COUNTY OF SAN DIEGO

TRANSFORMING BEHAVIORAL HEALTH

MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

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IF YOU CHANGE THE WAY YOU LOOK AT THINGS,

THE THINGS YOU LOOK AT CHANGE.

— Wayne Dyer

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: **San Diego**

☒ Three-Year Program and Expenditure Plan

☐ Annual Update

Local Mental Health Director	Program Lead
Name: **Alfredo Aguirre**	Name: **Adrienne Yancey**
Telephone Number: **(619) 261-4386**	Telephone Number: **(619) 584-5075**
E-mail: Alfredo.Aguirre@sdcounty.ca.gov	E-mail: Adrienne.Yancey@sdcounty.ca.gov
Local Mental Health Mailing Address: Health and Human Services Agency Behavioral Health Services Division 3255 Camino Del Rio South San Diego, CA 92108	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or 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 Three-Year Program and Expenditure Plan or 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 *October 28, 2014*.

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.

Alfredo Aguirre
Local Mental Health Director (PRINT)


Signature

10/29/14
Date

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: **Alfredo Aguirre**	Name: **Tracy Sandoval**
Telephone Number: **(619) 261-4386**	Telephone Number: **(619) 531-5413**
E-mail: Alfredo.Aguirre@sdcounty.ca.gov	E-mail: Tracy.Sandoval@sdcounty.ca.gov
Local Mental Health Mailing Address: Health and Human Services Agency Behavioral Health Services Division 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.

Alfredo Aguirre
Local Mental Health Director (PRINT)

Signature 10/29/14
Date

I hereby certify that for the fiscal year ended June 30, 2014, 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 11/14/14 for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2014, 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.

Tracy M. Sandoval
For County Auditor Controller / City Financial Officer (PRINT)

Signature Maryann Reed 11/20/14
Date

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

COUNTY OF SAN DIEGO
BOARD OF SUPERVISORS
TUESDAY, OCTOBER 28, 2014

MINUTE ORDER NO. 9

SUBJECT: MENTAL HEALTH SERVICES ACT THREE-YEAR PROGRAM AND EXPENDITURE PLAN: FISCAL YEAR 2014-15 THROUGH FISCAL YEAR 2016-17 (DISTRICTS: ALL)

OVERVIEW:
California's Proposition 63, the Mental Health Services Act (MHSA), which was approved by California voters in November 2004 and became effective January 1, 2005, provides funding for expansion of mental health services in California. The Act consists of five program components designated by the Act: Community Services and Support, Prevention and Early Intervention, Workforce Education and Training, Innovation, and Capital Facilities and Technological Needs. Pursuant to the Act and California Welfare and Institutions Code Section 5847, county mental health programs are required to prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for MHSA programs and expenditures.

The County of San Diego is in the process of implementing an integrated MHSA three-year program and expenditure plan for Fiscal Year 2014-15 through Fiscal Year 2016-17. The Plan incorporates all five MHSA components and provides expenditure projects for each component per year. The Plan contains newly proposed Innovation projects and programs identified by stakeholders for consideration, should additional funding become available. The majority of services listed in the Plan are a continuation of programs previously approved by the Board of Supervisors and stakeholders. As required by the MHSA, the Plan requires review and approval by the Board of Supervisors before submitting to the California Mental Health Services Oversight and Accountability Commission (MHSOAC). The MHSOAC reviews the Plan and is required to approve the Innovation projects prior to implementation.

Today's action requests the Board of Supervisors to receive and approve the County of San Diego Mental Health Services Act Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17. Today's action will also authorize the Director of Purchasing and Contracting to enter into negotiations for the procurement of contracts for proposed new Innovation projects as well as an evaluation of these projects. These actions support the County's adopted *Live Well San Diego* initiative by providing necessary resources and services for individuals with behavioral health needs to lead healthy and productive lives.

FISCAL IMPACT:
Funds for this request are included in the Fiscal Year 2014-15 Operational Plan for the Health and Human Services Agency. If approved, the services represented in this plan will result in current year cost and revenue of $134,834,208. The funding source is Mental Health Services Act (MHSA). There will be no change in net General Fund cost and no additional staff years.

BUSINESS IMPACT STATEMENT:
N/A

RECOMMENDATION:
CHIEF ADMINISTRATIVE OFFICER

1. Accept and approve the County of San Diego Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17; and authorize the Director of Health and Human Services Agency to submit the Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

2. In accordance with Section 401 et seq. of the County Administrative Code authorize the Director, Department of Purchasing and Contracting to issue competitive solicitations for proposed new MHSA Innovation funded projects; and upon successful negotiations and determination of a fair and reasonable price, award contracts for a term of one year with up to four (4) one-year options and up to an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to approval of the Director, Health and Human Services Agency and contingent upon approval by the MHSOAC and availability of funds.

3. In accordance with Section 401 et seq. of the County Administrative Code authorize the Director, Department of Purchasing and Contracting to issue a competitive solicitation for the evaluation of the proposed new MHSA Innovation funded projects; and upon successful negotiations and determination of a fair and reasonable price, award contract for a term of one year with up to five (5) one-year options and up to an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to approval of the Director, Health and Human Services Agency and contingent upon approval by the MHSOAC and availability of funds.

4. In accordance with Section 401 et seq. of the County Administrative Code authorize the Director, Department of Purchasing and Contracting to issue competitive solicitations for the future funding priorities already identified in the County of San Diego Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17, should funding become available; and upon successful negotiations and determination of a fair and reasonable price, award contracts for a term of one year with up to four (4) one-year options and an additional six months if needed, and to amend the contracts as needed to reflect changes to services and funding, subject to approval of the Director, Health and Human Services Agency and contingent upon approval by the MHSOAC, if necessary, and availability of funds.

ACTION:
ON MOTION of Supervisor Cox, seconded by Supervisor R. Roberts, the Board took action as recommended, on Consent.

AYES: Cox, Jacob, D. Roberts, R. Roberts, Horn

- - -

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.

THOMAS J. PASTUSZKA
Clerk of the Board of Supervisors

By_____
Marvice E. Mazyck, Chief Deputy

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TABLE OF CONTENTS

A LETTER FROM THE BEHAVIORAL HEALTH DIRECTOR

The County of San Diego Health and Human Services Agency Behavioral Health Services Division (BHS) *MHSA Three-Year Program and Expenditure Plan: FY 2014-15 through FY 2016-17* embodies the standards set by the Mental Health Services Act (MHSA) by the implementation of client-driven, integrated services that are culturally competent and focus on the wellness, recovery and resiliency of children, youth, families, transition age youth, adults and older adults.

Live Well San Diego, the County's long term visionary plan to promote healthy, safe and thriving communities, is interwoven throughout the Three-Year Plan with system changes, community partnerships and MHSA programs that focus on the whole person and address both physical and mental health. Some programs that are at the forefront of this approach offer in-home outreach to adults with serious mental illness (SMI), trans-disciplinary assessment and treatment for children with Serious Emotional Disturbance (SED), and support and education to parents, family members and caretakers.

Recognizing the impact that trauma has in overall wellness of individuals, the Health and Human Services Agency (HHSA) has adopted a trauma-informed model in philosophy, approach, and methods. All HHSA staff will have an understanding of how trauma can affect individuals, families, groups and communities. BHS is helping lead the efforts to move toward a trauma-informed system by requiring our MHSA contractors to provide services that are trauma-informed to accommodate the vulnerabilities of trauma survivors and delivered in a way that will avoid inadvertently re-traumatizing our clients. Additionally, the newly formed Prevention and Planning Unit within BHS represents Behavioral Health Services in the community by providing oversight, coordination and leadership around prevention and early intervention initiatives, stigma and discrimination reduction, and the integration of *Live Well San Diego* throughout BHS programs.

Through *Live Well San Diego* and the adoption of a trauma-informed model, we are set to achieve measurable goals that will impact the well-being of our communities. However, we could not do this without our community partners and BHS is appreciative for the participation of clients, family members, System of Care Council members, providers, education, Probation, First 5, health plans, and community members that joined in the robust Community Program Planning process that informed the development of this Three-Year Plan.

Live well,

ALFREDO AGUIRRE, LCSW, Director
Behavioral Health Services
County of San Diego Health and Human Services Agency

EXECUTIVE SUMMARY

In response to the request by Mental Health Services Oversight and Accountability Commission, the County of San Diego Health and Human Services Agency Behavioral Health Services Division has developed a Mental Health Services Act (MHSA) Three-Year Program and Expenditure Plan: Fiscal Year (FY) 2014-15 through FY 2016-17. This Three-Year Plan contains information on the programs and expenditures for Community Services and Support (CSS), Prevention and Early Intervention (PEI), Innovation (INN), Workforce Education and Training (WET), and Capital Facilities and Technological Need (CFTN). The planned total expenditures for FY 2014-15 through FY2016-17 for all components are $399,766,102. The Three-Year Plan also provides details of the community program planning process, future funding priorities, and proposals for new Innovation programs. This summary highlights the contents of the Three-Year Plan.

Community Program Planning Process

In addition to ongoing communication with stakeholders, Behavioral Health Services conducted a dynamic Community Program Planning (CPP) process to obtain stakeholder input specifically to inform the development of the Three-Year Plan. A total of 25 special MHSA CPP sessions were conducted from March 5 through May 14, 2014. During these sessions, 578 participants brainstormed ideas and voted on priorities for three of the components: Community Services and Supports, Prevention and Early Intervention, and Capital Facilities and Technological Needs. Input for these three components was also solicited through a community survey that was available to complete online and by paper copy. Two hundred and fifty five community members completed the survey.

Stakeholders were also given a 30-day period to submit concepts for the planning of future Cycle 3 Innovation programs. Seventy concepts were submitted and seven were selected for consideration. The seven concepts were discussed for feedback at stakeholder led councils and workgroup meetings during May 2014. Changes to WET programs and BHS' recommendation to transfer 3% of local PEI funds to CalMHSA for FY 2014-15 were also discussed in May 2014.

Should additional funding become available during the course of this Three-Year Plan, the priorities listed below were identified by stakeholders through the CPP process. These priorities are not listed in hierarchical order.

Future Funding Priorities for Fiscal Year (FY) 2014-15 through FY 2016-17

Community Services and Support

- Expand Full Service Partnerships
- Increase crisis housing and residential beds, especially for youth under 18 years of age
- Expand Psychiatric Emergency Response Services
- Increase permanent supportive housing
- Increase MHSA emergency housing for high risk population groups, such as veterans, military and runaway teens with SMI
- Increase supportive employment services, vocational training and placement services
- Expand services for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) clients and their family members

- Increase access to mental health services and clinicians within hospital and primary care settings

Prevention and Early Intervention

- Expand services like Kickstart countywide
- Fund school-based programs that empower youth/parents/teachers and address bullying and positive relationships skills
- Fund programs that support caregivers and families with Alzheimer's, dementia or SMI.
- Fund programs to provide mental health training and outreach to faith-based leaders and brokers
- Expand school-based programs for suicide prevention and mental health issues
- Expand *It's Up to Us* media campaign which focuses on stigma and discrimination reduction regarding mental health, and suicide prevention
- Expand mental health services for persons with co-occurring disorders
- Fund mental health prevention programs focusing on youth at risk for gang involvement

Capital Facilities and Technological Needs

- Improve Behavioral Health Services' technology for interoperability of the Anasazi system with providers' Electronic Health Records and the County of San Diego Knowledge Integration Project (KIP)
- Fund smartphone applications (apps) for suicide prevention and mental illness
- Fund a live chat feature with the Behavioral Health Services funded Access & Crisis hotline, and expand to include the Spanish language
- Develop technology to support an integrated assessment system for homeless persons with SMI
- Support expansion of technology to link at-risk veterans to mental health services and benefits

Cycle 3 Innovation Proposals

Seven concepts were selected as proposed Cycle 3 Innovation programs. In addition, the existing In-Home Outreach (IHOT) Innovation program (INN-10A) will be receiving funding during Cycle 3 based on County Board of Supervisors approval to expand services from three regions to the entire county. Here is a list of the proposed programs.

- In-Home Outreach Team Expansion (IHOT) (INN-10A)
- Care Giver Connection to Treatment (INN-11)
- Family Therapy Participation (INN-12)
- Faith-Based Initiative (INN-13)
- Ramp Up 2 Work (INN-14)
- Peer Assisted Transitions (INN-15)
- Urban Beats (INN-16)
- Innovations Mobile Hoarding Intervention Program (IMHIP) (INN-17)

LIVE WELL SAN DIEGO

San Diego County's long-term initiative to achieve the vision of
healthy, **safe** and **thriving** communities

OVERVIEW

In 2010, the County Board of Supervisors adopted a comprehensive initiative called *Live Well San Diego*. This long-term plan to advance the health, safety and overall well-being of the region is being built with community involvement. *Live Well San Diego* includes three parts: Building Better Health, adopted on July 13, 2010; Living Safely, adopted on October 9, 2012; and, because living well goes beyond health and safety, Thriving is planned for roll out in 2014 to focus on overall well-being.

There are four major strategies upon which the Live Well San Diego initiative is built:

- Building a Better Service Delivery System;
- Supporting Positive Choices;
- Pursuing Policy & Environmental changes; and
- Improving the Culture Within.

Implementation of the Mental Health Services Act (MHSA) in San Diego County demonstrates the County's commitment to collaborating with stakeholders, partners and businesses, aligning services to promote healthy, safe and thriving communities for all residents, and putting *Live Well San Diego* into action.

San Diego County has implemented the MHSA through the four major pillars of *Live Well San Diego* which are consistent with the tenets of MHSA.

Building a Better Service Delivery System is essential to improving the quality and efficiency of County government and its partners in the delivery of services to residents, contributing to better outcomes for clients and results for communities. Access to the right care at the right time is critical to achieving and maintaining the health of an individual. A few examples illustrating strides made towards building a better service delivery system through MHSA include:

- Integration of physical and behavioral health care;
- Implementation of two regional faith-based councils connecting local faith organizations to resources and providing tools to prepare faith leaders as first responders to mental health challenges in their congregations; and

- Collaboration with partners for the development of permanent supportive housing such as Citronica One, a transformative housing program with 15 apartments that have been designated for underserved, transition age youth with mental illnesses who are eligible for supportive services under MHSA.

Supporting Positive Choices is about providing information and resources to inspire county residents to take action and responsibility for their health, safety and well-being. Because the healthy choice is not always the easy choice, it is critical to remove barriers to making the right choice. A few examples of how MHSA funded programs are supporting positive choices are as follows:

- County of San Diego Regional Community Health Promotion and Aging Program Specialists are broadening the reach of education and training by incorporating physical health and behavioral health in their messaging;
- *It's Up to Us* Suicide Prevention and Stigma Reduction Media Campaign continues to provide wellness tips through quarterly bulletins and social media posts; and
- Expansion of the In-Home Outreach Team (IHOT) program to provide countywide intensive outreach and engagement services to individuals with serious mental illness who are reluctant to receive treatment and to their families or caretakers.

Pursuing Policy & Environmental Changes creates environments and adopts policies that make it easier for everyone to live well, and encourage individuals to get involved in improving their communities. A few MHSA funded examples that illustrate this include:

- Collaboration with community partners during a Regional Stigma Reduction Roundtable for San Diego and Imperial Counties to explore ways to engage community members and professionals to end the stigma around getting help for mental health challenges;
- Development of an implementation plan for the integration of trauma informed systems across the County's Health and Human Services Agency (HHSA);
- Active participation in statewide efforts to reduce the stigma around mental health; and
- Assisting in the development of a best practice for suicide prevention through the use of social media.

Improving the Culture Within increases understanding among County employees and providers about what it means to live well and the role that all employees play in helping county residents live well. A healthier and more knowledgeable workforce is increasingly productive and better at serving those who use County services. Behavioral Health Services staff participate in:

- Community events such as walks for mental health, suicide prevention and recovery;
- 2014 National Alliance on Mental Illness (NAMI) Walk and *Live Well San Diego* Expo; and
- 5-on-5, a basketball themed competition which challenges employees to eat a healthy diet including whole grains, vegetables, and fruits.

PROGRESS THROUGH PARTNERSHIPS

Live Well San Diego involves everyone. Only through a collective effort can meaningful change be realized in a region as large and diverse as San Diego County. Partners include cities and governments, diverse businesses (including healthcare and technology), military and veterans organizations, schools, and community and faith-based organizations. Most importantly, *Live Well San Diego* is about empowering residents to take positive actions for their own health, safety and well-being.

MAY YOUR CHOICES REFLECT YOUR HOPES,

NOT YOUR FEARS.

— Nelson Mandela

SAN DIEGO COUNTY DEMOGRAPHICS

San Diego County in California is located near the Pacific Ocean in the far southwest part of the United States. The County encompasses 4,261 square miles, has nearly seventy miles of coastline, lies just north of Mexico and shares an 80-mile international border. It is among the nation's most geographically varied regions, with urban, suburban, and rural communities throughout coastal, mountain, and desert environments. San Diego is the second most populous county in California, and the population was estimated at 3,143,429 people in 2012.

San Diego is one of the largest military cities and counties in the United States. The county is the fifth largest county by population in the United States, and is the number one destination of veterans returning from Iraq and Afghanistan. The military population has been estimated at 198,820 military personnel, families and dependents. That number is expected to grow as the war in Afghanistan comes to an end.

According to the American Community Survey (ACS) of 2012, in San Diego County 13.86% of residents were living below the federal poverty line, of which 9.98% were families, and 14.58% were families with children. Of the families with children, 27.95% were single parents with children under 18 years old.

The San Diego Regional Task Force on the Homeless (RTFH) conducted its annual point-in-time count of homeless persons living in San Diego County on January 26, 2012. Results showed an increase of the total number of homeless up from 9,020 in 2011 to 9,638 in 2012, an increase of 6.9%. The results of the survey indicated 31% of the individuals were chronically homeless, 30% suffered from serious mental health issues, 30% had chronic substance abuse, and 18% were military veterans.

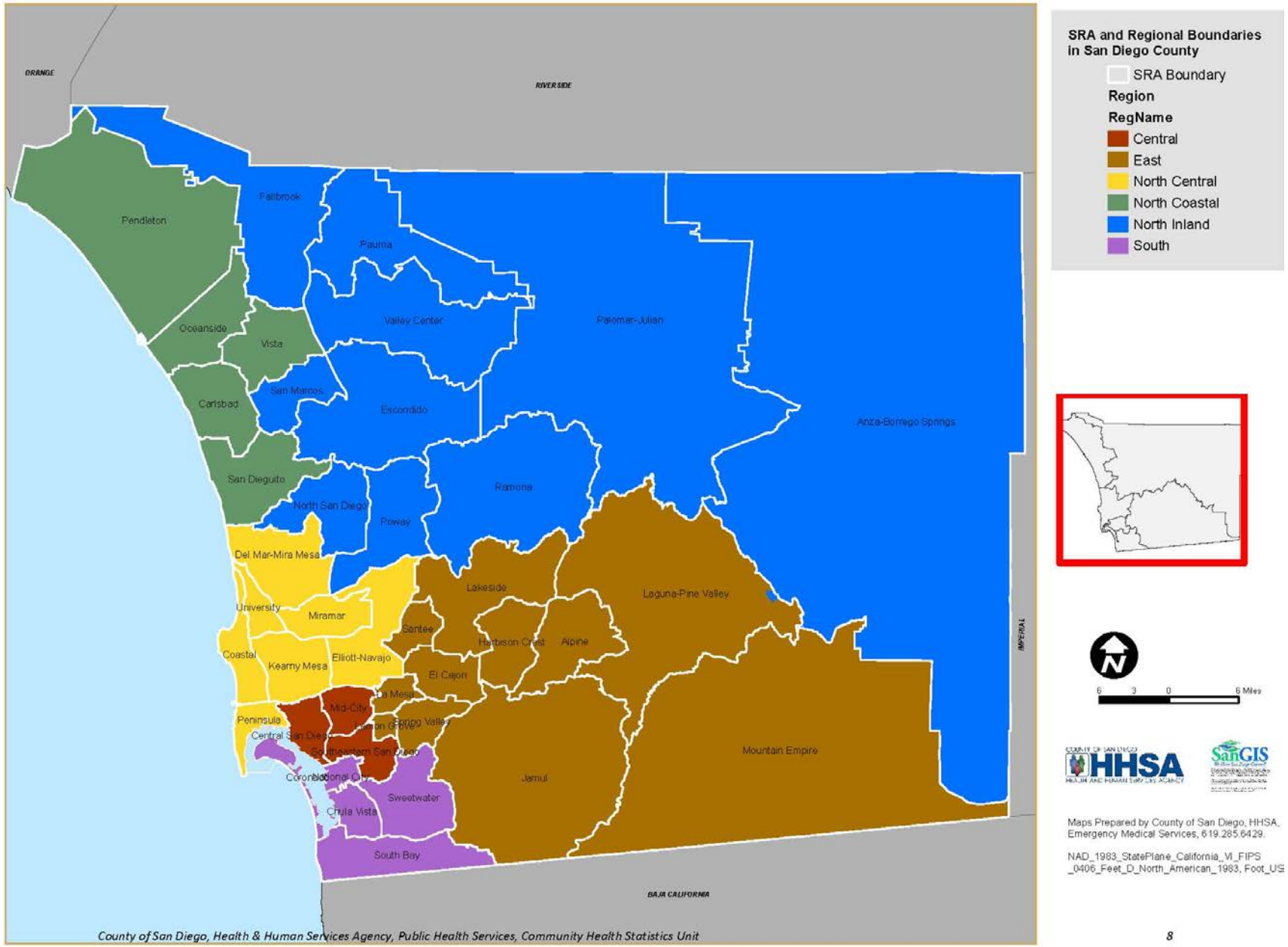
In 2012, the racial and ethnic makeup of the San Diego County population was 47% White, followed by 33% Hispanic, 11% Asian, 4% African American, 4% other, and less than 1% American Indian. San Diego Association of Governments predicts that by 2020, Hispanics will account for 59% of the population growth. The primary languages spoken in the County were English (63%) and Spanish (11%), with 21% of the population being bilingual. Spanish, Vietnamese, Tagalog and Arabic were the County's threshold languages. Threshold languages are any of a number of foreign languages most spoken by residents.

The age distribution in San Diego County in 2012 was as follows:

0 to 4 years -- 6.48%
5 to 14 years -- 12.67%
15 to 24 years -- 15.99%
25 to 44 years -- 28.31%
45 to 64 years -- 24.62%
65+ years -- 11.91%

Gender distribution for San Diego County was 50.13% male and 49.87% female.

The map and tables on the following pages provide further details on the Subregional Areas and Regional Operating boundaries of San Diego County, and the population characteristics within the County.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Fallbrook
Pauma
Valley Center
Palomar-Julian
Oceanside
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San Marcos
Escondido
Carlsbad
Anza-Borrego Springs
San Dieguito
Ramona
North San Diego
Poway
Del Mar-Mira Mesa
Lakeside
Laguna-Pine Valley
University
Miramar
Santee
Harbison Crest
Alpine
Coastal
Kearny Mesa
Elliott-Navajo
El Cajon
La Mesa
Mid-City
Peninsula
Spring Valley
Central San Diego
Mountain Empire
Jamul
Coronado
National City
Sweetwater
Chula Vista
South Bay
SRA and Regional Boundaries in San Diego County
SRA Boundary
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RegName
Central
East
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County of San Diego, Health & Human Services Agency, Public Health Services, Community Health Statistics Unit
8

San Diego County

Overview

Demographic Profile [2012 San Diego Association of Governments (SANDAG) Estimates)]

	Number	Percent
Total Population	3,143,429	100.00%
Age Distribution		
0 to 4 Years	203,829	6.48%
5 to 14 Years	398,416	12.67%
15 to 24 Years	502,716	15.99%
25 to 44 Years	890,051	28.31%
45 to 64 Years	773,882	24.62%
65+ Years	374,535	11.91%
Gender Distribution		
Male	1,575,943	50.13%
Female	1,567,486	49.87%
Race/Ethnicity		
White	1,492,320	47.47%
Hispanic	1,035,226	32.93%
Black	139,383	4.43%
Asian/Pacific Islander	355,935	11.32%
Other	120,565	3.84%

Income (2012 ACS) (*LWSD*)

	Number	Percent
Total Households	1,067,462	100.00%
Household Income		
< $35,000	293,329	27.48%
$35,000 to $50,000	134,338	12.58%
$50,000 to $75,000	184,939	17.33%
$75,000 to $100,000	141,272	13.23%
$100,000 to $150,000	168,530	15.79%
> $150,000	145,054	13.59%
Income per Person in HH		
Median HH Income		$70,926
Persons Per HH		2.76
Income per Person in HH		$25,697.83

Unemployment Estimates (2012 ACS) (*LWSD*)

Eligible Labor Force	
16+ Years	1,614,267
Labor Force	
Percent Unemployed	9.16%

Occupation (2012 ACS)

Labor Force (16+ Years)	
Unemployed Civilians	147,839
Armed Forces	79,603
Employed Civilians	1,386,825
Employed Civilian Occupation Category (16+ Years)	
Management, Professional, & Related	39.83%
Service	19.18%
Sales and Office	24.81%
Construction, Extraction, & Maintenance	8.06%
Production, Transportation, & Material Moving	8.12%

Industry (2012 ACS)

Industry of Civilian Employees	
Agriculture, Forestry, Mining	0.89%
Construction	6.08%
Manufacturing	9.39%
Wholesale Trade	2.56%
Retail Trade	11.15%
Transportation, Warehousing, and Utilities	3.75%
Information and Communications	2.34%
Finance, Insurance, and Real Estate	6.98%
Professional, Scientific, Management, Admin.	14.19%
Educational, Social and Health Services	20.88%
Entertainment and Hospitality related	10.91%
Other Services	5.36%
Public Administration	5.52%

Education [2012 American Community Survey (ACS) *Live Well San Diego* (*LWSD*)]

Total Population	
25+ Years Old	2,011,024
Completed Education	
< High School Graduate	14.60%
High School Graduate	19.00%
Some College or AA	31.99%
Bachelor Degree	21.40%
Graduate Degree	13.01%

School Enrollment (2012 ACS)

Population Eligible for Enrollment	
4 to 18 years	621,919
Private vs Public School Enrollment	
Percent Public Schools	92.17%
Percent Private Schools	7.83%

Language (2012 ACS)

Total Population	
5+ Years Old	2,895,150
Primary Language Spoken at Home	
English Only	62.87%
Spanish Only	10.92%
Asian/Pacific Island Language Only	3.63%
Other Language Only	1.56%
Bilingual	21.01%

Housing Estimates (2012 ACS)†

Occupancy	
Owner Occupied	54.53%
Renter Occupied	45.47%
Housing Costs	
Median House Value	$419,400
Median Rent	$1,282

Personal Vehicles (2012 ACS)

Household Vehicle Availability	
No Vehicle	6.14%
1 Vehicle	32.44%
>1 Vehicle	61.42%

Poverty Estimates (2012 ACS)†

Income Percent of Poverty Level	
<50%	6.60%
50 - 74%	3.09%
75 - 99%	4.17%
100 - 124%	4.55%
125 - 149%	4.43%
150% - 199%	8.91%
200% +	68.25%
Percent Below Poverty Level	
Population	13.86%
Families	9.98%
Families With Children	14.58%

Single Parent Homes (2012 ACS)

Total Family Households	
With Children <18 Years	335,944
Families With Children <18 Years	
Percent Single Parent	27.95%

†See *Supplemental Page* for more related data.
***LWSD* = *Live Well San Diego* Indicator**

San Diego County

Supplemental Page

Marital Status (2012 ACS)

	Number	Percent
Total Population		
15+ Years Old	2,504,138	100.00%
Marital Status		
Single, Never Married	884,854	35.34%
Married	1,191,967	47.60%
Separated	47,740	1.91%
Widowed	124,625	4.98%
Divorced	254,952	10.18%

Public Program Participation (2012 ACS)

Food Stamps/SNAP/CalFresh Benefits	
Households	4.75%
Families with Children	6.22%
Eligibility by Federal Poverty Level (FPL)	
Population ≤130% FPL	19.47%
Population ≤138% FPL	20.89%
Population 139% - 350% FPL	32.73%

Selected Status Populations (2012 ACS)

	Number	Percent
Disability Status		
Total Civilian Noninstitutionalized Population	2,996,858	100.00%
With a Disability	278,432	9.29%
With a Hearing Difficulty	79,486	2.65%
With a Vision Difficulty	48,915	1.63%
With a Cognitive Difficulty	106,726	3.56%
With an Ambulatory Difficulty	143,395	4.78%
With a Self-care Difficulty	61,864	2.06%
With an Independent Living Difficulty	112,662	3.76%
Veteran Status		
Civilian Population 18+ Years	2,297,505	100.00%
Veteran Population	235,877	10.27%
Foreign Born		
Total Population	3,143,429	100.00%
Foreign Born	720,485	22.92%
Foreign Born, Naturalized Citizen	340,977	10.85%
Foreign Born, Not a U.S. Citizen	379,508	12.07%

Selected Housing Characteristics (2012 SANDAG)

	Total Units	Occupied
Housing and Occupancy		
Total Housing Units	1,165,970	1,098,251
Single Family - Detached	566,143	542,874
Single Family - Multiple-Unit	136,249	127,367
Multi-Family	421,008	389,167
Mobile Home and Other	42,570	38,843

Older Adult Population (2012 ACS)

Total Population	
65+ Years Old	374,535
Household Type	
Married-Couple Family	53.92%
Family Household, No Spouse Present	14.88%
Non-Family Household	3.88%
Group Quarters	3.13%
Male, Living Alone	7.25%
Female, Living Alone	16.94%
Poverty	
Percent Below 100% FPL	7.83%
Percent Below 200% FPL	24.93%
Income	
Mean Household Earnings	$57,296
Percent with Earnings	36.10%
Percent with Social Security Income	88.80%
Percent with Supplemental Security Income	7.30%
Percent with Cash Public Assistance Income	1.50%
Percent with Retirement Income	50.80%
Percent with Food Stamps/SNAP Benefits	2.20%
Labor Force	
Percent in Labor Force	15.60%
Grandparents	
Living with Grandchild (<18 Years Old)	7.80%
Responsible for Grandchild (<18 Years Old)	1.50%

Selected Economic & Social Characteristics (2012 ACS) (*LWSD*)

Monthly Housing Costs as a Percentage of Household Income	
Less than 20% per Month	29.47%
20% to 29% per Month	22.22%
30% or more per Month	48.32%
Health Insurance Coverage Status	
Ages 0-17 Years	
With Health Insurance Coverage	90.21%
Without Health Insurance Coverage	9.79%
Ages 18-64 Years	
With Health Insurance Coverage	77.39%
Without Health Insurance Coverage	22.61%
Ages 65+ Years	
With Health Insurance Coverage	98.47%
Without Health Insurance Coverage	1.53%
All Ages	
With Health Insurance Coverage	82.93%
Without Health Insurance Coverage	17.07%
Commute to Work	
Car, Truck, or Van - Drove Alone	75.86%
Car, Truck, or Van - Carpooled	10.21%
Public Transportation (Excluding Taxis)	3.11%
Walked	2.72%
Other Means	1.84%
Worked from Home	6.26%

***LWSD* = *Live Well San Diego* Indicator.**

San Diego County

Language Spoken at Home among Monolinguals, Aged 5+

Estimates* from 2011 American Community Survey

Language Spoken at Home	Number*	Percent of *Monolingual*** Population	Percent of *Total* Population
Total Population, Aged 5+ Years	**2,895,150**		
Total Mono-lingual Population	2,286,759	100.00%	78.98%
English Only	1,820,082	79.59%	62.87%
Non-English Speakers:			
Spanish Only	316,282	13.83%	10.92%
Tagalog Only	34,156	1.49%	1.18%
Vietnamese Only	25,224	1.10%	0.87%
Chinese Only	19,631	0.86%	0.68%
Arabic Only	8,925	0.39%	0.31%
Korean Only	7,391	0.32%	0.26%
Japanese Only	5,664	0.25%	0.20%
Other and Unspecified Languages Only	5,618	0.25%	0.19%
Persian Only	5,603	0.25%	0.19%
African Only	4,387	0.19%	0.15%
Russian Only	4,047	0.18%	0.14%
Other Pacific Island Only	3,412	0.15%	0.12%
Laotian Only	3,271	0.14%	0.11%
Other Asian Only	2,719	0.12%	0.09%
Mon-Khmer, Cambodian	2,187	0.10%	0.08%
French Only	1,938	0.08%	0.07%
Hindi Only	1,539	0.07%	0.05%
German Only	1,523	0.07%	0.05%
Other Indo-European Only	1,515	0.07%	0.05%
Italian Only	1,505	0.07%	0.05%
Portuguese Only	1,385	0.06%	0.05%
Other Indic Only	1,168	0.05%	0.04%
Thai Only	1,134	0.05%	0.04%
Polish Only	984	0.04%	0.03%
Other Slavic Only	772	0.03%	0.03%
Urdu Only	755	0.03%	0.03%
Armenian Only	668	0.03%	0.02%
Gujarati Only	643	0.03%	0.02%
Serbo-Croatian Only	544	0.02%	0.02%
Hungarian Only	530	0.02%	0.02%
Hmong Only	380	0.02%	0.01%
Scandinavian Only	301	0.01%	0.01%
Greek Only	296	0.01%	0.01%
Other West Germanic Only	250	0.01%	0.01%
Hebrew Only	245	0.01%	0.01%

** In this case, "monolingual" refers to those who speak English only or another language at home and speak English less than very well.

*The 2012 American Community Survey universe is limited to the household population over 5 years old and excludes the population living in institutions, college dormitories, and other group quarters. Data are based on a sample are subject to sampling variability.

San Diego County

Language Spoken at Home Among Bilinguals, Aged 5+ Years

Estimates* from 2012 American Community Survey¨ (ACS)

Language Spoken at Home	Number*	Percent of *Bilingual*** Population	Percent of *Total* Population
Total Population, Aged 5+ Years	**2,895,150**		
Total English-Bilingual* Population	608,391	100.00%	21.01%
Spanish	397,311	65.31%	13.72%
Tagalog	55,919	9.19%	1.93%
Chinese	20,954	3.44%	0.72%
Vietnamese	15,348	2.52%	0.53%
German	9,456	1.55%	0.33%
Arabic	8,932	1.47%	0.31%
French	7,911	1.30%	0.27%
Persian	7,500	1.23%	0.26%
Korean	7,186	1.18%	0.25%
African	6,602	1.09%	0.23%
Japanese	6,542	1.08%	0.23%
Other Asian Languages	5,598	0.92%	0.19%
Other Pacific Island Languages	5,576	0.92%	0.19%
Other/Unspecified Bilingual	5,071	0.83%	0.18%
Hindi	4,648	0.76%	0.16%
Italian	4,513	0.74%	0.16%
Russian	4,455	0.73%	0.15%
Portuguese	4,004	0.66%	0.14%
Other Indo-European Languages	3,172	0.52%	0.11%
Other Indic Languages	3,164	0.52%	0.11%
Mon-Khmer, Cambodian	2,395	0.39%	0.08%
Laotian	2,259	0.37%	0.08%
Scandinavian Languages	2,153	0.35%	0.07%
Other West Germanic Languages	2,052	0.34%	0.07%
Polish	1,861	0.31%	0.06%
Other Slavic Languages	1,782	0.29%	0.06%
Serbo-Croatian	1,716	0.28%	0.06%
Urdu	1,678	0.28%	0.06%
Armenian	1,466	0.24%	0.05%
Gujarati	1,421	0.23%	0.05%
Greek	1,394	0.23%	0.05%
Hebrew	1,177	0.19%	0.04%
Thai	1,037	0.17%	0.04%
Hungarian	741	0.12%	0.03%
Hmong	716	0.12%	0.02%
Other Native North American Lang.	327	0.05%	0.01%
Yiddish	289	0.05%	0.01%
Navajo	65	0.01%	0.00%

** In this case, "bilingual" refers to those who speak English very well and speak another language at home.

*The 2012 American Community Survey universe is limited to the household population over 5 years old and excludes the population living in institutions, college dormitories, and other group quarters. Data are based on a sample are subject to sampling variability.

MENTAL ILLNESS IS NOTHING TO BE ASHAMED OF,

BUT STIGMA AND BIAS SHAME US ALL.

— Bill Clinton

COMMUNITY PROGRAM PLANNING PROCESS

The County of San Diego receives stakeholder input for community program planning on an ongoing basis through the monthly Behavioral Health Services (BHS) Mental Health Board, Alcohol and Drug Advisory Board, and System of Care (SOC) stakeholder-led councils and workgroup meetings. The stakeholder-led councils provide a forum for council representatives and the public to stay informed and involved in the planning and implementation of MHSA programs. Council members also share MHSA information with their constituents and other groups involved in behavioral health services and issues. Membership includes consumers and family members, as well as other key stakeholders in the community such as providers, Probation, First 5, health plans, program managers, representatives of consumer and family organizations, advocacy groups, law enforcement, education representatives, and County partners.

Input from these councils for the planning of the MHSA Three-Year Program and Expenditure Plan: FY 2014-15 through FY 2016-17 was collected through: 1) a series of special MHSA Community Program Planning (CPP) outreach sessions; 2) a community survey in English and four threshold languages; and 3) MHSA presentations at council/workgroup meetings. A total of twenty-five special MHSA CPP sessions were conducted from March 5 through May 14, 2014. A total of 578 stakeholders participated.

Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Capital Facilities and Technological Needs (CFTN) Components

In advance of each special CPP outreach session, BHS staff emailed stakeholders to briefly describe the purpose of the CPP stakeholder input process as well as to provide background documents that included FY 2013-14 County of San Diego BHS priorities; MHSA for Beginners; County of San Diego MHSA FY 2013-14 Annual Update Expenditure Plan; program summaries for currently funded CSS, PEI and CFTN programs; and the Mental Health Services Act (as revised July 2013). During each outreach session BHS staff distributed and reviewed the documents with participants, gave an overview of the input process, and collected stakeholder input utilizing an Affinity Diagram Process.

The Affinity Diagram Process allowed participants to brainstorm the priorities of the community, and identify gaps in services or unmet needs for three MHSA components—CSS, PEI, and CFTN. The priorities, gaps in services or unmet needs were recorded and grouped according to the related MHSA component. Each participant was asked to prioritize importance of the needs or gaps in service by voting for their top five in each component. This allowed for an organic process by which stakeholder groups could assess if currently funded MHSA programs should be modified or expanded, or if new programs were needed to address service gaps and unmet needs. After collecting stakeholder input, BHS staff compiled and categorized the top five CSS, PEI, and CFTN concepts of each individual outreach session. A summary document for all sessions was distributed to stakeholders.

Stakeholder input for the three components was also solicited via electronic and paper survey in English, Spanish, Vietnamese, Tagalog and Arabic. The survey (Appendix B) was designed to obtain input from stakeholders who were unable to attend an MHSA CPP outreach session or wished to provide additional feedback. Over four hundred surveys were submitted in English, nine in Spanish, and one each in Tagalog and Vietnamese. Two hundred and fifty-five stakeholders fully completed the surveys and 145 were partially completed.

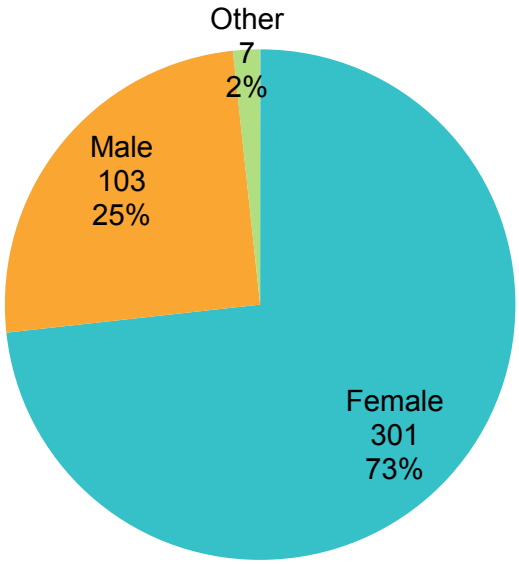
Input for the MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17 was also provided by members of the County's Health and Human Services Executive

Team. The same process was used as with the community and provider councils. A total of 15 executives participated in the process.

Priorities identified during the CPP process are listed in the respective component's section in this Three-Year Plan and will be considered for implementation at regular system reviews and the availability of funding.

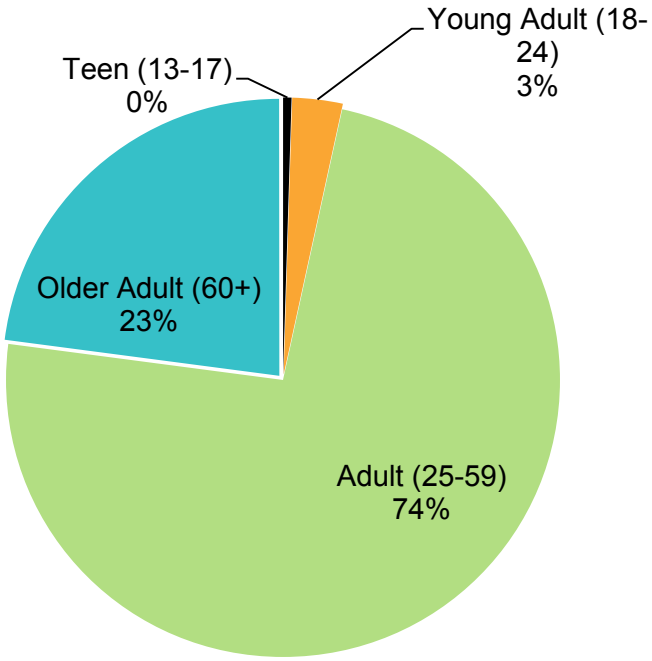
MHSA CPP SURVEY DEMOGRAPHICS

Chart 1: Survey Participants Gender
Total responses: 411



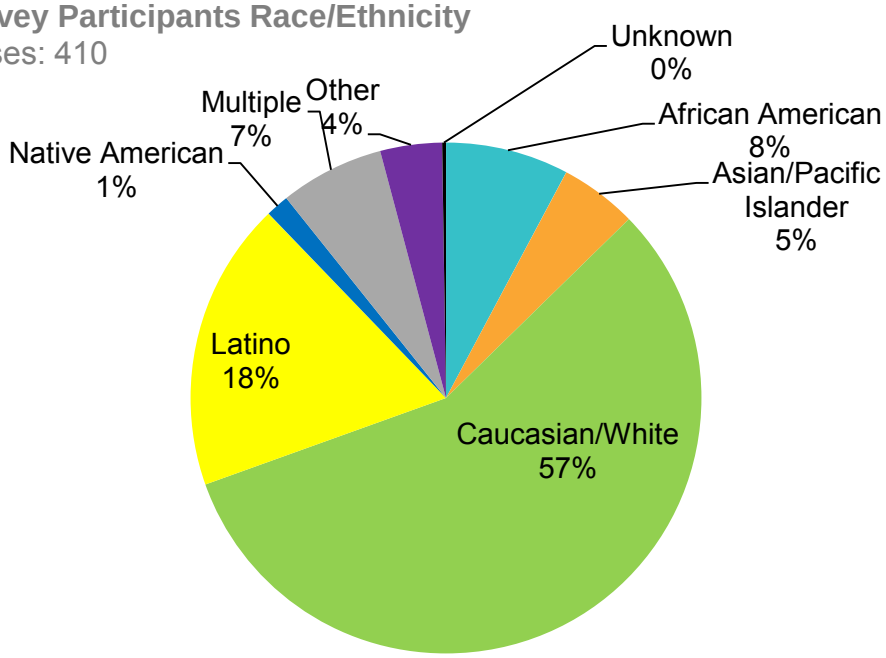
The majority of survey respondents were female (73%).

Chart 2: Survey Participants Age
Total responses: 410



The majority of survey respondents were adults aged 25-59 years (74%).

Chart 3: Survey Participants Race/Ethnicity
Total responses: 410



The majority of survey respondents were Caucasian/White (57%), followed by Latino (18%) and African American (8%).

COMMUNITY PROGRAM PLANNING STAKEHOLDER INPUT

The table below provides a listing of the various stakeholder groups, councils and workgroups that participated in the Community Program Planning process. Input provided was for the Community Services and Supports (CSS), Prevention and Early Intervention (PEI), and Capital Facilities Technological Needs (CFTN) components of the County of San Diego MHSA Three-Year Program and Expenditure Plan: FY 2014-15 through FY 2016-17.

	Date	Meeting	Participants	Region	Representation
1.	3/5/2014	Central Region Faith-Based Council	17	Central	Community
2.	3/6/2014	Housing Council	27	Countywide	Provider
3.	3/7/2014	Cultural Competency Resource Team	16	Countywide	Provider
4.	3/10/2014	Children Youth and Family System of Care Council	40	Countywide	Provider
5.	3/12/2014	North Inland Faith-Based Council	11	North	Community
6.	3/17/2014	Mental Health Contractors Association	18	Countywide	Provider
7.	3/18/2014	Adult System of Care Council	20	Countywide	Provider
8.	3/19/2014	Older Adult System of Care Council	17	Countywide	Provider
9.	3/25/2014	San Diego County Suicide Prevention Council	29	Countywide	Community
10.	3/25/2014	San Diego Mental Health Coalition	18	Countywide	Provider
11.	3/26/2014	Transition Age Youth Workgroup	17	Countywide	Provider
12.	4/4/2014	Family Youth Roundtable	19	Countywide	Community
13.	4/4/2014	NAMI San Diego	21	Countywide	Community
14.	4/8/2014	Mental Health America – Breaking Down Barriers African American Collaborative	19	Countywide	Community
15.	4/8/2014	San Diego Psychiatric Society	19	Countywide	Provider
16.	4/14/2014	Early Childhood Mental Health Subcommittee	15	Countywide	Provider
17.	4/15/2014	Regional Continuum of Care Council	60	Countywide	Provider
18.	4/17/2014	Alcohol and Drug Services Provider Meeting	41	Countywide	Provider
19.	4/18/2014	Hospital Partners	26	Countywide	Provider
20.	4/18/2014	Casa Del Sol Clubhouse	28	South	Community
21.	4/22/2014	Peer Liaison Meeting	49	Countywide	Community
22.	4/25/2014	Visions Clubhouse Latino Advisory Group	15	South	Community
23.	5/7/2014	Veteran Family Forum	24	Countywide	Community
24.	5/8/2014	Mental Health America – Breaking Down Barriers LGBTQ Collaborative	7	Countywide	Community
25.	5/14/2014	Mental Health America – Breaking Down Barriers Native American Collaborative	5	Countywide	Community
			578	**Total**	

Stakeholder input for the MHSA Innovation and Workforce Education and Training (WET) components was solicited utilizing the following processes:

Innovation Component

In October 2013, Behavioral Health Services distributed a Community Input Form requesting stakeholder concepts for the planning of future Cycle 3 Innovation programs. Stakeholders included community based organizations, Mental Health Board, Alcohol and Drug Advisory Board, System of Care (SOC) stakeholder-led councils and workgroup meetings, and contract providers. Membership within the stakeholder-led councils and workgroups include consumers and family members, as well as other key stakeholders in the community such as providers, program managers, representatives of consumer and family organizations, advocacy groups, education representatives, and County partners.

Stakeholders were given thirty days to provide input which could be submitted through email, fax, or mail. A total of seventy Cycle 3 Innovation Community Input Forms were submitted. Seven concepts were selected as proposed Cycle 3 Innovation programs. These proposed concepts (Appendix C), along with annual and three year funding totals, were discussed for feedback at stakeholder-led councils and workgroup meetings during the month of May 2014.

Workforce Education and Training Component

County MHSA WET Funds are a one-time allocation and must be expended by June 30, 2018, or revert back to the State. As of June 30, 2014, the projected unspent balance of local WET funds was approximately $5.8 million, $4.9 million of which is included this expenditure plan. Recommendations for allocation of the estimated remaining $900,000 and/or unspent WET funds were discussed for stakeholder input during May 2014 stakeholder-led councils and workgroup meetings.

MHSA CPP MILESTONES

	Date	Action
1.	10/31/2013	Community input received on concepts for Cycle 3 Innovation programs
2.	3/5/2014	CPP discussions at Council/Stakeholder/Community meetings began on CSS, PEI, and CFTN components of the MHSA 3-Year Plan
3.	5/1/2014	CalMHSA Prevention & Early Intervention and Innovation discussions commenced at Council/ Stakeholder/ Community meetings
4.	5/16/2014	Initial Community Input on MHSA 3-Year Plan period ended
5.	6/19/2014	Public Comment Period began for Draft MHSA 3-Year Plan
6.	7/21/2014	Public Comment Period ended
7.	8/7/2014	Public Hearing on final MHSA 3-Year Plan held at the Mental Health Board meeting
8.	10/28/2014	MHSA 3-Year Plan submitted to the County Board of Supervisors for approval
9.	11/25/2014	MHSA 3-Year Plan submitted to Mental Health Services Oversight and Accountability Commission

HEAVY BURDENS BECOME LIGHTER

WITH HELP FROM FAMILY

-Anonymous

MHSA FISCAL YEAR 2014-15 THROUGH FISCAL YEAR 2016-17 PROGRAM AND EXPENDITURE PLAN

The planned MHSA expenditure for Fiscal Year (FY) 2014-15 through FY 2016-17 is $399,766,102 [1].

This includes expenditure plans for each of the MHSA components listed below. See Appendix A for details of the MHSA Expenditure Plan for FY 2014-15 through FY 2016-17.

Component	FY14/15	FY15/16	FY16/17	Total	% of Overall
Community Services and Supports (CSS)	92,136,132	92,136,132	92,136,132	**$276,408,396**	69%
Prevention and Early Intervention (PEI)	26,826,338	26,137,238	26,137,238	**$79,100,814**	20%
Innovation (INN)	7,969,658	9,059,480	9,059,480	**$26,088,618**	7%
Workforce Education and Training (WET)	3,293,272	1,766,694	35,897	**$5,095,863**	1%
Capital Facilities and Technological Needs (CFTN)	4,608,808	8,042,572	421,031	**$13,072,411**	3%
Total	**$134,834,208**	**$137,142,116**	**$127,789,778**	**$399,766,102**	**100%**

[1] Calculations are inclusive of estimated MHSA and estimated Administrative costs only.

Community Services and Supports

FY 2014-15 through FY 2016-17 CSS Expenditure Plan = $276,408,396 [2]

Community Services and Supports (CSS) enhance the systems of care for delivery of mental health services to seriously emotionally and behaviorally challenged children, youth and their families, adults, and older adults with severe mental illness. Full Service Partnership (FSP) programs provide a full array of services to clients and families by embracing a "whatever it takes" approach to help stabilize the client and provide timely access to needed services for unserved and underserved children, youth and adults of all ages. Other programs funded through CSS provide outreach and engagement activities and system development. In FY 2012-13, a total of 52,611 unduplicated clients were served countywide. Outcome reports and highlights for CSS FSP programs in FY 2012-13 can be found in Appendix D.

The majority of our MHSA programs and strategies are implemented through the CSS component and approximately 69% of the total MHSA funding is allocated to these services. These programs ensure that individualized services are provided to children, youth, adults, and older adults who have severe emotional/mental illness. Programs provide children, youth, adults and seniors with medically necessary mental health services, medications, and supportive services set forth in their treatment plan.

MHSA HOUSING

County of San Diego Health and Human Services Agency Behavioral Health Services (BHS) partners with service providers and housing developers to address the dual stigmas of homelessness and mental illness. This partnership recognizes that housing matters, because housing in combination with mental health and social services can break the cycle of homelessness. Home is where recovery begins. A range of housing options are dedicated to or available so people with behavioral health issues in San Diego. The range of housing options includes Emergency Shelters, Crisis Residential Treatment Centers, Licensed Board & Cares (B&C), Independent Living, Transition in Place/Rapid Rehousing, Transitional Housing, Permanent Supportive Housing, and Affordable Housing.

Currently, there are 15 County MHSA projects — with an estimated investment of $33 million in state and local funding — identified for development across the region. These 15 supportive housing developments make up just one of the many elements of MHSA's supportive housing program. If all the existing projects are successfully developed, they will provide 864 affordable housing units, with 241 of the units designated solely for MHSA supportive housing residents. Participants hold their own leases, contribute to their rents, and are subject to the same rules and regulations as all other tenants.

PROGRAMS FOR CHILDREN, YOUTH AND FAMILIES (CYF)

Programs for children and youth provide wraparound services consisting of an array of services including assessment, case management, intensive mental health services and supports, psychiatric services, referrals, linkage with community organizations, and services that address co-occurring mental health issues and substance abuse. Services are strengths-based, family-oriented, focused on resilience and recovery, and encompass mental health education, outreach, and a range of mental health services as required by the needs of the target populations. Some program services are provided in the home or other sites chosen by the family.

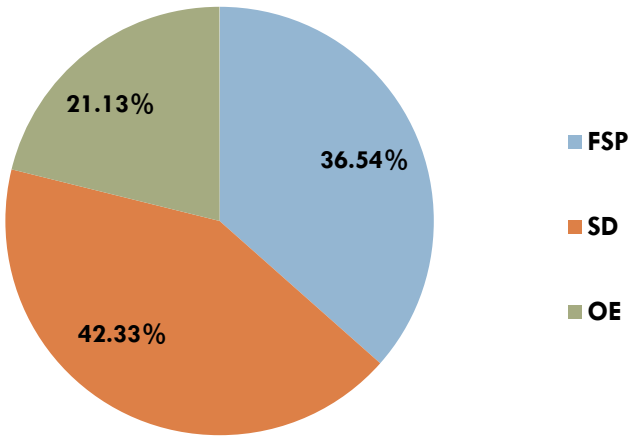
[2] Calculation is inclusive of estimated MHSA and estimated Administrative costs only.

CYF Clients in CSS Programs

There were 7,342 Children, Youth and Families (CYF) clients who received services from CSS programs in Fiscal Year 2012-13.

- More than one third of the CYF clients (36.54%) received services from Full Service Partnerships (FSP).
- Nearly one half of the CYF clients (42.33%) received services from System Development programs (SD).
- Nearly a quarter of all CYF clients in CSS programs (21.13%) received services from Outreach and Education programs (OE).

Chart 4: CYF Unduplicated Clients Served, FY 2012-13



Total CYF	FSP	SD	OE
7,342	2,683	3,108	1,551

Listed below are the Community Services and Supports programs for CYF for FY 2014-15 through FY 2016-17. The programs are grouped in the Expenditure Plan by the work plan acronym in parentheses. Detailed annual estimated costs below and costs per client are estimates for FY14/15 (one year) and are not inclusive of administrative costs. The detailed estimated costs below are inclusive of estimated MHSA, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount and other funding.

The annual projected unique clients for FY14/15 below may show slight variance from the number of unique clients served in Appendix D because some programs from FY12/13 no longer exist. The unique clients served by those programs were not included in projected annual number of unique clients to be served in FY14/15.

Full Service Partnership Projected Client Numbers and Costs

Children, Youth, and Families Full Service Partnership:
Annual Projected Unique Clients Served: 2,683
Projected Cost in FY14/15: $ 14,015,739
Average Projected Cost per Client: $ 5,224

It should be noted that some CYF programs were only enhanced with MHSA and may receive Medi-Cal funding through Early Periodic Screening, Diagnosis and Treatment program (EPSDT). MHSA may be an enhancement to core therapeutic services and the cost for each service is calculated separately (doesn't recognize that it is a duplicate client).

Children and Youth Full Service Partnership Programs (CY-FSP)

Cultural Language Specific Outpatient: The outpatient service is a culturally competent Full Service Partnership (FSP) and mental health services that is provided to Latino and Asian/Pacific Islander (API) children, youth and their families. The services “do whatever it takes” to assist clients in meeting their mental health goals. The goal is to increase the number of Latino and Asian/Pacific Islander children with Serious Emotional Disturbance (SED) served, and their families receiving mental health services.

- Population Focus:
    - Children and youth diagnosed with SED (up to age 21) and families
    - Latinos and Asian/Pacific Islanders
    - Uninsured and underserved, with a secondary focus on Medi-Cal underserved
    - Family Partners directed to the Southeast Mental Health Clinic
    - TAY

Homeless/Runaway Mental Health Services: This service provides a team-based approach to “do whatever it takes” to support homeless and runaway children and youth with SED access needed mental health services. Assertive outreach, FSP services and strong connections to community resources are provided.

- Population Focus:
    - Homeless and runaway children and TAY diagnosed with SED (up to age 21)
    - Uninsured and underserved, with a secondary focus on Medi-Cal underserved
    - Serves homeless youth Countywide

Wraparound Services: Wraparound mental health services are provided to clients and their families to assist with transitioning children and youth currently in Child Welfare Services (CWS) custody and residential placement back into a home environment. FSP services are provided to children, youth, and their families who are receiving Therapeutic Behavioral Services (TBS) and connects clients to a primary care provider. The goal of the Wraparound program is to return children to their family or to a family-like setting, support permanency and enhance long-term success.

- Population Focus:
  - Children and youth diagnosed with SED (age 3-21)
  - Children in CWS custody and residential placement
  - Clients with health issues including but not be limited to obesity, diabetes, poor diet, inactivity, and asthma

Child/Youth Case Management: The program enhances outpatient services to children, youth, and families in eight outpatient clinics, and provides FSP services. These clinics are located in six regions of San Diego County and their clients reflect the diversity of each region. By enhancing the number of Alcohol and Drug counselors, case managers, and FSP services, the clinic-based services system has been transformed and augmented into an integrated system of care.

- Population Focus:
  - Children and youth diagnosed with SED (up to age 21) and their families
  - Clients of mental health services in outpatient clinics
  - Clients with health issues including but not limited to obesity, diabetes, poor diet, inactivity, and asthma

Outreach and Engagement Programs Projected Client Numbers and Cost

Children, Youth, and Families Outreach and Engagement:

Annual Projected Unique Clients Served:	1,487
Projected Cost in FY14/15:	$ 2,945,738
Average Projected Cost per Client:	$ 1,981

Children and Youth Outreach and Engagement Programs (CY-OE)

School-Based Mental Health Services: Mental health services are provided at over 300 school sites across the County. Programs that are funded through Medi-Cal have expanded to include unserved clients (those with no access to services), and have increased outreach and access to services for youth and their families.

- Population Focus:
  - Children and youth with SED (up to age 21) and their families who are uninsured
  - Underserved Latinos and Asian-Pacific Islanders

Mobile Adolescent Services Team (MAST): Mental health assessment and treatment services are provided at Juvenile Court and Community School (JCCS) sites Countywide. This is a Medi-Cal funded program and has expanded to include clients with no access to services. The goal is to increase access to services to SED youth who attend JCCS and expand services to North County JCCS school sites.

- Population Focus:
  - Children and youth attending JCCS classes and their families
  - Uninsured and underserved
  - Children and youth expelled from home school districts and/or involved with juvenile justice system

System Development Programs Projected Client Numbers and Cost

Children, Youth, and Families System Development:
Annual Projected Unique Clients Served: 3,693
Projected Cost in FY14/15: $ 11,509,180
Average Projected Cost per Client: $ 3,116

Children and Youth System Development Programs (CY-SD)

Family and Youth Information/Education Program: This program conducts forums in each of the six regions emphasizing education and information on de-stigmatization of mental illness. These forums increase knowledge of mental illness and SED, improve children and family's ability to benefit from services, inform children and family about resources, and how to access mental health services, and decrease barriers to services.

- Population Focus:
  - Children and youth with SED (age 0-21) and their families
  - Emphasis on Latinos and Asian/Pacific Islanders

Family/Youth Peer Support Services: This service provides support and linkage to community resources for children, youth and their families being served by the Homeless Outreach program or currently receiving mental health treatment. The peer support service assists with continuity of treatment and transition from program to program or community resources, and improves the ability of children, youth, and their families to benefit from mental health services.

- Population Focus:
  - Children and youth with SED and their families
  - Clients receiving mental health services
  - Priority access to homeless and runaway clients receiving FSP services
  - Homeless youth (up to age 21)

Mobile Psychiatric Emergency Response & North County Walk-In Assessment Clinic: The mobile crisis mental health response in conjunction with the Walk-In Assessment Clinic has an assessment team of licensed clinicians able to respond to client calls within four hours and provide voluntary services. This reduces the use of emergency and inpatient services, prevents escalation, and promotes the management of mental illness.

- Population Focus:
  - Unserved, uninsured and underserved children and youth with SED (up to the age of 21) and their families
  - Individuals experiencing a mental health crisis or urgent need

Medication Support for Wards and Dependents: Support is provided for short term (no more than 3 months) stabilization with psychotropic medication and linkage to community-based or private facility for on-going treatment.

- Population Focus:
  - Children and youth with SED
  - Wards and dependents
  - Those without funding and/or who have exhausted medication resources
  - Referred by the Probation Department for Child Welfare Services

Early Childhood Mental Health Services/ChildNet SED: Mental health outpatient services are provided to SED children and their families using the "Incredible Years" evidence based practice model and a family approach. The goal is to increase access to mental health services to SED children and their families, while strengthening parenting skills, increasing parent competency and reducing behavioral problems.

- Population Focus:
  - Children (age 0-5)
  - Children diagnosed with aggressive behavioral problems
  - Uninsured or Medi-Cal eligible
  - Preschools in North region
  - Residents of the North region

Placement Stabilization Services: Through this program, clients and their families receive mental health services to stabilize and maintain children and youth in a home-like setting. Peer mentorship services are provided to CWS youth in placement. The goal is to return children and youth to their family or a family-like setting, deter children and youth from placement in a higher level of care, and stabilize their current placement.

- Population Focus:
  - Children and youth (up to the age of 21)
  - Reside at home, foster care or small group home (6 or less)
  - At risk of change of placement to a higher level of care
  - Juvenile probation wards and former foster youth engaged in a transitional housing program
  - Residents at San Pasqual Academy
  - Residents at Clark Center

Juvenile Justice and Probation Services: This program provides mental health screening of all youth detained in the Kearny Mesa Juvenile Detention Facility, and identifies youth with a diagnosed mental illness for release to appropriate mental health services. This reduces the number of youth in juvenile hall, provides advocacy for appropriate educational services, and decreases the number of mentally ill minority youth detained.

- Population Focus:
  - Youth (age 12-21)
  - Detained in the Kearny Mesa Juvenile Detention Facility
  - Identified as having a mental health diagnosis
  - Eligible for release into the community

PROGRAMS FOR TAY (AGE 16-24) AND ADULTS (AGE 18-59) AND OLDER ADULTS (AGE 60 AND OLDER)

These programs provide a variety of integrated services which may include supported housing (temporary, transitional, and permanent) with a focus of age and developmentally appropriate outreach and engagement, intensive case management 24-hours a day and 7-days a week, wraparound services, community-based outpatient mental health services, rehabilitation and recovery services, supported employment and education, dual diagnosis services, peer support services, and diversion and reentry services.

The County of San Diego Health and Human Services Behavioral Health Services (BHS) provides services to TAY through collaboration between Child Welfare Services (CWS), San Diego County Office of Education (SDCOE) and San Diego County Probation Department. Together these agencies and providers work collaboratively to assist TAY in achieving educational, employment and housing

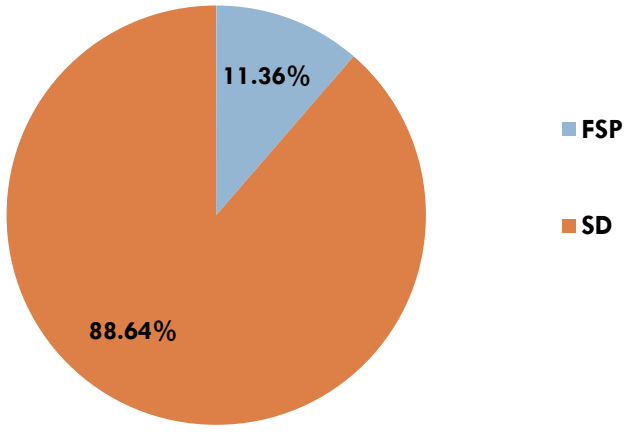
goals, while increasing access to comprehensive health care and establishing support systems to facilitate community integration.

TAY/Adult/Older Adult Clients in CSS Programs

There were 38,514 unduplicated Transition Age Youth, Adult, and Older Adult (TAOA) clients who received services from CSS programs in FY 2012-13.

- More than three quarters of all TAOA clients (88.64%) received services from System Development (SD) programs
- 11.36% TAOA clients received services from FSP programs

Chart 5: TAOA Unduplicated Clients Served, FY 2012-13



Total TAOA	FSP	SD
38,514	4,374	34,140

FY 2014-15 THROUGH FY 2016-17 PROGRAM PLAN

Listed below are the Community Services and Supports programs for TAY, Adults, and Older Adults for FY 2014-15 through FY 2016-17. These programs are grouped in the Expenditure Plan by the work plan acronym in parentheses.

Detailed annual estimated costs below and costs per client are estimates for FY14/15 (one year) and are not inclusive of administrative costs. The detailed estimated costs below are inclusive of estimated MHSA, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount and other funding.

The annual projected unique clients for FY14/15 below may show slight variance from the number of unique clients served in Appendix D because some programs that served clients during FY12/13 expired or were terminated. The unique clients served by those programs were not included in annual projected unique clients served in FY14/15.

Full Service Partnership Projected Client Numbers and Costs

Transition Age Youth and Adult Full Service Partnership:

Annual Projected Unique Clients Served:	3,792
Projected Cost in FY14/15:	$ 28,471,265
Average Projected Cost per Client:	$ 7,508

Older Adult Full Service Partnership:

Annual Projected Unique Clients Served:	923
Projected Cost in FY14/15:	$ 3,544,506
Average Projected Cost per Client:	$ 3,840

FSPs include a wide range of programs, such as Assertive Community Treatment (ACT) programs, which cost approximately $14,000 per client year with housing funding provided as needed. Strengths-based case management costs approximately $4,000 per client year.

Transition Age Youth Full Service Partnership Programs (TAOA-FSP)

Integrated Services and Supported Housing: This Assertive Community Treatment (ACT) Team program provides FSP services and supports, short-term, transitional, and permanent supportive housing. The goals are to increase mental health services for TAY, decrease incidence of homelessness, and increase client's self-sufficiency through development of life skills.

- Population Focus:
  - TAY (age 16-24)
  - Diagnosed with Serious Mental Illness
  - Homeless, clients of the justice system, and/or aging out of foster care
  - Countywide

Intensive Case Management: This short-term intensive transition team service provides assistance to individuals to connect with relevant housing and employment resources. This is an effort to reduce psychiatric hospitalization and improve community support through short-term intensive case management services.

- Population Focus:
  - Adults (age 18 and older)
  - Diagnosed with Serious Mental Illness (SMI)
  - Users of acute psychiatric inpatient care
  - Medi-Cal or are indigent

Adult and Older Adult Full Service Partnership Programs (TAOA-FSP)

Integrated Services and Supported Housing: This ACT Team program is a team-based approach to "do whatever it takes" to support clients attain housing and employment. The program offers FSP and housing services with an effort to reduce homelessness, by providing comprehensive "'wraparound" mental health services to those adults who are most severely ill, most in need due to severe functional impairments, and who have not been able to be adequately served by the current system.

- Population Focus:
  - Persons diagnosed with SMI who may have been unserved (age 18 and older)
  - Homeless or at risk of becoming homeless
  - High users of inpatient care, medical services or locked long-term care facilities
  - Specialized outreach to African-Americans and women
  - Countywide

Intensive Case Management: This short-term transition team service provides assistance to individuals to connect with relevant housing and employment resources. This is an effort to reduce psychiatric hospitalization and improve community support through short-term intensive case management services.

- Population Focus:
  - Adults (age 18-59 and older)
  - Diagnosed with Serious Mental Illness (SMI)
  - Users of acute psychiatric inpatient care
  - Medi-Cal or are indigent

Justice Integrated Services and Supported Housing: This ACT program assists those clients in the justice system attain housing and stability in the community to reduce incarceration, institutionalization and homelessness. The goal is to provide comprehensive 'wraparound' mental health services for adults who are the most severely ill, most in need due to severe functional impairments, and who have not been able to be adequately served by the current system.

- Population Focus:
  - Adults diagnosed with SMI (age 25-59)
  - Homeless or at risk of becoming homeless
  - Active or recent criminal justice involvement
  - Unserved or high users of inpatient care, medical services or locked long-term care facilities
  - Some programs have increased focus for African-Americans and women
  - Clients re-entering the community from the justice system
  - Countywide

System Development Projected Client Numbers and Costs

Transition Age Youth and Adult System Development:

Annual Projected Unique Clients Served:	27,015
Projected Cost in FY14/15:	$ 34,630,160
Average Projected Cost per Client:	$ 1,282

Older Adult System Development:

Annual Projected Unique Clients Served:	419
Projected Cost in FY14/15:	$ 226,999
Average Projected Cost per Client:	$ 542

Transition Age Youth System Development Programs (TAOA-SD)

Clubhouse and Peer Support Services: Clubhouses offer services that are designed for TAY with SMI who are in need of social and recreational activities, skill development, and employment and education opportunities. The goal is to increase access to mental health services for TAY and increase client self-sufficiency through development of life skills, creating and maintaining relationships, sustaining housing, and supporting employment and education.

- Population Focus:
  - TAY (age 18-24)
  - Underserved youth with SMI

Behavioral Health Court Calendar Diversion and Supported Housing: This program provides comprehensive, integrated, culturally-competent mental health services for individuals with a SMI who have been found guilty of a non-violent crime and are awaiting sentencing. The goal is to reduce incarceration and institutionalization, increase meaningful use of time and capabilities, reduce homelessness, and provide timely access to needed services.

- Population Focus:
  - Adults (age 18-59)
  - Older adults (age 60 and older)
  - Repeat offenders who may have received mental health services while incarcerated or in the community
  - Referred for services via the justice system

Enhanced Outpatient Mental Health Services for TAY: Enhanced outpatient mental health services are offered to TAY in need of mental health, rehabilitation and recovery services.

- Population Focus:
  - TAY (age 18-24)
  - Currently not utilizing mental health services due to access barriers, lack of engagement or awareness of services

Integrated Services and Supported Housing: This ACT program establishes the link between care coordination to physical healthcare providers, comprehensive housing and mental health services. The program includes FSP services to older adults with SMI. This increases the timely access to services and supports to assist older adults and family caregivers to maintain independent living thus reducing isolation, improving mental health, and remaining safely in their homes. The program seeks to reduce hospitalizations, recidivism, and increase client satisfaction.

