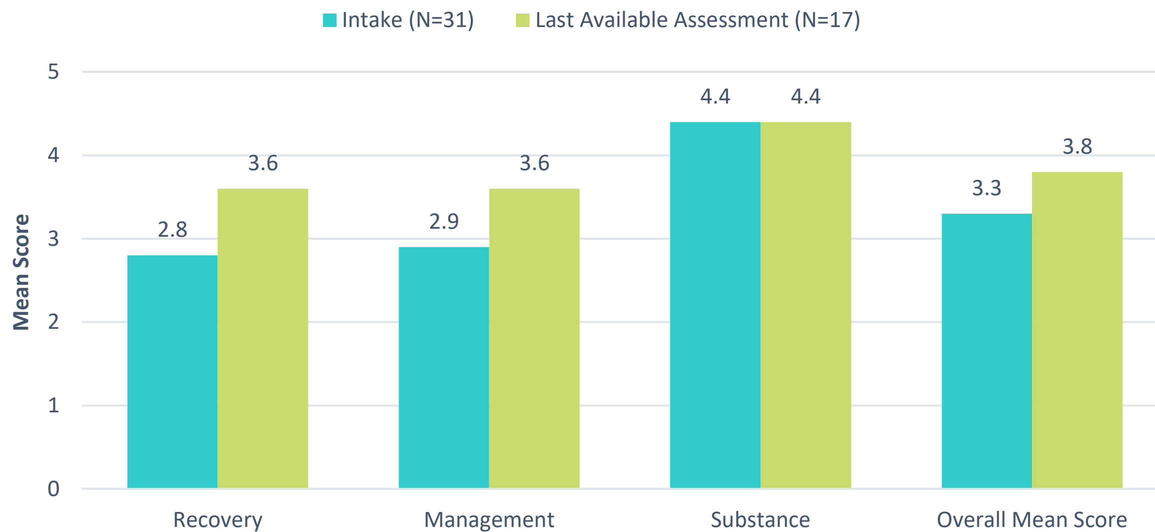
YOUTH OUTCOMES continued



In addition to analyzing the CANS subscales, the individual areas of need can also be evaluated. According to the clinicians' assessments, youth experienced the greatest needs at intake in the areas of psychosis (thought disorder), depression, social functioning, anxiety and sleep. On average, between the intake and the last assessment there were decreases in each of these areas of need. Separate analyses were conducted for youth with both an intake and at least one additional assessment. These analyses indicated statistically significant decreases in the areas of psychosis, depression, and sleep ($p<.001$). Appendix C presents the data for all CANS items and subscales at intake and last assessment.

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

OUTCOMES FOR YOUTH OVER 18



The IMR assessment is completed by the clinicians of participants 18 and older. Scores range between 1 and 5. An increase on any IMR subscale indicates improvement. On average, participants' overall mean scores improved between the intake and last available assessment. An additional analysis was conducted with participants who had both an intake and a second assessment. Participants included in this analysis showed statistically significant improvements on the Recovery, Management and Overall Subscales ($p<.05$).

The **Recovery Markers Questionnaire (RMQ)** is administered to participants 18 and older. Scoring ranges between 1 and 5. An increase on the RMQ mean score indicates improvement. Participants' scores improved between the intake assessment (mean= 3.5; N=28) and the last available assessment (mean = 3.7; N=15).

Note: Participants enrolled in the previous FY with at least one assessment submitted in the current FY are included in this analysis. For these clients, intake assessment data are taken from the prior FY.

FAMILY MEMBER INCREASES IN KNOWLEDGE

Of the 72 caregivers* who attended the family psycho-education group and completed both a pre-test and a post-test, 39 (54%) demonstrated an increase in knowledge of how to support youth with prodromal symptoms. Additionally, 16 caregivers (22%) had a perfect score on both the pre-test and the post-test.

72

CAREGIVERS ATTENDED THE GROUP AND COMPLETED BOTH A PRE-TEST AND A POST-TEST

39

CAREGIVERS DEMONSTRATED AN INCREASE IN KNOWLEDGE OF HOW TO SUPPORT YOUTH WITH PRODROMAL SYMPTOMS

16

CAREGIVERS HAD A PERFECT SCORE ON BOTH THE PRE-TEST AND POST-TEST

*May include duplicate data

COMMUNITY OUTREACH PSYCHO-EDUCATION GROUP

The most endorsed community role among outreach psychoeducation group participants was mental health professional (36%).

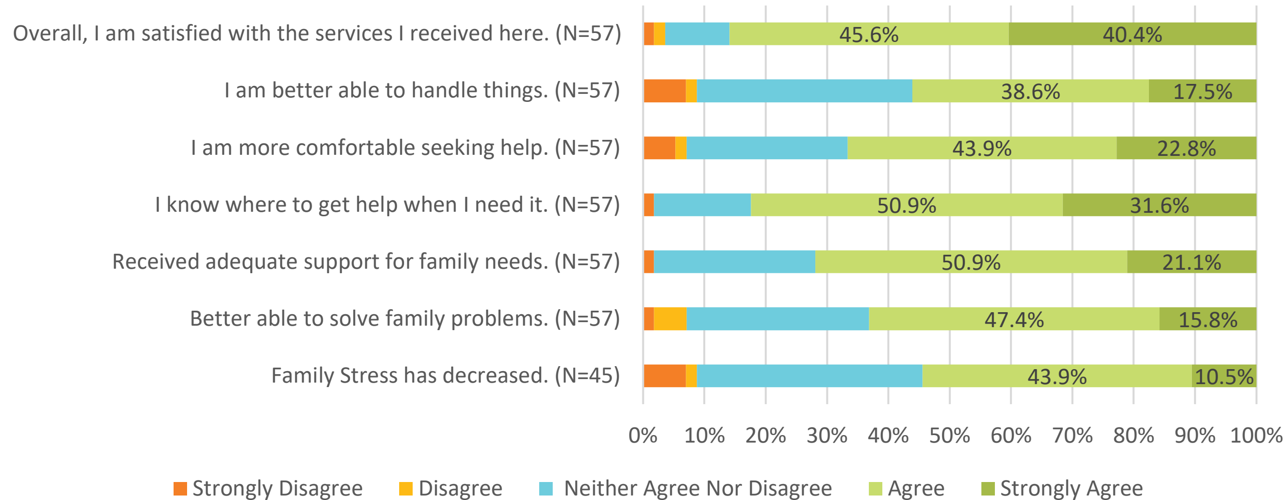
Of the 174 community members who attended the outreach trainings and completed both a pre-test and a post-test, 105 (60%) demonstrated an increase in knowledge of risk factors for the development of psychosis and early intervention procedures. Additionally, 22 community members (13%) had a perfect score on both the pre-test and the post-test.

Community Role* (N=278)	N	%
School Professional	15	5.4%
College Resident Assistant	<5	<1.0%
Medical professional	<5	<1.0%
Mental health professional	101	36.3%
Youth Worker	21	7.6%
Multicultural leader	<5	<1.0%
Employer	5	1.8%
Parent	10	3.6%
Member of a community group	<5	<1.0%
College student	15	5.4%
Missing	127	45.7%

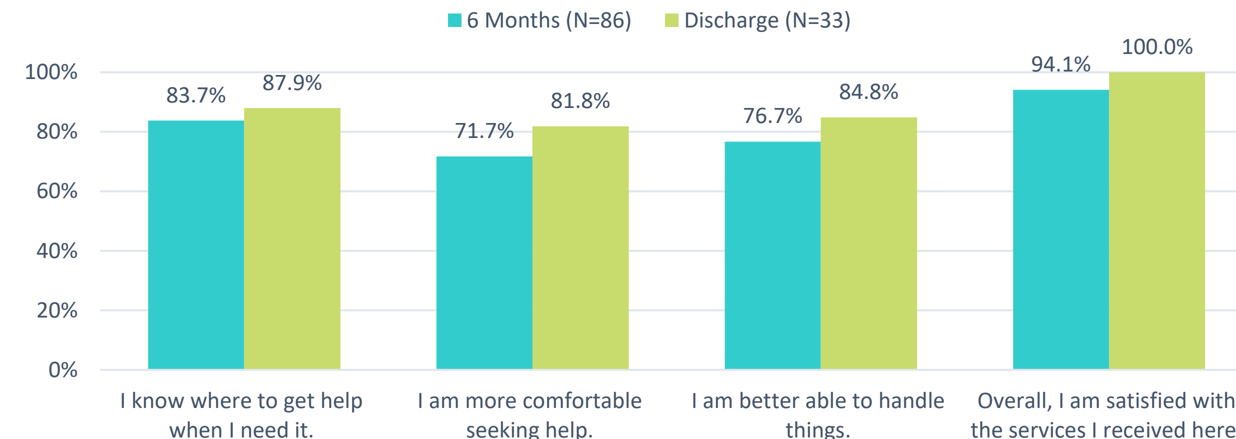
**The sum of the percentages may exceed 100% because participants can identify as more than one role.*

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

PARTICIPANT SATISFACTION* AND OUTCOMES



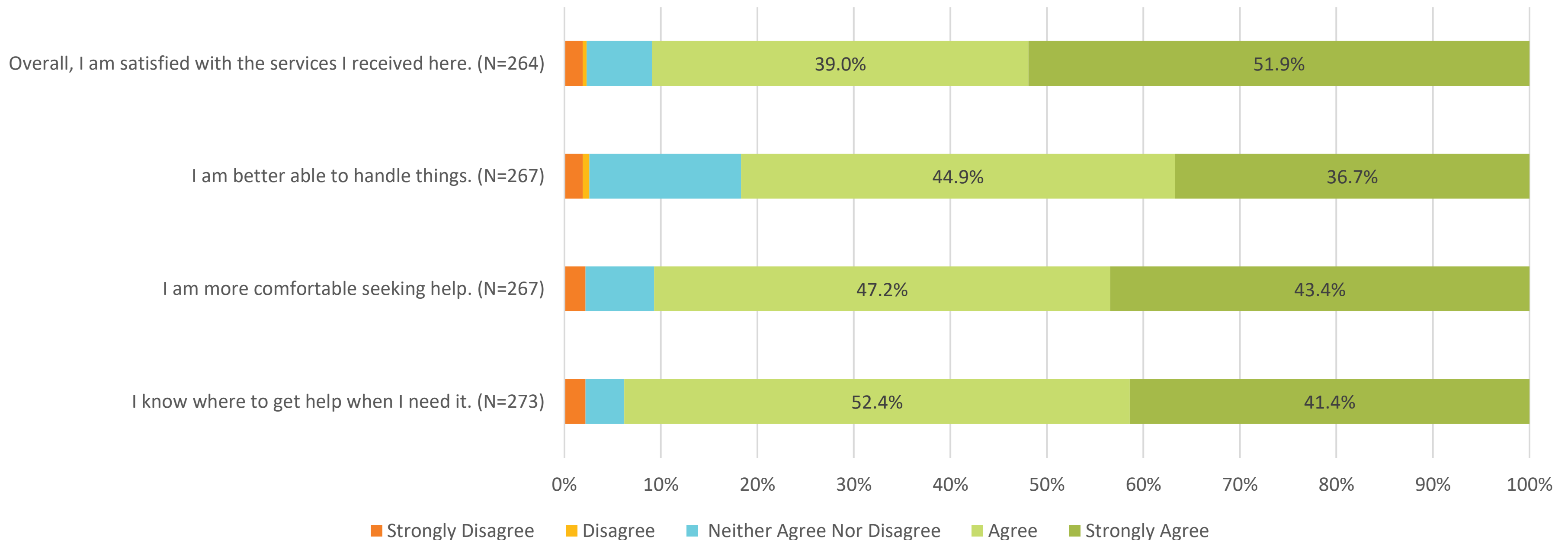
Eighty-six percent of caregivers who completed a satisfaction survey agreed or strongly agreed that they were satisfied with the services they received. Approximately 83% agreed or strongly agreed that they knew where to get help as a result of the Kickstart program, and 72% agreed or strongly agreed that they received adequate support for their family needs as a result of the Kickstart program.



The majority of youth who responded to satisfaction questions at 6 months agreed or strongly agreed that they were satisfied with the services they received (94%) and that they knew where to get help as a result of the Kickstart program (84%). Youth at discharge agreed or strongly agreed that they were satisfied with services they received (100%) and that they knew where to get help as a result of the kickstart program (88%).

*Satisfaction data are not available for all participants.

COMMUNITY OUTREACH PARTICIPANT PROGRAM SATISFACTION*



Of the participants who completed an outreach satisfaction assessment, most agreed that they knew where to get help when they needed it as a result of the program (94%). Most also said that they felt more comfortable seeking help after receiving services (91%). Overall, 91% of participants who responded were satisfied with the services they received.

*Satisfaction data are not available for all participants.

CHILD AND ADOLESCENT SERVICES RESEARCH CENTER

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

APPENDIX M

PEI COMPONENTS AND PRIORITIES

Prevention and Early Intervention (PEI) Priority Areas Fiscal Year 2024-25

Work Plan	Contractor	Name of Program	1 Child Trauma PEI	2 Early Psychosis	3 Youth Outreach	4 Cultural Comp	5 Older Adults
CO-03	National Alliance for Mental Illness, San Diego	Integrated Peer & Family Engagement (NAMI Next Steps)		x			x
DV-03	Union of Pan-Asian Communities	Alliance for Community Empowerment (Community Violence Response Team)	x				
DV-04	South Bay Community Services (SBCS), Home Start, Social Advocates for Youth (SAY), North County Lifeline	Community Services for Families - Child Welfare Services	x				
EC-01	Jewish Family Service of San Diego	Positive Parenting Program (Triple P)	x				
FB-01	Pathways Community Services, LLC	Early Intervention for Prevention of Psychosis		x	x		
NA-01	Southern Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x
NA-01	Indian Health Council, Inc.	Native American Prevention and Early Intervention				x	x
NA-01	San Diego American Indian Health Center	Native American Prevention and Early Intervention			x	x	
OA-01	Union of Pan-Asian Communities	Community-Based Services – For Older Adults				x	x
OA-02	Union of Pan-Asian Communities	Home Based Services - For Older Adults (Positive Solutions)				x	x
OA-06	Southern Caregiver Resource Center	Caregiver Support for Alzheimer & Dementia Patients				x	x
PS-01	Mental Health America of San Diego	ACEs Prevention Parenting Program for Fathers	x			x	
PS-01	Jewish Family Service of San Diego	Breaking Down Barriers				x	
PS-01	National Alliance on Mental Illness, San Diego	Clubhouse -Services Program				x	
PS-01	City of San Diego	Come Play Outside			x		
PS-01	Regents of the University of California, UCSD	County of San Diego - Community Health & Engagement			x		
PS-01	National Alliance for Mental Illness, San Diego	Family Peer Support Program				x	
PS-01	Mental Health America of San Diego	Mental Health First Aid				x	
PS-01	Urban Street Angels, Inc.	Recuperative Services and Support Program for Transitional Age Youth		x	x		
PS-01	Community Health Improvement Partners	Suicide Prevention Action Plan				x	
PS-01	Rescue Agency Public Benefit, LLC	Suicide Prevention and Stigma Reduction Campaign - It's Up to Us				x	
PS-01	San Diego Workforce Partnership	Supported Employment Technical Consultant Services				x	
RC-01	Vista Hill Foundation	Rural Integrated Behavioral Health & Primary Care Services		x			
RE-01	Community Health Improvement Partners	Independent Living Association (ILA)				x	
SA-01	Fred Finch Youth Center, Palomar Family Centers, San Diego Unified, South Bay Community Services, Vista Hill Foundation	Screening to Care Program	x				
SA-01	South Bay Community Services	School Based PEI - South	x				
SA-01	Vista Hill Foundation	School Based PEI - North Inland	x				
SA-01	Palomar Family Centers	School Based PEI - North Coastal	x				
SA-01	San Diego Unified School District	School Based PEI - Central and North Central	x				
SA-01	San Diego Unified School District	School Based PEI - Central and Southeastern	x				
SA-01	San Diego Youth Services	School Based PEI - East	x				
SA-02	San Diego Youth Services	School Based Suicide Prevention & Early Intervention			x		
SA-03	Harmonium Inc.	Youth & Family Support Services (YFSS)			x		
VF-01	Mental Health Systems, Inc.	Veteran & Family Outreach Education				x	

PRIORITY AREAS

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

APPENDIX N

INNOVATION REPORTS

ACCESSIBLE DEPRESSION AND ANXIETY PERIPARTUM TREATMENT (ADAPT) INNOVATIONS-18

Annual Report (7/1/2022 - 6/30/2023)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

v.12.22.2023

COUNTY OF SAN DIEGO Health and Human Services Agency

LIVE WELL SAN DIEGO

UC San Diego

Table of Contents

Executive Summary.. 1
Program Description 4
COVID-19 Impact.. 5
Participant Characteristics 5
Utilization of Program Services......................... 6
Primary Program Outcomes 8
ADAPT Participant Feedback Survey............... 13
Referral Partner Feedback Survey 16
Additional Program Activities.......................... 18
Primary Implementation Findings 20
Changes from Initial Program Design 22
Program Recommendations........................... 22
Conclusion 23
Appendix... 24

Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Accessible Depression and Anxiety Peripartum Treatment (ADAPT) program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). The ADAPT program was designed to address unmet needs, improve access to treatment and reduce the negative health outcomes of perinatal mood and anxiety disorders with a focus on women and families from underserved communities. A key component of the ADAPT program is the partnership with HHSA's Nurse Family Partnership (NFP) and Maternal Child Health (MCH) Home Visiting programs, with the goal of providing mental health services to Public Health Nursing (PHN) participants. ADAPT provides therapeutic treatment, peer support and advocacy, resource linkage and navigation to community resources and support for the entire family. Due to the COVID-19 pandemic, in fiscal year (FY) 2020-21 the ADAPT program transitioned from primarily in-home, in-person services to providing the majority of services via telehealth or telephone. The program has since re-introduced in-person services and is continuing to provide telehealth with reduced reliance on telephone-based services. ADAPT substantially expanded their referral partners during FY 2021-22 to accept eligible referrals (i.e., on Medi-Cal/qualify for Medi-Cal) from persons experiencing peripartum depression and anxiety anywhere in San Diego County.

Primary Findings for FY 2022-23

Consistent ADAPT Program Enrollment Serving Racially/Ethnically Diverse Participants

1. A total of 110 people enrolled in the ADAPT program during FY 2022-23 (103 initial enrollments into Level 1 and 7 initial enrollments into Level 2). For Level 1, this was a slight increase from FY 2021-22 (6.2%).
2. The ADAPT program served a racially and ethnically diverse population with the majority (62.7%) identifying as Hispanic/Latino and 17.3% indicating that Spanish was their primary language.

Participants Experienced Improvements and Viewed ADAPT Program Favorably

3. As reported through both clinician and participant assessments (described in more detail below), ADAPT participants experienced substantial reductions in depression and anxiety symptoms. Clinicians reported improved perceptions of participant recovery and illness management, particularly with regard to symptom distress, impairment in functioning, progress toward goals, and knowledge of and coping with their mental health. Participants reported improved mood and ability to think, satisfaction with relationships, and ability to carry out day-to-day activities. Fatigue and distress from emotional struggles decreased while participants reported increased hope as well as skills and resources to manage stress.

4. All ADAPT participants (100%) expressed satisfaction with the services received and that they now know where to get help when they need it. More than 95% of clients report that as a result of participating in ADAPT, they are now comfortable seeking help. Participants rated highly the availability and range of services as well as the cultural sensitivity of staff. One participant stated, "I have had the best experience here. My therapist really cares and always advocates for me."

ADAPT Program Continued to Evolve to Support Effective and Sustainable Service Delivery

5. During FY 2022-23, the ADAPT team continued to increase the amount of ADAPT treatment and support services delivered via telehealth while also providing more in-person services than was possible during the earlier years of the pandemic. Feedback indicated that most participants preferred a hybrid service delivery model with both telehealth services and the option for in-person connections as needed. However, some participants still expressed a preference for either primarily/exclusively in-person services or primarily/exclusively telehealth services, which highlighted the importance of the ADAPT program's flexibility and ability to personalize how services are provided to specific participants.

ADAPT Program Continued to Foster Partnerships

6. In a survey of ADAPT's many community referral partners, respondents reported that ADAPT has helped to ensure that their patients are connected to appropriate mental health services. Referral partners positively highlighted the ease of the referral process, care coordination, and communication with ADAPT providers. Many expressed a desire for expanded eligibility for the program, particularly related to health insurance restrictions (i.e., needing to have or be eligible for Medi-Cal).

7. In FY 2022-23, the ADAPT program manager and staff continued outreach efforts to increase referrals. Meetings with groups such as the regional PHN programs, San Diego Workforce Partnership, Family Support Connection, SAY San Diego and many others occurred to facilitate referral connections. ADAPT was represented at local conferences such as the 2022 Live Well Advance & School Summit, as well as the International Marcé Conference for Perinatal Mental Health.

8. Ongoing communication remains critical to effective coordination between ADAPT and PHN nurses. The ADAPT team facilitated six Mental Health Roundtable training opportunities for PHN programs. Presentation topics included: the peer support role at ADAPT; a training entirely in Spanish to facilitate a dialogue regarding culture, language, and mental health; training on Perinatal Mood and Anxiety Disorders (PMADs); case consultation opportunities; a review of peripartum treatment programs

including substance use disorders (SUD) during the peripartum period; and a training in Art Therapy which included the power of art, experiential practice, and reflection.

9. As described in more detail below, the ADAPT team continued to collaborate with UCSD to pilot test the integration of an evidence-based Sleep and Light Intervention (SALI) into ADAPT services, with preliminary results suggesting that: 1) SALI contributed to a reduction in depression symptoms among peripartum women and 2) SALI was feasible to implement within a community-based program such as ADAPT.

Conclusion

During FY 2022-23, enrollment into ADAPT continued to increase with over 100 (n=103) participants enrolling into ADAPT Level 1 services. The number of PHN referrals, which significantly decreased during the pandemic, are now on a rising trajectory. Additionally, ongoing outreach efforts to increase awareness of ADAPT throughout the County of San Diego have strengthened the referral network and led to more community connections.

Both clinician and participant assessments indicated that ADAPT participants experienced substantial reductions in depression and anxiety symptoms and improved their ability to manage their emotional well-being. Other improvements included better relationships and ability to handle daily activities, as well as better sleep and less fatigue. High levels of satisfaction were reported by participants and echoed by PHNs, who reported substantial benefits for their ADAPT-enrolled clients as related to improvements in their mental health and ability to manage life challenges. ADAPT services also attend to the well-being of participating families by directly providing or facilitating connections to additional resources that allow them to better care for their children and address basic needs related to food, clothing, shelter, and employment. Both participants and PHNs highlighted the importance of having ADAPT, a program that specializes in the unique needs of pregnant and postpartum women experiencing depression, in the community.

Primary Recommendations for FY 2023-24

1. Extend the expected duration of peripartum services beyond six months, as peripartum depression typically occurs during pregnancy and for up to at least a year post-pregnancy.

2. Update privacy practices to better match participant preferences for communication and improve accessibility by allowing engagement through text, alert systems and/or mobile applications.

3. Increase funding to support staff retention and minimize staffing turnover, which disrupts continuity of care and relationship-building. Specifically, resources are needed to reduce staff travel burden and increase training opportunities.

4. Continue community outreach to support communication and collaboration with existing and new referral partners to promote awareness of ADAPT and identification of appropriate referrals.

5. Develop a triage, case management/care coordination program specially designed to support individuals getting connected to the best-fit services and align with “no wrong door” policy, particularly for those referred to, but not eligible for, ADAPT services.

6. Reduce administrative burden and non-billable activities by updating policies to allow for strategic utilization of technologies, such as DocuSign, to improve efficiency and accessibility.

7. Continue emphasis on participant "choice and voice" in how services are provided and continue refinement of hybrid service provision models that integrate in-person and remote (e.g., telehealth) interactions.

Program Description

The County of San Diego HHSA BHS ADAPT program is funded through the INN component of the MHSA, with services provided by behavioral health clinicians and peer support staff from Vista Hill Foundation, a community-based nonprofit organization. MHSA INN funding for ADAPT services was extended and is now expected to continue through 12/31/2023. Based on the positive results achieved by the ADAPT program during the INN-funded pilot project phase, also BHS determined that ADAPT services should be integrated into the overall BHS system of care with the specialized peripartum services to continue past the end of the INN-funded services on 12/31/2023.

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

The ADAPT program was developed in response to concerns about the high prevalence of unmet treatment needs for perinatal anxiety and depression among the women served by the MCH and NFP programs, and the desire to prevent the negative consequences often related to perinatal mood disorders including challenges to the family unit, difficult infant temperament, emotional and cognitive delays in children, and suicidal ideation. ADAPT provides therapeutic treatment, peer support and advocacy, linkages and navigation to community resources, family support, and other therapeutic interventions such as skill-building education, group skill-building, and case management. Services are evidence-informed and include care coordination and case consultation. While ADAPT was designed to primarily provide in-home services, the COVID-19 pandemic demanded flexibility, which turned out to be a valuable component of ADAPT that remains today. Services are now provided in a variety of ways: in-home, via telehealth and even telephone when necessary.

A key innovative component of the ADAPT program is the partnership between ADAPT mental health clinicians, PHNs, and the certified peer support partners. During FY 2021-22, ADAPT began accepting eligible referrals (i.e., on Medi-Cal/qualify for Medi-Cal) from persons experiencing peripartum depression and anxiety anywhere in San Diego County.

The ADAPT program was designed to provide two tiers of services:

- **Level 1** participants meet criteria for Title IX specialty mental health services and peripartum criteria, evidenced by significant functional impairments including but not limited to clinically significant depression and/or anxiety. The persons in Level 1 received ongoing therapy as well as other supportive services.

- **Level 2** participants did not meet full criteria for specialty mental health services and presented with less acute symptoms. However, they demonstrated impairments in functioning as well as risk of perinatal mood disorders and anxiety based on assessment of biological, psychological, and social factors.
    - Level 2 also includes participants who would meet BHS eligibility for Level 1 services but are receiving services from another mental health provider or are not interested in receiving mental health services at the time of initial assessment.
    - Since ADAPT attempts to enhance the role of fathers/partners in therapeutic interventions as a way to reduce symptoms of maternal and paternal mental health disorders, Level 2 could also include family members of Level 1 participants.

COVID-19 Impact

In FY 2020-21, COVID-19 severely impacted the ability of the ADAPT program to provide in-home assessments and clinical sessions. Initially, services transitioned to telephone. As comfort level and capability with technology increased, the emphasis shifted to telehealth as the video component enabled the participants and service providers to see one another during sessions. As federal- and state-guided COVID-19 precautions became less stringent, ADAPT reinstated efforts to meet in person with participants. Initially, in-person visits typically occurred in outdoor settings accessible to the participant. Once COVID-19 safety guidelines permitted, providers were able to meet with clients in their homes or other preferred settings. Reflecting these broad changes in service delivery, during FY 2022-23 most services were still provided via telehealth while only about 15% were provided face-to-face (see Table 3).

Participant Characteristics

A brief overview of ADAPT participant characteristics is presented here, with a more complete listing in the appendix. As shown in Table 1, a total of 110 unique persons enrolled in the ADAPT program during FY 2022-23 (103 initial enrollments into Level 1 and 7 initial enrollments into Level 2). The 110 people enrolled into ADAPT during FY 2022-23 represented 109 different families with a total of 201 children in the households (including those not yet born at the time of ADAPT program enrollment). The 103 persons enrolled into Level 1 services during FY 2022-23 represented a slight increase (6.2%) from the 97 enrolled during FY 2021-22. A significant number of ineligible referrals (e.g., individuals with private insurance) was a barrier to enrollment.

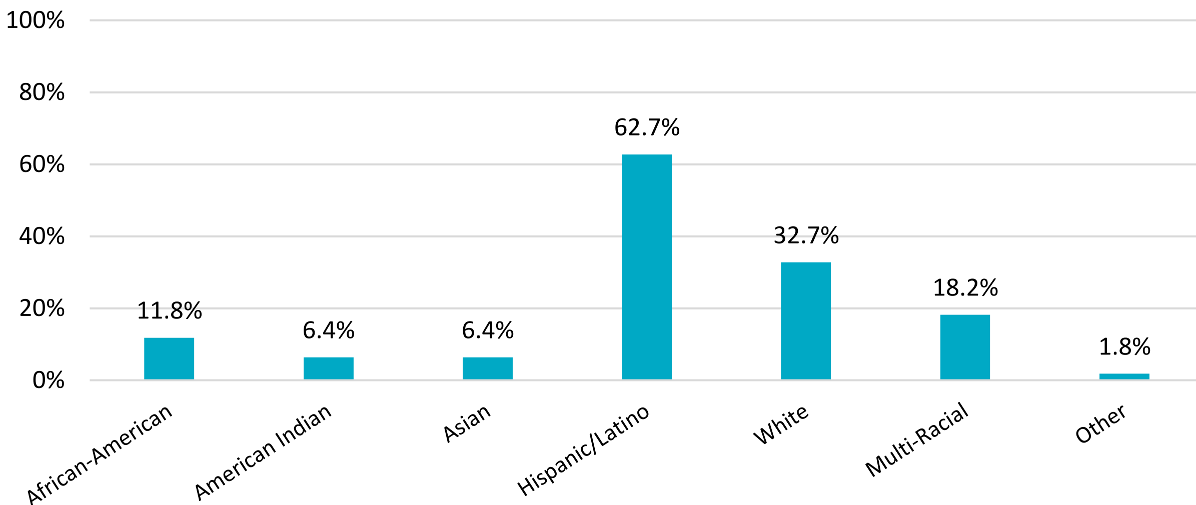
Table 1. ADAPT Program Enrollment for FY 2022-23 (N=110 unique persons)

	FY 2022-23
Enrollment by ADAPT Service Level	**n**
Level 1 services (i.e., ongoing therapy services)	103
Level 2 services (i.e., education and support services)	7
Total unique ADAPT enrollees	**110**

Across both service levels, 99.1% of participants identified as female (n=109). The majority indicated English was their primary language (79.1%; n=87), with 17.3% (n=19) selecting Spanish as their primary

language (served by Spanish-speaking ADAPT staff). Nearly 90% of participants (88.2%; n=97) identified as heterosexual or straight. While the majority of ADAPT participants were aged 26 or older (57.3%; n=63), almost half (42.7%; n=47) were Transitional Age Youth (TAY) aged 18-25. As shown in Figure 1, the ADAPT program served a racially and ethnically diverse population with the majority of ADAPT participants identifying as Hispanic/Latino (62.7%; n=69).

Figure 1. Race/Ethnicity of ADAPT Participants (N=110)



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

ADAPT participants completed the Adverse Childhood Experiences (ACE) questionnaire at program intake. The ACE seeks to quantify a person's exposure to specific types of childhood trauma at home. Scores range from 0 to 10, with higher values signifying more traumatic experiences. A score of 4 or more is considered to be a risk factor for experiencing health and mental health problems as an adult. The average ACE score among ADAPT participants was 4.4, with close to half (42.7%) having an ACE score of 4.0 or greater, indicating that many of the persons served by ADAPT have experienced substantial levels of childhood trauma that may be affecting their current well-being.

Utilization of Program Services

Level 1 Services

Based on data from the San Diego County BHS electronic health record system, Table 2 describes the number and type of services provided during an average 30-day period by licensed and license-eligible clinicians on the ADAPT team for persons enrolled in Level 1 during FY 2022-23.