- Population Focus:
  - Adults (age 60 and older)
  - History of repeated emergency mental health or inpatient services during the year prior to program admission
  - At risk for institutionalization
  - Homeless or at risk for homelessness

Housing Trust Fund: This fund develops an affordable permanent supportive housing for low income clients in FSPs. The goal is to increases permanent supportive housing opportunities for clients in the five FSP Integrated Homeless Programs.

- Population Focus:
  - TAY, adults and older adults
  - Enrolled in one of the Full Service Partnership programs

Adult and Older Adult System Development Programs (TAOA-SD)

Client-Operated Peer Support Services: This is a client-driven and client-operated countywide support service offered in a variety of settings. The goal is to empower people with SMI by decreasing isolation and increasing self-identified valued roles and self-sufficiency.

- Population Focus:
  - Persons with SMI (age 18 and older)
  - Unserved/underserved
  - Outreach to Latinos and Asian/Pacific Islanders
  - Outreach to those living in Board & Care or emergency shelter/transitional housing facilities

Family Education Services: This is a family-centered educational service about mental illness, stigma reduction and resources to improve access to care. This service promotes integration of family education services, increase family involvement and coping skills, and improves supportive relationships.

- Population Focus:
  - Family members or significant others of TAY, adults, & older adults with SMI

Clubhouse Enhancement and Expansion for Employment Services: Clubhouses are expanded for the purpose of social and community rehabilitation activities and employment services. The goal is to increase client self-sufficiency through development of life skills.

- Population Focus:
  - Adults with SMI (age 18 and older)
  - Some programs have increased focus to African-Americans, Latinos, Asian/ Pacific Islanders, Native Americans and females
  - Homeless adults with SMI

Supported Employment Services: Supported employment services and opportunities of employment for TAY, adults and older adults with SMI, and increased competitive employment are provided through this service.

- Population Focus:
  - Persons with SMI (age 18 and older)
  - Outreach to Latinos and Asian/Pacific Islanders
  - Residents of the Central or North Central region

Patient Advocacy Services for Board and Care Facilities: This program provides and expands patient advocacy services for mental health clients residing in County-identified board and care facilities who are without augmented service programs (ASP).

- Population Focus:
  - Clients residing in County-identified Board and Care facilities without Augmented Service Programs
  - Countywide

Enhanced Outpatient Mental Health Services: These services provide enhanced outpatient mental health services and increased access to mental health services. The goal is to reduce client barriers such as language, wait times, lack of knowledge or awareness of available services.

- Population Focus:
  - Adults (age 25 and older)
  - Persons with SMI
  - Outreach to Latinos and Asian/Pacific Islanders

Programs for All Ages

These programs serve families and individuals of all ages by offering a variety of outreach and engagement and outpatient mental health services with individualized/family-driven services and supports. Clients are provided with necessary linkages to appropriate agencies for medication management and services for co-occurring substance abuse disorders. Some of the 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.

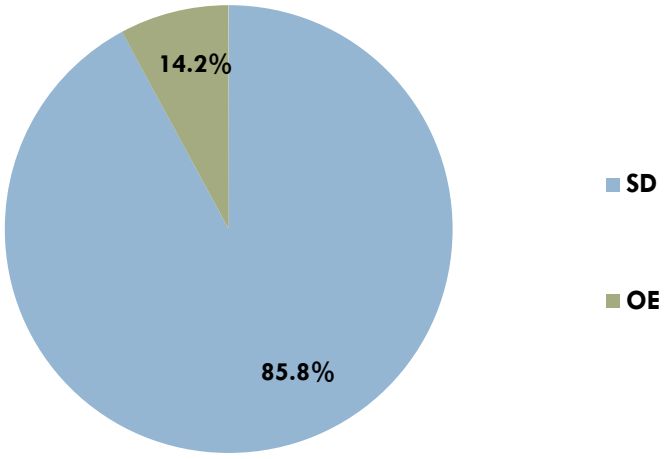
Detailed estimated costs below and costs per client are not inclusive of administrative costs. The estimated costs are inclusive of estimated MHSA, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount and other funding.

Clients in All Ages CSS Programs

There were 6,755 clients who received services from Community Services and Supports for All Ages programs in FY 2012-13.

- Most clients (85.8%) received services from System Development programs
- 14.2% received services from Outreach and Education programs

Chart 6: Clients Served by ALL Ages programs, FY 2012-13



Total ALL	OE	SD
6,755	957 (14.2%)	5,798 (85.8%)

All Ages Outreach and Engagement Projected Client Numbers and Costs

All Outreach and Engagement:

Annual Projected Unique Clients Served:	957
Projected Cost in FY14/15:	$ 2,050,046
Average Projected Cost per Client:	$ 2,142

All Ages Outreach and Engagement Programs (ALL-OE)

Services for Deaf & Hard of Hearing: This service helps clients who are deaf and hard of hearing achieve a more adaptive level of functioning and offers specialized outpatient services for individuals who may have a co-occurring substance use disorder.

- Population Focus:
  - Persons with SED and SMI (all ages)
  - Underserved/unserved
  - Deaf or hard of hearing
  - Individuals with co-occurring substance use disorder

Services for Victims of Trauma and Torture: This program specializes in provision of outpatient mental health services to uninsured clients who are victims of trauma and torture.

- Population Focus:
  - Persons with SED/SMI who are victims of trauma and torture
  - Uninsured/unserved
  - All ages
  - Countywide

Mental Health & Primary Care Services Integration: This service provides mental health assessment and treatment services at community health clinic settings across San Diego County. The goal is to increase countywide access to mental health services to unserved and uninsured people who have SED and SMI.

- Population Focus:
  - Persons with SED and SMI
  - Unserved/uninsured
  - All ages
  - Countywide

All Ages System Development Projected Client Numbers and Costs

All System Development:

Annual Projected Unique Clients Served:	5,798
Projected Cost in FY14/15:	$ 2,091,000
Average Projected Cost per Client:	$ 361

All Ages System Development Programs (ALL-SD)

Interpreter Services: Interpreter services are provided to non-English speaking populations in an effort to support outreach to unserved and underserved populations, and to improve the quality of the services offered to consumers and their families.

- Population Focus:
  - Unserved/underserved
  - Non-English speaking individuals who have difficulty in speaking or understanding English
  - All ages

Psychiatric Emergency Response Services: This service pairs trained law enforcement officers with 23 psychiatric emergency clinicians to serve children and adults throughout San Diego County. The goal of the collaboration is to have more humane and effective handling of incidents involving law enforcement officers and mentally ill individuals.

- Population Focus:
    - Individuals with a mental health crisis and/or who need immediate mental health crisis intervention and/or assessment
    - All ages
    - Some special outreach and programs focus on veterans, homeless, Native Americans
    - Countywide

Chaldean and Middle Eastern Outpatient Services: Outpatient mental health services for Chaldean and Middle Eastern populations in San Diego County provides culturally appropriate mental health, case management and linkage to services to Iraqi refugees and other Middle Eastern populations.

- Population Focus:
    - Chaldean and Middle Eastern populations
    - All ages

Mobile Outreach: The Countywide mobile outreach service identifies older adults in the community who are in need of mental health intervention and provide access to services at the most appropriate level of care. This program increases timely access to services, supports to assist older adults and family caregivers in maintaining independent living by reducing isolation, improving mental health, and helping older individuals remain safely in their homes.

- Population Focus:
    - Unserved and underserved
    - 60 years and older with unmet mental health needs
    - Homeless or at risk of homelessness
    - Families and care providers

Strengths-Based Case Management Services: This is a Case Management Recovery and Rehabilitation program that follows the 'Strengths Model', and provides FSP services to adults who have a SMI. The goal of the program is to reduce caseload size and provide TAY, adults, and older adults with relationship-based rehabilitation focused care coordination and support.

- Population Focus:
    - Adults (age 18 - 59 and older); older adults (age 60 and older) in North and South regions
    - Persons with SMI
    - Co-occurring substance abuse disorders
    - Outreach

Enhanced Outpatient Mental Health Services: These outpatient services increase access to mental health services and assist adults with overcoming barriers such as language, wait times, lack of knowledge or awareness of available services.

- Population Focus:
    - Adults (age 25 and older)
    - Persons with SMI
    - Outreach to Latinos and Asian/Pacific Islanders

Supplemental Security Income Advocacy/Legal Aid Services: This service reviews for accuracy and submits Supplemental Security Income (SSI) applications to the Social Security Administration (SSA) via clubhouse SSI Advocates. The goals are to increase the number of applicants that are granted SSI benefits, train new advocates and provide consultation to clubhouse members as needed.

- Population Focus:
    - Adults (age 18-59)
    - Older adults (age 60 and older)
    - Individuals not on General Relief, or not employed
    - Persons with severe and persistent mental illness who potentially meet the SSA criteria for disability

Walk-In Assessment Centers: These centers provide urgent mental health services to adults and older adults in North and Central Regions on a voluntary walk-in basis.

- Population Focus:
    - Adults (age 18-59)
    - Older adults (age 60 and older)
    - Medi-Cal beneficiaries and uninsured individuals
    - North and Central Regions

Peer Telephone Support Expansion: This peer-staffed program offers a non-crisis phone service seven hours a day, seven days a week for young adults and adults in recovery from mental illness. The goal of the program is for the support line to be a primary resource for persons recovering from mental illness who are living in the community by providing support, understanding, information and referrals.

- Population Focus:
    - Youth and adults (age 18 and older) with SMI

FUTURE FUNDING PRIORITIES FOR CSS

On an annual basis, BHS conducts an operational review of MHSA programs and contract funding based on utilization of services, duplication of services within the community, and changes in strategic direction/program design. Part of this review also includes BHS' ability to leverage contract dollars from other funding sources. BHS' operational overview determined reductions in FY 2014-15 due to underspending, underutilization or duplication for the following CSS services:

- a Medication Support for Wards and Dependents program,
- a Cultural Language Specific Outpatient program,
- a Child/Youth Case Management FSP program,
- a North County Walk-in Assessment program,
- a TAY FSP program for the North County Region, and
- an Outpatient Mental Health Services program for the North County Region.

Other contracts were identified for reduction or elimination in FY 2014-15 due to a change in the program design:

- a Family/Youth Peer Support Service program,
- Crisis Residential Beds for co-occurring disorders for TAY (Funding has been set aside for 12 beds in alternative housing and treatment program), and
- various school-based Outpatient and Day Treatment contracts, (less need to outreach due to Healthy Families transition to Medi-Cal, and one districts inability to continue the program).

As described earlier, BHS participated in a robust Community Program Planning (CPP) process for stakeholder input on which Community Services and Support programs should be continued, reduced or expanded based on community priorities. No CSS programs funded in FY 2013-14 were identified by stakeholders as a priority to reduce or eliminate. Eight CSS programs, listed below, were brought forth by stakeholders during the CPP process. Should additional funding become available during the course of this Three-Year Plan, BHS will work further with the community to structurally adapt any recommended priorities for programs that were previously reduced or eliminated due to underutilization to increase the likelihood of utilization in the future.

The below CSS priorities are not listed in hierarchical order.

- Expand Full Service Partnerships
- Develop crisis housing and residential beds, especially for youth under 18 years of age
- Expand Psychiatric Emergency Response Services
- Increase permanent supportive housing
- Increase MHSA emergency housing for high risk population groups, such as veterans, military and runaway teens with SMI
- Increase supportive employment services, vocational training and placement services
- Expand services for Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) clients and their family members
- Increase access to mental health services and clinicians within hospital and primary care settings

DON’T WAIT FOR EXTRAORDINARY OPPORTUNITIES. SEIZE COMMON OCCASIONS AND MAKE THEM GREAT.

-Anonymous

Prevention and Early Intervention

FY 2014-15 through FY 2016-17 PEI Expenditure Plan = $79,100,814 [3]

Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. To ensure access to appropriate support at the earliest point of emerging mental health problems and concerns, Prevention and Early Intervention (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 2012-13, a total of 65,289[4] unduplicated participants were served countywide, and of those 22,765[4] were under 18 years old.

Prevention and Early Intervention programs are designed to prevent mental illness from becoming severe and disabling. Twenty percent of our local MHSA funds are allocated to the PEI component. Programs utilize strategies to reduce negative outcomes that may result from untreated mental illness, such as: suicides, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes. Prevention programs bring mental health awareness into the lives of all members of the community through public education initiatives and dialogue. Outcome reports and highlights for PEI programs in FY 2012-13 can be found in Appendix D.

FY 2014-15 THROUGH FY 2016-17 PROGRAM PLAN

Below are the planned Prevention and Early Intervention programs for FY 2014-15 through FY 2016-17. The programs are grouped in the Expenditure Plan by the work plan acronym in parentheses.

Primary & Secondary Prevention – Public Outreach, Education and Support Lines (PS-01): There are several prevention programs, ranging from a Countywide media campaign geared towards suicide prevention and stigma discrimination, a Suicide Prevention Council to increase public awareness and understanding, parenting classes for African American fathers to strengthen parenting skills and the bond between father and child, and a Countywide family and youth peer support that offers a chat feature staffed by their peers. Friends in the Lobby and In Our Own Voice are outreach programs striving to create service awareness throughout the county with an emphasis on primary care or physical health settings, community, family and senior centers and groups.

- Population Focus:
    - Individuals with mental illness
    - Families of individuals with mental illness
    - General public
    - Children and Youth
    - Latinos
    - Native Americans
    - Lesbian, gay, bi-sexual, transgender and questioning (LGBTQ)
    - African immigrants and refugees
    - Children and youth of African American fathers in the Southeast Community
    - Adults, Older Adults
    - Underserved Asian and Pacific Islanders

[3] Calculation is inclusive of estimated MHSA and estimated Administrative costs only.
[4] Compiled from various PEI Outcomes Reports

Alliance for Community Empowerment (DV-03): The Community Violence Response Team provides services to siblings of identified gang members in an effort to increase the resiliency of individuals, families, and the community to combat the negative effects of gang violence.

- Population Focus:
    - Younger siblings (age 10-14) of adolescent/young adult gang members or affiliates
    - Communities exposed to violence
    - Central San Diego

Families as Partners (DV-01): This augmentation to Community Services to Families (CSF) is funded with PEI funds - $500,000 a year. The funds are used to pay for Clinicians and Parent Partners who work specifically with families identified as "FAP Families" by CWS. The Contactor staff members are co-located at CWS and work closely with the CWS FAP unit, often going on joint visits. The goal of this program is to assess families in order to identify what the parent's needs are in order to safely keep their children in their home as either a Voluntary or Prevention case. This is a modified version of Differential Response.

- Population Focus:
    - Children (age 0-17)
    - Families
    - South region

The goal and desired outcomes for the program are child safety, early intervention, prompt preventative services, cross system integration of services/resources, efficient care coordination, and improved permanency.

Positive Parenting Program (Triple P) (EC-01): The Triple P parenting program educates parents with children exhibiting behavioral/emotional problems in Head Start and Early Head Start Centers. The program reduces behavioral/emotional problems in children. Parents, staff, and educators skills are strengthened allowing for the development, growth, health, and social competence of young children.

- Population Focus:
    - Parents and children (age 0-5)
    - Enrolled in Head Start or Early Head Start centers
    - Military children
    - Central and North Coastal regions

School-Based Program (SA-01): The School-Based Program uses a family focused approach that engages families in their child's school success. School-Based interventions are coordinated and designed to improve school climate, educational success and child/parent social and emotional skills. The program reduces family isolation and stigma associated with seeking behavioral health services. It increases resiliency and protective factors for children, reduces parental stress, and improves school climate for children to thrive.

- Population Focus:
    - School-age children and their families
    - Underserved Latinos and Asian/Pacific Islanders

Helping, Engaging, Reconnecting and Educating (HERE) Now Project, School-Based Suicide Prevention (SA-02): Suicide prevention program serves students through education, outreach, screening, and referrals in schools. The school staff and families are also educated about the suicide prevention program. The goal of the program is to reduce suicides and the negative impact of suicide in schools, and increase education of the community and families.

- Population Focus:
    - Middle and Senior High school age youth, TAY (age 18-24)
    - School staff and gatekeepers
    - Families and caregivers

Kickstart (FB-01): This program provides services to individuals experiencing the onset of mental illness, and reduces the potential negative outcomes associated with mental health issues in the early stages of the illness.

- Population Focus:
    - Youth (age 10-17)
    - TAY (age 18-24)
    - Countywide

Dream Weaver Consortium (NA-01): This consortium of partners provides specialized culturally appropriate behavioral health PEI services to the American Indian/Alaska Native (AI/AN) community for regional tribes located in San Diego County, with a special focus on suicide prevention. Also provided are child abuse prevention case management, alcohol and drug treatment and recovery services for Native Americans and qualified family members residing on reservations or in urban settings.

- Population Focus:
    - AI/AN community for regional tribes and qualified family members residing on reservations or youth in urban settings
    - All age groups
    - Countywide

Elder Multicultural Access and Support Services (EMASS) (OA-01): Older adults act as peers in this peer-based program, offering outreach and engagement to older adults to support the prevention of mental illness. The program reduces ethnic disparities in service access, use, and increases access to care.

- Population Focus:
    - Older adults (age 60 and older)
    - Focus on Filipino, Latino, African refugee, African American, and Middle Eastern populations

Home Based Older Adult Services (OA-02): Older adults receiving meals via Aging and Independence Services receive services that provide outreach, prevention and early intervention through the Program to Encourage Active and Rewarding Lives for Seniors (PEARLS) model. Goals are to increase knowledge of signs/symptoms of depression and suicide risk for those who live/work with older adults, reduce stigma associated with mental health concerns, and reduce the disparities in access to services.

- Population Focus:
    - Homebound older adults at risk for depression or suicide (age 60 and older)

REACHing Out (OA-04): This program provides support to caregivers of Alzheimer's patients to prevent/decrease symptoms of depression, isolation, and the burden of care through bilingual/bicultural Peer Counselors. The goals are to improve the quality of well-being for the caregivers, families and provide services to an underserved/unserved populations.

- Population Focus:
    - Latino caregivers of older adult Alzheimer's patients
    - South region

SmartCare (RC-01): Individuals living in rural communities who may be at risk for or in the early stages of mental illness, receive assessment and short-term interventions in rural community clinics. The goal of the program is to prevent patients who are located in this region from developing an increased level of behavioral health issues, severe mental illness, or addiction.

- Population Focus:
    - Children, adolescents, transition age youth, adults, and older adults in community clinics located in the rural areas of San Diego County

Bridge to Recovery (CO-01): Contract ends 12/31/2014. Individuals arriving at crisis emergency facilities with high substance use issues and early mental health concerns, receive early intervention services through this program. Through early intervention, the goals are to instill hope, reduce stigma about seeking treatment, and prevent suicide for individuals in crisis presenting with co-occurring substance and mental health issues.

- Population Focus:
    - TAY (age 18-24), adults and older adults (age 25-60 and older) with substance use issues and emerging mental health issues
    - Referred from crisis emergency facilities

Integrated Health System Navigation Services and Support (CO-01): Starting 1/1/2015.
This is an integrated program that will provide a comprehensive approach to serving individuals during critical times of transition as they navigate the system of healthcare and social services in San Diego County. The aim of this program is to create a more streamlined and seamless service delivery system for a broader population, and to ensure that individuals and their families at the San Diego County Psychiatric Hospital (SDCPH) Emergency Psychiatric Unit (EPU) and other participating program sites, are connected with the appropriate care and support needed.

- Population Focus:
    - Adults (age 18 and older) who present at the SDCPH Crisis Recovery Unit (CRU); SDCPH-EPU and any other sites participating in the program
    - Family members of adults with a behavioral health condition who are requiring assistance in navigating the behavioral health system
    - Will operate in at least one County-operated or County-funded mental health treatment facility in North, Central, South and East regions
    - Will operate in at least one County-funded Alcohol and Other Drug (AOD) treatment facility in North, Central, South and East regions
    - Will operate in at least one Primary Care Site in North, Central, South and East regions

Courage to Call Program (VF-01): This program provides confidential, peer-staffed outreach, education, referrals and support services to the military community, their families and service providers. The goals are to increase awareness of the prevalence of mental illness in the military community, reduce mental health risk factors or stressors, and improve access to mental health, information, and support.

- Population Focus:
    - Veterans
    - Active duty military
    - Reservists
    - National Guard
    - Family members

Co-Occurring Disorder – Screening by Community-Based Alcohol and Drug Service Providers (CO-02): Mental health counselors have been added to residential and intensive outpatient Alcohol and Drug Services including justice directed treatment programs to identify and screen clients with or exhibiting mental health concerns. This effort supports integrated treatment of co-occurring disorder and issues for those enrolled in substance use disorders treatment. It reduces the stigma associated with mental health concerns and provide additional support or referrals according to need.

- Population Focus:
    - Individuals residing in contracted residential and intensive outpatient substance use programs including justice directed treatment programs with or exhibiting mental health concerns

South Region Trauma Exposed Services (DV-02): This program offers prevention for re-traumatization of children and families who experience trauma related to exposure to domestic and/or community violence. The program's goals are to promote healthy, effective parenting styles, and connect children with needed health and other related services.

- Population Focus:
  - Children identified as at risk of being removed from their home
  - Polinsky Children's Center residents
  - South region

Statewide Prevention and Early Intervention Programs

California counties have allocated a portion of their Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding for the administration of time-limited statewide projects through the California Mental Health Services Authority (CalMHSA), a Joint Power Authority. The combined allocations funded three statewide PEI projects: Suicide Prevention, Stigma and Discrimination Reduction, and the Student Mental Health Initiative. Over a four year period, BHS allocated an initial investment of $3,376,700[5] per year. This investment strengthened California's crisis delivery, student mental health, and stigma reduction infrastructure.

In this Three-Year Plan, BHS is dedicating the majority of its PEI dollars at the local level and local stigma reduction and suicide prevention program funding will continue. Due to the duplication of many of the statewide programs and with our successful local PEI programs, BHS is recommending $650,000, or 3% of local PEI funds, be transferred to CalMHSA for FY 2014-15. Behavioral Health Services is proposing to CalMHSA that the majority of this funding be placed toward the sustainment of the Student Mental Health Initiative and a smaller portion to maintain live chat functions at suicide and crisis intervention hotlines.

In May 2014, the County submitted a non-binding letter of acknowledgement to CalMHSA. A copy of the letter is provided in Appendix F.

[5] Approved by Board of Supervisors on December 9, 2008; also referenced in FY11/12 California Mental Health Services Authority (CalMHSA) Contract 09-79119-00 Reporting for FY Ending June 30, 2012

FUTURE FUNDING PRIORITIES FOR PEI

On an annual basis, BHS conducts an operational review of MHSA programs and contract funding based on utilization of services, duplication of services within the community, and changes in strategic direction/program design. Part of this review also includes BHS' ability to leverage contract dollars from other funding sources. BHS' operational overview determined reductions in FY 2014-15 underspending, underutilization, or duplication for the following PEI services:

- a Family/Youth Peer Support Line program,
- a community violence prevention service for Central region (new contract in FY 2014-15),
- an Elder Multicultural Access and Support Service (EMASS) (new contract in FY 2014-15),
- a School-Based Suicide Prevention Program, and
- a Home Based Older Adult Services (new contract in FY 2014-15),
- a Positive Parenting Program.

Other contracts were identified for reduction or elimination in FY 2014-15 due to a change in the program design:

- an Adult Family Peer Support Line (other Access Lines to be utilized),
- the Salud Program North Region
- (incorporated in implementation of ACA),
- the Salud Program South Region (incorporated in implementation of ACA),
- the Salud Program Evaluation (due to discontinuation of Salud Program),
- the housing anti-stigma campaign (will be integrated in the *It's Up to Us* media campaign),
- the *It's Up to Us* media campaign (new contract in FY 2014-15).

As described earlier, Behavioral Health Services participated in a robust Community Program Planning (CPP) process for stakeholder input on which Prevention and Early Intervention programs should be continued, reduced or expanded based on community priorities. No PEI programs funded in FY 2013-14 were identified by stakeholders as a priority to reduce or eliminate. Eight PEI programs, listed below, were brought forth by stakeholders during the CPP process. Should additional funding become available during the course of this Three-Year Plan, BHS will work further with the community to structurally adapt any recommended priorities for programs that were previously reduced or eliminated due to underutilization to increase the likelihood of utilization in the future.

The below PEI priorities are not listed in hierarchical order.

- Expand services like Kickstart countywide
- Fund school-based programs that empower youth/parents/teachers and address bullying, and positive relationships skills
- Fund programs that support caregivers and families with Alzheimer's, dementia or SMI
- Fund programs to provide mental health training and outreach to faith-based leaders and brokers
- Expand school-based programs for suicide prevention and mental health issues
- Expand *It's Up to Us* media campaign which focuses on stigma and discrimination reduction regarding mental health, and suicide prevention
- Expand mental health services for persons with co-occurring disorders
- Fund mental health prevention programs focusing on youth at risk for gang involvement

MAKE ONE HEALTHY CHOICE.
NOW MAKE ANOTHER.

-Anonymous

Innovation – Cycle 2 Programs

FY 2014-15 INN Expenditure Plan = $7,969,658 [6]

Innovation programs are short-term, novel, creative and/or ingenious mental health practices or approaches that contribute to learning. Six percent of the total MHSA funding is allocated to the Innovation component. At the conclusion of each program, a comprehensive analysis and report will be produced detailing what has been learned as a result of the program. For an evaluation of previous Innovation programs that have ended, please see Appendix E.

The FY 2014-15 budget includes funding for Cycle 2 Innovation programs that started in previous fiscal years and will end June 30, 2015, and are listed in the Expenditure Plan by the Innovation number in parentheses. The continuing Cycle 2 Innovation programs are:

Peer and Family Engagement (INN-02): This is a team of integrated transition age youth, adult, older adult and family peer support specialists that provide a number of services to new mental health clients at the clinic site. One team also serves individuals in the County Emergency Psychiatric Unit. The goal is to provide peer and family support to individuals and families at or prior to their first mental health visit. The support teams also focus on providing wellness and recovery support and education throughout service utilization.

- Population Focus:
  - TAY (age 18-24)
  - Adults (age 25-59)
  - Older adults (age 60 and older)
  - Diagnosed SMI
  - Program eligibility determined by the Nurse Care Coordinator at the mental health clinic site

After School Inclusion (INN-06): This program provides Inclusion Aides at existing integrated community-based after-school programs throughout the County to allow youth with social-emotional/behavior issues access to after-school programs that same-aged typical (i.e. non-disabled) peers attend. The goal of the program is to increase access to after-school programs to youth with social-emotional/behavioral issues who have been prevented from attending, discharged from, or at risk of discharge from inclusive after-school programs.

- Population Focus:
  - Youth with social-emotional/behavioral issues (age 5-14)
  - Enrolled in after-school program sites located at elementary and middle school throughout the County

Transition Age and Foster Youth (INN-07): This program enhances life skills, increases self-sufficiency and self-esteem, improves behavioral and mental health conditions and overall wellness for TAY and Foster Youth. The goal of this program is to reduce the mental health services access barriers presenting to TAY and Foster Youth. The desired end result is to facilitate a successful transition to independent living and increase the number of youth/TAY that transition out of the Children's and Adult Systems of Care.

- Population Focus:
  - Children (age 14-17) and TAY (age 18-25) currently in outpatient mental health clinics
  - Emphasis on Latino and African-American youth
  - Foster Youth

[6] Calculation is inclusive of estimated MHSA and estimated Administrative costs only. Up to 5% of the estimated MHSA cost is for evaluation.

Independent Living Facilities Project (INN-08): This program creates an Independent Living Facility (ILF) Association with voluntary membership and promotes the highest quality home environments for adults with severe mental illness.

- Population Focus:
  - ILF Operators
  - Individuals, families, discharge planners and care coordination who are seeking quality housing resources

In-Home Outreach Team Expansion (IHOT) (INN-10A): See below.

Innovation – Cycle 3 Proposed Programs

FY 2015-16 through FY 2016-17 INN Expenditure Plan = $18,118,960 [7]

A total of seventy concepts were submitted to BHS during the Cycle 3 Innovation Community Program Planning Process of which a total of eleven were deemed to meet the criteria to qualify as Innovation programs. Those eleven qualifying concepts were reviewed by BHS. Seven concepts were selected as proposed Cycle 3 Innovation programs. In addition, the existing In-Home Outreach (IHOT) Innovation program (INN-10A) will be receiving funding during Cycle 3 based on County Board of Supervisors approval to expand services from three regions to the entire county.

The following is a brief summary of the Cycle 3 Innovation programs. Detailed information for INN-11 through INN-17 proposed programs are provided in Appendix C. Upon approval from the Mental Health Services Oversight and Accountability Commission (MHSOAC), INN-11 through INN-17 will begin in FY 2015-16 through FY 2017-18. The proposed Cycle 3 Innovation programs are listed in the Expenditure Plan by the Innovation number in parentheses. The annual costs below for each program include estimated MHSA costs only which is inclusive of up to 5% estimated cost embedded for evaluation. Administrative costs are not included.

In-Home Outreach Team Expansion (IHOT) (INN-10A): IHOT is a voluntary program that provides outreach, engagement, screening, crisis management, case management, educational and supportive services to family members and individuals who are resistant to receiving mental health treatment. IHOT will expand from the original three regions to provide these services countywide. This will provide staff with more data about the community need, utilization patterns and trends in access to mental health and substance use services, length of treatment in these services, and associated costs and savings. Data regarding individuals served by IHOT who would potentially be eligible for Laura's Law will also be analyzed. This program will be expanded to operate mobile teams countywide. The program will continue to provide mobile in-home outreach and engagement services to family members and individuals with SMI who are reluctant to seek outpatient mental health services.

- Population Focus:
  - TAY, adult, older adult
  - Countywide
- Estimated Annual Cost: $2,834,838 (effective FY 2014-15)
- 3-Year Program Cost: $8,504,514

[7] Calculation is inclusive of estimated MHSA and estimated Administrative costs only. Up to 5% of the estimated MHSA cost is for evaluation.

Care Giver Connection to Treatment (INN-11): Pilot enhancing a countywide program serving age 0-5 with clinician and care coordinators who would focus on addressing the behavioral health needs of caregivers through direct care and comprehensive referrals.

- Population Focus:
  - Children (age 0-5) and their caregivers
  - Countywide
- Estimated Annual Cost: $228,500 (effective FY 2015-16)
- 3-Year Program Cost: $685,500

Family Therapy Participation (INN-12): This program will utilize parent partners to focus on increasing caregiver participation in family therapy. Emphasis on teaching the caregiver the benefit of active engagement in the treatment process and addressing barriers on an individualized level.

- Population Focus:
  - Children and TAY (up to age 21)
  - Countywide
- Estimated Annual Cost: $1,127,000 (effective FY 2015-16)
- 3-Year Program Cost: $3,381,000

Faith-Based Initiative (INN-13): This initiative has 4 components: Outreach and Engagement to Faith-Based congregations; Community Education; Crisis Response; and Wellness and Health Ministries.

- Population Focus:
  - Children, TAY, adult, older adult
  - Central & North Inland Regions
- Estimated Annual Cost: $498,525 (effective FY 2015-16)
- 3-Year Program Cost: $1,495,575

Ramp Up 2 Work (INN-14): This is an employment and job training program for users of the system of care that will include: job development, job coaching, and job support services. The goals of the program are to provide job readiness, training, and on-the-job paid apprenticeship, leading ultimately to paid competitive employment.

- Population Focus:
  - TAY, adult, older adult
  - Countywide
- Estimated Annual Cost: $1,229,653 (effective FY 2015-16)
- 3-Year Program Cost: $ 3,688,959

Peer Assisted Transitions (INN-15): The Peer Transitions Program is a person-directed, mobile program that works in partnership with designated acute inpatient hospitals and provides alternatives to hospitalization through programs to engage and provide transition services and support services to clients that will be discharged from inpatient care back to the community. Peer Support Coaches will engage with the client in the inpatient setting and assist clients' with planned discharge and transition back to the community; provide a Welcome Home Basket (WHomB); accompany participant to initial Mental Health, Alcohol and Other Drug program, or primary care appointment; educate participants to navigate BHS system of care; assist with access to support and recreational activities and housing resources; and assist with transportation.

- Population Focus:
  - TAY, adult, older adult
  - Central, North Coastal & North Inland regions
- Estimated Annual Cost: $1,111,449 (effective FY 2015-16)
- 3-Year Program Cost: $3,334,347

Urban Beats (INN-16): This is a strengths-based, culturally-sensitive, arts-focused program that will utilize various artistic approaches to work with urban at-risk youth. The program is intended to engage at-risk youth in wellness activities by providing a youth focused message created and developed by youth. These may include the visual arts, spoken word, videos, and performances.

- Population Focus:
  - TAY
  - Central region
- Estimated Annual Cost: $403,871 (effective FY 2015-16)
- 3-Year Program Cost: $1,211,613

Innovative Mobile Hoarding Intervention Program (IMHIP) (INN-17): This program will work to diminish hoarding behaviors long term among older adults. By combining an adapted cognitive behavior rehabilitation therapy with hands on training and support, participants will learn skills to reduce anxiety and depression; reduce acquisition of excess items; and practice organizing and discarding items so that a particular room in their home can once again be used for its intended function. The team will consist of specially trained professionals and peers who will also collaborate with the participant's other health providers. An aftercare support group will be developed to help participants maintain the skills learned and continue to apply them. An added component is Older Adult Prescription/Alcohol Misuse screening, education, and referrals.

- Population Focus:
  - Older Adults
  - Central region
- Estimated Annual Cost: $443,973 (effective FY 2015-16)
- 3-Year Program Cost: $1,331,919

ALL OUR DREAMS CAN COME TRUE,

IF WE HAVE THE COURAGE TO PURSUE THEM.

— Walt Disney

Workforce Education and Training

FY 2014-15 through FY 2016-17 WET Expenditure Plan = $5,095,863 [8]

The intent of the Workforce Education and Training (WET) component is to remedy the shortage of qualified individuals within the public mental health workforce that provides services to address severe mental illnesses. WET strategies include recruitment of high school and community college students for mental health occupations, development of curriculum to increase knowledge and skills of the existing workforce, promotion of the meaningful employment of consumers and their family members in the mental health system, and financial incentives that promote cultural and linguistic diversity in the public mental health workforce.

Local MHSA WET dollars are a one-time, rather than ongoing, funding source, which must be spent by June 30, 2018. The initial WET Plan for San Diego County was completed in 2009 using an extensive needs assessment and multiple stakeholder input processes. The WET plan for FY 2014-15 through FY 2016-17 reflects a continuation of and update to the original plan as reflected below. The programs are grouped in the Expenditure Plan by the work plan acronym in parentheses.

Workforce Staffing Support (WET-01)

WET Consultant: The WET Consultant will work with the WET Coordinator to facilitate the ongoing convening of the WET Collaborative and its sub-committees and will work with Collaborative members to identify and develop ways to sustain the Collaborative when dedicated WET funding is no longer available. (WET Plan Action 1 Coordination and Implementation)

Training and Technical Assistance (WET-02)

Behavioral Health Training Curriculum (BHTC): The BHTC is provided by the Behavioral Health Education and Training Academy (BHETA) at SDSU Research Foundation's Academy for Professional Excellence. The BHTC provides training and continuing education to Behavioral Health Services and contracted provider staff. Training is provided through instructor-led classes, webinars, eLearnings and conferences and incorporates principles of trauma-informed care, cultural competency, co-occurring disorders, and primary care/behavioral health integration. (WET Plan Action 2 Specialized Training Modules)

Early Childhood Mental Health Education: The Early Childhood Socio-Emotional & Behavior Regulation Intervention Specialist (EC-SEBRIS) program is an innovative certificate program in the Department of Child and Family Development at San Diego State University. This interdisciplinary program focuses on professional preparation and skills enhancement of early childhood educators and professionals who work with young children demonstrating socio-emotional and behavioral problems and their parents. The one-year certificate program is designed for working professionals, and courses can be applied towards a Master's degree in Child Development. (WET Plan Action 2 Specialized Training Modules)

Trauma Informed Systems Assessment and Integration: Through a contract with the Centre for Organization Effectiveness, a consultant with subject matter expertise guides the implementation of the Trauma Informed Action Plan resulting from assessment of behavioral health and other County programs' trauma-informed competencies. (WET Plan Action 2 Specialized Training Modules)

[8] Calculation is inclusive of estimated MHSA only. WET programs do not have Administrative costs.

Cultural Competency Academy: The Cultural Competence Academy (CCA) provides training to further the objectives identified by San Diego County Behavioral Health Service's (BHS) Cultural Competency Resource Team (CCRT) and the Cultural Competence Plan. CCA advances the Mental Health Services Act and BHS principles of wellness, recovery, resilience and family integration for ethnic and non-ethnic culturally diverse populations. CCA provides awareness, knowledge and skill based trainings that focus on clinical and recovery interventions for multicultural populations. It ensures that all trainings focus on being trauma informed from environmental to clinical applications. Training is provided for all levels in programs and organizations, including supervisors, clinicians, and administration support staff. (WET Plan Action 2 Specialized Training Modules)

Mental Health Career Pathways (WET-03)

Geriatric Certificate Training Program: This program provides training to mental health, aging, primary care, and allied health professionals on the bio-psychosocial health related issues of older adults. (WET Action 3 Public Mental Health Academy)

Recovery Innovations – California Peer Specialist and Advocacy Training: Recovery Innovations provides peer specialist training and peer advocacy training for transitional age youth (TAY), adults and older adults with experience of their own mental illness and recovery process. Training prepares these individuals to work as partners at the practice, program and policy levels. The Peer Employment Training is a 75-hour training that prepares consumers to work in the service system as a peer support specialist. (WET Plan Action 3 Public Mental Health Academy)

National Alliance on Mental Illness (NAMI) San Diego: NAMI San Diego offers the Peer to Peer Recovery Education Program for people with serious mental illness who are interested in establishing and maintaining their wellness and recovery. The course provides a catalyst to graduates interested in seeking and maintaining paid employment or volunteer opportunities in public mental health or other sectors of interest. (WET Plan Action 3 Public Mental Health Academy)

Alliant International University - The Community Academy: The Community Academy is a partnership between the Family and Youth Roundtable, NAMI, Recovery Innovations - California, and the California School of Professional Psychology (CSPP) at Alliant International University. It provides training, mentorship and employment assistance to support and empower individuals affected by mental illness along their pathway into the fields of public behavioral health. In addition the Community Academy supports the partners' existing certificates and has facilitated translation of these certificates into academic credit. (WET Plan Action 3 Public Mental Health Academy)

Health Sciences High School and Middle College (HSHMC) Mental Health Career Pathway Program: HSHMC is a public charter high school that provides students an opportunity to explore advances and opportunities in healthcare through its college preparatory curriculum, specialized electives and four year work-based internship program. The Mental Health Career Pathway Program is a specialized mental health worker career preparation track that provides a two year certificate program for junior and senior high school students. In addition, curriculum and activities are offered campus-wide to increase awareness and reduce stigma regarding mental illness. (WET Plan Action 4 School-Based Pathways/Academy)

San Diego City College Public Mental Health Academy: San Diego City College's Institute for Human Development has established a 19-unit Mental Health Worker Certificate of Achievement that serves as both as workforce development for entry level positions in the mental health and human services field and as an academic stepping stone toward higher academic degrees in the field of mental health. The Academy offers specialized academic counseling and support to students enrolled in the certificate program. In addition, an annual professional development conference for current and

prospective students and a mental health career fair with participation from community partners in the health and human services sector is provided. (WET Plan Action 3 Public Mental Health Academy)

California State University San Marcos (CSUSM) Nursing Partnership for Public Mental Health: The School of Nursing at CSUSM has developed and implemented curriculum and teaching modalities for an integrated Psychiatric/Mental Health Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) program. Upon completion the Advance Practice Nurse receives a Master of Science in Nursing, eligible for national certification, and may practice in inpatient, outpatient or community settings with prescriptive authority and skills in psychotherapy and other treatment modalities. (WET Plan Action 5 Nursing Partnerships for Public Mental Health Professions)

Residency and Internship Programs (WET-04)

UCSD Community Psychiatry Fellowship: Adult and Child & Adolescent Psychiatrists receive training to prepare for leadership roles in public behavioral health. Medical students and residents are exposed to principles of Community Psychiatry and the bio-psychosocial recovery model. (WET Plan Action 6 Community Psychiatry Fellowship and Action 7 Child Psychiatry Fellowship)

Alliant International University, MFT Consortium: Alliant University facilitates the San Diego MFT Educators' Consortium, which represents all MFT programs in San Diego County. The consortium is the host of the San Diego County MFT Residency/Internship Program, which employs culturally competent recruitment strategies, coordination of internship placements, support for clinical supervision and licensing exam preparation. (WET Plan Action 8 LCSW/MFT Residency/Internship)

San Diego State University, Linguistically and Ethnically Diverse (LEAD) MFT Residency/Internship Program: The LEAD Project increases the presence of ethnically and linguistically diverse licensed clinicians in San Diego County by funding stipends for bilingual/bicultural MFT interns in exchange for a commitment to practice in San Diego County's public mental health workforce. The program also provides supervision hours and classes to prepare interns for licensure. (WET Plan Action 8 LCSW/MFT Residency/Internship)

Financial Incentive Programs (WET-05)

SDSU – Masters in Rehabilitation Counseling; Specialization and Certificate in Psychiatric Rehabilitation: This program offers training for rehabilitation counselors to provide effective vocational rehabilitation interventions to promote greater workforce participation and integration of individuals with psychiatric disabilities

SDSU School of Social Work Advance Standing Program: This is a one-year MSW program for individuals with an undergraduate degree in social work. Stipends are also provided in the following programs: Alliant International University - The Community Academy; Health Sciences High School and Middle College (HSHMC) Mental Health Career Pathway Program; Alliant International University, MFT Consortium; San Diego State University, Linguistically and Ethnically Diverse (LEAD) MFT Residency/Internship Program; San Diego City College Public Mental Health Academy (WET Plan Action 9 Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff)

IF YOU CAN’T FLY, THEN RUN. IF YOU CAN’T RUN, THEN WALK. IF YOU CAN’T WALK, THEN CRAWL. BUT WHATEVER YOU DO, YOU HAVE TO KEEP MOVING FORWARD.

— Martin Luther King Jr.

Capital Facilities and Technological Needs

FY 2014-15 through FY 2016-17 CFTN Expenditure Plan = $13,072,411 [9]

MHSA Capital Facilities projects support the provision of MHSA services through the development of a variety of community-based facilities that support integrated service experiences. Funds may also be used to support an increase in peer-support and consumer-run facilities.

The goals of MHSA-funded Technological Needs projects and enhancements are to: 1) increase client and family empowerment and engagement by providing the tools for secure client and family access to health information through a wide variety of settings; and 2) modernize and transform clinical and administrative information systems to ensure quality of care, parity, efficiency and cost-effectiveness.

Capital Facilities and Technological Needs (CFTN) funding is one-time funding. Total one-time funding for this component is to be expended by June 30, 2018. .

Below are the Capital Facilities and Technological Needs programs for FY 2014-15 through FY 2016-17. The Technical programs are grouped in the Expenditure Plan by the work plan acronym in parentheses.

Capital Facilities

To further the integration goals of *Live Well San Diego*, Capital Facilities funds will be used to support a consumer-integrated health experience offering mental and other health and social services. Implementing a capital project involves a significant amount of due diligence, research, studies, and potentially special licensing. As a result, one project – the North Coastal Health Facility – will be the primary focus for capital facilities projects. Completion of the North Coastal Health Facility project proposes the partial demolition of an older County-owned facility in the North Coastal Region and replacement with a new, larger facility to house mental health and other human services, including rehabilitation, wellness, and skill development.

Technological Needs

Technological Needs projects address two MHSA goals: 1) increase client and family empowerment and engagement by providing the tools for secure client and family access to health information that is culturally and linguistically competent within a wide variety of public and private settings; and 2) modernize and transform clinical and administrative information systems to ensure quality of care, parity, operational efficiency and cost effectiveness as has been done with the implementation of Anasazi. The Technological Needs projects include:

Consumer Family Empowerment (SD-2): Consumer and Family Empowerment projects provide consumers and families with improved access to computer technology, allowing individuals to manage their personal health information and make more informed decisions.

Telemedicine Expansion (SD-5): Telemedicine Expansion provides video, secure email, and phone consultation to improve accessibility of care in rural and underserved areas. It will provide technological infrastructure for the mental health system to provide high quality, cost-effective services and supports for clients and their families.

[9] Calculation is inclusive of estimated MHSA and estimated Administrative costs only.

Mental Health Management Information System (MIS) Expansion (SD-6): MIS is a major project that transforms the core information system used by virtually all providers in our extended system of care. All billing and clinical information will be collected using a new automated system.

FUTURE FUNDING PRIORITIES FOR CFTN

As described earlier, Behavioral Health Services participated in a robust Community Program Planning process for stakeholder input on which Capital Facilities and Technological Needs programs should be continued, reduced or expanded based on community priorities. No CFTN programs funded in FY 2013-14 were identified by stakeholders as a priority to reduce or eliminate. Should additional funding become available during the course of this Three-Year Plan, the priorities below were identified by stakeholders. The priorities are not listed in hierarchical order.

- Improve Behavioral Health Services' technology for interoperability of the Anasazi system with providers' Electronic Health Records and the County of San Diego Knowledge Integration Project (KIP)
- Fund smartphone applications (apps) for suicide prevention and mental illness
- Fund a live chat feature with the Behavioral Health Services funded Access & Crisis hotline, and expand to include the Spanish language
- Develop technology to support an integrated assessment system for homeless persons with SMI
- Support expansion of technology to link at-risk veterans to mental health services and benefits

A LOT OF PEOPLE DON’T REALIZE THAT DEPRESSION IS AN ILLNESS. I DON’T WISH IT ON ANYONE, BUT IF THEY WOULD KNOW HOW IT FEELS, I SWEAR THEY WOULD THINK TWICE BEFORE THEY JUST SHRUG IT OFF.

— Jonathon Davis

APPENDICES

APPENDIX A – MHSA FY 2014-15 THROUGH FY 2016-17
EXPENDITURE SUMMARY

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Funding Summary

County: San Diego Date: 10/28/14

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	39,818,579	14,363,747	14,705,805	5,907,385	27,439,049	
2. Estimated New FY2014/15 Funding	99,866,835	26,631,156	6,657,789			
3. Transfer in FY2014/15[a/]	0					
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	139,685,414	40,994,903	21,363,594	5,907,385	27,439,049	
B. Estimated FY2014/15 MHSA Expenditures	92,136,132	26,826,338	7,969,658	3,293,272	4,608,808	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	47,549,282	14,168,565	13,393,936	2,614,113	22,830,241	
2. Estimated New FY2015/16 Funding	86,410,692	23,042,851	5,760,713			
3. Transfer in FY2015/16[a/]	0					
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	133,959,974	37,211,416	19,154,649	2,614,113	22,830,241	
D. Estimated FY2015/16 Expenditures	92,136,132	26,137,238	9,059,480	1,766,694	8,042,572	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	41,823,841	11,074,178	10,095,168	847,419	14,787,668	
2. Estimated New FY2016/17 Funding	93,012,747	24,803,399	6,200,850			
3. Transfer in FY2016/17[a/]	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	134,836,588	35,877,577	16,296,018	847,419	14,787,668	
F. Estimated FY2016/17 Expenditures	92,136,132	26,137,238	9,059,480	35,897	421,031	
G. Estimated FY2016/17 Unspent Fund Balance	42,700,456	9,740,340	7,236,538	811,522	14,366,637	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	42,193,120
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	42,193,120
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	42,193,120
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	42,193,120

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2014/15					
		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							
1.	CY-FSP Full Service Partnerships for Children & Youth	14,015,739	7773356	2,160,072	0	1944065	2,138,246
2.	TAOA-FSP Full Service Partnerships for Ages 18-65+*	32,015,771	27425968	4,073,162	0	360266	156,375
3.	CY-SD System Development for Children & Youth **	197,659	197659	0	0	0	0
4.	TAOA-SD System Development for Ages 18-65+ **	1,123,804	1123804	0	0	0	0
5.	ALL-SD System Development for All Ages**	89,775	89775	0	0	0	0
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.	* NON FSP Programs that provide svcs to FSP clients	0					
19.	** Includes $3.2 million for supportive housing for homeless individuals with severe mental illness						
Non-FSP Programs							
1.	ALL-OE Outreach & Engagement for All Ages	2,050,046	1912704	137,342	0	0	0
2.	ALL-SD System Development for All Ages	2,001,225	1995781	5,444	0	0	0
3.	CY-OE Outreach & Engagement for Children & Youth	2,945,738	2762681	95,730	0	86,157	1,170
4.	CY-SD System Development for Children & Youth	11,311,521	8294446	1,206,854	0	1,086,168	724,053
5.	TAOA-SD System Development for Ages 18-65+	33,733,355	28542202	5,113,153	0	0	78,000
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
CSS Administration		12,017,756	12,017,756	0	0	0	0
CSS MHSA Housing Program Assigned Funds* **		0	0	0	0	0	0
Total CSS Program Estimated Expenditures		111,502,389	92,136,132	12,791,757	0	3,476,656	3,097,844
FSP Programs as Percent of Total		51.5%					

*** Includes April 2008 allocation of $33M to CalHFA Permanent Supportive Housing Units that will still be implemented through FY 2016-17. No additional funding assigned.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2015/16					
		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							
1.	CY-FSP Full Service Partnerships for Children & Youth	14,015,739	7,773,356	2,160,072	0	1,944,065	2,138,246
2.	TAOA-FSP Full Service Partnerships for Ages 18-65+*	32,015,771	27,425,968	4,073,162	0	360,266	156,375
3.	CY-SD System Development for Children & Youth **	197,659	197,659	0	0	0	0
4.	TAOA-SD System Development for Ages 18-65+ **	1,123,804	1,123,804	0	0	0	0
5.	ALL-SD System Development for All Ages**	89,775	89,775	0	0	0	0
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.	* NON FSP Programs that provide svcs to FSP clients	0					
19.	** Includes $3.2 million for supportive housing for homeless individuals with severe mental illness						
Non-FSP Programs							
1.	ALL-OE Outreach & Engagement for All Ages	2,050,046	1,912,704	137,342	0	0	0
2.	ALL-SD System Development for All Ages	2,001,225	1,995,781	5,444	0	0	0
3.	CY-OE Outreach & Engagement for Children & Youth	2,945,738	2,762,681	95,730	0	86,157	1,170
4.	CY-SD System Development for Children & Youth	10,104,667	8,294,446		0	1,086,168	724,053
5.	TAOA-SD System Development for Ages 18-65+	33,733,355	28,542,202	5,113,153	0	0	78,000
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
CSS Administration		12,017,756	12,017,756	0	0	0	0
CSS MHSA Housing Program Assigned Funds* **		0	0	0	0	0	0
Total CSS Program Estimated Expenditures		110,295,535	92,136,132	11,584,903	0	3,476,656	3,097,844
FSP Programs as Percent of Total		51.5%					

*** Includes April 2008 allocation of $33M to CalHFA Permanent Supportive Housing Units that will still be implemented through FY 2016-17. No additional funding assigned.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2016/17					
		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							
1.	CY-FSP Full Service Partnerships for Children & Youth	14,015,739	7,773,356	2,160,072	0	1,944,065	2,138,246
2.	TAOA-FSP Full Service Partnerships for Ages 18-65+*	32,015,771	27,425,968	4,073,162	0	360,266	156,375
3.	CY-SD System Development for Children & Youth **	197,659	197,659	0	0	0	0
4.	TAOA-SD System Development for Ages 18-65+ **	1,123,804	1,123,804	0	0	0	0
5.	ALL-SD System Development for All Ages**	89,775	89,775	0	0	0	0
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.	* NON FSP Programs that provide svcs to FSP clients	0					
19.	** Includes $3.2 million for supportive housing for homeless individuals						
Non-FSP Programs							
1.	ALL-OE Outreach & Engagement for All Ages	2,050,046	1,912,704	137,342	0	0	0
2.	ALL-SD System Development for All Ages	2,001,225	1,995,781	5,444	0	0	0
3.	CY-OE Outreach & Engagement for Children & Youth	2,945,738	2,762,681	95,730	0	86,157	1,170
4.	CY-SD System Development for Children & Youth	11,311,521	8,294,446	1,206,854	0	1,086,168	724,053
5.	TAOA-SD System Development for Ages 18-65+	33,733,355	28,542,202	5,113,153	0	0	78,000
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
CSS Administration		12,017,756	12,017,756	0	0	0	0
CSS MHSA Housing Program Assigned Funds* **		0	-	0	0	0	0
Total CSS Program Estimated Expenditures		111,502,389	92,136,132	12,791,757	0	3,476,656	3,097,844
FSP Programs as Percent of Total		51.5%					

***Includes April 2008 allocation of $33M to CalHFA Permanent Supportive Housing Units that will still be implemented through FY 2016-17. No additional funding assigned.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2014/15					
		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 Programs							
1.	PS-01 Education and Support Lines	4,368,996	4,368,996				
2.	DV-01 Families as Partners	500,008	500,008				
3.	DV-02 South Region Trauma Exposed Services	701,907	701,907				
4.	DV-03 Alliance for Community Empowerment	400,000	400,000				
5.	EC-01 Positive Parenting Program	1,200,000	1,200,000				
6.	FB-01 Kick Start	1,775,000	1,775,000				
7.	NA-01 Dream Weaver	1,829,000	1,829,000				
8.	OA-01 Elder Multicultural Access & Support Services	569,153	569,153				
9.	OA-02 Positive Solutions	525,424	525,424				
10.	OA-04 Reaching Out	540,380	540,380				
11.	RC-01 SmartCare	1,395,000	1,395,000				
12.	SA-01 School Based Program	3,100,000	3,100,000				
13.	SA-02 Here Now	600,000	600,000				
14.	VF-01 Courage to Call	1,011,499	1,011,499				
15.	CO-01 Bridge to Recovery	2,092,500	2,092,500				
16.	CO-02 Co-Occuring Disorders	2,153,166	2,153,166				
17.		0					
18.		0					
19.		0					
20.		0					
21.		0					
22.		0					
23.		0					
24.		0					
25.		0					
26.		0					
27.		0					
28.		0					
29.		0					
30.		0					
PEI Administration		3,414,305	3,414,305	0	0	0	0
PEI Assigned Funds		650,000	650,000	0	0	0	0
Total PEI Program Estimated Expenditures		26,826,338	26,826,338	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2015/16					
	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 Programs						
1. PS-01 Education and Support Lines	4,368,996	4,368,996				
2. DV-01 Families as Partners	500,008	500,008				
3. DV-02 South Region Trauma Exposed Services	701,907	701,907				
4. DV-03 Alliance for Community Empowerment	400,000	400,000				
5. EC-01 Positive Parenting Program	1,200,000	1,200,000				
6. FB-01 Kick Start	1,775,000	1,775,000				
7. NA-01 Dream Weaver	1,795,000	1,795,000				
8. OA-01 Elder Multicultural Access & Support Services	569,153	569,153				
9. OA-02 Positive Solutions	525,424	525,424				
10. OA-04 Reaching Out	540,380	540,380				
11. RC-01 SmartCare	1,395,000	1,395,000				
12. SA-01 School Based Program	3,100,000	3,100,000				
13. SA-02 Here Now	600,000	600,000				
14. VF-01 Courage to Call	1,011,499	1,011,499				
15. CO-01 Bridge to Recovery	2,092,500	2,092,500				
16. CO-02 Co-Occuring Disorders	2,153,166	2,153,166				
17.	0					
18.	0					
19.	0					
20.	0					
21.	0					
22.	0					
23.	0					
24.	0					
25.	0					
26.	0					
27.	0					
28.	0					
PEI Administration	3,409,205	3,409,205	0	0	0	0
PEI Assigned Funds	0	0	0	0	0	0
Total PEI Program Estimated Expenditures	26,137,238	26,137,238	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Prevention and Early Intervention (PEI) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2016/17					
		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 Programs							
1.	PS-01 Education and Support Lines	4,368,996	4,368,996				
2.	DV-01 Families as Partners	500,008	500,008				
3.	DV-02 South Region Trauma Exposed Services	701,907	701,907				
4.	DV-03 Alliance for Community Empowerment	400,000	400,000				
5.	EC-01 Positive Parenting Program	1,200,000	1,200,000				
6.	FB-01 Kick Start	1,775,000	1,775,000				
7.	NA-01 Dream Weaver	1,795,000	1,795,000				
8.	OA-01 Elder Multicultural Access & Support Services	569,153	569,153				
9.	OA-02 Positive Solutions	525,424	525,424				
10.	OA-04 Reaching Out	540,380	540,380				
11.	RC-01 SmartCare	1,395,000	1,395,000				
12.	SA-01 School Based Program	3,100,000	3,100,000				
13.	SA-02 Here Now	600,000	600,000				
14.	VF-01 Courage to Call	1,011,499	1,011,499				
15.	CO-01 Bridge to Recovery	2,092,500	2,092,500				
16.	CO-02 Co-Occuring Disorders	2,153,166	2,153,166				
17.		0					
18.		0					
19.		0					
20.		0					
21.		0					
22.		0					
23.		0					
24.		0					
25.		0					
26.		0					
27.		0					
28.		0					
PEI Administration		3,409,205	3,409,205	0	0	0	0
PEI Assigned Funds		0	0	0	0	0	0
Total PEI Program Estimated Expenditures		26,137,238	26,137,238	0	0	0	0

Innovations (INN) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2014/15					
	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-02 Peer & Family Engagement	800,000	800,000				
2. INN-06 After School Inclusion	1,150,000	1,150,000				
3. INN-07 Transition Age and Foster Youth	1,716,706	1,716,706				
4. INN-08 Independent Living Facilities	428,593	428,593				
5. INN-10A In Home Outreach Team	2,834,838	2,834,838				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0		UPON MHSOAC APPROVAL			
13.	0					
14.	0					
15.	0					
16. * Up to 5% for evaluation is embedded in Estimated INN	0					
17. Funding	0					
18.	0					
19.	0					
20.	0					
INN Administration	1,039,521	1,039,521	0	0	0	0
Total INN Program Estimated Expenditures	7,969,658	7,969,658	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Innovations (INN) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2015/16					
		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-10A In Home Outreach Team	2,834,838	2,834,838				
2.	INN-11 Care Giver Connection to Treatment	228,500	228,500				
3.	INN-12 Family Therapy Participation	1,127,000	1,127,000				
4.	INN-13 Faith Based Initiative	498,525	498,525				
5.	INN-14 Ramp Up 2 Work	1,229,653	1,229,653				
6.	INN-15 Peer Assisted Transitions	1,111,449	1,111,449				
7.	INN-16 Urban Beats	403,871	403,871				
8.	INN-17 Innovative Mobile Hoarding Intervention Program	443,973	443,973				
9.		0					
10.		0					
11.		0					
12.		0		UPON MHSOAC APPROVAL			
13.		0					
14.		0					
15.		0					
16.	* Up to 5% for evaluation is embedded in Estimated INN	0					
17.	Funding	0					
18.		0					
19.		0					
20.		0					
INN Administration		1,181,671	1,181,671	0	0	0	0
Total INN Program Estimated Expenditures		9,059,480	9,059,480	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Innovations (INN) Component Worksheet

County: San Diego Date: 10/28/14

		Fiscal Year 2016/17					
		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-10A In Home Outreach Team	2,834,838	2,834,838				
2.	INN-11 Care Giver Connection to Treatment	228,500	228,500				
3.	INN-12 Family Therapy Participation	1,127,000	1,127,000				
4.	INN-13 Faith Based Initiative	498,525	498,525				
5.	INN-14 Ramp Up 2 Work	1,229,653	1,229,653				
6.	INN-15 Peer Assisted Transitions	1,111,449	1,111,449				
7.	INN-16 Urban Beats	403,871	403,871				
8.	INN-17 Innovative Mobile Hoarding Intervention Program	443,973	443,973				
9.		0					
10.		0					
11.		0					
12.		0		UPON MHSOAC APPROVAL			
13.		0					
14.		0					
15.		0					
16.	* Up to 5% for evaluation is embedded in Estimated INN	0					
17.	Funding	0					
18.		0					
19.		0					
20.		0					
INN Administration		1,181,671	1,181,671	0	0	0	0
Total INN Program Estimated Expenditures		9,059,480	9,059,480	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Workforce, Education and Training (WET) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2014/15					
	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-01 Workforce Staffing Support	295,958	295,958				
2. WET-02 Training & Technical Assistance	1,039,907	1,039,907				
3. WET-03 Mental Health Career Pathway Programs	719,787	719,787				
4. WET-04 Residency and Internship Program	899,204	899,204				
5. WET-05 Financial Incentive Program	338,416	338,416				
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0	0	0	0	0	0
Total WET Program Estimated Expenditures	3,293,272	3,293,272	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Workforce, Education and Training (WET) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2015/16					
	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	714,548	714,548				
2. WET-03 Mental Health Career Pathway Programs	56,500	56,500				
3. WET-04 Residency and Internship Program	891,039	891,039				
4. WET-05 Financial Incentive Program	104,607	104,607				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0	0	0	0	0	0
Total WET Program Estimated Expenditures	1,766,694	1,766,694	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan

Workforce, Education and Training (WET) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2016/17					
	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-01 Workforce Staffing Support	0					
2. WET-02 Training & Technical Assistance	0					
3. WET-03 Mental Health Career Pathway Programs	0					
4. WET-04 Residency and Internship Program	35,897	35,897				
5. WET-05 Financial Incentive Program	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	0	0	0	0	0	0
Total WET Program Estimated Expenditures	35,897	35,897	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2014/15					
	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-1 Juvenile Forensics Facility	67,507	67,507				
2. CF-2 North County MH Facility	1,309,660	1,309,660				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
1. SD-2 Consumer & Family Empowerment	1,110,266	1,110,266				
2. SD-5 Telemedicine Expansion	920,226	920,226				
3. SD-6 MH MIS Expansion	600,000	600,000				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	601,149	601,149	0	0	0	0
Total CFTN Program Estimated Expenditures	4,608,808	4,608,808	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2015/16					
	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 MH Facility	5,131,161	5,131,161				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
1. SD-2 Consumer & Family Empowerment	1,100,266	1,100,266				
2. SD-5 Telemedicine Expansion	762,114	762,114				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	1,049,031	1,049,031	0	0	0	0
Total CFTN Program Estimated Expenditures	8,042,572	8,042,572	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Diego Date: 10/28/14

	Fiscal Year 2016/17					
	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.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
1. SD-5 Telemedicine Expansion	366,114	366,114				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Administration	54,917	54,917	0	0	0	0
Total CFTN Program Estimated Expenditures	421,031	421,031	0	0	0	0

MHSA 3-Year Plan – Rolled-Up Average Cost Per Client

Summary - Cost Per Client

Roll-Up	Work Plan	Population	Budget FY14/15	Total #	Estimated Cost Per Client FY14/15
1	CY-FSP	Children	14,015,739	2,683	5,224
2	CY-OE	Children	2,945,738	1,487	1,981
3	CY-SD	Children	11,509,180	3,693	3,116
4	TAOA-FSP	Adults / TAY	28,471,265	3,792	7,508
5	TAOA-FSP	OA	3,544,506	923	3,840
6	TAOA-SD	Adults / TAY	34,630,160	27,015	1,282
7	TAOA-SD	OA	226,999	419	542
8	ALL-OE	ALL	2,050,046	957	2,142
9	ALL-SD	ALL	2,091,000	5,798	361
TOTAL			99,484,633	**46,767**	

Assumptions:

Detailed annual estimated costs and costs per client are estimates for FY14/15 (one year) and are not inclusive of administrative costs.

The detailed estimated costs are inclusive of estimated MHSA, Medi-Cal FFP, 1991 Realignment, Behavioral Health Subaccount and other funding.

The annual projected unique clients for FY14/15 may show slight variance from the number of unique clients served in Appendix D because some programs from FY12/13 no longer exist. The unique clients served by those programs were not included in projected annual number of unique clients to be served in FY14/15.

Cost per client is based on FY14/15 budget and FY12/13 actual number of clients served.

The averages are NOT weighted. They are a summary roll up by each work plan/population Actual costs per client will vary amongst the different services/contracts due to contracted rate, level of service and number of repeated clients that visit.

The cost per client averages are a summary of the **Total Budgeted Amount per Contract (rolled up by the service area) divided by Total Clients Served per Contract (rolled up by service area).**

Some clients are counted with CY, TAY, A, OA because particular contracts serve all three populations (must be included for overall cost per client average)

Note for CYF: Some CYF programs were only enhanced with MHSA (may receive Medi-Cal funding through EPSDT). MHSA may be an enhancement to core therapeutic services and the cost for each service is calculated separately (doesn't recognize that it is a duplicate client).

ASP clients based on $15 per day/per bed, fixed rate contract (24/7/365)

APPENDIX B – MHSA COMMUNITY PROGRAM PLANNING SURVEY

County of San Diego Health and Human Services Agency
Behavioral Health Services Division
Mental Health Services Act (MHSA)
Community Program Planning Survey

The County of San Diego Health and Human Services Agency's Behavioral Health Services Division is in the process of developing the County's Mental Health Services Act (MHSA) 3-Year Plan for Fiscal Years 2014-15 through 2016-17.

MHSA provides funding for expansion of mental health services in California. Services provided through the MHSA support the County's *Live Well San Diego* initiative* by enabling participants with mental health needs and the general public to access resources that can help them lead more healthy and productive lives.

In accordance with MHSA, the County of San Diego Health and Human Services Agency's Behavioral Health Services Division is conducting a Community Program Planning survey to gather stakeholder input. The feedback we receive via the survey below will help guide the development of MHSA-funded programs and services locally.

Please respond to the following survey questions:

DEMOGRAPHIC QUESTIONS

1. Which Stakeholder group(s) do <u>you</u> identify with (please check all that apply)?

- ☐ Community member
- ☐ Consumer of mental health services
- ☐ Education
- ☐ Faith-based organization
- ☐ Family member of a consumer of mental health services
- ☐ Family member of participant in alcohol and drug services and/or in alcohol and drug recovery
- ☐ Family member of someone affected by mental illness and/or substance abuse but not utilizing services
- ☐ Health and Human Services Agency (HHSA) staff
- ☐ County of San Diego staff (non-HHSA)
- ☐ Health care organization
- ☐ Homeless
- ☐ Law enforcement agency
- ☐ Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ)
- ☐ On probation or parolee
- ☐ Participant in alcohol and drug services or in recovery
- ☐ Provider of alcohol and drug recovery services
- ☐ Provider of mental health services
- ☐ Representative from veterans/ veterans support organization
- ☐ Social services agency (non-County)
- ☐ Veteran

2. What is <u>your</u> gender?

☐ Male ☐ Female ☐ Other

3. How old are <u>you</u>?

☐ Teen (13-17) ☐ Young Adult (18-24) ☐ Adult (25-59) ☐ Older Adult (60+)

4. What is <u>your</u> preferred language?

☐ American Sign Language ☐ English ☐ Tagalog ☐ Other_____
☐ Arabic ☐ Spanish ☐ Vietnamese _____

5. What is <u>your</u> race/ethnicity?

☐ African American ☐ Caucasian/White ☐ Native American ☐ Other
☐ Asian/Pacific Islander ☐ Latino ☐ Multiple ☐ Unknown

6. In what part of San Diego County do <u>you</u> live; or, if you are completing this survey as a Behavioral Health Services provider, where do you provide services? (Check all that apply)

☐ Carlsbad ☐ Imperial Beach ☐ San Diego
☐ Chula Vista ☐ La Mesa ☐ Santee
☐ Coronado ☐ Lemon Grove ☐ Solana Beach
☐ Del Mar ☐ National City ☐ Vista
☐ El Cajon ☐ Oceanside ☐ San Marcos
☐ Encinitas (Cardiff-by-the-Sea, Leucadia, Olivenhain) ☐ Poway ☐ Other unincorporated community:
☐ Escondido ☐ San Marcos _____

PROGRAMS AND SERVICES QUESTIONS

7. Do you feel that there are individuals living in San Diego County that are in need of services who do not currently receive them? If yes, what are San Diego County's unmet needs for mental health services? (Please list up to three unmet needs for mental health services.)

8. MHSA funding is used for Community Services and Supports (CSS) programs that provide mental health and other support services to people with serious mental health conditions whose needs are not currently met.

   In the future, what programs/services would you like the County of San Diego's Behavioral Health Services to consider for CSS? (Please list up to three programs/services.)

9. MHSA funding is used for Prevention and Early Intervention (PEI) programs that reduce the stigma and discrimination of mental illness and provide preventative services to avoid mental health crises.

   In the future, what programs/services would you like the County of San Diego's Behavioral Health Services to consider for PEI? (Please list up to three programs/services.)

10. MHSA funding is used for Capital Facilities (CF) efforts to buy and develop land and/ or build or renovate County buildings to expand access to mental health services. MHSA funding is also used for Technological Needs (TN) projects, which empower and engage clients and families by 1) providing tools for secure client and family access to health information, and 2) updating and improving information systems (such as computers and phones) to ensure quality of care, and cost effectiveness.

    In the future, what programs/services would you like the County of San Diego's Behavioral Health Services to consider for CF/TN? (Please list up to three programs/services.)

11. Do you have any other recommendations or comments about the County of San Diego's Behavioral Health Services' currently funded programs or services that you would like to share?

Submit your completed questionnaire no later than May 16, 2014 to one of the following:

Mail: MHSA Coordination, Attn: Gina Brown • 3255 Camino Del Rio South • San Diego, CA 92108

Email: MHSProp63.HHSA@sdcounty.ca.gov

Fax: 619-584-5080

Thank you for your participation in the Community Program Planning process!

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

APPENDIX C – INNOVATION COMMUNITY INPUT FORM AND CYCLE 3 PROPOSALS

County of San Diego Health and Human Services Agency

Mental Health Services Act Innovation

Mental Health Services Announces the Initiation of Community Planning for the Mental Health Services Act (MHSA) Innovation Component

MHSA Definition of Innovations

- Services that are novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.

General Requirements

- Participation by individuals must be voluntary.
- Counties must select one or more of these four purposes for each work plan. The selected purpose(s) will be the key focus for the work plan.
    - Increases access to underserved groups
    - Increases quality of services and outcomes
    - Promotes interagency collaboration
    - Increases access to services
- Work plan introduces a new practice, adapts an existing practice for a new setting, or introduces a new practice that has been successful in non-mental health settings.
- A practice with success in one setting cannot be funded in another setting unless it is changed in a way that contributes to the learning process.
- Similar to a pilot project, the work plan should be completed within a time frame that is sufficient to allow learning to occur and to demonstrate and communicate the efficacy/feasibility of the project.

General MHSA Standards Must be Upheld

- Wellness focused, client/family-driven, and creates an integrated service experience.
- Demonstrates cultural competency, community collaboration, and reduces disparities.
- Initiates and expands collaborations, especially with non-traditional mental health entities.
- Includes involvement of clients/family in staffing, implementation, evaluation, etc.

Scope of Innovation

- Target population can range from individuals, families, neighborhoods, tribal and other communities, counties, to regions.
- Areas of application may include: administrative/governance/organizational, advocacy, education and training, outreach, capacity building, community development, planning, policy and system development, PEI, education, research, and services.

County of San Diego Health and Human Services Agency

Mental Health Services Act

Innovation Community Input Form

Overview The Mental Health Services Act (MHSA) provides limited funding for the Innovation Component of the County's MHSA Plan. Funding will be used to increase access to underserved groups; increase the quality of services, including better outcomes; promote interagency collaboration; and increase access to services.

Innovations are defined as novel, creative, and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative. The Innovation Component allows Counties the opportunity to "try out" new approaches that can inform current and future mental health practices/approaches. Innovation ideas will introduce a new practice, adapt an existing practice for a new setting, or introduce a new practice that has been successful in a non-mental health setting.

We welcome all ideas, suggestions and recommendations for San Diego County's Innovation Plan. Please use this form to submit your ideas and suggestions by **October 31, 2013**. For more information visit the Network of Care Website at: http://sandiego.camhsa.org/innovation.aspx

1. Fundamental Concept: Please check the primary concept below that your recommendation will address.

- ☐ Increase access to underserved groups
- ☐ Increase the quality of services
- ☐ Promote interagency collaboration
- ☐ Increase access to services

2. Age Group: Please identify the age group that will be impacted by your recommendation. Please note that funds may support a project that transcends multiple age groups. Check all that apply:

- ☐ 0 to 18 years
- ☐ 16 to 25 years
- ☐ 18 to 59 years
- ☐ 60 years and above

3. What practice or approach should the County test/try out? Describe your idea.

County of San Diego Health and Human Services Agency

4. What challenging problem does your idea (approach or practice) address in the San Diego County mental health community?

5. What has prevented solutions to solving this problem in the past? Describe the barriers to resolving the problem.

6. What do we want to learn in overcoming the barriers and to resolving the identified problem or issue?

7. What should be measured (outcomes) and analyzed to show effectiveness?

8. Has this approach or practice been tried elsewhere or in other populations? If yes, please describe.

9. Contact Information (optional)

Name: Organization:

Phone: Email:

Attach any additional information that describes your idea, such as research or other information that demonstrates how the idea can be tested and/or successful. Return input via email to: MHSProp63.HHSA@sdcounty.ca.gov, fax to: (619) 563-2775, or mail to: 3255 Camino del Rio South P-531C, San Diego, CA 92108, Attention: Adrienne Yancey. For questions, contact us at: 1-888-977-6763. Thank you for your participation!

Innovation Work Plan Narrative: INN-11

Work Plan Name: Care Giver Connection to Treatment
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☒ INCREASE ACCESS TO UNDERSERVED GROUPS
☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

There is well-documented literature detailing the unique burden placed on caregivers. Caregiving has been shown to be an independent risk factor for mortality, and caregivers have higher levels of depressive symptoms, higher levels of anxiety and lower levels of perceived health (Schultz, et al 1999). Literature detailing the consequences of caregiver burden points to physical, psychological, emotional, social and financial consequences (Sorrell, 2014). Connecting caregivers to treatment and other types of support promotes wellness not only in the caregiver, but also for those whose care they provide. Historically the literature has evaluated the impact on those who care for the elderly or for those who care for persons with significant medical illnesses.

There is insufficient literature available that addresses the unique caregiver burden of those who have children ages 0-5 with complex emotional, behavioral and developmental issues and the subsequent benefit of treatment for both the caregiver and the child. There is no existing practice in San Diego County BHS system where caregivers of children ages 0-5 with complex needs who are our primary clients are routinely screened and connected to treatment. Traditional funding regulations have prohibited BHS-CYF from providing services specific to the caregiver. Anecdotally we know that caregiver stress can be a barrier to a child's treatment. Through implementation of the novel approach described below, we expect to increase access to mental health services for the caregivers of children in treatment for complex emotional, behavioral and developmental issues ages 0-5, increase caregiver satisfaction, and note improved overall emotional, behavioral and developmental gains for the child. As we move forward, we will be able to evaluate the extent of the need for caregiver mental health treatment and connection to resources and the impact of this treatment and connection to resources not only on the caregiver, but on the child receiving services within our system in the following ways:

- Children, Youth and Families (CYF) System of Care 0-5 Subcommittee identified the need for caregiver treatment separate and distinct from the treatment of the young child.
- Most caregivers of young children in the CYF System of Care do not meet criteria for public specialty mental health services typically available to those with Serious Mental Illness. However with the advent of the Affordable Care Act, more adults with mild or moderate symptoms will have access to care.
- Traditionally, caregivers who are overwhelmed with caring for a child with complex needs do not access mental health and drug and alcohol services for themselves.
- Programs serving children age 0 to 5 are focused on the child's needs in addition to
- parent / child interaction and at best provide referral information to caregivers for their own behavioral health needs.
- Programs can play a role in educating families about the toll of caregiver stress. Emotional consequences of caregiver stress include anger, anxiety and depression.

- Maternal depression adversely affects physical, cognitive, social, behavioral and emotional development of children (World Health Organization, 2008).
- Supporting the caregiver in their own mental health any recovery allows for increased availability to their child which ultimately enhances the whole family's quality of life and wellbeing.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

- Current CYF treatment programs focus on the mental health, and social/developmental needs of the child, with family work being done in direct relationship to the clinical presentation of the child. Expanding the focus to address the behavioral health and needs of the caregiver and analyze the effectiveness of this intervention on the child's treatment is not currently being done in our System of Care.
- Other systems have utilized family partners and/or other staff to engage and support caregivers, however there is no available data on the impact of this support on clients age 0 to 5.
- Given the significant developmental milestones from age 0 to 5, it is thought providing mental health treatment and connection to resources to the child's caregiver would have a measureable impact on the children in services for emotional, behavioral and developmental concerns.
- A 0 to 5 child serving program shall be augmented with a clinician who will offer support groups for caregivers focusing on providing educational information about stressors associated with caregiving in addition to providing support for the caregiver's behavioral health needs.
- The intent is for the clinician to offer specialty groups to address caregiver's symptomology such as depression, anxiety, and co-occurring disorders.
- With the advent of the Affordable Care Act and parity for behavioral health, mental health services are even more widely available to caregivers, but work is needed to make a meaningful connection to existing resources.
- Stigma associated with mental health treatment remains a barrier. Caregivers, particularly of young children, may prioritize the child's care over their own, not recognizing the impact parent mental health has on the family system.
- A Parent Care Coordinator position shall be added to ensure that parents in need of individual behavioral health services are connected to the appropriate resources.
- Care Coordinators shall form connections with Cal-Works and the Medi-Cal Health Plans who have existing behavioral health services for adults as both provide services to adults with mild to moderate mental health needs.
- The Care Coordinator shall function as the liaison between the child's treatment team and the caregiver provider.
- Care Coordinators shall be trained in Motivational Interviewing which is a clinical approach used to support those with chronic conditions make positive behavioral changes to support better health.
- A 0.5 FTE Licensed or Licensed Eligible clinician will be dedicated to screening, assessing, and coordinating with the tri-disciplinary treatment team the needs of caregivers. The clinician will offer behavioral health group sessions to family members who are assessed to have behavioral health needs.
- Two FTE Parent Care Coordinators will be available to offer caregiver support and make meaningful connections to individualized behavioral health services for the caregiver with an emphasis on identifying and addressing barriers to services.

- A research position will allow for data collection, analysis and an annual report to identify impact and offer best practices.

Based on community input and system analysis, current services focus on the child's needs and are not able to address mental health or substance abuse issues that the caregiver is at higher risk to face due to their caregiver role. To promote the health of the family unit, addressing the parent's needs is essential. Community resources are available however barriers prevent caregivers from accessing those services. A new approach of offering caregiver focused services from the team that is already working with the family to address the child's needs, as well as making some of the services available at the same site as where the child is accessing services is hypothesized to increase access to care for the caregiver and ultimately create a family unit that is healthier and better positioned to support the child.

- It is expected that 100% of families enrolled in the program will be screened to determine need.
- A Countywide program serves approximately 200 children annually with multiple caregivers per child.
- It is projected that a minimum of 200 caregivers will receive a screening and of those, roughly 50% will need and elect to receive care coordination and/or direct clinical services.
- Projected target of 200 screening and 100 treatment/care coordination participants.

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: The concept for this work plan was developed based on local stakeholder process for input on system needs. An Early Childhood Mental Health Subcommittee of the Children's System of Care Council which has four sector representation of public, private, education, and family & youth expanded the overall input of caregiver services to outline a co-location component. Care Coordinators will work to establish strong working relationships with community resources and medical and behavioral healthcare providers. This will include, but not be limited to, connection with Cal-WORKS, Federally Qualified Health Centers, primary care providers and community based behavioral health care providers. It is anticipated that these connections will, in turn, raise awareness of the importance of early intervention for children with emotional, behavioral and developmental needs.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes for unserved and underserved adults with mental illness. The program will work to establish, at baseline, disparities in services accessed by racial/ethnic, cultural and linguistic populations or communities. An independent assessor will identify and measure disparities when compiling data regarding the impact of the program on minority children and caregivers. This information will allow the program to tailor services to engage and retain caregivers of diverse racial/ethnic, cultural, and linguistic populations. This information will be incorporated into policy, program planning and service delivery. Program staff will receive ongoing training so they can best understand and address particular racial/ethnic, cultural and/or linguistic communities.

Client Driven and Family Driven Mental Health System: Provider input has given voice to family members who expressed desire to address their own mental health struggles outside of the work that is being done within the family unit. This program can offer more options to family members and addresses the barriers to access. This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination.

Impact on both clients and caregivers will be measured as an outcome of this project. Ultimately, the program strives to create healthier families in our community.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes recovery and wellness for caregivers with serious mental illness by increasing access to services. The goal is to strengthen the overall family unit by addressing individual needs that allow for a more stable and resilient family system with strength to sustain wellness.

Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members. Care Coordinators will be tasked with learning about public and private resources to optimize referrals. Focus will be on educating the family about their options as well as facilitating connections to needed services.

Number of Participants to be Served

- It is expected that 100% of families enrolled in the program will be screened to determine need.
- A Countywide program serves approximately 200 children annually with multiple caregivers per child.
- It is projected that a minimum of 200 caregivers will receive a screening and of those, roughly 50% will elect to receive care coordination and/or direct clinical services.
- Projected target of 200 screening and 100 treatment/care coordination participants.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$218,446	3 Year Program Cost	$655,338
Evaluation Cost (4.4% of Total)	$10,054	3 Year Evaluation Cost	$30,162
Total Annual Innovation Funding	$228,500	3 Year Grand Total	$685,500
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts.

The learning objective is to determine if having a component within a program that serves children 0-5 focusing on providing services to the caregiver will successfully engage caregivers in their own mental health treatment. The approach of having a traditional behavioral health child program specifically address the individual behavioral health needs of the caregiver is not currently practiced. Our goal is to learn if these new approaches will lead to improved access to mental health services for unserved and underserved caregivers. Furthermore, we hope to learn if new approaches will lead to improved outcomes for the children whose caregivers become engaged in their own care. Because the program

has two components of offering on site services as well as individualized connection to existing services, we will be able to look at the preferred method through utilization, and perhaps identify if cultural preferences exist.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication.

Implementation/ Completion Dates:	07/2015 – 06/2018
By 6/2015	Program contract procurement process ends
7/2015	Contract award. The contractor will be allowed up to 6 weeks start-up time to recruit, hire and train staff.
7/2015	Core services begin in July 2015, with innovation component implemented by mid-September 2015. Parents of children age 0-5 enrolled in services will be connected with the Care Coordinator and the process of assessment, motivational interviewing and linkage to services will begin. Provider shall establish mechanisms to obtain caregivers input and recommendations regarding the two distinct services they will be offered (on-site psychoeducation and mental health services and personalized and supported connection to existing mental health, substance abuse treatment and community resources) Hire an independent evaluator to initiate data analysis process.
7/2015	
8/2015	Care Coordinator begins formalizing referral pathways with other agencies that offer adult mental health and substance abuse services.
8/2015	Independent evaluator with contractor establishes a research and data collection outline and tools to capture effectiveness of caregiver component of the program. Provider shall identify a clear measure of increased access by caregiver.
9/2015	Begin ongoing data collection and evaluations.
1/2016	The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year-to-date; analysis of the barriers and successes of the project and recommendations based on lessons learned thus far.
8/2016	The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first semi-annual report but also include results of a consumer survey, as well as any new data elements and/or additional analyses recommended by the first report.
1/2017	Follows same format as 1/2016

8/2017	Follows same format of 8/2016
1/2018	Follows same format as 1/2016
8/2018	Provide final program assessment and outcome with recommendations. Report will be made available for review by other counties. Best practices shall be assembled into a document that will be shared across the CYF System of Care.
8/2018	Evaluation by Behavioral Health Services to determination of efficacy and feasibility or replication with other funding, dissemination of results.

An evaluation component will be embedded within the program with quarterly data reporting, annual reports and recommendations with a final project review to determine program effectiveness and identify the most successful practices from the implementation phase and measure system impact. This will also allow for review of new and adapted strategies that may increase the feasibility of the program for future replication.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

- All participants will be surveyed to determine the baseline percentage of caregivers accessing treatment. All new participants to the program will be surveyed on intake.
- Clinician shall offer a minimum of 5 group therapy sessions per week.
- Clinician shall serve a minimum of 100 caregivers per fiscal year.
- 100% of those caregivers engaged in group therapy will report high level of satisfaction with having coordinated services with their child's provider.
- Care Coordinator shall connect a minimum of 100 caregivers to their own behavioral health treatment per fiscal year.
- 100% of those caregivers receiving care coordination connection to their own behavioral health services will report high level of satisfaction with having linking services through their child's provider.
- Independent assessors will work to determine how much access increased (using access data gathered before Care Coordinators implemented)
- Independent assessors will work to determine if access increased more for subpopulations (e.g., caregivers who are married vs single, if a caregiver has other children, if a caregiver is employed, racial/ethnic minorities)
- Independent assessors will work to determine the impact on connecting caregivers to treatment has on the progress of the child enrolled in the program
- Families will be asked to complete questionnaires about satisfaction and what programmatic variables they found to be helpful.
- Contracted Evaluator shall compile data into a Tool Kit to be made available to CYF System of Care.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Contractor shall be tasked with exploring levering opportunities. This plan will directly provide additional staff support that will contribute to leveraging the following resources:

- San Diego County Behavioral Health Service Providers
- Specifically services through Cal-Works program
- Connections with Medi-Cal Health Plans
- Community Resources
- Faith Based Communities

Innovation Work Plan Narrative: INN-12

Work Plan Name: Family Therapy Participation Engagement
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☒ INCREASE ACCESS TO UNDERSERVED GROUPS
☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

It has been documented that parents who are engaged in the treatment of their child(ren) are a crucial component to positive outcomes and lasting change (Cunningham & Henggeler, 1999; Liddle, 1995; Szapocznik et al., 1988; Coatsworth, Santisteban, McBride, & Szapocznik, 2001). The County of San Diego has set a goal that 80% or more of clients in treatment for serious behavioral health issues shall receive a minimum of one family therapy contact per month with the client's biological, surrogate or extended family member. This goal is not being consistently met throughout our system. Literature and anecdotal reports tell us that parent expectations predict subsequent barriers to treatment. Existing practice of therapists and professional case managers educating and encouraging family participation in treatment has not led to desired level of parent involvement in care. This adapted Innovation Project would utilize specially trained Parent Partners in first establishing a relationship with the families of clients and then using motivational interviewing techniques to overcome barriers to involvement in treatment and activating change. There is no established literature that details the success of Parent Partners trained in motivational interviewing in mobilizing families to participate in family therapy services. We expect this project will allow treatment providers to learn about perceived barriers to involvement and will increase family therapy participation, thereby increasing the quality of services in the following ways:

- Hogue, Liddle, Dauber, and Samuolis (2004) point out, rigorous empirical studies have shown that family-based therapy can produce engagement and retention of drug users and their families in treatment (Henggeler et al., 1991); reduction or elimination of drug use (Liddle et al., 2001; Waldron, Slesnick, Brody, Turner, & Peterson, 2001).
- Family involvement in treatment leads to decreased involvement in delinquent activities (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993).
- Family involvement in treatment leads to improvement in multiple domains of psychosocial functioning such as school grades, school attendance, and family functioning (Liddle et al., 2000).
- Stakeholder input has identified a model of utilizing Parent Partners to join with caregivers in effort to increase parents understanding of value and therefore increase commitment to consistent participation in family therapy.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

- Due to low parent involvement in therapy, a systematic approach to increase caregiver participation in family therapy for existing client treatment would be implemented.
- The new practice would employ a Parent Partner whose primary role will be to engage the client's guardian in family therapy to enhance positive and sustainable gains from treatment.
- Currently Parent Partners are utilized to engage with families in a broader role and offer rehabilitative and case management services, but this would shift to a focal objective of engagement in family therapy.
- Priority efforts shall be made to engage underserved populations such as Latinos and African Americans.
- Significant predictors of low expectancy for therapy services include low SES, severity of the child's dysfunction, ethnic minority status and parental stress and depression (Nock, et al 2001).
- Parent expectations predict subsequent barriers to treatment including participation, treatment attendance and premature termination from therapy (Nock, et al 2001).
- Parent engagement will include education on the importance of authentic family participation in the child's treatment.
- Engagement will explore the reasons for lack of parent participation. It will allow the parent partner to establish a rapport with the family, to hear their concerns about their child and discuss the family's hopes for the future. Next the Parent Partner will help the client's family focus on what habits or behavioral patters the family hopes to change. The Parent Partner will evoke the family's motivation for change. Finally the Parent Partner will support the family in developing steps they can use/be involved in that will facilitate change.
- Parent Partner will provide information about increased effectiveness of treatment outcomes when parents are involved in family therapy as true change agents for the youth's behaviors.
- Existing strategies to reduce stigma associated with behavioral health services shall be utilized, but offered by a Parent Partner who is able to engage the family from a nontraditional system approach, with emphasis of individualizing the approach specific to the information provided by the family and their experience.
- Education will be offered to ensure that misperception parents relate to our providers that professionals are able to foster meaningful and lasting change without the active problem solving on the part of the family unit will be explored.
- The intent is to clarify, teach, and motivate the caregiver the value of their involvement in treatment and how it will directly support the success and outcomes for the family unit.
- The Parent Partner will be trained in Motivational Interviewing which is traditionally utilized by clinicians, and work with the parent to overcome identified barriers and assist the multidisciplinary team to better accommodate the family needs in order to foster participation.
- Training Parent Partners in Motivational Interviewing techniques is a new use of Motivational Interviewing.
- The Parent Partner would act as the program's "change agent" to work with the program staff on solutions that would foster caregiver involvement.
- Active engagement of families in treatment provides an opportunity to establish effective patterns of communication between family members.
- Stronger problem solving skills within a family unit leads to improved stability.
- A cohesive family unit leads to more stable and thriving communities.
- Each full time Parent Partner would engage a minimum of 40 caregivers per fiscal year.

- Each of the six regional treatment programs will extend the services to a minimum of 80 caregivers annually for a total of 480 families impacted.
- Two full time Parent Partners would join the clinical team of a program.
- One of the two Parent Partners in each program shall be bicultural and bilingual.
- The BHS workforce would be enhanced with 12 additional full time Parent Partner positions, with an additional emphasis on cultural competence.
- Parent Partners will meet the BHS-CYF definition of Family Support Partner as being an individual with experience as a parent/caregiver of a child/youth that has or is currently receiving services from a public agency serving children/families and who is employed full or part time to provide direct (potentially billable) services to a child, youth, or family receiving behavioral health services.
- Each of the six regional programs shall employ an analysts/research assistant to create tracking systems, analyze the data and prepare a best practices report out on the findings.
- One program shall be enhanced with a research position that will oversee and pull all six programs data collection into an annual report that trends the findings.

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: Members of the Children's System of Care that have experience with Parent Partners recognized the benefit to utilizing this resource in identifying barriers to treatment and establishing greater involvement in treatment. Increasing involvement of Family/Parent Partners has been presented as an emerging practice and program that utilize this resource have provided feedback to the group about the benefit of adding these members to the treatment team. The County of San Diego Children's System of Care represents multiple sectors including public, private, education, and family and youth.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes for unserved and underserved children and youth with mental illness. It is anticipated that Parent Partners will largely represent the racial/ethnic, cultural, and linguistic populations that our programs serve. This representation will further allow programs to ensure equal access to services, identify and measure disparities in services including bias, racism and other forms of discrimination, and allow treatment providers to have an increased understanding of diverse belief systems concerning mental illness, health, health and wellness. Working alongside Parent Partners, it is anticipated that programs will develop a greater awareness of diversity on all levels- from the administrative level to the direct service provider.

Client Driven and Family Driven Mental Health System: This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community. Families may feel better able to connect with Parent Partners and may, in addition to taking a more active role in their own family's care, be better equipped to provide educational information to their community.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes discovery and wellness for children and youth with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.

Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members.

Number of Participants to be Served

- Each full time parent partner would engage a minimum of 40 caregivers per fiscal year.
- Each of the six regional treatment programs will extend the services to a minimum of 80 caregivers annually for a total of 480 families impacted.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$1,077,412	3 Year Program Cost	$3,232,236
Evaluation Cost (4.4% of Total)	$49,588	3 Year Evaluation Cost	$148,764
Total Annual Innovation Funding	1,127,000	3 Year Grand Total	$3,381,000
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts.

The learning objective is to determine if the utilization of Parent Partners (defined as an individual with experience as a parent/caregiver of a child/youth that has or is currently receiving services from a public agency serving children/families) to provide outreach to families through motivational interviewing engages the family unit in family therapy services. Furthermore, we hope to learn what are the specific strategies and best practices that family partners can utilize to successfully assist caregiver see the value of consistently participating in family therapy. We want to know if the use of a Parent Partner to do this targeted work will be more successful in persuading caregivers to be involved in family therapy than the traditional model of the clinician outreach to the family. We intend to review if repeated engagement efforts correlated with successful engagement into family therapy.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication.

Implementation/ Completion Dates:	07/15 – 06/18
By 6/15	Amend regional contracts to include innovative component
7/2015	Innovation component goes into effect. Contractors will be allowed up to 6 week start-up time to recruit, hire and train Parent Partners.
7/2015	Hire an independent evaluator to initiate the data analysis process. A research and data collection outline to capture effectiveness of Parent Partner will be established. Clear measure of family participation and attitudes about participation will be determined
9/2015	Parent Partner services begin. Parent Partners initiate the process of engagement with families.
9/2015	Begin ongoing data collection and evaluations
1/2016	The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year-to-date, analysis of the barriers and success of the projects and recommendations based on lessons learned thus far
8/2016	The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first annual report but also include results of a consumer survey, as well as any new data elements and/or additional analyses recommended by the first
1/2017	Follows same format as 1/2016
8/2017	Follows same format as 8/2016
1/2018	Follows same format as 1/2016
8/2018	Provide final program assessment and outcome with recommendations.
8/2018	Report to be made available for review by other counties. Best practices shall be assembled into a document that will be share across the CYF System of Care Evaluation by Behavioral Health Services to determination of efficacy and feasibility or replication with other funding, dissemination of results.

An evaluation component will be embedded within the programs with quarterly data reporting, annual reports and recommendations with a final project review to determine program effectiveness and identify the most successful practices from the implementation phase and measure system impact. This will also allow for review of new and adapted strategies that may increase the feasibility of the

program for future replication. Focus will be on data that relate families perceived barriers to participating in treatment, data from Parent Partners detailing what they deemed to be helpful in engaging families, and data around actual family participation in treatment and impact on the child's clinical course of treatment.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

- Each contractor will identify recommendations based on what they implemented for best practices to engage caregivers in family therapy. The independent assessor will determine the best modality to gather data to make these recommendations. This may include surveys of the child, caregivers, Parent Partners, gathering data that reflects the number of family therapy sessions, length of treatment, outcome measures, etc.
- Data will be compared to baseline data available detailing participation in family therapy sessions.
- Data will be compared across the 6 individual programs that participate in this Innovations Project and will be reviewed collectively.
- Best practices shall be assembled into a document that will be shared across the Children, Youth and Families (CYF) system of care.
- The contract shall be monitored and evaluated in the following ways:
    - Quarterly Status Reports by program.
    - Data elements that will be tracked and monitored by the program.
    - Independent Evaluator shall complete annual reports and final evaluation of effectiveness of the intervention.
    - Independent Evaluator shall compile data into a Tool Kit to be made available to CYF System of Care.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Contractor shall be tasked with exploring levering opportunities. Although it is expected that six contracts will be amended to add the parent partner component, all will be set up to benefit from one external evaluation provider who can help implement a consistent evaluation methodology across programs.

Innovation Work Plan Narrative: INN-13

Work Plan Name: Faith Based Initiative
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☒ INCREASE ACCESS TO UNDERSERVED GROUPS
☐ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☒ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

After conducting a year-long stakeholder input process, Behavioral Health Services (BHS) and Faith Based (FB) leaders, pastors and clergy identified key recommendations primarily focusing on the African-American and Latino communities in the Central and North Inland regions of San Diego County. These communities have traditionally been disproportionately served and had limited access to appropriate and culturally relevant BHS services. Recommendations were documented in a compendium that outlined the year-long process which culminated in a Community Breakfast Dialogue where BHS providers, FB leaders, clergy, consumer, family members, advocates as well as community at large members participated. From this process, themes were identified and they are: developing meaningful collaborations and partnerships, increased outreach and engagement within the faith based communities, increased education and training about BHS; ability to partner with BHS contractually; identifying what services are available for individuals with serious mental illness (SMI) and serious emotional disturbance (SED) and where and how to access mental health and alcohol and drug services and other resources.

While there are previous efforts of mental health and the Faith community working together, this adaptation seeks to combine four (4) components into one program. The combined components unique to this adaptation include 1) Collaboration and Partnerships, 2) Community Education, 3) Crisis response and 4) Wellness and Health ministry. These components together will address the needs of the Faith Community as it relates to mental health. During the Innovation (INN) Community Planning Process, stakeholders submitted project ideas aligned with the key themes identified during the stakeholder process.

The main purpose for selecting this Faith Based INN project is to develop long standing collaborations and partnerships with Faith Based leaders/clergy and congregations and to address underserved populations. These services promote collaboration between BHS and various FB leaders and congregations in the identified regions. As well as cross education about each other and what services are provided in the community to reduce the effects of untreated mental illness.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

African-Americans and Latinos are disproportionally represented in the jail system (Source BHS Data Book 2012-2013) and are receiving for the first time mental health and AOD services while in detention. Furthermore, the faith based community and its congregations generally does not pursue behavioral health services due to stigma associated with seeking BHS, lack of knowledge about available resources and because many services are not culturally relevant and don't support a mental health model of service that is congruent with a faith-based approach to mental health and well-being. BHS wants to test if the community efforts described below facilitate improved collaborations and partnerships, de-stigmatizes the use of BHS, increases knowledge about services and increases access to appropriate community based mental health services thereby impacting the number of individuals with untreated mental illness that are found in the jail system.

The proposed project has four components (listed below) that address concomitant barriers in developing collaborations and partnerships in behavioral health services and faith communities in the African-American and Latino communities. While none of these four components are new individually to the faith community, the combination of the four components in one program focusing on mental health is the adaptation and therefore new.

- Collaboration and Partnerships - Outreach and engagement to Faith Based congregations – develop collaboration and partnerships with Faith-based congregation/clergy and identify "FB champions" or "FB community leaders" within the clergy/congregations to participate in a "Faith-Based Academy" to develop and increase knowledge about mental illness and wellness, BH services, in the community and in-jail mental health services, faith/spirituality principles and values and community support services. This innovative intensive educational community based training academy increases community collaboration and the development of long standing partnerships. Approximately 50 FB and BHS participants will enroll in the FB Academy from the two regions.
- Community Education – The Faith Based Champions will facilitate community educational series in both regions that focus on mental illness and BHS resources. Approximately 3 community educational presentations will be delivered annually in each of the regions.
- Crisis Response – A community based FB Team that pairs a licensed or master level clinician with a Faith-based clergy to respond to individual/family crisis situations, suicides, homicides, domestic violence on a 24/7 on-call system. Mobile FB Team will provide crisis intervention, counseling, support services and linkages to BH services and other community supports as needed in the home. It is envisioned that the Mobile FB Team will provide services to individuals and families for up to 90 days. Approximately 120 individuals/families will be served annually.
- Wellness and Health Ministry – Develop a Wellness and Health Ministry that focuses on Adults diagnosed with an SMI while in jail that includes: engaging individuals with schizophrenia or bipolar disorders while in jail and providing spiritual support; mental health and physical health wellness; information and counseling on the impact and effects of untreated mental illness, co-occurring disorders and trauma in adults/older adults that are diagnosed with a SMI and provide linkage and community based resources for re-integration back into the community. The Wellness and Health Ministry will provide support services consistent with pastoral counseling and the individual's faith and information, linkage and education about community based

resources. This Ministry will outreach individuals while in detention. Approximately 240 individuals annually will be outreached with an SMI diagnosis while in detention.

These proposed services integrates FB leaders and clergy with behavioral health providers to support the development of collaborations and partnerships, capacity building, address individuals in detention with SMI, educational practices that are cultural competent and trauma informed and focus on the resilience of communities.

General Standards Requirements

Community Collaboration: The concept for this INN program was developed after a year-long stakeholder input process; i.e., The Faith Based Community Dialogue Planning Committee for the Central Region and North Inland region respectively. Behavioral Health Services (BHS) and Faith Based (FB) leaders, pastors and clergy and community at large representatives identified key recommendations that were memorialized at the end of the planning meetings in a compendium of proceedings and provided at the two BHS and FB Community Dialogue Breakfasts' on December 2013. It is anticipated that the previously identified interventions will facilitate improved collaborations and partnerships to address the effects of untreated mental illness.

Cultural Competence: This program demonstrates cultural competence by focusing on the faith based community in two culturally diverse communities (African-American and Latino) by establishing collaborations and partnerships and by providing culturally competent community interventions that address the effects of untreated mental health illness that are disproportionally found in the adult and juvenile legal system by increasing awareness and knowledge about mental illness

Client Driven Mental Health System: This program will include participation of peers and family members in the program evaluation and review. Participants with lived experience in the Adult Council, TAY Workgroup, Children's Council and Faith Based Councils will provide input and feedback to the bi-annual evaluations for staff to make relevant adjustments to the interventions.

Family Driven Mental Health System: This program focuses on increasing access to underserved groups and promoting interagency collaboration. Engaged family members will be involved in activities including but not limited to development, implementation, evaluation and future dissemination where appropriate. Family members may also provide feedback that may inform different strategies or suggested revisions to the original model.

Wellness, Recovery and Resilience Focus: This program promotes resilience and wellness by developing collaborations and partnerships with the Faith Based culturally diverse leaders and communities to address the effects of untreated mental illness.

Integrated Service Experience: This program model integrates several approaches; i.e., the development of collaborations and partnerships, new innovative educational practices (Faith Based and BHS Academy), congregation and community education on mental illnesses, in-jail intervention by pairing clergy with a behavioral health specialists to increase engagement with outpatient treatment for SMI individuals, increase access to care and BHS resources and crisis response (in-home response with faith based clergy and clinician). These approaches provide needed information and referral and linkage information about the mental health system, AOD services and other needed resources. In addition, it is expected that this program integrates components or interventions in one of the six detention centers in San Diego.

Number of Participants to be Served

Outreach and Engagement: Engagement and partnership with 10 Faith Based congregations in the Central Region and 5 in the North Inland region. These partnerships will be the foundation for the development of the BHS/Faith Based Academy.

Community Education: At a minimum 12 community educational presentations in each region with a minimum 15 to 20 participants each.

Community Crisis Response: Minimum of one team composed of Faith Based leader/Clergy and Clinician to respond to community crisis, and 15 to 20 individuals/families to be provided services in the Central Region.

Wellness and Health Ministries: At a minimum one Health and Wellness Ministry in each region.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$473,599	3 Year Program Cost	$1,420,797
Evaluation Cost (5% of Total)	$24,926	3 Year Evaluation Cost	$74,778
Total Annual Innovation Funding	$498,525	3 Year Grand Total	$1,495,575
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

This innovation program provides multiple diverse community approaches that combined integrate new adaptations in faith based strategies with behavioral health services in two diverse communities to address meaningful collaborations and partnerships and the effects of untreated mental illness.

We hope to learn if the Wellness & Health Ministry by pairing a faith based leader/clergy and a BHS specialist increases engagement of individuals diagnosed with a serious mental illness while in jail in outpatient mental health treatment post discharge. We will compare and contrast success with existing data on this population.

We want to learn if collaborating and partnering with faith based leaders/clergy through outreach and engagement in a culturally relevant approach develops a cadre of “FB champions “ or “ FB Community Workers “ within congregations to assist in the development of trusting and lasting collaborations and partnerships that are culturally relevant and sensitive and are consistent with faith based beliefs.

We will seek to learn if this key collaborative program will increase the access to underserved groups to mental health care and reduce stigma in this community.

We also want to learn if the proposed outreach and engagement approaches increases awareness, knowledge and de-stigmatizes seeking mental health, alcohol and other drug and support services and how to access them.

At a practice level we want to learn if a community/home based mobile BH and FB crisis response team is a strategy that is effective in assisting FB leaders and clergy in their response to emergencies by providing support, consultation and resources to address untreated mental illness or mental health conditions, trauma, bereavement and other needed relevant resources for the individual or family.

At a systems level we want to learn if culturally competent collaborations and partnerships are formed, developed and sustained with faith-based congregations/clergy and community leaders to address unmet mental health needs and increase access to appropriate services in the community. It is envisioned that community and individuals, and families will be better informed to address the complex issues of untreated health issues.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/ Completion Dates:

10/14-6/15	Program contract procurement process will begin in October and commence in June 2015. The contractor will engage in start-up activities for six (6) weeks to include staff recruitment, hiring, training and establishment of a physical office.
6/15	The contract will be publically awarded to winning respondent and start-up activities will begin.
8/15-12/14	Services begin as per the Statement of Work including but not limited to outreach, marketing and collaboration with the Faith community in the Central Region.
1/30/16	A semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year to date and detail an analysis of any barriers, successes and recommendations based on the first 6 months.
07/16 through 2018	Annual evaluations completed and reviewed by Behavioral Health Services to review effectiveness of program specific to target population and planned interventions. (Annual evaluations of program to be provided annually for the 3 years of the program)
05/18-08/18	Evaluation by Behavioral Health Services to determine, results and feasibility of integrating into existing programs or replication. Results to be disseminated at the conclusion of the evaluation.

Project Review and Evaluation

Monthly program monitor meetings will be held with contractor(s) to ensure that program requirements are adhere to and to provide support and consultation to contractor regarding implementation and challenges encountered.

Year 1 through Year 3 of contract – a six month and yearly report of services and outcomes will be required for each of the 3 years of the program. Bi-annual and yearly reports will provide results that include: community participants that were provided services via the BHS/FB Team and outcomes, BHS and FB participants in the FB Academy, the development and the participation rate of in the Wellness and Health Ministry and the outreach and engagement activities that were conducted to enlist participants for the FB Academy and the development of collaborations and partnerships with BHS providers.

Pre and Post tests for the Community Education component and the FB Academy will be provided to participants to assess level of knowledge gained about mental illness, wellness and resources. FB focus groups, congregation focus groups, FB Champions and leads for Wellness and Health ministries will complete a survey to assess level of knowledge gain and how they utilize information.

Project Measurement:

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Results from the six month and yearly reports will be presented to the Central and North Inland Faith Based Councils for review and input. In addition report results will be presented to the Behavioral Health Services, Children's, TAY Workgroup, Adult and Older Adult Councils and the Cultural Competence Resource Team (CCRT) whose members include consumers, family members, advocates, and community at large members and BHS providers. These Council's and Workgroups by policy report directly to the BHS Director and provide recommendations on the BHS system of Care and they are the conduit for MHSA planning and review.

Specific data collected includes but is not limited to the following:

- Increased access to care- we will evaluate if access of care to this underserved population has been increased by client report and/or staff documentation.
- Interagency Collaboration- We will measure how many agencies are collaborated with in both the Faith community and mental health community. Tracking of this will be reported on a monthly report to the County.
- Collaboration and Partnerships: Outreach and Engagement of FB leaders/clergy - Outreach and engagement strategies are to be developed by FB leaders/clergy and contractor at the onset of the program to ensure relevance and alignment. We will identify which of the above mentioned engagement strategies are most successful. We will track the number of FB congregations/clergy outreached, engaged and partnerships developed and key elements that contributed to its success in identifying "FB Champions" that volunteered to participate in the FB Academy.
- FB Academy: Contractor is to develop the FB Academy curriculum by assembling key leaders from BHS and the FB leaders/ clergy that will inform the curriculum topics. It is envisioned that the FB academy will create a 40 hour curriculum provided over a 6 month period and address such topics as Mental Health and Wellness, which are the mental health conditions or illnesses,

treatment approaches, trauma informed practices, the nexus between wellness and spirituality, and community resources etc. In addition we will collect information on demographics, number of participants, level of knowledge gained and successful implementation of an integrated strategy to enhance collaborations, partnerships and how the increase in knowledge will be utilized.

- Wellness and Health Ministry: we will compare and contrast with existing data if intervention increases engagement for individuals outreached and engaged while in detention in outpatient treatment.
- Crisis Response - We will evaluate effectiveness of intervention with participant and family as assess by level of satisfaction and results; increased access to BHS, reduction of suffering, successful linkages to BHS services and community supports, number of individuals and families that were provided services by the mobile BHS/Faith Team and if any individuals were diverted from incarceration or juvenile detention due to this intervention.
- Other outcomes as indicated by stakeholders during review and evaluation process.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

We will work very closely with existing faith based leaders, clergy and congregations in both the Central and North Inland regions to implement components of this program. In addition we will work with the Sheriff's Department to implement the Wellness and Health Ministry in to be determined jail setting.

Innovation Work Plan Narrative: INN-14

Work Plan Name: Ramp Up 2 Work
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), when people feel good about having a job, they often see themselves in a more positive way. Work gives people structure and purpose. Having income offers more choices about what to buy and where to live in the community. However, for those affected with Serious Mental Illnesses (SMI) the challenge becomes finding job opportunities that are both meaningful and offer competitive wages. Collaborations and partnerships with the business and employer community need to be developed and strengthened to educate and increase the potential for employment for individuals with SMI.

The San Diego County stakeholder and consumer community have expressed a need for clients with SMI to have competitive and supported employment opportunities of their choosing. Some mental health programs in the community provide job coaching, readiness, and placement assistance for mental health consumers. Research identifies Supported Employment as an evidenced based best practice, which has been implemented in San Diego for over 20 years. However Supported Employment does not influence other employment areas that stakeholders requested via our community process to enhance the array of employment alternatives. Leadership has not been developed to bridge mental health consumers with an array of employment alternatives. The County of San Diego Behavioral Health Services (BHS) propose to take the leadership role in developing the following innovative activities: Consumer Owned Small Businesses (COSB)

- Social Enterprise is a relative new approach to business which create a self-sustaining employment environment that includes a social purpose that benefits a disadvantage community
- Outreach to volunteers/retirees as an apprentice/mentorship partner for individuals with SMI
- Develop collaborations and partnerships with the business sector that currently are not involved in providing employment opportunities to individuals with SMI.

Ramp Up 2 Work will also incorporate the following objectives, which have been adapted from Supported Employment:

- Educational component for businesses to address what mental disorders are and decrease stereotypes and stigma thereby increasing employment opportunities for individuals with SMI.
- Businesses will have the opportunity to meet individuals with lived experiences and hear their success stories, address stereotypes and concerns employers may have.

Number of Participants to be Served

- Job Preparation – minimum 50 participants
  - Includes initial screening and job coaching
  - Identify job skills within a consumer selected job
- Apprenticeship – minimum 25 participants
  - Subsidized apprenticeship in business or employment site
- Social Enterprise – minimum 10 participants
  - Develop a consumer owned small business model where guidance, preparation, job skills and apprenticeship will advance to the operation of a small consumer owned business.
- Volunteer Component - Minimum of 20 participants for clients that want this option

Evaluation Outcomes – Evaluation will include analyzing data from our HOMS data base system on employment goals and other measures to assess improvement in level of functioning. Outcome measures will include the IMR/RMQ for multiple questions regarding employment and participation in structure activities. The LOCUS will be used to monitor changes in level of care, and SATS-R will be used to assess recovery management for individuals with Co-occurring disorders.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Ramp Up 2 Work will provide an array of supported employment activities that will include consumer owned small business, and competitive employment and include job preparation and subsidized apprenticeships through the development of partnerships with businesses and employment programs. Employment preparation will include job development, job coaching and job support services with the goal of participants establishing employee own small businesses or paid competitive employment. Program aspects will also incorporate ideas of how a person can accommodate transition to employment while also maintaining a support system and participation in community activities to sustain long term employment.

The adaptation to supported employment that we will be testing includes:

- Consumer Owned Small Business, (COSB), through the acquisition of micro loans, grants or scholarships to start small business, and/or engaging volunteers/retirees as an apprentice/mentorship partner for individuals with SMI participating in the COSB. It is hoped that by introducing these adaptations to supportive employment activities consumers will increase their level of functioning, improve their quality of life and move toward self-sufficiency and long term employment.
- Subsidized apprenticeships are limited for consumers in San Diego County and as a result, we want to develop and expand through collaborations and partnerships with employers and businesses, apprenticeships in industries that have not traditionally been involved in providing apprenticeships for individuals with serious mental illness.
- Developing strategies to engage the business and employment sector
- A community-informed best practice approach to develop and identify what successful practices were used to engage the employers.

Through this innovative program, we will develop and implement above components by providing:

- Job preparation using traditional methods included in the SAMHSA's Individual Placement and Support (IPS) model of supported employment toolkit which will be utilized to assist consumers in starting their own COSB.
- Subsidized apprenticeships in industries that traditionally do not develop employment opportunities that transition to permanent employment of the client's choosing.
- Social Enterprise development as an opportunity to establish additional employment opportunities for individuals in the mental health community thereby promoting social responsibility at the local level.

This program intends to identify businesses and employment opportunities by casting a wide net in the business and employment sector not previously tapped. It is envisioned that employment apprenticeships will be identified with various business industries such as the service and tourist industry, health industry, parks and recreation and educational institutions such as community colleges throughout San Diego County.

Small business financing will also be explored with partners in the community. The program will identify and engage existing lending institutions in facilitating micro loans, grants, or scholarships for participants to assist with the establishment of small business. The program will seek lending institutions that may have in-house/philanthropic programs aligned with community and social service.

An educational component for businesses will also be included to address what mental illnesses are, the varying levels of functioning and skills and other stereotypes associated with persons who have a mental health condition. The businesses will also have opportunities to meet with consumers to address perceptions and reduce stigma and to hear success stories.

This work plan is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: The concept for this work plan was developed with community participation and supports collaboration between a number of different stakeholders that include service providers from mental health, employment specialists, peers and peer support specialists and job developers. In January 2014, a stakeholder's group was established to guide the development of a Supported Employment Strategic Plan. This group evolved from the development of the Strategic Plan to become the Supported Employment Collaborative as of September 2014.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program will develop employment opportunities that will support a range of diverse populations in order to reduce disparities in access to services and improve employment outcomes for adults, older adults, and transition age youth (TAY) with serious mental illness. Staff hired shall be linguistically and culturally competent for the population served.

Client Driven Mental Health System: This program includes the ongoing involvement of clients including but not limited to, implementation, evaluation, and future dissemination. Based on client feedback, certain strategies may be added or removed from the program and/or applied in other programs. This system will influence concepts to maintain and increase supports and community activities while transitioning to employment. Lived experience is a valued process for program development and system change.

Family Driven Mental Health System: This program will incorporate feedback from family members as requested by consumers. The intended population for this program includes Transiitonal Age Youth (TAY) through adulthood, and family involvement is determined by the program participant.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes wellness and recovery by engaging clients in a supportive work environment through an integrated approach that combines skill building activites, apprenticeship opportunities and social enterprise opportunities with high consideration for client preference.

Integrated Service Experience: This program encourages and provides for access to a full range of services provided by multiple agencies, businessess, programs and funding sources for clients ncluding mental health providers, peer supports, other health providers, and community resources. It is this collaborative approach that will create the safety net for the transition to employment be sucessfully maintained.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$1,168,170	3 Year Program Cost	$3,504,510
Evaluation Cost (5% of Total)	$61,483	3 Year Evaluation Cost	$184,449
Total Annual Innovation Funding	$1,229,653	3 Year Grand Total	$3,688,959
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

- We will learn what are the most effective ways to assist consumers with SMI to start and own their small businesses?
- Are subsidized apprenticeships for individuals with SMI an effective way to increase permanent employment for individuals with SMI.?
- Are Social Enterprises a viable way to increase employment opportunities for consumers of the mental health system?
- Are volunteers and retirees a significant mentor partner that can increase employment opportunities for consumers?
- What activities assist in developing collaborations and partnerships with un-tapped business industries? From this we will create a list of best practices.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication.

Implementation/ Completion Dates:	
09/2015	Program services begin, including Outcome Measures(IMR/RMQ at entry and every 6 months
12/2015	Begin ongoing, six-month evaluations thorugh the 3rd year. Each evaluation will inform what adjusments are necessary based on implemenation results. Milestones review will include Outcome Measures, connections with innovative employment opportunities, and number of program participants and their progress.
07/2016	First annual report and annually thereafter. The Consumer Owned Small Business (COSB) will be identiifed, and a plan for development will be in place.
01/2017	Consumer Owned Small Business (COSB) will have the self-sustaining plan identified.

At six-month intervals, the participating organizations will report results that capture participation rates, self-rating scores, observer ratings, and will include unique situations during the report period Outcome measures will include the IMR/RMQ for multiple questions regarding employment and participation in structure activities. The LOCUS will be used to monitor changes in level of care, and SATS-R will be used to assess recovery management for individuals with co-occurring disorders.

Evaluations at six-month intervals and annual reviews throughout implementation will allow the program to gather extensive baseline and follow-up information on each participant. Information on the effectiveness and impact of various strategies, especially with regard to different age, ethnic, and cultural populations, will be collected to measure program efficacy. Continuous measurement at the client and larger program level will allow for learning to occur as early as year one. Since assessment is integrated into the program design, the feasibility of replication may be determine within the first year or two of the project.

County of San Diego BHS has developed a larger employment initiative that has developed into an Employment Collaborative as of September 2014. The Employment Collaborative will provide input and feedback to the evaluations and annual reviews to provide recommendations. Other BHS Councils will be informed of ongoing progress, along with the Behavioral Health Services Board.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

The County utilizes an extensive information-sharing and collaboration process to ensure that stakeholders receive information and are able to provide feedback on MHSA programs. For this project, we will provide regular updates to our stakeholder-led TAY Workgroup as well as our Adult and Older Adult System of Care Councils, post information on our community Network of Care website, and provide opportunities for stakeholders to offer input at the program, client, family, staff, and community levels. Final reports may also be distributed to existing mental health service providers for posting.

Specific data to be gathered and evaluated includes, but is not limited to, the following:

- Steps taken by consumers to start their own small business
- Impact subsidized apprenticeships have had on consumer participants, including transition into competitive employment.
- Determine if Social Enterprises have created a viable route for consumers of the mental health system to increase their employment opportunities.
- Number and types of outreach to volunteers/retirees as an apprentice/mentorship partner for individuals with SMI that are mentors/coaches to participants in the consumer owned business.
- Employer outreach contacts for supported employment or apprenticeships and types of options available for program participants. Increase the understanding of what works to develop collaborations and partnerships with un-tapped business industries.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Participants of this program will be identified from Clubhouses and outpatient clinics in the system of care. We will work with existing community businesses and employers to develop the employment capacity for individuals with serious mental illness.

Innovation Work Plan Narrative: INN-15

Work Plan Name: Peer-Assisted Transitions
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

We believe that more solid evaluation is needed in the field of peer support for persons with serious mental illness, and propose designing a project that will add to the knowledge in the field. Peer support staffing and programs have become firmly established in our system of care since establishment of MHSA and are congruent with the practices and principles of recovery, yet the literature solidly correlating that to better outcomes or cost-effectiveness does not exist. An examination of cost in Georgia was done by Landers and Zhou ("The Impact of Medicaid Peer Support Utilization on Cost," MMRR 2014: Volume 4, Number 1), as that state has a well-established peer support system which has billed for peer support since 2001, and they identified that peer support was associated with a significantly higher total Medicaid cost, although it "…does support the principles of self-direction and recovery from severe mental illness."

The two most recent and comprehensive literature reviews of peer support using 'consumer-providers' to work with persons with serious mental illness were done by Pitt, et al ("Consumer-providers of care for adult clients of statutory mental health services," The Cochrane Library 2013, Issue 3) and Lloyd-Evans, et al (A systematic review and meta-analysis of randomized controlled trials (RCT) of peer support for people with severe mental illness," BMC Psychiatry 2014, 14:39). Their review of RCTs did not identify different symptom or service use outcomes, with the exception of some "low quality evidence that involving consumer-providers in mental health teams results in a small reduction in clients' use of crisis or emergency services (Pitt, et al).

Both reviews noted many limitations with obtaining solid findings from the reviewed studies, and noted the importance of further controlled trials. One of the cited reviews by Sledge, et al ("Effectiveness of peer support in reducing readmissions of persons with multiple psychiatric hospitalizations," Psychiatric Services 2011, 62:5) had significant limitations but did have some findings indicating that use of consumer-providers may be helpful in reducing hospitalization. Other studies by Davidson, et al (Psychiatric Services 2000; Journal of Community Psychology 2004) have pointed to the likely importance of supporting social activities to promote successful community tenure for persons who have been hospitalized. We plan to explore the possibility of establishing a RCT with this program, so that we may significantly add to the research in the field. If we are unable to establish a RCT due to research challenges, we will pursue alternative ways to evaluate data made available through this project through such means as comparison sites and pre/post-measures including items such as hospitalization and crisis house use rates.

Through the provision of peer specialist coaching incorporating shared decision-making and active social supports, this project is designed 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 not effectively connected with community resources. As many who use such the most acute services do not become effectively connected with relevant follow-up services and have limited social supports, our system has identified the need for better engagement of persons diagnosed with serious mental illness to connect with the variety of services and supports available in the community. This program is particularly focused on those persons who, in addition to needing to use hospital and/or crisis house services, have a limited social support network and are most likely to not be effectively connected with relevant services.

Priority for services will be to persons diagnosed with serious mental illness (who have Medi-Cal or are potentially eligible for Medi-Cal) who are not connected or engaged with an outpatient mental health program, Strengths-Based Case Management or Assertive Community Treatment Team program, who present at a particular crisis house or hospital, and who (in order of descending priority):

- Have been hospitalized or in crisis house at least twice in the prior year (in addition to the current visit);
- Have been hospitalized or in crisis house at least once in the prior year (in addition to the current visit);
- Persons who are homeless;
- Persons who live alone and have minimal or no contact with family or friends;
- Persons who may live with others (e.g., at a Board & Care or Independent Living setting) but have a very limited social support network.

The program will make specific use of shared decision-making tools and coaching to support and promote the person's primary decision-making role in identifying relevant services and supports and in actively planning for their discharge. The concept of shared decision-making is welcome in our system, but we have seen little use of formal resources to promote this beyond the specialized use of 'CommonGround' at our ACT programs. The program will also provide a 'Welcome Home Basket' of sundries (e.g., toiletries, plants, healthy food, resource information) to welcome persons back to their home, and provide regular social outings to help persons bridge the gap between use of acute crisis resources and community-based resources, through reducing isolation and building social relationships.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length - one page)

This project will employ Peer Specialist Coaches (PSCs) to each year serve approximately 480 adults annually (age 18+) diagnosed with serious mental illness, promoting engagement through peer support, use of 'Welcome Home Baskets' and social/recreational activities, and mentoring them through provision of shared decision-making strategies designed to help them connect with relevant services and supports. Services will be provided at a variety of sites to help identify where the best applicability is, including a primary focus on crisis residential facilities ('crisis houses'), with additional trials at a non-County-operated psychiatric hospital.

It will provide peer specialist support and active support for the person's role in discharge planning to persons at least three of the County's six crisis houses, utilizing specific strategies of shared

decision-making and social/recreational outings and, unless we are able to establish a RCT at all six crisis houses, will compare outcomes with persons at the other three crisis houses where these Innovation services were not available. The PSC will work closely with the person and the crisis house-assigned discharge planner and participate with the client in the discharge planning team to promote use of shared decision-making and ensure that the person is actively involved in his/her discharge planning process. Tracking of readmission to the crisis houses and/or psychiatric hospitals is available through the County's Management Information System, and can provide clear information about such recidivism to determine if the peer services with focused shared decision-making strategies makes a significant difference in re-hospitalization rates and number of days in the community (versus in hospital or in crisis house).

The project proposes to initially include the same type of services to persons with Medi-Cal or no health insurance at least one private psychiatric hospital, as County Behavioral Health Services has not previously provided peer support services at such a site, and will participate and work closely with the person and the hospital-assigned discharge planner to promote shared decision-making in the discharge planning process. Connection of peer staff to the current 'Transition Team,' which works to connect hospitalized persons with relevant services and which has established connections with all private psychiatric hospitals serving persons with Medi-Cal will be explored. Consideration is also being made to provide the service at a locked long-term care facility to persons who have not previously effectively connected with the more formal support services available to them upon discharge.

Average length of service is expected to be three months, with active provision of and coaching about shared decision-making, linkage to relevant community services occurring during that time, and social/recreational outings. Caseloads will be low to ensure that the service providers have sufficient time to provide highly individualized support to each person, as well as coordinating and participating in social outings with individuals and groups of persons served.

This project is informed in part by the following projects: *"The Welcome Basket Project: Consumers Reaching Out to Consumers"* (*Psychiatric Rehabilitation Journal*, Summer 2000, with phone follow-up with co-author Larry Davidson), SAMHSA's *"Shared Decision-Making in Mental Health"* (decision tools made available in 2012), *"Adding Consumer-Providers to Intensive Case Management Does It Improve Outcome" (Rivera, Psychiatric Services, June 2007), "Supported Socialization for People with Psychiatric Disabilities (Davidson, Journal of Community Psychology, May 2004)*, and *"Effectiveness of Peer Support in Reducing Readmissions of Persons with Multiple Psychiatric Hospitalizations"* (*Psychiatric Services*, May 2011).

This work plan is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: The concept for this work plan was developed from ideas and needs presented by a wide variety of community partners and service providers that support peer provision of services, shared decision-making, and the importance of social connectedness.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to serve persons diagnosed with serious mental illness through provision of services provided by persons who have first-hand experience of having been diagnosed with a mental illness. Shared decision-making strategies will further promote person-directed services and will therefore increase the cultural competence of delivered services.

Client-Driven Mental Health System: This program includes the ongoing involvement of clients in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the

program strives to create healthier individuals and families in our community through increased engagement and support of persons diagnosed with serious mental illness who have not previously become effectively engaged with helpful support systems.

Family Driven Mental Health System: This program focuses on persons who are not connected or engaged with ongoing services, and will support family values of effective engagement, support, and linkage for loved ones with serious mental illness.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes recovery and wellness for adults age 18+ diagnosed with serious mental illness and their families and friends by instilling hope through peer role models, providing social supports and recreational activities, and promoting shared decision-making.

Integrated Service Experience: This program encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients and family members. The program follows a person from the time of a mental health crisis through when they have become solidly connected with useful community supports.

The project will serve approximately 480 persons each year. Approximate staffing will include one full-time equivalent (FTE) Program Manager (licensed or license-eligible), 1.5 FTE office support staff, 2 FTE Senior PSCs (Masters or Bachelor's degree level, who will have significantly smaller caseloads and provide additional support to the PSCs), and 7 FTE PSCs.

Number of Clients to be Served: At a minimum up to 120 unduplicated clients from Crisis Residential Treatment Programs (CRTP) on an annual basis and up to 120 clients annually from one or more hospitals (with efforts to match hospitals if more than one is used).

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$1,055,877	3 Year Program Cost	$3,167,631
Evaluation Cost (5% of Total)	$55,572	3 Year Evaluation Cost	$166,716
Total Annual Innovation Funding	$1,111,449	3 Year Grand Total	$3,334,347
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length - one page)

In our review of outcomes related to peer support for persons diagnosed with serious mental illness, we have identified little if any solid research that supports any increased efficacy or cost savings through use of peer support—but much of that appears to be due to the paucity of solid research in that area. If we are able to design and implement a randomized controlled trial, we have the opportunity to make a

significant contribution to the field, as most of the previous RCTs have been small or had significant challenges. If we are unable to do this project as a formal RCT, we still will be able to evaluate and compare outcomes based on sample matching, comparison sites, and pre-post measures on key items such as hospitalization and recovery status. In addition, while there has been some limited use of specific shared decision-making tools and strategies in our system, specific tools and strategies has not regularly been a key element in most program delivery. We therefore hope to learn if incorporating a major shared decision-making element into this program, by utilizing resources such as SAMHSA's Shared Decision-Making tools and/or other shared decision-making tools (e.g., elements of the web-based application CommonGround), will result in improved outcomes in clients participating in this project versus clients in another acute setting. This will be a significant adaptation to the peer support program our County operated through an earlier Innovations program, and we believe this may be a key factor to increase such a program's impact.

We also propose that this project's focus on providing a peer coach/mentor support, 'welcome home basket', and experiences in social/recreational outings is a way to increase client engagement, improve well-being, level of functioning and promote the continuation of social activities after their involvement with this program ends. This strategy may promote engagement for those who otherwise would not be interested in such, and is also a significant adaptation to the peer support program our County operated through an earlier Innovations program.

We will learn that by comparing and contrasting outcomes for the people using this Innovations service at the crisis houses and designated hospital compared to a similar sample of people who did not use this innovations service at crisis houses and hospitals, and plan to examine both aggregate and individual outcomes.

We have had elements of peer specialist coaching provided at our County-operated psychiatric hospital, but have not used it at a privately operated psychiatric hospital. This project builds on our earlier efforts and gives us an opportunity to pilot the service at such sites, with the addition of the shared decision-making and social/recreational components, to see if it can be effectively used at such non-County-operated settings.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length - one page)

Implementation/ Completion Dates:	7/1/2016-6/30/19
07/01- 08/15/2016	This project will be encompassed within a three year period commencing on 07/01/2016. As it is a new project, the contractor will be allowed the typical 6 week start-up time to recruit, hire, and train staff and to establish an office.
08/2016- 12/30/2016	The provider will begin to work with identified community partners, which are expected to include agencies such as the County's crisis houses and the 'Transition Team.' Prior to establishment of this program, the County will have established protocol for the evaluation, which will include at least opportunities for comparison among different sites and/or pre-post comparison, and may be able to incorporate elements necessary to establish a randomized clinical trial. The program will be required to report on a number of data elements (detailed

below in the project measurement section.

01/30/2017	The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year to date, analysis of the barriers and successes of the project and recommendations based on lessons learned thus far.
07/30/2017	The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first annual report but also include results of an initial evaluation, as well as any new data elements and/or additional analyses recommended by the first report. (This date may be adjusted earlier to allow for timely contractual changes to be incorporated for year two of the project.)
01/30/2018	Follows same format of 01/30/2017
07/30/2018	Follows same format of 07/30/2017
01/31/2019	An interim report encompassing the 2.5 years of the project to date will be requested in order for the project to be considered for continued funding, sustainability via other ongoing services, or termination.
07/30/2019	A final report will be due evaluating the successes and challenges faced by the project throughout its duration and lessons learned. [Note: The evaluation component may continue past this time in order to include relevant follow-up data for persons served during the last year of the program.]

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

The following items will be tracked and measured. The project will be assessed on an annual basis and the resultant report will be made available to the County of San Diego's Adult Council, Older Adult Council, and Transitional-Age Youth Workgroup. The County's internal Performance Outcomes Team will also review the reports.

Data to be gathered and evaluated includes, but is not limited to, the following:

- Number of hospitalizations and hospitalization days
- Number of crisis house admissions and days
- Linkage with formal support services
- Number of people in a person's active social support network
- Level of recovery as measured by participant report and scale (e.g., Recovery Markers Questionnaire)
- Level of recovery as measured by provider report and scale (e.g., PHQ-9, IMR)
- Client input, including focus groups, about shared decision-making element of the project
- Client input, including focus groups, about the 'welcome home basket' element of the project
- Client input, including focus groups, about social/recreational activities element of the project
- Other outcomes as indicated by stakeholders during the review process

Monitoring, Data Collection, Outcomes and Evaluation

- Explore obtaining expert consultation from specialist in trial design to test effectiveness of mental health services delivered at both the individual and institutional level and pursue possibility of establishing a RCT. If RCT is not possible, identify alternate best ways to obtain meaningful comparison data to analyze likely program effects on client outcomes and costs.
- Monthly/Quarterly Reports, including number of potential participants to whom engagement efforts were made, and number of persons enrolled in the program
- Yearly report beginning with year 1
- Evaluation of outcomes – Identify outcomes to be tracked per INN guidelines
- Determine role of QI

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

We plan to work with our Crisis House contractor to ensure that the services can be provided at and integrated into at least three of their six Crisis Houses. Project staff will work closely with the Crisis House staff, particularly with the assigned discharge planner, to promote use of shared decision-making in treatment and discharge planning.

We also plan to negotiate with our Transition Team contractor and at least one private psychiatric hospital about best ways to provide these services to some of their clients, and plan to link these services with other related services such as hospital discharge planning.

The project will work closely with existing Clubhouses, as those are excellent resources to support some persons' interests in social and recreational activities.

We will work closely with existing or new programs that share some elements with this program to ensure that duplication does not occur.

Innovation Work Plan Narrative: INN-16

Work Plan Name: Urban Beats
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Transitional Age Youth (TAY) are difficult to engage and retain in traditional models of mental health treatment, which impacts their engagement in services which often negatively impacts their outcomes. The field recognizes that "the most effective program models are those that address the personal, familial, and societal variables that are essential to healthy transitional age development and are community based. These programs help the transitional age youth in developing increased personal competence and connectedness to pro-social elements of a larger community" (California Institute for Mental Health (CIMH); 2005). While there are Evidence Based Practices regarding music therapy, there is little to no research on engaging and retaining TAY via multiple models of artistic expression in the mental health system thereby improving outcomes. This innovation will meet the community need with an adaptive model and inform literature on how to improve TAY outcomes via successful engagement. This project is an adaptation to existing similar programs and it is designed to test whether a culturally sensitive program that focuses on engagement via multiple models of artistic expression is successful at engaging severely mentally ill TAY that are currently enrolled in behavioral health programs as well as at-risk TAY who show existing or emerging diagnostic characteristics consistent with early onset of SMI. These TAY are unserved or underserved due to their lack of consistent engagement in traditional treatment. The at-risk TAY wil complete a pre and post risk assessment while TAY with diagnosed SMI who are opened to a behavioral health treatment program will be assessed for level of impairment with a tool such as MORS both at the initial engagement and post participation in this model. The program will focus on improving the quality of services, from the TAY perspective, by serving African American and Latino TAY in the Central Region of San Diego. With increased quality of service via TAY friendly engagement strategies, we anticipate that outomes will improve. Unique to this adaptation is engaging SMI and at-risk TAY via artistic mediums to both receive and deliver messaging thereby reducing stigma, increasing participation in needed behavioral health services and producing improved outcomes.

Additionally, stakeholders expressed that TAY have long been difficult to engage and retain in mental health services. This approach provides wellness activities and messaging in an innovative way that proposes to reach TAY who otherwise would remain disconnected from or prematurely leave our system of care. Stakeholders also expressed that urban TAY often encounter stigma within their community regarding both accessing and maintaining behavioral health services. TAY often report feeling a disconnect from traditional services and the people providing them.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (Suggested length - one page)

Urban Beats focuses on engagement that includes the use of multiple models of artistic expression including visual arts, spoken word, music, videos and performances created and developed by TAY who are clients of the mental health system (SMI) or at-risk of mental health challenges, to improve their engagement in quality services and access to services while reducing stigma and improving outcomes to this underserved population. This model seeks to deliver a customized service to youth created by TAY with a serious mental illness (SMI) and at-risk TAY who incorporate their message into TAY friendly social media and artistic expression that creatively combines therapeutic, stigma reducing, cultural expression and social justice messaging to the TAY community. This innovation seeks to improve outcomes by enhancing empowerment, increasing participation and/or accessing quality treatment/services, increasing level of funcitioning, and reducing stigma, in this often difficult to engage population.

This innovative approach is an adaptation to existing similar efforts that will include SMI TAY receiving services in the mental health system and Transition Age Youth who are at-risk for mental illness and who will be selected to participate in the creation and development of the social media artistic expressions. Urban Beats will be a strength based, culturally sensitive, trauma informed, artistic approach to social work practice with the adaptation of focusing on urban SMI and at-risk TAY, with an emphasis on African American and Latino TAY. The program will utilize different types of popular youth culture to promote quality TAY behavioral health among TAY participating in existing mental health programs and at-risk TAY who are resistant to more traditional forms of mental health messaging and treatment by providing a safe zone where various modes of artistic expression can be used to reduce stigma and gain access to or knowledge of behavioral health needs and services within the community. This model also seeks to promote and facilitate inter-agency collaboration both within the behavioral health system and the community as a whole. Urban Beats will be creating/facilitating artisistic expressions such as music, spoken word, movement, dance, art, performance and social media developed and created by TAY in existing mental health services to engage both SMI and at-risk urban youth.

Via this artistic medium, it is hoped that TAY will be drawn to quality TAY services and improve their outcomes by enhancing their knowledge of and access to services and reducing stigma attached to both having mental health conditions and receiving services. This program will also provide culturally responsive trauma informed care for marginalized youth fostering self-worth, dignity, healthy relationships, and healing among youth and their communities.

Program Components:

- Staffing representative of the TAY to be served and who have artistic and/or behavioral health experience
- Outreach and education of programming/referrals to mental health providers of TAY in the Central Region

- Engage at minimum 600 TAY annually by exposing them to parcipate in showings or performances either in person or via social media
- At a minimum, 3 TAY groups (composed of TAY consumers, non-consumer TAY, program staff) will be established to develop and create the scripts, the medium and the message for the selected activities/performances.
- Create youth leaders within the urban TAY community that are either currently receiving services in the mental health system or at risk of behavioral health conditions. Social marketing and outreach to both SMI and at-risk TAY.
- Use of social media, performances, messages, YouTube, Spoken Word to dissimanate information about mental illness, mental health, wellness and resource information in a way that reduces effects of untreated mental illness in TAY.
- Foster self-worth and healthy relationships among SMI TAY receiving mental health services and at risk youth and their community.
- Provide behavioral and whole health promotion and prevention services to diverse TAY populations.
- Increase access to and knowledge of wellness including physical, behavioral, spiritual and mental wellness.
- Measure outcomes of TAY both at engagement and completion of program

This work plan is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: The concept for this work plan was developed with community participation and supports collaboration between different service providers from the mental health, peer and family support and community partners such as schools, community centers, faith communities and our TAY Workgroup representatives.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program will determine which methods of peer engagement and support are most effective for this diverse population in order to reduce disparities in access to services and improve outcomes for TAY with serious mental illness. Staff hired shall be linguistically and culturally competent for the population served.

Client Driven Mental Health System: This program includes the ongoing involvement of TAY clients in roles such as, but not limited to, implementation, evaluation, and future dissemination. Based on client feedback, different strategies may be added or removed from the program and/or applied in other programs.

Family Driven Mental Health System: This program will include ongoing involvement of TAY family members, if the TAY gives permission for said involvement. Engaged family members will be involved in activities including but not limited to implementation, evaluation and future dissemination. Family members will also provide feedback that may inform different strategies or augmentations to the orgininal model.

Wellness, Recovery and Resilience Focus: This program focuses on reducing stigma via TAY to TAY messaging, increases resilience and promotes recovery and wellness for Transition Age Youth who have a serious mental illness or are at risk through an integrated approach that combines artistic expression and social media that provides increased knowledge of mental health counseling and

treatment, physical health wellness and education, trauma prevention, and social and independent skill-building activites.

Integrated Service Experience: This program encourages and provides access to a full range of TAY services provided by multiple agencies, programs and funding sources for clients and family members including mental health providers, peer supports, other health providers, and community resources. The overall objectives of this program is to evaluate if the creation and expression of multiple artistic models by TAY with serious mental illness or at risk TAY promotes wellness, reduces stigma and increases access to services for TAY in urban settings.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$383,677	3 Year Program Cost	$1,151,031
Evaluation Cost (5% of Total)	$20,194	3 Year Evaluation Cost	$60,582
Total Annual Innovation Funding	$403,871	3 Year Grand Total	$1,211,613
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (Suggested length - one page)

TAY can be difficult to engage and maintain in traditional forms of treatment. Artistic expression through a social/community model has been successful in engaging typical (not SMI or at-risk of SMI) TAY. This Innovation work plan is an adaptation to existing approaches as it combines multiple artistic expressions to engage SMI TAY who are receiving mental health services and at-risk TAY who may need access to care to maintain or achieve wellness. This work plan is unique in that it encourages SMI and at-risk TAY to share their stories and experiences through a process of creating music, dance, spoken word, and/or creative expression while promoting positive mental health/wellness, well-being and connection among TAY utlizing performance and social media.