On average, during a 30-day period in ADAPT, participants typically received approximately 4.0 services. Most often, service contacts were therapy (an average of 2.4 services in 30 days) with other supportive services provided as needed (e.g., assessment, case management, and rehabilitation). Therapy visits included both individual, group, and family therapy. Although family therapy was rarely utilized as a specific treatment modality, ADAPT services benefit the overall family unit directly and indirectly through case management and resource support. Of note, ADAPT team members were available to respond to crisis events, but did so on less than five occasions during FY 2022-23. The rarity of such events suggests

that the ADAPT team was generally available to provide support and services that prevented the need for crisis care for almost all participants, highlighting the importance of having a program like ADAPT connected with these persons to address potentially serious situations.

Table 2. ADAPT Level 1 Services during FY 2022-23 (N=139)

ADAPT Service Type	Persons with at least one service		Total ADAPT services provided	Average number of services per person, per 30-day period
	n	%		
Any ADAPT service	132	95.0%	1,753	4.0
Assessment/Tx. plan development	108	77.7%	226	0.5
Therapy (i.e., by licensed clinician)	109	78.4%	1,062	2.4
Rehabilitation (i.e., by peer support or other professional)	32	23.0%	111	0.3
Peer/self-help services	14	10.1%	36	0.1
Crisis	<5[1]	<3.6%	<5[1]	<0.1
Case management	67	48.2%	185	0.4
Other services (e.g., collateral)	61	43.9%	133	0.3

[1]*Exact number masked due to the small number of persons experiencing this event.*

The average time in the ADAPT program was 139.1 days, with a median time of 145 days for the 97 persons who discharged from Level 1 services during FY 2022-23. There was quite a bit of variation in length of engagement, with about 25% participating for less than 50 days and 25% participating for more than 180 days. Overall, the typical length of time receiving ADAPT services was 5-6 months, which was similar to program durations during FY 2021-22.

As shown in Table 3, the method used to deliver ADAPT services fundamentally shifted over the years due to the onset of the COVID-19 pandemic.

Table 3. Type of ADAPT Service Contact

	FY 2019-20		FY 2020-21		FY 2021-22		FY 2022-23	
Contact Type	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Telehealth	150	9.4%	720	59.3%	1,175	64.7%	1,238	70.6%
Telephone	426	26.7%	368	30.3%	275	15.1%	218	12.4%
Face-to-face	1,011	63.5%	112	9.2%	357	19.7%	292	16.7%
Other	6	0.4%	14	1.2%	9	0.5%	5	0.3%
Total Services	**1,593**	**100%**	**1,214**	**100%**	**1,816**	**100%**	**1,753**	**100%**

Prior to the pandemic, the majority of ADAPT services were provided face-to-face. During the initial months of the pandemic (i.e., the end of FY 2019-20), services shifted to primarily telephone based. As COVID-19 safety concerns decreased from FY 2020-21 to FY 2022-23, the percentage of face-to-face visits

increased (from 9.2% to 16.7%). Telephone visits also decreased during the same timeframe (from 30.3% to 12.4%) due to the increased emphasis on telehealth. Utilization of telehealth has steadily increased over time (9.4% in FY 2019-20 to 70.6% in FY 2022-23) reflecting an increased capacity for and comfort of both staff and participants engaging in this treatment modality.

Level 2 Services

A total of 19 people participated in Level 2 services during FY 2022-23, receiving a total of 256 unique service contacts. This is a decrease in the total number of people receiving Level 2 services and total services provided as compared to the prior year (30 people and 296 services, respectively).

Table 4 highlights the most common types of services provided during Level 2 service contacts, which typically focused on educational/skill-building opportunities or assistance with basic needs. Both staff and participants noted the importance of being able to help address basic needs (e.g., food insecurity) as this can alleviate a major source of family distress. Additional types of supports provided to some Level 2 participants addressed a wide range of other issues including housing assistance, employment services, navigating public benefits or legal issues, or assistance with obtaining needed physical health care.

Table 4. Most Common Types of FY 2022-23 ADAPT Level 2 Service Encounters

	ADAPT Level 2 Service Encounters			
	Total persons (N=19)		Total services (N=256)	
	Number of persons with service	% of persons with service	Number of services	% of total services*
Goalsetting skills	14	73.7%	39	15.2%
Self-Regulation Skills	14	73.7%	75	29.3%
Mental Health Education	14	73.7%	26	10.2%
Mindfulness Skills	11	57.9%	48	18.8%
Basic Needs	11	57.9%	32	12.5%
Physical Health Assistance	9	47.4%	13	5.1%
Parenting Skills	7	36.8%	20	7.8%
Nutrition Education	5	26.3%	7	2.7%

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

For the 17 persons who discharged from Level 2 ADAPT services during FY 2022-23, the average time in the ADAPT program was 143.6 days (median of 142.0 days). The length of time of Level 2 participation was generally similar to that of persons receiving Level 1 services, with some requiring services beyond the standard 6-month program duration.

Primary Program Outcomes

Due to the small number of Level 2 participants enrolled during FY 2022-23 and their differing service needs, participant outcomes referenced in this section only include Level 1 participants.

Edinburgh Postnatal Depression Scale

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

As shown in Table 5, during FY 2022-23 the average EPDS score at intake was 12.4, which reduced to 8.7 at the last EPDS follow-up assessment. This statistically significant change in the total EPDS score reflects an overall reduction in symptoms as reported by ADAPT program participants. A total of 70.4% of all participants demonstrated at least some reduction in depression symptoms at follow-up. A statistically significant reduction of similar magnitude was also identified during the prior year, FY 2021-22 (i.e., from 12.2 at intake to 8.6 at follow-up). Additional analyses that compared the FY 2022-23 EPDS at intake to the EPDS administered closest to 30 days post-ADAPT enrollment found a statistically significant reduction to 11.2. This finding suggests that, on average, a reduction in depressive symptoms begins within the first 30 days of ADAPT participation, and continued improvement occurs with further treatment beyond that point.

While the EPDS total score is generally utilized as an indicator of the extent to which a person is experiencing depressive symptoms, an examination of the individual EPDS items can help identify the specific types of changes experienced. For people served by ADAPT, changes were evident across all dimensions. In FY 2022-23, the items with the largest changes from intake consisted of reductions in self-blame, anxiousness, and unhappiness (i.e., average EPDS differences of at least 0.5). While not commonly endorsed at intake, it is important to also note that a critical risk item ("thoughts of self-harm") decreased significantly at follow-up (See Table 5). The pattern of reductions across the individual items paralleled the changes observed in FY 2021-22. Overall, ADAPT participants generally reported experiencing fewer symptoms of depression and anxiety after participating in the ADAPT program.

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

	FY 2022-23			FY 2021-22		
		Initial EPDS	Last available EPDS		Initial EPDS	Last available EPDS
EPDS Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
		Scale of 0 to 3 where higher value = worse condition			*Scale of 0 to 3 where higher value = worse condition*	
I have been able to laugh and see the funny side of things	108	0.6	0.5	98	0.5	0.4*
I have looked forward with enjoyment to things	108	0.9	0.5**	98	0.7	0.4**
I have blamed myself unnecessarily when things went wrong	108	1.7	1.4*	98	1.8	1.3**
I have been anxious or worried for no good reason	108	1.9	1.4**	98	1.9	1.4**
I have felt scared or panicky for no very good reason	108	1.4	0.8**	98	1.3	0.9**
Things have been getting on top of me	108	1.8	1.3**	98	1.8	1.4**
I have been so unhappy that I have had difficulty sleeping	108	1.2	0.9*	98	1.3	1.0*
I have felt sad or miserable	108	1.4	1.0**	98	1.4	1.0**
I have been so unhappy that I have been crying	108	1.3	0.8**	98	1.2	0.7**
The thought of harming myself has occurred to me	108	0.2	0.1*	98	0.2	0.1*
EPDS Total Score	**108**	**12.4**	**8.7****	**98**	**12.2**	**8.6****
Likely Depression (i.e., score >=10)	-	**78 (72.2%)**	**41 (38.0%)**	-	**68 (69.4%)**	**41 (41.8%)**

**statistical significance at $p < 0.05$; **statistical significance at $p < 0.01$*

Illness Management and Recovery Scale-Reduced

To measure clinician perceptions of client recovery and improved illness management, a shortened version of the Illness Management and Recovery-Reduced (IMR-R) scale was completed by ADAPT providers. Representatives from ADAPT, BHS and the UCSD evaluation team reviewed and chose 9 of the 15 items from the full IMR that were most relevant to the ADAPT program services and the focal service population (see Table 6). Each item on the scale has a 5-point behaviorally defined response option tailored to that specific domain, with higher values indicating less impairment/better functioning. The IMR-R was administered upon entry into ADAPT and then at 90-day follow-up intervals, documenting the

amount of potential initial impairment and the extent to which changes may have occurred while receiving ADAPT services from the perspective of the ADAPT clinicians.

As shown in Table 6, the initial IMR-R ratings varied substantially across the individual items. For FY 2022-23, average ratings for many items were between 2 and 3, which is generally indicative of moderate impairment. Symptom distress was the lowest rated item at 2.1, indicative of fairly high levels of mental health-related distress upon entry into ADAPT. Conversely, medication management and substance abuse were rated as areas that were not a concern (i.e., intake ratings of 4.9 or higher). This pattern of FY 2022-23 intake IMR-R scores was similar to that observed during FY 2021-22.

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

	FY 2022-23			FY 2021-22		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
IMR-R Item	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
		Scale of 1 to 5 where higher value = better functioning			*Scale of 1 to 5 where higher value = better functioning*	
Progress towards personal goals	69	2.6	3.7**	62	3.0	3.5**
Knowledge about symptoms, treatment, coping strategies, and medication	72	3.0	3.8**	64	3.0	3.7**
Involvement of family and friends in MH treatment	73	2.8	3.2*	64	2.8	3.3**
Symptom distress	73	2.1	3.3**	64	2.2	3.2**
Impairment of functioning	73	2.6	3.6**	63	2.6	3.4**
Coping with mental or emotional illness from day to day	73	2.8	3.7**	64	2.8	3.7**
Effective use of psychotropic medication	7[1]	4.9	4.4	4	5.0	5.0
Impairment of functioning through alcohol use	71	5.0	5.0	62	5.0	5.0
Impairment of functioning through drug use	71	5.0	5.0	62	5.0	5.0
Overall	**73**	**3.2**	**3.9****	**64**	**3.3**	**3.9****

**statistical significance at $p < 0.05$; **statistical significance at $p < 0.01$*

[1] This item was only completed for participants who were taking psychotropic medications at the time of the initial and last IMR-R assessment.

During FY 2022-23, the overall IMR-R score increased from 3.2 to 3.9, indicating a statistically significant change and clinically meaningful improvements within the participant population. Among the individual items, medication management and substance use maintained their positive intake levels (i.e., high functioning/less impairment), and many of the other items achieved a gain of 0.5 to 1.0. Particularly notable were the ratings of symptom distress improving from 2.1 to 3.2, indicating clients went from being bothered "quite a bit" by their symptoms at intake to only "somewhat" at follow-up. Consistent with prior year results, FY 2022-23 IMR-R results indicated the achievement of important improvements in minimizing symptom distress and impairment while also increasing knowledge, coping skills, and progress towards personal goals, which help to maintain benefits and minimize risk of future symptom recurrence.

Wellness Survey Questionnaire

The ADAPT Wellness Survey is a self-report tool administered to participants upon enrollment into ADAPT and then every 90 days thereafter. Survey items were rated on a scale from 1 to 5, with higher values representing better reported wellness.

During FY 2022-23, self-reported improvements occurred across multiple dimensions with statistically significant changes occurring for ratings of quality of life, physical health, mental health/mood, satisfaction with social activities/relationships, ability to carry out everyday activities, emotional problems, sleep, and fatigue (see Table 7). Notably, ratings of hopefulness about the future also improved substantially as well as belief that they have the skills and resources needed to manage stress related to interpersonal conflicts. Findings from FY 2022-23 were similar to those identified during FY 2021-22.

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

	FY 2022-23			FY 2021-22		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
		Scale of 1 to 5 where higher value = better condition			*Scale of 1 to 5 where higher value = better condition*	
In general, would you say your quality of life is:	72	3.1	3.3*	65	3.2	3.5**
In general, how would you rate your physical health?	71	2.8	2.9	65	2.9	3.2*
In general, how would you rate your mental health, including your mood and your ability to think?	71	2.2	3.0**	65	2.3	3.1**
In general, how would you rate your satisfaction with your social activities and relationships?	70	2.6	3.1**	65	2.5	3.1**
In general, please rate how well you carry out your usual social activities and roles.	72	3.0	3.4**	65	3.0	3.4**
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	72	4.0	4.5**	65	3.8	4.2*
How often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?	72	2.4	3.2**	65	2.3	3.2**
My child(ren) had emotional and/or behavioral problems.	51	4.1	4.0	48	3.9	4.0
I felt hopeful about the future.	72	3.6	4.1**	65	3.7	4.0^
I felt spiritually connected.	72	3.4	3.7*	65	3.6	3.8
I lived in a home that made me feel safe.	72	4.6	4.7	65	4.6	4.7
I used substances (alcohol, illegal drugs, etc.) too much.	72	4.8	4.8	65	4.9	4.9

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

	FY 2022-23			FY 2021-22		
		Initial Asmt.	Last Asmt.		Initial Asmt.	Last Asmt.
Select Wellness Survey Items	**N**	**Mean**	**Mean**	**N**	**Mean**	**Mean**
		Scale of 1 to 5 where higher value = better condition			*Scale of 1 to 5 where higher value = better condition*	
How would you rate your fatigue on average?	72	3.0	3.4**	65	2.8	3.3**
I get the emotional help and support I need from supportive others.	72	3.5	3.8	54	3.6	3.8
When I am in distress, I can identify supportive others and may use my supportive others.	72	3.6	3.8	54	3.9	4.1
Conflict with my partner or supportive others interferes with my ability to respond to everyday life challenges.	72	3.7	3.9	54	3.5	3.8
I have the skills and resources needed to manage stress stemming from conflict with my partner or supportive other.	72	3.3	4.0**	54	3.6	4.1**
	N	**Mean**	**Mean**	**N**	**Mean**	**Mean**
		Scale of 1 to 10 where higher value = worse condition			*Scale of 1 to 10 where higher value = worse condition*	
How would you rate your sleep?	72	5.5	4.7*	54	5.8	2.6**
How would you rate your sense of rest?	72	6.0	5.0*	54	6.0	2.6**
How would you rate your alertness?	72	3.8	3.3	54	4.1	2.5
How would you rate your pain on average?	72	2.9	2.3	65	3.5	2.9**

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

ADAPT Participant Feedback Survey

Every 90 days and at discharge, ADAPT participants were asked to rate the extent to which they were achieving specific ADAPT objectives. For FY 2022-23, 100% of participants indicated they knew where to get help and 92.9% indicated they were better able to handle things because of participating in ADAPT (see Table 8). Further, participants were extremely positive about their experiences. At least 95% indicated that services were available at convenient times, they were able to receive all services needed, that staff were sensitive to cultural background, and they were satisfied with services. These findings, particularly as related to service availability and cultural support, indicate that the ADAPT program has accomplished the goal of connecting with participants and meeting their needs in a manner which is convenient for and respectful of the participants.

Table 8. ADAPT Participant Feedback Survey

	FY 2022-23 (N=70)	FY 2021-22 (N=65)
ADAPT Participant Feedback Survey Item	Agree/Strongly Agree	Agree/Strongly Agree
***As a result of participating in ADAPT*:**	%	%
I know where to get help when I need it.	100%	93.8%
I am more comfortable seeking help.	95.8%	92.3%
I am better able to access services in the community.	89.9%	90.8%
I am better able to handle things.	92.9%	92.3%
Experiences with ADAPT services:	%	%
Services were available at times that were good for me.	95.7%	98.4%
I was able to get all the services I thought I needed.	97.2%	98.4%
Staff were sensitive to my cultural background (race, religion, language, etc.).	98.5%	98.4%
Overall, I am satisfied with the services I received here.	100%	98.4%

In June 2023, the UCSD evaluation team and ADAPT leadership developed a series of questions with BHS input to elicit additional feedback about the program from participants. A total of 20 program participants provided feedback. Given that this information was collected from a sample of people receiving services at one particular time during the FY, the findings may not reflect the perceptions of all ADAPT participants. Additionally, it should be noted that the interviews were conducted by ADAPT program staff and therefore could be positively biased. However, many of the findings were consistent with data collected in prior years and via other feedback mechanisms such as the ADAPT Participant Feedback Survey administered throughout the year, which increases confidence in their generalizability to the overall ADAPT program.

Many respondents (65.0%; n=13) indicated that they had not received services and/or medication to help with mental health or substance use related concerns in the five years prior to ADAPT participation. For some clients, the peripartum depression and anxiety symptoms experienced may be their first mental health challenges that rose to the level of needing intervention. For others, they may have had difficulty with or discomfort seeking services for symptoms in the past. Regardless of past need or level of usage, participants noted that ADAPT offers timely support and mental health resources. Nearly all respondents (90%; n=18) said they would refer a friend or family member to ADAPT. They described how the program helped them, so it could help others as well. One participant stated, “I have had the best experience here. My therapist really cares and always advocates for me.”

The following sections present key themes that emerged from the qualitative participant responses.

The ADAPT Program was Different from Prior Treatment Experiences

Clients shared feedback about ADAPT as compared to services they had received previously. A selection of comments are as follows:

> "I have a peer support partner which is less formal and is comfortable for me. She also comes to my home which is different."
>
> "The consistency of meeting with someone weekly was super helpful. Also, I would not have been able to afford care like this on my own. I am so grateful to have gotten this counseling at no cost!"
>
> "ADAPT staff cares. My therapist went above and beyond. The support felt different."
>
> "The postpartum specialization is different, and I've never had the option for the peer support aspect. I also like the ability to call my therapist if I needed to."

Client Preferences for In-Person and Telehealth Services Vary

When ADAPT began in FY 2019-20, services were primarily provided in person. Due to the onset of COVID-19, there was a rapid shift to remote services (i.e., telephone or telehealth with video). As safety demands of COVID-19 have decreased, clients have had more opportunities for in-person visits when desired. When asked about their preference between the available options (i.e., in-person vs. remote), respondents answered as follows:

- 10 respondents (50.0%) stated they prefer only/primarily remote services
- 6 respondents (30.0%) indicated they prefer having both remote and in-person services
- 3 participants (15.0%) stated they prefer only/primarily in-person services

The primary reason for preferring remote services was convenience. Others preferred telehealth due to the flexibility and/or other obligations, for example, "The convenience of having my baby near in case she needs me while being able to pay full attention to the session." Clients who appreciated the choice between in-person and remote services shared, "Because sometimes it's more flexible to meet via zoom" and "Video calls are convenient when I'm busy. It's also nice seeing my peer support partner in person." For the remaining clients, they found in-person services to be more attentive and personable. As one client who preferred in-person services shared, "I find meeting with someone in person more personable and it's also easier for me not to get distracted."

This feedback highlighted the importance of ADAPT program flexibility and ability to personalize how services are provided to specific participants.

Positive Impact of ADAPT on Clients

All 20 of survey respondents (100%) stated that ADAPT has had a positive effect on their life. Impacts included improved communication skills, emotion management, relationships, and better understanding of themselves and/or others. Responses included the following:

"I have learned so many helpful tools to manage the extreme emotions from postpartum. This has helped my marriage immensely and given my husband and I the tools to work through our stress and be better partners and parents."

"Being part of the program helped me understand myself better which has improved my relationships. I learned about my attachment style, how to show myself self-compassion, and I feel like I have better skills as a mom with multiple children."

"I have overcome my trauma and learned how to respond to stress and challenges in a healthier way. I have a better relationship with my [family]."

Other clients mentioned a new awareness of community resources. Furthermore, they felt heard and supported based on their experiences in ADAPT.

Participant Recommendations

More than half (55.0%; n=11) of the survey respondents offered no recommendations to improve the program and were happy with it as is. Approximately 15.0% (n=3) suggested that to improve ADAPT, the length of program should be extended. Other suggestions were about increasing options for electronic communication, specifically the desire to be able to text their therapist or for there to be an app to keep track of appointments (as well as cancel or reschedule appointments). As one participant shared, "I've tried mental health services that had their own app and that could be helpful to have everything contained in one place. I could message my therapist, log in to my sessions and have even more security, even though that is not something I worry much about." Another participant suggested that ADAPT should be "accessible to all new moms…having it as an option after childbirth and getting new moms enrolled right away."

Referral Partner Feedback Survey

In June 2023, PHNs and other referral partners were asked to complete a brief online survey to obtain feedback regarding their experiences with the ADAPT program. Survey questions were largely open-ended and served to explore referral partners' understanding of the ADAPT program and elicit recommendations for program improvement. A total of 108 referral partners (e.g., PHNs and representatives from seven other service providers) were invited and 42 completed the online survey for an overall response rate of 38.9%. At the organizational level, 87.5% of organizations had at least one respondent complete the survey. While the response rate for individuals may warrant some caution when interpreting the results, the core themes (presented below), were consistent with feedback received in prior years and from other feedback mechanisms such as through the PHN consultations and roundtables. Those who did participate generally had an ongoing relationship with the ADAPT program with the majority (71.4%; n=30) indicating they had referred at least three clients and 47.6% (n=20) having referred 6 or more clients to ADAPT in FY 2022-23. Responding referral partners represented public health programs (71.4%; n=30), local hospitals and clinics (14.3%; n=6), and other community agencies (14.3%; n=6). While the sample sizes were too small for detailed comparisons and conclusions, in general, the feedback was similar between the types of referral partners. Several themes emerged from the referral partners' feedback.

Increased Access to Care

Almost all respondents (97.6%, n=41) mentioned that the ADAPT program has helped to ensure that their patients are connected to appropriate mental health services and significantly increased overall support for patients (92.9%; n=39). Specifically, referral partners most commonly selected "opportunities/availability for case consultation," (83.3%; n=35) and "increased mental health competency for nurses through education, consultation, and/or collaboration" (57.1%; n=24) as the key ways in which a partnership with ADAPT has enhanced their ability to serve clients. In addition, referral partners noted the ease of the ADAPT program's referral process.

Desire for Expanded Eligibility

Given the overall success of clients who engage with ADAPT services, in the prior fiscal year (2021-22) many referral partners expressed a desire to have wider eligibility requirements for the program. This theme emerged again in the FY 2022-23 survey, with 33.3% (n=14) of referral partners mentioning private insurance as a barrier to services. One referral partner remarked that ADAPT "only accepts Medi-Cal and we receive many referrals for individuals with private or dual insurance."

Program Benefits

The majority of referral partners highlighted "care coordination" (71.4%; n=30) followed by "communication with ADAPT providers," (52.4%; n=22) and "the referral pathway" (52.3%; n=22) as aspects of the ADAPT program that were working particularly well. Referral partners shared that their clients have had positive feedback about ADAPT:

> "My clients who stick with the program find it very helpful with managing symptoms of anxiety and depression."

Referral partners also shared what they perceived as potential negative impacts of not having a program like ADAPT available:

> "Negative impact on clients, some may be able to get care through their medical provider, but the ability to offer a resource specific to their needs in relation to maternal-child health and interactions is a comfort on its own. If their provider isn't able to assist, having ADAPT is an additional safety net for them and gives them some comfort just knowing its available to them."

> "If ADAPT services were no longer available, it would be very difficult to find an accessible resource for our clients. It is challenging to find and contact other local resources in a timely manner regarding service availability and eligibility, the partnership that ADAPT has with our programs has been such a big help."

PHN survey respondents, in particular, highlighted the benefits of participating in ADAPT with 86.2% (n=25) indicating that the ADAPT program helped with reducing the mental health symptoms of their clients.

Program Challenges

Lack of participant buy-in (i.e., openness to services, willingness to participate, motivation) was the most prominent challenge among referral partners (47.6%, n=20), followed by barriers to engagement (i.e.,

transportation, childcare, accessibility issues) (35.7%, n=15), and clients not knowing or understanding requirements (28.6%, n=12). Referral partners acknowledged the importance (and challenges) of coordinating communication and follow through after they submit a referral to ADAPT. They also requested expanded eligibility and an extension of the program service time. In terms of service, referral partners recommended that more in-person visits be allowed and that clinicians can receive and return texts from clients.

Additional Program Activities

Community Resources and Engagement

Support of Public Health Nurses

ADAPT continued to provide support to the PHNs by providing 219 case consultations in FY 2022-23. During these case consultations, ADAPT clinicians and Peer Support may provide PHNs with care coordination regarding participants goals, progress, gains, and identified needs; education and collaboration on ways in which providers can work together to meet participant goals; psychoeducation on participants behavioral health symptoms, impairments, and state change; and plan of care updates and collaboration. In addition, consultations may include programmatic eligibility and treatment recommendations. ADAPT also facilitated six Mental Health Roundtable training opportunities for PHNs. Presentation topics included the following: the Peer Support role at ADAPT, including the importance of this role, collaborative role characteristics, education, and examples of case conceptualizations; a training entirely in Spanish, facilitating a dialogue regarding culture, language, and mental health; a case consultation opportunity, review of PMADs, and review ADAPT services; a case consultation opportunity, review of Peripartum Treatment Programs and Services, SUD and the Peripartum Period, and ADAPT referral process; Training on PMADs and Sleep and Light intervention; and a training on Art Therapy, the power of art, experiential practice, and reflection.

Community Outreach to Increase Awareness of ADAPT

In addition to regular communication with PHNs and periodic "roundtables" to allow for greater education about ADAPT and provide opportunities for asking questions of ADAPT team members, ADAPT representatives attended community meetings and presented information about ADAPT to other potential referrals sources including: the Postpartum Health Alliance, Perinatal Care Network at 2-1-1 San Diego, San Diego Workforce Partnership, YMCA, Neighborhood House Association, Black Infant Health, American Academy of Pediatrics, First Five First Steps, Sharp Mary Birch, and Best Start among others. These efforts to enhance community partnerships directly support the ADAPT scope of work and resulted in a total of 274 referrals to ADAPT during FY 2022-23 (193 from PHNs and 81 from other community organizations).

Connection to Community Resources

ADAPT helps participants connect to and navigate community resources that both increase their immediate quality of life as well as work toward future goals. For example, ADAPT helped participants to obtain necessary baby care items, including baby formula, laundry detergent, diapers, pacifiers, baby wipes, swaddles, and baby soothers from donation funding through Vista Hill. A recipient shared, "I've been so stressed about financial stuff and working full time is still hard to make ends meet. I just feel so

thankful and it's such a relief to have these things for my son." One participant was provided with a multi-motion baby swing and others were given gift cards to address basic needs like groceries. ADAPT helped participants connect with clothing resources for older children and professional clothing for job interviews, emergency food supplies and hygiene items. Another participant successfully accessed childcare resources with ADAPT support and is working towards gaining employment.

Housing resource connections were another area of assistance. For example, a new Level 1 participant shared significant distress surrounding housing insecurity at admission. The participant was immediately provided with multiple resources to access housing and support their goals in this area. Within a week, the participant was able to contact, apply, and access housing services with Home Start. Other participants received assistance with applying for housing vouchers and/or rental assistance such as that offered by San Diego Housing Commission.

Another notable community connection was made with the Chula Vista Ladies Quilt Guild who provided ADAPT with handmade quilts for participants. Additionally, the ADAPT team worked to assemble holiday gift donations for participants as well as participant's children. The staff supported many families with limited economic resources through providing access to meaningful gifts and by delivering the gifts to the participants. ADAPT staff reported experiencing great joy while supporting participants during the holiday season.

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

The SALI community-academic research partnership continued throughout FY 2022-23. SALI is a brief (two-week), non-pharmacological, in-home intervention that utilizes a one-night adjustment in the timing and duration of sleep. The adjusted sleep night is coupled with two weeks of a 30-minute per day light therapy box session at a specified time to reset circadian rhythms and reduce perinatal depressive symptoms. This protocol has demonstrated high levels of fast-acting and durable effectiveness at treating perinatal depression in research settings.

As part of an effort to move SALI into community settings, the pilot research study led by Drs. Barbara Parry and David Sommerfeld from the UCSD Department of Psychiatry is designed to test the feasibility, acceptability, and effectiveness of training community providers to deliver SALI. ADAPT participants are informed of the opportunity to participate in SALI as an additional strategy to address their depressive symptoms and are given the choice as to whether they would like to enroll in the pilot study of the SALI for treating peripartum depression. This study was approved by County BHS and the UCSD Institutional Review Board (IRB) and administered by ADAPT clinicians. The study is ongoing with initial results indicating meaningful improvements in mood and sleep, with the benefits persisting even for those experiencing a range of significant psychosocial stressors. Additionally, feedback from staff indicated that it is feasible to integrate SALI into usual care practices and that participants were able to successfully complete the steps of SALI. The first night of adjusted sleep was challenging for some, so the UCSD and ADAPT team collaborated to develop a "Mom's Night In" resource document intended to help women develop a plan for engaging in pleasant self-care activities during the one night of adjusted sleep. The findings to-date suggest that SALI is a feasible and effective treatment approach for addressing peripartum depression within community care settings. The information learned from this study is expected to inform future widespread dissemination of SALI to other community care providers and programs that treat perinatal depression.

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual ADAPT Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, ADAPT, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual ADAPT Staff Survey was a brief online questionnaire conducted at the end of FY 2022-23 inquiring about experiences with, perceptions about, and recommendations for the program. Of the 13 ADAPT staff invited to participate, 12 completed a survey for a response rate of 92.3%. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes.

Program Strengths

Team and Leadership

When asked about strengths of the ADAPT program, nearly every staff member mentioned the quality of the team and leadership. Staff described the team as “dedicated" and highlighted the team’s willingness to “adapt to the individual and nuanced needs of our participants.” Another staff member shared that “The ADAPT program has great supervision provided to the clinicians and the team is very supportive of personal growth and learning. The team also supports clients and ensures continuity of care.”

Flexibility

The flexibility of the ADAPT program was also noted as a strength. As one staff member described, “The flexibility of being able to work remotely/hybrid has been really helpful in being able to reach and provide services to more individuals.” Others mentioned the uniqueness of ADAPT in this respect; the flexibility offered is not typically characteristic of mental health service agencies. As one staff member stated, “clinicians can use Telehealth which gives them more flexibility for scheduling client sessions.”

Accessibility

Since the start of the COVID-19 pandemic, staff have found unique ways to meet with participants while ensuring safety. Appointments are set up via telehealth, outdoors with social distancing, or via the phone. ADAPT staff arrange times to drop off tangible items such as diapers, formula, and other necessities without face-to-face contact.

Staff credited this accessibility as a key component of program success and contributing factor their ability to reach more participants. Offering both telehealth and in-person services has been beneficial to both staff and participants. Offering bilingual services, both from clinicians and peer partners, was highlighted as another key component of successful recruitment and retention. As one survey respondent remarked, “Flexibility and availability to meet participant needs including but not limited to hybrid remote positions, efforts to hire and recruit Spanish-speaking clinicians, and advocating for both internal forms and partnerships to include Spanish-speaking participants.”

PHN and ADAPT Program Coordination

Compared to FY 2021-22, ADAPT staff during FY 2022-23 describe the positive collaboration between themselves and PHN. One staff member noted the benefits of PHNs gaining more “knowledge of ADAPT

services and scope of practice." Another staff member shared the advantages of PHNs engaging and communicating with clients "if clients are not engaging" in ADAPT services.

Program Challenges

Staff reported waitlists for services, documentation requirements, and ineligible referrals among key challenges for the program. Other challenges mentioned by staff included resource awareness of community programs, client engagement, and telehealth access issues.

Resource Awareness

Although one staff member stated that the team "all pulled from one another's knowledge regarding resources in San Diego to support our clients," to assist with the processing of ineligible referrals, other staff members noted the need for increased knowledge of community programs. For instance, one staff member stated that "connection with housing, childcare, and employment/school resources," was a major challenge in providing and continuing services. Another staff member shared the following:

> "San Diego County programs are impacted heavily so it is very difficult for people to get the resources that they need. Housing is impacted. Childcare is impacted or costs too much and financial assistance is very difficult to maneuver and obtain. Low-income housing is still too expensive for mothers who don't have jobs and don't have anyone to watch their children to get jobs."

Engagement

As was the case in prior years, efforts by ADAPT staff to keep participants and referral partners engaged in the program have been substantial. Staff reported frequent and consistent communication and scheduling flexibility as two key components in retention. Several staff mentioned the potential benefit of expanding allowable communication methods to include texting and e-mailing clients.

One unique aspect of ADAPT is the inclusion of family members in the treatment process. As the participant must approve of included family members, one staff member pointed out the importance of engaging "family members in a variety of case management and counseling avenues." Other staff added that it is good practice to invite key support people for a session with the client and explain to them the many facets of pregnancy and motherhood physically and emotionally. However, not all clients have familial support, as one staff member noted, "Many of our clients don't have support from their family members or their family members are a source of conflict and trauma. I've also had clients who are supported by their family but are not interested including them in their treatment goals." Another survey respondent suggested "offering psychoeducation handouts or worksheets that the participant can use with their family members. psychoeducation for clients on how to discuss mental health and treatment with family members."

Telehealth

Based on FY 2022-23 survey responses, the majority of staff liked providing telehealth services. While the telehealth option does come with some challenges, staff reported that internet interruptions disrupted services less than 10% of the time. ADAPT staff facilitated efforts to successfully keep clients connected to telehealth services which included searching for a location with sufficient connectivity and/or "hotspots" if maintaining an internet connection is difficult and/or helping clients navigate technological

steps for accessing telehealth services. Where telehealth was not feasible or desirable, ADAPT provided in-person services. Despite these challenges, staff perceived numerous benefits of providing telehealth service options to clients; for instance, one staff member shared that delivering "services via telehealth has allowed the clients to meet more consistently with their therapist for sessions."

ADAPT Staff Recommendations and Additional Feedback

Several survey respondents shared a desire for more support and educational materials. ADAPT staff would like more opportunities for training, including perinatal and peripartum mental health, Eye Movement Desensitization and Reprocessing (EMDR), and Dialectical Behavior Therapy (DBT). The staff also suggested the need to increase administrative support to assist with the documentation requirements. As one staff member stated there are "…changes to documentation and various role's responsibilities. Clarity around these changes and requirements that is actually consistent would allow us to carry out our duties more smoothly." To reduce turnover, staff recommended wage increases, hiring additional peer support, extending the length of the program, and updating program policy to allow texting and e-mailing clients.

Changes from Initial Program Design

There were no significant changes to the overall design or strategy of how ADAPT services were provided during FY 2022-23. The ADAPT program continued to engage in community outreach activities to expand the number of potential community referral partners and increase the network of organizations that can provide additional supplemental resources for ADAPT clients.

Program Recommendations

1. Extend the expected duration of services beyond six months, as peripartum depression typically occurs during pregnancy and for up to at least a year post-pregnancy.
2. Update privacy practices to better match participant preferences for communication and improve accessibility by allowing engagement through text, alert systems and/or mobile applications.
3. Increase funding to support staff retention and minimize staffing turnover which disrupts continuity of care and relationship-building. Specifically, resources are needed to reduce staff travel burden and increase training opportunities.
4. Continue community outreach to support communication and collaboration with existing and new referral partners to promote awareness of ADAPT and identification of appropriate referrals.
5. Develop a triage, case management/care coordination program specially designed to support individuals getting connected to the best fit services and align with "no wrong door" policy, particularly for those referred to, but not eligible for, ADAPT services.
6. Reduce administrative burden and non-billable activities by updating policies to allow for strategic utilization of technologies such as DocuSign to improve efficiency and accessibility.
7. Continue emphasis on participant "choice and voice" in how services are provided and continue refinement of hybrid service provision models that integrate in-person and remote (e.g., telehealth) interactions.

Conclusion

During FY 2022-23, enrollment into ADAPT continued to increase with over 100 (n=103) participants enrolling into ADAPT Level 1 services. The number of PHN referrals, drastically lessened during the pandemic, are now on a rising trajectory. Additionally, ongoing outreach efforts to increase awareness of ADAPT throughout the County of San Diego have strengthened the referral network and led to more client connections.

Both clinician and participant assessments indicate that after participating in ADAPT, individuals experience substantial reductions in depression and anxiety symptoms and improve their ability to manage their emotional well-being. ADAPT services also attend to the well-being of participating families by directly providing or facilitating connections to additional resources that allow families to better care for their children and address basic needs related to food, clothing, shelter, and employment. Other reported improvements include better social relationships and ability to handle daily activities, as well as better sleep and less fatigue. High levels of satisfaction were reported by participants and echoed by PHNs, who report substantial benefits for their ADAPT-enrolled clients as related to improvements in their mental health and enhanced ability to manage life challenges. Both participants and PHNs highlighted the importance of having ADAPT, a program that specializes in the unique needs of pregnant and postpartum women experiencing depression, in the community.

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

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Appendix

Characteristics of Participants Who Enrolled During FY 2022-23

Characteristic	Total Participants (N=110)	
Gender	**n**	**%**
Female	109	99.1
Male	1	0.9
Total	**110**	**100**
Age Group	**n**	**%**
18-25	47	42.7
26-35	46	41.8
>35	17	15.5
Total	**110**	**100**
Primary Language	**n**	**%**
English	87	79.1
Spanish	19	17.3
Other/Missing/Prefer not to answer	4	3.6
Total	**110**	**100**
Race/Ethnicity	**n**	**%**
African American	13	11.8
American Indian	7	6.4
Asian	7	6.4
Hispanic/Latino	69	62.7
White	36	32.7
Multiple	20	18.2
Other	2	1.8
Total[1]	-	-
Sexual Orientation	**n**	**%**
Heterosexual or Straight	97	88.2
Bisexual/Pansexual/Sexually fluid	10	9.1
Another sexual orientation/Missing/Prefer not to answer	3	2.7
Total	**110**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

Appendix (continued).

Characteristic	Total Participants (N=110)	
Military Status	**n**	**%**
Never served in the military	107	97.3
Other/Missing/Prefer not to answer	3	2.7
Total	**110**	**100**
Disability	**n**	**%**
Yes, has a disability	18	16.4
No, no disability	90	81.8
Prefer not to answer	2	1.8
Total	**110**	**100**
Type of Disability	**n**	**%**
Learning Disability	6	5.5
Physical Disability/Chronic Health	8	7.3
Other Physical Disability	10	9.1
Other Mental Disability	<5[3]	<4.5
Total[2]	-	-

[2] *Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.*
[3] *Values were suppressed due to small n size.*

BHCONNECT INNOVATIONS-19

Annual Report (7/1/2022 - 6/30/2023)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

v.12.22.2023

UC San Diego

Table of Contents

Executive Summary..1
Program Description......................................4
Participant Characteristics..............................5
Referrals for BHConnect Services.........................5
Utilization of Program Services..........................5
Primary Program Outcomes.................................7
BHConnect Participant Feedback..........................12
Additional Program Activities...........................13
BHConnect Referral Partner Feedback.....................14
Primary Implementation Findings.........................15
Changes from Initial Program Design.....................18
Conclusion..18
Appendix..19

Executive Summary

Program Overview

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Telemental Health program (commonly known as BHConnect) focuses on persons who have received crisis-oriented psychiatric care services, but are otherwise unconnected to behavioral health treatment services and identified as likely having barriers to accessing traditional outpatient services. The goal is to reduce the recurrence rate for psychiatric crisis services among these individuals by offering an alternative method of care that relies primarily on telehealth treatment. BHConnect provides clients with the technology necessary to maintain contact with telehealth professionals, such as a tablet or phone equipped with built-in internet access. The BHConnect service provider team is comprised of: 1) licensed and associate clinicians who provide therapeutic care services, and 2) Health Navigators who support the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed. BHConnect provides services to children, youth and families (CYF) and adults/older adults (AOA).

During fiscal year (FY) 2022-23, a determination was made by BHS that the BHConnect program would not continue past the Mental Health Service Act (MHSA) Innovations-funded phase of the pilot program. While recognizing the benefits of the treatment services provided to BHConnect clients, primary reasons for not continuing BHConnect included less than expected enrollment and the greater availability of telehealth services throughout the overall network of BHS-funded treatment service providers. BHConnect stopped enrolling new clients at the end of FY 2022-23 and will focus on completing treatment and/or transitioning care to other service providers during the first part of FY 2023-24.

Primary Findings for Fiscal Year 2022-23

BHConnect Enrollment, Referrals, and Referral Partners

1. During FY 2022-23, a total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients). This represented an increase of approximately 25% in total new enrollments from FY 2021-22. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served by BHConnect in FY 2022-23. While

BHConnect enrollment increased from the prior year, it remained below initial program targets of 250 persons served each year.

2. From FY 2021-22 to 2022-23, BHConnect referrals from community partners increased 40.2% (256 to 359). Referrals for CYF clients increased 36.8% (117 to 160) and AOA client referrals increased 43.2% (139 to 199).
3. Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 17 different organizations (7 CYF and 10 AOA) referred at least five clients to BHConnect compared to 12 organizations in FY 2021-22. Many of these referrals (34.7% of CYF and 45% of AOA referrals) enrolled into BHConnect. If enrollment was unsuccessful, the primary reason was that BHConnect was unable to contact the person.
4. BHConnect prioritized a quick response to client referrals, with 31.7% of persons enrolled within one day and over half (51.1%) of persons enrolled within five days of referral.

BHConnect as an Important Community Resource

5. As indicated in the referral partner feedback survey, BHConnect was perceived to be an important resource by their referral partners throughout San Diego County. Respondents to the Referral Partner Survey highlighted the ease of the referral process, the immediacy of available services, and the minimal (if any) waitlist, which is key in a community where waitlists, transportation, and insurance coverage are significant barriers to those who need services. As one partner noted, “there are other referral options, but they come with longer waitlists and other barriers” and another stated “BHConnect fills a gap in services and overcomes barriers that already exist in which services delivery is compromised.”
6. Similarly, respondents in the Participant Survey noted the high quality of services offered by BHConnect. Participants particularly valued the capability of receiving help remotely. Clients highlighted the convenience of telehealth, as childcare and/or transportation barriers are alleviated. Clients stated that they would delay or not seek out treatment if they did not have access to BHConnect services.

BHConnect Program Engagement and Service Delivery Patterns

7. When BHConnect enrollment was unsuccessful, the primary reason was that the program was unable to locate/contact the person (25.6% of CYF and 42.7% of AOA referrals). For both CYF and AOA referrals, only about 16% declined to participate (21.9% and 11.1%, respectively), suggesting a high degree of interest in participating in BHConnect once contact has been initiated. In an effort to increase the number of clients that BHConnect is able to directly engage as part of the referral and recruitment process, during FY 2022-23 BHConnect established an on-site presence at Sharp Mesa Vista to facilitate “warm handoff” from crisis care to outpatient treatment. This practice of co-locating with potential referral sources was originally part of the design of BHConnect, but was terminated at the onset of the COVID-19 pandemic.
8. Individuals, both youth and adult, who enrolled in BHConnect typically participated for about four months. These findings indicate that BHConnect was frequently able to maintain persons in treatment once they have established an initial therapeutic relationship.

9. CYF clients and AOA clients were provided an average of 4.2 and 4.5 BHConnect services per month (i.e., every 30 days enrolled in BHConnect), respectively. This represented a 20% increase for CYF clients and a 5% increase for AOA clients from the prior year.

BHConnect Program Outcomes and Participant Perceptions

10. Service utilization patterns (described in more detail below) indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services as evidenced by fewer inpatient psychiatric hospitalizations, particularly among AOA clients (e.g., 37.5% of AOA clients had psychiatric hospitalizations in the 90 days prior to enrolling in BHConnect compared to less than 6.3% with psychiatric hospitalizations in the 90 days after enrolling in BHConnect). Additionally, decreased crisis stabilization and Psychiatric Emergency Response Team (PERT)/Mobile Crisis Response Team (MCRT) contacts were evident among CYF clients after enrolling in BHConnect.

11. For clients with assessment data at both intake and follow-up, many youth and adult clients had improvements in well-being and symptom management identified via clinician and self-reported assessments. Nearly half of parents and caregivers reported medium or large improvements in impairment after participation in BHConnect, and another 21.4% reported at least a small improvement. Similarly, adult clients reported significant improvements in illness management and recovery, with lessened need for psychiatric hospitalizations and increased ability to participate in structured roles (i.e., work, student, parent).

12. The target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remained a challenge to serve. However, based on feedback from BHConnect CYF and AOA clients, the BHConnect program accomplished the primary goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services.

Conclusion

During FY 2022-23, a total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients). To facilitate referrals, BHConnect engaged in outreach efforts including meeting with representatives of potential partner organizations to educate them about available services and develop processes for identifying and screening potential clients. Additionally, they continued to build upon and expand their referral partner network by giving presentations at multiple community service provider meetings to increase awareness of BHConnect services. These efforts were reflected in a 25% increase in total new enrollments from FY 2021-22. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served in FY 2022-23; however, this remained below initial program targets of 250 persons served each year.

Once enrolled in BHConnect and receiving services, both CYF and AOA clients remained in care and typically engaged with BHConnect for approximately four months. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. Additionally, an examination of the data from the electronic health record system that documents participation in county-funded BHS programs indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services. Both youth and

adults experienced fewer inpatient psychiatric hospitalizations after enrolling in BHConnect, and youth also had fewer crisis stabilization visits and PERT/MCRT contacts after engagement with BHConnect.

However, the target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remains a challenging population to serve with many demonstrating a need for further behavioral health improvements. Homelessness, symptom complexity, attrition and difficulties with electronic devices were identified as barriers in maintaining consistent contact with clients and maintaining engagement in services.

Overall, the BHConnect program continued to experience significant growth during FY 2022-23, but did not reach the intended goal of providing services to at least 250 unduplicated clients. While acknowledging the accomplishments of BHConnect to engage and provide treatment to a population of persons who were previously unconnected to care, BHS determined during FY 2022-23 that the BHConnect program would not continue past the conclusion of the Innovations-funded phase of the pilot program. Primary reasons for not continuing BHConnect included less than expected enrollment into the program and the greater availability of telehealth services at other outpatient treatment programs throughout the BHS system than when BHConnect started.

Program Description

The County of San Diego BHS BHConnect program is funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). Services are provided through the Vista Hill community-based organization. BHConnect was developed to increase access and connection to follow-up behavioral health services after a psychiatric emergency in which a San Diego resident utilized a psychiatric hospital, emergency screening, and/or crisis response services. MHSA INN funding for the BHConnect program ended on 10/31/2023 with the remaining client caseload transitioning to other service providers.

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

The BHConnect service provider team is comprised of licensed and associate clinicians who provide therapeutic care services as well as Health Navigators who support the clinical team by maintaining engagement and communication with clients and providing other care management and supports to clients as needed. Services are offered on a telehealth platform, after an initial onsite evaluation by a case manager. To facilitate better access to care services, BHConnect provides clients with the technology necessary to maintain contact with telehealth professional. Clients may install a communication app on an existing personal device, or the program will provide a phone/tablet to use while receiving BHConnect services that is equipped with built-in internet access and the communication app. Clients receive a full tutorial on how to use the technology, as well as assistance with in-home setup prior to being connected with a behavioral health professional.

Participant Characteristics

A brief overview of the BHConnect participant characteristics is presented here with a more complete listing in the report appendix. The BHConnect program provided mental health outpatient treatment services to clients of all ages through both the CYF and AOA BHS service systems. During FY 2022-23, a total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients). This represented an approximate 25% increase in total new enrollments from FY 2021-22. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served by BHConnect (a 40% increase from FY 2021-22).

Referrals for BHConnect Services

BHConnect received a total of 359 referrals from community referral partners during FY 2022-23, which represented a 40.2% increase from the prior year (n=256). The growth in referrals was due to receiving substantially more CYF and AOA referrals. From FY 2021-22 to 2022-23, CYF referrals increased 36.8% (117 to 160) and AOA referrals increased 43.2% (139 to 199).

A total of 13 different organizations referred CYF clients to BHConnect. Consistent with prior years, Rady Children's Hospital was the primary referral source with 77 referrals coming from either the emergency room or behavioral health urgent care. Other prominent CYF referrals sources that emerged during FY 2022-23 included the SmartCare and Child and Adolescent Psychiatry Services with 27 and 18 referrals, respectively. Many of these referrals enrolled into BHConnect (45%).

A total of 20 organizations referred AOA clients to BHConnect with over 35% (37.2%; n=74) originating from Sharp Mesa Vista. Additional primary referrals sources included Adult Protective Services (n=24), SmartCare (n=15), Paradise Valley Hospital/Bayview (n=14), and Strength Based Case Management-Central/North (n=13). Overall, approximately 35% (34.7%) of these referrals enrolled in BHConnect.

Reflecting the efforts of the BHConnect program to expand the number of ongoing referral partners, a total of 17 different organizations (seven CYF and ten AOA) referred at least five clients to BHConnect during FY 2022-23 as compared to 12 organizations achieving this threshold in FY 2021-22.

For both CYF and AOA referrals, if enrollment was unsuccessful the primary reason was that BHConnect staff were not able to locate or contact the person based on the referral information (25.6% and 42.7% of all referrals, respectively). Only about 15.9% of all referrals declined to participate (21.9% CYF and 11.1% AOA), suggesting a high degree of interest in participating in BHConnect once contact has been initiated. During FY 2022-23 BHConnect re-established an onsite presence at Sharp Mesa Vista to facilitate rapid "warm handoffs" from the crisis care services into BHConnect for outpatient treatment. This practice of co-locating with potential referral sources was originally part of BHConnect operations, but was terminated at the onset of the COVID-19 pandemic.

Utilization of Program Services

BHConnect Services – Duration and Discharge Status

The BHConnect program was very responsive to referrals with 31.7% of persons enrolled within one day and over half (51.1%) enrolled within five days of the referral to BHConnect.

As shown in Table 1, of the 105 youth and 101 adults who were enrolled in BHConnect services during FY 2022-23, there were 50 youth and 47 adults still active in the program as of 6/30/2023. These persons were typically enrolled for approximately 4 months (i.e., median duration of 117.0 days and 130.0 days, respectively). Of the persons who discharged from BHConnect prior to 6/30/2023, the amount of time enrolled in BHConnect was similar (median of 126.0 and 106.0 for youth and adults, respectively), which suggests that the majority of both youth and adults stay connected with the program for at least 3 months.

Table 1. BHConnect Program Participation Duration and Discharge

	Youth (N=105)		Adult (N=101)	
	Still in program	Discharged	Still in program	Discharged
n (persons)	50	55	47	54
Mean (days)	173.2	236.7	187.7	154.7
Median (days)	117.0	126.0	130.0	106.0

BHConnect Services – Type and Amount

CYF clients and AOA clients were provided, respectively, an average of 4.2 and 4.5 BHConnect services per month (i.e., 30 days) (see Table 2). This represented a slight increase from the 3.5 and 4.3 average monthly services provided during FY 2021-22. For both CYF and AOA BHConnect clients, therapeutic sessions were the primary type of service contact. These sessions represented approximately 60% of all monthly service contacts (56.3% and 59.8%, respectively) with an average of 2.4 and 2.7 psychotherapy contacts provided to each CYF and AOA client each month. Conducting assessments and providing case management services as well as other forms of support such as working with collateral contacts were the other primary forms of interactions.

Table 2. Average Number of BHConnect Services Provided Per Month during FY 2022-23

	Youth (N=105)	Adults (N=101)
Type of BHConnect Service	Average Number of Services per 30 Days	
Any BHConnect service	4.2	4.5
Psychosocial assessment	0.5	0.5
Therapy	2.4	2.7
Rehabilitation	<0.1	0.3
Case management	0.7	0.8
Other services (e.g., collateral)	0.5	0.2

Primary Program Outcomes

Utilization of BHS Crisis and Acute Oriented Services

An examination of the BHS crisis and acute care service utilization patterns before and after enrolling in BHConnect can help identify the extent to which participation in BHConnect was associated with a reduced need for such services. The following analyses were accomplished by reviewing the electronic health record that documents participation in county-funded BHS crisis and acute care-oriented services during the 90 days before and after enrolling in BHConnect. To ensure equal 90-day observation periods for all persons, only clients enrolled at least 90 days prior to 6/30/2023 were included in the analysis. Of note, a limitation of these analyses is that they only include BHS-funded services, so any crisis services received outside the BHS system are not reflected. As such, the results presented in Table 3 should be interpreted cautiously as they do not reflect all services received, particularly for the youth population given that many received behavioral health-related care at Rady Children's Hospital Urgent Care.

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

	Youth (N=84)				Adult (N=80)			
	90 days before enrolling in BHConnect		90 days after enrolling in BHConnect		90 days before enrolling in BHConnect		90 days after enrolling in BHConnect	
	n	%	n	%	n	%	n	%
Inpatient Psychiatric Hospitalization	15	17.9%	<5[1]	<6.0%	30	37.5%	<5[1]	<6.3%
Crisis Residential	0	-	0	-	<5[1]	<6.3%	<5[1]	<6.3%
Crisis Stabilization	26	31.0%	7	8.3%	<5[1]	<6.3%	<5[1]	<6.3%
Urgent Outpatient	0	-	<5[1]	<6.0%	<5[1]	<6.3%	<5[1]	<6.3%
PERT/MCRT[2]	12	14.3%	6	7.1%	<5[1]	<6.3%	6	7.5%

[1] *Due to the small number of persons experiencing this service the exact number is masked.*

[2] *PERT = Psychiatric Emergency Response Teams; MCRT = Mobile Crisis Response Team*

Overall, the service utilization pattern for both youth and adult BHConnect participants demonstrated a reduced need for crisis and acute care services after enrolling in BHConnect. This improvement was particularly evident among inpatient psychiatric hospitalizations for adult clients, as 37.5% had at least one inpatient psychiatric hospitalization in the 90 days prior to enrolling in BHConnect while less than 6.3% utilized these services during the 90 days afterward. Reductions in hospitalizations, crisis stabilization visits, and PERT/MCRT contacts were also evident for youth participating in BHConnect. While these analyses only include BHS services and may therefore not reflect all crisis services received, the results suggest that participation in BHConnect helped to reduce the need for crisis and acute care services.

Child/Youth Assessments

Child and Adolescent Needs and Strengths

The Child and Adolescent Needs and Strengths (CANS) assessment is a structured tool used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In BHConnect, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 50 clients were enrolled at least six months and had a follow-up or discharge CANS completed during FY 2022-23 to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a "2" or "3" indicating a specific area that could potentially be addressed in the particular service or treatment plan. Table 4 shows the mean number of needs at initial assessment and last available assessment for the domains of child behavioral and emotional needs, life functioning, and risk behaviors. Overall, the findings indicated statistically significant reductions for all three CANS domains.

Table 4. CANS Average Change from Initial Assessment (N=50)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Behavioral/Emotional	2.6	2.0*
Life Functioning	2.9	2.3*
Risk Behaviors	0.8	0.6^

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

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a "2" or "3" at initial assessment to a "0" or "1" on the same item at the discharge assessment). As shown in Table 5, for each CANS domain, approximately 55-65% of the children and youth served by BHConnect experienced at least one reduction in a need item identified during the initial assessment.

Table 5. Persons with CANS Improvement at Follow-up (N=50)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Behavioral/Emotional	46	27	58.7%
Life Functioning	40	26	65.0%
Risk Behaviors	26	14	53.8%

The percent of persons with an improvement across these three domains was lower than what was reported in the FY 2021-22 Systemwide Annual Report for the overall County of San Diego CYF BHS for discharged clients, as approximately 75% of discharged clients had at least one improvement area. This

difference is likely due, in part, to the nature of the population served by BHConnect, which is comprised of youth who have had difficulty engaging in traditional outpatient treatment programs. Overall, client improvements on the CANS suggests that the BHConnect team was generally successful at engaging children, youth, and their families who had barriers to participating in treatment via telehealth, and achieving improvements in well-being at rates almost as high as those observed across the broader CYF service system.

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below in Table 6.

In FY 2022-23, the PSC-35 was administered at initial entry into BHConnect, at 6-month reassessment, and discharge. However, as a voluntary self-report tool, the completion rate at follow-up or discharge was lower than clinician-completed tools such as the CANS. A total of 28 caregivers and 29 youth in FY 2022-23 completed both a baseline and follow-up assessment. Table 6 shows that the majority of both parents and youth (60.7% of parents and 79.3% of youth) reported PSC total scores at entry into BHConnect that met or exceeded the PSC total score cut point for clinical concerns[1]. At follow-up, this had reduced substantially, particularly among youth, with 42.9% of parents and 37.9% of youth indicating PSC total scores that exceeded the clinical threshold. Likewise, an examination of mean score changes showed statistically significant reductions (i.e., improvement) in total PSC scores for both parents and youth. Among the PSC subscales, there were indications of improvements from initial Internalizing scores for both caregivers and youth. With the reduced sample sizes for completed self-report PSC assessments, the findings should be interpreted cautiously as they may not reflect the broader experiences of the full BHConnect youth population; however, the results are generally consistent with prior years, which supports greater confidence in the overall pattern of findings to reflect improvements among children and youth who remain in BHConnect long enough and are willing to complete a follow-up assessment.

Table 6. PSC Average Change from Baseline

	Parent/Caregiver Report (N=28)					Child/Youth Report (N=29)				
Subscales	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**
Attention	28	28.6%	17.9%	5.0	4.2^	29	41.4%	17.2%	5.6	4.8*
Internalizing	28	67.9%	46.4%	6.0[1]	4.7*	29	75.9%	55.2%	6.2[1]	4.5**
Externalizing	28	25.0%	28.6%	4.6	4.7	29	20.7%	13.8%	3.1	2.3
Total Score	**28**	**60.7%**	**42.9%**	**30.6[1]**	**25.5[1]***	**29**	**79.3%**	**37.9%**	**31.4[1]**	**22.7****

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

[1] Score above clinical cutoff. Note: PSC clinical cutoff scores by subscale (higher scores indicate worse condition): Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28

To better understand the extent to which PSC scores changed within the BHConnect client population and to facilitate comparisons with the overall CYF BHS system, analyses were also conducted that examined the level of change from initial PSC assessment. Consistent with the FY 2021-22 Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 7. Distribution of FY 2020-21 Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=28)		Child/Youth Report (N=29)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	7	25.0%	4	13.8%
No improvement (i.e., 0-1 point reduction)	2	7.1%	2	6.9%
Small improvement (i.e., 2-4 point reduction)	6	21.4%	3	10.3%
Medium improvement (i.e., 5-8 point reduction)	5	17.9%	5	17.3%
Large improvement (i.e., 9+ point reduction)	8	28.6%	15	51.7%

There was substantial variability among BHConnect clients and their self-reported experiences of behavioral health changes. As shown in Table 7, while a quarter of parents/caregivers (28.6%) and half of children/youth (51.7%) in BHConnect reported large improvements from their initial PSC assessment, 25.0% of caregivers and 13.8% of children reported increased impairment. Similar variability and distribution patterns in PSC change score analyses were also evident in the overall CYF BHS system as reported in the FY 2021-22 Systemwide Annual Report where 45% of caregivers and children/youth reported improvements while 20% reported increased impairment from initial PSC assessment. When comparing BHConnect clients to the overall BHS system, BHConnect youth were more likely to report large improvements (i.e., 51.7% compared to 45%); however, caregivers were less likely to report large improvements (i.e., 28.6% compared to 41%).

Adult Assessments

Recovery Markers Questionnaire

The Recovery Markers Questionnaire (RMQ) is a 26-item questionnaire that assesses elements of recovery from the client's perspective. It was developed to provide the mental health field with a multifaceted measure that collects information on personal recovery. The RMQ is administered at initial entry into BHConnect, at 6-month reassessment, and at discharge. The results listed below have been rescaled to the following: 1 = Strongly Disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; and 5 = Strongly Agree, with higher values corresponding to higher levels of well-being. The RMQ asks respondents to answer questions as it is "true for you now."

The total mean score for the 33 adult participants who completed the RMQ at intake and at a follow-up assessment during FY 2021-22 was 3.4 at baseline and 3.7 at follow-up. This change was in the desired direction and is statistically significant. An important individual item from the RMQ with a statistically

significant and clinically meaningful increase was "My symptoms are bothering me less since starting services here" which increased from a 3.2 to 4.2. This difference corresponds to an initial "neutral" response to an "agree/strongly agree" response at follow-up. As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average RMQ at intake for other BHS treatment programs (e.g., outpatient, Assertive Community Treatment (ACT), case management, and TAY residential programs) was 3.3 with a follow-up RMQ of 3.7. It appears that BHConnect participants self-report generally similar assessments of their recovery status and outlook on life as do clients in other BHS programs.

Illness Management and Recovery

To measure clinician perception of client recovery, the Illness Management and Recovery (IMR) scale was completed by BHConnect staff at initial program entry, at 6-month reassessment, and at discharge. The IMR scale has 15 items, each addressing a different aspect of illness management and recovery. Each item can function as a domain of improvement.

Table 8. IMR Assessments for BHConnect Adult Clients (N=39)

		Intake	Follow-Up
Individual Assessment Items	**n**	**Mean[1]**	**Mean[1]**
		Scale of 1 to 5 where higher value = better functioning	
Involvement of family and friends in his/her mental health treatment: How much are family members, friends, boyfriends or girlfriends, and other people who are important to him/her (outside the mental health agency) involved in his or her health treatment?	39	3.1	2.9
Time in structured roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment?	38	2.7	3.3**
Psychiatric hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?	39	3.3	4.3**
Using medication effectively: How often does s/he take his/her medication as prescribed?	29	4.4	4.4
IMR Subscales	**n**	**Mean[1]**	**Mean[1]**
Recovery	39	3.0	3.6***
Management	39	2.3	3.0**
Substance Abuse	33	4.1	4.4
Overall IMR	39	3.0	3.6***

***statistically significant at $p < 0.01$; ***statistically significant at $p < 0.001$;*

[1] IMR scores range from 1 to 5, where 5 = highest level of recovery

Additionally, there are three subscales known as Recovery, Management, and Substance Abuse. IMR scores range from 1 to 5, with 5 representing the highest level of recovery. A total of 39 participants completed an intake and a follow-up assessment in FY 2022-23 (see Table 8). The mean overall IMR score at intake was 3.0, which increased to 3.6 at last available follow-up, a statistically significant improvement. Primary domains where improvements were observed included greater recovery (i.e., reduced impairment due to symptoms) and better management of their illness.