We seek to learn if this adapted application/approach is successful at engaging SMI and at-risk TAY in wellness and recovery by improving the quality of engagement and retention in treatment with an improved outcome. We hope to learn how the strategies in this program will lead to increased participation in services, decreased stigma and isolation thereby improving outcomes for TAY. This model will help us learn whether engaging TAY in a youth friendly and artistic manner improves outcomes by enhancing wellness, coping strategies,access to care, ILS, and ability to socialize in a positive healthy manner, while imparting a message of wellness to other TAY. Learning will also focus on whether youth artistic messaging engages this TAY population in services and is a bridge to well-being. We will also learn if the purposeful integration of elements of artistic expressions and culture facilitated in a therapeutic setting increases access or acceptance of services and increases the level

of functioning by participating in meaningful activities. The Behavioral Health system in San Diego will learn if this unique segment of the TAY population benefits from engagement from an artistic social expression perspective which can then improve their participation in and outcomes associated with treatment. We also hope to learn if this model is effective in increasing knowledge of mental health treatment and increasing access to care while building a stronger sense of community. We will learn which program components are necessary for successful implementation and effectiveness. This program will provide our system of care with an opportunity to evaluate alternative strategies that can be integrated into our traditional TAY service array and used to engage SMI and at-risk TAY in mental health servcies more consistently and effectively. This model will also test if providing a safe and age appropriate, supportive space for SMI or at-risk TAY to share their stories, experiences and healing through processes of creating music, spoken word, dance and creative expression improves their well-being and connection.

If the program is successful, it will impact the direction of engagment and treatment for TAY who are at risk of SMI or who have a serious mental illness in other Adult and Children's in our communities. The successful techniques from this program will broaden the array of engagement and retention services available for clients in our system of care. Our learnings will be disseminated formally on our system of care network, councils, stakeholders and TAY collaboratives to effectively communicate learnings to improve TAY quality of services and outcomes.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (Suggested length - one page)

Implementation/-Completion Dates:	This Innovations program will begin on 07/01/2015 and operate for three consecutive years ending on 06/30/2018. The contractor will engage in start-up activities for six (6) weeks to include staff recruitment, hiring, training and establishment of a physical office.
10/14-6/15	Program contract procurement process will begin in October and commence after a Source Selection Committee approval in June 2015.
6/15	The contract will be publically awarded to winning respondent and start-up activities will begin.
8/15-12/15	Services begin as per the Statement of Work including but not limited to outreach, marketing and collaboration with TAY programming in the Central Region. Referrals will be received and screened for groups and performances. Pre-intervention measurements will be given.
1/30/16	A semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year to date and detail an analysis of any barriers, successes and recommendations based on the first 6 months.

7/16 through 2018	Annual evaluations completed and reviewed by Behavioral Health Services to review effectiveness of program specific to target population and planned interventions. (Annual evaluations of program to be provided annually for the 3 years of the program)
05/18-08/18	Evaluation by Behavioral Health Services to determine, results and feasibility of integrating into existing programs or replication. Results to be disseminated at the conclusion of the evaluation.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

In order to measure the impact of this intervention, this project proposes to follow and assess clients over a three-year period of time. Evaluations will be conducted at six (6) months and at the end of years one, two and three to determine learnings and idenfity any modifications that need to be made to the model. At monthly intervals, the contractor will report results that capture participation rates, self-rating scores, observer ratings, measurable outcomes and possibly school functioning reports.

Evaluations at monthly intervals and annual reviews throughout implementation will also allow the program to gather extensive baseline and follow-up information on each participant. Information on the effectiveness and impact of various strategies, especially with regard to different age, ethnic, and cultural populations will be collected to measure program efficacy.

Also evaluated will be TAY engagement and participaton, increased knowledge of or access to services, reduced stigma and increased community engagement and support. Continuous measurement at the client and larger program level will allow for learning to occur as early as year one. Since assessment is integrated into the program design, the feasibility of replication may be determined within the first year or two of the project.

Community TAY Stakeholders will be engaged to provide feedback to the program routinely as part of the programs outreach efforts. These Stakeholders will also be involved in the review of the annual evaluation of this program and will provide feedback that will be deliverd and implemented if appropriate. This stakeholder collaboration and evaluation will include clients and staff at participating site(s).

Specific data to be gathered and evaluated includes, but is not limited to, the following:

- Number of SMI or at-risk TAY who's access to services has improved/increased
- Number of SMI TAY with who's level of impairment improved (e.g. MORS)
- Number of at-risk TAY who's risk assessment/level improved
- Number of TAY who demonstrate reduced stigma via pre and post-test
- Number of SMI and at-risk TAY who have an increased knowledge of how to access care
- Number of TAY who have an increased knowledge of whole health
- Number of TAY who report a positive impact from the artistic expression model
- Client, family, community and staff satisfaction surveys
- Number of TAY who show improved social functioning/connectedness
- Other outcomes as identified by stakeholders prior to the final review process.

The County of San Diego utilizes an extensive information-sharing and collaboration process to ensure that stakeholders receive information and are able to provide feedback on MHSA programs. For this project, we will provide regular updates to our stakeholder-led Children's and Adult Councils, as well as the TAY Workgroup. Information will be posted on our community Network of Care website, and provide opportunities for stakeholders to offer input at the program, client, family, staff, and community levels. Final reports may also be distributed to existing mental health service providers for posting.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

SMI and at-risk TAY in one or more outpatient mental health programs will be sought out to participate in Urban beats thereby leveraging current traditional outpatient services with this new program. In addition existing media production companies will be invited to participate to inform the development of this program.

Innovation Work Plan Narrative: INN-17

Work Plan Name: Innovative Mobile Hoarding Intervention Program "IM HIP"
County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

☐ INCREASE ACCESS TO UNDERSERVED GROUPS
☒ INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
☐ PROMOTE INTERAGENCY COLLABORATION
☐ INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

There is very little research about hoarding behaviors in older adults; nevertheless, it is well known that late life hoarding is a serious psychiatric and community problem that deserves considerable attention.

Hoarding is more prevalent in older than younger age groups. Initial onset of hoarding symptoms is believed to occur in childhood or adolescence with a chronic and progressive course throughout the lifespan; increasing in severity with every decade of life. Thus, older adults experience very serious levels of hoarding. This increase in hoarding symptoms is particularly interesting given findings of decreased prevalence of other psychiatric disorders in late life. Other than dementia, hoarding may be the only psychiatric disorder that actually increases in severity and prevalence throughout the life course.

Hoarding is particularly dangerous for older persons, who may have physical and cognitive limitations. Basic functioning in the home may be impaired as the acquisition of items piled up in various rooms prevents the use of the rooms intended function. One study found that 45% could not use their refrigerators; 42% could not use their kitchen sink; 20% could not use their bathroom sink; and 10% could not use their toilet. Hoarding can present a physical threat due to fires, falling, unsanitary conditions, and inability to prepare food. Many suffer from great social impairment due to the unwelcoming state of the home. Most seniors live on a fixed income and suffer from financial problems due to paying for extra storage space; purchasing unneeded items, or housing fires. Older adults are at risk for eviction or premature relocation to less desirable housing.

(Adapted from an article about Hoarding in Older Adulthood by Catherine R. Ayers, Ph. D. ABPP on the website of the International Obsessive Compulsive Disorders Foundation)

The proposed Innovative Mobile Hoarding Intervention Program's (IM HIP) primary essential purpose is to increase quality of services, including better outcomes, by testing a proposed intervention practice to determine its effectiveness and replication to decrease hoarding behaviors of older adults. The mobile nature of the project will increase access to services for a population of older adults who tend to be isolated and who have many times lost their social contacts and family connections due to the hoarding behaviors. The promotion of interagency collaboration will also be a result of this project. Project staff will be working collaboratively with referring or servicing agencies such as Code Enforcement; local Fire Departments; Aging and Independence Services; Animal Services; Vector Control; and/or various Home Health and Mental Health providers who may already have varying degrees of awareness and involvement with these at risk seniors. Family members will also be encouraged to refer their loved ones.

The eligible population will be uninsured, Medi-Cal and or Medi-Cal/Medicare beneficiaries who are 60 and older who meet medical necessity criteria for psychiatric conditions.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (Suggested length - one page)

This work plan is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Program Description:

This approach diminishes hoarding behaviors long term in older adults by utilizing an approach such as combining an adapted cognitive behavior rehabilitation therapy with hands on training and support. Participants will learn skills to reduce anxiety and depression related to hoarding behaviors; reduce acquisition of excess items; and practice organizing and discarding items so that all rooms in the home have safe and unimpeded egress; and a particular room in their home can once again be used for its intended function. Example: A bedroom has a bed that can be slept in; a kitchen can be used to prepare a meal; store food and wash dishes; or a living room can be used to relax in and entertain visitors.

- The team will consist of specially trained professionals, clinicians and peers. Participants who require psychiatric medication will be linked to appropriate mental health providers. This program will collaborate with the participant's other health providers.
- An added component is Older Adult Prescription/Alcohol Misuse screening, education, and referrals.
- An aftercare support group will be developed to help participants maintain the skills learned and continue to apply them.

Components:

- Outreach and education about the program to; review of referrals from; and collaboration with: mental health providers, primary care, Aging and Independent Services, Psychiatric Emergency Response Team (PERT), Fire Dept., Vector Control, Code Enforcement, Animal Services, private fiduciaries, professional organizers, etc. Referrals also accepted from family members.
- Screening and hoarding baseline established by Clutter scales and/or other hoarding measures
- Screening, Brief Intervention and Referral to Treatment (SBIRT) for Older Adult Prescription/Alcohol misuse
- Home-based Exposure/sorting therapy along with adapted Cognitive Behavior Therapy
- After-care support group to maintain acquired skills
- Psychoeducation components developed from following possible models such as:
    - 24-26 weeks of Cognitive Rehabilitation and skill building
    - "Buried Treasure" curriculum (Help for Compulsive Acquiring, Saving & Hoarding)
    - 15 week support group, graduates become "action group" which follows with intense 8 weeks of active de-cluttering with a clutter buddy

Community Collaboration: The concept for this work plan was developed with participation from older adult stakeholders who are part of the County's Older Adult Council. This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, outreach, implementation, evaluation, and future dissemination. Peer Staff will be part of the outreach and treatment team. Ultimately, the program strives to create healthier older adults in our community who will not be facing the threat of displacement from their homes or apartments due to hoarding behaviors.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to the older adult population by employing a diverse workforce to relate to the multiple ethnicities residing in the primary target region where services are to be provided.

Client and Family Driven Mental Health System: This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Based on client and family feedback, certain strategies may be added or removed from the program and/or applied in other programs. This system will influence concepts to maintain and increase supports and community activities.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes recovery and wellness for an older adult population at risk of homelessness and physical decline due to safety and sanitary risks associated with compulsive acquisition. The seniors in this project will learn new skills and insight to manage their hoarding behaviors by reducing clutter in their homes; improving safe access throughout the home; improving social interaction by making their home's appearance more welcoming and by participating in an aftercare group which will also support maintenance of new skills. Seniors will also be educated about the proper use of prescribed medication and safe drinking practices for seniors.

Integrated Service Experience: This program encourages and provides for access to a full range of services provided by multiple agencies, programs and funding sources for clients. The program will screen all referrals for mental health and substance use disorders and work to link clients to appropriate services while working to engage qualified clients for the hoarding interventions provided directly by this project. Clients will be educated about the range of services available for which they are qualified and linked.

Number of Participants to be Served

Minimum 100 referrals and 30 participants at a minimum treated on an annual basis

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	$421,774	3 Year Program Cost	$1,265,322
Evaluation Cost (5% of Total)	$22,199	3 Year Evaluation Cost	$66,597
Total Annual Innovation Funding	$443,973	3 Year Grand Total	$1,331,919
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (Suggested length - one page)

Barriers: Challenges include that the person who hoards typically does not seek treatment for their condition even if there is a crisis related to the behavior such as safety, sanitary or homelessness risks. There's also a lack of financial resources to pay for clean out services for low income persons even when they are willing to engage such a service. There is also a lack of awareness and reporting from those who might be able to identify persons with at risk hoarding behaviors before a crisis develops which would allow the time required for significant improvement to be demonstrated. Furthermore, there are also few trained professionals that have specialized expertise in this area for any adult much less seniors. Even fewer are willing or able to make house calls to coach individuals to de-clutter and/or teach them new skills to manage compulsive hoarding. Once identified and the individual wants to change, diminishing hoarding behaviors takes commitment from providers and is time intensive to implement.

Learning: This project is expected to add new learning to the mental health field on effective practices to abate hoarding behaviors in older adults. Research on treatment models for hoarding behaviors is relatively new and there's limited knowledge (usually single case studies) on how to effectively treat the condition in older adults particularly those with serious mental illness. Studies by Dr. Catherine Ayers show that effective hoarding interventions for older adults require specialized training such as adapted Cognitive Behavior Therapy/cognitive restructuring along with home-based coaching. This has not been tested in the field as yet.

Implementing this project over a three year period will invite a promising practice to be field-tested for effectiveness with older adults and hopefully introduce a new practice or approach that can be replicated with similar populations in other locations.

Learning Goals & Objectives:

- What is an effective model to treat hoarding behaviors in Older Adults with serious mental illness?
- What are the most effective ways to engage a senior to participate in interventions geared for hoarding behaviors?
- Are peer supports effective with seniors who have hoarding behaviors either individually and/or as part of an aftercare support group?

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (Suggested length - one page)

Implementation/ Completion Dates:	7/1/2015 - 6/30/2018
07/01- 08/15/2015	This project will be encompassed within a three year period commencing on 07/01/2015. As it is a new project, the contractor will be allowed the typical 6 week start-up time to recruit, hire, and train staff and to establish an office.
08/2015- 12/30/2015	The next step will be outreach and marketing to likely referral sources which include regulatory agencies mentioned earlier in this document; many of whom attend an already established task force- the San Diego Hoarding Collaborative. It will be imperative to screen all referrals appropriately as there is considerable demand for these services by agencies frustrated by the barriers they face when seeking solutions to various hoarding situations. Seniors eligible for these services must be determined to have the capacity to learn even if the insight and desire is lacking. Seniors with cognitive decline or such major medical conditions that they cannot physically engage in the intervention process will not be eligible and will need to be referred elsewhere. While these services will be offered to eligible seniors residing in the Central Region of the county, provision will be made in the contract to accept eligible referrals from adjacent regions if sufficient enrollments cannot be generated at the six month milestone of the project. The contract will request at least 100 seniors to be contacted annually with at least 30 unique individuals meeting criteria enrolled and treated annually. The program will be required to report on a number of data elements (detailed below in the project measurement section) including outreach efforts and enrollments via monthly meetings and reports.
01/30/2016	The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year to date; analysis of the barriers and successes of the project and recommendations based on lessons learned thus far.
07/30/2016	The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first annual report but also include results of a consumer survey; as well as any new data elements and/or additional analyses recommended by the first report. (This date may be adjusted earlier to allow for timely contractual changes to be incorporated for year two of the project.)
01/30/2017	Follows same format of 01/30/2016
07/30/2017	Follows same format of 07/30/2016
01/31/2018	An interim report encompassing the 2.5 years of the project to date will be requested in order for the project to be considered for continued funding; sustainability via other ongoing services or termination.

07/30/2018	A final report will be due evaluating the successes and challenges faced by the project throughout its duration and lessons learned.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

The following items will be tracked and measured. The project will be assessed on a semi-annual basis and the resultant report will be made available to the County of San Diego's Older Adult Council, composed of older adult stakeholders, for review and questions. The County's internal Performance Outcomes team will also review the reports.

Outcomes

- Number of community participants outreached
- Number of community participants enrolled in program
- Number of reduced hoarding related evictions
- Reduce mental health symptoms, compulsive behaviors, and substance use
- Improve safety of senior participant by reducing clutter that poses trip danger, fire and pest infestation potential, unhealthy sanitation and other hazardous conditions
- Improve quality of life as measured by participant report and scale
- Reduced clutter as evidenced by improved scores on clutter scales (example: recovered a room for intended use) at conclusion of treatment as well as 30, 90, 180 days f/u
- Improved quality of life as evidenced by client self-reporting (QOL measure;1 page)
- Improved mental health by Milestones Of Recovery Scale (MORS) or other measure- Recovery Markers Questionnaire (RMQ)

Monitoring, Data Collection, Outcomes and Evaluation

- Monthly/Quarterly data tracking reports
- Semi-annual data tracking; analysis and recommendation reports
- Evaluation of outcomes – Identify outcomes to be tracked per INN guidelines
- Determine role of QI
- Determine if Evaluation is to be sourced out and included in the budget.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

This project will not provide **psychiatric medication services**. Enrollees who require medication services will be linked with their health or County mental health providers; this program will collaborate with these providers.

Potential enrollees who are found to be in need of **urgent housing** will be linked to housing services via 211 or County mental health full service partnership programs, if appropriate.

Those seniors who are in need of **substance use services** will be linked to County contracted substance use providers.

Others:

Legal assistance- Legal Aid Society of San Diego, Inc.

Benefits- Family Resource Centers; Social Security Administration; SSI Advocates at mental health Clubhouses

Case or money management- County contracted services; Aging and Independence Services; or private fiduciaries

Others services will be leveraged as needs develop.

APPENDIX D – OUTCOMES REPORTS

MHSA CSS: UNDUPLICATED CLIENTS FISCAL YEAR 12-13
Run Date: July 9, 2013

There may be some variance in some of the unique unduplicated client numbers calculated in the MHSA Fiscal Year 2014-15 through Fiscal Year 2016-17 Program and Expenditure Plan section of this report because several of the programs that served clients in FY12/13 are no longer in existence. Therefore, the unique clients from the programs that are no longer in existence are not included in the FY14/15 cost per client projections. In addition, several of the programs below serve children, transition aged youth, adults and older adults so there may be variances between the unduplicated client numbers below and the MHSA Fiscal Year 2014-15 through Fiscal Year 2016-17 Program and Expenditure Plan section of this report because the unique clients served within each age group and the associated costs were included with that age group when determining cost per client.

ID	Work Plan Name	Contractor Program Name	FY 12-13 Program Unduplicated	FY 12-13 Total Unduplicated
CY-FSP	Children and Youth Full Service Partnership	Harmonium FYPP	89	2,683
		County Southeast Clinic	69	
		SDYS Counseling Cove	185	
		NA TBS	199	
		Fred Finch Wraparound Eff. Q2	434	
		CRF CARE	145	
		CRF Crossroads CM FSP	177	
		CRF Crossroads AD Counselor	39	
		CRF Douglas Young CM	151	
		CRF Douglas Young AD Counselor	47	
		CRF Nueva Vista CM	118	
		CRF Nueva Vista Rady Central Clinic	30	
		Rady Central Clinic FSP	225	
		Rady CES School FSP	147	
		Rady N Coastal Clinic FSP	401	
		Rady N Inland Clinic FSP	113	
		SYHC YES CM FSP	13	
		SYHC YES AD Counselor	17	
		UPAC CTC CM FSP	32	
		UPAC AD Counselor	17	
		SDUSD Unified Day Rehab FSP	9	
		SDUSD Outpatient FSP	26	

ID	Work Plan Name	Contractor Program Name	FY 12-13 Program Unduplicated	FY 12-13 Total Unduplicated
CY-OE	Children and Youth Outreach & Engagement	CRF Crossroads	31	1,551
		CRF Douglas Young	83	
		CRF Nueva Vista	178	
		FHC Central	98	
		FHC East	80	
		MHS School-Based	26	
		NC Lifeline Oceanside	13	
		NC Lifeline Vista	32	
		PFC Fallbrook	99	
		PFC NI/Coastal	137	
		Providence Cornerstone	24	
		Rady N Coastal	47	
		Rady N Inland	14	
		SAY Marshall	1	
		SBCS	18	
		SDCC East	30	
		SDUSD MHRC OP	6	
		SDUSD IY	82	
		SDYS East	40	
		SYHC BHG	160	
		UPAC CENTRAL MHSA	14	
		UPAC NORTH MHSA	7	
		VH Escondido	47	
		VH N Inland	28	
		YMCA TIDES	131	
		CRF MAST	125	

MHSA CSS: UNDUPLICATED CLIENTS FISCAL YEAR 12-13
Run Date: July 9, 2013

ID	Work Plan Name	Contractor Program Name	FY 12-13 Program Unduplicated	FY 12-13 Total Unduplicated
CY-SD	Children and Youth Outreach & Engagement	FYRT	N/A	3,108
		SDYS-FYPSS	93	
		New Alternatives- CAC	83	
		Rady Walk-in Assess	407	
		New Alternatives- ESU	889	
		Vista Hill Juv. Court Clinic	146	
		Phoenix House	45	
			41	
		PFC Child Net	163	
		FFYC Placement Stabilization/CASS	215	
		NA San Pasqual Academy	9	
		Vista Hill Found- Incredible Families	90	
			83	
		SDCC Clark	22	
		Juvenile Forensics Services	431	
			82	
		SDCC Multi Dimensional Treatment Foster Care	14	
		SDCC Multi Dimensional Treatment Foster Care (mtfc-p)	12	
		SD Unified School District - MST- ACT	283	

MHSA CSS: UNDUPLICATED CLIENTS FISCAL YEAR 12-13
Run Date: July 9, 2013

ID	Work Plan Name	Contractor Program Name	FY 12-13 Program Unduplicated	FY 12-13 Total Unduplicated
TAOA-FSP	Transition Age Youth, Adult & Older Adult Full Service Partnerships	CRF Downtown Impact FSP	322	4,374
		CRF Maria Sardinas - Case Management	140	
		CRF South Bay Guidance - Case Management	157	
		MHS, Inc. Case Management North	201	
		MHS North Star ACT FSP	113	
		CRF Impact FSP	275	
		County Institutional Case Management	473	
		Telecare ACT In-Reach for long-term care	232	
		Telecare ACT Long-Term Care	172	
		ECS Safe Haven	19	
		MHS Center Star ACT FSP	156	
		PCS Catalyst	275	
		MHS Vista Clinic YTP TAY	44	
		Telecare Transition Team	510	
		Telecare ACT	343	
		Alpine Starting Point TAY DUAL DX/TX PROGRAM	61	
		Casa Pacifica Transitional Residential	41	
		CRF Senior IMPACT	145	
		Telecare - Agewise SBCM	308	
		Telecare - Agewise Institution	387	

ID	Work Plan Name	Contractor Program Name	FY 12-13 Program Unduplicated	FY 12-13 Total Unduplicated
TAOA-SD	Transition Age Youth, Adult & Older Adult System Development	RI-COPSS	2,209	34,140
		NAMI-FES	311	
		API DISCOVERY	379	
		CRF-EASTCORNER	1,038	
		CRF-CASADELSOL	930	
		CRF-VISIONS	714	
		CRF-CORNER	1,227	
		CRF-ECS-FRIEND2FRIEND	600	
		MHS-ESCONDIDO	536	
		MHS-MARIPOSA	631	
		NHA-FRIENDSHIP	436	
		PVH-BAYVIEW	280	
		TMP-MEETINGPLACE	346	
		UPAC-EASTWIND	619	
		MHS (UPAC) - Employment Solutions	251	
		Jewish Family Services	1,766	
		PCS-OASIS	542	
		UPAC Midtown Center	19	
		UPAC East Wind Clinic	5	
		UCSD Gifford Clinic	1,201	
			139	
			250	
		NHA Project Enable TAY	73	
		CRF Heartland Center TAY	163	
		MHS Kinesis N Escon TAY	54	
		MHS Vista Clinic TAY	39	
		CRF Douglas Young TAY	96	
		CRF SB Guidance TAY	135	
		CRF A. Crowell TAY	91	
		CRF MSC TAY	123	
		UPAC Midtown Center	393	
		NHA Project Enable	680	
		MHS Kinesis N Escondido	324	
		MHS Kinesis N Fallbrook	69	
		MHS Kinesis N Ramona	60	
		MHS BPSR Vista	383	
		MHS North Inland MHC	942	
		MHS North Coastal MHC	1,129	
		CRF Douglas Young Clinic	567	
		(cell left blank intentionally)		

		CRF SBGC	673	
			40	
		CRF A Crowell Center	526	
		CRF Jane Westin Center	1,832	
		FHC Logan Heights	201	
		Heartland	476	
			89	
		CRF MSC WRC	553	
			38	
		LEGAL AID SOCIETY OF SD	149	
		Exodus Recovery Walk-in	1,312	
		Exodus Recovery Escondido	541	
		Warmline	7,960	
ALL-OE	All Ages Outreach & Engagement	Deaf Community Services - Recovery/Activity Center	63	957
		Deaf Community Services (A)	46	
		Deaf Community Services (C)	5	
		Survivors of Torture (A)	79	
		Survivors of Torture (C)	12	
		Community Clinics Health Network-PCI-MHSA-A	566	
		Community Clinics Health Network-PCI-MHSA-OA	81	
		Community Health Clinic Network-PCI-MHSA-C	22	
		Vista Hill SmartCare Integrated Behavioral Health	83	
ALL-SD	All Ages System Development	*Interpreters Unlimited	1,850	5,798
			1,513	
		PERT	2,204	
		Chaldean/Middle Eastern (A)	211	
		Chaldean/Middle Eastern (C)	20	

***Interpreters Unlimited will include significant duplication due to the fact that they provide services to clients of other MH programs.**

All numbers from Optum Admissions and Discharge Census (ADC) Report except those shaded in red. Those numbers come from the Monthly Service Reports and the Quarterly Service Reports.

Full Service Partnerships
OUTCOMES REPORT

Children, Youth & Families FSP Summary

FY 2012-13

What is This?

Full Service Partnership (FSP) programs are comprehensive behavioral health programs which provide all necessary services and supports, including intensive services, to clients with a high level of need to enable them to live in their community. Services may include in-home and community-based intensive case management to provide support and assistance in obtaining such services as benefits for low-income families, health insurance, parent education, tutoring, mentoring, youth recreation, and leadership development. FSPs may also assist with connections to resources such as physical health services, interpreter services, and acquisition of food, clothing, and school supplies.

Why Is This Important?

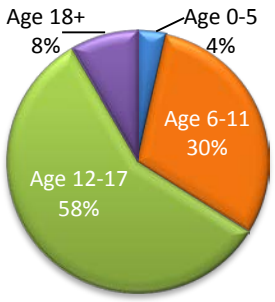
FSP programs support individuals and families, using a "whatever it takes" approach to establish stability and maintain engagement. The programs build on client strengths and assist in the development of abilities and skills so clients can become and remain successful. They help clients reach identified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

Who Are We Serving?

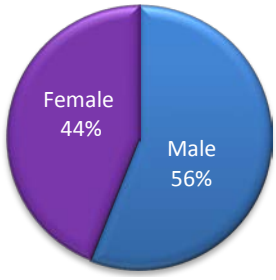
In Fiscal Year (FY) 2012-13, 2,494 unduplicated clients received services through 18 FSP programs, a 41% increase from the number of FSP clients served in FY 2011-12 (N=1,768).

FSP Client Demographics and Diagnoses (N=2,494)

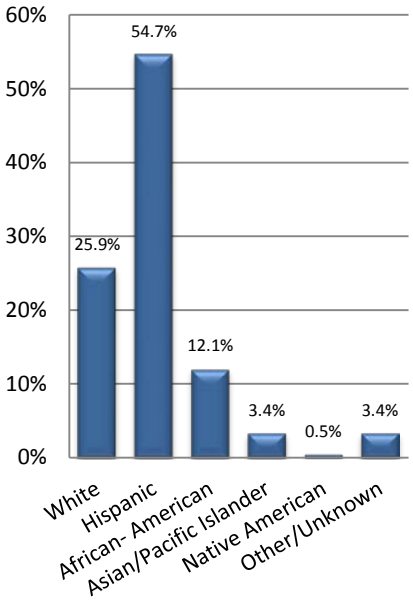
AGE



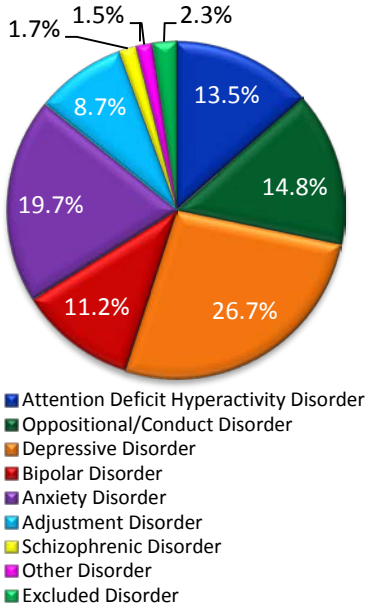
GENDER



RACE/ETHNICITY



PRIMARY DIAGNOSIS

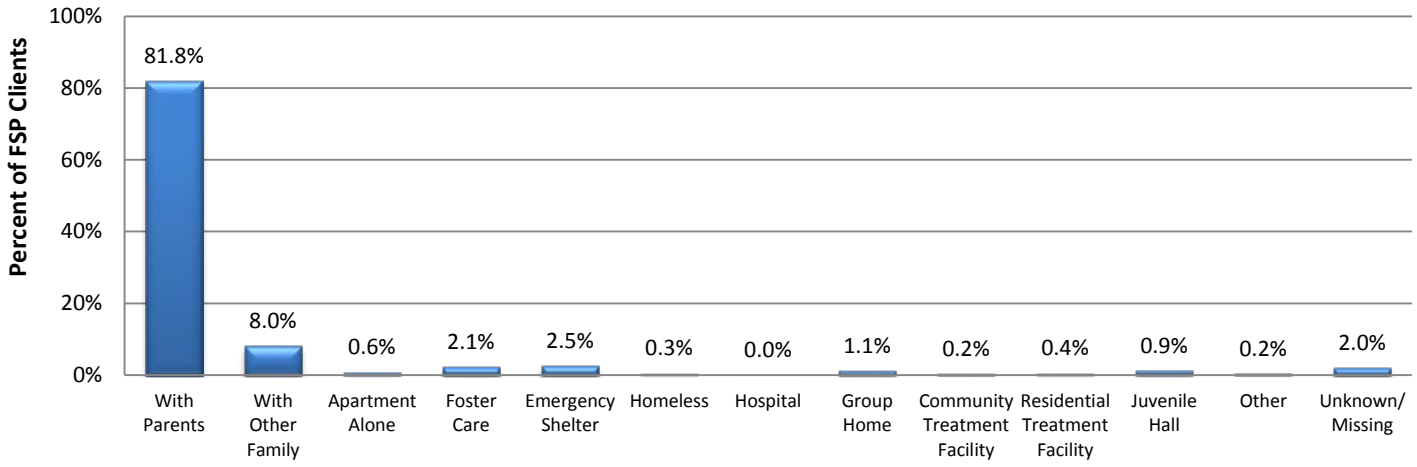


Who Are We Serving?

FSP providers collected client and outcomes data using the Department of Health Care Services (DHCS) Data Collection & Reporting System (DCR). Residential status and risk factors were entered for new clients to FSP programs in FY 2012-13. Referral sources were also entered; FSP referrals in order of frequency were as follows: family member (27%), school system (23%), mental health facility (16%), Juvenile Hall (8%), primary care physician (5%), social service agency (5%), acute psychiatric facility (3%), self-referral (3%), other county agency (3%), homeless shelter (2%), friend (1%), emergency room (1%), or substance use facility (<1%). The remaining 3% were referred by an unknown or unspecified source.

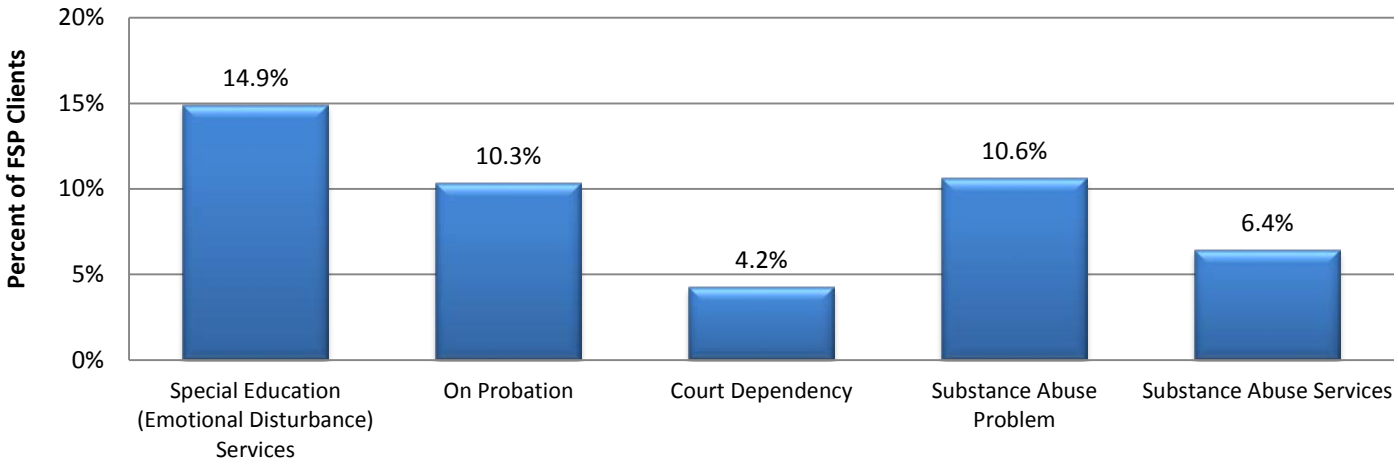
Residential Status at Intake (n=1,630)*

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



Risk Factors at Intake (n=1,630)*

The most prevalent risk factor for more intensive service use among youth entering FSP programs was receipt of Special Education services due to a serious emotional disturbance. Clients may have had more than one risk factor.



**Total number of clients entered in the DCR differs from total number of clients in the Anasazi MIS.*

Who Are We Serving?

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

Forensic Services

In FY 2012-13, nine FSP clients had an arrest recorded in the DCR. Three FSP clients were noted to have been on probation.

Inpatient and Emergency Services

Of the 2,494 unduplicated clients who received services from an FSP program in FY 2012-13, 64 (2.6%) had at least one inpatient (IP) episode and 63 (2.5%) had at least one emergency service unit (ESU) visit during the treatment episode, as compared to 41 (2.3%) and 42 (2.4%), respectively, of 1,768 unduplicated clients in FY 2011-12.

Are Children Getting Better?

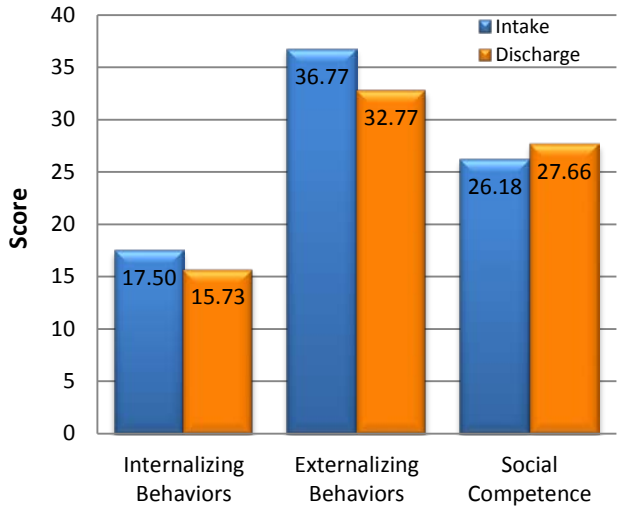
FSP providers collected outcomes data with the Child and Adolescent Measurement System (CAMS) and the Children's Functional Assessment Rating Scale (CFARS). Scores were analyzed for youth discharged from FSP services in FY 2012-13, who were in services at least three weeks (CFARS) or two months (CAMS) and had a maximum of two years between intake and discharge assessment, and who had both Intake and Discharge scores for all measure domains. Additionally, the Personal Experience Screening Questionnaire (PESQ) was implemented in FY 2012-13; scores were analyzed for youth discharged from FSP Alcohol and Drug programs in FY 2012-13, who were in services at least one month.

FSP CAMS Scores

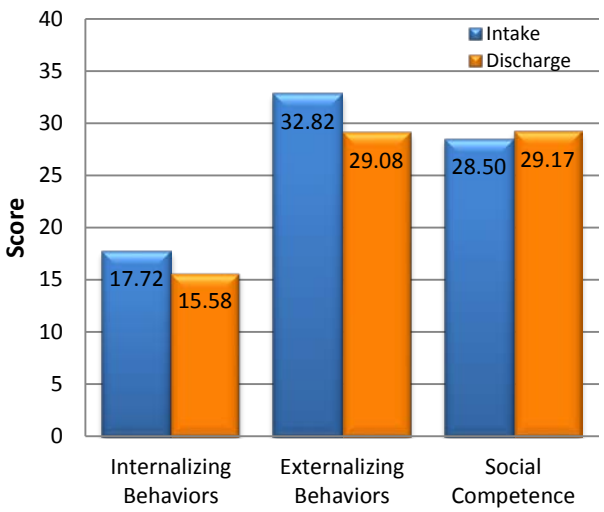
The CAMS measures a child's social competency, behavior and emotional problems; it is administered to all caregivers, and to youth ages 11 and older. A *decrease* on the Internalizing (e.g., depressive or anxiety disorders) and/or Externalizing (e.g., ADHD or oppositional disorders) CAMS score is considered an improvement. An *increase* in the Social Competence (e.g., personal responsibility and participation in activities) score is considered an improvement.

These CAMS results (n=390 Parent CAMS and n=274 Youth CAMS) **revealed improvement in youth behavior and emotional problems following receipt of FSP services**.

FSP Caregiver CAMS (n=390)



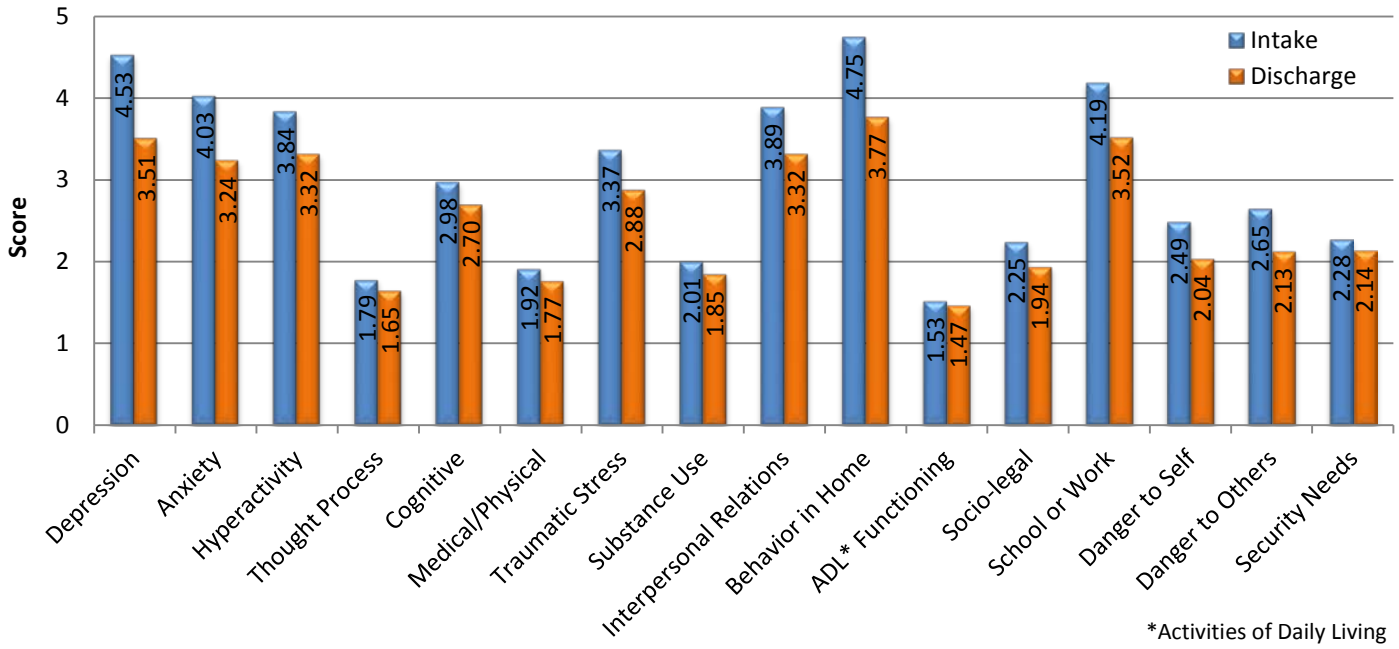
FSP Youth CAMS (n=274)



Are Children Getting Better?

FSP CFARS Scores (n=1,043)

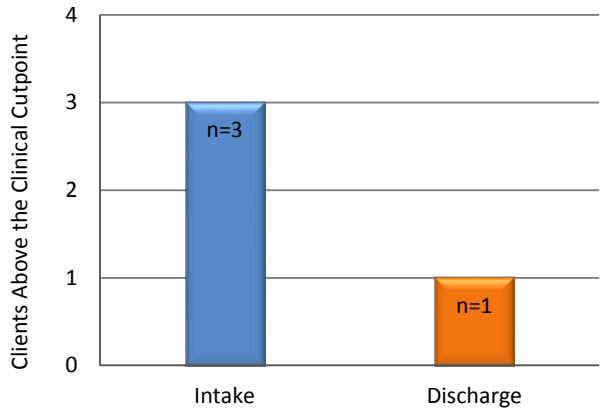
The CFARS measures level of functioning on a scale of 1 to 9 and is completed by the client's clinician. A *decrease* on any CFARS domain is considered an improvement. CFARS data were available on 1,043 FSP clients and **revealed improvement in youth symptoms and behavior** following receipt of FSP services.



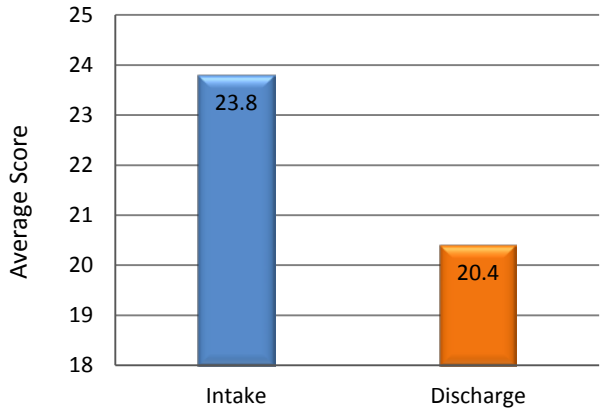
FSP PESQ Scores

The PESQ measures potential substance abuse problems and is administered to youth ages 12-18 by their AD 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 19 discharged clients in FY 2012-13.

PESQ Clinical Cutpoint



PESQ Severity Scale (n=19)

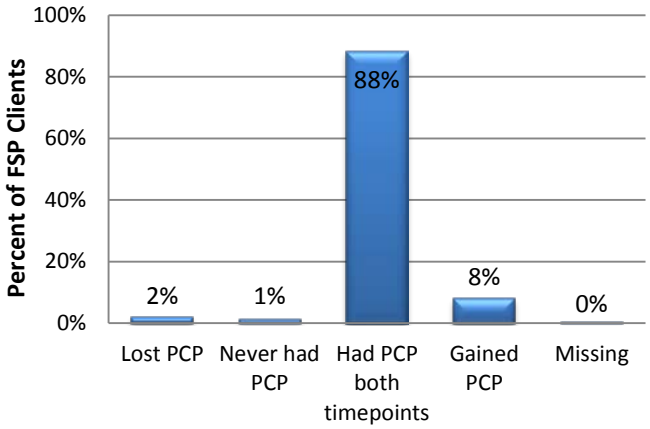


Are Children Getting Better?

FSP Providers also collected client and outcomes data on primary care physician status, school attendance, and academic performance; these were tracked in the DCR for continuing clients with multiple assessments. Analyses of these tracked outcomes were limited to clients with an intake and a 3, 6, 9, or 12 month assessment; the most recent assessment was compared to intake.

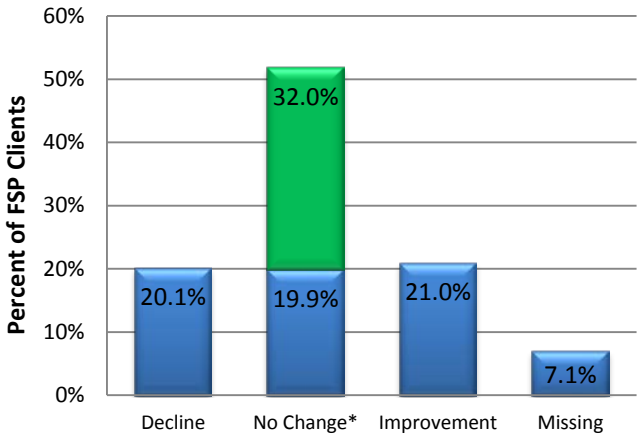
Primary Care Physician (PCP) Status (n=1,502)

88% of FSP clients had and maintained a PCP.



School Attendance (n=1,502)

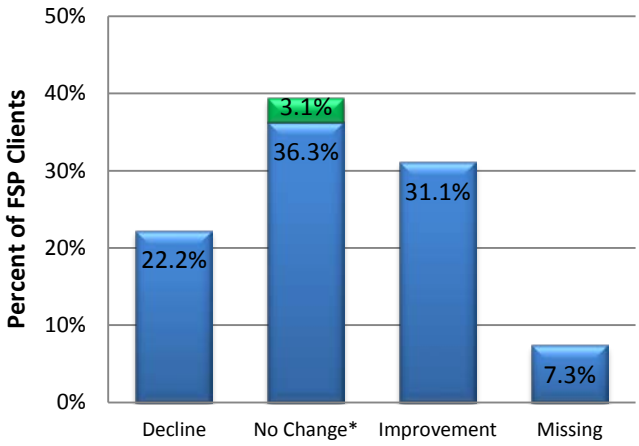
53% of FSP clients either improved or maintained excellent school attendance at follow-up assessment as compared to intake.



**Of the 52% of clients for whom no change was noted, 32% (green portion of bar) had consistently excellent attendance.*

Academic Performance (n=1,502)

34% of FSP clients either improved or maintained excellent grades at follow-up assessment as compared to intake.



**Of the 39% of clients for whom no change was noted, 3% (green portion of bar) had consistently excellent grades.*

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 at San Diego, San Diego State University, University of San Diego and University of Southern California. The mission of CASRC is to improve publicly funded mental health service delivery and quality of treatment for children and adolescents who have or are at high risk for the development of mental health problems or disorders.

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

Systemwide FSP ACT Model Report

Fiscal Year 2012-13

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

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

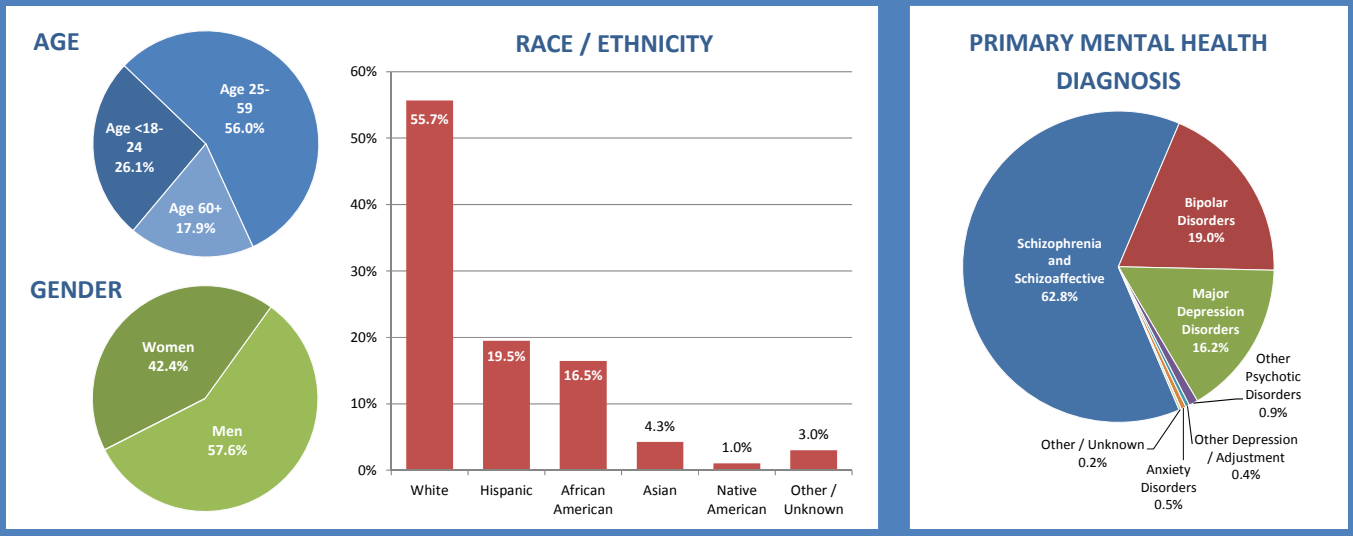
San Diego County Full Service Partnership (FSP) programs promote recovery and resilience through comprehensive, integrated, consumer-driven, strength-based care and a "whatever it takes" approach. Targeted to help those clients with the most serious mental health needs, services are intensive, highly individualized, and focused on helping clients achieve long-lasting success and independence.

Full fidelity assertive community treatment (ACT) teams—which include psychiatrists, nurses, mental health professionals, employment specialists, peer specialists, and substance-abuse specialists—provide medication management, vocational services, substance abuse services, and other services to help clients sustain the highest level of functioning while remaining in the community.

Clients receive services in their homes, at their workplace, or in other settings in the community they identify as the most beneficial to them or where support is most needed. Crisis intervention services are available 24 hours a day, 7 days a week.

Drawing from a variety of sources, this report presents information on service use and recovery-oriented treatment outcomes for individuals who received Full Service Partnership services during Fiscal Year 2012-13. Demographic data and information on the use of inpatient and emergency psychiatric services come from the San Diego County Anasazi data system. Data on basic needs (Housing, Employment, Education, Access to Primary Care Physician) and placements in restrictive and acute medical settings (Jail/Prison, State Hospital, Long-term Care, and Medical Hospital) are drawn from the California Department of Health Care Services (DHCS) Data Collection and Reporting (DCR) System used by all FSPs. Recovery outcomes and progress toward recovery data presented are from San Diego County's Health Outcomes Management System (HOMS).

959 Clients Served in FY 2012-13 — Demographics and Diagnoses



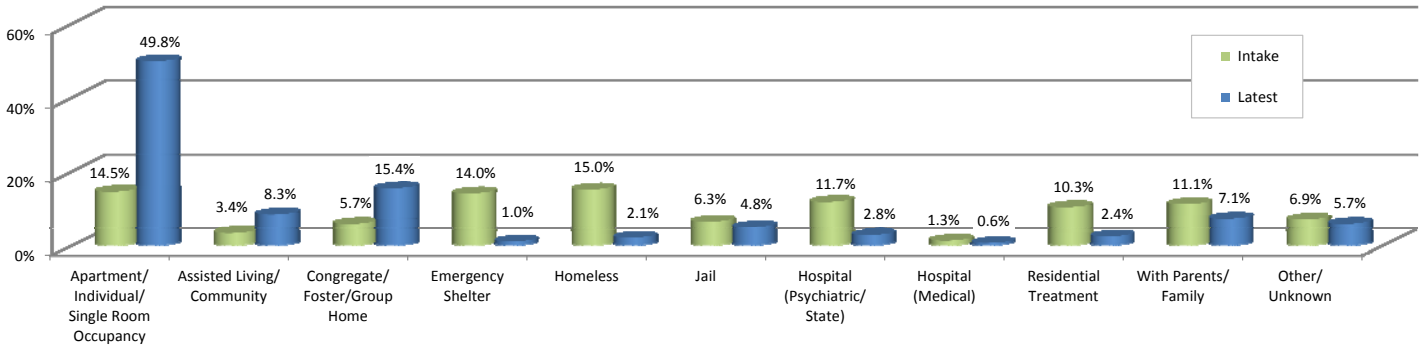
Data source: Anasazi 10/2013 download

The following programs' data are included in this report (program name and Subunit #): Community Research Foundation (CRF) Impact (3401), North Star (3361), Center Star (3411), Providence Catalyst (3391), and CRF Senior Impact (3481).

MEETING FSP ACT CLIENTS' BASIC NEEDS

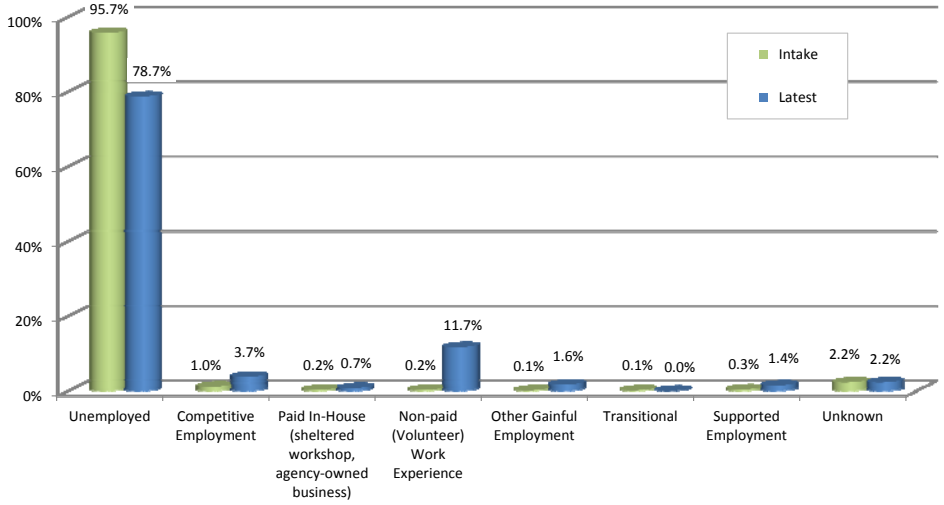
In FY 2012-13, FSP clients showed improvement in several areas of basic needs. Significant improvements were seen in movement of people from homelessness (15.0% at intake vs. 2.1% latest) and emergency shelter (14.0% at intake vs. 1.0% latest) into better living arrangements. Significantly larger percentages of clients were able to secure more adequate housing: 49.8% in an apartment or individual living situation and 15.4% in congregate, foster, or group homes.

HOUSING



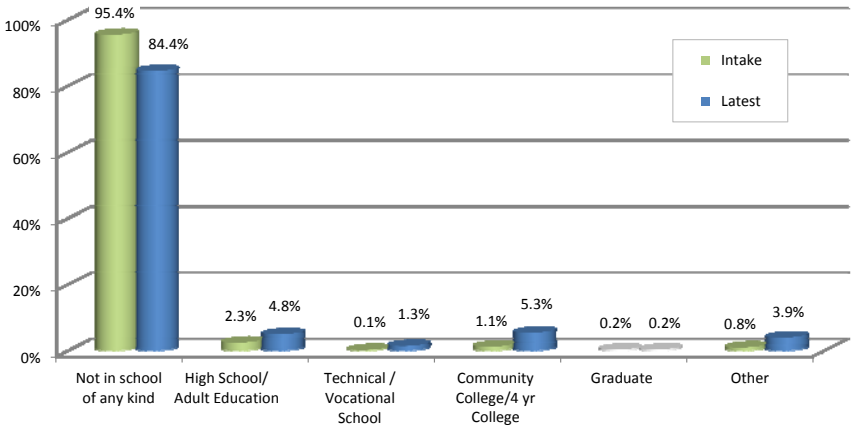
For some clients, involvement in meaningful occupational activities is an important part of recovery. FSPs can help connect clients to a variety of employment opportunities ranging from volunteer work experience to supported employment in sheltered workshops, to competitive, paid work. While most clients remained unemployed (78.7%), there was an improvement from intake to latest assessment with some clients moving from unemployed to other occupational statuses. The biggest gains were seen in movement into non-paid (volunteer) work experience (from 0.2% to 11.7%) and competitive employment (from 1.0% to 3.7%).

EMPLOYMENT



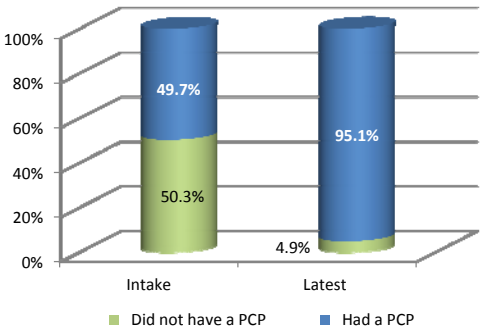
Education is a goal for some, but not all, people who received services. At intake, 4.6% of clients were enrolled in educational settings vs. 15.6% at the latest assessment.

EDUCATION



At the time of FSP enrollment, 49.7% of people reported having access to a primary care physician (PCP), while 95.1% of clients reported having a PCP at the time of their latest assessment.

CLIENTS WITH A PRIMARY CARE PHYSICIAN



Data source for all charts on this page: DHCS DCR 12/16/2013 download; Active clients in any period of FY 2012-13, N=858; Education data missing for 34 clients at intake and 31 clients at time of latest assessment.

CHANGES IN SERVICE USE AND SETTING

The "whatever it takes" model of care provided by full fidelity FSP ACT programs aims to help people avoid the need for emergency care (EPU, PERT, Crisis Residential and Psychiatric Hospital). Overall, use of these services in FY 2012-13 decreased by 58.9% as measured by number of services used, and 53.9% when considering the number of individuals using services. The mean number of emergency services used per person decreased across EPU (6.5%) and Crisis Residential (6.4%) categories. The mean number of Psychiatric Hospital inpatient services used per person increased by 17.3%, while the mean number of PERT services per person increased by 4.9%. The overall number of services used per person decreased 11.0%.

USE OF INPATIENT & EMERGENCY SERVICES (PRE/POST)

	# OF SERVICES			# OF CLIENTS			MEAN # OF SERVICES PER CLIENT		
TYPE OF EMERGENCY SERVICE	PRE	POST	% CHANGE	PRE	POST	% CHANGE	PRE	POST	% CHANGE
EPU	628	169	-73.09%	278	80	-71.22%	2.26	2.11	-6.64%
PERT	192	139	-27.60%	129	89	-31.01%	1.49	1.56	4.70%
Crisis Residential	362	91	-74.86%	201	54	-73.13%	1.80	1.69	-6.11%
Psychiatric Hospital	552	313	-43.30%	244	118	-51.64%	2.26	2.65	17.26%
Overall	**1,734**	**712**	**-58.94%**	**414***	**191***	**-53.86%**	**4.19**	**3.73**	**-10.98%**

*The overall numbers of clients PRE (n=414) and POST (n=191) indicate unique clients, many of whom used multiple, various services, while some clients used no emergency services.

PRE period data encompass the 12 months prior to each client's FSP enrollment and are from Anasazi downloads from FY 2008-09, Q2 to FY 2012-13, Q4 and Insyst downloads from FY 2005-06, Q1 to FY 2008-09, Q1; FY 2012-13 DHCS DCR data from 12/16/2013 download used to identify active clients and for POST period data.

Clients in this analysis (n=680) had an enrollment date <= 7/1/2012 and discontinued date (if inactive) > 7/1/2012. Data may include people who were discharged from FSP during the Fiscal Year but who continued to receive services.

In FY 2012-13, there was an overall decrease in the mean number of days per individual spent in restrictive settings: jail/prison, state hospital, and long-term care. The data on placement in acute medical settings are considered separately in the table below. 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 other illnesses requiring hospice or hospital-based medical care.

- Overall, both the number of days spent in restrictive settings and the number of people in placement decreased (by 78.0% and 54.7%, respectively).
- The largest decrease in the number of people in placement was for State hospital, with an 84.2% decrease.
- Both the number of days and number of individuals in acute medical settings increased (by 63.4% and 79.0%, respectively), suggesting that clients' access to medical treatment increased after FSP enrollment.
- Overall, the average number of days per individual in restrictive settings decreased by 51.4% while the overall average number of days per person in medical settings decreased 8.7%.

PLACEMENTS IN RESTRICTIVE & ACUTE MEDICAL SETTINGS (PRE/POST)

	# OF DAYS			# OF CLIENTS			MEAN # OF DAYS PER CLIENT		
TYPE OF SETTING	PRE	POST	% CHANGE	PRE	POST	% CHANGE	PRE	POST	% CHANGE
Jail/Prison	12,746	2,356	-81.52%	131	57	-56.49%	97.30	41.33	-57.52%
State Hospital	1,807	32	-98.23%	19	3	-84.21%	95.11	10.67	-88.78%
Long-Term Care	2,633	1,399	-46.87%	11	11	0.00%	239.36	127.18	-46.87%
Overall	**17,186**	**3,787**	**-77.96%**	**150***	**68***	**-54.67%**	**114.57**	**55.69**	**-51.39%**
Medical Hospital	946	1,546	63.42%	57	102	78.95%	16.60	15.16	-8.67%

Data source: DHCS DCR 12/16/2013 download; 12 month pre-enrollment DCR data rely on client self-report.

Clients in this analysis (n=609): had an Enrollment date <= 7/1/2012 and Discontinued date (if inactive) >6/30/2013 ; Clients had to be active throughout FY 2012-13 to be included.

*The overall numbers of clients PRE (n=150) and POST (n=68) indicate unique clients, many of whom used multiple, various services, while some clients used no services.

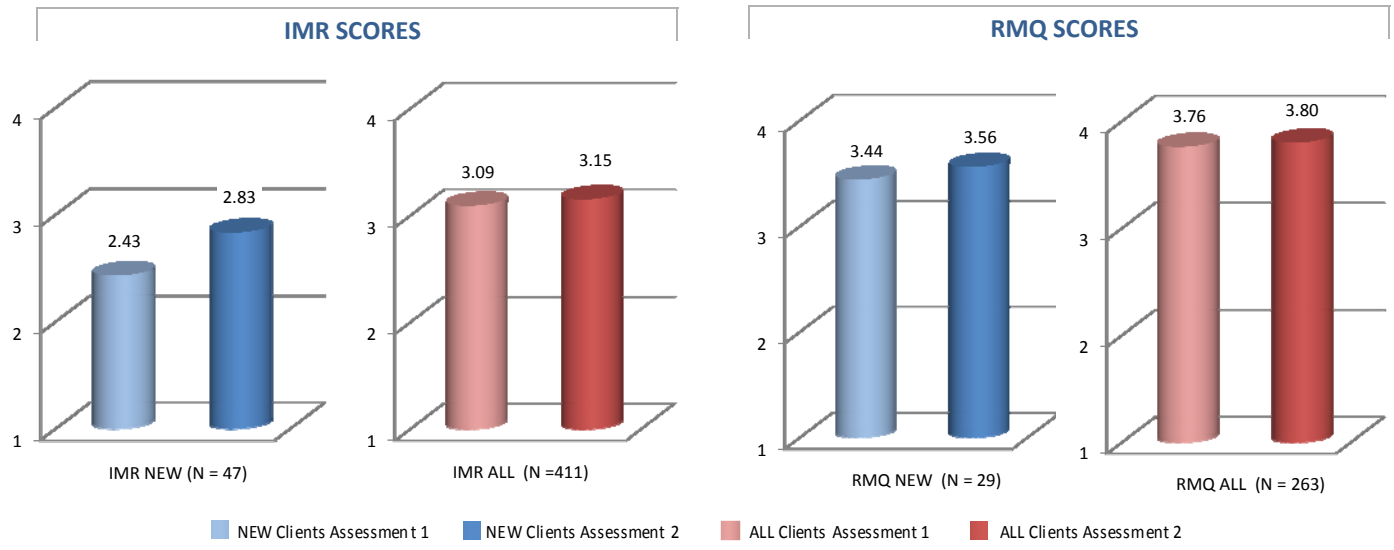
MEASURING PROGRESS TOWARDS RECOVERY

Comparing NEW and ALL FSP ACT Program Clients

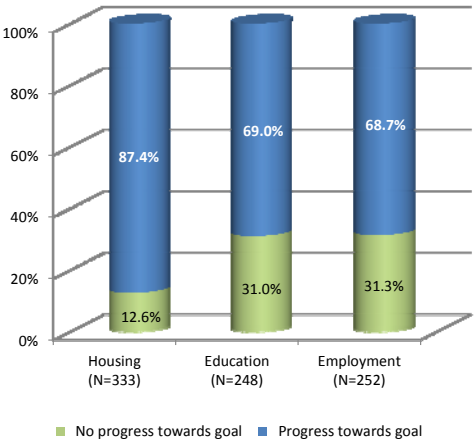
FSP ACT Program clients' progress toward recovery is measured using two different instruments—the Illness Management and Recovery Scale (IMR) and the Recovery Markers Questionnaire (RMQ). Clinicians use the IMR scale to rate their clients' progress towards recovery. The IMR has 15 individually scored items; scores can also be represented using subscales or overall scores. Individuals receiving services use the 24-item RMQ scale to rate their own progress towards recovery. Higher ratings on both the IMR and the RMQ indicate greater recovery. Scores range from 1-5.

The IMR and RMQ scores displayed in the charts below compare scores of "NEW" clients to those of "ALL" clients. NEW clients are those who started receiving services in 2012 or later, who had two IMR/RMQ assessments during FY 2012-13 (Assessments 1 and 2), and whose first service date was within 30 days of their first IMR assessment; ALL Clients includes every individual who had two IMR/RMQ assessments during FY 2012-13 (Assessments 1 and 2), regardless of how long they have received FSP services. Scores for NEW Clients more directly demonstrate the effect of FSP services on client outcomes because ALL Clients includes those people who may have been receiving services for long periods of time, starting before the implementation of FSP programs.

IMR and RMQ scores increased for both NEW and ALL clients. NEW clients' IMR scores at intake were lower than ALL clients' scores but NEW clients achieved much greater gains between intake and latest assessment. Both NEW and ALL clients' RMQ scores were higher than their IMR scores, indicating that both NEW and ALL clients tend to rate their progress higher than clinicians do . RMQ scores for NEW clients showed slightly more progress than RMQ scores for ALL clients.



MAKING PROGRESS TOWARDS KEY TREATMENT GOALS



All FSP ACT Clients Whose Treatment Plan Includes Key Progress Goals — Progress at Latest IMR Assessment

In their IMR assessments, clinicians also note client progress toward goals related to housing, education, and employment. The chart on the left illustrates progress made by those individuals whose treatment plan included one or more of these key goals. It should be noted that both education and employment are longer-term goals than housing.

Of those people with a housing goal on their treatment plan, 87.4% demonstrated progress toward the goal, while 12.6% did not. Of those with an education goal on their treatment plan, 69.0% demonstrated progress, while 31.0% did not demonstrate progress. And of those people with an employment goal on their treatment plan, 68.7% demonstrated progress toward the goal, while 31.3% did not.

Data source for all charts on this page: HOMS FY 2012-13; Data include all HOMS entries as of 12/16/2013 for clients who received services in FSP ACT Model Programs, finished IMR/RMQ assessment 2 during FY 2012-13, and who had paired IMR/RMQ assessments within 4-8months.

FSP Program: Cultural Access Resource Enhancement (CARE)

Outcomes

CAMS Scores	Caregiver (N=93)		Youth (N=45)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	16.87	14.47	16.96	15.04
Externalizing Behaviors	34.70	29.98	31.47	28.33
Social Competence	26.77	28.46	28.40	28.82

CFARS Scores (N=125)	Intake	Discharge	*Change*
Depression	4.51	2.90	*-1.61*
Anxiety	3.96	2.62	*-1.34*
Hyperactivity	3.49	2.62	*-0.87*
Thought Process	1.74	1.41	*-0.33*
Cognitive	3.11	2.46	*-0.65*
Medical / Physical	1.92	1.56	*-0.36*
Traumatic Stress	2.93	1.92	*-1.01*
Substance Use	1.42	1.38	*-0.04*
Interpersonal Relations	4.24	2.98	*-1.26*
Behavior in Home	4.77	3.33	*-1.44*
Activities of Daily Living Functioning	1.60	1.38	*-0.22*
Socio-legal	1.39	1.26	*-0.13*
School or Work	4.56	3.30	*-1.26*
Danger to Self	2.06	1.46	*-0.60*
Danger to Others	1.89	1.37	*-0.52*
Security Needs	1.42	1.25	*-0.17*

Primary Care Physician Status‡	Number	%
Lost PCP	2	1.9%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	97	91.5%
Gained PCP	7	6.6%
Missing	0	0.0%
Total	106	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡	Number	%
Decline	9	8.5%
No Change	14	13.2%
No Change--Consistently Excellent	62	58.5%
Improvement	19	17.9%
Missing	2	1.9%
Total	106	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡	Number	%
Decline	12	11.3%
No Change	39	36.8%
No Change--Consistently Excellent	3	2.8%
Improvement	49	46.2%
Missing	3	2.8%
Total	106	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Crossroads

Outcomes

CAMS Scores	Caregiver (N=24)		Youth (N=12)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	18.42	15.33	18.92	15.75
Externalizing Behaviors	39.88	32.83	32.17	28.92
Social Competence	24.17	26.96	27.25	28.67

CFARS Scores (N=35)	Intake	Discharge	*Change*
Depression	4.40	3.23	*-1.17*
Anxiety	4.03	2.83	*-1.20*
Hyperactivity	3.71	2.83	*-0.88*
Thought Process	1.71	1.49	*-0.22*
Cognitive	3.06	2.37	*-0.69*
Medical / Physical	1.34	1.20	*-0.14*
Traumatic Stress	3.60	2.51	*-1.09*
Substance Use	1.91	1.49	*-0.42*
Interpersonal Relations	3.60	2.94	*-0.66*
Behavior in Home	4.34	3.57	*-0.77*
Activities of Daily Living Functioning	1.09	1.20	*0.11*
Socio-legal	1.51	1.40	*-0.11*
School or Work	4.09	3.06	*-1.03*
Danger to Self	2.79	1.80	*-0.99*
Danger to Others	2.03	1.66	*-0.37*
Security Needs	1.37	1.71	*0.34*

Primary Care Physician Status‡	Number	%
Lost PCP	2	1.3%
Never Had PCP	1	0.7%
Had PCP Both Timepoints	137	91.3%
Gained PCP	10	6.7%
Missing	0	0.0%
Total	150	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡	Number	%
Decline	34	22.7%
No Change	54	36.0%
No Change--Consistently Excellent	29	19.3%
Improvement	33	22.0%
Missing	0	0.0%
Total	150	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡	Number	%
Decline	35	23.3%
No Change	54	36.0%
No Change--Consistently Excellent	5	3.3%
Improvement	56	37.3%
Missing	0	0.0%
Total	150	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Douglas Young

Outcomes

CAMS Scores‡	Caregiver (N=0)		Youth (N=0)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=0)‡	Intake	Discharge	*Change*
Depression	-	-	-
Anxiety	-	-	-
Hyperactivity	-	-	-
Thought Process	-	-	-
Cognitive	-	-	-
Medical / Physical	-	-	-
Traumatic Stress	-	-	-
Substance Use	-	-	-
Interpersonal Relations	-	-	-
Behavior in Home	-	-	-
Activities of Daily Living Functioning	-	-	-
Socio-legal	-	-	-
School or Work	-	-	-
Danger to Self	-	-	-
Danger to Others	-	-	-
Security Needs	-	-	-

‡Measure not currently collected.