As reported in the mHOMS Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average overall IMR intake score for other outpatient programs was 2.8, which increased to 3.4 at most recent follow-up. This pattern indicates that BHConnect adult clients have similar levels of impairment and recovery/management skills at program intake as other BHS programs and can achieve similar or greater improvements at follow-up.

BHConnect Participant Feedback

During June of 2023, BHConnect staff asked program participants to engage in a short qualitative survey to elicit feedback on the program. Participants were asked a series of questions which had been developed by the University of California San Diego (UCSD) evaluation team in collaboration with BHConnect leadership and BHS input. A total of 19 participants provided feedback regarding their experiences with and perceptions of BHConnect.

Given the participation rate relative to the number of clients served by BHConnect during FY 2022-23, a limitation of the findings presented is that they may not reflect the perceptions of the entire BHConnect program participant population. Additionally, it should be noted that the interviews were conducted by BHConnect program staff and therefore could be positively biased.

From the collected data, the following themes emerged:

The BHConnect program model improves service accessibility.

> “I know people genuinely care about me when receiving services.”

> “Participating in [BHConnect] services has affected me in a positive way. I get the help I need from my therapist and case management when needed. I feel like it’s a more personalized service, I always know if I reach out to my therapist she always gets back with me and makes time for me when in crisis.”

> “Easier to access, via in person would be more of a challenge to make it to sessions.”

> “In the past it has been difficult to get to in person sessions verses telephonic sessions. It’s more flexible for me to be able to connect with my therapist when needed. I had to miss a few appointments with my therapist but luckily they were able to be flexible with my schedule so I could make up the missed sessions.”

BHConnect clients prefer the hybrid model over traditional in-person services.

> “I like the fact that I can do therapy sessions over zoom and the phone with my clinician, whom I have grown to trust, without leaving home.”

"I like the screen share ability so we do our practices together."

"It's more convenient. No need to find child care."

The BHConnect experience has differed from prior providers.

"Since starting services, my trust level with mental health workers has improved."

"More experienced people working there."

"It's a more personal connection."

"I like that my privacy is kept private with [BHConnect], I didn't really feel the same way with my previous program."

"I find it easier to open up to my therapist in telephonic sessions."

These findings, combined with the themes found in the open-ended survey responses, indicate that the BHConnect program has accomplished the goal of connecting with and helping a population of persons who have been historically underserved by behavioral health systems due to barriers accessing traditional outpatient services. Special considerations should be made in the future to accommodate youth clients who may struggle with the logistics of telehealth services.

Clients also reported concerns related to the need to transition to a new service provider once BHConnect closes. One client stated, "I'm stressed now to find another good therapist and hate having to go through that process again, and again." Clients emphasized the importance of treatment consistency and the difficulties related to establishing relationships with therapists, particularly while in the midst of experiencing the symptoms of their mental illness. Other clients reported that they would delay or not seek out treatment if they did not have access to BHConnect services.

Additional Program Activities

In FY 2022-23, BHConnect engaged in activities to further develop provider knowledge and skills in treating individuals with serious mental illness (SMI). This process included participation in a range of ongoing trainings and educational conferences. Additionally, weekly team meetings included an agenda item to share virtual interventions, applications, and websites the team discovered to help engage with or teach mental health-related interventions. Examples of mental health apps included the following:

- ACT coach
- CBT-I Coach (for insomnia)
- Mindfulness Coach
- PTSD Coach

More general wellness applications explored and incorporated into client devices included:

- OscarER
- OscarER Jr. (for community resources)
- Insight Timer (for stress management)
- Sleep Cycle (for insomnia)
- Lose It (for weight management)
- MyFitnessPal and Strides (to track exercise)
- Clarity (to log moods and symptoms)

The team also worked to develop a library of books on virtual interventions for youth, families and adults including art-based websites (e.g., drawing, coloring), websites that have games (e.g., creating a doll

house together, two-player games, creating an avatar that expresses feeling states and moods). Books reviewed as a team included "Teletherapy Toolkit" by Dr. Roseann Capanna-Hodge, "Telemental Health with Kids Toolbox" by Amy Marschall, and "Therapy Games for Teens" by Kevin Gruzewski.

Additionally, as discussed above, the number of persons enrolling in BHConnect increased during FY 2022-23. This increase was the result of the ongoing outreach and engagement efforts on the part of BHConnect leadership to increase awareness of BHConnect services throughout the County of San Diego and expand the number of referral partner organizations. Essential to the outreach activities was participation in various service provider related meetings and presentations regarding BHConnect services.

BHConnect Referral Partner Feedback

During June of 2023, BHConnect referral partners were asked to engage in a short survey to elicit feedback about their experiences with and perceptions of the BHConnect program. Referral partners were asked a series of questions which had been developed by the UCSD evaluation team in collaboration with BHConnect leadership and BHS input. Referral partners were emailed a link to complete the online survey. Of the 93 referral partners invited to participate (representing 14 different organizations), 35 completed the survey (representing 11 organizations) for an individual response rate of 37.6% and an organizational response rate of 78.6%. Given the response rate, a limitation of the findings presented is that they may not fully reflect the perceptions of the BHConnect referral partner population. From the collected data, the following themes emerged from the qualitative data feedback:

BHConnect offers immediate services to clients in need.

> "I love how responsive the team has been when referrals are summitted. The partnership we have with BHConnect is phenomenal."
>
> "The referral process is simple and straightforward. BHConnect staff are responsive and engaging."
>
> "That there is minimal waitlist, they are responsive, and they are a good lifeline for patients that are coming out of a crisis."
>
> "My experience with BHConnect was a seamless process. I found it very easy to get in contact with Vista Hill and found that responses to emails and telephone calls were prompt, friendly and extremely helpful. Even after just one interaction it was made very clear to me that BHConnect is maintaining a culture of excellent service toward members, cooperation with other providers and a true passion for helping members get connected to these valuable therapeutic services."

BHConnect reduces barriers to therapy.

> "There are other referral options, but they come with longer waitlists and other barriers (transportation, not set up to treat severe concerns)."
>
> "Client that are interested in receiving therapy but are impacted by different barriers that make it difficult for them to receive traditional therapy. I often refer clients that self-isolate or are agoraphobic, due to their difficulty in public settings."

> "Limited access to care both through Medi-Cal coverage but also areas in County without many resources. Those whose parents have limited transportation and time to travel."

BHConnect fills a gap in services in the community.

> "[BHConnect] fills a gap in services and overcomes barriers that already exist in which services delivery is compromised. For all the reasons listed in previous answers... transportation, waiting lists..."

> "We always have them in mind and have also recommended them to clients cold-calling for resource support."

> "We believe that it has improved the quality of care for patients transitioning from the hospital and are hoping that it would prevent patients needing to return to the hospital."

Referral partners would like more collaboration and follow-up after the referral has been made.

> "Provide a follow up email to the referring party to confirm receipt of referral, what services (if any) the client has been offered, and the client's response. It can be very helpful to us because if we have a relationship with the client we can remind and support them in getting connected."

> "Improve communication with organizations about services available and appropriate referral process."

> "Collaborate with the referring provider, at least to the extent that we know our clients are being served."

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual BHConnect Staff Survey. The stakeholder meetings were held throughout the year with representatives from BHS, BHConnect, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual BHConnect Staff Survey was conducted at the end of FY 2022-23. BHConnect program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Of the 13 BHConnect staff invited to participate in the survey, 12 did so, for a response rate of 92.3%. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify the following emergent themes.

Program Strengths

According to annual survey feedback, the flexibility offered by BHConnect is an overwhelming strength of the program. BHConnect staff described their ability to accommodate clients in terms of therapy modality (i.e., offering telehealth when in-person sessions are not possible), scheduling, and location.

One staff member captured the lengths to which the BHConnect team goes to meet the needs of clients:

> "Therapists and health navigators are flexible in scheduling and providing clients with session times that work for them. Therapists make several attempts to engage and re-engage clients who have disconnected from therapy. Therapists use interventions to build rapport with clients."

Staff identified the unparalleled approach of the BHConnect team in this respect:

> "This program is outstanding and unique. We serve a very unique population. The clients in the program would most likely NOT make the effort to receive services in another setting due to the efforts that they would most likely choose not to make. Without our program, most of my clients would most likely not receive treatment and would consequently decline mentally."

Program Challenges

During FY 2022-23, BHConnect staff identified forming relationships with referral partners, waitlists for services, level of client complexity/acuity of treatment, client attrition, and staff turnover and shortages as the biggest challenges to reaching program goals.

Staff also mentioned the difficulties experienced by participants, as well as supporting participants:

> "Some are homeless and lose contact due to moving around or they lose or damage their devices. Also, with the high-needs population, many have severe mental health issues or they are addicts and have difficulty with follow through and consistency in meeting with their provider. Some lose track of the day of the week, or the time that their appointment was scheduled for."

However, some of these concerns have been addressed, according to one staff member:

> "We have provided extra training and supervision support in order to addressed the high-risk nature of this population. We have provided additional trainings on risk assessment, suicide, and vicarious trauma to meet the needs of clinical staff. In addition, staff need more self-care support in order to address burnout."

BHConnect Participant Engagement and Retention

As a program designed to work with clients who have experienced a mental health-related crisis but were otherwise unconnected to outpatient services, issues with client engagement were anticipated and have been a focus since the beginning. As one staff member stated,

> "We can provide services to them, but they too have to participate in services. Some are not ready to work on their mental health, and some have to hit rock bottom before they are ready and willing. We can continue to reach out and continue to the best of our ability to assist them, but ultimately it is up to them to participate and engage in services."

Staff also highlighted the importance of program flexibility in maintaining client engagement. The hybrid treatment model offers options for treatment location and modality, as well as scheduling flexibility:

> "I think it is important to be flexible in scheduling by adapting to the clients' needs. It is helpful to have more than one session per week when these clients are struggling and considering emergency services, and space out appointments when stable. For unconnected clients, any participation in treatment (and not emergency services) is a plus for them. Work with them in short segments to recognize the benefit."

BHConnect staff also recognized the need to effectively address co-occurring substance abuse issues with BHConnect participants. Staff mentioned the need for partnerships with substance use treatment programs, to receive further training in assisting this population and/or to refer the clients to those programs when BHConnect cannot effectively serve them.

Facilitating Client Referrals

The establishment and maintenance of referral sources has been a necessary goal of BHConnect since its inception. In FY 2022-23, ongoing BHConnect outreach efforts included meeting with representatives of potential partner organizations to educate them about BHConnect services and develop processes for identifying and screening potential clients. Additionally, BHConnect gave presentations at multiple community service provider meetings to increase awareness of BHConnect services.

Multiple staff noted the program manager's commendable efforts at outreach and connection with potential referral sources and the resulting increase in referrals. Respondents mentioned the need for additional adult referral sources, in an effort to fill midday appointments which are historically underutilized.

Supports, Tools, and Trainings

In the survey, staff were asked to identify supports, tools, and trainings that they would like more of to do their job well. The responses fell into three categories:

1. Additional training to build upon therapeutic skills (i.e., cognitive behavioral therapy, dialectical behavior therapy, training on working with high-risk clients and co-occurring disorders, parenting skills training, and generalized education on evidence-based practices)
2. Organizational and process skills (i.e., billing and paperwork processing)
3. Telehealth technical support

Experiences with Telehealth Services

The most commonly reported challenges when attempting to provide telehealth services was technical difficulties both with the telehealth platform and devices. However, several staff members also reported the relative ease and convenience of providing telehealth services.

As one staff member shared regarding their views on the many benefits of telehealth services:

> "Telehealth/Virtual Sessions have been an instrumental opportunity for use in assisting the population we serve, which has various challenges in obtaining services. The populations that we serve include, but are not limited to those with physical health challenges whom are unable to leave the home, those with multiple children whom are unable to attend in person appointments due to lack of childcare resources, and those with agoraphobia, and have extreme fear of leaving the home."

Other potential benefits of telehealth services through BHConnect, include less reliance on transportation and fewer no-shows. In addition, clients can access services from wherever they are and can potentially attend a virtual appointment even if they are sick with a virus, such as a cold or COVID-19.

Changes from Initial Program Design

During FY 2022-23, BHConnect continued to expand the network of community partners sending referrals to the program, particularly among adult/older adult clients. However, no changes were implemented that substantially differed from prior year program operations.

Conclusion

A total of 146 persons enrolled in BHConnect (73 CYF and 73 AOA clients) during FY 2022-23, which reflected a 25% increase in total enrollment as compared to FY 2021-22. BHConnect's efforts to expand their referral partner network contributed to the increased enrollment, with 17 different organizations referring at least five clients to BHConnect (compared to 12 reaching this threshold in FY 2021-22) and a 40% increase in the total number of referrals received by BHConnect during FY 2022-23. Including persons who entered BHConnect during FY 2021-22 and continued to receive services in FY 2022-23, a total of 206 persons (105 CYF and 101 AOA clients) were served in FY 2022-23. Despite the increase from prior years, this number remained below initial program targets of 250 persons served each year.

Once enrolled in BHConnect and receiving services, both CYF and AOA clients typically engaged with BHConnect for approximately four months. Based on self- and clinician-report assessment tools, many BHConnect youth and adult clients exhibited improvements in well-being and symptom management. However, the target population served by BHConnect (i.e., those with treatment needs but not engaged in treatment) remains a challenging population to serve with many demonstrating a need for further behavioral health improvements. Common challenges included homelessness, symptom complexity, and co-morbid substance use. An examination of BHS service utilization patterns indicated that participation in BHConnect services was associated with a reduction in the need for crisis and acute care services. Both youth and adults experienced fewer inpatient psychiatric hospitalizations after 90 days in BHConnect, and youth also had fewer crisis stabilization visits and PERT/MCRT contacts after engagement with BHConnect.

During FY 2022-23, the BHConnect program continued to experience significant growth but did not reach the original goal of providing services to at least 250 unduplicated clients. The lower-than-expected enrollment and increased availability of telehealth services throughout the BHS System of Care contributed to a determination by BHS to not continue the BHConnect program after the end of the Innovations-funded phase of the pilot program. The BHConnect program stopped enrolling new clients at the end of FY 2022-23 and will either complete treatment or identify and transition care to service providers who appear to best meet any needs for ongoing treatment services during the first quarter of FY 2023-24. While the BHConnect program will not be incorporated into the BHS System of Care as an ongoing service, it is expected that the lessons learned during the Innovations-funded phase of the pilot project will help inform other BHS efforts to ensure continuity of care and the provision of appropriate and accessible treatment options for persons receiving crisis/acute care services but not connected to treatment services. This information will be a primary focus of the Final Report for the BHConnect program.

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

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Appendix

Characteristics of Participants who Enrolled during FY 2022-23

Characteristic	Child/Youth (N=73)		Adult (N=73)	
Gender	**n**	**%**	**n**	**%**
Male	25	34.2	24	32.9
Female	38	52.1	46	63.0
Another gender identity/Prefer not to answer	10	13.7	3	4.1
Total	**73**	**100**	**73**	**100**
Primary Language	**n**	**%**	**n**	**%**
English	63	86.3	66	90.3
Other	10	13.7	7	9.7
Total	**73**	**100**	**73**	**100**
Race/Ethnicity[1]	**n**	**%**	**n**	**%**
African American	19	26.0	19	26.0
American Indian	<5[2]	<6.8	<5[2]	<6.8
Asian	6	8.2	6	8.2
Hispanic/Latino	34	46.6	26	35.6
White	29	39.7	27	37.0
Multiple	19	26.0	9	12.3
Other	2	1.7	1	1.4
Missing/Unknown	2	2.7	2	2.7
Total[1]	**-**	**-**	**-**	**-**
Sexual Orientation	**n**	**%**	**N**	**%**
Heterosexual or straight	45	61.6	51	69.9
Gay or Lesbian	<5[2]	<6.8	<5[2]	<6.8
Bisexual/Pansexual/Sexually Fluid	7	9.6	10	13.7
Queer	<5[2]	<6.8	<5[2]	<6.8
Questioning/Unsure	<5[2]	<6.8	-	-
Missing/Prefer not to answer	16	21.9	7	9.6
Total	**73**	**100**	**73**	**100**
Disability	**n**	**%**	**N**	**%**
Has a disability	22	30.2	26	35.6
Does not have a disability	46	63.0	44	60.3
Declined/Prefer not to answer	5	6.8	3	4.1
Total	**73**	**100**	**73**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*
[2] *Values were suppressed due to small n size.*

Appendix (continued).

Characteristic	Child/Youth (N=73)		Adult (N=73)	
Type of Disability[2]	**n**	**%**	**n**	**%**
Communication (i.e., seeing, hearing)	7	9.6	7	9.6
Learning Disability	11	15.1	6	8.2
Physical Disability/Chronic Health	<5[2]	<6.8	14	19.2
Other Mental Disability	8	11.0	<5[2]	<6.8
Other	6	8.2	<5[2]	<6.8

[2] *Values were suppressed due to small n size.*

Characteristic	Child/Youth (N=73)		Characteristic	Adult (N=73)	
Age Group	**n**	**%**	**Age Group**	**n**	**%**
5 to 14	35	47.9	18 to 25	21	28.8
15 to 18	38	52.1	26+	52	71.2
Total	**73**	**100**	**Total**	73	**100**

JUST BE U INNOVATIONS-21

Final Report (7/1/2018 – 6/30/2023)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

v.12.22.2023

UC San Diego

Table of Contents

Table of Contents 1
Executive Summary 1
Program Description 2
Program Model 2
Assessment of Primary Project Objectives 3
Future Directions 5
JBU Enrollment 5
Participant Characteristics 6
Utilization of Program Services 7
Key Evaluation Findings 9
Behavioral Health Service Utilization Patterns 13
Photovoice Project 15
Primary Implementation Findings 16
Composite of JBU Youth Experiences 22
Changes from Initial Program Design 24
Conclusion 24
Appendix 25

Executive Summary

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Just Be U (JBU) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA) from 7/1/2018 to 6/30/2023. JBU was designed to improve the mental health and quality of life outcomes of Transitional Age Youth (TAY; age 18-25; referred to as "youth" throughout this report) with serious mental illness (SMI) who are homeless or otherwise at risk of homelessness and repeatedly utilize acute or emergency mental health services but are otherwise unconnected to services. JBU, operated by the Urban Street Angels nonprofit organization, provides short-term housing for youth in a supportive environment that provides whole-health services targeting healthy eating, exercise, sleep, and a range of holistic interventions coupled with occupational therapy (OT) to teach skills needed to accomplish personal goals. JBU identifies and facilitates connections to individualized treatment, housing, and other community resources. Primary innovative features of JBU include the emphasis on youth-centric, whole-health/holistic services and the utilization of technology as an important tool for communicating with and engaging youth.

Overall, the findings from the Innovations-funded portion of the JBU program indicated that key objectives were successfully achieved. The program was able to consistently contact and engage with their priority youth population, create linkages to appropriate mental health and substance use treatment, and improve the general well-being of the youth who participated in JBU services. However, many of the youth have one or more factors that inhibit greater short- and long-term gains including co-occurring substance use disorder (SUD), complex physical health needs, and difficulty transitioning to external treatment providers, among others. Based on the successful results obtained by the JBU program during the Innovations-funded phase, BHS decided to continue to fund the JBU program as part of the ongoing and overall behavioral health service system.

Program Description

Using BHS Electronic Health Record (EHR) data, BHS personnel identified youth who met core criteria: age 18-25, multiple acute/crisis-related BHS service contacts, SMI diagnosis, unconnected to behavioral health services, and homeless or at risk of homelessness. After JBU received the list of eligible names from BHS, intensive outreach efforts were made by JBU staff to locate and contact each youth using available contact information provided by County databases, street searches, and coordination with other County and support agencies. Due to difficulties with physically locating many of the identified youth, during Fiscal Year (FY) 2020-21, a BHS-approved change was made to allow for "open" referrals, as well, so that JBU was allowed to enroll youth who were referred from other organizations such as community social service agencies and mental health service providers if they met the core criteria as listed above.

The overarching goal of JBU is to engage and stabilize youth by offering short-term housing (typically around 120 days) while providing holistic youth-centric recuperative services. Eligible youth are contacted, given an explanation about the program's offerings, and asked to enroll in the program. Throughout their residence at JBU, youth are linked with ongoing treatment, housing, and supportive services with the goal of improving mental health and quality of life. The dormitory-style housing facilitates easy access to many resources in one location. A centralized kitchen is available with cooking and nutritional classes. Youth can access integrative medicine, holistic healthcare and other wellness services including acupuncture, yoga, massage therapy, chiropractic care, meditation and mindfulness education. Further, other support services available include case management, peer support, group outings, and various in-house community-building training and events.

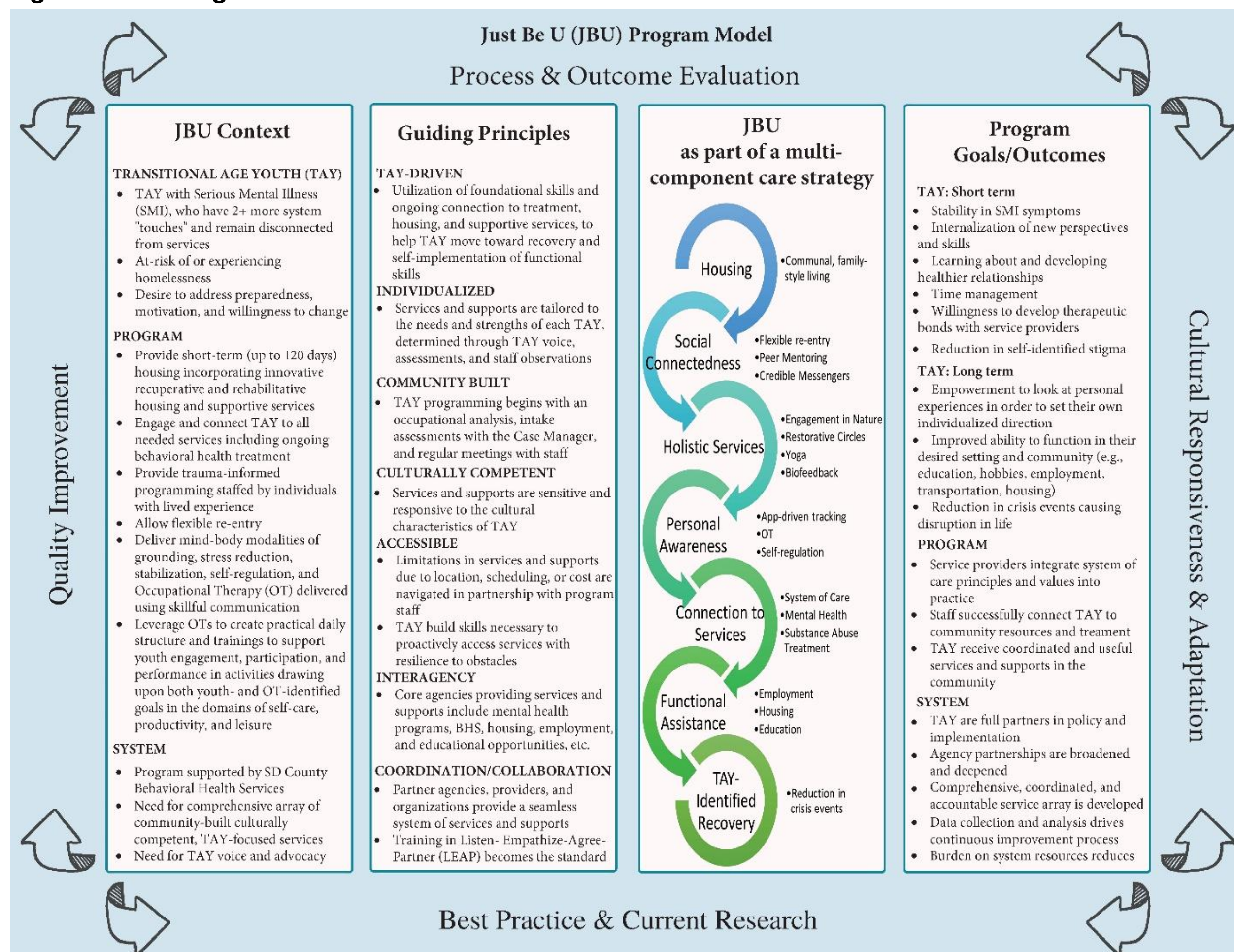
The program's emphasis on community-building, de-stigmatization of mental illness and homelessness, and active engagement in self-care through psychoeducation and engagement with holistic and integrative therapies helps to attract and retain this historically difficult-to-reach cohort of the homeless population. Ideally, JBU programming breaks the cycle of homelessness early in the process, avoiding youth hardening in identity as homeless and/or helpless and mentally ill. This has the additional benefit of minimizing the tendency of this population to repeatedly utilize disruptive and financially burdensome levels of emergency and mental health services. Further, the program's emphasis on community and well-being provides a model of care and continuity that is characteristic of a well-functioning family, the historical foundation for ensuring safety, growth, and wellness in a well-functioning human society.

Program Model

JBU leadership, the UCSD evaluation team, and BHS representatives met regularly during the Innovations-funded phase of the program to review evaluation practices, share updates on the program operations, and better understand the experiences of JBU as an innovative and evolving program. To define JBU's multi-faceted service approach more clearly within a broader strategy of youth care, the team endeavored to develop a JBU Program Model. The model outlines the complicated context in which JBU operates, which is critical to understanding how improvements may be made and where successes are truly occurring. The model also includes guiding principles, various parts of the multi-component care strategy of JBU, and goals/outcomes as defined across multiple levels (i.e., individual, program, and system-based levels).

Programmatically, JBU relies on individual youth to engage in services and outside providers to have accessible treatment options reliably available for youth. Within the JBU program, there remains a commitment to using current research, engaging in culturally-informed responses, and improving quality of care. The JBU Program Model is presented in Figure 1. A full-size rendering of the Program Model is available to review in the appendix.

Figure 1. JBU Program Model



Assessment of Primary Project Objectives

The main goals of the JBU Innovation-funded project included the following:

1. ***Use a habilitation model to demonstrate the ability to identify, engage, and retain TAY who are unconnected to treatment and have repeatedly utilized acute care, STARTs, EDs, PERT, EPU and jail mental health services.***

   In the beginning stages of the Innovations-funded phase of JBU, BHS provided a list of youth appearing to meet eligibility criteria (i.e., the BHS CO-19 report). It was difficult to physically locate challenging many of the youth, which prompted the change to allow for "open" referrals from other organizations for youth who also met the core eligibility criteria. Despite difficulties locating youth, once contact was made and JBU was explained to youth by the JBU outreach workers, most youth (typically 75% or

more) agreed to enroll in the program. Youth identified the provision of housing as a key factor for initially agreeing to enter JBU. A total of 204 youth enrolled into JBU during the Innovations-funded phase. JBU successfully created an inclusive environment with much gender, race/ethnicity, and sexual orientation diversity reflected among the enrolled youth.

The JBU program also demonstrated the capacity to retain youth in services, despite working with a population of youth with potentially significant impairments (i.e., 65% of youth had a diagnosis of schizophrenia or other psychosis and 58.3% had a co-occurring SUD). JBU was designed to operate as a short-term linkage and support program, initially 90 days and then extended to allow for 120-day stays if needed. In reality, youth typically remained in residential care and support services from JBU for approximately 75 days; however, 43.1% (n=88) were in JBU for at least 90 days and about one-quarter (25.5%; n=52) required services lasting more than 120 days.

2. ***Decrease TAY's inappropriate utilization of acute care services and/or returning to jail.***

While enrolled in JBU, participants demonstrated approximately 50% reduced need for crisis and acute care BHS services (i.e., inpatient psychiatric hospitalizations, crisis stabilization visits, and crisis residential admissions). This is likely due to the increased participation in treatment services (i.e., outpatient, Assertive Community Treatment (ACT), and urgent outpatient care) as well as the care and support provided directly by JBU. The decreased engagement with crisis/acute care services persisted in the 180 days following discharge, markedly lower than the 180 days prior to enrollment. Across the service types of inpatient psychiatric hospitalizations, crisis stabilization visits, crisis residential admissions and psychiatric emergency response (PERT)/mobile crisis response team (MCRT), the prevalence across the youth (i.e., the percentage of persons experiencing at least one service contact) dropped approximately 30-40%.

3. ***Increase TAY's ability to manage their symptoms and improve their level of functioning and ability to live independently.***

For the 103 TAY with completed baseline and follow-up assessments on the Milestones of Recovery Scale (MORS), statistically significant and clinically meaningful improvements were evident in their symptom management and recovery orientation. The MORS is scored on a scale of 1 to 8, with lower numbers meaning higher risk. Upon entrance into JBU, the majority of youth scored 3 (i.e., "experiencing high risk/engaged with mental health provider") or worse. At the end of services, the majority scored 6 (i.e., "coping/rehabilitating") or better. The average MORS rating increased from 3.4 at baseline to 5.7 at follow-up.

OT services were comprehensively incorporated into JBU practices via both individual and group interactions. Structured OT assessments helped youth to identify, develop and take steps to achieve goals commonly related to education, employment, and/or personal growth/skill building. Outcome data indicated TAY were able to achieve desired objectives and increased their satisfaction from completing identified tasks.

Additionally, JBU helped connect youth to available housing resources by getting approved and trained to administer the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. All JBU youth who completed the VI-SPDAT were identified as needing housing supports, with the majority demonstrating the highest level of need and

prioritized for permanent supportive housing. JBU has increased their capacity to successfully connect youth with housing-related assistance throughout the Innovations-funded phase of the program.

4. ***Increase connection with an ongoing outpatient mental health program.***

   The JBU program demonstrated substantial success in facilitating connections to needed outpatient treatment services. Compared to 180 days prior to JBU enrollment, more youth had at least one outpatient visit (i.e., 18% to 62.2%) and the average number of visits across all youth increased from 1.4 to 12.8. While engagement in outpatient treatment reduced post-JBU, this was likely because engagement with ACT increased. While only 2.3% had ACT engagement prior to JBU, nearly one-third (29.7%) were connected to an ACT program upon discharge. Overall, the majority of JBU were connected to either outpatient treatment programs and/or ACT through their involvement with the JBU program.

Future Directions

After the Innovations-funded phase of the JBU program concluded on 6/30/23, JBU was incorporated into the overall BHS system of care as an ongoing service using MHSA Prevention and Early Intervention funds. Following the conclusion of an open Request for Proposal review process in which other organizations could propose to provide JBU services, the JBU program will continue to be operated by the Urban Street Angels organization. Reflecting the successful experiences during the Innovations-funded phase, the priority population for JBU services will continue to be TAY (ages 18-25) who have or are at risk for SMI, may have a co-occurring SUD, are homeless or at risk of homelessness, are unconnected to services, and are repeat utilizers of acute/emergency mental health services. Likewise, the specific type of services provided through JBU and the overall orientation for how to approach service delivery will be very consistent with how JBU was operated during the Innovations-funded phase. As such, the core service delivery strategies will continue to be providing 24 hour/7 days-per-week residential care and support services that have a restorative and habilitative emphasis specifically tailored to meet all life domains for eligible youth. Primary objectives will continue to be facilitating connections to all needed behavioral health treatment services and providing opportunities for social connectedness and personal wellness and growth. JBU will also help youth better meet some of their basic living needs by providing job training and assistance with finding post-JBU housing.