Primary Care Physician Status§	Number	%
Lost PCP	3	1.8%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	152	93.3%
Gained PCP	8	4.9%
Missing	0	0.0%
Total	163	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§	Number	%
Decline	25	15.3%
No Change	55	33.7%
No Change--Consistently Excellent	31	19.0%
Improvement	51	31.3%
Missing	1	0.6%
Total	163	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§	Number	%
Decline	38	23.3%
No Change	56	34.4%
No Change--Consistently Excellent	0	0.0%
Improvement	68	41.7%
Missing	1	0.6%
Total	163	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Nueva Vista

Outcomes

CAMS Scores‡	Caregiver (N=0)		Youth (N=0)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=0)‡	Intake	Discharge	*Change*
Depression	-	-	-
Anxiety	-	-	-
Hyperactivity	-	-	-
Thought Process	-	-	-
Cognitive	-	-	-
Medical / Physical	-	-	-
Traumatic Stress	-	-	-
Substance Use	-	-	-
Interpersonal Relations	-	-	-
Behavior in Home	-	-	-
Activities of Daily Living Functioning	-	-	-
Socio-legal	-	-	-
School or Work	-	-	-
Danger to Self	-	-	-
Danger to Others	-	-	-
Security Needs	-	-	-

‡Measure not currently collected.

Primary Care Physician Status§	Number	%
Lost PCP	2	2.9%
Never Had PCP	1	1.4%
Had PCP Both Timepoints	65	92.9%
Gained PCP	2	2.9%
Missing	0	0.0%
Total	70	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§	Number	%
Decline	23	32.9%
No Change	9	12.9%
No Change--Consistently Excellent	26	37.1%
Improvement	11	15.7%
Missing	1	1.4%
Total	70	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§	Number	%
Decline	23	32.9%
No Change	25	35.7%
No Change--Consistently Excellent	1	1.4%
Improvement	20	28.6%
Missing	1	1.4%
Total	70	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Fred Finch Youth Center

Outcomes

CAMS Scores

	Caregiver (N=128)		Youth (N=111)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	17.02	16.00	16.87	15.60
Externalizing Behaviors	37.05	35.04	33.87	30.53
Social Competence	26.75	27.20	29.26	29.04

CFARS Scores (N=182)

	Intake	**Discharge**	*Change*
Depression	5.03	4.02	*-1.01*
Anxiety	4.13	3.40	*-0.73*
Hyperactivity	3.96	3.44	*-0.52*
Thought Process	2.31	1.94	*-0.37*
Cognitive	3.23	3.03	*-0.20*
Medical / Physical	1.84	1.77	*-0.07*
Traumatic Stress	4.04	3.49	*-0.55*
Substance Use	3.55	3.01	*-0.54*
Interpersonal Relations	4.60	3.85	*-0.75*
Behavior in Home	5.36	4.29	*-1.07*
Activities of Daily Living Functioning	1.55	1.42	*-0.13*
Socio-legal	4.64	3.46	*-1.18*
School or Work	4.85	4.14	*-0.71*
Danger to Self	2.84	2.49	*-0.35*
Danger to Others	3.44	2.62	*-0.82*
Security Needs	3.37	3.11	*-0.26*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	4	2.3%
Never Had PCP	4	2.3%
Had PCP Both Timepoints	148	85.1%
Gained PCP	16	9.2%
Missing	2	1.1%
Total	174	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	50	28.7%
No Change	38	21.8%
No Change--Consistently Excellent	34	19.5%
Improvement	44	25.3%
Missing	8	4.6%
Total	174	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	45	25.9%
No Change	59	33.9%
No Change--Consistently Excellent	6	3.4%
Improvement	56	32.2%
Missing	8	4.6%
Total	174	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Southeast Mental Health and Harmonium

Outcomes

CAMS Scores

	Caregiver (N=1)		Youth (N=0)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	14.00	19.00	-	-
Externalizing Behaviors	44.00	50.00	-	-
Social Competence	30.00	25.00	-	-

CFARS Scores (N=3)

	Intake	**Discharge**	*Change*
Depression	5.33	5.00	*-0.33*
Anxiety	2.33	3.67	*1.34*
Hyperactivity	4.67	4.00	*-0.67*
Thought Process	1.33	1.33	*0.00*
Cognitive	4.00	3.67	*-0.33*
Medical / Physical	2.67	2.67	*0.00*
Traumatic Stress	2.00	3.00	*1.00*
Substance Use	2.67	2.33	*-0.34*
Activities of Daily Living Functioning	3.33	4.00	*0.67*
Behavior in Home	5.00	3.67	*-1.33*
ADL† Functioning	1.67	1.33	*-0.34*
Socio-legal	1.67	3.67	*2.00*
School or Work	4.00	2.33	*-1.67*
Danger to Self	3.33	1.33	*-2.00*
Danger to Others	3.00	3.00	*0.00*
Security Needs	1.00	3.00	*2.00*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	1	2.7%
Never Had PCP	1	2.7%
Had PCP Both Timepoints	31	83.8%
Gained PCP	4	10.8%
Missing	0	0.0%
Total	37	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	12	32.4%
No Change	7	18.9%
No Change--Consistently Excellent	12	32.4%
Improvement	1	2.7%
Missing	5	13.5%
Total	37	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	11	29.7%
No Change	9	24.3%
No Change--Consistently Excellent	0	0.0%
Improvement	12	32.4%
Missing	5	13.5%
Total	37	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Mental Health Systems-Therapeutic Behavioral Services

Outcomes

CAMS Scores‡	Caregiver (N=0)		Youth (N=0)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=42)	Intake	Discharge	*Change*
Depression	3.86	3.12	*-0.74*
Anxiety	3.88	3.26	*-0.62*
Hyperactivity	4.79	3.69	*-1.10*
Thought Process	1.52	1.48	*-0.04*
Cognitive	3.29	2.69	*-0.60*
Medical / Physical	1.62	1.45	*-0.17*
Traumatic Stress	2.45	2.33	*-0.12*
Substance Use	1.14	1.19	*0.05*
Interpersonal Relations	4.14	3.48	*-0.66*
Behavior in Home	5.29	3.64	*-1.65*
Activities of Daily Living Functioning	1.88	1.74	*-0.14*
Socio-legal	1.83	1.60	*-0.23*
School or Work	4.40	3.45	*-0.95*
Danger to Self	2.29	1.81	*-0.48*
Danger to Others	3.24	2.36	*-0.88*
Security Needs	2.50	2.24	*-0.26*

Primary Care Physician Status§	Number	%
Lost PCP	0	0.0%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	12	100.0%
Gained PCP	0	0.0%
Missing	0	0.0%
Total	12	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§	Number	%
Decline	3	25.0%
No Change	0	0.0%
No Change--Consistently Excellent	8	66.7%
Improvement	0	0.0%
Missing	1	8.3%
Total	12	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§	Number	%
Decline	4	33.3%
No Change	2	16.7%
No Change--Consistently Excellent	1	8.3%
Improvement	4	33.3%
Missing	1	8.3%
Total	12	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: New Alternatives-Therapeutic Behavioral Services

Outcomes

CAMS Scores‡	Caregiver (N=0)		Youth (N=0)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=124)	Intake	Discharge	*Change*
Depression	4.22	3.44	*-0.78*
Anxiety	3.62	3.28	*-0.34*
Hyperactivity	4.70	4.10	*-0.60*
Thought Process	1.96	1.75	*-0.21*
Cognitive	3.47	3.25	*-0.22*
Medical / Physical	1.95	1.92	*-0.03*
Traumatic Stress	3.35	3.05	*-0.30*
Substance Use	1.27	1.25	*-0.02*
Interpersonal Relations	4.44	3.83	*-0.61*
Behavior in Home	5.93	4.60	*-1.33*
Activities of Daily Living Functioning	1.85	1.78	*-0.07*
Socio-legal	2.21	2.05	*-0.16*
School or Work	4.88	4.12	*-0.76*
Danger to Self	3.36	2.73	*-0.63*
Danger to Others	4.20	3.23	*-0.97*
Security Needs	3.73	3.16	*-0.57*

Primary Care Physician Status§	Number	%
Lost PCP	1	2.4%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	37	88.1%
Gained PCP	3	7.1%
Missing	1	2.4%
Total	42	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§	Number	%
Decline	7	16.7%
No Change	10	23.8%
No Change--Consistently Excellent	13	31.0%
Improvement	11	26.2%
Missing	1	2.4%
Total	42	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§	Number	%
Decline	5	11.9%
No Change	25	59.5%
No Change--Consistently Excellent	1	2.4%
Improvement	10	23.8%
Missing	1	2.4%
Total	42	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Rady Central

Outcomes

CAMS Scores	Caregiver (N=39)		Youth (N=19)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	17.67	15.82	18.89	18.00
Externalizing Behaviors	36.00	32.59	29.68	29.26
Social Competence	25.74	27.03	27.74	27.79

CFARS Scores (N=105)	Intake	Discharge	*Change*
Depression	3.91	3.10	*-0.81*
Anxiety	4.00	3.26	*-0.74*
Hyperactivity	3.58	3.19	*-0.39*
Thought Process	1.65	1.75	*0.10*
Cognitive	3.17	3.01	*-0.16*
Medical / Physical	2.01	1.81	*-0.20*
Traumatic Stress	2.36	2.24	*-0.12*
Substance Use	1.41	1.39	*-0.02*
Activities of Daily Living Functioning	3.46	3.19	*-0.27*
Behavior in Home	4.29	3.57	*-0.72*
ADL† Functioning	1.76	1.77	*0.01*
Socio-legal	1.48	1.50	*0.02*
School or Work	3.79	3.36	*-0.43*
Danger to Self	2.50	2.12	*-0.38*
Danger to Others	2.44	2.07	*-0.37*
Security Needs	1.97	1.98	*0.01*

Primary Care Physician Status‡	Number	%
Lost PCP	3	1.7%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	159	91.9%
Gained PCP	11	6.4%
Missing	0	0.0%
Total	173	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡	Number	%
Decline	30	17.3%
No Change	36	20.8%
No Change--Consistently Excellent	40	23.1%
Improvement	63	36.4%
Missing	4	2.3%
Total	173	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡	Number	%
Decline	60	34.7%
No Change	59	34.1%
No Change--Consistently Excellent	5	2.9%
Improvement	46	26.6%
Missing	3	1.7%
Total	173	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Rady Central/East/South

Outcomes

CAMS Scores

	Caregiver (N=12)		Youth (N=16)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	14.58	15.25	19.13	16.13
Externalizing Behaviors	30.25	30.42	33.19	28.38
Social Competence	25.00	28.92	29.06	29.81

CFARS Scores (N=52)

	Intake	**Discharge**	*Change*
Depression	4.67	3.63	*-1.04*
Anxiety	4.02	3.12	*-0.90*
Hyperactivity	3.75	3.54	*-0.21*
Thought Process	1.48	1.35	*-0.13*
Cognitive	2.81	2.52	*-0.29*
Medical / Physical	2.02	1.75	*-0.27*
Traumatic Stress	2.98	2.19	*-0.79*
Substance Use	1.27	1.35	*0.08*
Interpersonal Relations	3.75	3.13	*-0.62*
Behavior in Home	4.42	3.19	*-1.23*
Activities of Daily Living Functioning	1.46	1.31	*-0.15*
Socio-legal	1.44	1.40	*-0.04*
School or Work	4.87	4.04	*-0.83*
Danger to Self	1.83	1.46	*-0.37*
Danger to Others	1.58	1.37	*-0.21*
Security Needs	1.40	1.37	*-0.03*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	1	1.0%
Never Had PCP	2	1.9%
Had PCP Both Timepoints	89	84.8%
Gained PCP	13	12.4%
Missing	0	0.0%
Total	105	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	19	18.1%
No Change	20	19.0%
No Change--Consistently Excellent	47	44.8%
Improvement	19	18.1%
Missing	0	0.0%
Total	105	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	16	15.2%
No Change	52	49.5%
No Change--Consistently Excellent	0	0.0%
Improvement	35	33.3%
Missing	2	1.9%
Total	105	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Rady North Coastal

Outcomes

CAMS Scores

	Caregiver (N=63)		Youth (N=37)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	18.75	16.37	18.68	14.38
Externalizing Behaviors	38.79	32.22	32.76	26.57
Social Competence	25.40	27.81	26.43	29.38

CFARS Scores (N=191)

	Intake	**Discharge**	*Change*
Depression	4.19	3.35	*-0.84*
Anxiety	3.74	3.25	*-0.49*
Hyperactivity	3.79	3.34	*-0.45*
Thought Process	1.53	1.52	*-0.01*
Cognitive	2.66	2.42	*-0.24*
Medical / Physical	1.98	1.83	*-0.15*
Traumatic Stress	2.92	2.63	*-0.29*
Substance Use	1.66	1.62	*-0.04*
Interpersonal Relations	3.33	3.07	*-0.26*
Behavior in Home	4.26	3.53	*-0.73*
Activities of Daily Living Functioning	1.34	1.30	*-0.04*
Socio-legal	1.58	1.54	*-0.04*
School or Work	3.66	3.07	*-0.59*
Danger to Self	2.15	1.67	*-0.48*
Danger to Others	2.15	1.88	*-0.27*
Security Needs	1.94	1.80	*-0.14*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	7	2.8%
Never Had PCP	5	2.0%
Had PCP Both Timepoints	224	90.0%
Gained PCP	13	5.2%
Missing	0	0.0%
Total	249	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	44	17.7%
No Change	28	11.2%
No Change--Consistently Excellent	118	47.4%
Improvement	43	17.3%
Missing	16	6.4%
Total	249	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	52	20.9%
No Change	99	39.8%
No Change--Consistently Excellent	17	6.8%
Improvement	65	26.1%
Missing	16	6.4%
Total	249	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: Rady North Inland

Outcomes

CAMS Scores

	Caregiver (N=27)		Youth (N=17)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	19.70	17.30	19.06	16.00
Externalizing Behaviors	39.26	34.00	35.06	29.24
Social Competence	25.81	27.33	28.71	30.12

CFARS Scores (N=58)

	Intake	**Discharge**	*Change*
Depression	4.40	3.60	*-0.80*
Anxiety	3.97	3.40	*-0.57*
Hyperactivity	3.16	2.97	*-0.19*
Thought Process	1.72	1.76	*0.04*
Cognitive	2.74	2.62	*-0.12*
Medical / Physical	1.72	1.67	*-0.05*
Traumatic Stress	3.00	2.67	*-0.33*
Substance Use	1.78	1.66	*-0.12*
Interpersonal Relations	3.95	3.45	*-0.50*
Behavior in Home	4.41	3.83	*-0.58*
Activities of Daily Living Functioning	1.31	1.55	*0.24*
Socio-legal	1.55	1.59	*0.04*
School or Work	3.84	3.45	*-0.39*
Danger to Self	2.40	2.19	*-0.21*
Danger to Others	2.28	2.12	*-0.16*
Security Needs	2.21	2.40	*0.19*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	1	1.3%
Never Had PCP	2	2.6%
Had PCP Both Timepoints	70	92.1%
Gained PCP	3	3.9%
Missing	0	0.0%
Total	76	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	21	27.6%
No Change	15	19.7%
No Change--Consistently Excellent	30	39.5%
Improvement	7	9.2%
Missing	3	3.9%
Total	76	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	11	14.5%
No Change	39	51.3%
No Change--Consistently Excellent	3	3.9%
Improvement	19	25.0%
Missing	4	5.3%
Total	76	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: SDUSD Day Rehab

Outcomes

CAMS Scores‡

	Caregiver (N=0)		Youth (N=0)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=1)

	Intake	**Discharge**	*Change*
Depression	4.00	4.00	*0.00*
Anxiety	5.00	5.00	*0.00*
Hyperactivity	5.00	5.00	*0.00*
Thought Process	1.00	1.00	*0.00*
Cognitive	2.00	2.00	*0.00*
Medical / Physical	1.00	1.00	*0.00*
Traumatic Stress	4.00	4.00	*0.00*
Substance Use	6.00	6.00	*0.00*
Interpersonal Relations	5.00	5.00	*0.00*
Behavior in Home	6.00	6.00	*0.00*
Activities of Daily Living Functioning	1.00	1.00	*0.00*
Socio-legal	7.00	7.00	*0.00*
School or Work	6.00	6.00	*0.00*
Danger to Self	5.00	5.00	*0.00*
Danger to Others	5.00	5.00	*0.00*
Security Needs	5.00	5.00	*0.00*

Primary Care Physician Status§

	Number	**%**
Lost PCP	0	0.0%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	4	100.0%
Gained PCP	0	0.0%
Missing	0	0.0%
Total	4	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§

	Number	**%**
Decline	1	25.0%
No Change	0	0.0%
No Change--Consistently Excellent	2	50.0%
Improvement	1	25.0%
Missing	0	0.0%
Total	4	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§

	Number	**%**
Decline	1	25.0%
No Change	2	50.0%
No Change--Consistently Excellent	0	0.0%
Improvement	1	25.0%
Missing	0	0.0%
Total	4	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: SDUSD Outpatient Central

Outcomes

CAMS Scores

	Caregiver (N=2)		Youth (N=2)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	17.50	20.50	22.00	21.00
Externalizing Behaviors	32.50	29.50	34.00	35.00
Social Competence	28.50	31.50	26.00	29.50

CFARS Scores (N=6)

	Intake	**Discharge**	*Change*
Depression	5.33	5.17	*-0.16*
Anxiety	3.83	3.83	*0.00*
Hyperactivity	5.50	5.50	*0.00*
Thought Process	2.00	2.33	*0.33*
Cognitive	5.33	5.33	*0.00*
Medical / Physical	1.83	1.83	*0.00*
Traumatic Stress	3.33	3.33	*0.00*
Substance Use	2.17	2.17	*0.00*
Interpersonal Relations	4.17	4.33	*0.16*
Behavior in Home	4.17	3.67	*-0.50*
Activities of Daily Living Functioning	2.17	2.33	*0.16*
Socio-legal	2.17	2.00	*-0.17*
School or Work	5.33	5.50	*0.17*
Danger to Self	3.50	3.17	*-0.33*
Danger to Others	1.83	2.17	*0.34*
Security Needs	1.17	1.17	*0.00*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	1	5.3%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	15	78.9%
Gained PCP	1	5.3%
Missing	2	10.5%
Total	19	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	1	5.3%
No Change	2	10.5%
No Change--Consistently Excellent	4	21.1%
Improvement	3	15.8%
Missing	9	47.4%
Total	19	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	2	10.5%
No Change	5	26.3%
No Change--Consistently Excellent	0	0.0%
Improvement	2	10.5%
Missing	10	52.6%
Total	19	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: San Diego Youth Services Counseling Cove

Outcomes

CAMS Scores

	Caregiver (N=1)		Youth (N=15)	
	Intake	**Discharge**	**Intake**	**Discharge**
Internalizing Behaviors	10.00	15.00	17.80	15.07
Externalizing Behaviors	32.00	28.00	30.67	26.47
Social Competence	30.00	31.00	29.73	31.00

CFARS Scores (N=119)

	Intake	**Discharge**	*Change*
Depression	5.39	4.08	*-1.31*
Anxiety	4.97	3.66	*-1.31*
Hyperactivity	3.43	3.08	*-0.35*
Thought Process	1.73	1.66	*-0.07*
Cognitive	2.21	2.09	*-0.12*
Medical / Physical	2.16	2.04	*-0.12*
Traumatic Stress	5.06	4.40	*-0.66*
Substance Use	2.80	2.53	*-0.27*
Interpersonal Relations	3.18	2.81	*-0.37*
Behavior in Home	4.03	3.46	*-0.57*
Activities of Daily Living Functioning	1.26	1.32	*0.06*
Socio-legal	2.31	1.83	*-0.48*
School or Work	3.05	2.90	*-0.15*
Danger to Self	2.45	2.01	*-0.44*
Danger to Others	2.29	1.83	*-0.46*
Security Needs	1.53	1.55	*0.02*

Primary Care Physician Status‡

	Number	**%**
Lost PCP	2	1.8%
Never Had PCP	4	3.6%
Had PCP Both Timepoints	76	68.5%
Gained PCP	29	26.1%
Missing	0	0.0%
Total	111	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance‡

	Number	**%**
Decline	20	18.0%
No Change	8	7.2%
No Change--Consistently Excellent	17	15.3%
Improvement	11	9.9%
Missing	55	49.5%
Total	111	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance‡

	Number	**%**
Decline	18	16.2%
No Change	17	15.3%
No Change--Consistently Excellent	4	3.6%
Improvement	17	15.3%
Missing	55	49.5%
Total	111	

‡Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: SYHC YES

Outcomes

CAMS Scores‡	Caregiver (N=0)		Youth (N=0)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=0)‡	Intake	Discharge	*Change*
Depression	-	-	-
Anxiety	-	-	-
Hyperactivity	-	-	-
Thought Process	-	-	-
Cognitive	-	-	-
Medical / Physical	-	-	-
Traumatic Stress	-	-	-
Substance Use	-	-	-
Interpersonal Relations	-	-	-
Behavior in Home	-	-	-
Activities of Daily Living Functioning	-	-	-
Socio-legal	-	-	-
School or Work	-	-	-
Danger to Self	-	-	-
Danger to Others	-	-	-
Security Needs	-	-	-

‡Measure not currently collected.

Primary Care Physician Status§	Number	%
Lost PCP	0	0.0%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	2	100.0%
Gained PCP	0	0.0%
Missing	0	0.0%
Total	2	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§	Number	%
Decline	2	100.0%
No Change	0	0.0%
No Change--Consistently Excellent	0	0.0%
Improvement	0	0.0%
Missing	0	0.0%
Total	2	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§	Number	%
Decline	1	50.0%
No Change	1	50.0%
No Change--Consistently Excellent	0	0.0%
Improvement	0	0.0%
Missing	0	0.0%
Total	2	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

FSP Program: UPAC

Outcomes

CAMS Scores‡	Caregiver (N=0)		Youth (N=0)	
	Intake	Discharge	Intake	Discharge
Internalizing Behaviors	-	-	-	-
Externalizing Behaviors	-	-	-	-
Social Competence	-	-	-	-

‡Measure not currently collected.

CFARS Scores (N=0)‡	Intake	Discharge	*Change*
Depression	-	-	-
Anxiety	-	-	-
Hyperactivity	-	-	-
Thought Process	-	-	-
Cognitive	-	-	-
Medical / Physical	-	-	-
Traumatic Stress	-	-	-
Substance Use	-	-	-
Interpersonal Relations	-	-	-
Behavior in Home	-	-	-
Activities of Daily Living Functioning	-	-	-
Socio-legal	-	-	-
School or Work	-	-	-
Danger to Self	-	-	-
Danger to Others	-	-	-
Security Needs	-	-	-

‡Measure not currently collected.

Primary Care Physician Status§	Number	%
Lost PCP	0	0.0%
Never Had PCP	0	0.0%
Had PCP Both Timepoints	20	100.0%
Gained PCP	0	0.0%
Missing	0	0.0%
Total	20	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

School Attendance§	Number	%
Decline	6	30.0%
No Change	5	25.0%
No Change--Consistently Excellent	8	40.0%
Improvement	1	5.0%
Missing	0	0.0%
Total	20	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

Academic Performance§	Number	%
Decline	2	10.0%
No Change	8	40.0%
No Change--Consistently Excellent	0	0.0%
Improvement	10	50.0%
Missing	0	0.0%
Total	20	

§Analysis limited to clients with a 3, 6, 9, or 12 month assessment in the current fiscal year. Most recent assessment compared status at intake.

CHILD & FAMILY PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

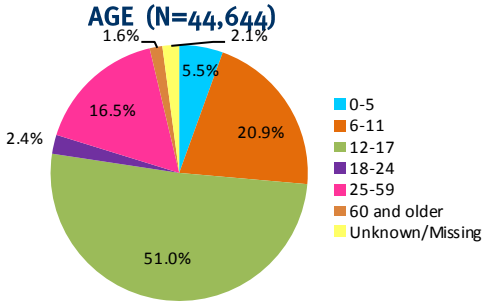
FISCAL YEAR 2012—13 ANNUAL REPORT

The Mental Health Services Act Prevention and Early Intervention 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. San Diego County has funded 13 contractors to provide prevention and early intervention (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. This information is summarized in the following report.

DATA: Child and Adolescent PEI Programs
REPORT PERIOD: 7/1/2012-6/30/2013
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 44,644 (Unduplicated)*
**Data for all students participating in the Yellow Ribbon Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.*

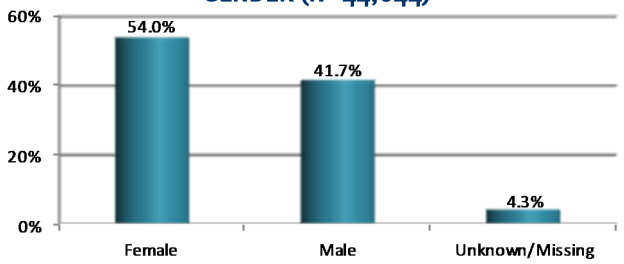
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

AGE (N=44,644)



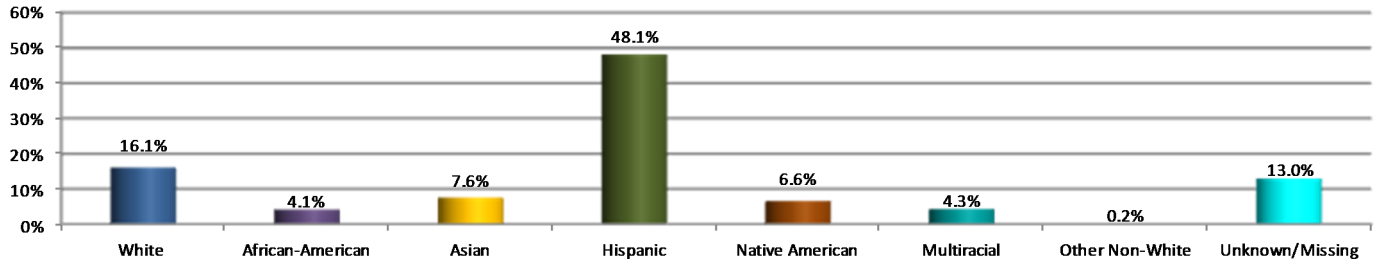
Fifty-one percent of participants were ages 12-17. Some participants were older than 18 because several children's PEI programs include caregivers and community members.

GENDER (N=44,644)

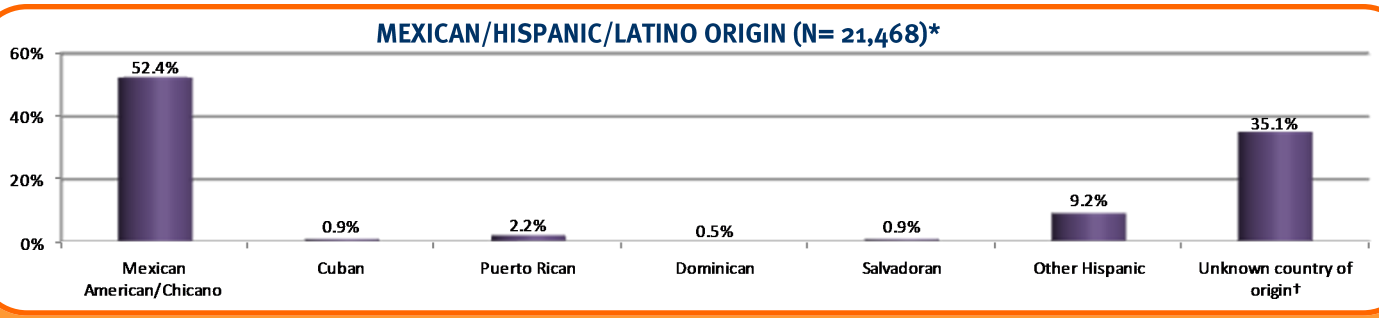


Fifty-four percent of the participants who received services identified their gender as female.

RACE/ETHNICITY (N=44,644)



Forty-eight percent of participants who received services identified their race/ethnicity as Hispanic.

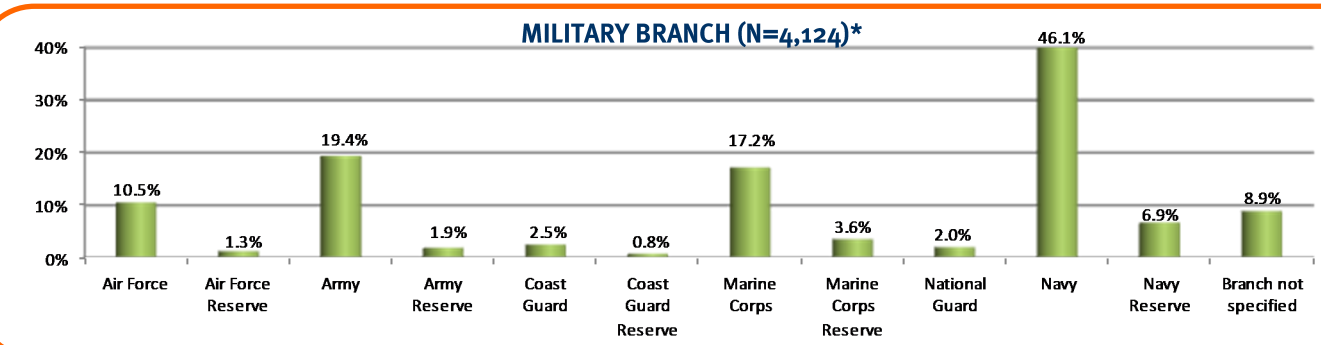


Of the Hispanic population served, 52% identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

†Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

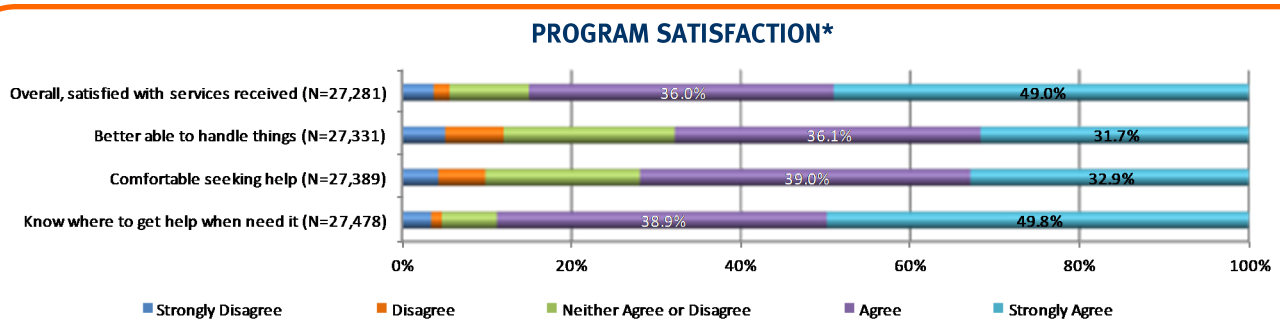
CAREGIVER INVOLVEMENT IN MILITARY SERVICE



Of the 22,625 participants for whom caregiver involvement in the military was reported, 4,124 (18%) reported that the youth's caregiver had served in the military. Of these caregivers, 1,902 (46%) served in the Navy, 799 (19%) served in the Army and 708 (17%) served in the Marine Corps. The remaining branches were not as highly represented.

**Participants could have served in more than one military branch so numbers and percentages may add up to more than the N or 100%.*

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 61% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 85% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

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.

CHILD & ADULT PEI PROGRAMS

SYSTEMWIDE SUMMARY

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

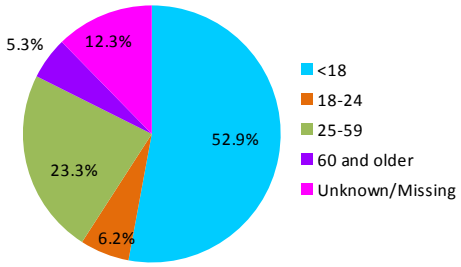
FISCAL YEAR 2012—2013 ANNUAL REPORT

The Mental Health Services Act Prevention and Early Intervention 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. San Diego County has funded 25 contractors to provide prevention and early intervention (PEI) programs for adults and older adults, and 13 contractors for youth and transition age youth 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. This information is summarized in the following report.

DATA: Child and Adult PEI Programs
REPORT PERIOD: 7/1/2012-6/30/2013
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 65,295 (Unduplicated)*
**Data for all students participating in the Yellow Ribbon Suicide Prevention program were calculated from a representative sample of students who provided demographic and satisfaction information.*

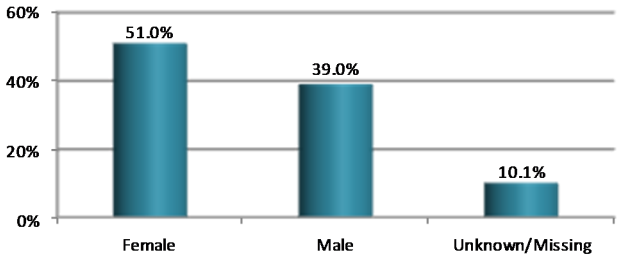
SYSTEMWIDE PARTICIPANT DEMOGRAPHICS

AGE (N=65,295)



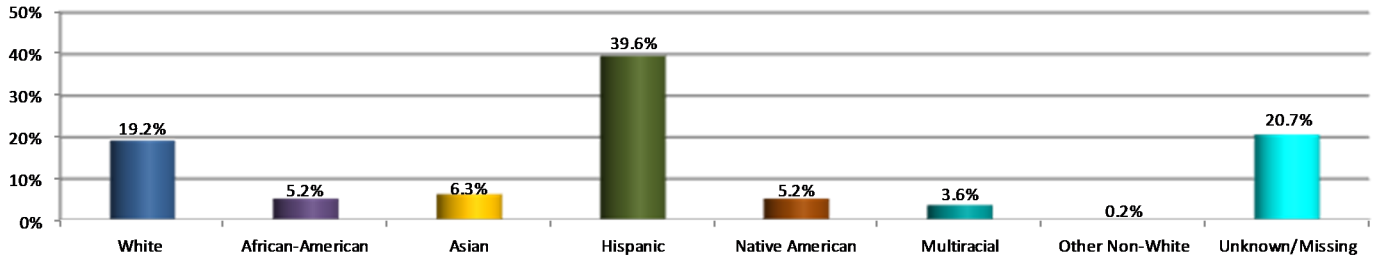
Fifty-three percent of participants were under the age of 18; 23% were between the ages of 25-59.

GENDER (N=65,295)

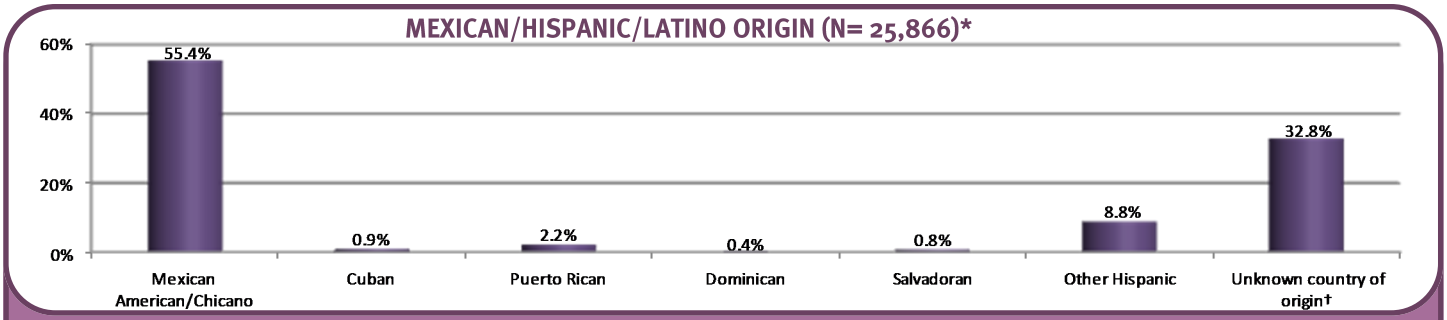


Fifty-one percent of participants who received services identified their gender as female.

RACE/ETHNICITY (N=65,295)



Nearly 40% of participants who received services identified their ethnic background as Hispanic.

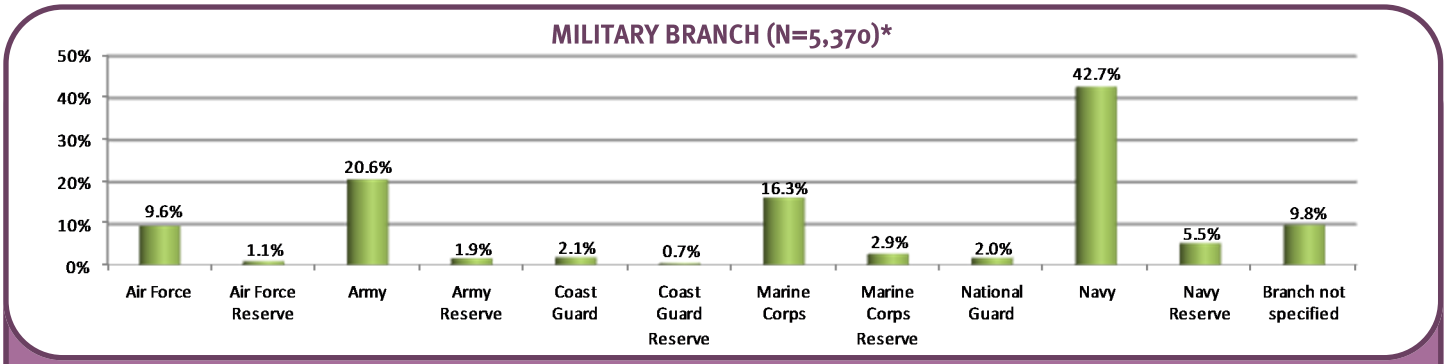


Of the Hispanic population served, 55% identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

†Some PEI programs did not ask Hispanic participants to list their country of origin. Participants from these programs are included in the unknown category.

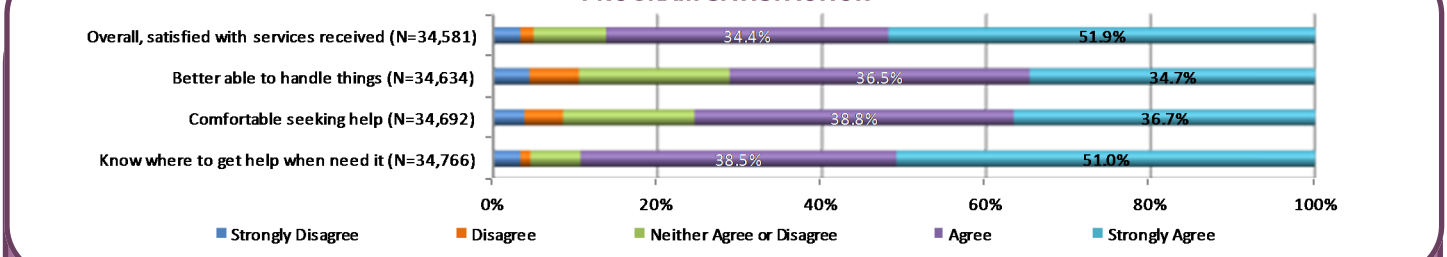
MILITARY SERVICE



In the adult PEI programs, participants were asked about their own military involvement. The children's PEI programs reported whether the children's caregivers had served in the military. Of the 24,909 participants in both systems for whom military service status was known, 5,370 (22%) stated that either they or their child's caregiver had served in the military. The majority of these individuals served in the Navy (43%), the Army (21%), the Marine Corps (16%) or the Air Force (10%). The remaining military branches were not as highly represented.

**Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Information on satisfaction with the PEI programs was available for approximately 53% of the participants. Of these participants, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 86% of the participants who responded were satisfied with the services they received.

**Satisfaction data not available for all participants.*

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.

The Health Services Research Center (HSRC) at University of California, San Diego is a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County 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.

FAMILIES AS PARTNERS (DV01)

SOUTH BAY COMMUNITY SERVICES

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

FISCAL YEAR 2012—13 ANNUAL REPORT

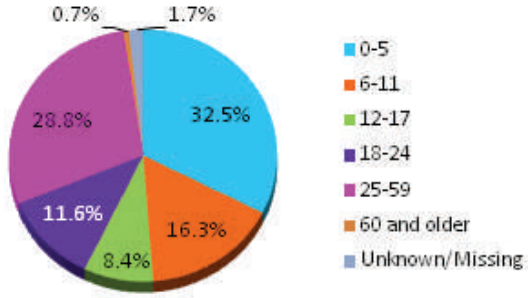
REGION: SOUTH– DISTRICT 4

Families as Partners (FAP) is a San Diego South Region partnership between families, Child Welfare Services, and community service providers. The goal of the partnership is to establish a community safety net for the well-being of the South Region's children and their families who are at risk of becoming involved in the child welfare system. Families are referred from the child welfare hotline, and FAP provides services immediately to help them maintain a safe home and reduce the effects of trauma exposure. FAP clinicians visit families in their homes, conduct thorough assessments of the families' needs and strengths, and help families connect with resources in their community. In some cases, families receive information and support from Parent Peer Partners, parents with former experience with the child welfare system. Families also participate in team decision-making meetings (TDM) with the FAP team, and help develop safety plans for their children.

CONTRACTOR: South Bay Community Services	
CONTRACT START DATE: 5/1/2009	**DATA COLLECTION START DATE: 5/1/2009**
PROGRAM SERVICES START DATE: 5/1/2009	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 535 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 1990 (May include duplicates)**

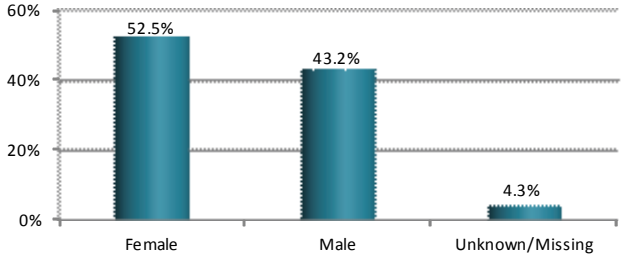
YOUTH AND CAREGIVER DEMOGRAPHICS

AGE (N=535)



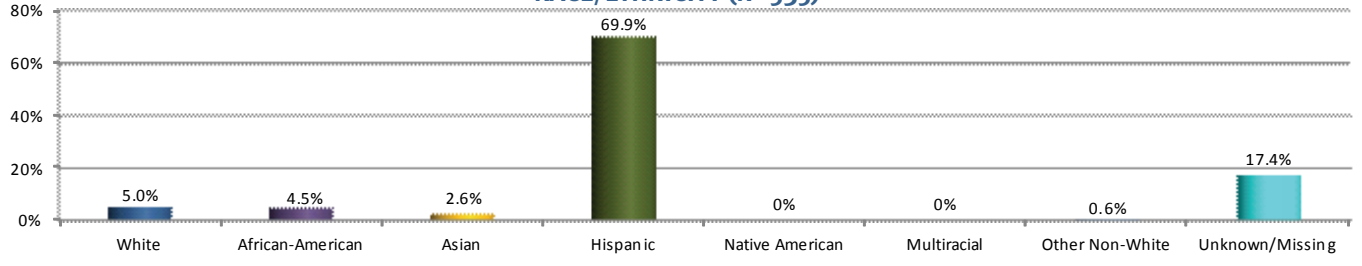
Children and youth ages 0 to 17 comprised 57% of the population served.

GENDER (N=535)

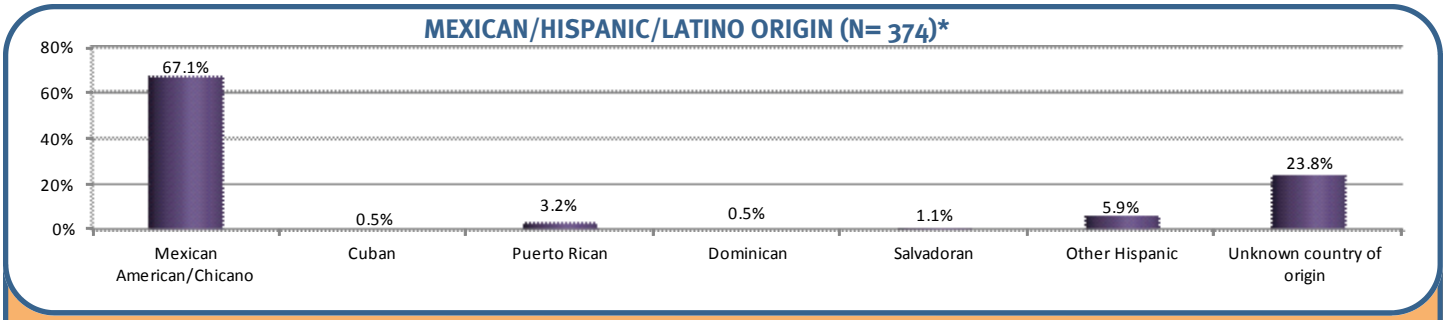


Fifty-three percent of the participants who received services were female.

RACE/ETHNICITY (N=535)



Seventy percent of the participants who received services identified their race/ethnicity as Hispanic. Approximately 17% of all participants served did not report their race.



Sixty-seven percent of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

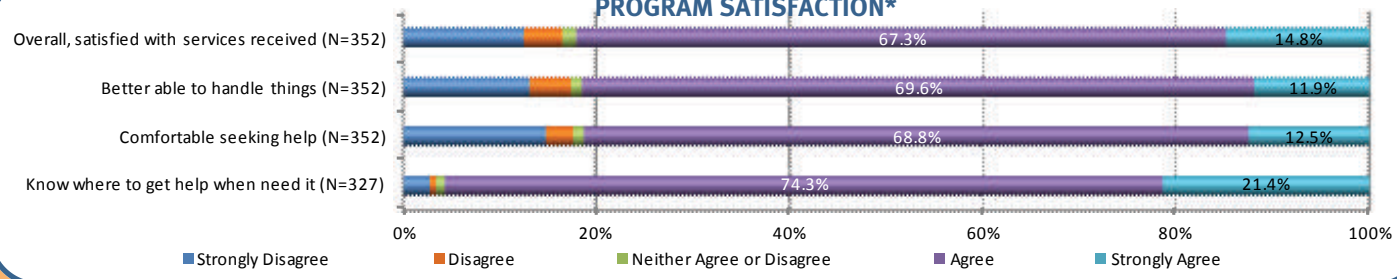
**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE*

Of the 442 participants who responded to this question, the majority (96%) reported that the youth's caregiver had not served in the military. Of the 16 caregivers who had served in the military, 7 (44%) served in the Navy, 4 (25%) served in the Army, 2 (13%) served in the National Guard, 1 (6%) served in the Air Force, 1 (6%) served in the Marine Corps, and 1 (6%) served in the Navy Reserve.

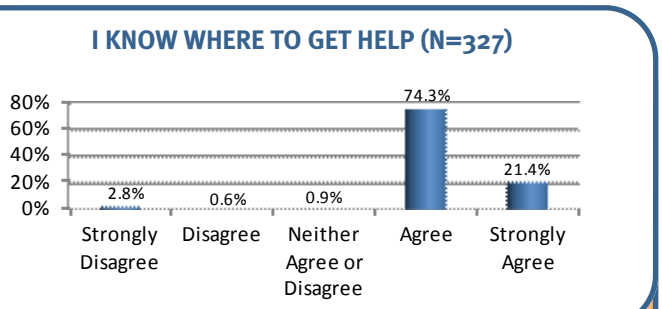
**Caregivers could have served in more than one military branch so numbers and percentages may add up to more than the N or 100%.*

PROGRAM SATISFACTION



Of the parents that responded to the satisfaction questions, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they felt more comfortable seeking help now. Overall, roughly 82% of the participants who responded were satisfied with the services received.

**Satisfaction data not available for all participants.*



Ninety-six percent of participants who responded to this question reported that they knew where to get help when they needed it. Approximately 3% did not agree with this statement.

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.

SOUTH REGION TRAUMA EXPOSED SERVICES (DV02)

FRED FINCH YOUTH CENTER

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

FISCAL YEAR 2012—13 ANNUAL REPORT

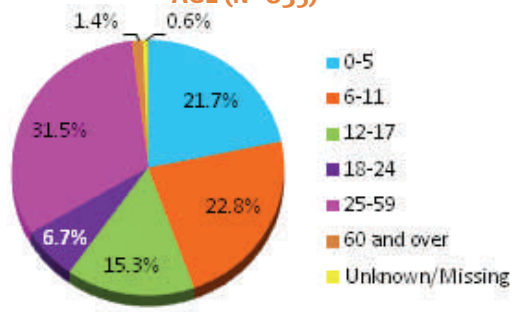
REGION: SOUTH– DISTRICT 1

The Fred Finch Youth Center (FFYC) Triple P Positive Parenting Program is an evidence-based, comprehensive prevention and early intervention program to help prevent re-traumatization of children and families who experience contact with the child welfare system. The program serves children and their families that recently had involvement with Child Welfare Services, but do not require voluntary or dependent services. However, Child Welfare Services deems that these families could benefit from parenting and/or support in order to prevent further child welfare involvement. The Triple P Program helps parents develop stronger parenting skills and effectively manage child misbehavior.

CONTRACTOR: Fred Finch Youth Center	
CONTRACT START DATE: 7/1/2010	**DATA COLLECTION START DATE: 1/1/2011**
PROGRAM SERVICES START DATE: 1/1/2011	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 835 (Unduplicated) **NUMBER OF FAMILIES WITH DATA IN FY 2012-13: 190 (Unduplicated)**	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 2468 (May include duplicates)**

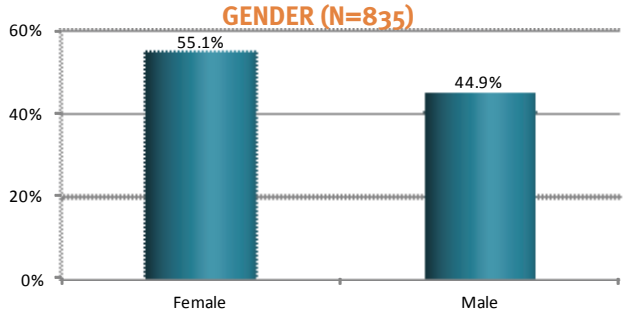
YOUTH AND CAREGIVER DEMOGRAPHICS

AGE (N=835)



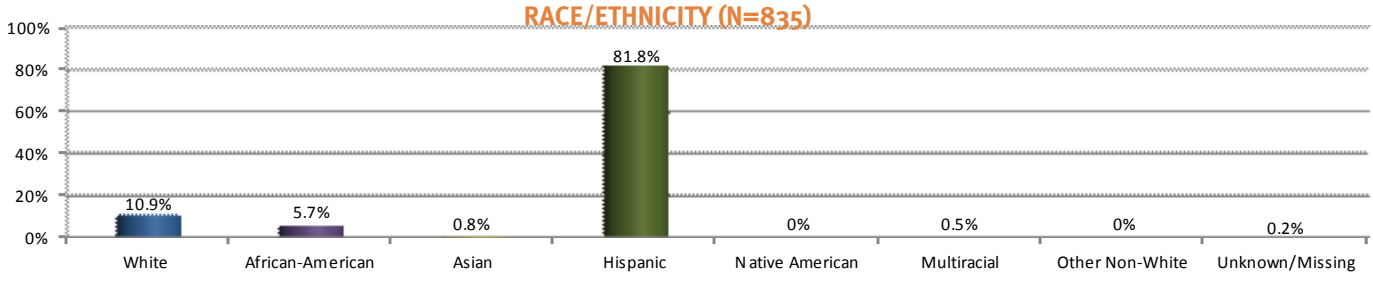
Children and youth ages 0 to 17 comprised 60% of the population served.

GENDER (N=835)

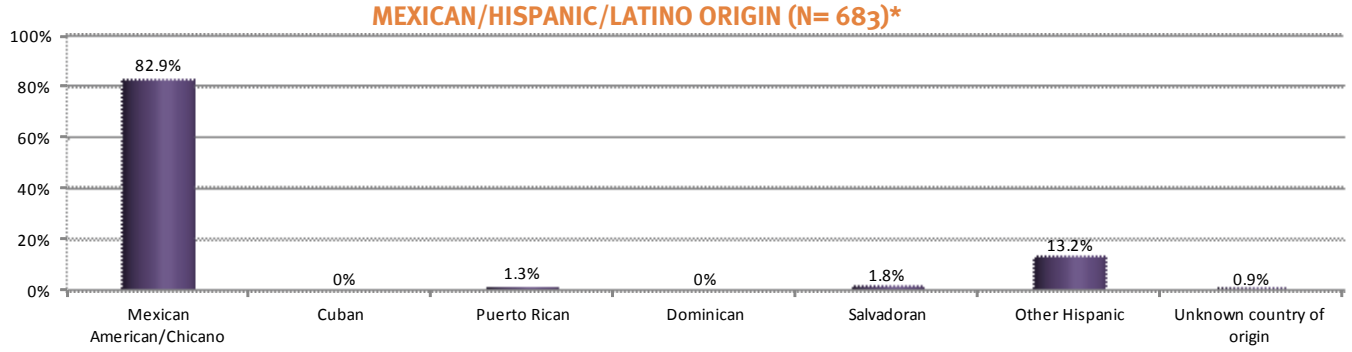


The program served slightly more female (55%) than male (45%) participants.

RACE/ETHNICITY (N=835)



Eighty-two percent of participants identified their race/ethnicity as Hispanic.



The majority (83%) of the Hispanic population served identified their ethnic background as Mexican American/ Chicano.

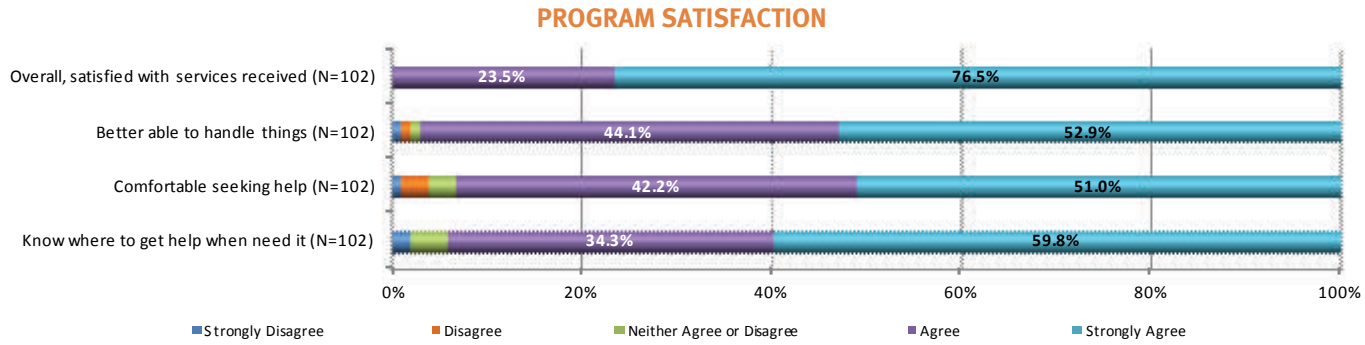
**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE*

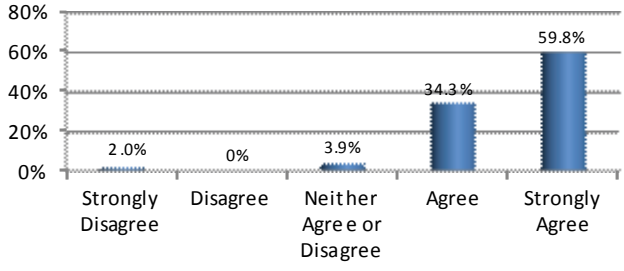
Of the 190 participants who responded to this question, 96% reported that the youth's caregiver had not served in the military. Of the 8 caregivers who had served in the military, 3 (38%) served in the Navy, 2 (25%) served in the Army, 1 (13%) served in the Army Reserve, 1 (13%) served in the Marine Corps, and 1 (13%) served in an unspecified branch.

**Caregivers could have served in more than one branch so numbers and percentages may add up to more than the N or 100%.*

PROGRAM SATISFACTION



The majority of participants did not complete the satisfaction questionnaire, which is distributed at close of service. Of those who did, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they felt more comfortable seeking help now. Overall, 100% of the participants who responded were satisfied with the services received.



Ninety-four percent of participants who responded to this question reported that they knew where to get help when they needed it. Two percent of participants who responded did not agree with this statement.

"I know where to get help when I need it."

NUMBER OF RETURNING CLIENTS

Of the 835 participants with data in the FY 2012-13 reporting period, 804 participants were new to the program. The remaining 31 participants previously received Triple P services.

NUMBER OF RETURNING FAMILIES

Of the 190 families with data in the FY 2012-13 reporting period, 183 families were new to the program. The remaining 7 families previously received Triple P services.

FAMILY INVOLVEMENT

FAMILY INVOLVEMENT IN TRIPLE P		
TRIPLE P LEVELS (N=190)*	**N**	**%**
Resource Only	40	21.1
Level 3 Primary	1	0.5
Level 3 Primary + Stepping Stones	0	0.0
Level 4 Standard	96	50.5
Level 4 Standard + Stepping Stones	1	0.5
Pathways	6	3.2
Missing	53	27.9

Level 4 Standard was the most commonly received Triple P service. Approximately 21% of clients did not participate in the parent training components.

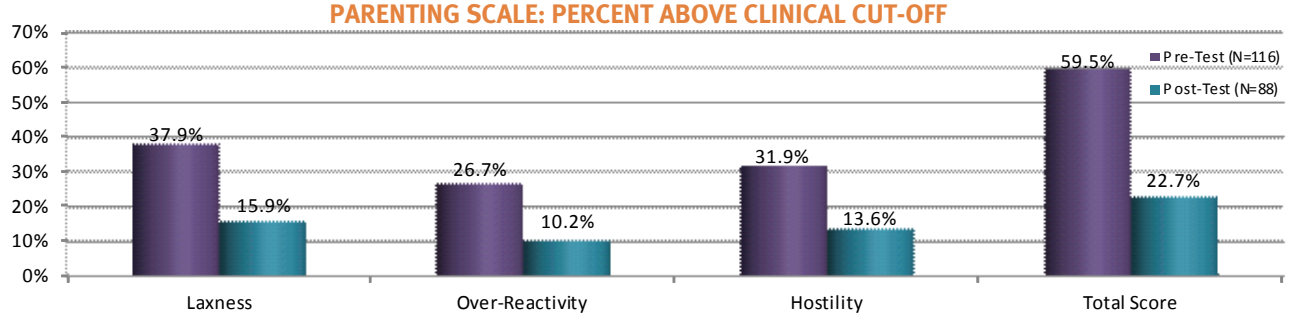
**Participants may receive more than one level so numbers and percentages may add up to more than the N or 100%.*

CHANGES IN PARENTING: PARENTING SCALE

PARENTING SCALE		
PARENTING SCALE DOMAINS (1-7)	**PRE-TEST (N=116) MEAN (STANDARD DEVIATION)**	**POST-TEST (N=88) MEAN (STANDARD DEVIATION)**
Laxness (permissive, inconsistent discipline)	3.08 (1.21)	2.37 (1.05)
Over-reactivity (harsh, emotional, authoritarian discipline and irritability)	3.01 (1.24)	2.27 (1.09)
Hostility (use of verbal or physical force)	2.06 (1.09)	1.53 (0.79)
Total Score	**3.39 (0.67)**	**2.61 (0.74)**

A decrease in any domain indicates improvement. On average, scores on the Parenting Scale assessment improved from pre-test to post-test. Additionally, for clients with two assessments, the change in the laxness and over-reactivity subscales and the change in total score were statistically significant at the p<.001 level.

PARENTING SCALE: PERCENT ABOVE CLINICAL CUT-OFF



The scores above the clinical cut-off indicate dysfunctional parenting. The percentage of clients above the clinical cut-off decreased from pre-test to post-test across all subscales.

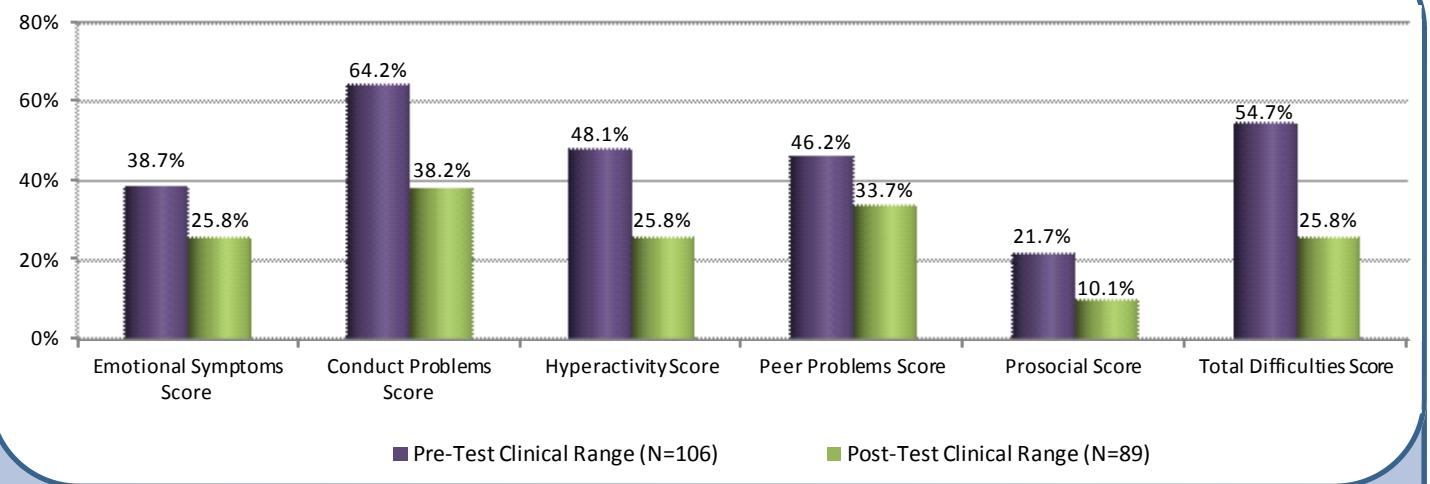
PARENTING SCALE: POSITIVE CHANGE IN CLINICAL CUT-OFF*†		
PARENTING SCALE DOMAIN	**N**	**%**
Laxness (N=30)	22	73.3
Over-reactivity (N=21)	15	71.4
Hostility (N=23)	15	65.2
Total Score (N=54)	**36**	**66.7**
Nearly sixty-seven percent of the parents whose total Parenting Scale score was above the clinical cut-off at pre-test assessment scored below the clinical cut-off at post-test assessment.		

**Positive change defined as a score above the clinical cut-off on the pre-test and below the clinical cut-off on the post-test.*
†Analysis limited to clients with a pre- and post-test, who were above the clinical cut-off on the pre-test.

CHANGES IN CHILD BEHAVIOR: OVERALL PARENT REPORT

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)		
SDQ SCALE DOMAINS (RANGE)	**PRE-TEST MEAN (N=106) (STANDARD DEVIATION)**	**POST-TEST MEAN (N=89) (STANDARD DEVIATION)**
Emotional Symptoms Score (1-10)	3.04 (2.49)	1.94 (1.99)
Conduct Problems Score (1-10)	3.80 (2.52)	2.72 (2.68)
Hyperactivity Score (1-10)	5.44 (2.86)	3.71 (2.80)
Peer Problems Score (1-10)	2.75 (2.17)	2.03 (1.98)
Prosocial Behavior Score (1-10)	7.26 (2.57)	8.20 (1.94)
Total Difficulties Score (1-40)	**15.02 (7.59)**	**10.40 (7.41)**
An increase in the Prosocial Behavior domain indicates improvement; a decrease in any other domain indicates improvement. On average, children's behavior problems improved following receipt of Triple P services.		

SDQ: PERCENT IN CLINICAL RANGE: ABNORMAL/BORDERLINE



Scores in the clinical range of the SDQ indicate that a child may have emotional or behavioral problems. The percentage of youth who had scores in the clinical range on the Total Difficulties Score decreased from pre-test to post-test.

SDQ: POSITIVE CHANGE IN CLINICAL RANGE*†		
SDQ SCALE DOMAIN	**N**	**%**
Emotional Symptoms Score (N=36)	24	66.7
Conduct Problems Score (N=57)	32	56.1
Hyperactivity Score (N=37)	25	67.6
Peer Problems Score (N=40)	22	55.0
Prosocial Behavior Score (N=17)	16	94.1
Total Difficulties Score (N=44)	**30**	**68.2**
Over sixty-eight percent of children who had scores in the clinical range at pre-test scored below the clinical range at post-test.		

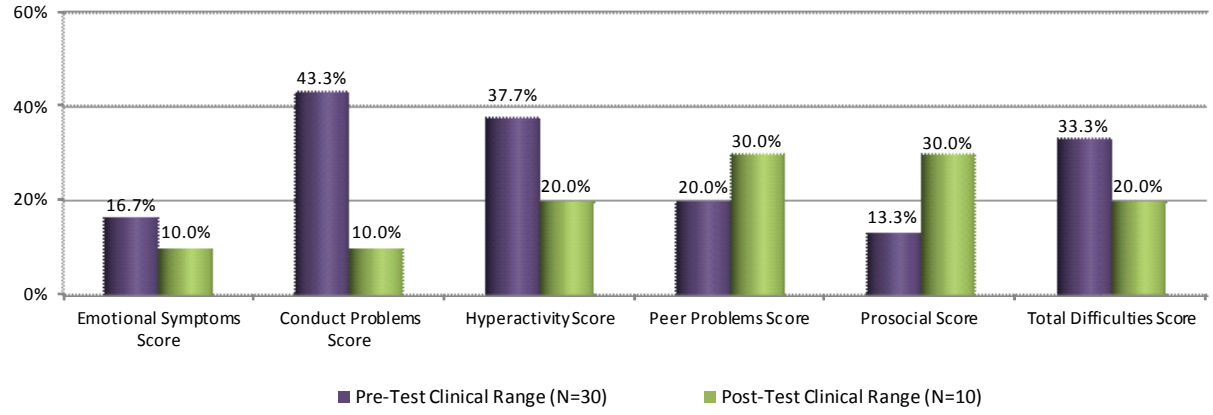
**Positive change defined as a score in the abnormal range on the pre-test and borderline or normal range on the post-test, or a score in the borderline range on the pre-test and normal range on the post-test.*

†Analysis limited to clients with a pre- and post-test, who scored in the borderline or abnormal range on the pre-test.

CHANGES IN CHILD BEHAVIOR: OVERALL YOUTH REPORT

STRENGTHS AND DIFFICULTIES QUESTIONNAIRE (SDQ)		
SDQ SCALE DOMAINS (RANGE)	**PRE-TEST MEAN (N=30) (STANDARD DEVIATION)**	**POST-TEST MEAN (N=10) (STANDARD DEVIATION)**
Emotional Symptoms Score (1-10)	3.30 (2.34)	2.60 (2.55)
Conduct Problems Score (1-10)	3.17 (2.56)	2.10 (2.08)
Hyperactivity Score (1-10)	4.73 (2.88)	2.80 (3.26)
Peer Problems Score (1-10)	1.87 (1.96)	1.70 (1.83)
Prosocial Behavior Score (1-10)	7.40 (1.89)	7.40 (2.17)
Total Difficulties Score (1-40)	**13.07 (7.88)**	**9.20 (8.64)**
An increase on the Prosocial Behavior domain indicates improvement; a decrease in any other domain indicates improvement. On average, children's behavior problems improved following receipt of Triple P services.		

SDQ: PERCENT IN CLINICAL RANGE: ABNORMAL/BORDERLINE



Scores in the clinical range of the SDQ indicate that a child may have emotional or behavioral problems. The percentage of youth who had scores in the clinical range on the Total Difficulties Score decreased from pre-test to post-test. While the percentage of youth who had scores in the clinical range of the Peer Problems scale increased, the number of youth with post-tests was small, and in small samples a difference in one or two cases can lead to larger differences in percentages.

SDQ: POSITIVE CHANGE IN CLINICAL RANGE*†		
SDQ SCALE DOMAIN	**N**	**%**
Emotional Symptoms Score (N=2)	2	100.0
Conduct Problems Score (N=5)	4	80.0
Hyperactivity Score (N=3)	2	66.7
Peer Problems Score (N=0)	0	0.0
Prosocial Behavior Score (N=1)	0	0.0
Total Difficulties Score (N=3)	**2**	**66.7**
Over sixty-six percent of children who had scores in the clinical range at pre-test scored below the clinical range at post-test.		

**Positive change defined as a score in the abnormal range on the pre-test and borderline or normal range on the post-test, or a score in the borderline range on the pre-test and normal range on the post-test.*

†Analysis limited to clients with a pre- and post-test, who scored in the borderline or abnormal range on the pre-test.

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.

ALLIANCE FOR COMMUNITY EMPOWERMENT(DV03)

UNION OF PAN ASIAN COMMUNITIES

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

FISCAL YEAR 2012—13 ANNUAL REPORT

REGION: SOUTH– DISTRICT 4

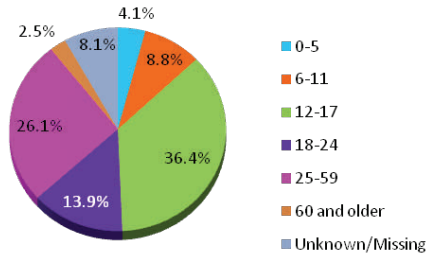
The Alliance for Community Empowerment (ACE) provides six different PEI programs that help prevent community violence and support families in San Diego: the Community Violence Response Team, Parent and Youth Gang Awareness groups, the Leadership Academy, Support Groups, and the Strengthening Families program. The Community Violence Response Team provides assistance to individuals who are impacted by acts of violence. The Gang Awareness groups teach both caregivers and youth about the risk factors for gang involvement, and the Leadership Academy is an on going intervention designed to help prevent youth ages 12-16 from participating in gangs. This intervention teaches youth how to improve their decision-making skills and handle peer pressure. The Support Groups help community members who are grieving the loss of loved ones, many of whom were victims of violence. Finally, the Strengthening Families Program is a research-based intervention that provides training in parenting, communication, and problem-solving skills to increase families' resilience and reduce the risk of substance abuse, delinquency, and school failure.