JBU Enrollment

A total of 204 unduplicated youth enrolled into the JBU program throughout the MHSA Innovations-funded phase of the program that ended on 6/30/2023. Of the 204 enrollees, 104 (51.0%) originated from the BHS CO-19 report of homeless youth with recent emergency BHS service contacts and 100 (49.0%) were identified from other referral sources (see Table 1).

Since allowing "open" referrals into JBU for youth with similar histories to those included on the BHS CO-19 report starting in FY 2020-21, the open referrals have comprised the majority of the newly enrolled youth. The final year of the Innovations-funded phase of the pilot project (FY 2022-23), open referrals represented 84.8% of the newly enrolled youth.

Table 1. JBU Program Enrollment (N=204)

Type of JBU Enrollee	n	%
Identified via BHS CO-19 report	104	51.0%
Open referrals from other service provider organizations	100	49.0%
Total JBU enrollees	**204**	**100%**

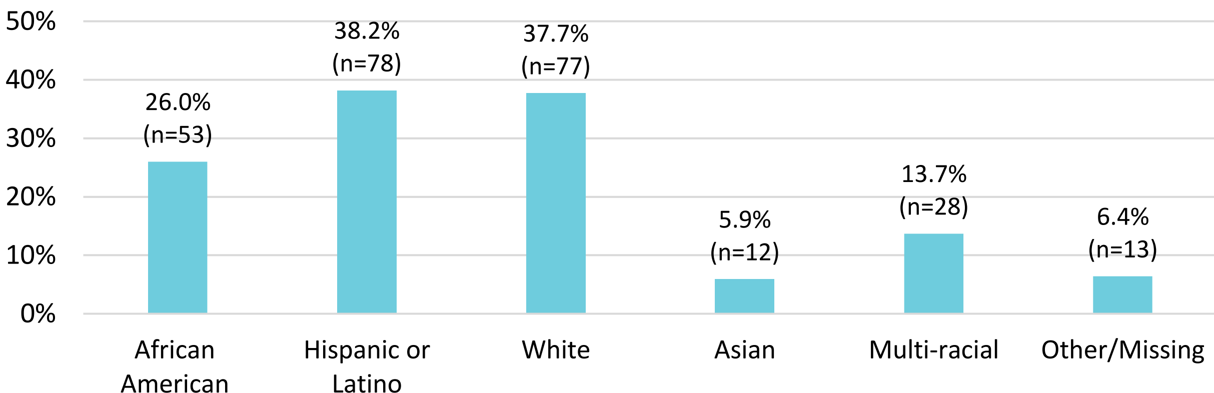
Participant Characteristics

A brief overview of JBU participant characteristics is presented here with a more complete listing in the report appendix. Of the 204 unique youth who enrolled in JBU during the Innovations-funded phase of the JBU program, the majority (n=121; 59.3%) identified as male. Almost all JBU youth (n=198, 97.1%) spoke English as their primary language. Approximately two-thirds of youth enrolled in JBU had a diagnosis of schizophrenia/psychotic disorders (n=133; 65.2%). Other common diagnoses included bipolar (n=41; 20.1%) and depressive disorders (n=19; 9.3%). More than half of all youth also have a co-occurring SUD (n=119; 58.3%).

JBU provided services to a substantial number of sexual minorities with at least 8.3% (n=17) identifying as Bisexual/Pansexual/Sexually Fluid, 2.5% (n=5) identifying as gay or lesbian and 3.9% (n=8) identifying as another sexual orientation. Since approximately 30% (29.9%; n=61) of the youth did not answer the question, it is likely that the actual number of sexual minorities served by JBU is even higher than reported.

As shown in Figure 2, JBU youth were also racially and ethnically diverse. Nearly identical numbers of youth identified as Hispanic/Latino and Caucasian (n=78; 38.2% and n=77; 37.7%, respectively) followed by 26.0% (n=53) identifying as African American and 5.9% (n=12) as Asian.

Figure 2. Race/Ethnicity of Youth Who Enrolled in JBU (N=204)



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

Many JBU youth had additional challenges as well as those related to their mental health, including cognitive and sensory differences affecting their ability to process information and engage with certain environments. Many also presented with other complex physical health issues and/or intellectual and developmental disabilities that required support from additional agencies such as the San Diego Regional Center and specialized healthcare providers.

Utilization of Program Services

OT at JBU

Throughout the final three years of the JBU program, there were up to eight OT interns providing services to JBU youth, who collectively provided over 5,000 hours of volunteer support services to the JBU program. Interns were graduate students enrolled in either Masters or Doctorate programs in OT at one of several university partners, including the University of St. Augustine for Health Sciences and San Jose State University who were supervised by licensed OT specialists on JBU staff.

The OT team conducted an initial interview with each youth to develop an occupational profile (e.g., client history, strengths, interests, goals, and barriers) as well as standardized and non-standardized assessments to measure client factors impacting performance skills and patterns (e.g., time-use, cognitive, sensory, and goal-focused assessments). Together with the youth, they developed intervention plans which included individualized short- and long-term goals related to 1) self-care (e.g., grooming and hygiene, community mobility, sleep hygiene, health management), 2) productivity (e.g., work, financial management, school, volunteering), and 3) leisure (e.g., social activities, activities for fun).

In collaboration with the JBU team, OTs would determine a uniquely tailored service delivery method and outcome measurement approach. The OTs conducted individual client intervention sessions every one to three weeks to address identified client needs and goals, as well as running as-needed weekly group interventions addressing topics such as: leisure exploration, social participation, time management and organization, employment seeking and maintenance, pursuing volunteer opportunities, managing finances, home maintenance, meal preparation, community exploration and engagement, medication management, and self-care. OT group session typically lasted about one hour with an average attendance of 6.6 youth.

OTs conducted observations and activity analyses during a client's transition into the program and their participation in services. These observations served to identify barriers to participation (i.e., being able to do the activities or tasks they want and/or need to do). Youth would review their personal intervention plan with OTs every month and modify as needed. OT services at JBU also provided consultation to the JBU team regarding supporting clients with additional needs including cognitive challenges, neurological or sensory differences, physical disabilities, and/or significant mental health challenges. Additionally, the OT team supported the participation of JBU youth in program and organization-wide activities, such as the completion of a mural in the downtown Urban Street Angels location (as shown below).

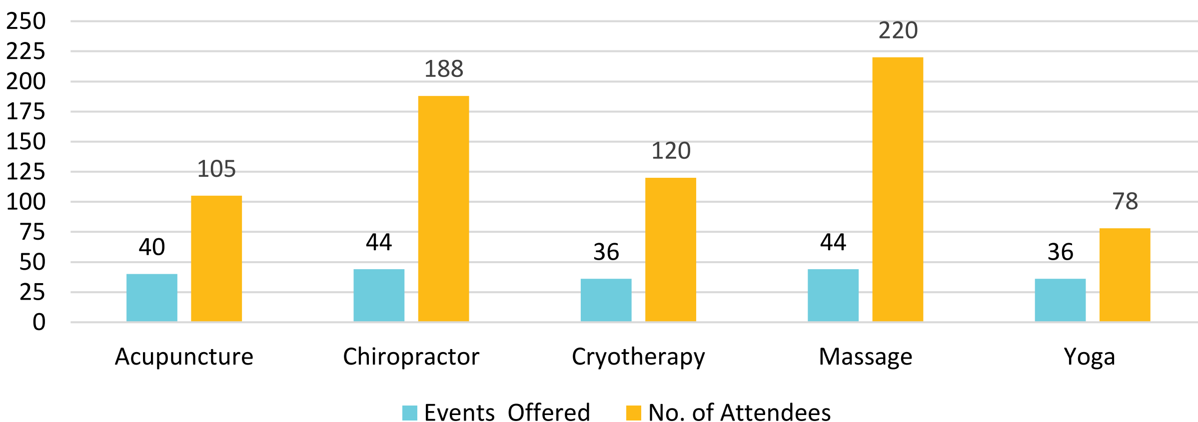
Urban Street Angels mural that JBU youth helped to paint with OT support.

Engagement in JBU Activities

Holistic Wellness Services

In addition to the ongoing support and encouragement of the youth through daily personal interactions with JBU staff and peer supports, JBU offered a wide range of wellness-oriented group and individual structured activities that covered a range of holistic services and general living/educational events such as yoga, reiki, meditation, cooking classes, acupuncture, and others. In addition to promoting relationships and skill-building, participation in these activities seeks to promote improvements in personal well-being such as greater self-esteem and a more hopeful outlook for the future. Many of these activities were impacted by the onset of the pandemic as they were frequently led by external professionals. Some services were able to be completed remotely (e.g., following an instructor via a video call), others transitioned to being led by onsite staff, and others were discontinued. Based on these experiences and an assessment of youth attendance and interest levels, JBU holistic wellness services regularly offered during the final year of the Innovations-funded phase (i.e., FY 2022-23) included: acupuncture, chiropractor, cryotherapy, massage, and yoga. Figure 3 indicates number of sessions and total youth participation across these activities during FY 2022-23.

Figure 3. JBU Sponsored Wellness Activities



Group Outings

JBU youth participated in both major and relatively more minor group outings. The major outings included overnight trips to Harrison Serenity Ranch (HSR) on Mount Palomar. HSR is a working ranch located over 50 miles from downtown San Diego. The facility offers recreation, relaxation and wildlife encounter opportunities. These outings were facilitated by the full JBU staff team, while more minor group outings were facilitated primarily by Peer Support with assistance from OT interns and other staff as needed. Examples of these minor outings include trips to the movie theater, makeovers at a salon, Living Coast and Birch Aquarium, trampoline park, elderly dog rescue “Frosted Faces,” San Diego Pride Parade, the Japanese Friendship Garden at Balboa Park, rollerblading, bowling, the beach, a San Diego Padres baseball game, hikes and various other outings. Additionally, some activities focused on engagement were provided in-house such as gardening, embroidery, mask making, and game nights.

JBU Services – Duration and Discharge Status

As shown in Table 2, of the 204 youth who received JBU services, 189 had discharged as of the end of the Innovations-funded phase of the project on 6/30/2023 and 15 were still active. The average and median length of time receiving residential care and support services from JBU was approximately 75 days; however, 43.1% (n=88) were in JBU for at least 90 days and about one-quarter (25.5%; n=52) required services lasting more than 120 days. These data indicated that JBU was generally adhering to the initial goal of operating as a short-term linkage and support program while also allowing somewhat extended (but not long-term) care for youth who needed additional time in the program.

Table 2. JBU Program Participation Duration and Discharge (N=204)

	JBU Youth (N=204)	
	Still in program 6/30/2023	Discharged as of 6/30/2023
n (persons)	15	189
Mean (days)	76.5	75.6
Median (days)	74.0	71.0

Key Evaluation Findings

Milestones of Recovery Scale

The Milestones of Recovery Scale (MORS) captures the stage of mental health recovery, as assessed by staff, using a single-item recovery indicator. Participants are placed into one of eight stages of recovery based on their level of risk, level of engagement within the mental health system, and the quality of their social support network. Raters are instructed to select the level describing the modal milestone of recovery that an individual displayed over the previous month. Higher MORS ratings indicate greater recovery.

As shown in Table 3, the results indicated substantial changes in recovery status at follow-up. At intake, only 8.7% (n=9) of youth were considered as coping or in recovery, whereas 60.2% (n=62) were doing so at follow-up. The number of youth in the "extreme/high risk" categories dropped from 52 to 7 (50.5% to 6.8%) from intake to follow-up. Overall, 84.5% (n=87) improved at least one level at follow-up and the average MORS score increased from 3.4 at intake (corresponds most closely to "high risk, engaged") to 5.7 at follow-up (corresponds most closely to "coping/rehabilitating").

As reported in the Mental Health Outcomes Management System (mHOMS) Annual Outcomes Report for FY 2021-22 (the most recent version available for comparison), the average MORS score for other adult BHS programs was 4.5 at intake and 4.9 at follow-up. The findings from JBU indicate that youth typically entered the program with a lower-than-average MORS score (i.e., more impaired/less engaged in treatment), but had a higher-than-average MORS score at follow-up (i.e., less impaired/more engaged in treatment).

Table 3. MORS Results for JBU Youth with Follow-up (N=103)

		Baseline		Last Follow-Up	
Value	**MORS Category**	**n**	**%**	**n**	**%**
1/2	Extreme risk / High risk, not engaged	37	35.9%	<5[1]	<4.9%
3	High risk, engaged	15	14.6%	<5[1]	<4.9%
4	Not coping, not engaged	37	35.8%	12	11.6%
5	Not coping, engaged	5	4.9%	22	21.4%
6	Coping/rehabilitating	5	4.9%	42	40.8%
7	Early recovery	<5[1]	<4.9%	7	6.8%
8	Advanced recovery	<5[1]	<4.9%	13	12.6%
	Mean MORS	**3.4**		**5.7***	

[1]*Exact number masked due to the small number of persons in this category. *Statistical significance at* $p < 0.01$

The lower-than-average MORS score at intake was consistent with the JBU focal population (i.e., youth with serious mental illness who were not currently in or seeking treatment), with the substantial positive change in MORS score suggesting a high capability of the JBU team to support and connect with youth and get them linked to appropriate levels of treatment. Of note, since follow-up MORS scores were not available for all JBU participants, these results may not generalize to the entire JBU population and potentially overstate the typical level of improvement experienced by JBU youth; however, the results clearly indicate substantial portions of the JBU client population improve in their illness management and recovery orientation by the time they discharge from the program.

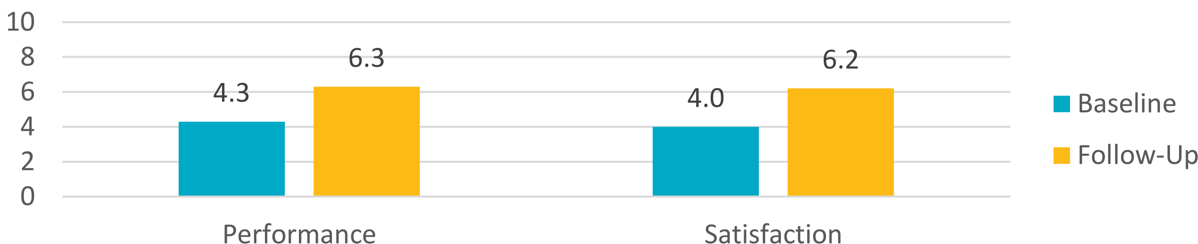
Canadian Occupational Performance Measure

The Canadian Occupational Performance Measure (COPM) is a widely used (e.g., translated into more than 35 languages), individualized, client-centered, evidence-based outcome measure designed to document a client's self-perception of performance in everyday living at multiple time points. The COPM is a standardized instrument, in that there are specific instructions and methods for administering and scoring the test. It is designed as an outcome measure, with a semi-structured interview format and structured scoring method. The COPM asks individuals to identify everyday activities that they want or need to do but are currently unable to do or are dissatisfied in the way they are doing them, across all areas of life, including self-care, leisure, and productivity. The assessment then asks clients to rate these activities on a 1-10 scale for importance, performance, and satisfaction with performance with "1" representing not important/not able to do it/not satisfied at all. Typically, differences of two points or more between the pre- and post-OT intervention scores are considered clinically important.

Over the final two years of the Innovation-funded phase of JBU, 63 JBU youth developed 289 unique goals in collaboration with the OT specialists. Primary goal domain areas included: personal hygiene/self-care, getting/maintaining employment, social interactions, obtaining needed resources, developing positive hobbies, and furthering education. A total of 28 JBU youth had baseline and follow-up COPM assessments completed by 6/30/2023. Figure 4 shows that average performance assessment increased from 4.3 to 6.3 at follow-up and the satisfaction score increased from 4.0 to 6.2. Both the performance and satisfaction

domains had average change scores of approximately two, indicating clinically important improvements for youth overall. Of the 28 youth with both baseline and follow-up scores, the majority 53.6% (n=15) had score changes indicating clinically important changes on performance and 57.1% (n=16) had clinically meaningful improvements regarding task satisfaction. The COPM results indicate that the JBU OT team was able to increase the capabilities of many JBU youth to function successfully in their daily lives; however; the COPM data also reveal that JBU youth have relatively low initial abilities to accomplish their goals and that substantial numbers of youth continue to experience challenges even after working with JBU staff. These findings highlight both the promise of what JBU and the participating youth can accomplish together to improve their lives while also reflecting the difficulties of consistently achieving such objectives.

Figure 4. COPM Mean Scores for JBU Youth with Follow-up (N=28)



Youth Feedback Regarding OT Experiences

JBU youth were asked about their experiences with OT as part of JBU. Responses fell into the following categories:

Participants Enjoyed Working with OT Providers

> "The OT interns were enjoyable to be around, easy to talk to. They didn't make you feel bad for coming to them…They wouldn't pressure you to have a conversation. They listened. They'll do activities with you if you need it and it will help you. They don't expect you to do things if you're not comfortable. They would ask me to do things, and if I didn't want to, they might ask me just to try, and then check in after if it helped me and I would realize after that it did. But they were not pressuring me or to continuously do things if it didn't work for me."

> "It helped me get through the program by having some extra support… People from occupational therapy positively impacted my life. They gave me hope that I can succeed and do better and improve my habits. The interns were super nice and a positive influence and encouraging. They would help you out whenever you felt down, they were uplifting."

> "I was satisfied on how OTs made everyone engaged in group activity and made everyone have a good time. I liked how the OTS planned engaging group activities (i.e., pill bottles for medication management). We also got to play basketball together in one of our sessions."

OT Offered New Experiences for Participants

> "Helped me spend time with people I wouldn't normally... It helped me meet and make more friends."

"It gets you out of your comfort zone and makes you feel comfortable with being uncomfortable. OT is my favorite group because it makes you get up and get out to do stuff you don't necessarily want to do, which creates a sense of structure."

OT Helped Participants with Goals and Skills

"[Helped with…] a lot of tasks that I was embarrassed to ever ask anyone for advice on."

"I like occupational therapy because it actually puts my goals into practice."

"Going on walks, encouraging me to do better activities instead of just smoking or hanging out all day on the couch e.g., reading manga, getting a job, getting up on time, going to groups/activities, eating (regularly)."

"It continued to help me after the program as I search for a new job."

OT was Fun

"Occupational therapy is a way of being in a fun environment and doing fun stuff but also being intimate and focusing on what you need."

"It is an outlet as well as just having fun and gets you involved with the people around you."

Overall, participant feedback was very positive. One participant summarized, "I hate therapy in general, but OT is different than regular therapy... It's like you're not just sitting there, you're building a connection…it actually helps you figure out what you can do to fix it, instead of just sitting there talking about it."

Increased Connections to Housing and Housing Assistance

Near the end of the Innovations-funded phase of the JBU program, to support efforts to connect JBU to housing, the JBU program began administering the Vulnerability Index – Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) upon enrollment into JBU. The VI-SPDAT is a tool used to assess housing needs and risks in order to establish prioritization of housing-related assistance. Organizations trained to utilize the VI-SPDAT with their clients are then able to enter the resulting information into a centralized data system that assists with matching available housing resources with expressed needs. The VI-SPDAT helps to inform the type of housing intervention or support that may be most beneficial, as well as the order in which individuals should be served. Table 4 presents the VI-SPDAT scores for the 32 youth who had this assessment completed upon enrollment into JBU.

Table 4. VI-SPDAT Score at Time of Enrollment into JBU (N=32)

Baseline Score (N=32)	n	%
Score of 0 to 3: No Housing Intervention	0	0.0%
Score of 4 to 7: Assessment for Rapid Re-Housing	5	15.6%
Score of 8+: Assessment for Permanent Supportive Housing/Housing First	27	84.4%

The results indicate a high level of housing need among JBU, with almost 85% scoring in the highest priority category with a recommendation for permanent supportive housing. The average score for JBU was 10.1. The substantial need for housing among JBU youth indicated that the JBU program was successfully connecting with the intended focal population given the overall objectives to serve youth with an SMI who are currently homeless or at risk of homelessness.

While the short-term nature of the JBU program presented challenges in matching youth with housing prior to program discharge, youth were connected to local housing resources directly as a result of the VI-SPDAT scores. In addition, JBU staff were able to successfully connect 18 JBU youth to other housing supports such as assistance with maintaining current living situation, obtaining vouchers to access affordable housing options, and other forms of support to reduce vulnerability to homelessness.

Behavioral Health Service Utilization Patterns

San Diego County BHS Services Utilized Before, During, and After JBU

BHS utilization patterns before, during, and after leaving the residential portion of JBU can help identify the extent to which participation in JBU is associated with a fundamental shift in the mix of service utilization (i.e., increased engagement in treatment and reduced interaction with crisis/acute care). The following analyses were accomplished by reviewing the electronic health record that documents County-funded BHS services provided throughout San Diego County to identify other mental health services received by JBU participants. Given the variable length of time that a youth might be in the residential portion of the JBU program, a standardized metric was created to enable equivalent comparisons for the three time periods of interest. The standardized metric for the "during JBU" period reflects the average amount of services JBU youth would be expected to receive during a 180 day stay with JBU. This metric facilitates comparisons to the 180-day period immediately preceding JBU enrollment and the 180-day period after leaving the residential phase of the JBU program.

The standardized "during JBU" metric was computed by summing the total number of BHS services (by service type) that occurred while the youths were enrolled in JBU and dividing that by the total number of days that all youth were enrolled in JBU. The resulting values represents the average number of each specific BHS service that a JBU youth received per day, which is then multiplied by 180 to generate the estimate of BHS services that JBU youth would receive if they were enrolled in JBU for 180 days. For the 180 days prior to JBU, all BHS services (by service type) were summed and then divided by the total number of JBU clients to generate an estimate of the average number of BHS services received by JBU clients prior to enrolling in JBU. A similar calculation was made for the 180-day period after youth left the residential phase of the JBU program.

The analyses presented in Table 5 include all JBU participants who enrolled at least 180 days before the end of FY 2022-23 to ensure full and equivalent 180-day "post-JBU" observation periods for all persons.

As shown in Table 5, the 172 JBU youth included in these analyses had either no or limited involvement with BHS outpatient treatment services in the 180 days prior to entering JBU (average of 1.4 outpatient sessions across all youth). However, that changed substantially during their time enrolled in JBU as 62.2% of the youth linked to outpatient care and the 180-day average number of outpatient sessions increased to 12.8. After leaving the residential phase of JBU, outpatient visits remained more prevalent than pre-JBU but decreased to an average of 2.8 sessions per youth. For some, this reduction in outpatient services

post-JBU can likely be explained by linkages to the ACT programs that the youth made while in the JBU program. Approximately 30% (29.7%) of all youth were linked to ACT post-JBU, with the average of 7.8 sessions compared to 0.3 pre-JBU and 2.6 during JBU.

Table 5. BHS Service Utilization Patterns Before, During, and After JBU Participation (N=172)

	180 Days Prior to JBU Enrollment			Standardized 180 Days During JBU Residential Phase			180 Days After Leaving JBU Residential Phase		
	% of youth	# of visits/ episodes	Average per JBU youth	% of youth [1]	# of visits/ episodes[1]	Stdzd. average per JBU youth	% of youth	# of visits/ episodes	Average per JBU youth
Outpatient	18.0%	234	1.4	62.2%	938	12.8	47.7%	486	2.8
ACT	2.3%	49	0.3	19.8%	187	2.6	29.7%	1,340	7.8
Urgent Outpatient	40.7%	131	0.8	35.5%	76	1.0	29.7%	91	0.5
PERT/MCRT	30.8%	73	0.4	10.5%	28	0.4	21.5%	63	0.4
Crisis Stabilization	37.2%	128	0.7	8.1%	23	0.3	20.3%	71	0.4
Inpatient Psychiatric Hospitalization	46.5%	130	0.8	13.4%	30	0.4	27.9%	90	0.5
Crisis Residential	30.8%	71	0.4	7.0%	16	0.2	17.4%	40	0.2

[1]The number of persons and number of visits/episodes during JBU is not comparable to "prior" and "after" JBU since the average length of time in JBU was less than 180 days (i.e., mean = 77.0 days). Only the average is comparable across all time periods.

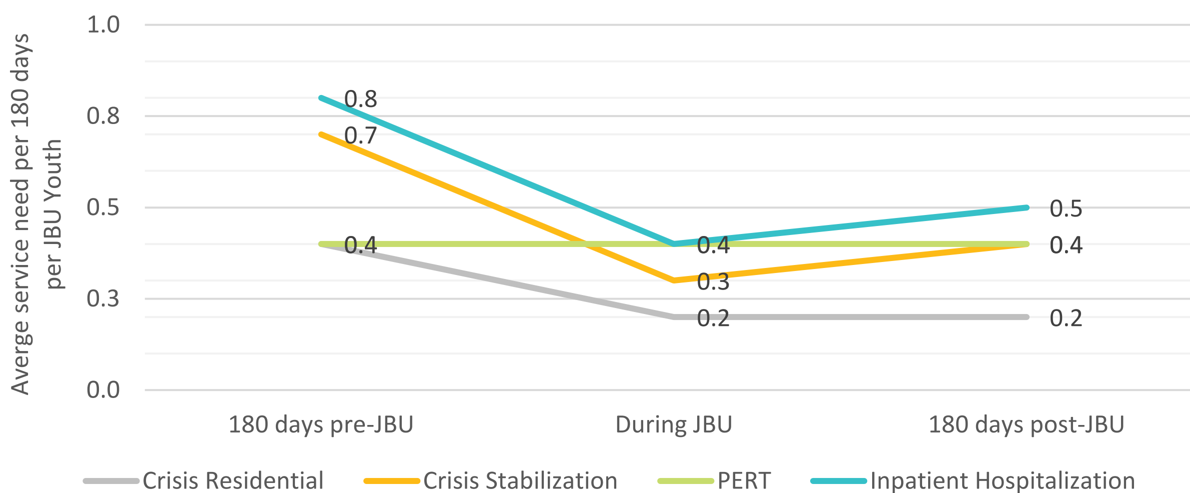
The patterns evident among acute/crisis-oriented type BHS services were more nuanced. Interestingly, the average number of urgent outpatient visits decreased from before JBU to after JBU (0.8 to 0.5, respectively) but was slightly higher during JBU (1.0). This can likely be explained by the fact that JBU staff facilitated access to needed urgent outpatient care in an effort to avoid situations escalating into the need for a crisis stabilization visit or inpatient hospitalization, both of which occurred much less frequently during JBU than pre-JBU (i.e., dropping from 0.7 and 0.8 pre-JBU to 0.3 and 0.4 during JBU, respectively).

When comparing pre-JBU to post-JBU service utilization, the percentage of youth accessing crisis-oriented BHS services was lower after participating in JBU. This was most evident for crisis stabilization services which reduced from 37.2% of youth having at least one crisis stabilization visit during the 180-days before JBU compared to 20.3% in the 180 days after leaving JBU, with the average visits per 180 days dropping from 0.7 to 0.4 (a 42.9% reduction) and total visits reduced from 128 to 71, (a 44.5% reduction). A similar pattern was evident for inpatient hospitalizations (i.e., reducing from 0.8 pre-JBU to 0.5 post-JBU) with total hospitalizations reducing from 130 to 90 (a 30.8% reduction) in the 180 days before JBU compared to the 180 days after JBU.

With the small sample sizes, caution is warranted when interpreting findings, however it is evident that JBU increased engagement with outpatient treatment services and facilitated connections to ACT programs (a preferred discharge destination for many JBU youth). As shown in Figure 5, there was a small

reduction in crisis and acute care behavioral health service utilization from pre-JBU to post-JBU, however the utilization patterns were higher than while in the residential phase of the JBU program.

Figure 5. Visualization of Average Crisis and Acute Care Service Utilization Per JBU Youth Per 180 Days Before, During, and After JBU Residential Phase



This pattern suggests the need to explore options for how to better support JBU youth for longer-term improvements across a larger proportion of JBU participants. This may require exploring the provision of additional services by JBU for a longer period of time and/or more extensive partnerships with other long-term services with a TAY-specific orientation such as case management that can seek to maintain and build upon the gains experienced while in the JBU program.

Photovoice Project

In May 2021, youth were invited to participate in a structured photovoice project. Photovoice is a visual research method employed with the intention of addressing social issues and fostering change. It is defined as a process where "people can identify, represent, and enhance their community through a specific photographic technique." Photovoice provides the opportunity for community members to creatively document their concerns and simultaneously act as "catalysts for change."

Additionally, it is designed to promote interest in important topics that are relevant within a community and allows a community to communicate through what they chose to include in their photographs. Photovoice breaks past language and traditional communication barriers that often prevent members of a group from expressing their concerns. Photovoice is a highly customizable community-based intervention and is an excellent tool to use when there is a need to create awareness around a certain issue or concern, particularly when the issue of concern is one that is traditionally difficult to address or discuss. As such, it was determined by JBU leadership and BHS that Photovoice would be an appropriate method of evaluation in partnership with JBU youth.

In collaboration with 11 JBU youth, the evaluation question was identified: "How does participation in JBU affect my life?" The full Photovoice results were included in the FY 2020-21 JBU Annual Report with the main findings reported as follows:

Overall Key Takeaways

1. Housing was the most important part of JBU.
2. JBU provided a sense of stability.
3. Community can be uncomfortable for JBU youth, but they recognized its importance.
4. A sense of control was important while youth worked towards independence.
5. Youth believed that participation in JBU gets them to independence faster than if they tried on their own.

> "We are all here to better our lives.
> We aren't where we want to be, so we don't leave because we are here trying to get our lives together. We aren't just going to throw that away. We've put the effort in to be here."

Primary Implementation Findings

Findings reported in this section were derived from two primary data sources: 1) stakeholder meetings and 2) the Annual JBU Staff Survey. Stakeholder meetings were held throughout the year with representatives from BHS, JBU, and the UCSD evaluation team. Primary objectives for these meetings were to review program operations, evaluation approaches, and outcome data. The Annual JBU Staff Survey was conducted at the end of each year. JBU program staff were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Open-ended survey question responses were coded by a UCSD evaluator and reviewed by a second evaluator to identify emergent themes. The following themes emerged throughout the Innovations-funded phase of the JBU program:

Program Strengths

JBU Team

JBU staff identified their team as a primary strength of the program. Staff described coworkers as caring, compassionate, and communicative. One staff member highlighted "the skill set [and] life experiences that the staff can use to support each other and support the youth." Another team member recounted the collaboration of all team members where "through staff meetings each staff would dictate their roles for the week and update their progress," as well as "a solid teamwork ethic and bond" and "an organized plan" for operations. Team members are described as having "passion and drive to help their clients be successful."

Staff members shared the following:

> "I genuinely believe [staff] are there with an open heart and compassion to support residents to the best of their abilities."
>
> "We all get along very well and have all the same goals in mind for the success of the youth and the program."

> “The program provides the participants with housing, food, holistic resources, and a routine that would otherwise not be accessible. The team is made up of people who are empathetic, care deeply about the participants, and work diligently to support everyone's success. The staff serve as some of the first and only healthy attachments to the youth and model healthy behaviors as well.”

> “The team - good relationships among staff and youth. Holistic view of the youth and the complex interaction between mental health, substance use, trauma, and all of the other negative past experiences they have had in their lives including racism, sexism, transphobia, homophobia, ableism, and just general stigmatization.”

JBU strives to create a home-like environment for the clients, in an effort to “provide advocacy for daily functioning.” Staff described their ability to work together as exceptional, as well as their ability to “understand one another to better move through program challenges.” Such ability is in part due to “weekly team meetings, building good relationships and partnerships with housing programs, good team communication and delegation of tasks.” Moreover:

> “The collaborative efforts of the interdisciplinary team, including the Case Manager (CM), Program Manager (PM), Peer Support Specialists (PSS), and Occupational Therapist (OT)/Occupational Therapy Interns, collectively work together to support the connection to these necessary services. Although this goal falls directly under the CM's role, the other members of the team have made great effort to support this goal and advocate for the client's needs.”

According to survey responses, this effort is reflected in the overall feel of the program. JBU strives to create a home-like environment for the clients, in an effort to create a “sense of connection and belonging.” Staff describe the climate of JBU as “tight-knit,” “cohesive,” “personable and homey” and “more of a family feeling than just staff and clients.”

> “Staff is very open and caring toward the clients. They understand and sympathize with where they came from and what they have experienced. Staff provide the necessary resources for the clients to achieve their goals.”

Connections to Outside Providers

Providing secure housing is a primary goal of JBU, as well as connecting clients with mental health services. To do this, JBU staff work hard to build linkages with outside organizations. Several staff describe case managers’ hard work to identify and connect with housing and mental health services. “Regular communication” and “connection with our community mental health partner providers” is key to JBU’s successful case management efforts. Staff also describe “outreach connections to public defender’s office and psychiatric hospitals to receive youth” and “connections with therapy and psychiatry, as well as holistic care providers.”

As one staff member put it:

> “Connecting [clients] with mental health care is instrumental towards having a solid foundation for themselves and helps prevent repeating the cycle of experiencing homelessness again.”

According to staff, “connecting clients with mental health services,” is a primary goal of JBU. To do this, JBU staff work hard to build linkages with outside organizations. Several staff describe case managers’ hard work to identify and connect with housing and mental health services, as well as enrolling clients in the Community Queue Partnerships. Staff also describe “familiarity with the community partnerships (i.e., The Center, The County of San Diego BHS, UPAC, Timmy's, The Lucky Duck Foundation, Family Health Services, among others).”

Client Engagement

The above-described staff characteristics, combined with the ability to link clients with outside providers, helped the JBU program with client engagement and retention. When asked to identify the most effective engagement strategies, staff members described:

> “Collaborative efforts to support the clients and express empathy for where the clients are at in their journey of independence, recovery, and mental health. Understand the client’s needs and interests and connect the clients to activities that engage their interests in a safe space.”

> “Dedicated and persistent staff members at JBU who go the extra mile to ensure their clients are receiving or being connected to the resources they need to be successful.”

One team member described the team’s non-judgmental and engaged approach with clients:

> “Recognizing where they are at and not punishing them for lack of engagement. Harm reduction principles (as much as possible) re. substance use. Outings - a chance to connect socially where nothing is expected of them other than having fun. Supporting them with reminders about medication/appointments etc.”

Staff also identified communication about goals as an important component of success:

> “Occupational therapy and peer support staff help develop and assist in achieving youth goals for self-sufficiency (in areas of establishing employment/income, physical and mental health self-care skills and other personal development).”

Additionally, concrete elements for successful retention were also shared:

> “Incentivizing participation. Focusing on youth wants/needs and planning events/groups around these wants/needs”

> “Being honest with them about how the program works and why we have the expectations of them, such as what needs to happen for us to get funding and why we want them to engage with programs, rather than just telling them that's just the way it is. Also, treating them like peers and not like children or lesser than.”

> “The greatest challenge to connecting the services for use is the youth's level of readiness to connect to services and trust between the youth and the people in the organization. This can be surpassed with rapport-building, supporting the youth through challenges, and being consistent with the services provided.”

Staff also identified communication about goals as an important component of success:

> “Identifying meaningful goals and connecting those goals to the services provided.”

> “Reminding them of their goals and helping them achieve them.”

> “Continuing to have conversations [about] what they are working towards.”

Additionally, concrete elements for successful retention were named: food, gift cards, engaging outings and recreational activities, as well as individualized incentives/rewards for participation.

OT as a Core Component of JBU Services

The use of OT to assist youth in their goals and treatment plan was cited as a significant strength for the JBU program. OTs aid their clients with vocational and leisure pursuits, social engagements, financial management, medication management, community mobility, among other things. When asked about the potential benefits of OT, JBU staff had much to share:

> “Skill building with OT: advocacy skills, time management. Working on IADLs in OT to ensure youth can be independent in housing: home maintenance/management, meal preparation, housekeeping, safety”

> “OT services connects the gaps of the organization that are unable to be filled by the interdisciplinary team, including identifying occupational performance problems and sensory deficits, collaborating with clients to complete routine building/maintenance, and performing activity analysis and other skilled OT intervention.”

The value of OT services led one staff member to suggest the following:

> “I recommend hiring an occupational therapist full-time to increase the frequency of OT services and support the client's ability to perform and participate in daily occupations…OT services provides residents an opportunity to understand and work towards their personal goals. The OT supports residents in gaining autonomy towards their goals by assessing their needs and creating a treatment plan that is specific to each resident.”

Program Challenges

Program Relocated Multiple Times, then Returned to Original Downtown San Diego Location

The JBU program moved multiple times in order to try alternative types of housing arrangements. The program ultimately returned to the original downtown San Diego location after having brief periods of operations within a residential community in Clairmont as well as operating within a rehabilitated motel in Chula Vista. The JBU staff identified the moves as creating some challenges for meeting program objectives given the need to establish new relationships with a range of behavioral health and other service providers in their new community as well as the added time and efforts required to complete the actual move. A couple of staff members noted the disorganization they had to face when changing locations. However, one staff member shared the following benefit of relocating back to the original downtown San Diego location:

> “Having a safe environment or a program environment with additional security that help our youths feel safe and secured (as compared to our last placement in the facility at Chula Vista).”

Several staff members suggested ways to improve the location. For instance:

> “A "village" of houses with mental health/SUD/primary care/dental/LGBTQ-affirming services all in the one neighborhood.”

> “The facility must have a recreational/communal area for the clients to engage in leisure activities (i.e., playing board games/video games, watch digital media, use computers, be outdoors, a communal place to eat and possibly cook, and access to bathrooms. The facility must also have 24/7 surveillance and a security check upon entrance to increase the safety of the clients and staff on-site.”

Staff Support Concerns

Some of the staff mentioned staff concerns, particularly in terms of overwork and staff shortages.

> “Achieving this goal is a team effort and requires team support. At the time of my internship, there were several occasions in which staff shortages limited the team's ability to meet this goal due to a lack of support.”

> “Extreme burnout felt in work culture. Limited staff insights or staff with background on how to support youths struggling with substance use.”

Client Factors

Client factors are the primary challenges named by JBU staff. Client resistance is identified as a significant inhibiting factor in the success of JBU. Staff describe client resistance due to negative experiences with treatment and/or institutions in the past, or difficulty engaging with services due to the severity of their mental health symptoms. Other reasons for such client resistance listed by staff include, stigma, “youth reporting not wanting services due to fear of being labelled/fear of being ‘drugged out’ on medications,” not identifying with their mental health diagnosis, belief that they do not need medication, losing motivation for obtaining services due to waitlists or an inordinate number of steps (or paperwork burden) to access services, lack of staff follow through or support due to low staffing, providers cancelling appointments with youth or rescheduling appointments to dates beyond allotted JBU program time. One staff member also reported the ACT teams may be “denying clients they deem ‘not severe enough’,” while another staff member mentioned “youth struggling with the amount of tasks and expectations,” as reasons for client resistance or lack of follow through.

Substance use can pose an additional hurdle. In the past, JBU staff reported difficulties in connecting with SUD providers who had availability to admit new clients. This continued to be a theme in FY 2022-23. One staff member described the program “not having an adequate SUD approach.” Other staff shared that there is a need for in-house SUD counseling and/or more support from addiction specialists including group therapy and interventions targeting substance use and addiction.

Transportation was a challenge as well. Staff described how some clients struggle with utilizing public transportation and staff are not always available to provide private transit to/from appointments.

According to staff, medication resistance can create particularly serious difficulties in the engagement process: “resistance to medication... creates room for more youth to experience psychosis.” In this case, depending on the severity, duration, and willingness/ability of person to engage in relevant treatment, the client may need to receive crisis services or be hospitalized.

Finally, lack of long-term housing options was another common concern noted by staff:

> "If housing matches aren't yielding from time worked with case management near the end of the program (2 and a half to 3-month range), some youths have reported feeling they are "in survival mode" and no longer feeling secure, leading to a dramatic disengagement with staff and services or decline in quality of engagements from loss of hope for long-term stability."

> "Youth's interest and motivation in participating in provided services can be difficult due to their different mental illnesses. Follow-through and scheduling also pose as difficulties as many of them have challenges with organizing their schedules. Additionally, using public transportation to get to services is difficult for some youth."

> "Youth who have described feeling so traumatized/hurt by the previous mental health/medical care they've received (Not being heard/acknowledged in their care, being forced to take medication they didn't understand, feeling violated or abused) that they are resistant to the idea of services."

Program Duration

A few staff members shared a desire for clients to be able to stay in the program longer. Staff describe how the program duration is "not enough time to affect change." Other relevant statements are as follows:

> "120-days is not a long enough time for client to receive all services and care necessary"

> "Not long enough of a duration for the clients in the program to be connected to services and gather missing documents as well as rehabilitate in understanding their SMI diagnosis."

> "Four months is not long enough for the youth to be stable in their mental health, get housing services, and stable on their medications."

One staff member also suggested that there needs to be a guaranteed "next level" transitional housing program for youth to go after completing and gaining stability in JBU, as well as the need for easier access to "youth psychiatric/behavioral health records (not all records of diagnostic information/history of service engagements are listed in CERNER which has been detrimental in getting people connected to services and permanent housing programs)."

In addition, staff reported the need for long term housing options for clients:

> "Improved coordination or tools to connect to longer-term housing options/programs for youths at the end of their program duration through County or stakeholders."

> "Lack of viable housing options for our youth (Reportedly from multiple case managers from this program and other USA programs) despite utilization of VI-SPIDAT tools designed to provide housing matches."

Other concerns around gaps in service were also noted by staff:

> "I recommend increasing or allocating funding towards hiring an additional PSS or PRN PSS to fulfill the needs of the team and prevent staffing shortages. Although there is no solution to end homelessness and create more housing opportunities, the CM and PM can collaborate to connect with housing organizations and create a 'funnel' program depending on the level of independence of the participants."

> "Clients without insurance, clients in higher level of care unable to access mental health services, or little staffing from mental health clinics unable to serve our clients."

Telehealth

Telehealth can be a solution for clients who cannot attend appointments in person. However, a reliable internet connection and private space are necessary for successful utilization of telehealth services and these things are not always available. Besides having better WIFI connections, staff suggested setting up private spaces with a webcam for clients to use exclusively for telehealth services.

> "Some youth have felt they do not have a space with enough privacy in order to conduct their Telehealth calls (We have two office spaces with a joint den space, however one has to cross through the den space in order to access staff in the office)."

Additionally, one staff member described how some medical providers "require in-person visits as the youth may be less engaged or inconsistent during their telehealth appointments/attending telehealth appointments."

Composite of JBU Youth Experiences

JBU youth have a variety of experiences and needs when they arrive at the program. To reflect the types of experiences we developed the following composite infographic (see Figure 6), derived from multiple youth accounts. While all examples are from JBU youth, it is important to recognize youth entering and exiting the program will have a variety of experiences.

Please see the next page for the infographic characterizing youth experiences with the JBU program.

Figure 6. Infographic Characterizing Youth Experiences with the JBU Program

Changes from Initial Program Design

As a residential program serving homeless youth, a population at considerable risk for exposure to disease, the COVID-19 pandemic required JBU to implement many policies and procedures to comply with CDC and County public health guidelines. JBU successfully navigated these changes to manage risk to participants and maintained the ability to provide in-person services. Examples of policies and procedures are as follows: holding staff safety procedure trainings, providing quarantine and isolation plans, increasing security and protocols for building entry, posting COVID-19 safety education materials, implementing staff and youth mask requirements and rigorous sanitation procedures, and complying with County public health safety measures. While the basic residential component continued without interruption, JBU had to periodically suspend or alter the provision of in-person holistic services except those which could be socially distanced or completed via remote technologies (i.e., yoga, fitness, mindfulness, and biofeedback). Public outings to promote education, enrichment, and/or growth with peers continued, but were more limited during due to COVID-19. Where possible, activities and events were held outdoors to promote safety among staff and youth. Due to potential exposures to COVID-19 or infections, various JBU staff were required to periodically isolate from JBU youth, which did create additional burdens and challenges for staff to cover JBU operations amidst staffing disruptions. Additional strategic changes from the initial design included:

1. After reviewing outcome data and collecting experiences of JBU youth, JBU stakeholders recognized the difficulties of trying to address the multiple needs of youth within 90 days. While still maintaining the emphasis on short-term support, it was decided to extend the in-residence phase of the JBU program from 90 days to 120 days for those youth who needed additional time in JBU.

2. To increase the number of youth enrolled in JBU, referrals were expanded beyond those provided by BHS. Youth identified through JBU outreach efforts and/or referrals from other community partners could also be admitted into JBU as long as they exhibited similar characteristics and histories as youth referred by BHS (i.e., SMI diagnosis, homeless, utilization of BHS crisis/acute services, and not engaged in treatment). This change was fully implemented during FY 2020-21.
3. The availability of OT services was expanded, with OT services becoming an essential component of how JBU engages with and supports youth. Through interactions with the OT personnel, youth were encouraged to develop and then act on achieving personal goals.

Conclusion

Overall, the findings indicated that the JBU program was able to achieve key objectives of contacting and engaging with their target youth population, creating linkages to appropriate mental health and substance use treatment, and improving the general well-being of the youth who participated in services. A key contributing factor to the success of JBU was the addition of OT services, which helped to further strengthen and focus efforts on developing and implementing individualized, goal-oriented self-improvement activities among the JBU youth. However, substantial challenges remain to enable even more youth to experience greater short- and long-term recovery given that many youths have multiple factors inhibiting such gains including co-occurring SUD, complex physical health needs, limited housing options, and difficulty transitioning to external treatment providers among others.

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

Characteristics of Participants who Enrolled in JBU

Characteristic	Total Participants (N=204)	
Gender	**n**	**%**
Male	121	59.3
Female	70	34.3
Another Gender Identity/Missing	13	6.4
Total	**204**	**100**
Age Group	**n**	**%**
18-21	93	45.6
22-25	111	54.4
Total	**204**	**100**
Primary Language	**n**	**%**
English	198	97.1
Other	6	2.9
Total	**204**	100
Race/Ethnicity	**n**	**%**
African American	53	26.0
Asian	12	5.9
Hispanic or Latino	78	38.2
White	77	37.7
Multi-Racial	28	13.7
Other/Missing	**13**	**6.3**
Total[1]	-	-
Mental Health Diagnosis[2]	**n**	**%**
Schizophrenia or other psychotic disorder	133	65.2
Bipolar Disorder	41	20.1
Depressive Disorder	19	9.3
Other/Missing	11	5.4
Total	**204**	**100**

[1] *Total may exceed 100% since participants could select more than one response.*

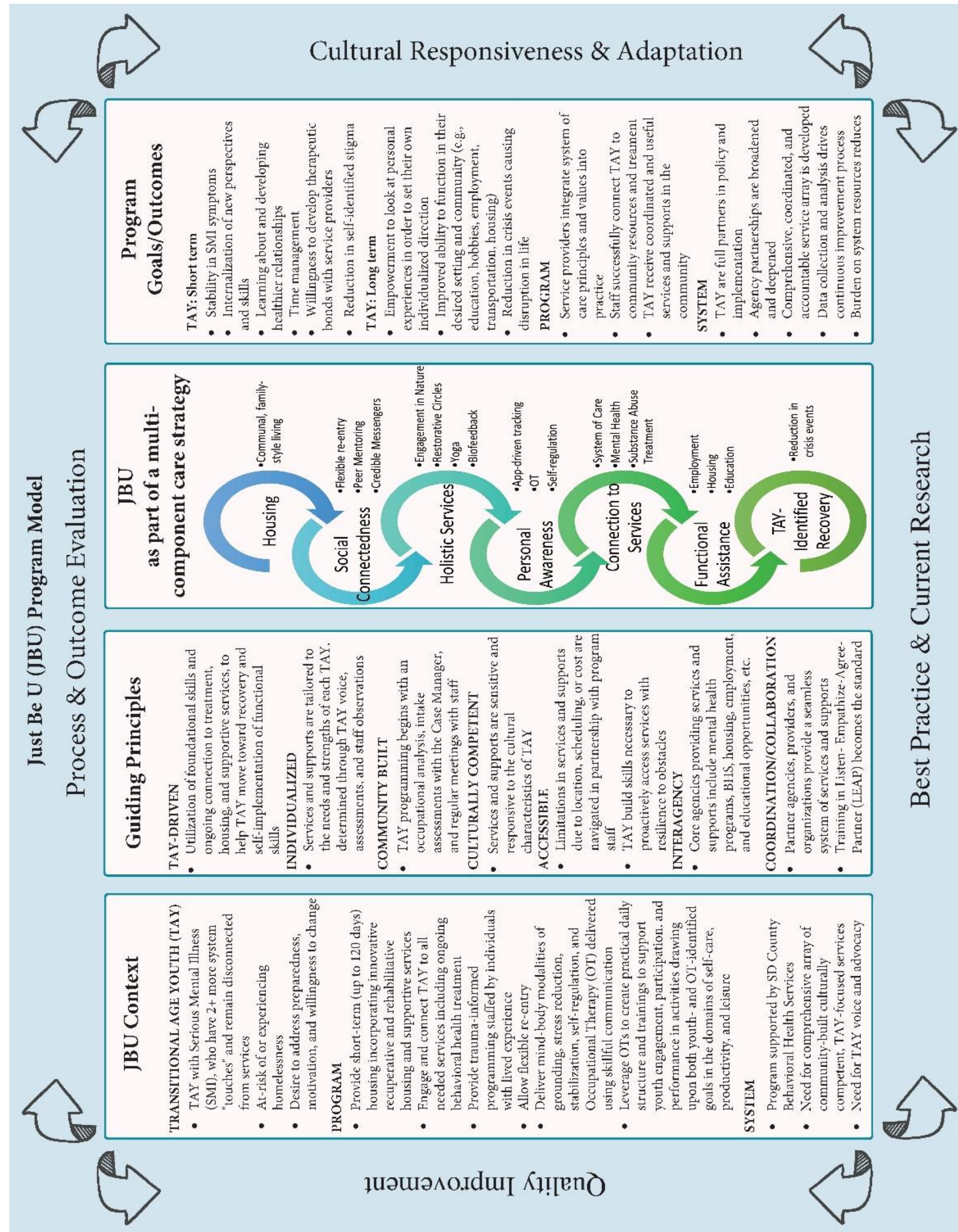
[2] *Mental health and substance use diagnosis information is obtained from BHS Cerner data system.*

Appendix (continued).

Characteristic	Total Participants (N=204)	
Co-Occurring Substance Use Diagnosis[2]	**n**	**%**
Yes	119	58.3
No	85	41.7
Total	**204**	**100**
Sexual Orientation	**n**	**%**
Heterosexual or straight	113	55.4
Bisexual/Pansexual/Sexually Fluid	17	8.3
Gay or lesbian	5	2.5
Another orientation	8	3.9
Missing/Prefer not to answer	61	29.9
Total	**204**	**100**
Disability	**n**	**%**
Yes, has a disability	49	24.1
No, does not have a disability	97	47.5
Declined/Prefer not to answer	58	28.4
Total	**204**	**100**
Type of Disability	**n**	**%**
Learning/Developmental	47	22.7
Physical/Chronic/Other	20	9.6
Total[3]	**-**	**-**

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

JBU Program Model



THE CENTER FOR CHILD AND YOUTH PSYCHIATRY (CCYP) INNOVATIONS-22

Final Report
(7/1/2018 - 12/31/2022)

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

v.12.22.2023

UC San Diego

Table of Contents

Executive Summary 1
Program Description 1
Assessment of Primary Project Objectives 2
Future Directions 5
CCYP Enrollment 6
Participant Characteristics 6
Utilization of Program Services 7
BHS Utilization Patterns 9
Primary Program Outcomes 11
Primary Implementation Findings 15
Changes from Initial Program Design 19
Conclusion 19
Appendix 21

Executive Summary

The County of San Diego Health and Human Services Agency's (HHSA) Behavioral Health Services (BHS) Center for Child and Youth Psychiatry (CCYP) program was funded through the Innovations (INN) component of the Mental Health Services Act (MHSA). CCYP was developed to provide medication support to select children and youth who have completed behavioral health treatment services yet require ongoing monitoring of complex psychotropic medications that were essential for their wellness and stability, but not easily managed by their primary care provider (PCP). Psychiatric care services were designed to be delivered primarily via telehealth in order to reduce barriers to accessing care and service youth and families throughout the entire County of San Diego. MHSA INN funding for CCYP services ended on 12/31/2022; however, by successfully achieving the primary program objective and demonstrating the capacity to keep youth stable for extended periods of time through the provision of medication management services, CCYP has been incorporated into the existing BHS System of Care as an ongoing service funded through non-INN resources. In addition to providing psychiatric evaluation and treatment to children and youth who have completed behavioral health treatment yet require ongoing and complex medication monitoring not viable with their PCP, CCYP supported the overall BHS Child, Youth and Family (CYF) System of Care (SOC) by providing psychiatric care services when other BHS-funded treatment programs experienced temporary gaps in their ability to offer timely psychiatric care (e.g., due to psychiatrist departures or leaves of absence). This role of providing services to "ancillary" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere) ensured continuity of care and has become part of standard CCYP operations. During fiscal year (FY) 2021-22, CCYP expanded their support of the BHS CYF SOC by providing psychiatric care services to youth enrolled in BHS-funded Short-Term Residential Therapeutic Programs (STRTP) that were too small (i.e., 12 or fewer beds) to feasibly provide their own psychiatric services.

Program Description

The CCYP program was developed to provide medication support to select children and youth who have completed behavioral health treatment services yet require ongoing monitoring of complex psychotropic medications that were essential for their wellness and stability which is not easily managed by their PCP. For children and youth with complex combinations of mental health problems or with complex mental disorders (e.g., PTSD, bipolar disorder, schizophrenia, autism with aggression, ADHD with mood

dysregulation), it can be difficult to find a primary care doctor prepared to manage the medication treatment aspect of their care. Services were provided through a variety of means, including a centrally located psychiatric clinic as well as strong emphasis on telepsychiatry to reduce barriers to accessing care and to extend the reach of CCYP services across San Diego County, a large geographic area covering over 4,250 square miles (an area larger than the combined size of the states of Rhode Island and Delaware). The CCYP program provided linkages and facilitated access to psychotropic medication, including the administration of long-acting injectable psychotropic medication when indicated and necessary for the child or youth's stability. Additional goals of CCYP include improved communication and collaboration between CCYP, local referral partners (e.g., full-service clinics, schools, PCPs), and the communities they serve. The CCYP program also provided psychoeducation opportunities for the families of CCYP participants as well as for the broader San Diego community. A San Diego-based community organization, New Alternatives Incorporated (NAI), was contracted to provide CCYP services during the Innovations-funded phase of the pilot project.

The CCYP program also developed into an important county-wide BHS CYF SOC resource that can fulfill the need for psychiatric services when other county-funded programs experience a temporary gap in their capability to offer timely psychiatric care (e.g., primarily due to psychiatrist departures or leaves of absence). Providing continuity of psychiatric care in these situations was determined to be an important ongoing benefit that CCYP could contribute to the CYF SOC. Youth who were admitted via this additional service strategy (i.e., ancillary referrals), differed from the traditional maintenance CCYP enrollees in that they continued to receive psychotherapeutic care services from the referring agency while CCYP provided needed medication management support. This required additional communication and coordination between CCYP and the organization providing the therapy services. During FY 2021-22, a new role was added such that CCYP was responsible for providing medication management services to youth enrolled in BHS-funded STRTPs with less than 12 beds.

The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to administrative and institutional barriers, the anticipated partnerships were eventually determined to not be feasible, so an emphasis on the medically fragile was not implemented as part of CCYP operations.

MHSA INN funding for CCYP services ended on 12/31/2022; however, with the successful achievement of program objectives, BHS decided that the CCYP program should be incorporated into the existing BHS System of Care as an ongoing service that will be funded through non-INN resources.

Assessment of Primary Project Objectives

The main goal of the CCYP Innovation-funded project was:

1. ***To determine if a Medication Clinic could serve as a specialty program for children and youth who have been clinically stabilized and require sophisticated psychiatric services sufficient to meet their ongoing complex prescribing needs (i.e., too complex for primary care physicians).***

   A total of 760 unique “maintenance” enrollees (i.e., those requiring medication management services, but not therapy services) enrolled into the CCYP program throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. The majority (70.1%; n=533) of clients enrolled in CCYP were at least 12 years old. More females enrolled than males (50.4%; n=383 and 44.3%; n=337,

respectively). CCYP served a racially and ethnically diverse population. The largest group of participants identified as Hispanic or Latino (58.6%; n=445), followed by White (40.1%; n=305). While most clients reported English as their primary language (85.8%; n=652), more than 10% selected Spanish (11.3%; n=86).

As described in more detail in other report sections below, the pattern of lengthy CCYP program participation of maintenance clients (i.e., average and median CCYP duration 431.5 and 344.5 days, respectively for clients who discharged prior to 12/31/2022), coupled with similar or reduced frequency of BHS crisis and acute care services utilized while in CCYP, indicated that CCYP achieved the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy. Additionally, although therapeutic services were not provided through CCYP, both clinician and caregiver/youth self-report (as documented by the CANS and PSC, respectively) indicated that many youth and family members experienced improvements in their well-being following enrollment in CCYP. In quantitative and qualitative feedback, both caregivers and youth typically indicated high levels of satisfaction with CCYP services. These findings provide evidence that CCYP successfully accomplished the overall goal of providing psychiatric services to maintain the stability of a diverse population of children and youth living throughout San Diego County who had completed therapy but needed ongoing medication management support.

Additional objectives from the original design of the CCYP program included:

2. ***Provide coordinated and co-located access to care for children and youth who access primary care in Developmental Pediatricians' Offices due to having complex medical needs*.**

The CCYP program was originally expected to have a specific emphasis on providing psychiatric services to medically fragile children and youth who had complex ongoing psychotropic medication needs. Due to administrative and institutional barriers, the anticipated partnerships were ultimately determined not to be viable. Therefore, the specific partnership to support medically fragile clients was not implemented as part of CCYP operations during the Innovations-funded pilot phase of CCYP.

3. Expand access to care by developing telepsychiatry options in multiple locations throughout the County of San Diego for children and youth who do not have or have not accessed Specialty Psychiatric Care due to geographical distance, cultural reluctance, stigma, fear, or socioeconomic concerns.

The initial design of CCYP included a substantial reliance upon telehealth services to provide psychiatric care throughout the entire county. Telehealth visits with psychiatrists were initially available at select clinics or in the clients' home during home visits by a CCYP care coordinator or nurse to facilitate the telehealth visits. With the onset of the COVID-19 pandemic in March 2020, home visits and most clinic visits were suspended, and telehealth visits occurred directly with clients and/or their families using their own devices. Since 6/30/2020, almost all service contacts provided by CCYP occurred via telehealth (i.e., phone or video). At the beginning of the project, however, telehealth was a relatively novel service modality and there was some uncertainty about the capability of building client rapport when services were not face-to-face. The results of multiple staff surveys throughout the Innovations-funded phase of CCYP indicated that staff typically rated client interactions via telehealth as better than in-person services. The highest rated items were patient willingness to

schedule sessions and a lowered rate of no-shows. Patient openness, provider/patient relationships, patient/client engagement and focus during sessions were all rated as better with telehealth as compared to in-person sessions. Technological capabilities (i.e., access to high-speed internet) were noted as factors that inhibited delivery of telehealth services, but this was perceived as a diminishing barrier over time. Overall, CCYP demonstrated that telehealth modalities could be successfully utilized to provide medication management and other needed support services to clients throughout the County of San Diego.

4. ***Address workforce shortages by exploring telepsychiatry with psychiatry groups who may be outside of the County of San Diego.***

   During the Innovation-funded phase of CCYP program, the program was able to identify and utilize a team of psychiatrists based in the County of San Diego. In this regard, supplementing the local psychiatric workforce with persons residing in other areas was not needed; however, the success with utilizing telehealth modalities for providing medication management services suggests that utilizing non-local psychiatrists who maintain the necessary licenses would likely be a viable option to pursue in the future.

5. ***Provide evening programs to families on relevant topics and host resource fairs for families to obtain psychoeducation- and medication management-related information and resources via videos, books, pamphlets, websites, and other materials.***

   During the initial years of the Innovations-funded phase of CCYP, the program offered educational sessions at multiple locations throughout the County of San Diego that covered topics such as: 1) psychopharmacology, 2) medication administration & storage, and 3) trauma and how it affects the bodies, minds, and behaviors of kids. Likewise, resource fairs were developed and held at publicly accessible locations such as local libraries that brought together a range of community partners to provide education and support to CCYP clients and the general community. These in-person events had relatively low rates of attendance (typically about 10 persons or less), despite offering childcare. With the onset of the COVID-19 pandemic in 2020, in-person events were no longer feasible and the CCYP program shifted to providing opportunities for remote psychoeducation via video conferences/webinars and hosted sessions such as "Ask a Psychiatrist," which allowed CCYP clients and the general public to have an opportunity to engage with psychiatrists in a more informal interaction. Additionally, CCYP developed and enhanced other mechanisms for providing psychoeducation and support to CCYP youth, parents/caregivers, and community members via a monthly newsletter and website (https://www.ccypsd.org/). Based on CCYP experiences, even without pandemic-related concerns, hosting in-person community psychoeducation events may not represent a good utilization of CCYP staff time and energy and should be considered cautiously rather than an ongoing expectation of CCYP operations.

6. ***Support the overall CYF SOC by providing psychiatric coverage for programs that have disruptions in access to psychiatric consultation services.***

   While not without some challenges, CCYP fulfilled the supplementary objective of supporting the overall CYF SOC by providing continuity of care for youth who would have otherwise faced disruption in accessing psychiatric medication management services at the location where they participated in ongoing therapy (e.g., due to unexpected leaves). Since FY 2021-22, CCYP also partnered with small

Short-Term Residential Therapeutic Programs (STRTPs; i.e., those with 12 or fewer beds) to meet any medication management needs for youth participating in these programs. A total of 180 youth received CCYP services through these arrangements. When CCYP initially began accepting ancillary referrals, there were some CCYP workforce challenges since providing services for these youth required additional communication and coordination with their treatment providers and these youth had higher levels of need than the maintenance clients who had successfully completed their treatment services prior to enrolling in CCYP. Over time, CCYP leadership adjusted assessment coordinator task requirements and expectations such that their workload requirements were similar regardless of whether providing services to maintenance or ancillary/STRTP clients. Overall, CCYP was able to successfully support the overall CYF SOC by strategically providing psychiatric services when other treatment programs experienced temporary disruptions in their ability to offer medication management services and partnering with select small organizations (e.g., STRTPs) without regular access to psychiatric services.