CONTRACTOR: Union of Pan Asian Communities (UPAC)	
CONTRACT START DATE: 12/1/2009	**DATA COLLECTION START DATE: 1/4/2010**
PROGRAM SERVICES START DATE: 1/4/2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13*: 712 (Unduplicated)	**FAMILIES SERVED SINCE PROGRAM INCEPTION: 1666 (May include duplicates)**

**Not all data are available for every participant.*

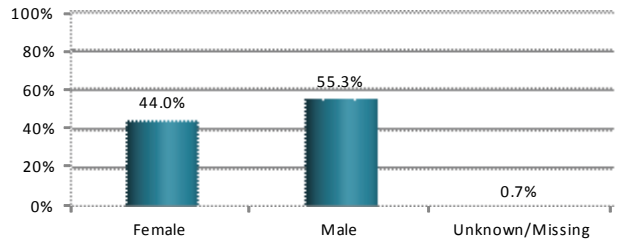
PARTICIPANT DEMOGRAPHICS*

AGE (N=712)



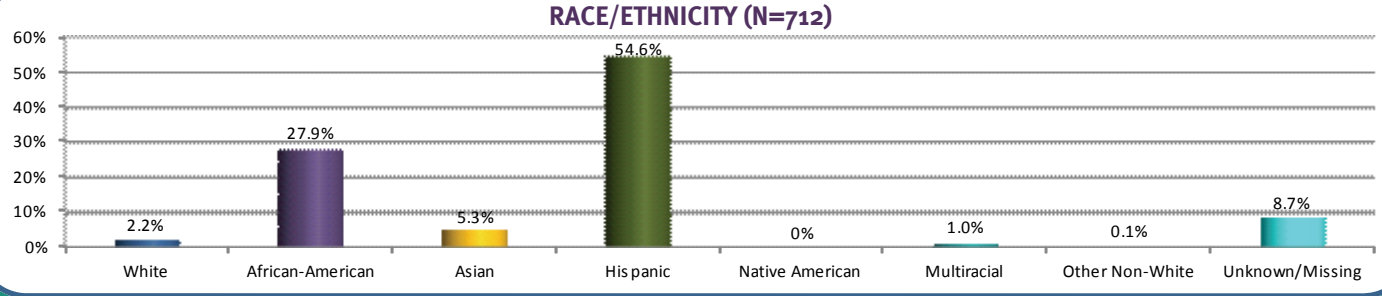
Forty-nine percent of participants were children and youth between the ages of 0-17. Age was not reported for 8% of participants.

GENDER (N=712)



Fifty-five percent of participants were male and 44% were female.

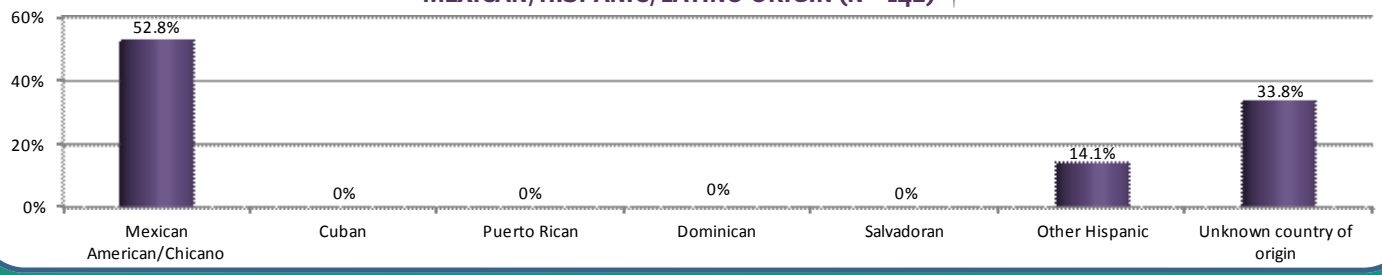
RACE/ETHNICITY (N=712)



Fifty-five percent of participants identified their race/ethnicity as Hispanic.

**Data were only available for clients with a referral form and clients who received services from the community violence response team.*

MEXICAN/HISPANIC/LATINO ORIGIN (N= 142)*†



Fifty-three percent of the Hispanic population identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

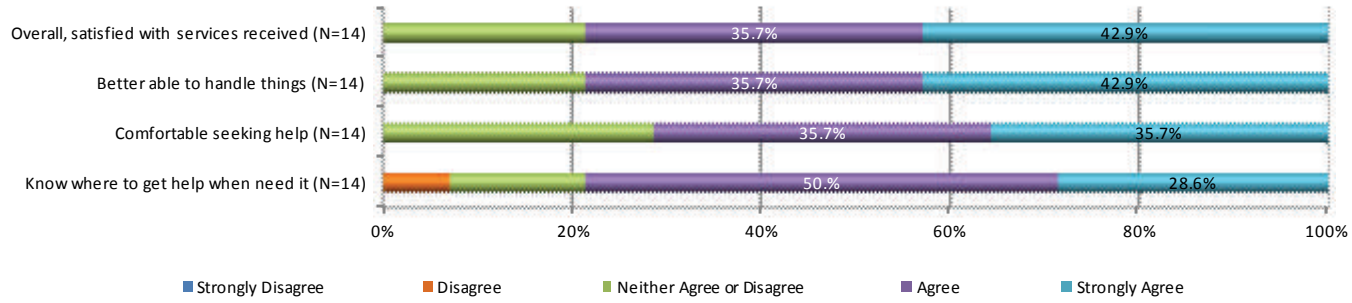
†Data only available for clients with a referral form.

MILITARY SERVICE

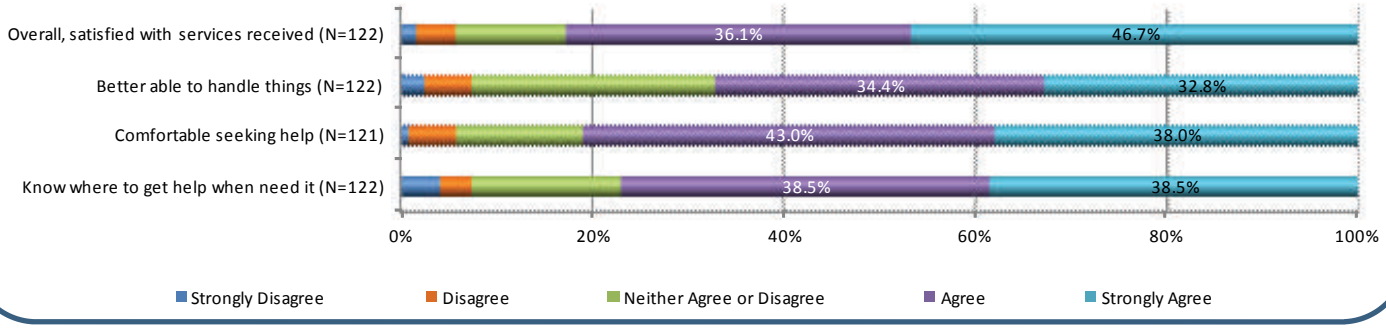
Military status data not available for clients.

SATISFACTION BY PROGRAM (includes duplicated participants)

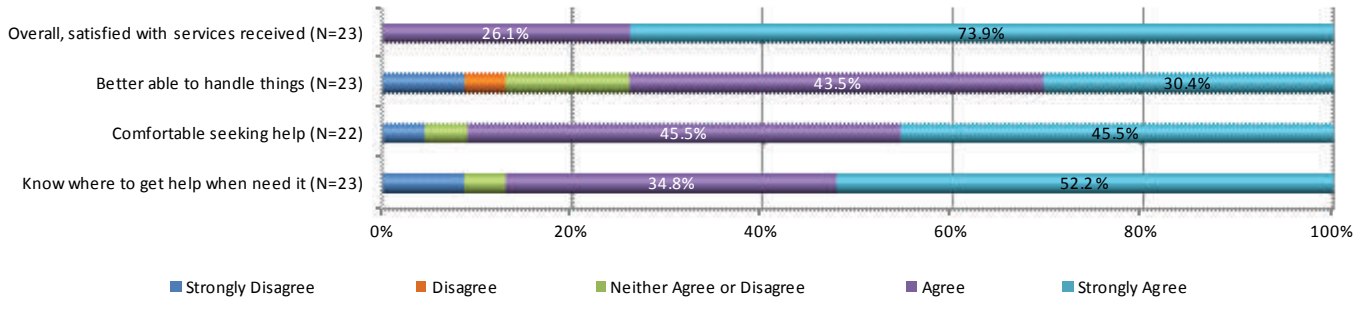
GANG AWARENESS—PARENT PROGRAM SATISFACTION



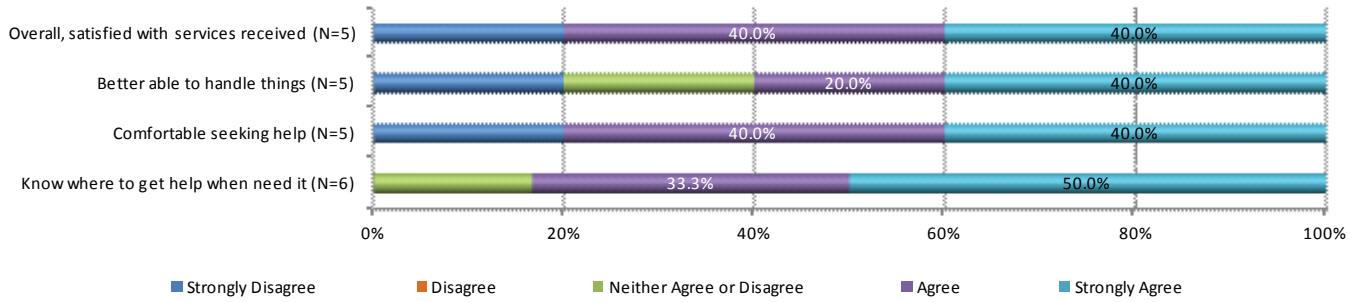
GANG AWARENESS—YOUTH PROGRAM SATISFACTION



STRENGTHENING FAMILIES GROUP PROGRAM SATISFACTION



OTHER GROUP PROGRAM SATISFACTION



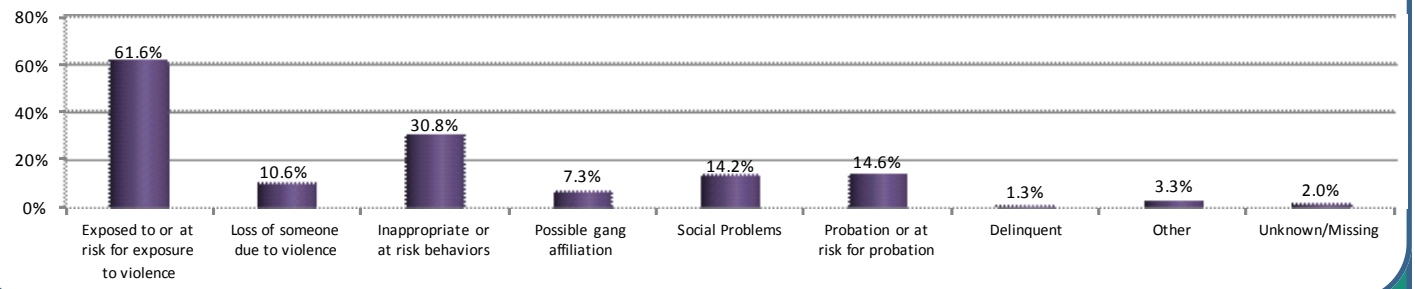
Satisfaction data were not available for all participants in all programs. Participants in the Strengthening Families program were the most satisfied with services received; satisfaction in other UPAC programs polled was much lower by comparison.

REFERRALS

REFERRALS	N
Number of clients referred to ACE PEI Programs	302
Number of referred clients who attended ACE PEI Programs*	197

**Clients did not always sign in when they attended ACE programs so this count may be low.*

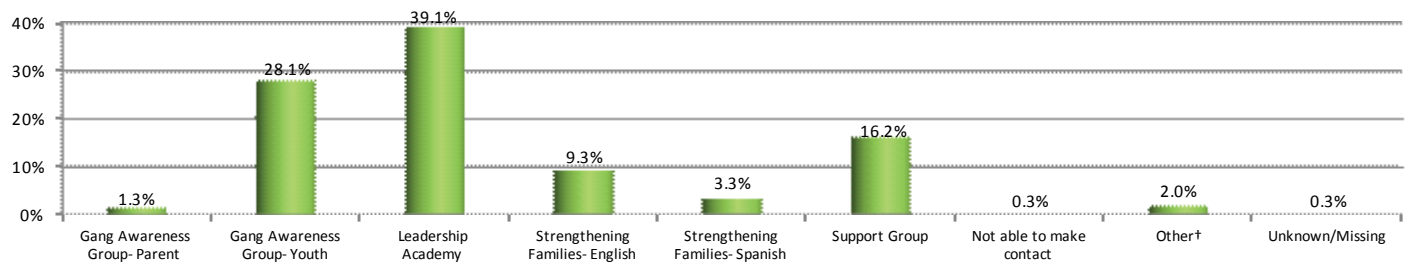
REASON FOR REFERRAL (N= 302)*



The majority of referrals were for individuals who had been exposed to or were at risk for exposure to violence.

**Participants can be referred for multiple reasons so percentages may add up to more than 100%.*

REFERRALS TO SPECIFIC PROGRAMS (N= 302)*



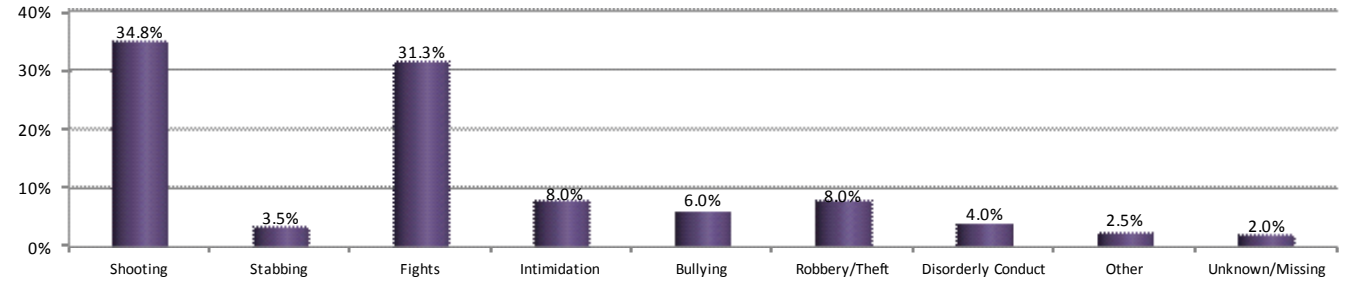
Most of the individuals who were referred for PEI services were referred to the Leadership Academy or the Youth Gang Awareness group.

**Participants can be referred to more than one program so percentages may add up to more than 100%.*

†Other referrals can include referrals to counseling or other case management services.

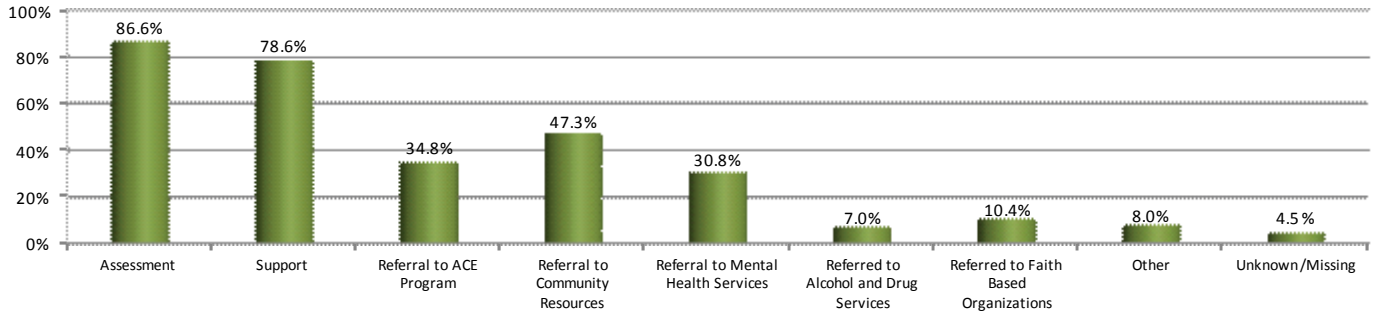
COMMUNITY VIOLENCE RESPONSE TEAM

COMMUNITY VIOLENCE INCIDENT TYPE (N=201)



More than 66% of incidents the Community Violence Response team responded to were fights or shootings.

SERVICES PROVIDED BY THE COMMUNITY VIOLENCE RESPONSE TEAM (N=201)*



The most common services provided by the Community Violence Response Team were assessments and support.

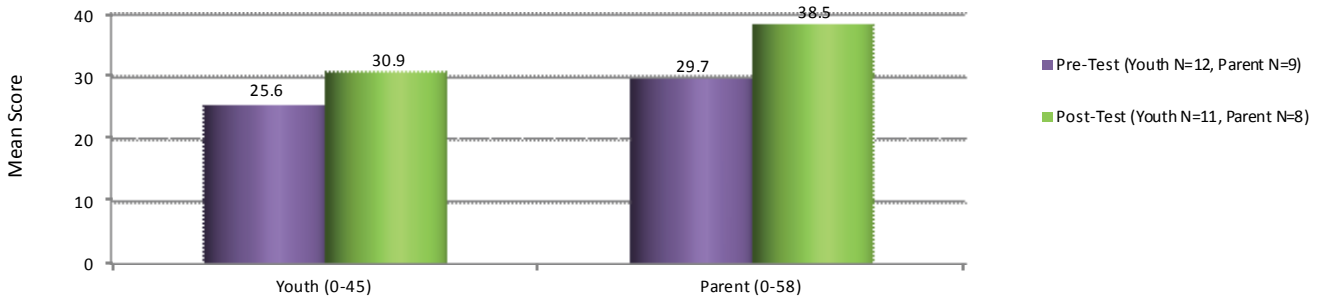
**Multiple services can be provided for each incident so the percentages may add up to more than 100%.*

GROUP PROGRAM ATTENDANCE

ATTENDANCE AT ACE GROUP PROGRAMS*	N
Gang Awareness- Parent	21
Gang Awareness- Youth	147
Strengthening Families	12
Leadership Academy	98
Support Groups	30
Other	31
**Attendance may be underreported.*	

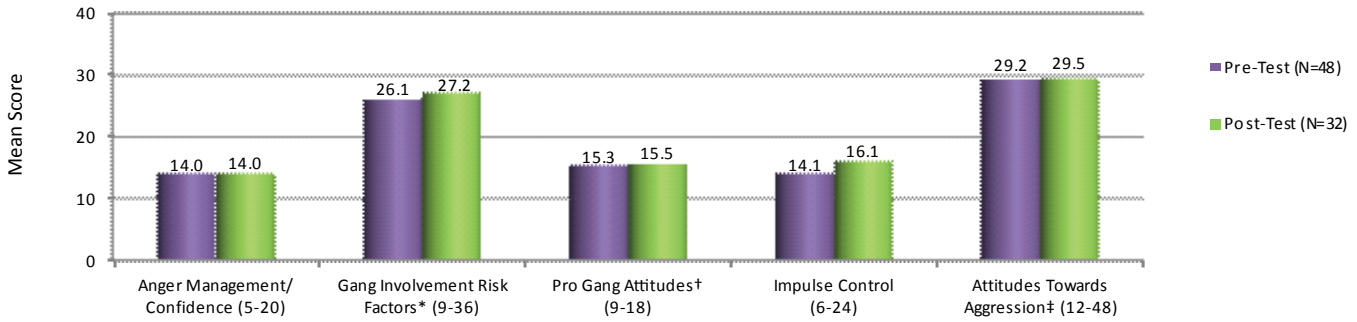
GROUP PROGRAM SPECIFIC OUTCOMES

STRENGTHENING FAMILIES*



On average, both youth and parent scores on the Strengthening Families assessment increased from pre-test to post-test, indicating improvements in family functioning. However, few individuals completed these assessments. An additional analysis was conducted with seven parents who had both an intake and a second assessment. Participants included in this analysis showed statistically significant improvements in parenting techniques ($p<.01$).

LEADERSHIP ACADEMY



On average, participant scores on the Leadership Academy assessment did not change very much from pre-test to post-test.

**Pre-Test N=47; Post-Test N=31.*

†Pre-Test N=47.

‡Post-Test N=30.

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.

POSITIVE PARENTING PROGRAM - TRIPLE P (EC01)

JEWISH FAMILY SERVICES (JFS)

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

FISCAL YEAR 2012—13 ANNUAL REPORT

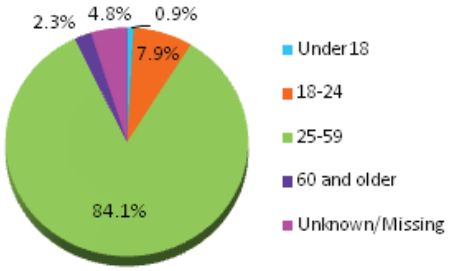
REGION: NORTH CENTRAL – DISTRICT 4

The Triple P – Positive Parenting Program promotes the development, growth, health, and social competence of young children. Services which are offered at Head Start (HS) and Early Head Start (EHS) Centers are designed to benefit the child by teaching caregivers and Head Start staff specific parenting skills and techniques for managing misbehavior. This Triple P program provides both group-based trainings and individual treatment. Staff are also trained to provide ongoing support to the family/caregiver once the Triple P curriculum is completed. This program serves the Central and North Coastal regions of San Diego.

CONTRACTOR: Jewish Family Services	
CONTRACT START DATE: 9/1/2009	**DATA COLLECTION START DATE: Outcomes: 9/29/2009 Demographics: 1/3/2010**
PROGRAM SERVICES START DATE: 9/29/2009	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 1845 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 5005 (May include duplicates)**

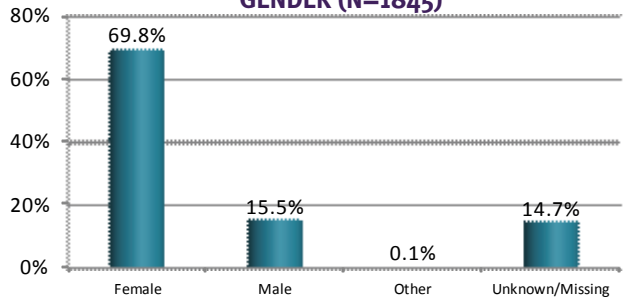
CAREGIVER DEMOGRAPHICS

AGE (N=1845)



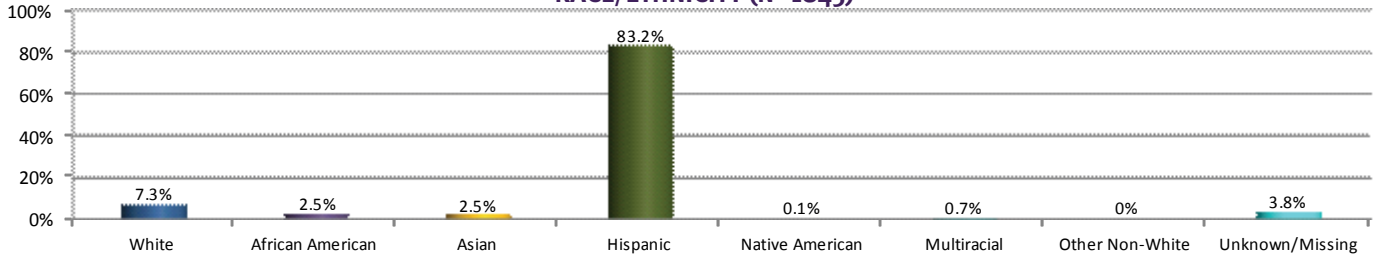
The majority (84%) of the participants served were ages 25-59. Young adults ages 18-24 comprised 8% of the population served.

GENDER (N=1845)



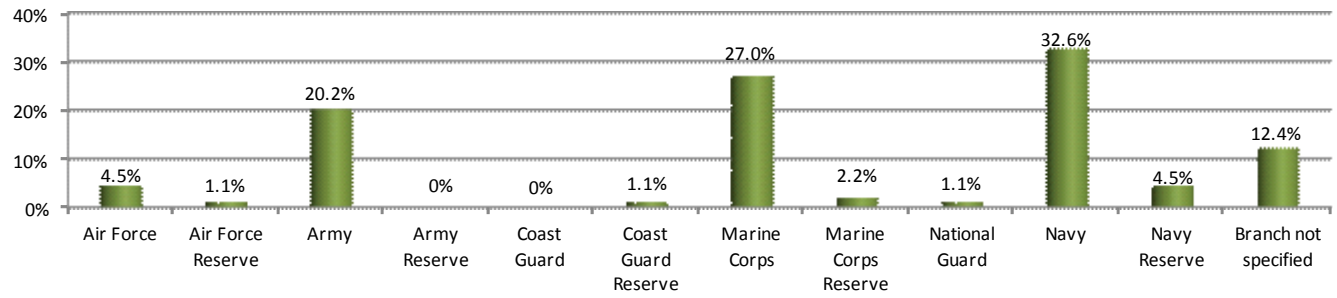
Seventy percent of participants who received services were female.

RACE/ETHNICITY (N=1845)



More than 83% of participants who received services identified their race/ethnicity as Hispanic; the majority of Hispanic clients identified their ethnic background as Mexican American/Chicano. Seven percent of participants identified their race/ethnicity as White.

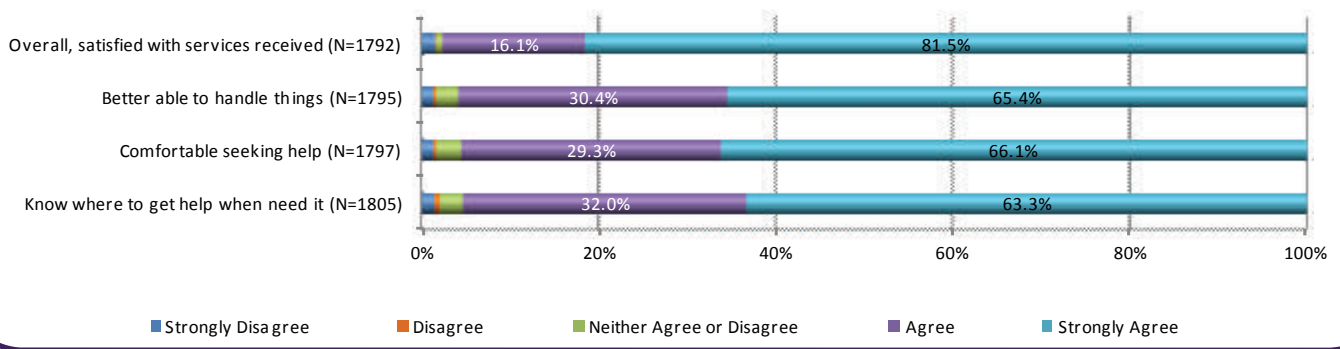
MILITARY SERVICE



Of the 1606 participants who responded to this question, 95% reported that caregivers had not served in the military. Of the 89 caregivers reported to have served in the military, 29 (33%) served in the Navy, 24 (27%) served in the Marine Corps, 18 (20%) served in the Army and 11 (12%) served in an unspecified branch. The remaining branches were not as highly represented.

**Participants could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



Most responses to these questions reflected a better ability to handle things and solve problems as a result of the program. Most respondents also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 98% of the respondents indicated satisfaction with the services received.

**Satisfaction data includes duplicated participants.*

PROGRAM COMPONENTS

PARTICIPATION IN PROGRAM COMPONENTS (N= 615)*	N	Percent
Pilot Seminarł	576	93.7%
Community Seminar‡	405	65.9%
Head Start/ Early Head Start Seminar	574	93.3%
Individual Consultation	49	8.0%
Group Program	239	38.9%
Unknown	24	3.9%
Attendance was the greatest at Pilot and Head Start/ Early Head Start seminars.		

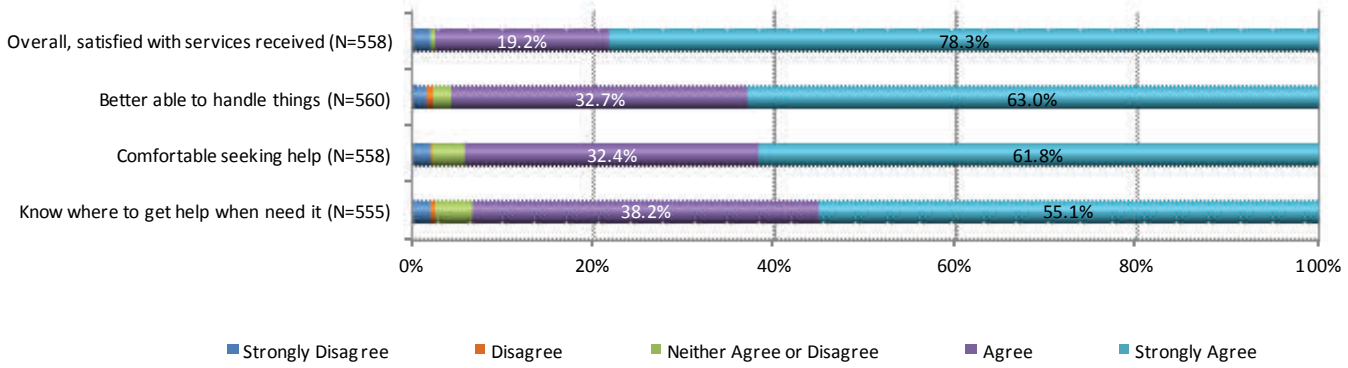
**Participants could have attended more than one component so percentages may add up to more than 100%.*

łPilot seminars are held solely at schools throughout the county. These seminars are for the parents/ caregivers of enrolled children.

‡Community seminars are held at various community organizations throughout the county, not including schools. All parents and caregivers are welcome however, there is an emphasis on childcare providers.

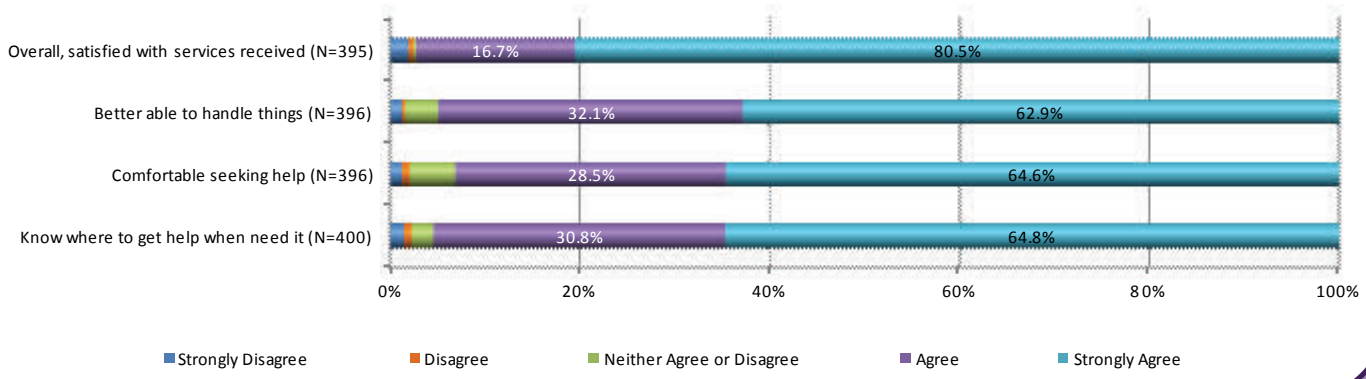
SATISFACTION BY PROGRAM COMPONENT (Includes duplicated participants)

PILOT SEMINAR SATISFACTION



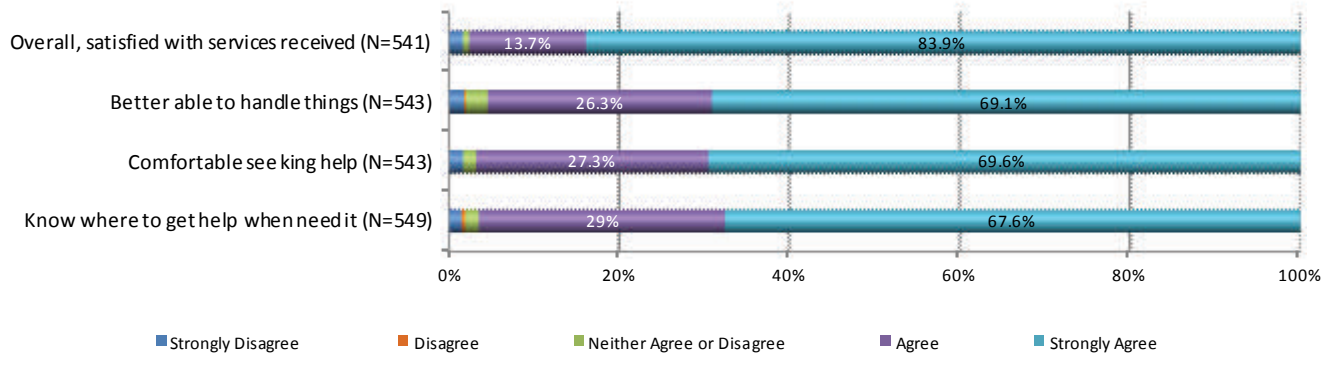
Overall, 98% of the respondents indicated satisfaction with the services received.

COMMUNITY SEMINAR SATISFACTION



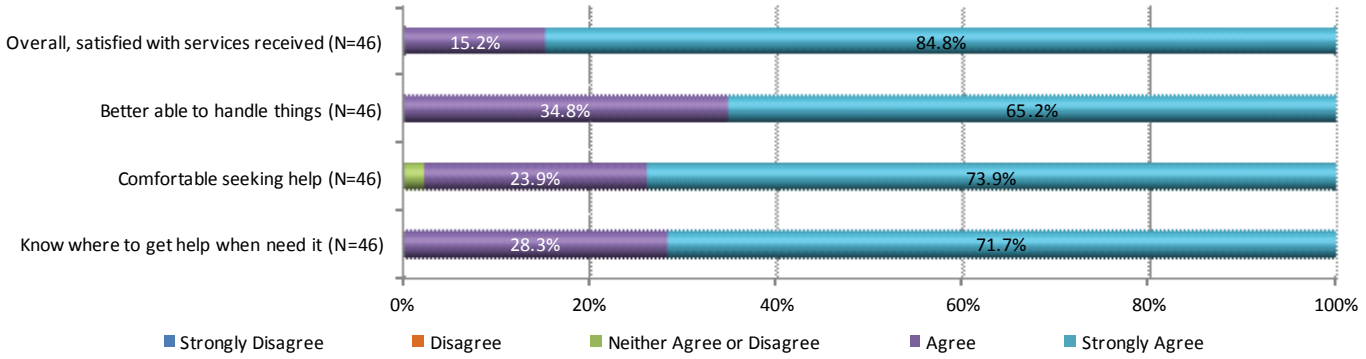
Overall, 97% of the respondents indicated satisfaction with the services received.

HEAD START/ EARLY HEAD START SEMINAR SATISFACTION



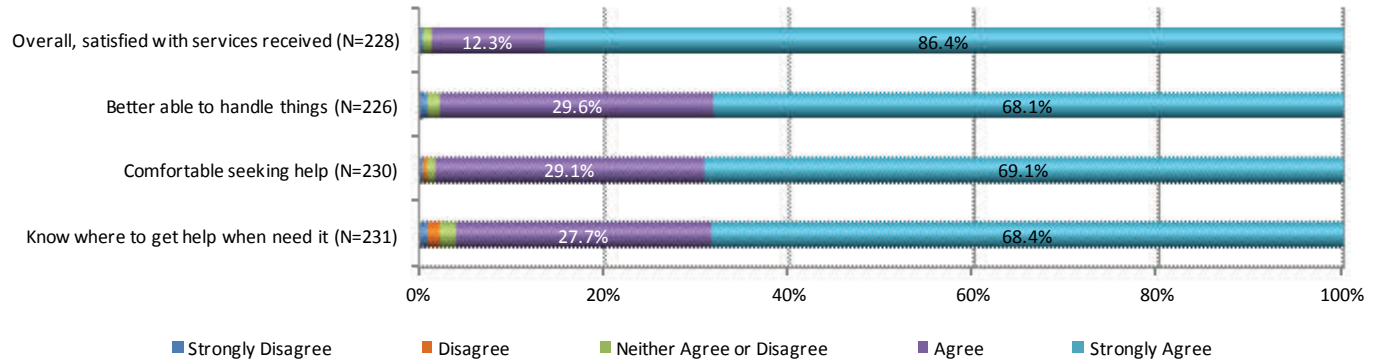
Overall, 98% of the respondents indicated satisfaction with the services received.

INDIVIDUAL CONSULTATION SATISFACTION



Overall, 100% of the respondents indicated satisfaction with the services received.

GROUP PROGRAM SATISFACTION



Overall, 99% of the respondents indicated satisfaction with the services received.

Overall, the majority of participants who responded to the satisfaction questions were very satisfied with each of the services offered by Triple P.

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KICKSTART (FB01)

PROVIDENCE COMMUNITY SERVICES

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

FISCAL YEAR 2012—13 ANNUAL REPORT

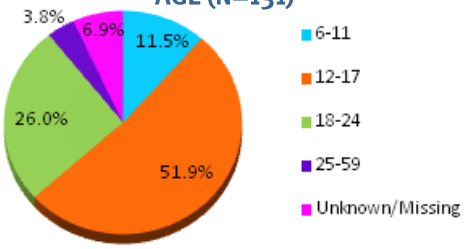
REGION: CENTRAL & NORTH CENTRAL– DISTRICT 4

The purpose of this program is to provide prevention and early intervention services to children, adolescents and transition-age youth (TAY) who may have prodromal symptoms of psychosis. The prevention component of the program focuses on community leaders who may have contact with children, youth and TAY 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 provides an initial screening for youth who are identified as being at-risk for the development of psychosis. Youth who screen positive and decide to participate in the program receive in-depth assessments of their mental health and overall functioning. Youth also receive psycho-education classes, support services, and treatment interventions.

CONTRACTOR: Providence Community Services	
CONTRACT START DATE: 12/1/2009	**DATA COLLECTION START DATE: May 2010**
PROGRAM SERVICES START DATE: 4/1/2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF YOUTH CLIENTS WITH DATA IN FY 2012-13: 131 (Unduplicated) **NUMBER OF COMMUNITY CLIENTS WITH DATA IN FY 2012-13: 479 (Duplicated)**	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION (Duplicated):** **Community Members who received trainings: 1447** **Youth screened: 445** **Youth enrolled: 212**

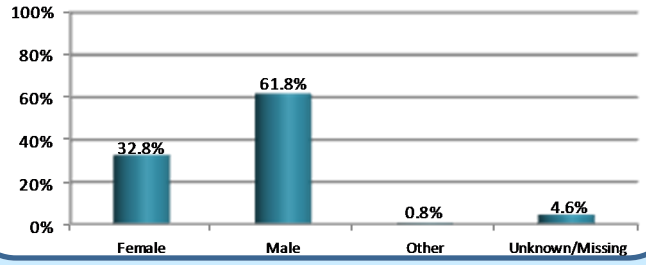
YOUTH DEMOGRAPHICS

AGE (N=131)



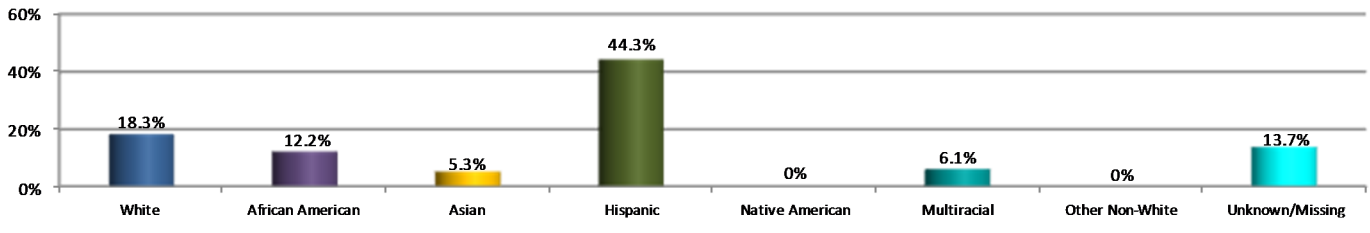
Adolescents and TAY ages 12-24 comprised approximately 78% of the population served.

GENDER (N=131)



Sixty-two percent of the participants who received services were male.

RACE/ETHNICITY (N=131)



Forty-four percent of the participants who received services identified their race/ethnicity as Hispanic; 86% of Hispanic clients indicated they were of Mexican American/Chicano origin. Approximately 14% of all participants did not identify their race/ethnicity.

MILITARY SERVICE

Of the 85 participants who responded to this question, 93% indicated that their caregiver had not served in the military. Of the six participants who reported that their caregiver had served in the military, 3 (50%) served in the Navy and 3 (50%) did not identify the branch in which their caregiver served.

PHONE SCREENS

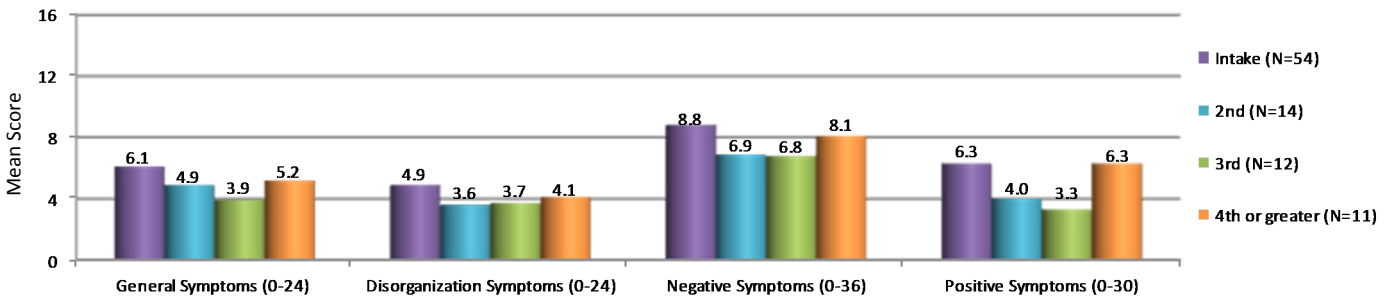
SYMPTOMS REPORTED AT INITIAL SCREENING	N	%
Changes in thinking (odd ideas, grandiosity, suspiciousness, difficulty concentrating), N=49	47	95.9
Changes in perception (auditory, visual, tactile, olfactory abnormalities), N=47	43	91.5
Changes in speech (disorganized communication, tangential speech), N=42	36	85.7
Changes in view (of self, others, or the world in general), N=47	39	83.0
Changes in emotions (depression, mood swings, irritability, flat affect), N=50	47	94.0
Vegetative symptoms (sleep problems, changes in appetite, social isolation), N=50	46	92.0
Family history of mental illness (schizophrenia, bipolar disorder, schizoaffective disorder, psychosis), N=46	31	67.4
Dramatic reduction of overall functioning, N=44	36	81.8

In FY 12-13, 81 youth were screened for admission into the Kickstart program. Of those 81 youth, 64 were eligible for a further evaluation. Of the 64 youth who were evaluated, 51 were eligible for Kickstart services. Not all clients had complete data for every item on the phone screen. The majority of the clients who screened positive for the Kickstart program had experienced changes in emotions, changes in thinking, and vegetative symptoms. Most of the clients had experienced a dramatic reduction in functioning.

PARTICIPANTS' CHANGE OVER TIME

CHANGE IN PRODROMAL SYMPTOMS

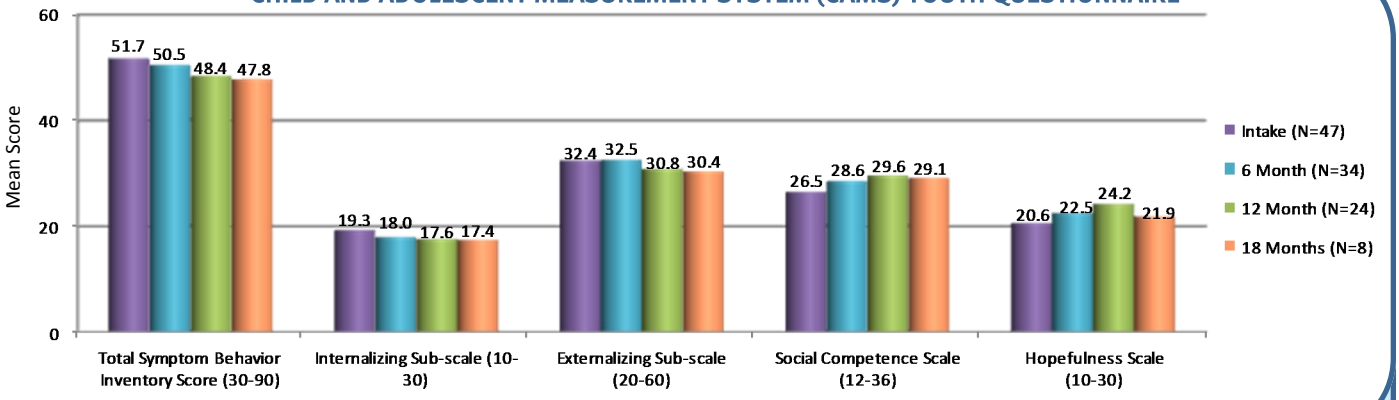
SCALE OF PRODROMAL SYMPTOMS (SOPS)



Higher scores on any of these SOPS domains indicate higher symptom severity. On average, by the fourth or greater assessment, the severity of prodromal symptoms decreased as compared to intake. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvements in the Positive Symptoms scale (N=30, p<.01) and in the Disorganization Symptoms scale (N=30, p<.05).

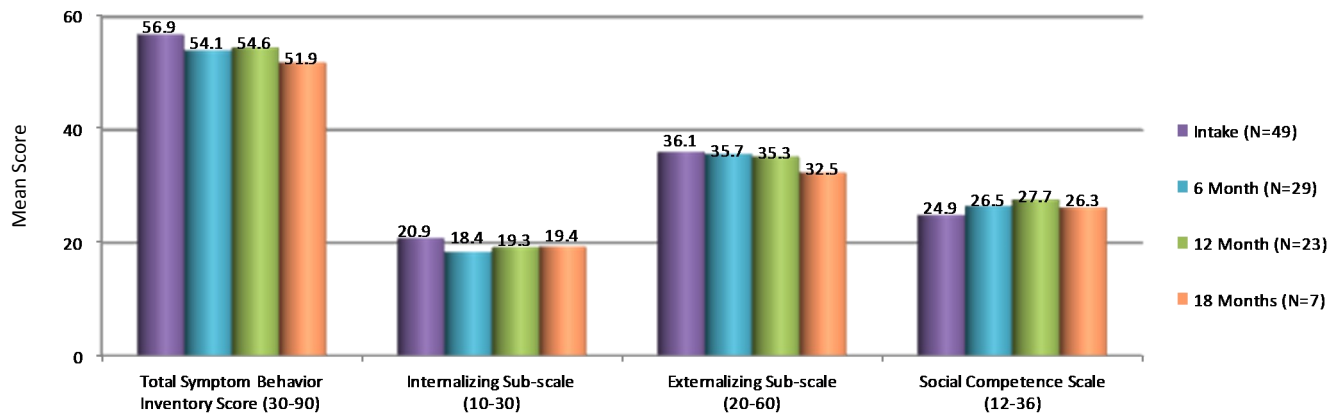
CHANGE IN GENERAL MENTAL HEALTH SYMPTOMS

CHILD AND ADOLESCENT MEASUREMENT SYSTEM (CAMS) YOUTH QUESTIONNAIRE



A *decrease* on the Total Symptom Behavior, Internalizing or Externalizing scale indicates improvement, and an *increase* on the Social Competence or Hopefulness scale indicates improvement. Twelve months after entry into the Kickstart program, the majority of youth participants reported slight improvements in symptoms of internalizing and externalizing disorders as compared to intake. On average, youth reported an increase in their own social competence and their feelings of hopefulness. A decrease was noted in the hopefulness and social competence scales at 18 months as compared to 12-month scores. However the number of youth with 18-month assessments was very small and thus these results may not be generalizable. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvement in their total scores (N=45, p<.001) and their scores on each of the subscales– Internalizing (N=45, p<.001), Externalizing (N=45, p<.001), Social Competence (N=44, p<.01) and Hopefulness (N=44, p<.01).

CHILD AND ADOLESCENT MEASUREMENT SYSTEM (CAMS) PARENT QUESTIONNAIRE



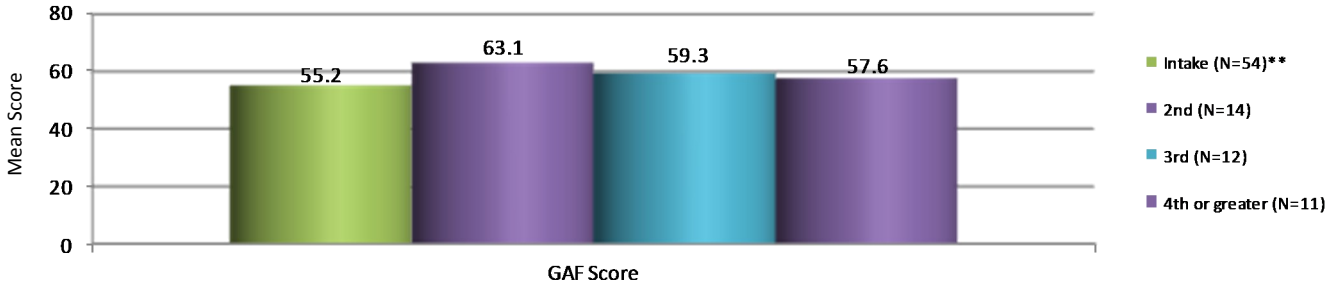
A *decrease* on the Total Symptom Behavior, Internalizing or Externalizing scales, and an *increase* on the Social Competence scale, indicates improvement. Twelve months after entry into the Kickstart program, most parents reported improvement in their child's social competence, as well as symptoms of internalizing and externalizing disorders, as compared to intake. A decrease was noted in the parent report of their child's social competence at 18 months as compared to 12-month scores. However, the number of parents with 18-month assessments was very small and thus these results may not be generalizable. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvement in their total scores (N=41, p<.001) and their scores on each of the subscales– Internalizing (N=41, p<.001), Externalizing (N=41, p<.01) and Social Competence (N=41, p<.001).

CHILDREN'S FUNCTIONAL ASSESSMENT RATING SCALE (CFARS)			
CFARSDomain (1-9)*	Intake (N=23) Mean (SD)	Second Assessment (N=15) Mean (SD)	Third Assessment (N=8) Mean (SD)
Depression	4.0 (1.8)	3.3 (1.4)	3.3 (0.8)
Anxiety	3.5 (1.3)	3.8 (1.6)	3.6 (1.4)
Hyperactivity	2.9 (1.4)	3.3 (1.6)	3.0 (1.6)
Thought Process	4.0 (1.7)	3.6 (1.6)	3.7 (1.5)
Cognitive Performance	3.3 (1.7)	2.7 (1.7)	2.6 (1.8)
Medical /Physical	1.2 (0.7)	1.0 (0.0)	1.3 (0.7)
Traumatic Stress	2.3 (1.6)	3.0 (2.4)	2.9 (1.4)
Substance Use	1.9 (1.6)	1.3 (0.5)	2.0 (1.6)
Interpersonal Relationships	3.6 (1.4)	3.4 (1.8)	2.5 (1.4)
Behavior in "Home" Setting	3.2 (2.0)	3.1 (2.2)	2.7 (1.3)
ADL Functioning	1.7 (1.3)	1.5 (0.7)	1.5 (0.7)
Socio-Legal	1.4 (0.8)	1.7 (1.4)	1.9 (1.7)
Work/School	4.7 (2.0)	3.7 (1.7)	4.0 (1.8)
Danger to Self	2.5 (2.1)	2.0 (1.3)	3.0 (1.3)
Danger to Others	1.2 (1.4)	1.8 (1.5)	1.9 (1.7)
Security/Management Needs	1.8 (1.3)	2.1 (1.5)	2.2 (1.5)

A decrease on any CFARS variable is considered an improvement. On average, clinicians reported improvement on 10 of the 16 CFARS domains from intake to the second assessment. However, the number of clients with a third assessment was very small and thus these results may not be generalizable. Additional analyses were conducted with participants who had both an intake and a second assessment. Participants included in these analyses showed statistically significant improvements in depression (N=19, p<.01), hyperactivity (N=19, p<.01) and thought process (N=19, p<.01) domains.

** Range of Scores: 1 = No Problem, 9 = Extreme Problem.*

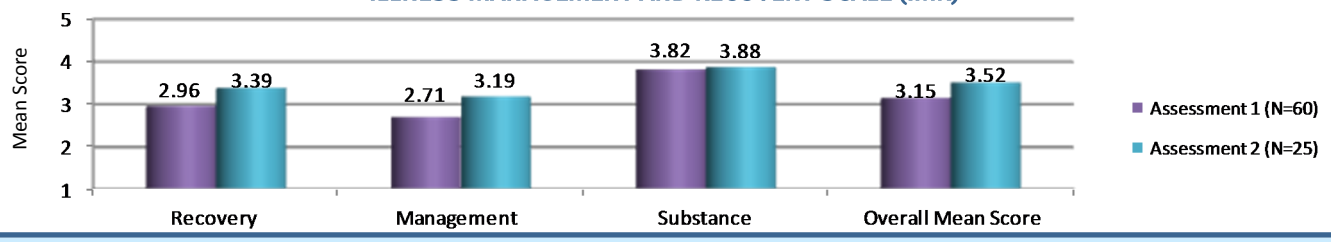
CHANGE IN GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCORES



The GAF is scored on a scale of 0-100; a higher score indicates better social and psychological functioning. On average, participants' functioning had improved by the fourth or greater Kickstart assessment as compared to intake.

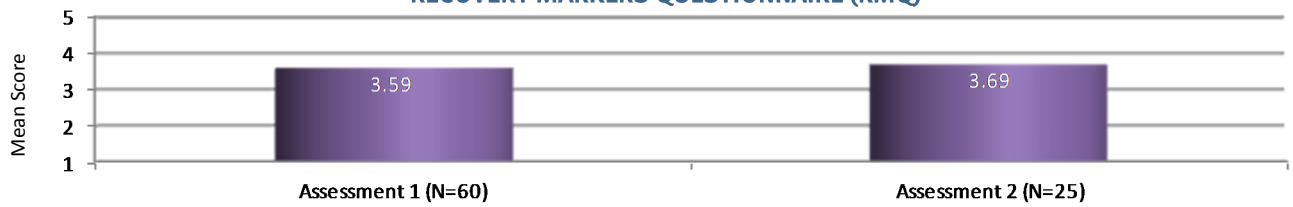
***2 participants were missing a GAF score.*

ILLNESS MANAGEMENT AND RECOVERY SCALE (IMR)



The IMR assessment is completed by clinicians for participants who are ages 18 and older. Scoring ranges between 1-5; an increase on any IMR domain indicates improvement. Client scores on the IMR increased following intake into the Kickstart program. This indicates that clients became better at managing their illness and achieving their goals. 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 management sub-scale (N=25, p<0.1).

RECOVERY MARKERS QUESTIONNAIRE (RMQ)



The RMQ assessment is given to participants who are ages 18 and older. Scoring ranges between 1-5; an increase on the RMQ indicates improvement. On average, client scores on the RMQ showed an increase from the first to the second assessment in the Kickstart program.

SUBSTANCE ABUSE TREATMENT SCALE-REVISED (SATS-R)		
SATS-R STATUS	Intake (N=54) n (%)	Second Assessment (N=16) n (%)
In Remission or Recovery	22 (40.7%)	4 (25.0%)
In Treatment	12 (22.2%)	8 (50.0%)
Persuasion*	7 (13.0%)	2 (12.5%)
Engagement†	8 (14.8%)	2 (12.5%)
Pre-Engagement‡	5 (9.3%)	0 (0%)
By the second assessment, the majority (75%) of Kickstart clients who received a SATS-R were in treatment or in remission/recovery.		

**Client has regular contact with a counselor or case manager and has reduced his or her substance abuse in the past month.*

†Client has some contact with a case manager and/or counselor and meets criteria for substance abuse of dependence.

‡Client does not have contact with any case managers or counselors and meets criteria for substance abuse or dependence.

CHANGE IN SUBSTANCE ABUSE TREATMENT SCALE-REVISED (SATS-R, N=16)*		
CHANGE	N	%
Decline†	5	31.3
No Change	4	25.0
Positive Change	5	31.3
Remission both time points	2	12.5
Forty-four percent of Kickstart clients improved or sustained remission from intake to most recent assessment.		

**Change in SATS-R status for clients with an intake and second assessment.*

†A decline in remission status is considered a movement downward in the SATS-R status domain chart above.

PARTICIPANTS' CHANGE IN FUNCTIONING (clients ages 18 and up)

RESIDENTIAL STATUS		
RESIDENTIAL STATUS DOMAINS	Intake (N=30) n (%)	Last Assessment (N=25) n (%)
Assisted/Supported*	17 (56.7%)	16 (64.0%)
Independent Living Facility	7 (23.3%)	4 (16.0%)
Supervised Facility	4 (13.3%)	4 (16.0%)
Treatment Institutions	1 (3.3%)	0 (0.0%)
Homeless not seeking change†	1 (3.3%)	1 (4.0%)
Sixty-four percent of Kickstart clients were in an assisted/supported living situation (this includes youth living at home with their family) at the most recent assessment.		

**Client lives in a house, apartment or similar setting and may live alone or with others. Client has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for monitoring and/or assisting with residential responsibilities.*

†Client is not working toward obtaining housing.

CHANGE IN RESIDENTIAL STATUS (N=24)*		
CHANGE	N	%
Decline†	6	25.0
No change	16	66.7
Positive Change	2	8.3
Nearly 67% of Kickstart clients did not experience a change in residential status from intake to most recent assessment.		

**Change in residential status for clients with an intake and second assessment.*

†A decline in residential status is considered a movement downward in the residential status domain chart above.

EDUCATIONAL STATUS		
EDUCATIONAL STATUS DOMAINS	Intake (N=31) n (%)	Last Assessment (N=27) n (%)
Trade School	2 (6.5%)	2 (7.4%)
Vocational Center	7 (22.6%)	7 (25.9%)
High School or GED	0 (0.0%)	0 (0.0%)
Adult Education	12 (38.7%)	2 (7.4%)
Other	0 (0.0%)	1 (3.7%)
Exploring Education	0 (0.0%)	0 (0.0%)
Considering Education	3 (9.7%)	7 (25.9%)
No education of any kind	4 (12.9%)	6 (22.2%)
Missing	3 (9.7%)	2 (7.4%)
A greater percentage of Kickstart clients were considering education at most recent assessment (26%), as compared to intake (10%).		

CHANGE IN EDUCATIONAL STATUS (N=25)*		
CHANGE	N	%
Decline†	5	20.0
No change	13	52.0
Positive Change	7	28.0
Slightly more Kickstart clients experienced a positive change (28%) versus a negative change (20%) in educational status from intake to most recent assessment. Some clients may not be pursuing improvements in education due to current employment.		

**Change in educational status for participants with an intake and second assessment.*

†A decline in educational status is considered a movement downward in the educational status domain chart above.

EMPLOYMENT STATUS		
EMPLOYMENT STATUS DOMAINS	Intake (N=30) n (%)	Last Assessment (N=26) n (%)
Independent Competitive Employment	0 (0.0%)	0 (0.0%)
Assisted Competitive	4 (13.3%)	8 (30.8%)
Job Coach	1 (3.3%)	1 (3.8%)
Transitional Employment	0 (0.0%)	0 (0.0%)
Agency Paid Transitional Employment	0 (0.0%)	0 (0.0%)
In-House Transitional Employment	0 (0.0%)	0 (0.0%)
Work Crew	0 (0.0%)	0 (0.0%)
Sporadic/Casual Employment	0 (0.0%)	0 (0.0%)
Non-paid Work Experience	1 (3.3%)	3 (11.5%)
Exploring Employment	0 (0.0%)	1 (3.8%)
Considering Employment	6 (20.0%)	5 (19.2%)
No Employment of Any Kind	5 (16.7%)	5 (19.2%)
Missing	13 (43.3%)	3 (11.5%)
A greater percentage of Kickstart clients were employed or engaged in work experience at most recent assessment (46%), as compared to intake (20%).		

CHANGE IN EMPLOYMENT STATUS (N=20)*		
CHANGE	N	%
Decline†	2	10.0
No change	6	30.0
Positive Change	12	60.0
Sixty percent of Kickstart clients experienced a positive change in employment status from intake to most recent assessment. Some clients may not be pursuing improvements in employment due to current educational status.		

**Change in employment status for participants with an intake and second assessment.*

†A decline in employment status is considered a movement downward in the employment status domain chart above.

FAMILY MEMBER PARTICIPATION

FAMILY EDUCATION WORKSHOP*

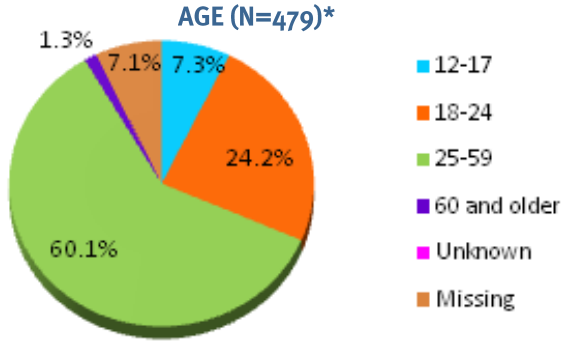
Of the 79 caregivers who attended the family psycho-education group and completed both a pre-test and a post-test, 33 (41.8%) demonstrated an increase in knowledge of how to support youth with prodromal symptoms. Additionally, 18 caregivers (22.8%) had a perfect score on both the pre-test and the post-test.

**May include duplicate clients.*

COMMUNITY SEMINARS OUTREACH COMPONENT

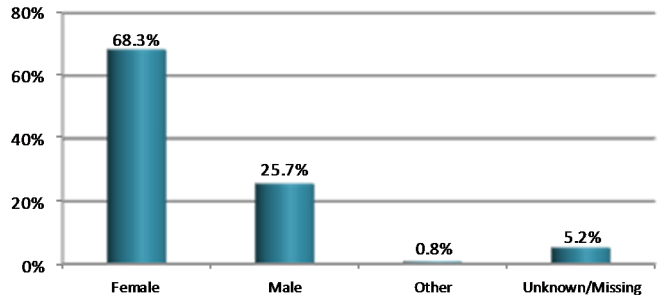
DEMOGRAPHICS

AGE (N=479)*



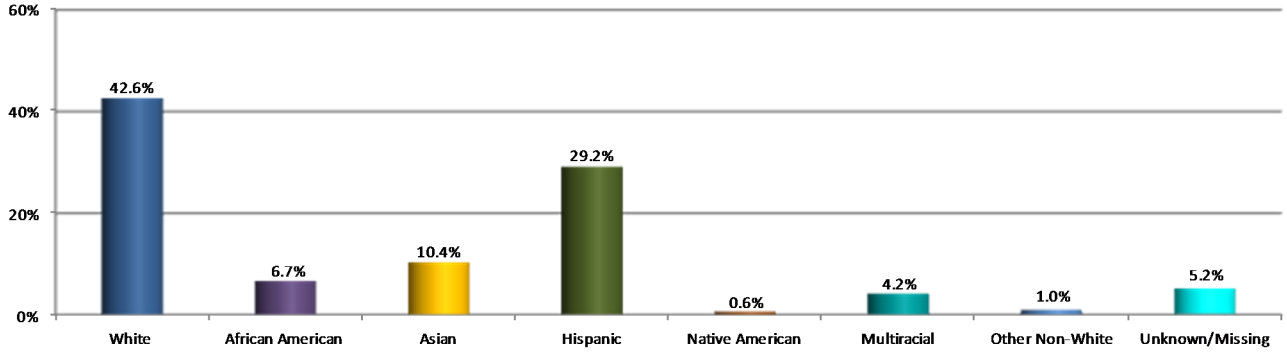
More than 84% of community members that were served by the outreach component were ages 18-59.

GENDER (N=479)*



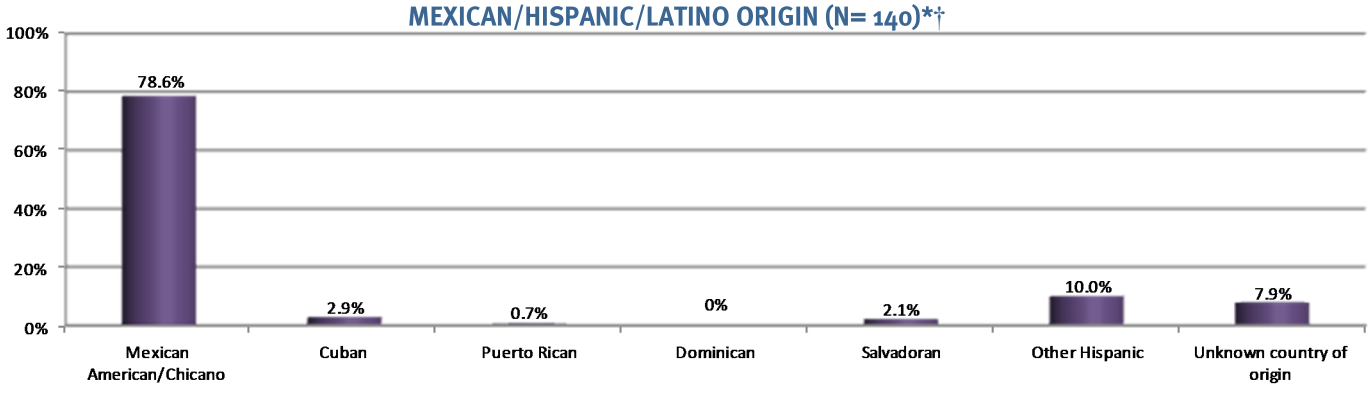
Approximately 68% of the community members who participated in the outreach component were female.

RACE/ETHNICITY (N=479)*



Seventy-two percent of community members who participated in the outreach component identified their ethnic background as White or Hispanic.

MEXICAN/HISPANIC/LATINO ORIGIN (N= 140)*†



Seventy-nine percent of the Hispanic population served identified their ethnic background as Mexican American/ Chicano.

**Outreach demographics may include duplicated clients.*

†Participants can self-identify as more than one race so percentages may add up to more than 100%.

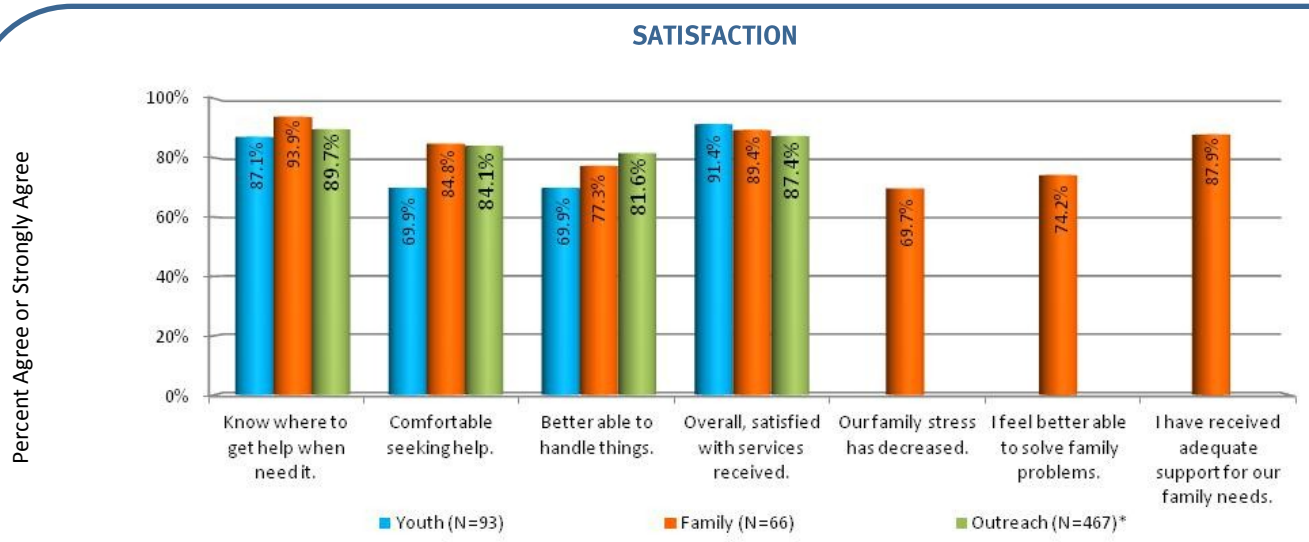
COMMUNITY ROLE	
EMPLOYMENT STATUS DOMAINS	FY12-13 (N=479)* n (%)
PROFESSIONALS	
Medical Professional	19 (4.0%)
Mental Health Professional	110 (23.0%)
School Professional	65 (13.6%)
Law Enforcement Professional	5 (1.0%)
Substance Abuse Counselor	17 (3.5%)
Employer	21 (4.4%)
COMMUNITY MEMBERS AND LEADERS	
Member of Community Group	55 (11.5%)
Multicultural Leader	10 (2.1%)
Member of Clergy	5 (1.0%)
Member of Media	1 (0.2%)
Parent	52 (10.9%)
STUDENTS AND STUDENT LEADERS	
Youth Worker	59 (12.3%)
College Resident Assistant	5 (1.0%)
Middle School Student	4 (0.8%)
High School Student	35 (7.3%)
College Student	185 (38.6%)
Thirty-seven percent of the participants in the outreach program were mental health or school professionals.	

**Participants can self-identify as more than one role so numbers and percentages may add up to more than the N or 100%.*

GATEKEEPER TRAINING

Of the 479 community members who attended the outreach trainings and completed both a pre-test and a post-test, 341 (71.2%) demonstrated an increase in knowledge of risk factors for the development of psychosis and early intervention procedures. Additionally, 37 community members (7.7%) had a perfect score on both the pre-test and the post-test.

KICKSTART PARTICIPANT SATISFACTION



Most of the youth, caregivers, and community members who responded to satisfaction questions agreed that they were better able to handle things and solve problems as a result of the Kickstart program.

** "Know where to get help" had N=465; "Comfortable seeking help" had N=466; Overall satisfaction had N=462.*

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.

DREAM WEAVER CONSORTIUM (NA01)

INDIAN HEALTH COUNCIL

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

FISCAL YEAR 2012—13 ANNUAL REPORT

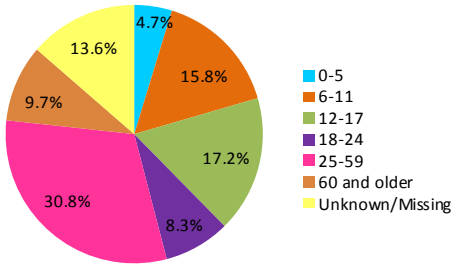
REGION: COUNTY-WIDE

The Dream Weaver Consortium offers four different PEI programs provided by the Urban Youth Center, Indian Health Council, Southern Indian Health Council, and the Sycuan Medical/Dental Center. Sycuan Medical/Dental Center did not see clients during FY 2012-13. These providers offer prevention activities that promote community and cultural awareness. These activities include: traditional health gatherings, cultural programs, basket weaving instruction (a local tradition for many tribes), nutrition programs, self-esteem workshops, positive parenting classes, exercise programs, and the promotion of overall increased medical and dental health. Additionally, the Urban Youth Center provides counseling services. All of these activities are intended to prevent the onset of serious mental health problems.

CONTRACTOR: Indian Health Council	
CONTRACT START DATE: 4/13/2009	DATA COLLECTION START DATE: April 2009
PROGRAM SERVICES START DATE: April 2009	REPORT PERIOD: 7/1/2012-6/30/2013
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 4,645 (May include duplicates)	PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 14,736 (May include duplicates)

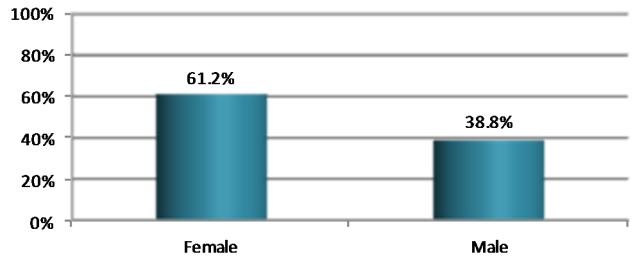
YOUTH AND CAREGIVER DEMOGRAPHICS*

AGE (N=4,645)



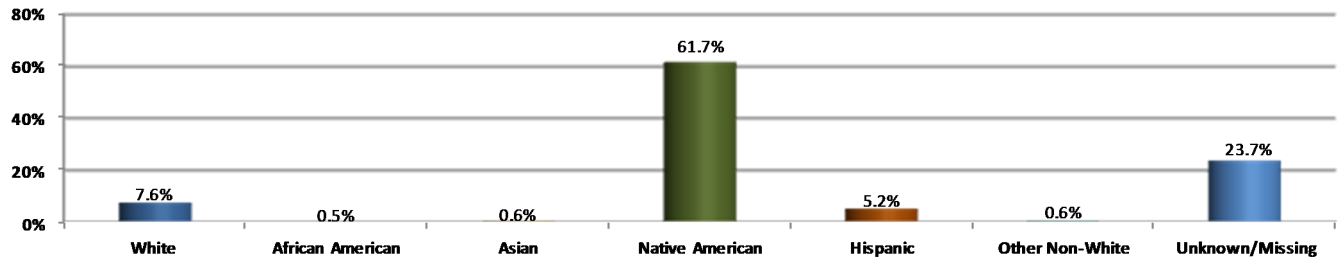
Children and youth ages 0 to 17 comprised 38% of the population served. The majority of the adults were ages 25-59 (31%).

GENDER (N=4,645)



Sixty-one percent of participants were female.

RACE/ETHNICITY (N=4,645)

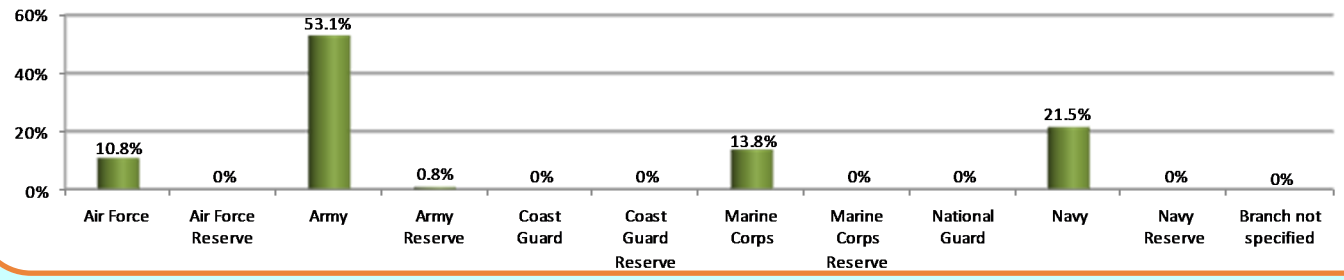


Sixty-two percent of participants who received services identified their race/ethnicity as Native American.

**Demographics data were compiled from QSRs because HOMS data were unavailable. Different participant counts were reported for each variable.*

MILITARY SERVICE

MILITARY BRANCH (N=130)*

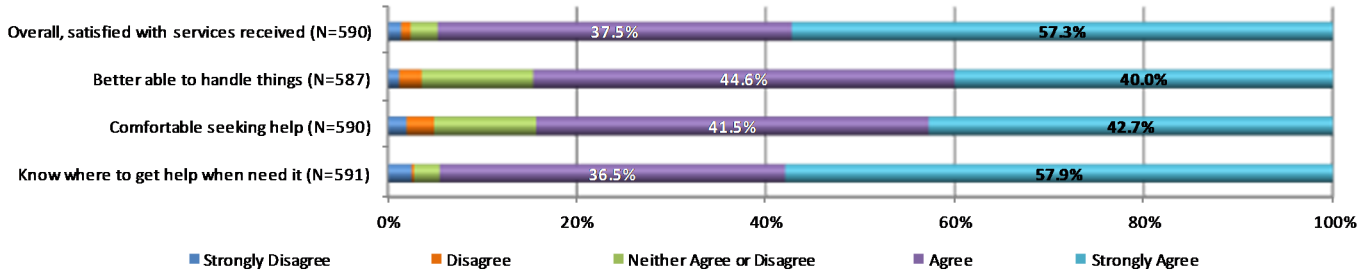


Caregivers were asked in which branch of the military they had served. Of the 130 who responded, 69 (53%) served in the Army, 28 (22%) served in the Navy, 18 (14%) served in the Marine Corps, 14 (11%) served in the Air Force, and 1 (1%) served in the Army Reserve.

**Participants may have served in more than one branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION

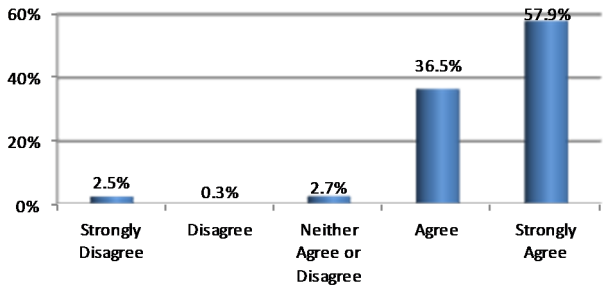
PROGRAM SATISFACTION*



The majority of participants did not respond to program satisfaction questions. Of those that did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they felt more comfortable seeking help now. Overall, 95% of the participants who responded to these questions were satisfied with the services received.

**Satisfaction data not available for all participants.*

I KNOW WHERE TO GET HELP (N=591)

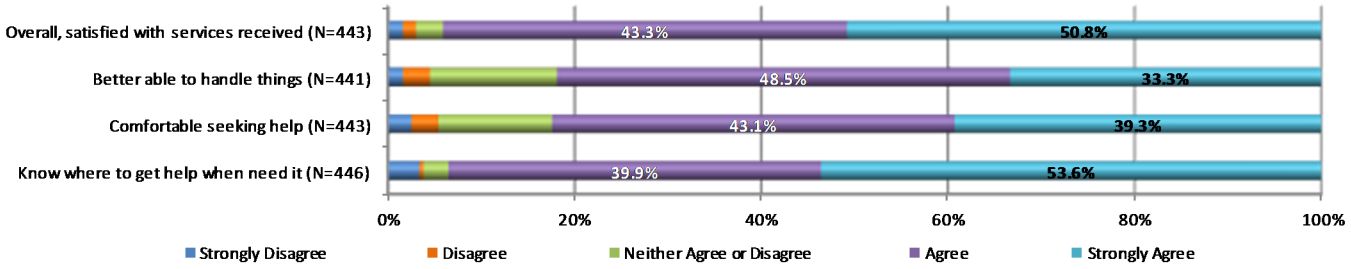


Ninety-four percent of participants responding to this question reported that they knew where to get help when they needed it. Approximately 3% did not agree with this statement.

"I know where to get help when I need it."

SATISFACTION BY PROVIDER

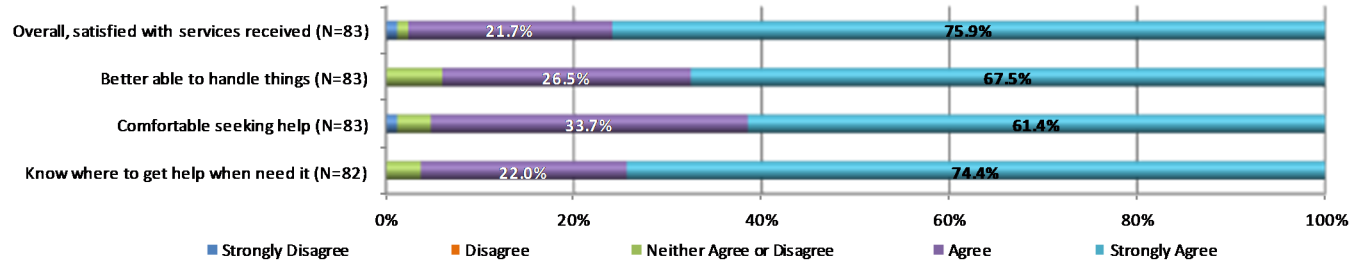
PROGRAM SATISFACTION: INDIAN HEALTH COUNCIL*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Indian Health Council programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 94% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

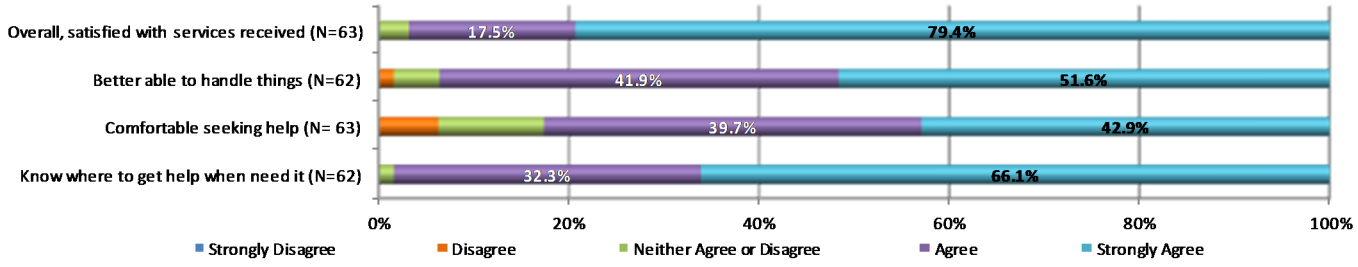
PROGRAM SATISFACTION: SOUTHERN INDIAN HEALTH COUNCIL*



Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Southern Indian Health Council's programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 98% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

PROGRAM SATISFACTION: URBAN YOUTH CENTER*



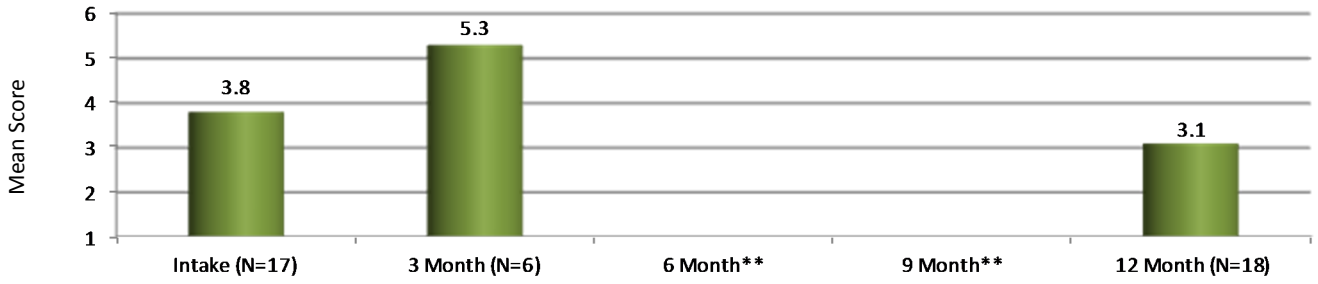
Most participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the Urban Youth Center programs. Most also said that they knew where to get help when they needed it, and that they felt more comfortable seeking help now. Overall, 97% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*

URBAN YOUTH CENTER SPECIFIC OUTCOMES

SYMPTOMS OF DEPRESSION

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)



The PHQ-9 is a 9-item assessment of depression. Scores can range between 0-27, and scores greater than 5 suggest mild to severe depression. A decrease on the PHQ-9 indicates improvement. In general, clients had few symptoms of depression. On average, UYC client scores were lower at their most recent assessment as compared to intake.

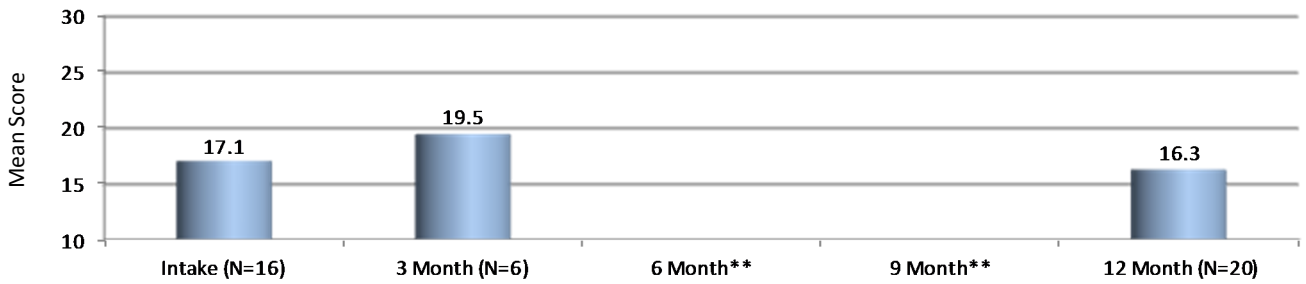
***Mean score not calculated for timepoints with fewer than two assessments.*

CHANGE IN PHQ-9 (N=12)*		
CHANGE	**N**	**%**
Improvement	6	50.0
No change (no depression at intake)	1	8.3
No change	0	0.0
Decline	5	41.7
Seven of the twelve UYC clients either improved or remained symptom-free from intake to their most recent assessment. The remaining five clients had an increase in the severity of his/ her depression.		

**Change in PHQ-9 for clients with an intake and second assessment.*

SELF-ESTEEM

ROSENBERG SELF-ESTEEM SCALE (RSE)



The RSE is a 10-item measure of self-esteem. Scores range between 10-40 and a decrease on the RSE indicates improvement. On average, UYC client scores on the RSE were lower at their most recent assessment as compared to intake.

***Mean score not calculated for timepoints with fewer than two assessments.*

CHANGE IN RSE (N=13)*		
CHANGE	**N**	**%**
Improvement	**7**	**53.8**
No change (Perfect score at intake and most recent assessment)	**0**	**0.0**
No change	**2**	**15.4**
Decline	**4**	**30.8**
Seven of the thirteen UYC clients had an improvement in their level of self-esteem from intake to their most recent assessment. Four clients showed declines in their levels of self-esteem.		

**Change in RSE for clients with an intake and second assessment.*

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.

PEER2PEER FAMILY SUPPORTLINE (PS01)

MENTAL HEALTH SYSTEMS INC.

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

FISCAL YEAR 2012—13 ANNUAL REPORT

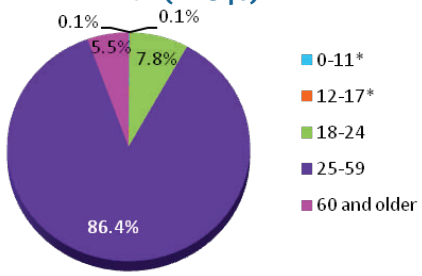
REGION: NORTH CENTRAL– DISTRICT 4

Peer2Peer provides non-emergency, confidential, telephone peer-counseling services to youth and families in San Diego County. The Family Supportline is staffed by caretakers who have children who have been involved with the behavioral health system. The staff provide culturally-competent information, support, and referrals to needed resources. Services are provided during late afternoons and evenings for a minimum of five days per week. A licensed supervising clinician is available for four hours per week to provide consultation on handling complex phone contacts. *Participant responses to demographics and satisfaction questions were reported to an automated telephone system. Therefore, data for this program are reported in a different manner from other programs.*

CONTRACTOR: Mental Health Systems Inc.	
CONTRACT START DATE: 5/10/2010	**DATA COLLECTION START DATE: 7/1/2010**
PROGRAM SERVICES START DATE: 5/17/2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 846 (May include duplicates)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 2493 (May include duplicates)**

CAREGIVER DEMOGRAPHICS

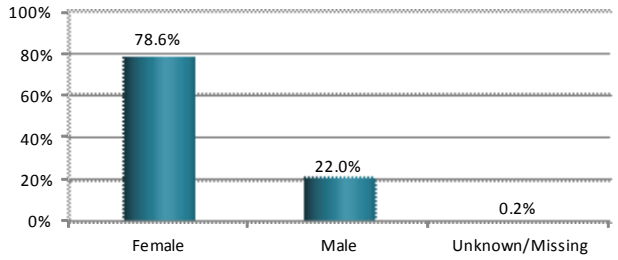
AGE (N=846)



The majority (87%) of callers were ages 25-59; approximately 8% of callers were adolescents and young adults ages 12-24.

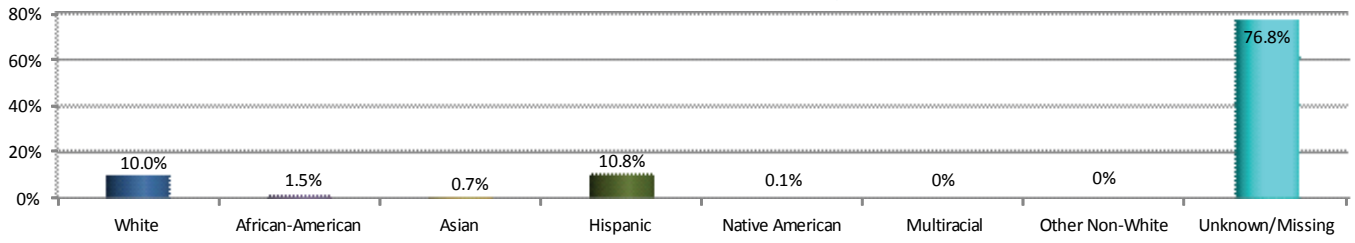
**Sometimes youth call the Family Supportline and prefer to remain speaking to the Supportline staff rather than transferring to the Youth Talkline.*

GENDER (N=846)



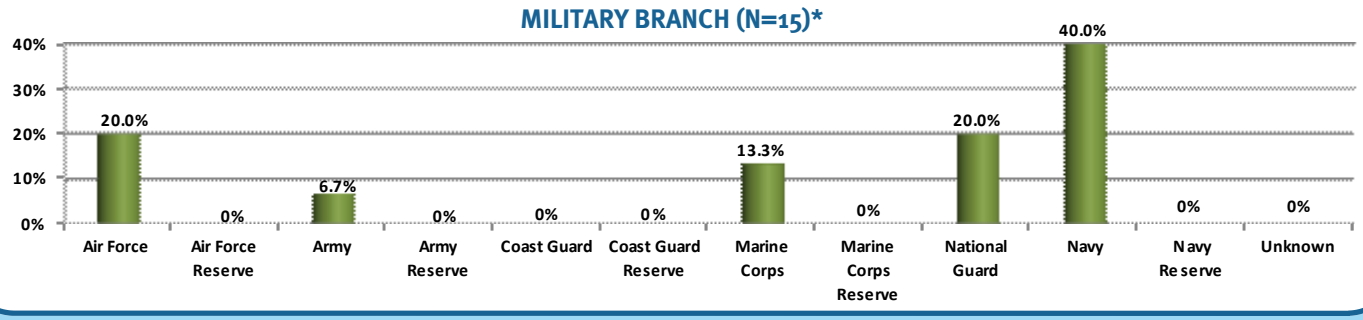
Seventy-nine percent of callers reported they were female; 22% of callers reported they were male.

RACE/ETHNICITY (N=846)



The majority of the callers (77%) did not identify their race/ethnicity. Approximately 11% of callers identified their race/ethnicity as Hispanic and 10% of callers identified their race/ethnicity as White. Of those identifying as Hispanic, the majority (78%) indicated they were Mexican American/Chicano.

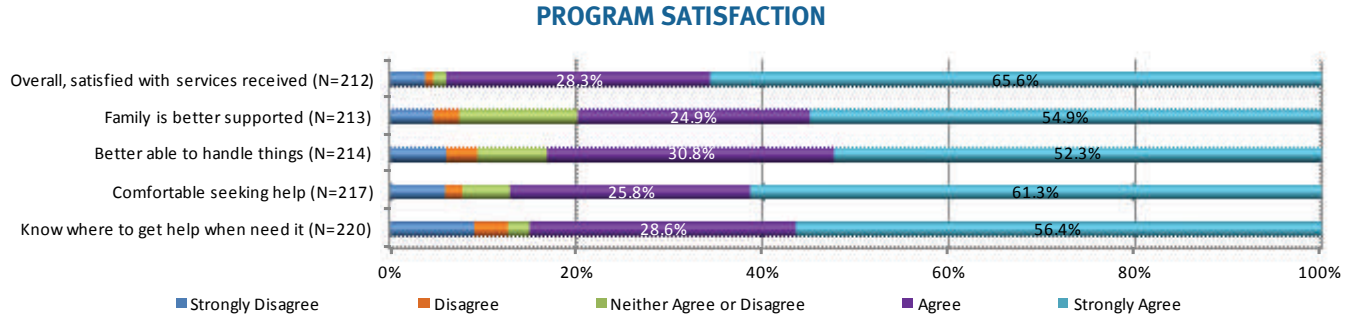
MILITARY SERVICE



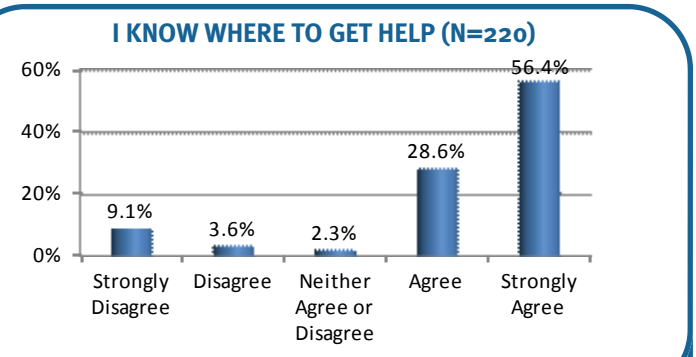
Callers were asked if the youth's caregiver had served in the military. Of the 180 callers who responded, 15 (8%) reported caregiver service in the military. Six (40%) reported service in the Navy, 3 (20%) reported service in the Air Force and 3 (20%) reported service in the National Guard. The remaining branches were not as highly represented.

**Caregivers could have served in more than one branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION



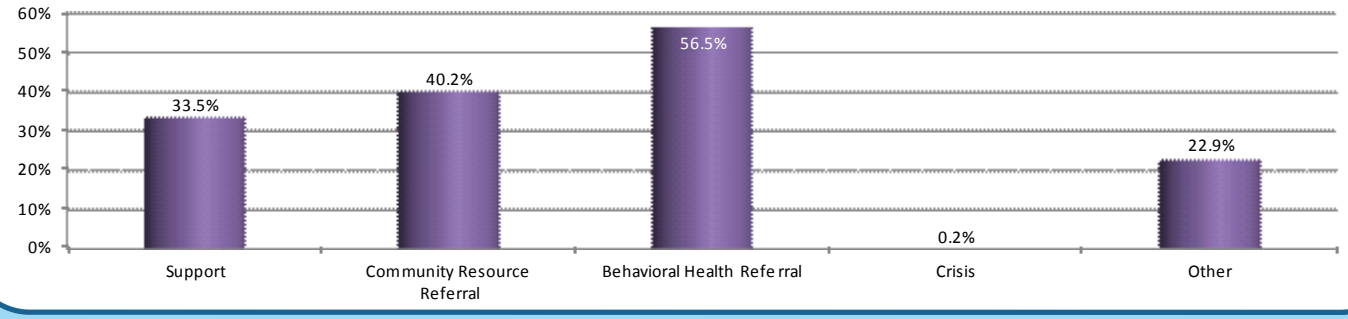
The majority of callers did not respond to program satisfaction questions. Of those that did respond, most agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they felt more comfortable seeking help now. Overall, 94% of the callers who responded were satisfied with the services received.



Eighty-five percent of callers responding to this question reported that they knew where to get help when they needed it. Approximately 13% did not agree with this statement.

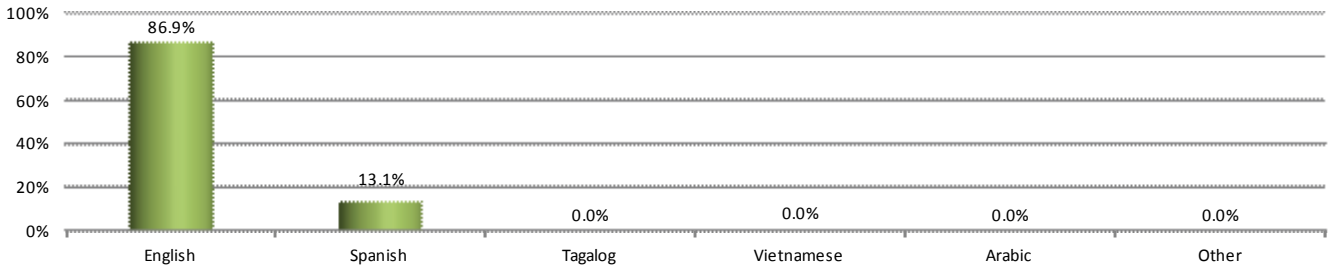
PROGRAM SPECIFIC QUESTIONS

FAMILY SUPPORTLINE TYPE OF CALL (N=846)



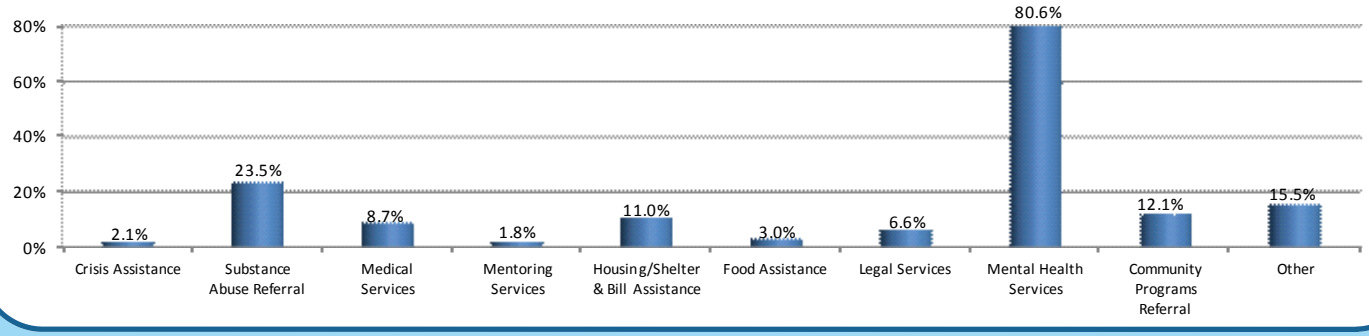
The majority (57%) of Family Supportline calls were classified as behavioral health referrals. Forty percent of calls were community resource referrals. The remaining calls were categorized as support (34%), crisis (0.2%) and other topics not specified (23%).

FAMILY SUPPORTLINE CALL LANGUAGE (N=846)



The majority (87%) of calls transpired in English. The remaining 13% of calls took place in Spanish.

FAMILY SUPPORTLINE REFERRAL CATEGORIES (N=846)*



The majority of callers received referrals for mental health services (81%) and substance abuse services (24%). Approximately 12% received referrals for community programs.

**Some callers may receive referrals to more than one type of program so percentages may add up to more than 100%.*

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.

PEER2PEER YOUTH TALKLINE (PS01)

MENTAL HEALTH SYSTEMS INC.

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

FISCAL YEAR 2012—13 ANNUAL REPORT

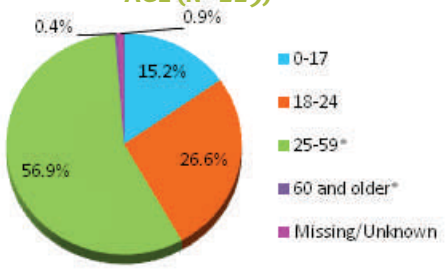
REGION: NORTH CENTRAL– DISTRICT 4

Peer2Peer provides non-emergency, confidential, telephone peer-counseling services to youth and families in San Diego County. The Youth Talkline is staffed by youth who have had prior experience with the behavioral health system. The staff provide culturally-competent information, support, and referrals to needed resources, as well as appropriate services. Services are provided during late afternoons and evenings for a minimum of five days per week. A licensed supervising clinician is available for four hours per week to provide consultation on handling complex phone contacts. *Participant responses to demographics and satisfaction questions were reported to an automated telephone system. Therefore, data for this program are reported in a different manner from other programs.*

CONTRACTOR: Mental Health Systems Inc.	
CONTRACT START DATE: 5/10/2010	**DATA COLLECTION START DATE: 7/1/2010**
PROGRAM SERVICES START DATE: 5/17/2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 229 (May include duplicates)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 720 (May include duplicates)**

YOUTH DEMOGRAPHICS

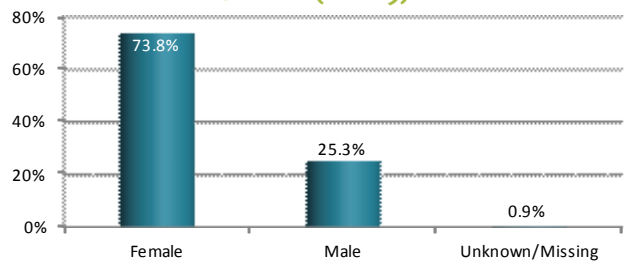
AGE (N=229)



Fifty-seven percent of callers who responded to this question were adults ages 25-59, and 27% were young adults ages 18-24.

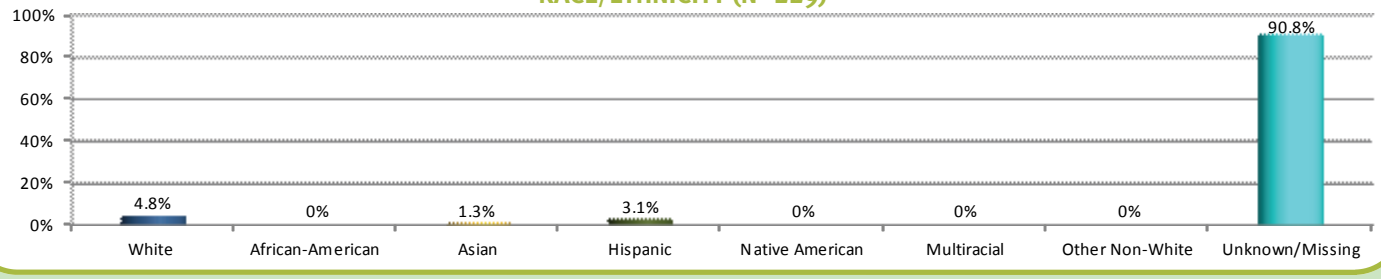
**Sometimes adults call the Youth Talkline and prefer to remain speaking to the youth specialist rather than transferring to the Family Support line.*

GENDER (N=229)



Seventy-four percent of the callers receiving services were female.

RACE/ETHNICITY (N=229)

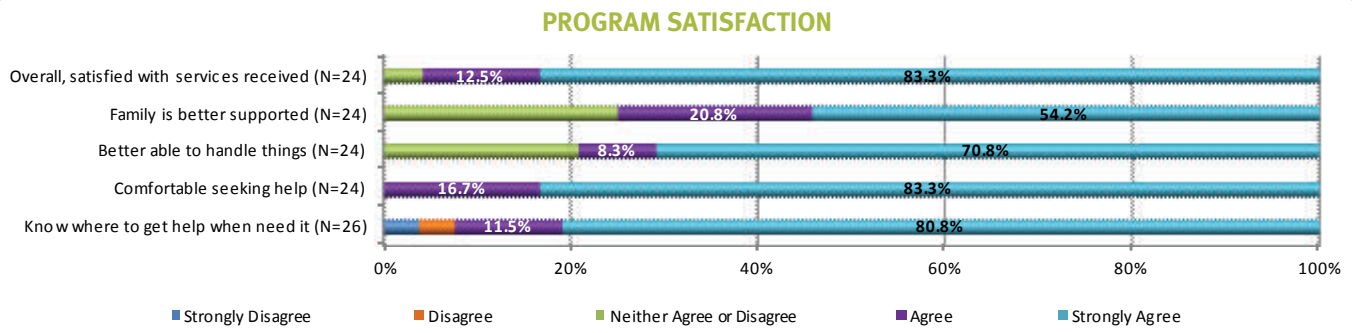


Almost 91% of the callers did not identify their race/ethnicity. Five percent of the callers identified their race/ethnicity as White, 3% identified their race/ethnicity as Hispanic and 1% of the callers identified their race/ethnicity as Asian. Of those identifying as Hispanic, the majority (57%) indicated they were Mexican American.

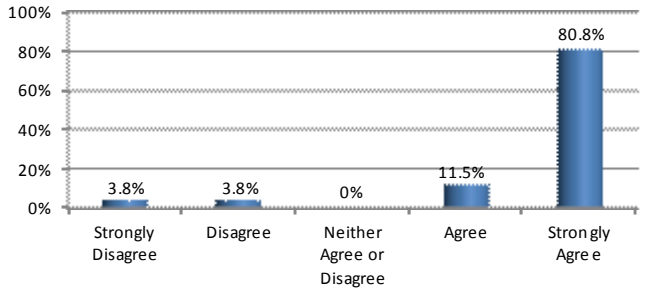
MILITARY SERVICE

Callers were asked if the youth's caregiver had served in the military. Of the 16 callers who responded, 2 (13%) reported caregiver service in the military. Both callers (100%) reported service in the Navy.

PROGRAM SATISFACTION



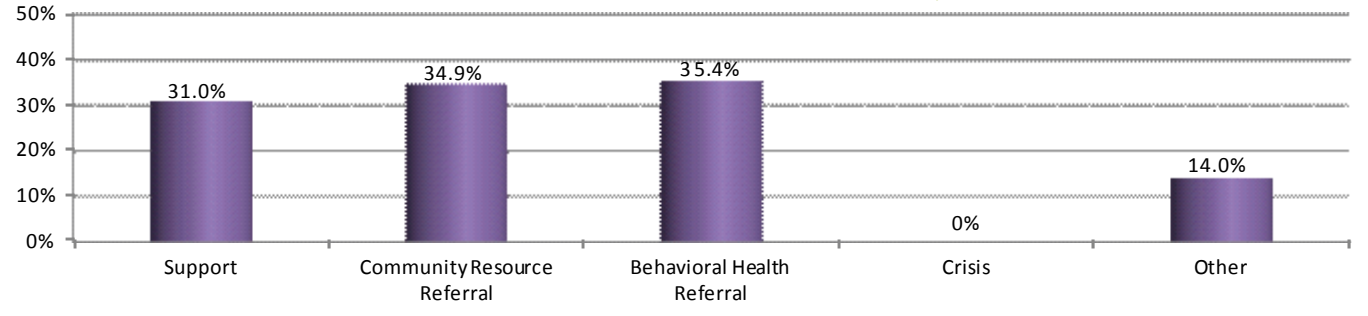
The majority of callers did not respond to program satisfaction questions. Of those that did respond, most agreed that they were better able to handle things and solve problems as a result of the services. Most also said that they felt more comfortable seeking help now. Overall, 96% of callers who responded to these questions were satisfied with the services received.



Ninety-two percent of the callers responding to this question reported that they knew where to get help when they needed it. Approximately 8% did not agree with this statement.

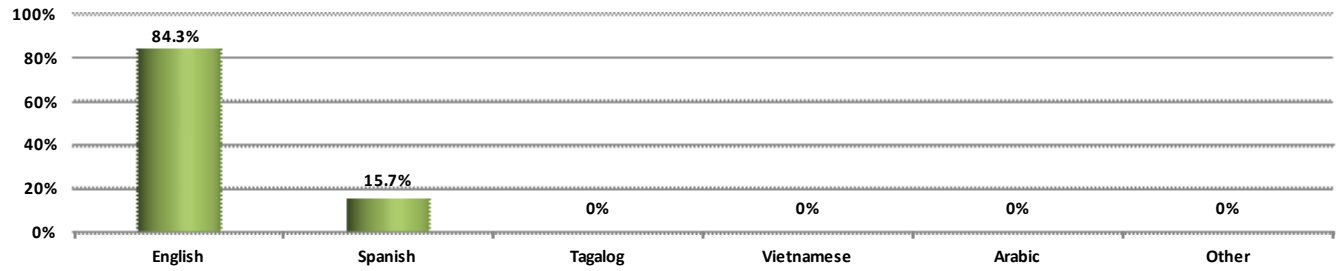
"I know where to get help when I need it."

PROGRAM-SPECIFIC QUESTIONS



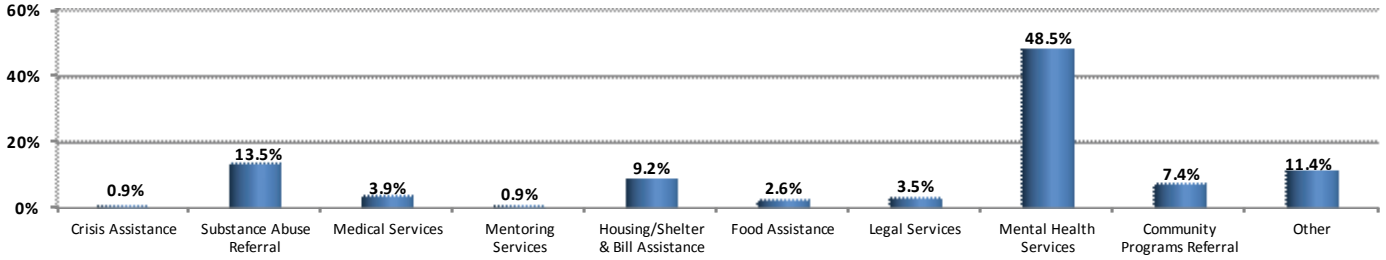
The majority of the Youth Talkline calls were classified as behavioral health (35%) and community resource (35%) referrals. Thirty-one percent of calls were related to support, and 14% concerned other unspecified topics.

YOUTH TALKLINE CALL LANGUAGE (N=229)



The majority of calls transpired in English (84%). The remaining 16% of the calls took place in Spanish.

YOUTH TALKLINE REFERRAL CATEGORIES (N=229)*



The majority of the callers who received referrals were referred to mental health services (49%). Nearly 14% of callers received referrals for substance abuse.

**Some callers may receive referrals to more than one type of program so percentages may add up to more than 100%.*

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.

SCHOOL BASED PROGRAM - EAST COUNTY (SA01EC): FAMILY PROGRAMS

SAN DIEGO YOUTH SERVICES

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

FISCAL YEAR 2012—13 ANNUAL REPORT

REGION: NORTH CENTRAL– DISTRICT 4

This program provides family-focused prevention and early intervention services for children who attend La Mesa Dale and Avondale elementary schools and their families. The program has two components: a school-based component and a family-based component. The family component includes parenting support groups, which use the Incredible Years curriculum, and culturally appropriate activities for caregivers that promote health and wellness. These interventions are designed to increase resiliency and protective factors for children by improving child/caregiver social and emotional skills and reducing caregiver stress. *This report focuses solely on the family component. For information about the school component, please see the annual report completed by Duerr Evaluation Resources.*

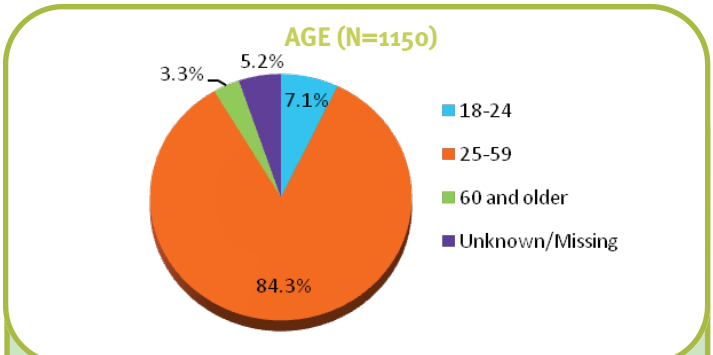
CONTRACTOR: San Diego Youth Services	
CONTRACT START DATE: 7/1/2010	**DATA COLLECTION START DATE: 1/10/2011**
PROGRAM SERVICES START DATE: 9/27/2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 1150 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 3168 (May include duplicates)**

PROGRAM ATTENDANCE

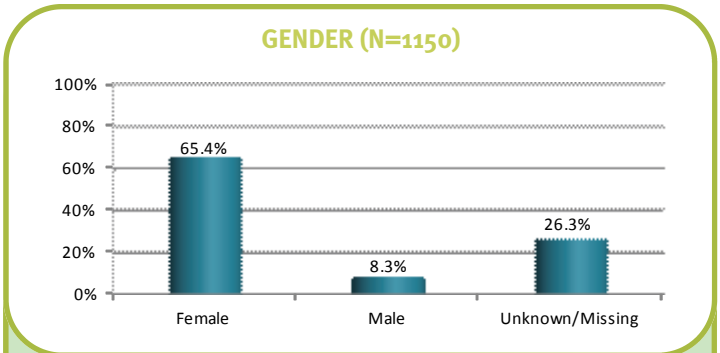
PROGRAM ATTENDANCE*	N	PERCENT
AVONDALE: PARENTING SUPPORT GROUP	75	6.5
AVONDALE: FAMILY PREVENTION EVENT	168	14.6
LA MESA: PARENTING SUPPORT GROUP	33	2.9
LA MESA: FAMILY PREVENTION EVENT	166	14.4
BANCROFT ELEMENTARY: PARENTING SUPPORT GROUP	16	1.4
BANCROFT ELEMENTARY: FAMILY PREVENTION EVENT	144	12.5
UNKNOWN LOCATION OR TYPE	556	48.3

**Numbers and percentages may add up to more than the total or 100% because parents may have attended more than one location or type of activity.*

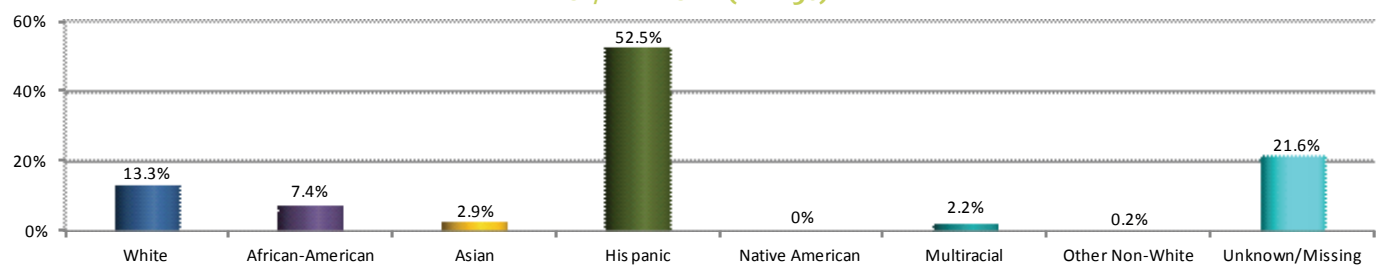
CAREGIVER DEMOGRAPHICS



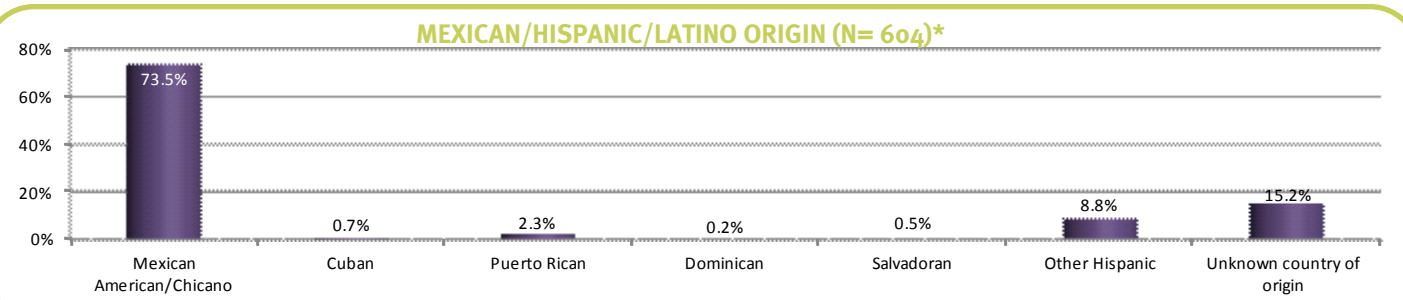
The majority of caregivers who participated in the family interventions (91%) were between the ages of 18-59. The age breakdown is representative of the adult population that is targeted by this part of the intervention.



Sixty-five percent of caregivers who participated in the family interventions were female. Gender was not known for 26% of caregivers.



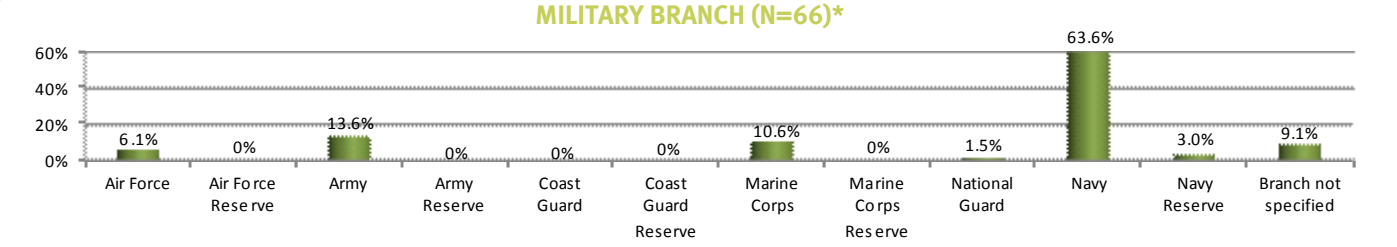
Fifty-three percent of caregivers who participated in the family interventions identified their racial/ethnic background as Hispanic. Nearly 21% identified as White or African-American.



Seventy-four percent of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

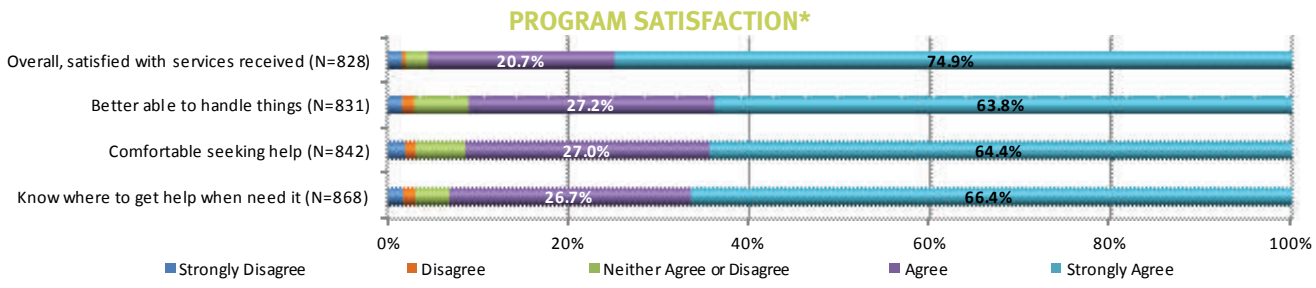
MILITARY SERVICE



Of the 837 caregivers who responded to this question, only 66 (8%) caregivers reported having served in the military. Of these, 42 (64%) served in the Navy, 9 (14%) served in the Army and 7 (11%) served in the Marine Corps. The remaining branches were not highly represented.

**Participants could have served in more than one military branch so percentages may add up to more than 100%.*

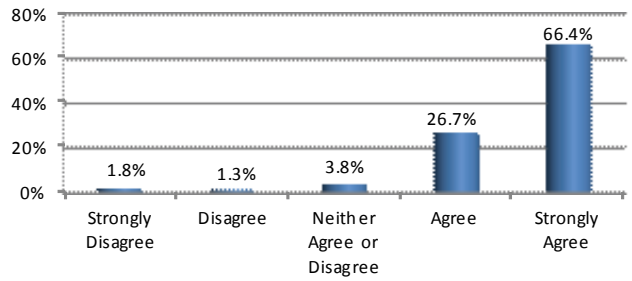
PROGRAM SATISFACTION



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the intervention. Most said that they felt more comfortable seeking help following participation in the program. Overall, 96% of the caregivers were satisfied with the services received.

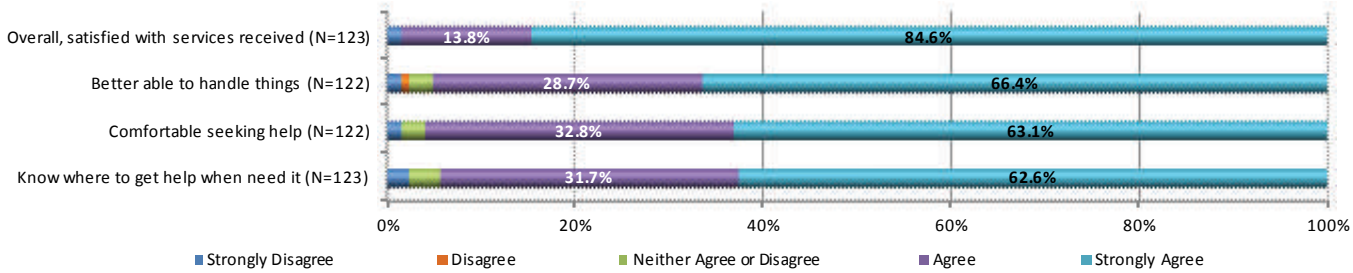
**Satisfaction data includes duplicated participants.*

I KNOW WHERE TO GET HELP (N=868)



Ninety-three percent caregivers responding to this question reported that they knew where to get help when they needed it. Only 3% did not agree with this statement.

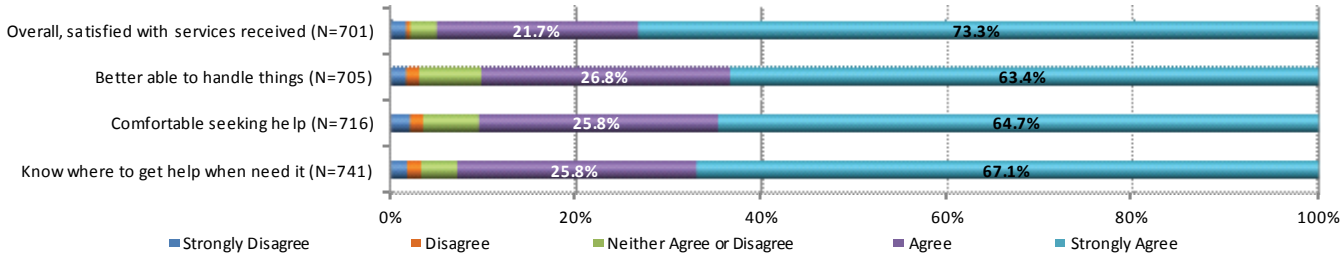
SUPPORT GROUP SATISFACTION*



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of participation in the support group. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help following the intervention. Overall, 98% of the caregivers were satisfied with the services received in the support groups.

**Satisfaction data includes duplicated participants.*

PREVENTION EVENTS SATISFACTION*



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the prevention events. Most said that they knew where to get help when they needed it, and that they felt more comfortable seeking help as a result of participation in the events. Overall, 95% of the caregivers were satisfied with the services received.

**Satisfaction data includes duplicated participants.*

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SCHOOL BASED PROGRAM - NORTH COUNTY (SA01NC): BEST UNIVERSAL PREVENTION

PALOMAR FAMILY COUNSELING SERVICES

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

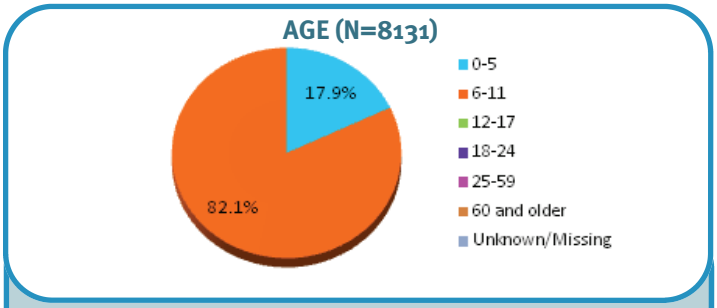
FISCAL YEAR 2012—13 ANNUAL REPORT

REGION: NORTH INLAND– DISTRICT 3

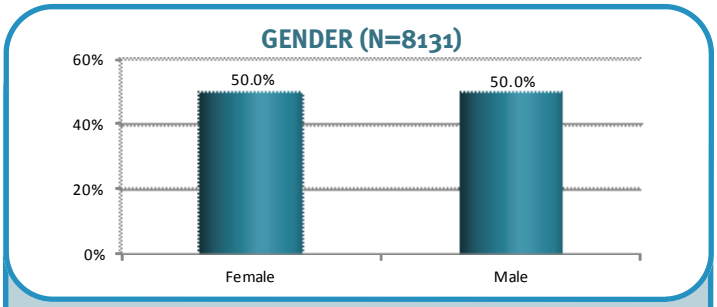
This program provides family-focused prevention and early intervention services for school-age children and their families in 11 schools in Escondido and Oceanside. The program has three components: a universal prevention component, BEST, a school-based component, School-Age Services (SAS), and a family-based component, the Family Community Partnership (FCP). The universal prevention component involves the implementation of the BEST Behavior evidence-based intervention at a school-wide level to all schools. The aim of the BEST intervention is to improve school climate, by establishing school-wide behavioral expectations and helping teachers create a more structured classroom environment, in order to promote positive behavior. This report focuses on the BEST component of NCPEI.

CONTRACTOR: Palomar Family Counseling Services	
CONTRACT START DATE: 11/2/2009	**DATA COLLECTION START DATE: 1/1/2010**
PROGRAM SERVICES START DATE: 11/2/2009	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 8131 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 19,742 (Duplicated)**

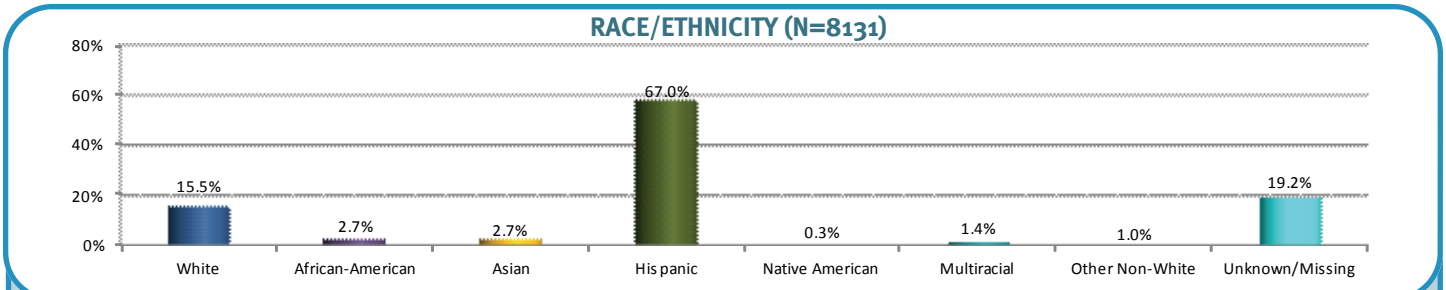
YOUTH DEMOGRAPHICS



Eighty-two percent of participants were ages 6-11 and 18% were ages 0-5; this age breakdown is representative of the youth population targeted by the BEST universal prevention intervention.



Fifty percent of participants who received BEST universal prevention services were male and 50% were female.



Sixty-seven percent of participants who received BEST universal prevention services were identified as Hispanic. Approximately 16% of participants were identified as White. Race was not identified for 19% of participants.

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.

SCHOOL BASED PROGRAM - NORTH COUNTY (SA01NC): FAMILY COMMUNITY PARTNERSHIP

PALOMAR FAMILY COUNSELING SERVICES

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

FISCAL YEAR 2012—13 ANNUAL REPORT

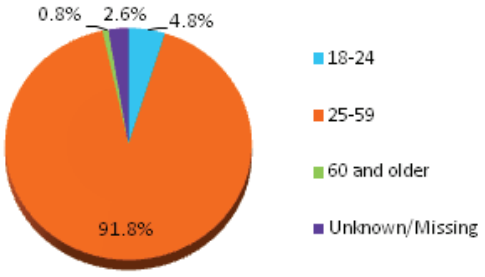
REGION: NORTH INLAND– DISTRICT 3

This program provides family-focused prevention and early intervention services for school-age children and their families in 11 schools in Escondido and Oceanside. The program has three components: a universal prevention component, BEST, a school-based component, School-Age Services (SAS), and a family-based component, the Family Community Partnership (FCP). The FCP component provides outreach services to all families of schools served. Going beyond school boundaries, FCP encourages parent involvement as well as assisting parents in accessing additional resources. FCP services are provided by bilingual community outreach specialists and case manager/educators who give referrals to community resources and provide group targeted activities for families that strengthen collaboration between families, communities, and schools, involve parents in their child's education, and increase family wellness and resiliency. This report focuses on the FCP component of NCPEI.

CONTRACTOR: Palomar Family Counseling Services	
CONTRACT START DATE: 11/2/2009	**DATA COLLECTION START DATE: 1/1/2010**
PROGRAM SERVICES START DATE: 11/2/2009	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 2095 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 4639 (May include duplicates)**

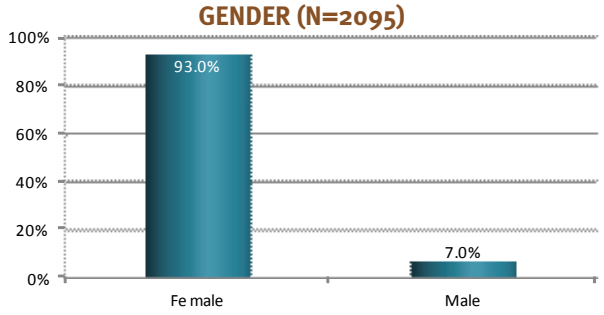
CAREGIVER DEMOGRAPHICS

AGE (N=2095)



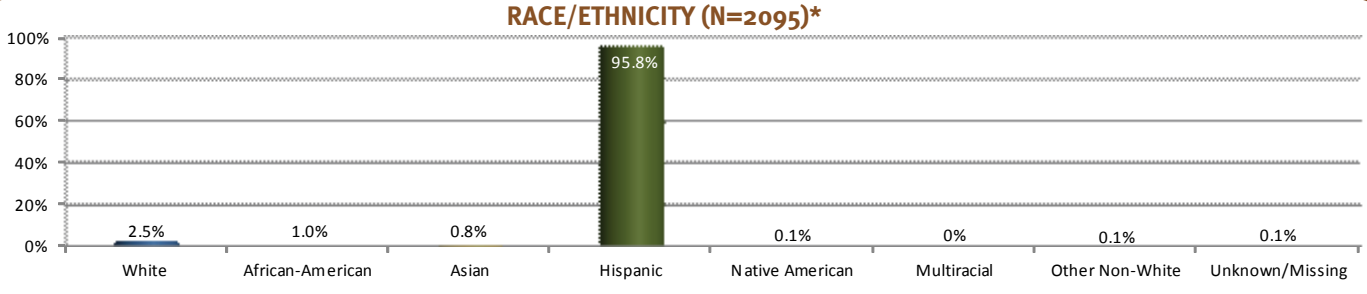
The majority (92%) of caregivers who received Family Community Partnership Services were ages 25-59.

GENDER (N=2095)



Ninety-three percent of caregivers who received services were female. Seven percent of caregivers who received services were male.

RACE/ETHNICITY (N=2095)*



Approximately 96% of caregivers who received services identified their racial/ethnic background as Hispanic. Of those identifying as Hispanic, the majority (91%) indicated they were of Mexican American/Chicano origin.

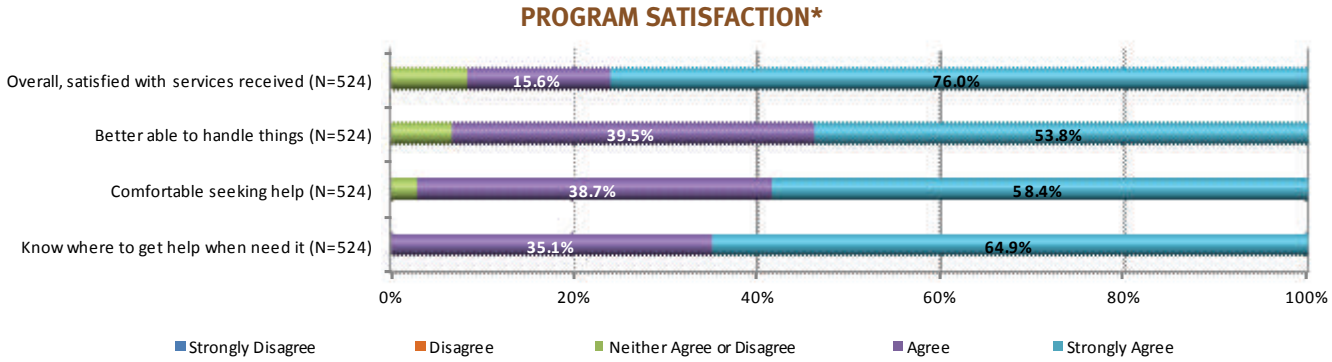
**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE*

Of the 2093 caregivers who responded to this question, the majority (98%) reported that they had not served in the military. Of the 39 caregivers who said they had served in the military, 25 (64%) reported serving in the Marine Corps, 6 (15%) served in the Navy, 4 (10%) served in the Army, 3 (8%) served in the Marine Corps Reserve and 1 (3%) served in the Army Reserve.

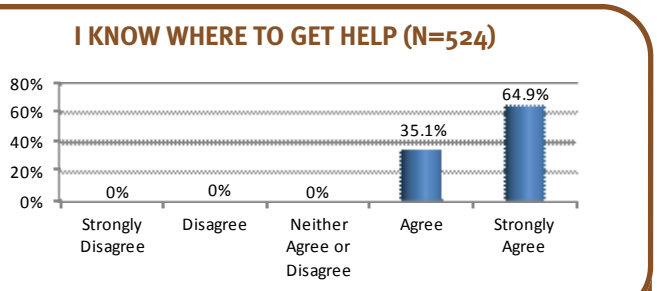
**Caregivers could have served in more than one military branch so numbers and percentages may add up to more than the N or 100%.*

PROGRAM SATISFACTION



The majority of caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of participation in the program. Most also said that they felt more comfortable seeking help. Overall, 92% of the caregivers were satisfied with the services received.

**Satisfaction data not available for all participants.*



One-hundred percent of participants responding to this question reported that they knew where to get help when they needed it.

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.

SCHOOL BASED PROGRAM - NORTH COUNTY (SA01NC): SCHOOL AGE SERVICES

PALOMAR FAMILY COUNSELING SERVICES

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

FISCAL YEAR 2012—13 ANNUAL REPORT

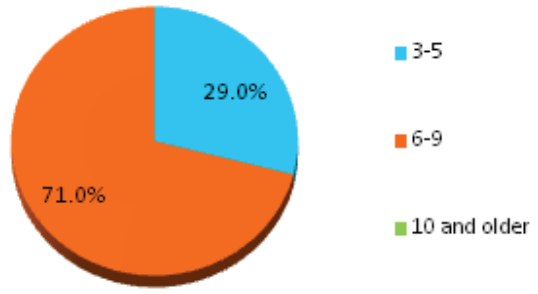
REGION: NORTH INLAND– DISTRICT 3

This program provides family-focused prevention and early intervention services for school-age children and their families in 11 schools in Escondido and Oceanside. The program has three components: a universal prevention component, BEST, a school-based component, School-Age Services (SAS), and a family-based component, the Family Community Partnership (FCP). In the SAS component, the Incredible Years curriculum is offered in preschool through third grades. This evidence-based curriculum helps students improve their social and emotional skills. Children are screened for signs of behavioral problems and receive prevention activities tailored to their specific needs. This report focuses on the SAS component of NCPEI.

CONTRACTOR: Palomar Family Counseling Services	
CONTRACT START DATE: 11/2/2009	**DATA COLLECTION START DATE: 1/1/2010**
PROGRAM SERVICES START DATE: 11/2/2009	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 817 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 2210 (May include duplicates)**

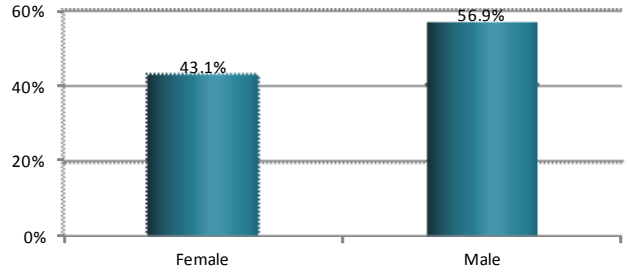
YOUTH DEMOGRAPHICS

AGE (N=817)



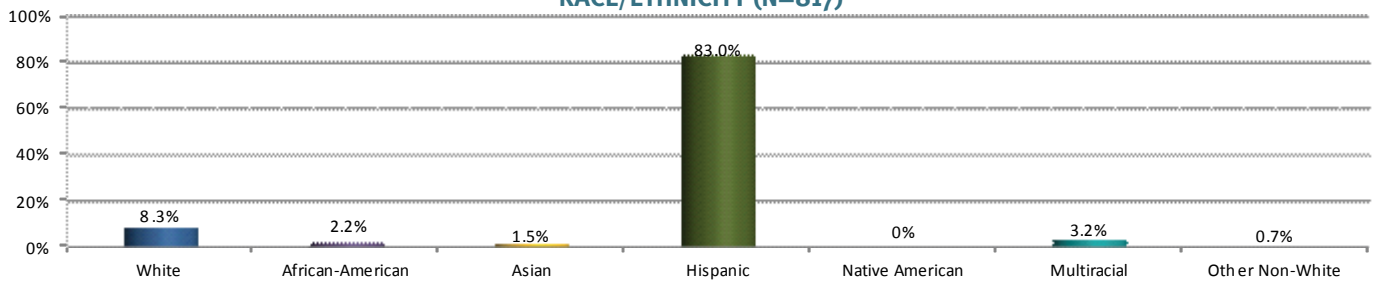
One hundred percent of SAS participants were ages 3-9, which is representative of the population targeted by this intervention. Seventy-one percent of the participants were ages 6-9.

GENDER (N=817)



Fifty-seven percent of participants who received services were male while the remaining 43% of participants were female.

RACE/ETHNICITY (N=817)*



Eighty-three percent of participants who received services were identified as Hispanic. Approximately 10% of participants were identified as White or African-American. Of those identifying as Hispanic, the majority (99%) indicated they were of Mexican American/Chicano origin.

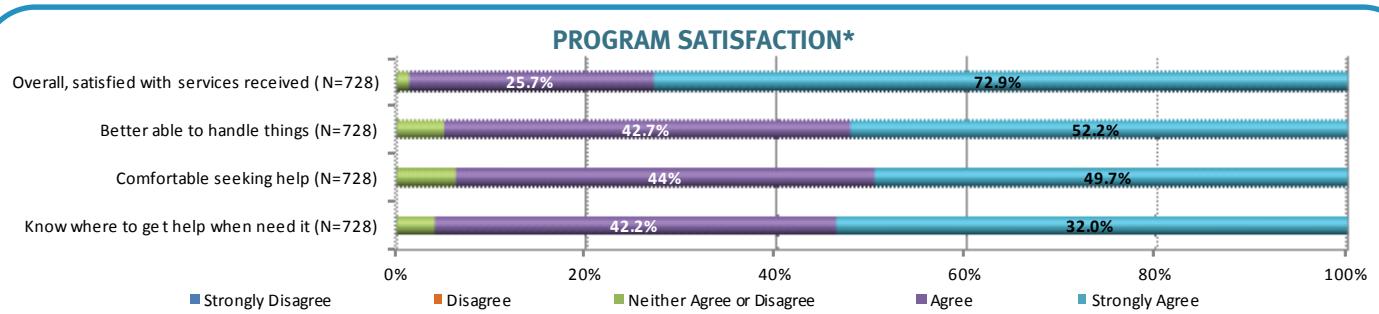
**Participants can self-identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE*

Of the 779 participants who responded to this question, the majority (96%) reported that the child's caregiver had not served in the military. Of the 32 caregivers reported to have served in the military, 12 (38%) served in the Marine Corps, 8 (25%) served in the Army, 7 (22%) served in the Navy Reserve, 2 (6%) served in the Air Force Reserve, 1 (3%) served in the Air Force, 1 (3%) served in the Coast Guard, 1 (3%) served in the Marine Corps Reserve and 1 (3%) served in the Navy.