Future Directions

After the Innovations-funded phase of the CCYP program concluded on 12/31/22, CCYP was incorporated into the overall BHS CYF SOC as an ongoing service. Reflecting the evolution of the CCYP during the Innovations-funded phase, expectations for ongoing CCYP services continued the emphasis on three core populations including:

- Children and youth who have successfully completed their behavioral health treatment but have complex medication requirements that are difficult to manage by PCPs.
- Children and youth receiving behavioral health treatment services at providers who have temporarily experienced a disruption in the capability to provide psychiatric services.
- Youth enrolled in STRTPs with 12 or fewer beds.

Given the success of CCYP to serve as a centralized resource providing needed CYF-oriented psychiatric care, several additional populations will be emphasized in the ongoing CCYP services:

- Youth who are involved in the justice system.
- Youth with co-morbid substance use concerns who may benefit from medication assisted treatment (MAT) approaches.
- Youth who are dependents of the court and for whom consultation, review, and/or feedback is required regarding Juvenile Court JV-220 applications to start or change utilization of psychotropic medications.

Psychoeducation

Providing opportunities for psychoeducation, particularly related to psychotropic medication, will continue to be a priority for ongoing CCYP services. However, based on the experiences of the CCYP program during the Innovations-funded pilot phase, the emphasis will be on electronic forms of communicating information such as via website and newsletters rather than attempting to host in-person community education and training events.

Relationships with Community Providers

Consistent with an area of emphasis during the latter years of the Innovations-funded phase of CCYP, relationships will be fostered with local PCPs and medical groups such as the Children's Primary Care Medical Group (CPCMG), as well as other programs like Smart Care. During the Innovations-funded phase of CCYP, it was common for clients to receive services for more than a year. However, that limited the capacity of CCYP to enroll new children and youth into services. These relationships with outside providers will be essential to allow CCYP to achieve the newly established goal of transitioning most of their clients within a year. The approach currently adopted by CCYP will try to balance the need for stable access to psychiatric care (for up to a year), while also setting up expectations that CCYP will facilitate the needed support and education to ultimately transition medication management responsibilities to other service providers.

CCYP Enrollment

As shown in Table 1, a total of 935 unique persons were enrolled into the CCYP program throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. Of the 935 enrollees, 760 (81.3%) were considered maintenance enrollees who met the standard eligibility criteria (i.e., requiring medication management services, but not therapy services), 175 (18.7%) were considered ancillary enrollees including 44 (4.7%) youth enrolled in CCYP services as part of the new partnership with small STRTP programs (i.e., those with 12 beds or less), in which CCYP is responsible for medication management while other forms of treatment and support occur within the STRTP program.

Table 1. CCYP Program Enrollment (N=935)

Type of CCYP Enrollee	n	%
Maintenance enrollees (i.e., not receiving therapy elsewhere)	760	81.3%
Ancillary enrollees (i.e., receiving therapy elsewhere)	175	18.7%
Total CCYP enrollees	**935**	**100%**

Participant Characteristics

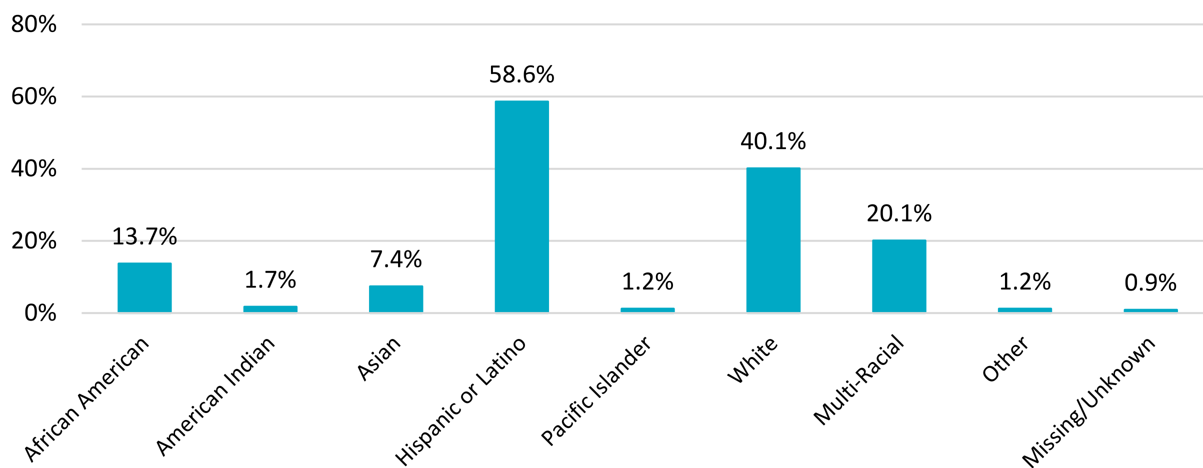
During the life of the program, 935 people enrolled in CCYP. Key characteristics of maintenance participants are discussed below. Additional analyses not reported here found similar demographic characteristics between maintenance and ancillary clients. More detailed information for both maintenance and ancillary participants can be found in the appendix.

The majority (70.1%; n=533) of maintenance clients enrolled in CCYP were at least 12 years old. More females enrolled than males (50.4%; n=383 and 44.3%; n=337, respectively). Over half of clients identified as heterosexual (55.8%; n=424), with 13.3% (n=101) indicating being bisexual, pansexual, or sexually fluid and 23.2% (n=176) declining to select an orientation.

As shown in Figure 1, CCYP served a racially and ethnically diverse population. The largest group of participants identified as Hispanic or Latino (58.6%; n=445), followed by White (40.1%; n=305), multiple racial/ethnic backgrounds (20.1%; n=153), African American (13.7%; n=104), and Asian (7.4%; n=56).

While most clients reported English as their primary language (85.8%; n=652), more than 10% selected Spanish (11.3%; n=86).

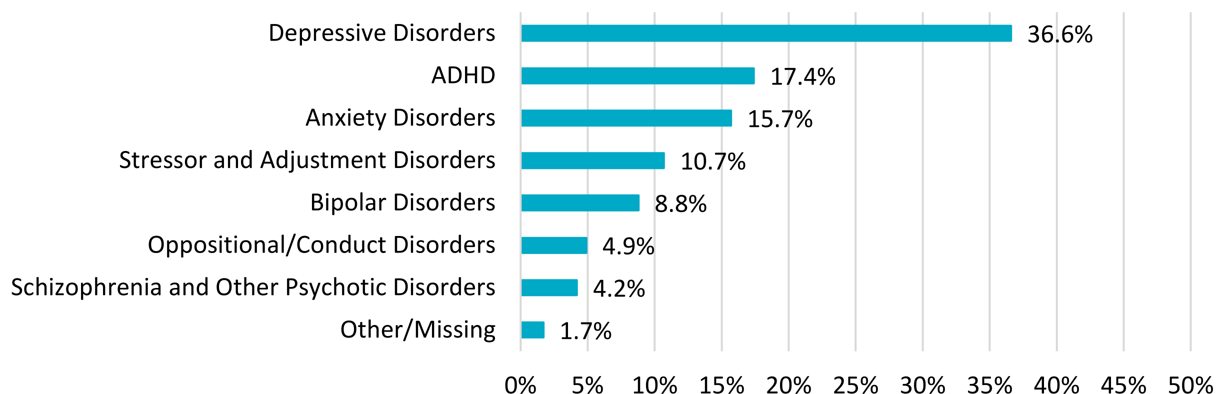
Figure 1. Race/Ethnicity of Clients Who Enrolled in CCYP (N=760)



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

The youth served by CCYP had a wide range of mental health diagnoses (see Figure 2). The most common diagnoses included depression (36.6%; n=279), attention-deficit/hyperactivity disorder (ADHD) (17.4%; n=132), and anxiety disorders (15.7%; n=119).

Figure 2. Primary Mental Health Diagnosis of Youth Who Enrolled in CCYP (N=760)



The most common disability reported among CCYP participants was a learning disability (8.8%; n=67).

Utilization of Program Services

Program Service Contacts/Service Utilization

The CCYP program served a total of 935 unique youth (760 maintenance and 175 ancillary) throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. The number of youth served annually was substantial: 500 or more youth served per year during the final two years. This level of service was consistent with the original program goals of providing CCYP services to 500 unique youth

each year. Once enrolled, many youth participated in CCYP for more than a year (discussed in more detail below).

Table 2 presents the average number of services received for each 30 days (i.e., one month) of CCYP enrollment across primary service types. On average, maintenance and ancillary/STRTP youth received 1.50 and 1.69 CCYP services per 30 days, respectively. The 0.19 overall difference reflects a narrowing of the gap between maintenance and ancillary evident in earlier years (e.g., 0.28 in FY 2020-21), in which ancillary youth were creating some staffing burdens due to requiring more service contacts per 30 days of receiving CCYP services. This shift highlights successful efforts by CCYP leadership to adjust assessment coordinator task requirements and expectations such that their workload requirements were similar regardless of whether providing services to maintenance or ancillary clients.

Table 2. Average Number and Type of CCYP Services Received by Client Per Month (N=935)

Type of CCYP Service	Mean Number of Services per 30 Days	
	Maintenance (N=760)	Ancillary/STRTP (N=175)
Any CCYP service	1.50	1.69
Psychosocial assessment	0.21	0.26
Medication management	0.70	0.79
Nurse consult	0.37	0.41
Other services (e.g., collateral)	0.22	0.23

For both groups of CCYP clients, medication management services and nurse consultations represented approximately 50% and 25%, respectively, of the average total monthly CCYP services provided. The remaining 25% of contacts were related to psychosocial assessments to track client needs as well as other supportive services such as collateral contacts with other providers.

As shown in Table 3, the method used to deliver CCYP services fundamentally shifted over the years due to the onset of the COVID-19 pandemic. Prior to the pandemic, the majority of CCYP services were provided face-to-face (often with a CCYP team member in the home facilitating a telehealth visit with the psychiatrist). During the initial months of the pandemic (i.e., the end of FY 2019-20), many services shifted to telephone-based, with only a small portion of services provided as telehealth with video directly to clients. Throughout FY 2020-21, CCYP adapted their approach and increased utilization of telehealth such that by the end of the Innovations-funded CCYP project, slightly under 50% of services were provided via telehealth.

Table 3. Type of CCYP Service Contact

	FY 2018-19		FY 2019-20		FY 2020-21		FY 2021-22	
Contact Type	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Telehealth with video	119	6.4%	419	11.1%	1,790	40.6%	2,029	48.3%
Telephone	403	21.7%	1,658	43.7%	2,544	57.7%	2,125	50.6%
Face to face	1,335	71.9%	1,713	45.2%	75	1.7%	46	1.1%
Total Services	**1,857**	**100%**	**3,790**	**100%**	**4,409**	**100%**	**4,200**	**100%**

Program Duration

Enrollment duration and discharge status were analyzed for all maintenance and ancillary CCYP clients to generate a better understanding of typical CCYP participation patterns. As shown in Table 4, for maintenance clients still participating in CCYP services as of 12/31/2022, the average duration of enrollment was 15 months (459.5 days) and the median duration (i.e., the midpoint value where 50% are shorter and 50% are longer) was 289.0 days. For ancillary clients, the average was 386.3 days, and the median was 360.5 days. This difference between mean and median in maintenance clients was largely driven by a group of long-term CCYP clients, who have been receiving services for multiple years and thereby increase the average duration value. A similar pattern was evident among maintenance youth who had discharged from CCYP prior to 12/31/2022 (i.e., mean and median of 431.5 and 344.5, respectively). The mean and median duration of ancillary clients who had discharged was substantially shorter (276.1 and 222.0, respectively), suggesting that more recent ancillary clients were continuing with CCYP program for longer periods of time.

Table 4. CCYP Duration for Youth Receiving Services (N=935)

	Maintenance (N=760)			Ancillary/STRTP (N=175)		
	n	Number of Days		n	Number of Days	
		Mean	Median		Mean	Median
Open in CCYP as of 12/31/2022	156	459.9	289.0	24	386.3	360.5
Discharged from CCYP prior to 12/31/2022	604	431.5	344.5	151	276.1	222.0

BHS Utilization Patterns

BHS Services Utilization Before and During CCYP

To assess the extent to which CCYP was able to support stable mental health among their clients without need for crisis or acute care services, BHS service utilization patterns before and during CCYP enrollment were compared. This was accomplished using the Cerner administrative database that documents the provision of BHS-funded services throughout San Diego County to identify mental health services received by CCYP clients from other BHS providers.

Since the amount of time enrolled in CCYP varies considerably between maintenance and ancillary clients, and can be quite lengthy (i.e., frequently more than a year for maintenance clients), a standardized metric was created to enable equivalent comparisons for BHS service utilization before and during CCYP. The standardized metric for the "during CCYP" period reflects the average amount of services youth would be expected to receive during a 180-day period with CCYP. This metric facilitates comparisons to the 180-day period immediately prior to entering CCYP, and between maintenance and ancillary clients. The standardized or average utilization of other BHS services during a 180-day period while enrolled in CCYP was calculated by adding all BHS services (by service type) that occurred while clients were enrolled in CCYP and dividing that by the total number of days that all clients were enrolled in CCYP. The resulting

value represents the average number of BHS services that CCYP clients received per day, which is then multiplied by 180 to generate the estimate of BHS services that CCYP clients would receive during any 180-day period in CCYP. This allows for an equivalent comparison to the average amount of BHS services utilized by youth during the 180 days prior to CCYP.

Table 5. Comparison of BHS Service Utilization Prior to and During CCYP (N=935)

	Maintenance Clients (N=760)		Ancillary/STRTP Clients (N=175)	
	Average number of BHS services per person, per 180 days			
	Prior to CCYP	In CCYP	Prior to CCYP	In CCYP
Inpatient hospitalization	0.05	0.03	0.17	0.08
Crisis stabilization visits	0.14	0.10	0.48	0.34
PERT/MCRT[1] visits	0.03	0.04	0.11	0.09
Therapeutic behavioral services	2.45	0.22	1.82	0.70
Outpatient sessions (not CCYP)	17.76	2.10	16.77	12.48

[1] *Psychiatric Emergency Response Team (PERT) /Mobile Crisis Response Team (MCRT)*

For the 760 maintenance youth served by CCYP, prior to their CCYP enrollment they utilized crisis/acute care services such as inpatient hospitalizations, crisis stabilization visits, and PERT/MCRT contacts relatively rarely (i.e., averaging much less than one instance per person in the 180-day period; see Table 5). Further, the average number of instances for these services was nearly the same from the 180 days pre-enrollment to 180 days in CCYP which is consistent with CCYP program design (i.e., that persons referred to CCYP have been determined to be relatively stable and not in need of ongoing therapy in order to maintain their health and well-being).

An additional component of the CCYP concept is that the program provides psychiatric care without requiring participation in therapy. Given this design, the average number of non-CCYP outpatient sessions understandably reduced substantially from 17.76 in the 180 days prior to CCYP to 2.10 during the 180 days enrolled in CCYP. Feedback from CCYP staff indicated the non-CCYP outpatient visits that did occur were frequently related to situations where emergent circumstances resulted in the need for a youth to reconnect with a program that offered ongoing therapy. To facilitate the transition, a “warm-handoff” occurred during which a person was simultaneously enrolled in both CCYP and another outpatient treatment program.

Results highlighted differences in service needs between maintenance and ancillary clients. A comparison of the behavioral health service utilization patterns of maintenance and ancillary clients prior to CCYP and while enrolled in CCYP reveals some key differences. While still relatively rare events, inpatient hospitalizations, crisis stabilization visits, and Psychiatric Emergency Response Team (PERT) encounters were approximately 2-4x as common in ancillary clients prior to CCYP enrollment and then remained higher during CCYP enrollment when compared to maintenance clients. These findings were consistent with the expectation that maintenance clients had been previously evaluated and determined to be more stable and not in need of ongoing therapeutic services. Meanwhile, the ancillary clients were still in active treatment elsewhere and relied upon CCYP to provide need medication management services to address

a temporary disruption in access to psychiatric care or as a strategic partner for medication management services for select programs such as STRTPs. For the same reason, it is not surprising that ancillary clients exhibited a much higher utilization of non-CCYP outpatient treatment services while enrolled in CCYP compared to maintenance clients (12.48 and 2.10, respectively). This apparent difference in service utilization patterns between maintenance and ancillary clients provides evidence that overall, CCYP was able to successfully identify clients who had completed their treatment and were no longer in need of therapeutic services to maintain mental health stability.

For maintenance clients, additional examinations of BHS service utilization patterns were conducted to assess for differences based on age (i.e., 12 or younger compared to those older than 12), gender, race/ethnicity, language (English compared to Spanish-speaking) and duration in CCYP (i.e., 90 days or less in CCYP compared to those in CCYP for more than 90 days). Overall, the pattern of maintaining or reducing the amount of interaction with BHS crisis-oriented services while enrolled in CCYP coupled with substantially reduced outpatient visits (i.e., from approximately 18 sessions during the 180 days pre-CCYP to two during each 180 days in CCYP) did not vary based on age, gender, race/ethnicity, or language. These findings indicate that the benefits of long-term stability provided by CCYP were generally experienced similarly across clients with a wide range of demographic characteristics.

For the approximately 10% of clients who were in CCYP for 90 days or less, these persons exhibited higher levels of crisis interactions with BHS before and during their time in CCYP compared to those who were in CCYP for more than 90 days and had substantially higher incidence of needing outpatient therapy while enrolled in CCYP. These results suggest that approximately 10% of the persons who enrolled in CCYP likely still needed additional treatment and/or decompensated relatively quickly after enrolling into CCYP and needed to be transitioned back to other forms of treatment.

Overall, findings demonstrate that CCYP was typically able to successfully maintain stable mental health among their participants, particularly among the maintenance client population. Notably, the findings regarding BHS service utilization have been consistent during each annual report review. Identifying this pattern of findings across multiple years, combined with the lengthy CCYP program participation (i.e., often more than a year) indicate that CCYP was consistently able to maintain the stability and well-being of youth by providing regular psychiatric consultation services.

Primary Program Outcomes

Three assessment-based outcome tools are reported in this section of the report: the Child and Adolescent Needs and Strengths (CANS), the Pediatric Symptoms Checklist (PSC), and Caregiver/Youth Feedback Surveys. The CANS and PSC are BHS-required tools to evaluate services provided across all levels and types of care. It is important to note that the primary goal of CCYP is maintaining stability through medication management only; thus, it is not necessarily expected that significant improvements would be seen between initial enrollment into CCYP and later follow-up assessments. Note that only maintenance clients, the primary target population, are included in these analyses (i.e., those who are only receiving CCYP medication management services and not receiving therapy services in other programs).

Child and Adolescent Needs and Strengths

The CANS is a structured assessment used for identifying actionable needs and useful strengths among youth aged 6 to 21. It provides a framework for developing and communicating a shared vision by using assessment and interview information generated from both the youth and family members to inform planning, support decisions, and monitor outcomes. In CCYP, the CANS is completed by providers at initial intake, 6-month reassessment, and discharge. A total of 656 clients were enrolled for at least six months and had a follow-up or discharge CANS completed to allow for an assessment of change.

The CANS assessment includes a variety of domains to identify the strengths and needs of each youth. Each domain contains a certain number of questions that are rated 0 to 3, with a "2" or "3" indicating a specific area that could be potentially addressed in the service or treatment plan (many of these areas are not specifically addressable by the medication management services provided by CCYP). Table 6 shows the mean number of needs at initial assessment and last available assessment for the domains of Child Behavioral/Emotional Needs, Life Functioning, and Risk Behaviors. These findings show statistically significant reductions at the last available follow-up for the Child Behavioral/Emotional Needs domain. These ratings suggest that although only medication management services were provided by CCYP, there were still some areas of need identified at intake that improved while participating in CCYP.

Table 6. CANS Average Change from Initial Assessment (N=656)

Key CANS Domains	Initial Mean Number of Needs	Follow-up Mean Number of Needs
Child Behavioral	2.0	1.5***
Life Functioning	1.2	1.2
Risk Behaviors	0.2	0.1

****statistical significance at $p < 0.001$*

An alternative approach to assess for CANS improvements is to identify the percent of persons who had a reduction of at least one need within a CANS domain (i.e., moving from a '2' or '3' at initial assessment to a '0' or '1' on the same item at the discharge assessment). For Child Behavioral/Emotional Needs and Life Functioning domains, approximately 55-60% of the children and youth served by CCYP experienced at least one reduction in a need item identified during the initial assessment (see Table 7). This reduction in need is close, but slightly less than found in traditional outpatient programs (i.e., where 70-75% typically have at least one improvement for each domain). Given that CCYP does not provide therapeutic services to address specific treatment needs, the findings highlight the importance of consistent medication management and the associated care team: the majority of the CCYP population with needs at baseline experienced improvements in their overall well-being in these treatment-related domains while receiving CCYP services. For Risk Behaviors, only a small number of CCYP clients had such a need, but of those, most (66.7%) had a reduction in need in this area at follow-up.

Table 7. Persons with CANS Improvement at Follow-up (N=656)

Key CANS Domains	Persons with at Least One Need at Initial Assessment	Persons with any Item Improved to not be a Need at Follow-up	% of Persons with an Improvement at Follow-up
Child Behavioral	537	292	54.4%
Life Functioning	402	237	59.0%
Risk Behaviors	57	38	66.7%

Pediatric Symptoms Checklist

The Pediatric Symptoms Checklist-35 (PSC-35) is a screening tool designed to support the identification of emotional and behavioral needs. Caregivers complete the PSC-Parent version on behalf of children and youth ages 3 to 18, and youth ages 11 to 18 complete the self-report PSC-Youth version. Clinical cutoff values indicating impairment for the total PSC score and the three subscales are located below Table 8.

The PSC-35 was administered at entry into CCYP, at 6-month reassessment, and at discharge. However, as a voluntary self-report tool, the completion rates at follow-up or discharge are lower than clinician-completed tools such as the CANS. A total of 323 caregivers and 231 youth completed both an initial and follow-up/discharge PSC assessment. At program entry, 47.7% of parents and 39.4% of youth reported PSC scores that indicated clinical concern (see Table 8). At follow-up, fewer parents and youth (37.5% and 30.3%, respectively) reported clinically significant scores. PSC scores indicate that even without a therapeutic component, providing access to ongoing medication management services can be associated with perceived improvements in behavioral outcomes for at least a portion of parents and youth.

Table 8. PSC Average Change from Baseline

	Parent/Caregiver Report (N=323)					Child/Youth Report (N=231)				
Subscales	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**	**N**	**% above clinical cutoff[1] at baseline**	**% above clinical cutoff[1] at follow-up**	**Mean Score at Baseline**	**Mean Score at Follow-up**
Attention	323	37.2%	28.5%	5.4	4.9*	231	31.6%	24.2%	4.9	4.7
Internalizing	323	42.1%	39.6%	4.1	3.8*	231	42.0%	38.1%	4.0	3.7
Externalizing	323	27.9%	23.8%	4.5	4.3	231	8.2%	9.1%	2.8	2.5*
Total Score	**323**	**47.7%**	**37.5%**	**27.0**	**25.3***	**231**	**39.4%**	**30.3%**	**24.2**	**22.0***

**statistical significance at $p < 0.05$*

*[1] PSC clinical cutoff scores by subscale (higher scores indicate worse condition)**:** Attention: ≥ 7, Internalizing: ≥ 5, Externalizing: ≥ 7, Total: ≥ 28*

An examination of mean score changes in parent self-report shows a small, but statistically significant reduction (i.e., improvement) for both the Attention subscale and the total PSC score. Among youth

respondents, a small but statistically significant reduction (i.e., improvement) was found for the Externalizing subscale and total PSC score. With the reduced sample sizes for completed self-report PSC assessments (as compared to the clinician completed CANS), the findings should be interpreted cautiously as they may not reflect the broader experiences of the full CCYP population.

To better understand the distribution of PSC change scores within the CCYP client population and to facilitate comparisons with the overall CYF BHS system, analyses were conducted that examined the level of change from initial PSC assessment. Consistent with the Systemwide Annual Report, PSC change thresholds were operationally defined using the following 5 categories: increase in impairment (1+ point increase), no improvement (0-1 point reduction), small improvement (2-4 point reduction), medium improvement (5-8 point reduction), and large improvement (9+ point reduction).

Table 9. Distribution of Change Scores from Initial PSC Assessment

	Parent/Caregiver Report (N=323)		Child/Youth Report (N=231)	
Amount of Change	**n**	**%**	**n**	**%**
Increased impairment (i.e., 1+ point increase)	130	40.2%	81	35.1%
No improvement (i.e., 0-1 point reduction)	32	9.9%	36	15.6%
Small improvement (i.e., 2-4 point reduction)	42	13.0%	32	13.8%
Medium improvement (i.e., 5-8 point reduction)	51	15.8%	36	15.6%
Large improvement (i.e., 9+ point reduction)	68	21.1%	46	19.9%

As shown in Table 9, approximately one-third of parents/caregivers (36.9%) and children/youth (35.5%) in CCYP reported a medium or large improvement from their initial PSC assessment. Alternatively, 40.2% of caregivers and 35.1% of children reported a higher PSC score at follow-up, indicating perceptions of increased impairment. Given that the CCYP population was determined to be relatively stable and not needing ongoing therapy upon entrance into CCYP, this finding of increased impairment likely reflects, at least in part, a “ceiling effect” in that there was not much room for improvement for many youths so it is not surprising that a portion of parents and youth might identify a few additional concerns at a later time point. Overall, these findings suggest substantial variability among CCYP clients and their self-reported experiences of behavioral health changes.

Substantial variability and similar distribution patterns were also evident in PSC change score analyses conducted within the overall CYF BHS system as reported in the FY 2021-22 Systemwide Annual Report. Approximately 40% of caregivers and children/youth reported large improvements while about 20-25% reported increased impairment from initial PSC assessment. While caution is warranted when making any direct comparisons between CCYP and CYF PSC change score analyses, it is not surprising that the CCYP population appears to exhibit lower levels of PSC improvement, given the specific nature of the CCYP population (i.e., demonstrating mental health stability without a perceived need for ongoing therapy), and the fact that the CYF analyses only include persons with completed discharge assessments (i.e., have concluded treatment goals). However, the variability of PSC change scores among CCYP clients is a reminder that there are CCYP clients who may benefit from additional therapeutic support and may require linkage to ongoing behavioral health care outside of CCYP.

Caregiver and Client Perspectives on CCYP Services

A total of 190 caregiver feedback surveys and 154 youth feedback surveys were completed at either the 6-month time point or discharge. As shown in Table 10, a high percentage of both caregivers and youth indicated that they were satisfied with CCYP services (91.6% and 86.4%, respectively). In general, more caregivers than youth reported positive feedback regarding CCYP services and impact on child functioning and help-seeking. More caregivers reported improvements in functioning (83.2%), compared to 74.0% of children/youth. Likewise, 90.0% of caregivers reported knowing where to get help and 82.6% felt comfortable seeking help, compared to 81.2% and 73.4%, respectively, among youth. Similarly, more caregivers than youth reported feeling that their needs were met by the program (85.8% and 74.7%, respectively). The above findings should be interpreted with some caution as the number of caregivers and youth who completed a feedback survey was relatively low (i.e., approximately 25% of all CCYP participants) and may not reflect the perspective of all participants.

Table 10. CCYP Services Feedback Survey

	% Agree/Strongly Agree	
Feedback Survey Item	**Caregivers (N=190)**	**Youth (N=154)**
As a result of this program, my child is/I am able to function better.	83.2%	74.0%
As a result of this program, my child/I know where to get help.	90.0%	81.2%
As a result of this program, my child is/I am more comfortable seeking help for myself.	82.6%	73.4%
My child's/my needs were met by this program.	85.8%	74.7%
Overall, I am satisfied with the services I received here.	91.6%	86.4%

For the open-ended caregiver and youth feedback survey questions, at least two evaluators reviewed and coded the individual question responses, and any discrepancies were discussed to arrive at a consensus on the key response themes. Overall, the open-ended feedback provided by clients and caregivers across the years of the Innovations-funded phase of CCYP indicated that they felt supported by the program and found the medication management services to be helpful. Caregivers particularly appreciated the flexibility and variability of appointments (e.g., increased accessibility via telepsychiatry visits) and some caregivers and youth reported positive client/family outcomes as a result of the program. In the last year of the program, caregivers and clients were asked about the new transition planner role. Overall perceptions were that the transition planner was helpful, specifically in providing referrals, information, and resources. Very few suggestions for improving CCYP services were indicated across the reports by a small number of caregiver and client respondents.

Primary Implementation Findings

Findings in this section were derived from three primary data sources: 1) CCYP stakeholder meetings, 2) the Annual CCYP Staff/Psychiatrist Survey and 3) semi-structured interviews with psychiatrists conducted during Spring 2021. The stakeholder meetings were held throughout the year with representatives from BHS, CCYP, and the UCSD evaluation team. Primary objectives for these meetings were to review program

operations, evaluation approaches, and outcome data. The Annual CCYP Staff/Psychiatrist Survey was conducted at the end of each FY during which program staff and contracted psychiatrists were asked to participate in a brief online survey about their experiences with, perceptions about, and recommendations for the program. Survey response rates were typically above 90%. For the primary open-ended staff survey questions, at least two evaluators reviewed and coded the individual responses, and any discrepancies were discussed to arrive at a consensus on the key response themes.

Program Strengths

CCYP Staff & Leadership

When asked which factors helped most toward achieving goals, staff and psychiatrists consistently highlighted the availability of licensed psychiatrists, strong management, and high performing staff. A typical response was offered by one staff member who described “a strong team of psychiatrists, program leadership, [and a] solid team of staff who are dedicated and loyal,” while another highlighted “committed team members working to improve mental health outcomes for kids and families.”

Outreach and Recruitment

Across the years, outreach and recruitment were not perceived as substantial challenges for the CCYP program. The CCYP program appeared to be well-known throughout the county and accepted referrals from many different organizations & providers (both maintenance and ancillary referrals). In response to the continued substantial demands for youth psychiatric services, additional partnership opportunities were developed each year including the formal relationship with BHS-funded STRTP operating throughout San Diego County, in which CCYP would be responsible for medication management while the partner organization continued to provide needed counseling/therapy services.

Client Engagement and Retention

The CCYP program was successful at retaining clients in services as evidenced by lengthy program participation and few program dropouts. A goal for the final years of the Innovations-funded phase of CCYP was to enhance client engagement strategies, and staff reported using several strategies such as a focus on listening during clinical interactions, providing psychoeducation, day-to-day tips, follow-up outreach, appointment reminders and separate appointments with the caregiver when necessary. Overall, these strategies appeared to have been successful, as CCYP staff overall did not indicate client engagement as a significant area of concern by the end of the Innovations-funded phase of CCYP. When asked about how they facilitated client and caregiver engagement in CCYP services, the most common responses were communication with clients/families including appointment reminders, follow-ups, and simply listening, as well as working to set appropriate expectations about the service and educating clients and caregivers about medication management.

This represents an improvement across the years as engagement in care was previously identified as a challenge in terms of no-shows and lack of client responsiveness during medication management services. A hypothesized reason for the lack of engagement was the shift away from care coordinators having ongoing contact with clients and families. Once the program began setting expectations for families in terms of their contact with care coordinators and psychiatrists, as well as using engagement strategies such as, a focus on listening during clinical interactions, providing psychoeducation, day-to-day tips,

follow-up outreach, appointment reminders and separate appointments with the caregiver when necessary, engagement ceased to be a common theme in open-ended feedback survey responses.

When psychiatrists were asked to comment specifically on factors affecting client medication adherence, providers mentioned: a lack of available resources for clients who need additional supports, difficulties in obtaining labs, a lack of understanding among clients regarding why medication is needed, and a lack of understanding among clients about medication side effects. Resources needed include increased psychoeducation materials, assistance with completing lab draw appointments, assessment coordinators to provide increased reminders and check-ins, and supports such as telephone alarms and pill boxes.

Telehealth

The initial design of CCYP, which already included a reliance upon telehealth services, allowed CCYP to adjust to the onset of the COVID-19 pandemic without substantial disruption to ongoing services. At the beginning of the project, however, telehealth was a relatively novel service modality and there was some uncertainty about the capability of building client rapport when services are not face-to-face. In the FY end surveys, staff were asked to rate their client interactions: how does telehealth compare to in-person sessions?

By the final few years of the Innovation-funded phase of CCYP, staff typically rated client interactions via telehealth as better than in-person services. The highest rated items were often patient willingness to schedule sessions and a reduction in the rate of no-shows. Patient openness, provider/patient relationships, patient/client engagement and focus during sessions were all rated as better with telehealth as compared to in-person sessions. Confidentiality and quality of patient communication were rated the lowest, although still well in favor of telehealth.

In the last year of the survey (FY 2021-22) on a scale of 1 to 5 where 1 = strongly disagree and 5 = strongly agree, staff indicated they like providing telehealth services (4.9) and they feel confident about their ability to provide services via telehealth (4.8). Staff strongly agreed that the agency has done a good job supporting the shift to telehealth services (4.5) and that providing telehealth services should continue to be a high priority (4.8).

Prior to the onset of the pandemic in March 2020, CCYP was providing a mixture of in-person and telepsychiatry services. Both CCYP psychiatrists and other staff indicated across the years that they generally did not perceive a substantial difference between in-person and telehealth visits with regard to developing relationships with clients, the quality of communication, client focus during sessions, and client openness to sharing personal information. Staff indicated that the telehealth mode of service delivery provides unique insight into life at home (e.g., family dynamics), that clients can be more open and comfortable at home, a decreased no-show rate, and increased flexibility of scheduling. Strategies to further facilitate telehealth included giving clients a choice between phone and video conferencing for appointments (to address personal preferences and/or technology challenges) and providing equipment to obtain essential vital signs as home.

Program Challenges

Referrals to other Community Services

In the final staff survey (i.e., FY 2021-22), staff scored various aspects of referrals to other services as the most challenging domain for providing CCYP services. On occasion, a CCYP participant may need a referral for additional therapeutic or social assistance services. The limited availability of other community services, wait lists for other services, and clients not completing their referrals were scored on average as 4.6, 4.5 and 4.0 on a scale of 1 to 5 where 1= not challenging at all and 5 = very challenging. There were some differences in how psychiatrists and non-psychiatrists rated items (see Table 11).

Table 11. Ratings of Service Delivery Challenges by Role

	Psychiatrist Mean Score (N=4)	Non-Psychiatrist Mean Score (N=9)
Limited availability of other community services	5.0	4.4
Waitlists for services clients were referred to	5.0	4.2
Difficulties getting required documentation completed (e.g., BHAs, updated vitals)	2.8	3.8
Forming relationships with community partners	3.8	3.1
Program staff turnover	3.0	3.8
Client attrition/not completing program	2.0	2.4
Clients not actively engaging with CCYP services (i.e., frequent no shows or rescheduling, limited "buy-in")	3.3	3.1
Clients not completing referrals for other services	4.0	4.0

On average, psychiatrists found the following more challenging than non-psychiatrist staff: limited availability of other community services, waitlists for services clients were referred to, and forming relationships with community partners. One survey respondent stated a need for "allowing CCYP to make referrals to programs county-wide in order to assist caregivers and clients that may be struggling to get connected." Non-psychiatrists found program staff turnover and client attrition more challenging than psychiatrists. Both groups rated client engagement and lack of client follow-through on referrals similarly challenging.

Barriers to Telehealth with Video

While overall impressions of telehealth with video were favorable, staff and psychiatrists reported that some caregivers and clients are unable to engage in services this way. Staff reported that 5-10% of clients are unable to consistently utilize telehealth with video (i.e., do not have a suitable device or reliable internet) and 5-10% of video sessions experience tech-based difficulties. However, the number of clients who prefer not to use telehealth with video was less than 5%. This discrepancy implies that there are clients willing to and may even prefer telehealth with video but are unable to successfully utilize it. While

familiarity and access to the technology to conduct telehealth visits have improved over recent years, one staff member shared:

> “There may be caregivers that are not familiar with how to connect to the video session. There may be some families where the internet connection may be poor making it difficult to connect to the video session.”

Changes from Initial Program Design

1. The proposed partnership with UCSD to serve medically complex patients who have psychiatric medication needs did not come to fruition due to administrative and logistical reasons that did not allow for integrated services as originally envisioned. After substantial negotiations, BHS determined that this aspect of the initial design for CCYP would not be implemented.
2. The initial approach to providing psychiatry visits via telehealth was to have clients visit select clinics set up to facilitate telehealth visits with a remotely located psychiatrist or to have a CCYP team member (typically a nurse or care coordinator) travel to the home of the client with the device used to complete the telehealth visit with the psychiatrist. After the onset of the pandemic in March of 2020, telehealth visits were more typically accomplished by directly connecting with clients and utilizing their computer or smartphone to conduct the telehealth visit.
3. The Care Coordinator position that was part of the original program design morphed in several ways over the life of the program. When the program started, Care Coordinators were licensed clinicians who provided ongoing support to families from intake to discharge with CCYP. Given CCYP is designed for clients who have completed a course of psychotherapy, Care Coordinators were asked not to provide clinical services to their clients and yet this proved difficult with the original service structure design and position title. Over the course of the program, Care Coordinators (who remained licensed clinicians) transitioned to being named (and recruited) as “Assessment Coordinators,” and their role was more clearly and narrowly defined as focused on the initial intake with some minimal check-ins and support during treatment, primarily focused on supporting psychiatrist recommendations.
4. During FY 2021-22, CCYP began a partnership with the BHS-funded STRTP programs to provide medication management services for youth participating in small STRTPs (i.e., 12 or fewer beds).
5. During FY 2021-22, a “Transition Planner” was added to the CCYP service delivery team to help with connecting youth and families to relevant post-CCYP services. This position was created after the team observed a “bottleneck” where clients were experiencing delays in discharge, sometimes after years in the program. These delays were preventing new clients from being served.
6. In addition to the Transition Planner position, CCYP worked for the second half of the Innovations-funded phase of the program to foster a pipeline to some larger pediatric and family medicine practices, including CPCMG. CCYP identified and worked with CPCMG lead physicians who had some experience and interest in serving clients with psychiatric needs to create a seamless referral process.

Conclusion

The CCYP program served a total of 935 unique youth (760 maintenance and 175 ancillary) throughout the MHSA Innovations-funded phase of the program that ended on 12/31/2022. During the final two full

years of the project CCYP provides services to approximately 500 youth and their families each year. Once enrolled, many youth participated in CCYP for more than a year. CCYP successfully served a diverse client population (58.6% Hispanic) as evidenced by a pattern of lengthy CCYP program participation of maintenance clients (i.e., average and median CCYP duration 431.5 and 344.5 days, respectively for clients who discharged prior to 12/31/2022), coupled with similar or reduced frequency BHS crisis and acute care services utilized while in CCYP. These findings indicated that CCYP was able to achieve the core program objective of maintaining client stability through the provision of psychiatric services to youth who were anticipated to not need ongoing therapy.

Additionally, although therapeutic services were not provided through CCYP, both clinician and caregiver/youth self-report (as documented by the CANS and PSC, respectively) indicated that many youth and family members experienced improvements in their well-being following enrollment in CCYP. In quantitative and qualitative feedback, both caregivers and youth typically indicated high levels of satisfaction with CCYP services. Overall, these findings provide evidence that CCYP successfully accomplished the overall goal of providing psychiatric evaluation and treatment to a diverse population of children and youth living throughout San Diego County who had completed therapy services but needed ongoing and complex medication monitoring not viable with their PCP.

As a centralized resource with capacity to provide needed child and adolescent psychiatry services, CCYP supported the overall BHS SOC by providing psychiatric care services when other BHS-funded treatment programs experienced temporary gaps in their ability to offer timely psychiatric care as well as for select small programs who were determined to be unable to provide their own psychiatric services. This role of providing services to "ancillary" referrals (i.e., youth who need psychiatric care, but are still receiving ongoing therapy elsewhere) ensured continuity of care and has become part of standard CCYP operations.

Based on the findings from the Innovations-funded CCYP pilot project, it was decided by the County of San Diego to incorporate the CCYP medication clinic services into the ongoing BHS SOC so this resource will be available to children, youth and families for the foreseeable future.

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

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

Appendix

Characteristics of CCYP Participants

Characteristic	Maintenance Participants (N=760)		Ancillary Participants (N=175)	
Age Group	n	%	n	%
5 to 11	227	29.9	36	20.5
12 to 15	265	34.9	61	34.9
16 to 17	210	27.6	67	38.3
18 to 20	58	7.6	11	6.3
Total	**760**	**100**	**175**	**100**
Gender	n	%	n	%
Male	337	44.3	75	42.9
Female	383	50.4	85	48.6
Transgender	8	1.1	<5[4]	<2.9
Genderqueer/Gender non-conforming	13	1.7	<5[4]	<2.9
Questioning/Unsure of gender identity	7	0.9	<5[4]	<2.9
Another gender identity	7	0.9	6	3.4
Prefer not to answer	5	0.7	0	0.0
Total	**760**	**100**	**175**	**100**
Sex at Birth	n	%	n	%
Male	324	42.6	71	40.6
Female	403	53.0	93	53.1
Missing/Prefer not to answer	33	4.4	11	6.3
Total	**760**	**100**	**175**	**100**
Sexual Orientation	n	%	n	%
Heterosexual or straight	424	55.8	97	55.4
Gay or lesbian	17	2.2	7	4.0
Bisexual/Pansexual/Sexually fluid	101	13.3	25	14.3
Questioning/Unsure of sexual orientation	28	3.7	<5[4]	<2.9
Other sexual orientation	14	1.8	<5[4]	<2.9
Missing/Prefer Not to Answer	176	23.2	38	21.7
Total	**760**	**100**	**175**	**100**

Appendix (continued).

Characteristic	Maintenance Participants (N=760)		Ancillary Participants (N=175)	
Language	**n**	**%**	**n**	**%**
English	652	85.8	152	86.9
Spanish	86	11.3	19	10.9
Other/Prefer not to answer	22	2.9	4	2.2
Total	**760**	**100**	**175**	**100**
Race/Ethnicity	**n**	**%**	**n**	**%**
African American	104	13.7	40	22.9
American Indian	13	1.7	6	3.4
Asian	56	7.4	13	7.4
Hispanic/Latino	445	58.6	85	48.6
Pacific Islander	9	1.2	<5[4]	<2.9
White	305	40.1	74	42.3
Multiple	153	20.1	41	23.4
Other	9	1.2	<5[4]	<2.9
Missing/Prefer not to answer	7	0.9	40	22.9
Total[1]	-	-	-	-
Mental Health Diagnosis[2]	**n**	**%**	**n**	**%**
ADHD	132	17.4	16	9.1
Oppositional/Conduct Disorders	37	4.9	9	5.1
Depressive Disorders	279	36.6	68	38.8
Bipolar Disorders	67	8.8	12	6.9
Anxiety Disorders	119	15.7	14	8.0
Stressor and Adjustment Disorders	81	10.7	42	24.0
Schizophrenia and Other Psychotic Disorders	32	4.2	11	6.3
Other/Missing	13	1.7	3	1.8
Total	**760**	**100**	**175**	**100**

Appendix (continued).

Characteristic	Maintenance Participants (N=760)		Ancillary Participants (N=175)	
Substance Use Disorder (SUD) Diagnosis	**n**	**%**	**n**	**%**
Yes, has SUD Diagnosis	17	2.2	23	13.1
No, does not have SUD Diagnosis	743	97.8	152	86.9
Total	**760**	**100**	**175**	**100**
Disability	**n**	**%**	**n**	**%**
Yes, has a disability	166	21.9	19	10.9
No, does not have a disability	565	74.3	137	78.2
Declined/Preferred not to answer	29	3.8	19	10.9
Total	**760**	**100**	**175**	**100**
Type of Disability	**n**	**%**	**n**	**%**
Seeing	36	4.7	<5[4]	<2.9
Hearing	18	2.4	<5[4]	<2.9
Other Communication Disability	14	1.8	<5[4]	<2.9
Learning	67	8.8	9	5.1
Developmental	45	5.9	<5[4]	<2.9
Other Mental Disability	12	1.6	<5[4]	<2.9
Physical Disability	12	1.6	<5[4]	<2.9
Chronic Health	7	0.9	<5[4]	<2.9
Other	44	5.8	<5[4]	<2.9
Total[3]	-	-	-	-

[1] Total may exceed 100% since participants could select more than one response.
[2] Mental health diagnosis information is obtained from BHS Cerner data system.
[3] Since participants could select more than one specific non-mental-health-related disability, the percentages may total more than the percent who indicated having any disability.
[4] Values were suppressed due to small n size.

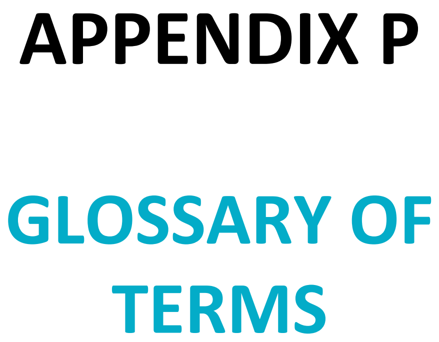
APPENDIX O

GLOSSARY OF ACRONYMS

Glossary of Acronyms

ACE – Alliance for Community Empowerment
ACL – Access and Crisis Line
ACT – Assertive Community Treatment
ASP – Augmented Services Program
ASO – Administrative Services Organization
API – Asian/Pacific Islander
AOA – Adults and Older Adults
B&C – Board & Care
BHAB – Behavioral Health Advisory Board
BHS – County of San Diego Health and Human Services Agency, Behavioral Health Services
BPSR – Bio-Psycho Social Rehabilitation
CalMHSA – California Mental Health Services Authority
CalWORKs – California Work Opportunity and Responsibility to Kids
CASRC – Child and Adolescent Research Center
CCRT – Cultural Competency Resource Team
CFTN – Capital Facilities and Technological Needs
CHW – Community Health Workers
CLAS – Culturally and Linguistically Appropriate Services
CSEC - Commercially Sexually Exploited Children
CPP – Community Planning Process
CSU – Crisis Stabilization Unit
CSS – Community Services and Supports
CYF – Children, Youth, and Families
DMC/ODS – Drug Medi-Cal Organized Delivery System
EMASS – Elder Multicultural Access and Support Services
ESU – Emergency Screening Unit
FSP – Full Service Partnership
FY – Fiscal Year
HHSA – Health and Human Services Agency
HCDS – Housing and Community Development Services
HOW – Homeless Outreach Workers
HSRC – Health Services Research Center
ICM – Institutional Case Management
IHOT – In-Home Outreach Team
ILA – Independent Living Association
IMAR – Illness Management and Recovery
INN – Innovation
LGBTQ ± – Lesbian, Gay, Bisexual, Transgender, Queer
MDT – Multidisciplinary Team
MHFA – Mental Health First Aid
MHSA – Mental Health Services Act
MHSOAC – Mental Health Services Oversight and Accountability Commission
MIS – Management Information System
NAMI – National Alliance on Mental Illness
NPLH – No Place Like Home
OE – Outreach and Engagement

PERT – Psychiatric Emergency Response Team
PEI – Prevention and Early Intervention
POFA – Project One for All
QI – Quality Improvement
RER – Revenue and Expenditure Report
ReST – Recuperative Services Treatment
ROAM – Roaming Outpatient Access Mobile Services
RMQ – Recovery Markers Questionnaire
SATS-R – Substance Abuse Treatment Scale, Revised
SBCM – Strengths-Based Case Management
SBIRT – Screening, Brief Intervention and Referral to Treatment
SD – System Development
SDCPH – San Diego County Psychiatric Hospital
SDHC – San Diego Housing Commission
SED – Serious Emotional Disturbance
SMI – Serious Mental Illness
SSI ± Supplemental Security Income
START – Short-Term Acute Residential Treatment
SUD – Substance Use Disorder
TAOA – Transition Age Youth, Adults and Older Adults
TAY – Transition Age Youth
TN – Technological Needs
UCSD – University of California, San Diego
WET – Workforce Education and Training
WIC – (California) Welfare and Institutions Code
WRAP – Wellness Recovery Action Plan



APPENDIX P

GLOSSARY OF TERMS

Glossary of Terms

Aftercare: a program of outpatient treatment and support services provided for individuals discharged from an institution, such as a hospital or mental health facility, to help maintain improvement, prevent relapse, and aid adjustment of the individual to the community. Aftercare may also refer to inpatient services provided for convalescent patients, such as those who are recovering from surgery.

Assertive Community Treatment (ACT): a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7. ACT is based around the idea that people receive better care when their mental health care providers work together. ACT team members help the person address every aspect of their life, whether it is medication, therapy, social support, employment, or housing.

CalAIM: (California Advancing and Innovating Medi-Cal) is a multi-year initiative by the California Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi- Cal members through broad delivery system, program, and payment reform across the Medi-Cal program.

Case Management: a range of services provided to assist and support individuals in developing their skills to gain access to needed medical, behavioral health, housing, employment, social, educational, and other services essential to meeting basic human services.

Cognitive Training: a term that reflects the theory that cognitive abilities can be maintained or improved by exercising the brain, in an analogy to the way physical fitness is improved by exercising the body.

Complex Behavioral Health Conditions: can include serious mental illness (e.g., schizophrenia, bipolar disorder, or major depressive disorder) or other mental health conditions, with or without co-occurring substance use disorders that, individually or in combination, have an impact on one or more functional abilities. Functional limitations can impede an individual's ability to live independently at home and engage in the community.

Crisis Intervention: is the brief 'first-aid' use of psychotherapy or counseling to persons who have undergone a highly disruptive experience, such as an unexpected bereavement or a disaster. Crisis intervention may prevent more serious consequences of the experience, such as posttraumatic stress disorder. It is also a psychological intervention provided on a short-term, emergency basis for individuals experiencing mental health crises, such as an acute psychotic episode or attempted.

Culturally Appropriate: community interventions that are defined as meeting each of the following characteristics: (a) The intervention is based on the cultural values of the group, (b) the strategies that make up the intervention reflect the subjective culture (attitudes, expectancies, norms) of the group, and (c) the components that make up the strategies reflect the behavioral preferences and expectations of the group's member.

Family Engagement: a family-centered and strengths-based approach to making decisions, setting goals, and achieving desired outcomes for children and families. It encourages and empowers families to be their own champions, working toward goals that they have helped to develop based on their specific family strengths, resources, and need.

Family Groups: a therapeutic method that treats a family as a system rather than concentrating on individual family members. The various approaches may be psychodynamic, behavioral, systemic, or structural, but all regard the interpersonal dynamics within the family as more important than individual intrapsychic factors.

Full Service Partnership (FSP): a collaborative relationship between the County of San Diego and the client, and when appropriate the client's family, through which the client may access a full spectrum of community services to achieve identified goals.

Outreach: an activity of providing services to any populations who might not otherwise have access to those services. In addition to delivering services, outreach has an educational role, raising the awareness of existing services.

Peer Support: counseling or support by an individual who has experience and/or status equal to that of the client.

Personal Health Record (PHR): an electronic application through which individuals can access, manage and share their health information, and that of others for whom they are authorized, in a private, secure, and confidential environment. A PHR includes health information managed by the individual. The clinician's record of patient encounter, a paper- chart or electronic medical record (EHR) is managed by the clinician and/or health care institution.

Primary Care: basic or general health care a patient receives when he or she first seeks assistance from a health care system provided by licensed general practitioners, family practitioners, internists, obstetricians, gynecologists, and pediatricians.

Psychiatric Assessments: evaluations based on present problems and symptoms, of an individual's biological, mental, and social functioning, which may or may not result in a diagnosis of a mental illness.

Serious Emotional Disturbance (SED): a condition that affects persons from birth up to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual (DSM) that results in functional impairment, which substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Serious Mental Illness (SMI): a condition that affects persons who currently or at any time in the past year have had a diagnosable mental, behavioral, or emotional disorder (excluding developmental and substance use disorders) of sufficient duration to meet diagnostic criteria specified within the DSM that has resulted in serious functional impairment, which substantially interferes with or limits one or more major life activities such as maintaining interpersonal relationships, activities of daily living, self-care, employment, and recreation.

Stigma: includes prejudicial attitudes and discriminating behavior directed towards individuals with mental health problems or the internalizing by the mental health sufferer of their perception of discrimination.

Strengths Based Approach: a specific method of working with and resolving problems experienced by the presenting person. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person's resources (or what may need to be added) and strengths that will lay the basis to address the challenges resulting from the problems.

Substance Use Disorder (SUD): recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.

Suicide Prevention: an umbrella term used for the collective efforts of local community-based organizations, health professionals and related professionals to reduce the incidence of suicide; reduce factors that increase the risk for suicidal thoughts and behaviors; and increase the factors that help strengthen, support, and protect individuals from suicide.

Supplemental Security Income benefits (SSI): pays benefits to disabled adults and children who have limited income and resources. SSI benefits also are payable to people 65 and older without disabilities who meet the financial limits. SSI is a federal income supplement program funded by general taxes. It is designed to help aged, blind, and disabled people, who have little or no income and provides cash to meet basic needs for food, clothing, and shelter.

Supportive Housing: an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services for people experiencing homelessness, as well as other people with disabilities.

Trauma Informed Care: a style of care that accounts for the widespread impact of trauma and the understanding of potential paths for recovery. It includes the recognition of the signs and symptoms of trauma in clients, families, staff, and others. Organizations that are trauma informed fully integrate knowledge about trauma into policies, procedures, and practices and actively avoid re-traumatization.

Warning signs: behaviors that may be signs that someone is thinking about suicide, examples include:

- Talking about wanting to die or to kill oneself.
- Looking for a way to kill oneself, such as searching online or buying a gun.
- Talking about feeling hopeless or having no reason to live.
- Talking about feeling trapped or unbearable pain.
- Talking about being a burden to others.
- Increasing the use of alcohol or drugs.
- Acting anxious or agitated, behaving recklessly.
- Sleeping too little or too much.
- Withdrawing or feeling isolated.
- Showing rage or talking about seeking revenge.
- Displaying extreme mood swings.

APPENDIX Q

STAKEHOLDER COMMENTS

#	Date	Source	Comment	Response
1	4/2/24	Smartsheet	p 111 lists 6 Councils, however Peer Council is not included-this council started in FY 22-23 and should be recognized as the venue for the consumer voice. Supported Employment is noted throughout many program descriptions, however the overarching initiative is missing--which demonstrates significant outcomes since program inception--starting at 9% and as of FY 22-23 15% or individuals are in competitive employment. A link to the Supported Employment Strategic Plan would be helpful.	Noted
2	4/3/24	Smartsheet	I encourage more intentional and a proportional investment of MHSA funding towards prevention in the form of child services, including an investment in First 5 San Diego for their Healthy Development Services programming. First 5 San Diego programs contribute to and absolutely enhance sustainability in the areas of child and family well-being, the environment, and the economy. For over 20 years, this county has benefited from First 5"s investment in the early mental health intervention services for children ages Birth-5. With the decline in Cigarette taxes, reduced funding to First 5 San Diego places in jeopardy the continued mental health preventative care and screening structures in place throughout early childhood environments in the community, through clinics, non-profits and preschools. I want to draw attention to the profound support offered to parents and caregivers for behavioral screenings, developmental delay screenings, and treatment for up to 27,681 0-5 year olds. First 5 San Diego and partners have done this important work with the resources available. Yet, this is only a portion of the actual need for direct treatment in this age group. Many of the same organizations that partner with First 5 also continually request philanthropic support to provide families with young children much needed intervention services at a time of development when interventions are know to yield the highest result. Additionally, any intervention provided to families of children under the age of 5, will continue to have ripple effects on other children raise in the same family/environment. First 5 San Diego data is transparent and accessible. Many families experience long waiting lists, delays in assessment, and a lack of direct services. This is concerning, and the worry in lack of resources only compounds when considering the projected and significant decrease of funding from the state. What's more, when we look to follow these resources and data into 5-17 populations very little can be found. When considering mental health equity, well-being, and the use of MHSA funds in San Diego, we have to choose to care for a true continuum- from children and youth to adults. We cannot only have a discussion about our adult populations!!!! We must work on better collaboration and transparent data sharing across the Child and Family Well-Being Department, including First 5 San Diego, and the Behavioral Health Services Department. Please make this transparent for the community to understand. Proportionately investing in children and youth is a prevention, is a significant need, and can improve with greater intention. Sincerely, Lucia Wiechers Garay Independent Consultant Retired Executive Director Early Education Services, SDCOE	Noted

#	Date	Source	Comment	Response
3	4/22/24	Smartsheet	This document contains a lot of separate documents and takes a lot of time to read and understand. Please provide a summary for ease of understanding.	Noted
4	4/25/24	Smartsheet	Mental and behavioral health services for our young children, kids, and youth should be fairly funded through our Mental Health Services Act dollars. There is no comprehensive tracking or plan with regard to 0-17 year-olds in this plan, outside of meaningful but still disparate programming addressing their specific needs. We need a transparent dashboard demonstrating the continuum of care happening starting from birth to 17, which includes who is taking what parts and pieces of this care. That collaboration and coordination should be managed by BHS in partnership with the new Child and Family Well-Being Department. This should also track the investment to demonstrate that this age-range is receiving a proportionate allotment of the budget according to their 20% of the population (and 33% of MediCal eligible community members). There needs to be documented wait times beyond simply anecdotal evidence. Any current funding for children and youth should be protected considering Proposition 1, and any additional general funding coming into the County should be proportionally allocated to the 0-17 population. This would be inclusive of specifically supporting the workforce development of pediatric professionals in the mental and behavioral health space. Our children and families do not live in silos, and neither should their services when it comes to administering care for mental and behavioral health support. This should be coordinated at the County-level with a seamlessness across departments. Finally, if we are serious about prevention, we MUST start early. We know that chronic adult homelessness due to acute mental illness must be addressed, but we cannot do this at the expense of the very necessary investments in young child, kid, and youth mental health services now, because if we do, we will only pay for it later.	Noted

#	Date	Source	Comment	Response
5	4/30/24	Smartsheet	Thank you for the opportunity to share feedback on the MHSA Annual Report for Fiscal Year 24-25. The YMCA of San Diego County nurtures the spirit, mind, and body so all can thrive. As a partner with the County of San Diego we are grateful for the ongoing collaboration to support children, youth, families, and individuals. All children and youth need support in building their protective factors, which are proven to buffer stress and promote better outcomes for those who face adversity. When protective factors simply aren't enough, all children and youth should have access to mental and behavioral health support that meets them where they are, especially in community-based settings that offer positive childhood experiences proven to mitigate the effects of adverse childhood experiences (ACEs). Services related to prevention, early intervention, psychiatric support, and treatment should be unrestricted by their type of insurance and severity of symptoms. Healing-centered engagement should be driven by individual needs, and not simply a diagnosis. Additionally, we humbly make the following recommendations for consideration. A proportional investment of MHSA funding towards prevention in the form of child and youth services, including but not limited to an investment in First 5 San Diego for their Healthy Development Services programming. We must work together on better collaboration and transparent data sharing across the Child and Family Well-Being Department, including First 5 San Diego, and the Behavioral Health Services Department. The hope is that greater transparency will help the community understand a continuum of care, objectives for each age group, and actionable items to meet the growing needs of the community.	Noted
6	5/01/24	Smartsheet	San Diego Foundation inspires enduring philanthropy and enables community solutions to improve our quality of life. We recognize the need to invest in the future of our region, which requires sustained funding for the services that support children and youth across the county. A recent report from Rady Children's Hospital indicates a 30 percent spike in children experiencing a mental health crisis. This reflects the struggles that kids in our community are facing and highlights the critical need for local solutions and support. San Diego Foundation believes that child and youth mental and behavioral health services funding in fiscal year 24/25 should remain at fiscal year 22/23 levels to maintain access to these critical services. It is our hope that continued funding will be allocated and maintained to ensure children and youth have much-needed access to mental and behavioral health services.	Noted

#	Date	Source	Comment	Response
7	4/30/24	Smartsheet	• I encourage more intentional and a proportional investment of MHSA funding towards prevention in the form of child and youth services, including but not limited to an investment in First 5 San Diego for their Healthy Development Services programming. • Healthy Development Services is a critical program in San Diego that is vastly under-resourced compared to the scale of the need for behavioral screenings, developmental delay screenings, and treatment for 0-5 year olds. HDS helps set children on their most likely path toward a healthy and thriving life, and yet the County's lack of investment for these young children but for the limited and dwindling First 5 tobacco-tax funding overlooks this pivotal opportunity to address challenges before they become barriers. The County has indirectly supported HDS for too long. With First 5 funding significantly decreased, it is well past time for the County to step up. • It's also critical that the County look to serve the large population of youth ages 5-17 much more significantly into the future. Youth mental health is at a staggering crisis point, and failing to provide behavior supports and mental health interventions in critical places where youth are such as afterschool and summer programming leaves young people out to dry and threatens their sense of belonging and connection in these programs. We have a vast youth-serving workforce in San Diego, but these amazing professionals are not equipped to provide the mental and behavioral supports that children are presenting. It's time the County provide supports for youth where the youth are – their schools, afterschool programs, and their intercession camp programs. • When considering mental health equity, well-being, and the use of MHSA funds in San Diego, we have to choose to care for a true continuum- from children and youth to adults. We can not only have a discussion about our adult populations. • We must work on better collaboration and transparent data sharing across the Child and Family Well-Being Department, including First 5 San Diego, and the Behavioral Health Services Department. • Please make this transparent for the community to understand. Proportionately investing in children and youth is a prevention, is a significant need, and can improve with greater intention.	Noted
8	5/3/24	Smartsheet	Per my public comment at the FY2024-25 Mental Health Services Act Public Hearing held yesterday I summarized my comment here. My concern is that our Behavioral Health Advisory Board has not, in the past decade from my own experience, been provided an opportunity to collaborate with our Behavioral Health System, nor the ability to review and approve, as required by WIC 5604.2(4)(a) to "(4) (A) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process." We are facing significant changes and challenges in the behavioral health marketplace. Without documenting and getting approval of our strategizing and planning earnest engagement with stakeholders, including utilizing available funds for training, educating, and bringing stakeholders up to speed so they can contribute, we are failing our community. Until the BHAB has the ability to conduct its responsibilities mandated, and funded, through the MHSA/BHSA, then we are not meeting the requirements to receive or spend any Mental Health Fund monies under the Performance Contract we sign and submit each year. My blog at BHABrehab.com explains more and I encourage stakeholders to connect. Thank you.	Noted