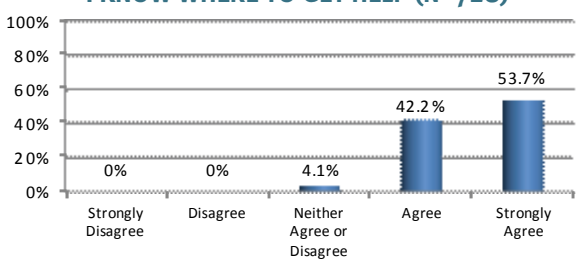
**Caregivers could have served in more than one branch so numbers and percentages may add up to more than the N or 100%.*

PROGRAM SATISFACTION



The majority of participants who responded to these questions agreed that they were better able to handle things and solve problems as a result of the program. Most also said that they felt more comfortable seeking help. Overall, 99% of the participants were satisfied with the services received.

**Satisfaction data not available for all participants.*



Ninety-six percent of participants who responded to this question reported that they knew where to get help when they needed it.

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YELLOW RIBBON SUICIDE PREVENTION (SA02): CAREGIVER OUTCOMES

MENTAL HEALTH RESOURCE CENTER

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

FISCAL YEAR 2012—13 ANNUAL REPORT

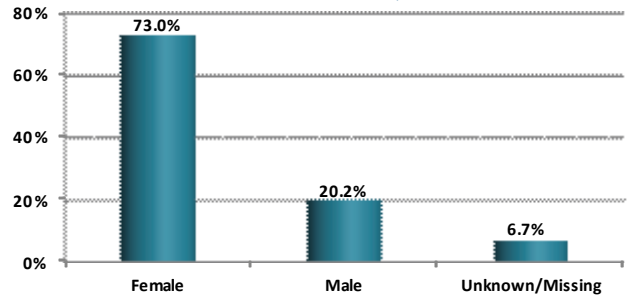
REGION: NORTH CENTRAL– DISTRICT 4

The School-Based Suicide Prevention program provides presentations in school settings on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and caregivers. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013.

CONTRACTOR: Mental Health Resource Center	
CONTRACT START DATE: November 2009	**DATA COLLECTION START DATE: October 2010**
PROGRAM SERVICES START DATE: August 2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 89 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 848 (May include duplicates)**

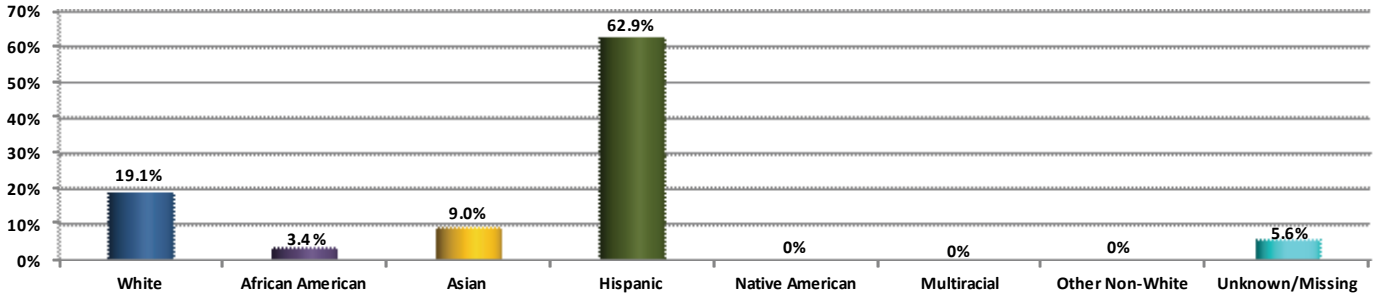
CAREGIVER DEMOGRAPHICS

GENDER (N=89)



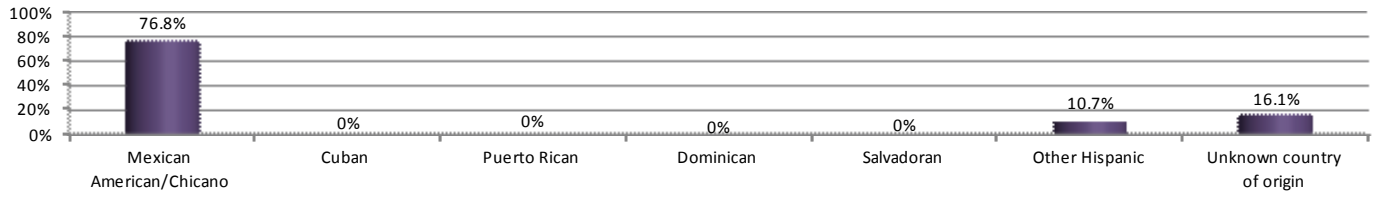
Seventy-three percent of the caregivers were female.

RACE/ETHNICITY (N=89)



Approximately 63% of the caregivers identified their ethnic background as Hispanic. Nineteen percent of the caregivers identified their ethnic background as White, and 9% identified their ethnic background as Asian. The remaining racial/ethnic backgrounds were not highly represented.

MEXICAN/HISPANIC/LATINO ORIGIN (N= 56)*

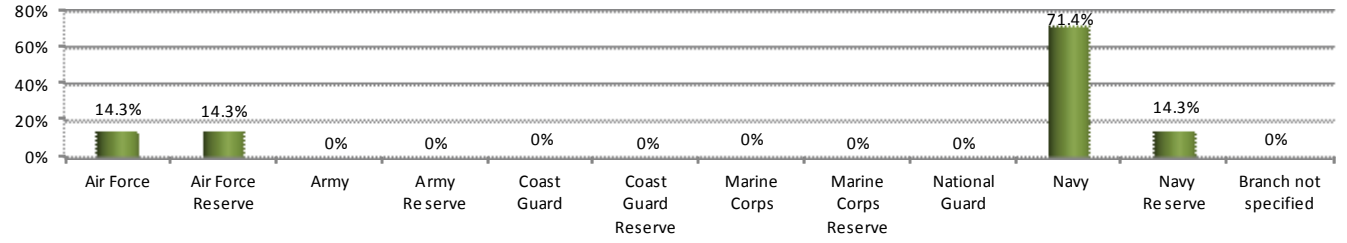


Seventy-seven percent of the caregivers in the sample of Hispanic origin identified their ethnic background as Mexican American/Chicano.

**Participants can self identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE

MILITARY BRANCH (N=7)*

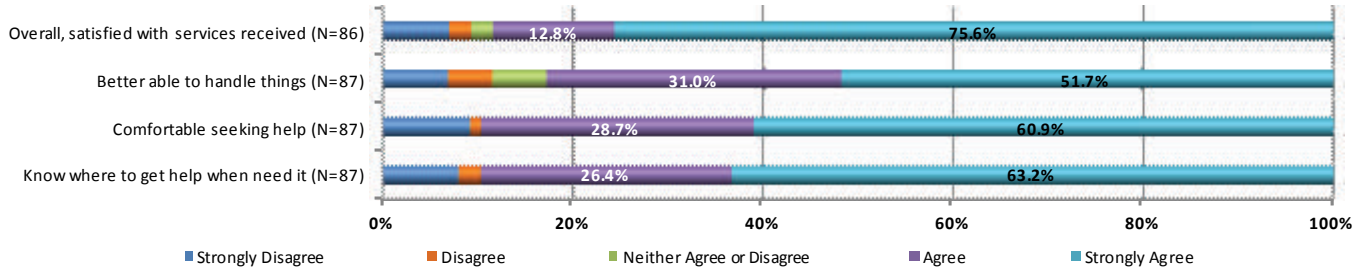


Of 80 caregivers that responded to this question, the majority (91%) reported that they had not served in the military. Of the 7 caregivers that reported they have served in the military, 5 (71%) served in the Navy, 1 (14%) served in the Navy Reserve, 1 (14%) served in the Air Force and 1 (14%) served in the Air Force Reserve. The remaining branches were not represented.

**Participants could have served in more than one military branch so percentages may add up to more than 100%.*

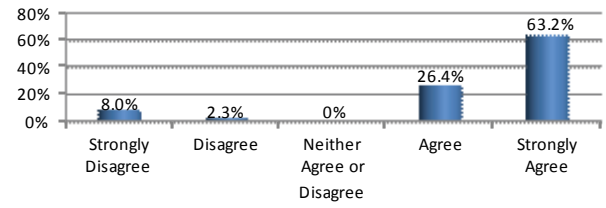
PROGRAM SATISFACTION

PROGRAM SATISFACTION



Most caregivers who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they felt more comfortable seeking help now. Overall, 88% of the caregivers were satisfied with the services received.

I KNOW WHERE TO GET HELP (N=87)

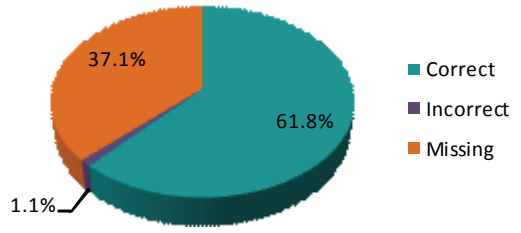


Ninety percent of caregivers responding to this question reported that they knew where to get help when they needed it. Approximately 10% did not agree with this statement.

"I know where to get help when I need it."

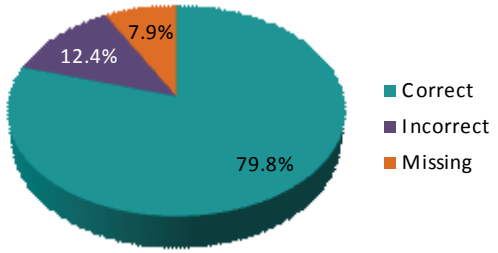
PROGRAM SPECIFIC OUTCOMES (N=89)

PERCENT OF CAREGIVERS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE



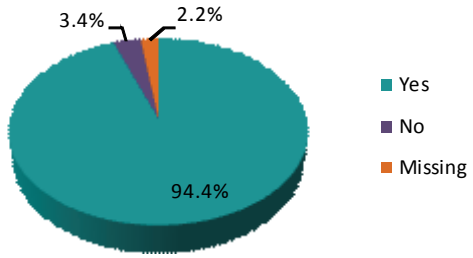
Following the presentation, approximately 62% of caregivers correctly identified the warning signs of suicide.

PERCENT OF CAREGIVERS WHO CORRECTLY IDENTIFIED THE PROTOCOL STEPS ON THE ASK 4 HELP CARD



Following the presentation, approximately 80% of caregivers correctly identified the protocol steps on the Ask 4 Help card.

IF A STUDENT CAME TO ME BECAUSE THEY WERE DEPRESSED OR HAVING SUICIDAL THOUGHTS, I WOULD KNOW WHO TO REFER THE STUDENT TO FOR HELP



Following the presentation, 94% of the caregivers reported that if a student came to them because they were depressed or were having suicidal thoughts, they would know who to refer them to for help.

SUICIDE RISK ASSESSMENTS

Assessment data was not available for FY2012-13.

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YELLOW RIBBON SUICIDE PREVENTION (SA02): SCHOOL STAFF OUTCOMES

MENTAL HEALTH RESOURCE CENTER

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

FISCAL YEAR 2012—13 ANNUAL REPORT

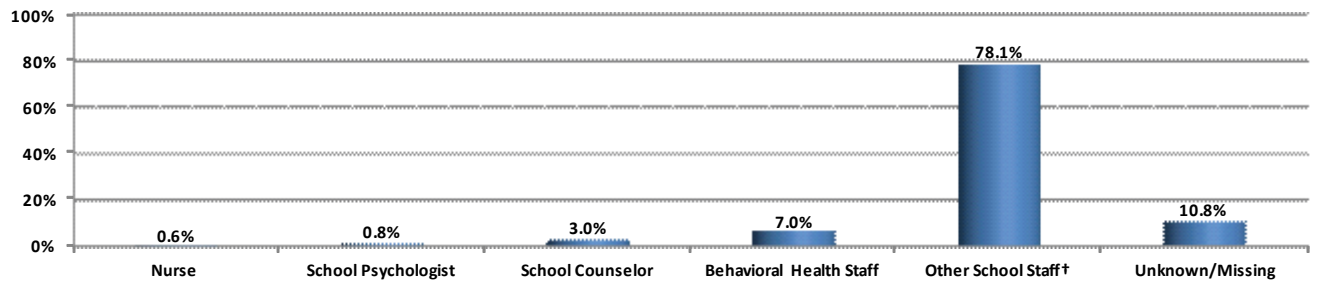
REGION: NORTH CENTRAL– DISTRICT 4

The School-Based Suicide Prevention program provides presentations in school settings on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and parents. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013.

CONTRACTOR: Mental Health Resource Center	
CONTRACT START DATE: November 2009	**DATA COLLECTION START DATE: October 2010**
PROGRAM SERVICES START DATE: August 2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 658 (Unduplicated)	**PARTICIPANTS SERVED SINCE PROGRAM INCEPTION: 4275 (May include duplicates)**

STAFF DEMOGRAPHICS

STAFF TYPE (N=658)*

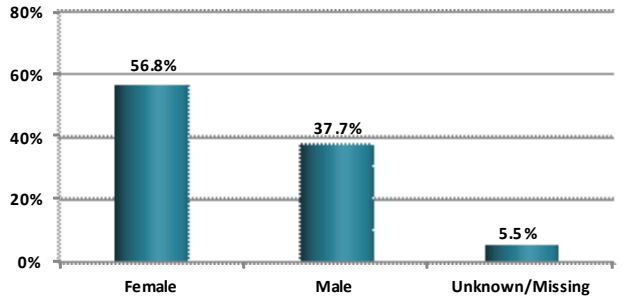


Seventy-eight percent of staff were not physical or behavioral health care providers.

**Staff can self-identify as serving in more than one position so percentages may add up to more than 100%.*

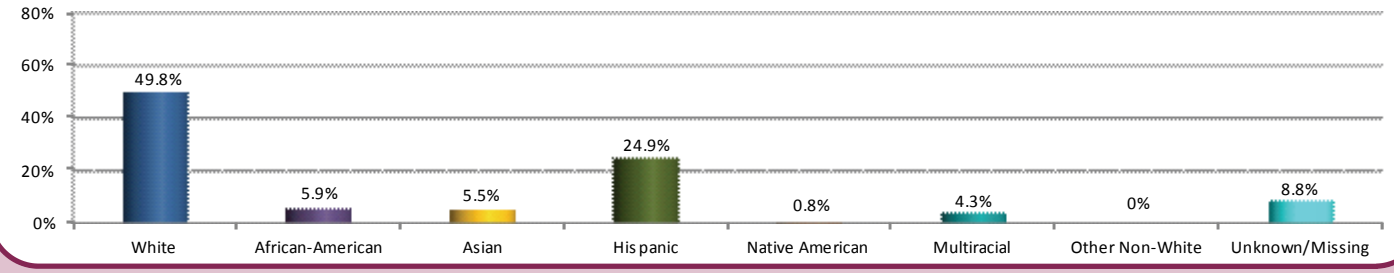
†The majority of staff in this category are teachers.

GENDER (N=658)



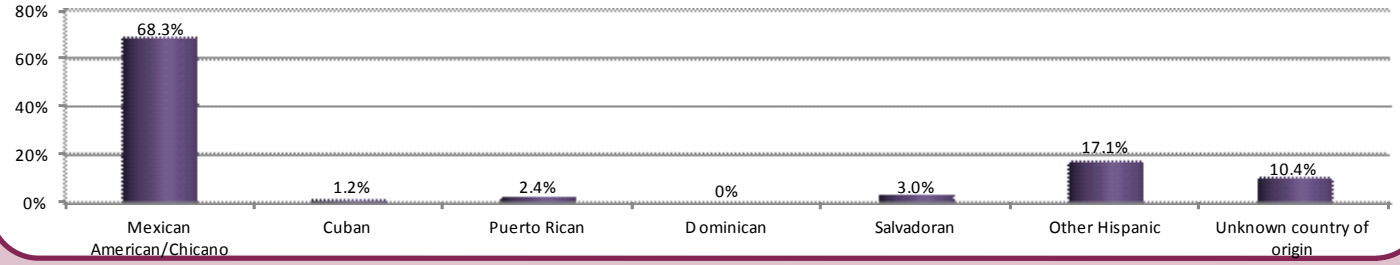
Approximately 57% of the staff were female.

RACE/ETHNICITY (N=658)



Almost 50% of the staff identified their ethnic background as White, and approximately 25% of staff identified their ethnic background as Hispanic. Nine percent of staff did not identify their racial/ethnic background.

MEXICAN/HISPANIC/LATINO ORIGIN (N= 164)*

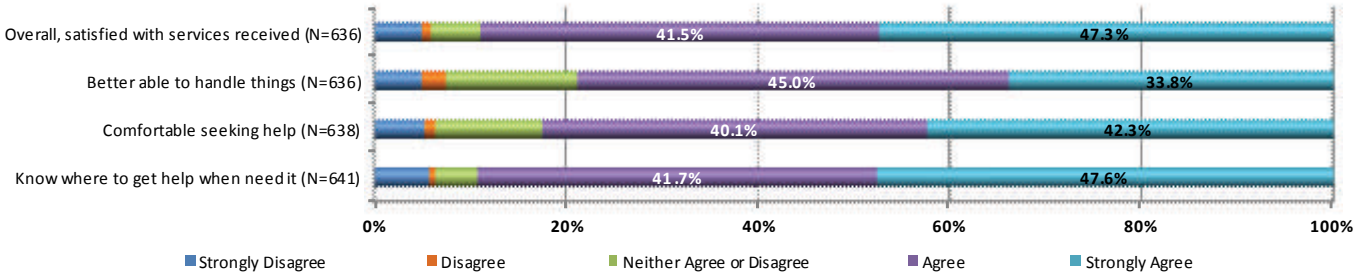


Sixty-eight percent of the Hispanic population served identified their ethnic background as Mexican American/Chicano.

**Participants can self identify as more than one race so percentages may add up to more than 100%.*

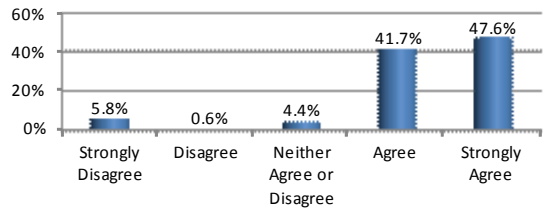
PROGRAM SATISFACTION

PROGRAM SATISFACTION



Most staff who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they felt more comfortable seeking help now. Overall, 89% of the staff were satisfied with the services received.

I KNOW WHERE TO GET HELP (N=641)

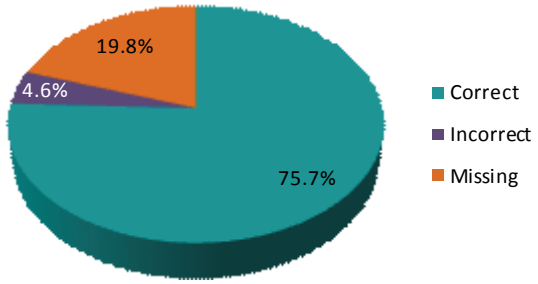


Eighty-nine percent of staff responding to this question reported that they knew where to get help when they needed it. Approximately 6% did not agree with this statement.

"I know where to get help when I need it."

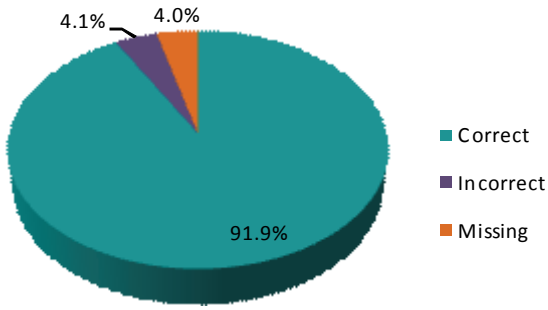
PROGRAM SPECIFIC OUTCOMES (N=658)

PERCENT OF STAFF WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE



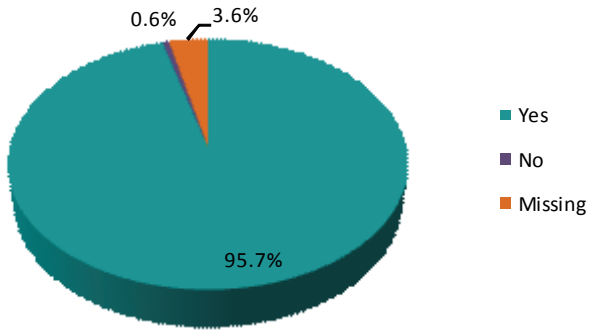
Following the presentation, approximately 76% of staff correctly identified the warning signs of suicidal ideation/behavior.

PERCENT OF STAFF WHO CORRECTLY IDENTIFIED THE PROTOCOL STEPS ON THE ASK 4 HELP CARD



Following the presentation, approximately 92% of staff correctly identified the protocol steps on the Ask 4 Help card.

IF A STUDENT CAME TO ME BECAUSE THEY WERE DEPRESSED OR HAVING SUICIDAL THOUGHTS, I WOULD KNOW WHO TO REFER THE STUDENT TO FOR HELP.



Following the presentation, approximately 96% of the staff reported that if a student came to them because they were depressed or were having suicidal thoughts, they would know who to refer them to for help.

SUICIDE RISK ASSESSMENTS

Assessment data was not available for FY2012-13.

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.

YELLOW RIBBON SUICIDE PREVENTION (SA02): STUDENT OUTCOMES

MENTAL HEALTH RESOURCE CENTER

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

FISCAL YEAR 2012—13 ANNUAL REPORT

REGION: NORTH CENTRAL– DISTRICT 4

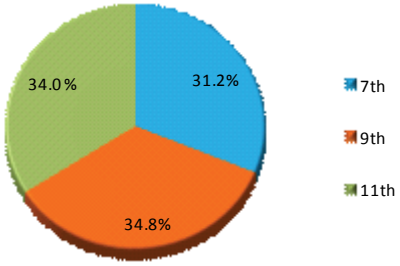
The School-Based Suicide Prevention program serves children, youth and transition-age youth (ages 18-24) in school settings. This program provides presentations on the risk factors for suicide, how to respond to youth showing suicidal ideation, and where to go for help. The presentations, which are based on the Yellow Ribbon Suicide Prevention Program, are given to 7th, 9th, and 11th grade students, as well as to school staff, and parents. One of the goals of this program is to give presentations at every school in the San Diego Unified School District by the end of 2013. Due to the large number of students served, CASRC collects data on a representative sample (based on school size) of 25% of the youth who attended the presentations.

CONTRACTOR: Mental Health Resource Center	
CONTRACT START DATE: November 2009	**DATA COLLECTION START DATE: October 2010**
PROGRAM SERVICES START DATE: August 2010	**REPORT PERIOD: 7/1/2012-6/30/2013**
NUMBER OF PARTICIPANTS WITH DATA IN FY 2012-13: 5589 (Unduplicated)	**PARTICIPANTS SERVED* IN FY 2012-13: 20,189 (May include duplicates)** **PARTICIPANTS SERVED* SINCE PROGRAM INCEPTION: 42,258 (May include duplicates)**

STUDENT DEMOGRAPHICS

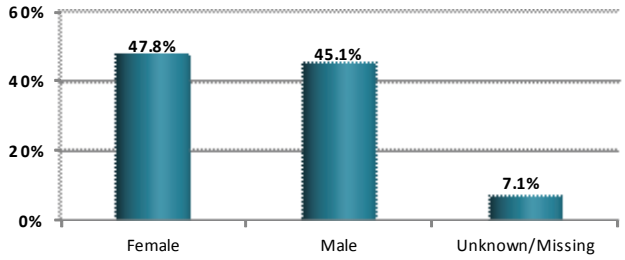
**This number is calculated from projected participant counts provided by the school district.*

SCHOOL GRADE (N=5589)



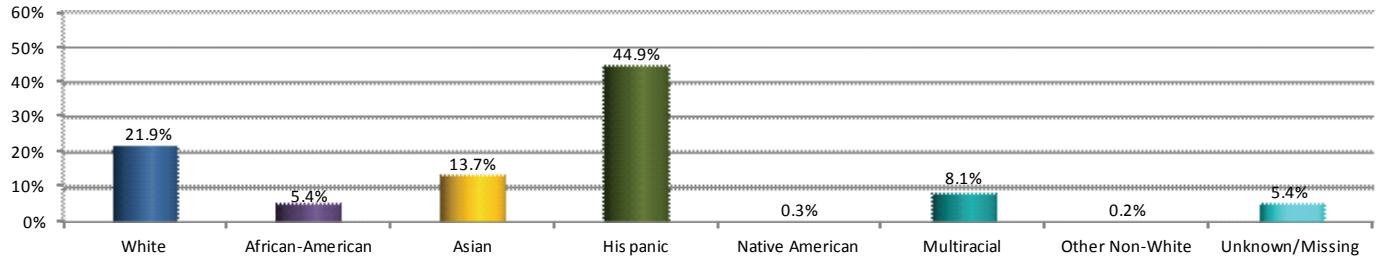
The sample population contained slightly more 9th graders (35%) and 11th graders (34%) than 7th graders (31%).

GENDER (N=5589)



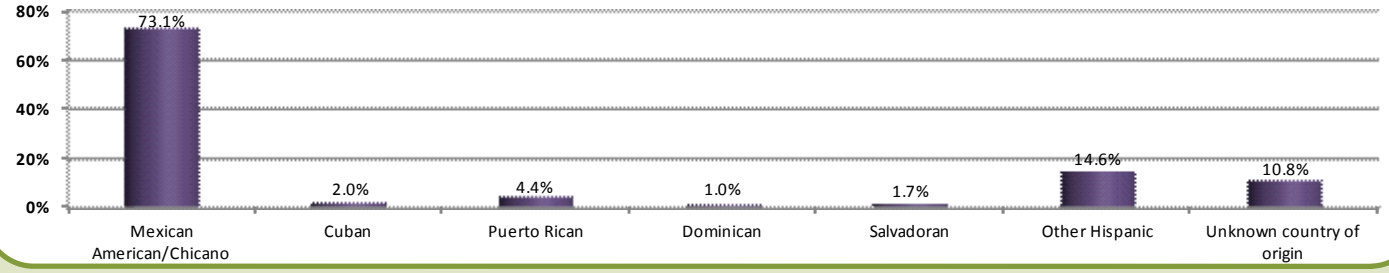
Approximately 48% of the sample population identified their gender as female.

RACE/ETHNICITY (N=5589)



More than 44% of the students in the sample identified their race/ethnicity as Hispanic. Approximately 22% of students identified their race/ethnicity as White, and 14% identified as Asian.

MEXICAN/HISPANIC/LATINO ORIGIN (N= 2509)*

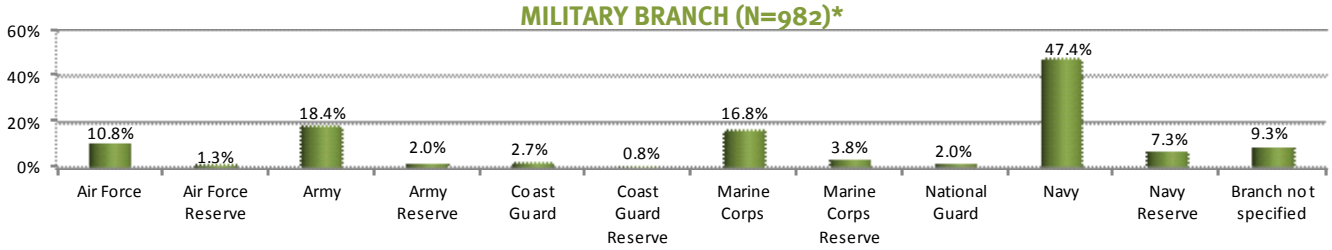


The majority of the Hispanic population in the sample identified their ethnic background as Mexican American/Chicano.

**Participants can self identify as more than one race so percentages may add up to more than 100%.*

MILITARY SERVICE

MILITARY BRANCH (N=982)*

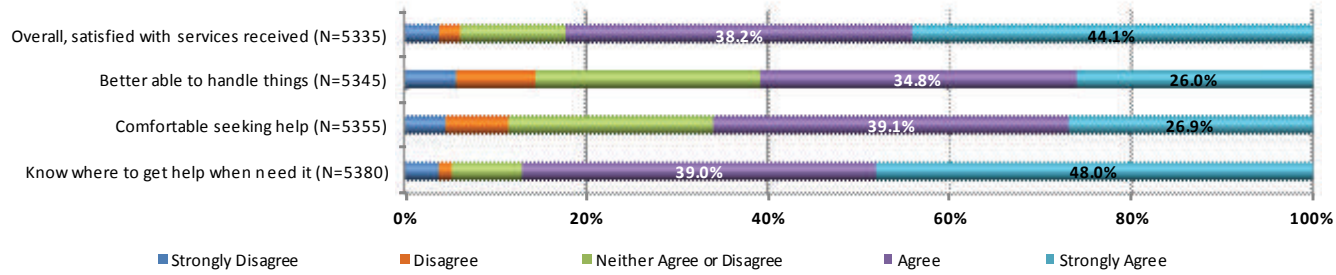


Of 4522 students in the sample that responded to this question, 78% reported that their caregivers had not served in the military. Of the 982 students who reported that their caregiver had served in the military, 465 (47%) reported service in the Navy, 181 (18%) reported that service in the Army, 165 (17%) reported service in the Marine Corps and 106 (11%) reported service in the Air Force. The remaining military branches were not highly represented.

**Caregivers could have served in more than one military branch so percentages may add up to more than 100%.*

PROGRAM SATISFACTION

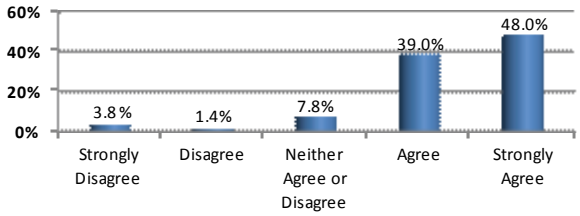
PROGRAM SATISFACTION*



Most students in the sample who responded to these questions agreed that they were better able to handle things and solve problems as a result of the presentation. Most also said that they felt more comfortable seeking help now. Overall, 82% of the students in the sample were satisfied with the services received.

**Satisfaction data not available for all participants.*

I KNOW WHERE TO GET HELP (N=5380)

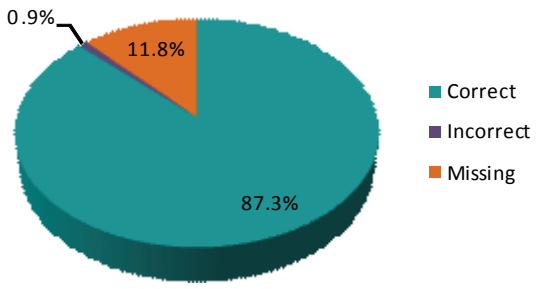


The majority of students in the sample who responded to this question reported that they knew where to get help when they needed it. Approximately 5% did not agree with this statement.

"I know where to get help when I need it."

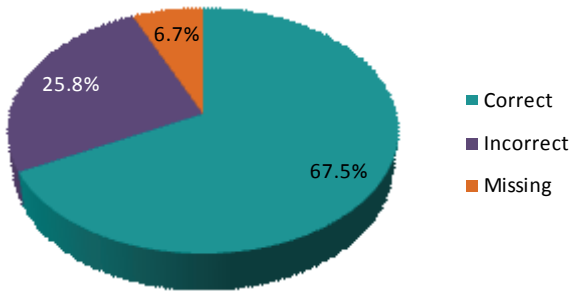
PROGRAM SPECIFIC OUTCOMES (N=5589)

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED WARNING SIGNS OF SUICIDE



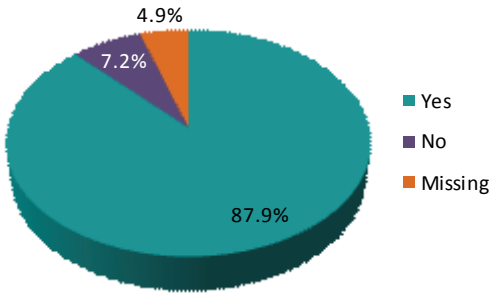
Following the presentation, approximately 87% of students in the sample correctly identified the warning signs of suicidal ideation/behavior.

PERCENT OF STUDENTS WHO CORRECTLY IDENTIFIED THE STEPS TO TAKE IF A FRIEND SAYS HE/SHE IS CONSIDERING SUICIDE



Following the presentation, approximately 68% of students in the sample correctly identified the steps to take if a friend is considering suicide.

IF I FELT DEPRESSED OR WAS HAVING SUICIDAL THOUGHTS, I KNOW WHO TO GO TO FOR HELP



Following the presentation, approximately 88% of students in the sample reported that if they were depressed or were having suicidal thoughts, they would know who to go to for help.

SUICIDE RISK ASSESSMENTS

Assessment data was not available for FY2012-13.

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.

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Bridge to Recovery

CO01 – North Central Region, District 1
University of California, San Diego

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

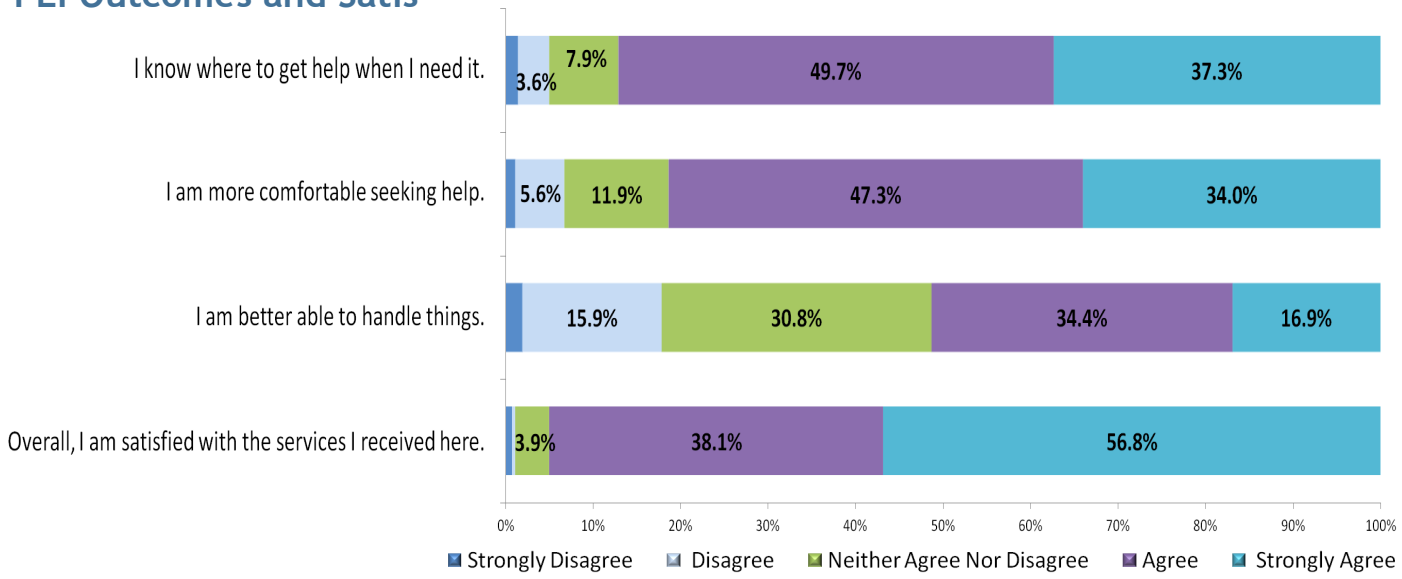
In Fiscal Year (FY) 2012-13, the University of California, San Diego (UCSD) Bridge to Recovery Program provided screening, brief intervention, and referral to treatment (SBIRT) services to 1,375 unduplicated, new clients in the San Diego County Psychiatric Hospital's (SDCPH) Crisis Recovery Unit (CRU) and Emergency Psychiatric Unit (EPU), Gary and Mary West Senior Wellness Center, Gifford Walk-In Clinic, Jane Westin Walk-In Clinic, Bridge to Recovery Walk-In, and Bridge to Recovery Case Management Program. All participants had co-occurring disorders.

The goal of the UCSD Bridge to Recovery program, part of the Prevention and Early Intervention (PEI) plan, is to provide screening, brief intervention, education, linkages, outreach, and referrals to individuals with co-occurring disorders who access one of the locations mentioned above. Then, the program offers follow-up short-term case management support to link appropriate participants to needed treatment or other resources to create stability, instill hope, reduce stigma about seeking treatment, and reduce suicidal risk factors.

Using a short-term case management model, brief intervention is delivered to educate and engage at-risk individuals with substance abuse issues, who would benefit from interventions by peer specialists and/or clinicians. The Bridge to Recovery program also provides referral to specialty care services for those identified as needing more extensive treatment.

The UCSD Bridge to Recovery Program is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

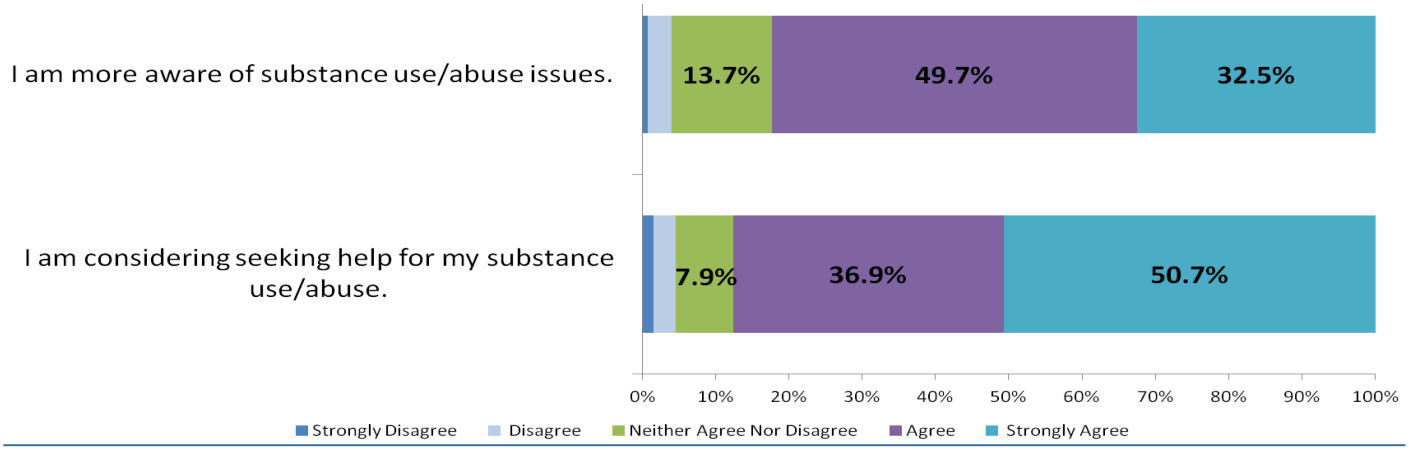
PEI Outcomes and Satis-



Participants were asked to assess both their improvement and their satisfaction with several areas of the Bridge to Recovery Program after completion of the first session of the intervention. The majority of participants either "Agreed" or "Strongly Agreed" that, because of the intervention, "I know where to get help when I need it" (87.0%) and "I am more comfortable seeking help" (81.3%). Half of respondents "Agreed" or "Strongly Agreed" that, "I am better able to handle things" (51.3%). It is likely that fewer participants agreed with this question because of the timing of the survey—only a moderate response on overall improvement in coping can be expected after one contact with a participant. Most participants "Agreed" or "Strongly Agreed" that, "Overall, I am satisfied with the services I received here" (94.9%).

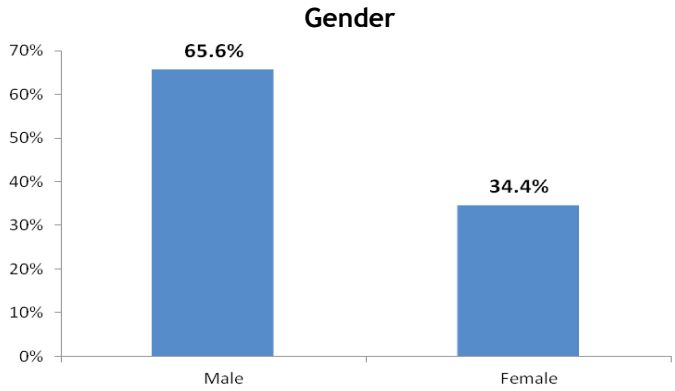
Program Specific Outcomes

Bridge to Recovery participants also assessed benefits they received from the program related to their substance use. A majority of the participants either "Agreed" or "Strongly Agreed" that, because of the program, "I am more aware of substance use/abuse issues" (82.2%) and, "I am considering seeking help for my substance use/abuse" (87.6%).

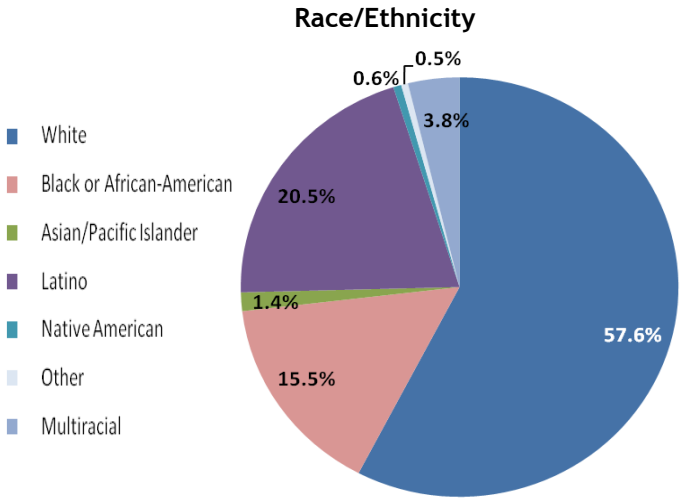


Participant Demographics

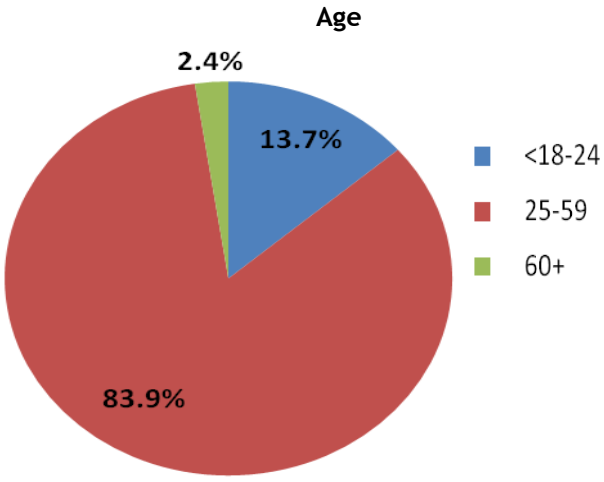
During FY 2012-13, Bridge to Recovery provided services to 1,375 new participants. The majority of participants were male (65.6%), White (57.6%), and 25-59 years old (83.9%). Participants' average age was 38.1 years. A small percentage of participants had served in the military (6.5%), with most serving in the Navy (27.2%), Army (23.9%), or Marine Corps (19.6%).



Note. Other gender was reported by 2 participants and were not included



Note. 190 participants did not provide race/ethnicity and were excluded



HEALTH SERVICES RESEARCH CENTER is a non-profit research organization within the University of California, San Diego Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Behavioral Health Services to evaluate and improve mental 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 participant quality of life. For more information about HSRC please contact Andrew Sarkin, PhD at 858-622-1771.

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Community Based Alcohol and Drug Services Program

CO02 – Central, East, South, N. Coastal,
N. Inland, N. Central Regions
Districts 1, 2, 4, 5

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

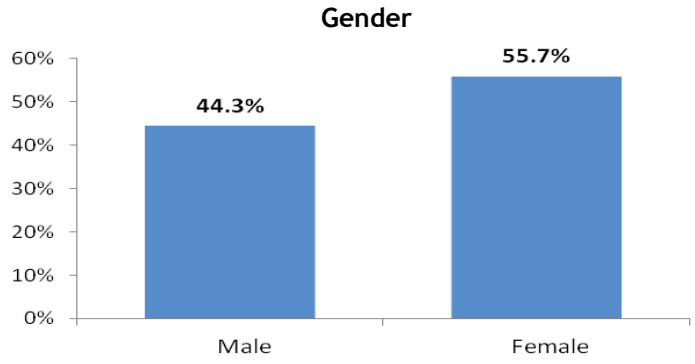
This Prevention and Early Intervention (PEI) project has added mental health counselors to 28 Alcohol and Drug Services (ADS) treatment programs to identify and screen for clients who exhibit mental health concerns. Interventions applied are best practices that are age appropriate, integrated, accessible, culturally competent, and strength based.

The Community Based Alcohol and Drug Services Program ensures that clients with substance abuse issues who are experiencing co-occurring mental health problems receive services that comprehensively address both issues. This approach supports clients in their efforts to attain and maintain an alcohol and drug free style of living. Mental health counselors in the programs conduct mental health screenings at on-site ADS treatment sites, including developmentally appropriate screenings for children and older adults.

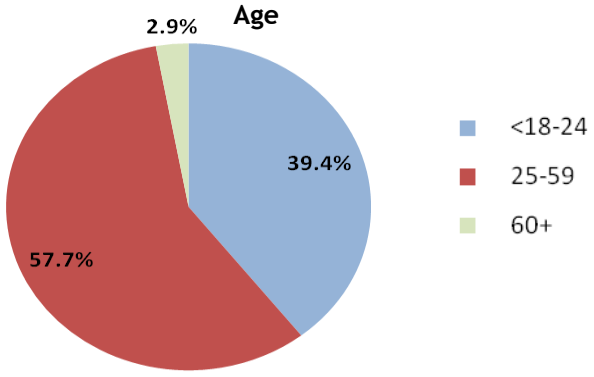
Counselors perform assessments, provide mental health education and brief counseling to reduce risk factors or stressors, facilitate linkages to additional mental health services, and assist clients in developing life skills to help them maintain longer periods of sobriety. They also provide support to ADS staff through consultation in team meetings. Counselors also provide services that support the treatment and recovery of clients' family members, offering: prevention groups for children of parents in recovery that build protective factors and communication skills; family assessment and linkage to behavioral health and other services to decrease stress; and information and education for parents about early signs of problems with their children and ways to manage them.

Participant Demographics

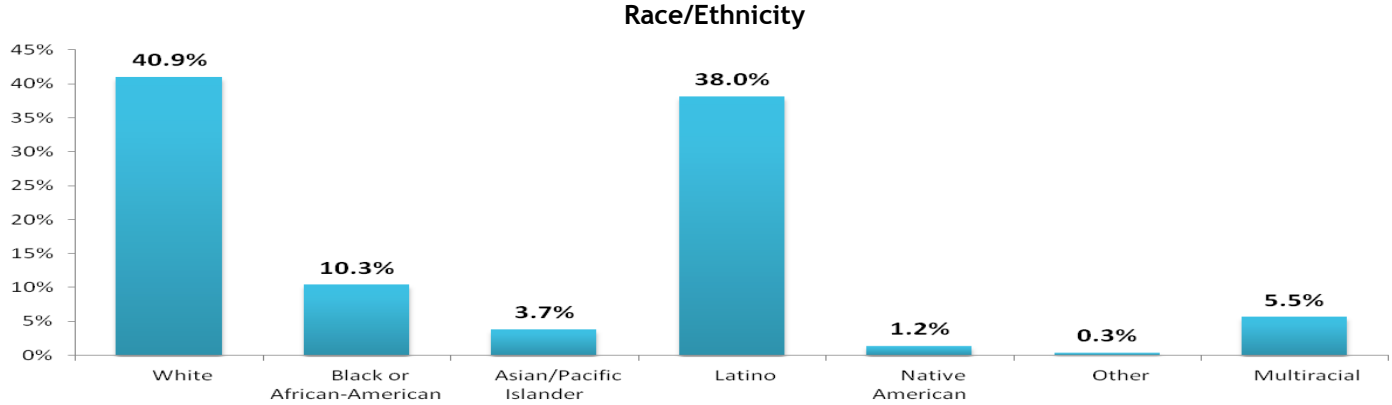
Demographics were collected for 879 PEI participants. Participants reflect the diverse population found in San Diego County. About 4% of the participants served in the military.



Note. 1 participant reported 'other', and 56 did not report gender and were excluded



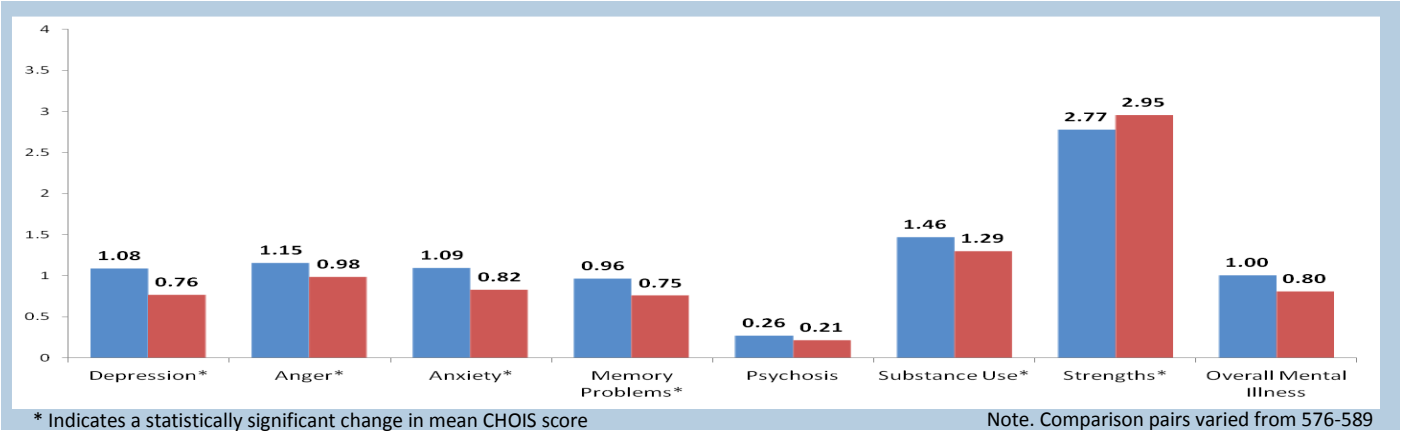
Note. 143 participants did not report age and were excluded



Note. 185 participants did not provide race/ethnicity and were excluded

PARTICIPANT OUTCOMES

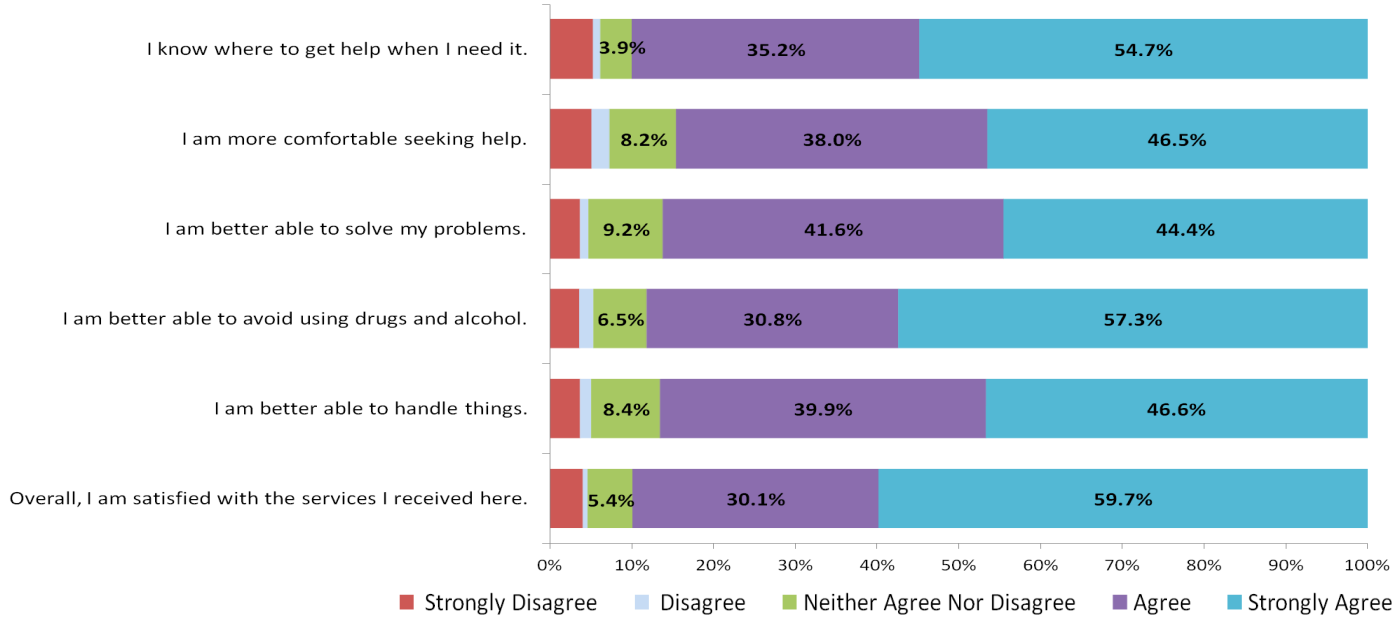
Although more work is needed to further examine the effect of programs in all domains of the testing instrument being used (Creating Healthy Outcomes: Integrated Self-Assessment; CHOIS), preliminary results show that PEI ADS programs are making an important impact on treatment and recovery. The potential range for the Depression, Anger, Anxiety, Memory Problems, Psychosis, and Strengths subscales is 0 to 4 (Likert items ranging from "Never" to "Always"), and the potential range for the Substance Use subscale is 0 to 3 (Likert items ranging from "Never" to "Past Month"). The Overall Mental Illness subscale represents the mean of every item within the Depression, Anger, Anxiety, Memory Problems, Psychosis, and Substance Use subscales. In each of the subscales, with the exception of Strengths, lower ratings indicate reduced mental illness symptoms. For the Strengths subscale, higher scores indicate greater resilience and protective factors.



* Indicates a statistically significant change in mean CHOIS score

Note. Comparison pairs varied from 576-589

Upon completion of the program, participants are asked six questions regarding their satisfaction with the program, and how the program helped them. These items were only given to participants who completed the intervention, and the number of respondents varied for each item. Most participants "Strongly Agreed" or "Agreed" that as a result of the program, "I know where to get help when I need it" (89.9%), "I am more comfortable seeking help" (84.5%), "I am better able to solve my problems" (86.0%), "I am better able to avoid using drugs and alcohol" (88.1%), and "I am better able to handle things" (86.5%). Overall, 89.8% of the participants were satisfied with the additional mental health services.



This report was prepared by the HEALTH SERVICES RESEARCH CENTER at University of California, San Diego, a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Behavioral Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data used to help improve the behavioral health care system and, ultimately, to improve client quality of life. For more information about HSRC please contact Andrew Sarkin, PhD at 858-622-1771.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

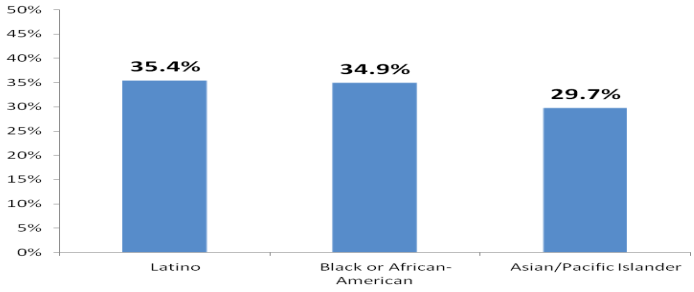
Elder Multicultural Access and Support Services

OA01 – Central and North Inland Regions, Districts 1, 2, 5

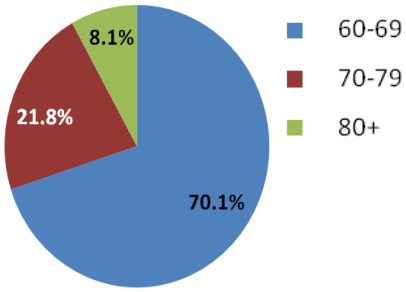
The Prevention and Early Intervention (PEI) Elder Multicultural Access and Support Services (EMASS) program provides multicultural outreach, education, advocacy, peer support, and transportation services to older Latinos, Filipinos, African refugees, and African American adults. This program is implemented by the Union of Pan Asian Communities (UPAC), in partnership with the National Alliance on Mental Illness (NAMI) of San Diego County, and the Somali Family Services of San Diego. Utilizing the "Promotoras Model," an identified best practice model to outreach underserved and un-served communities, EMASS offers educational/support sessions about medications management, grief, and mental health.

EMASS was funded by the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early interventions to help decrease severity.

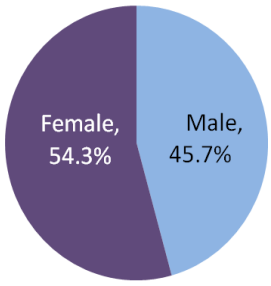
Race/Ethnicity



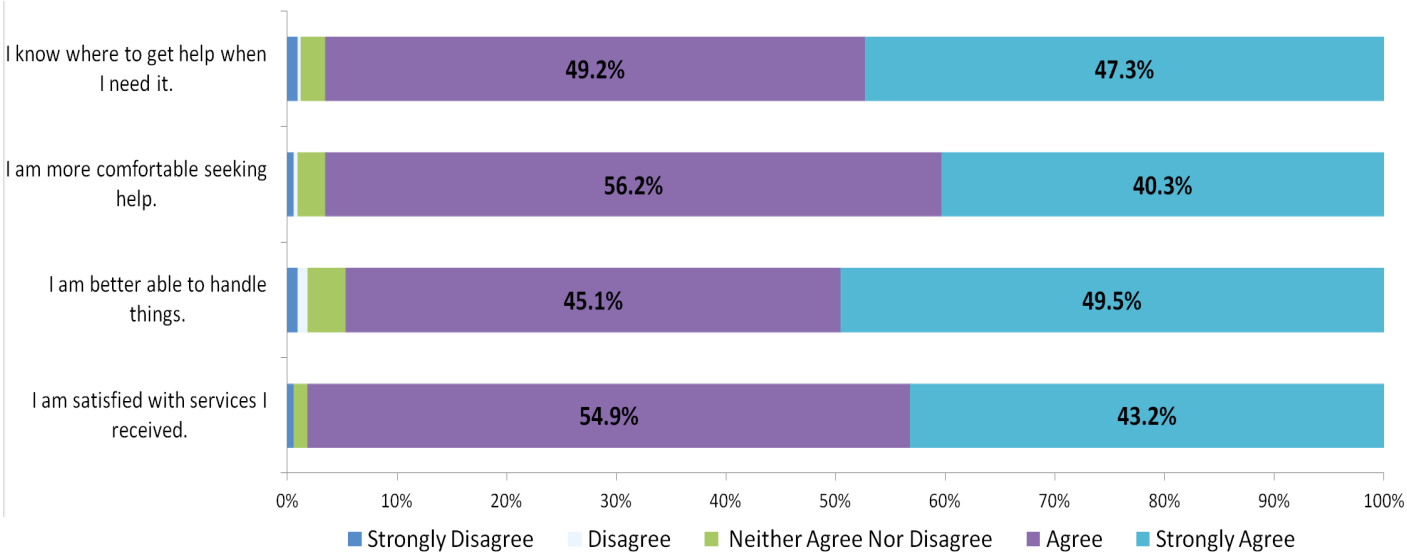
Age



Gender



Program Satisfaction



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PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Positive Solutions

OA02 – Central and North Coastal Regions, Districts 1, 5
Union of Pan Asian Communities

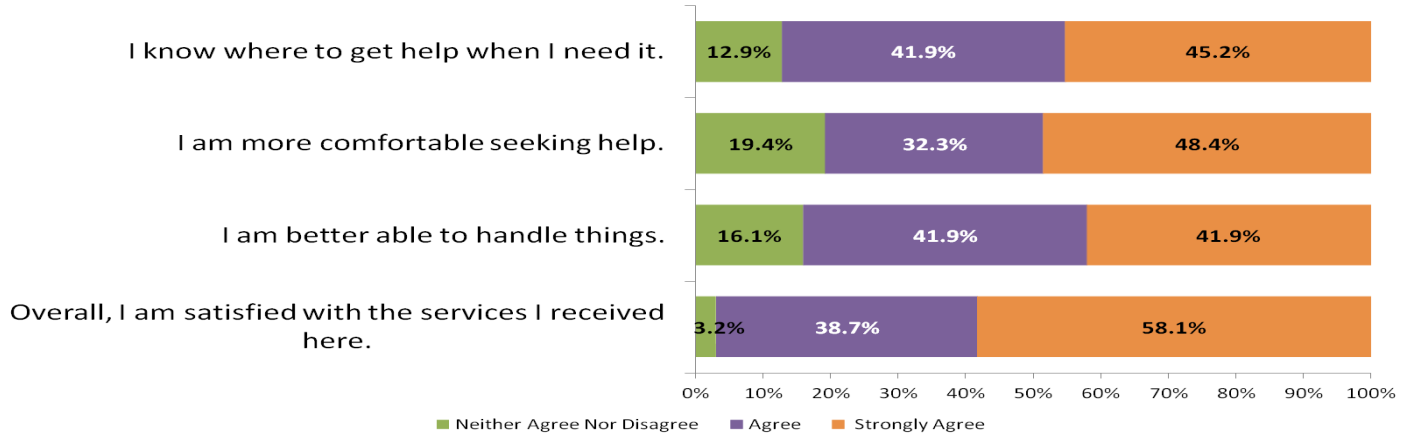
In San Diego County, in the year 2000, almost 15% of the total population was aged 60 and over. San Diego County older adults have a higher risk of committing suicide than any other age group. According to data from the Centers for Disease Control, the suicide rate among older adults in San Diego has been generally higher (27.6%) than in the State of California (23.7%) and the United States (18.5%) since 1979 (Community Health Improvement Partners Report on Suicide in San Diego, 2004). Depression and suicide in older adults have a strong correlation; therefore identifying and treating depression is an essential strategy for reducing risk of suicide.

The goals of the Positive Solutions program, part of the Prevention and Early Intervention (PEI) plan, are to increase knowledge of depression symptoms and suicide risk, provide education and support to reduce stigma, and to promote linkage with services and supports. The target population includes racially, ethnically and culturally diverse older adults who are underserved, and are at risk for depression, medication misuse, and substance abuse. Services provided address needs of at-risk homebound seniors for prevention and early intervention, and those less likely to seek traditional mental health services.

This program combines evidence-based practices to deliver multicultural, gender sensitive, in-home PEI Services to older adults in San Diego County. PEI services include outreach, education, depression screening, mental health assessment, suicide risk assessment, brief intervention, counseling, linkage, referral to community resources and follow-up. The Home Based PEI Gatekeeper Program and the Meals on Wheels Mental Health Outreach Program are two components used to identify and recruit at-risk individuals, and those in need of aging and/or mental health services. Brief interventions are delivered by the PEI Program Specialist to help reduce depressive symptoms and increase social activities. The PEI Program Specialist may also provide referral and linkages to additional service providers. Senior Peer Counselors provide supportive counseling services and companionship to reduce isolation and depression risk.

Positive Solutions is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

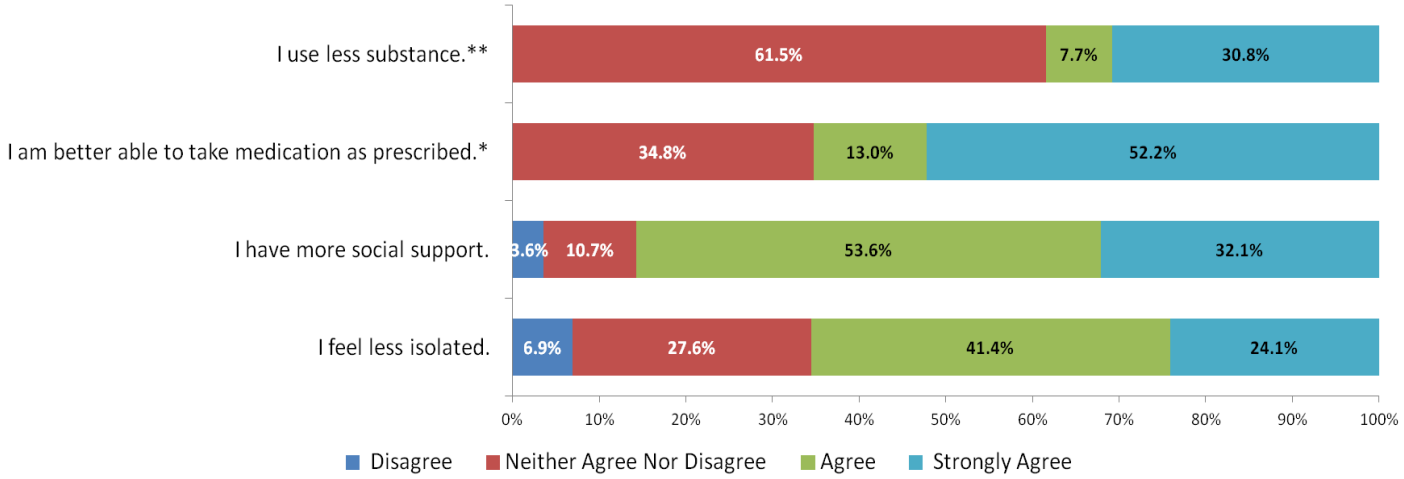
Program Satisfaction



Participants were asked to assess both their improvement in several areas and their satisfaction with the Positive Solutions program. These items were assessed only for the 31 participants who completed the intervention. A majority of the participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (87.1%), "I am more comfortable seeking help" (80.7%), "I am better able to handle things" (83.8%), and "Overall, I am satisfied with the services I received here" (96.8%).

Program Specific Outcomes

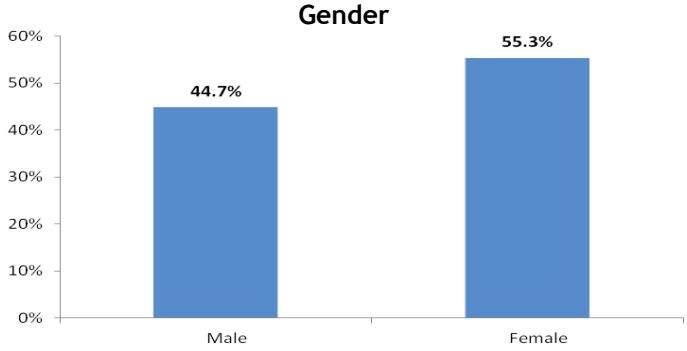
Positive Solutions participants also assessed the benefits they received from the program. These items were again only assessed for participants who completed the intervention, and the number of respondents varied for each item. Over a quarter of participants "Agreed" or "Strongly Agreed" that, "I use less substance" (38.5%). A majority of the participants either "Agreed" or "Strongly Agreed" that because of Positive Solutions, "I am better able to take prescription medication as prescribed" (65.2%), "I have more social support" (85.7%), and, "I feel less isolated" (65.5%).



Participant Demographics

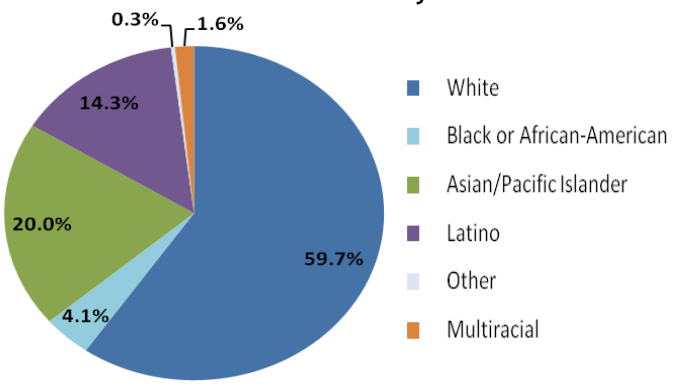
During Fiscal Year (FY) 2012-13, Positive Solutions provided services to 924 participants. The majority of the participants were female (55.3%), White (59.7%) or Asian/ Pacific Islander (20.0%), and 70 or older (75.0%). Of the Latino/Hispanic participants who reported their origin, a large portion were Mexican American/Chicano (60.6%). Almost a quarter of participants served in the military (22.8%) with, the majority having served in the Army (28.6%)

Gender



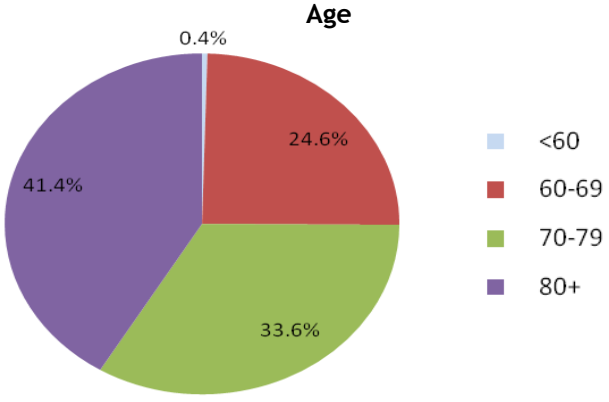
Note. 11 participants did not report gender and 1 participant reported 'Other' and were excluded

Race/Ethnicity



Note. 53 participants did not report race/ethnicity and were excluded
1 participant reported race/ethnicity as 'Native American'

Age



Note. 15 participants did not report age and were excluded

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Resource for enhancing Alzheimer's Caregiver Health (REACHing Out)

OA04– North Central Region, District 4
University of California, San Diego

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Development of the REACH Intervention

5.2 million Americans over the age of 65 have Alzheimer's Disease (AD), and the incidence is expected to increase, particularly for Hispanics in the United States. *

Caregivers of Alzheimer's Disease (AD) patients have been shown to suffer from high rates of depression, physical illness, psychotropic medication use, social isolation, health care utilization, sleep problems and decreased quality of life.

To combat the physical and emotional strain put on caregivers of AD patients, the National Institutes of Health granted funding to several universities to develop interventions to help family caregivers. This initiative began in 1995, and led to the development of the Resources for Enhancing Alzheimer's Caregiver Health (REACH) program. The REACH program is an evidence-based, multi-component intervention that provides resources and emotional support to caregivers of AD patients. The goal of REACH is to prevent or reduce symptoms of depression that manifest from the isolation and the burden of care often experienced by this vulnerable population. Many types of existing home and community based interventions were tested across the country, and the most successful methods became the model for the REACH program.

To improve the quality of life for the growing population of AD patients and caregivers, the County of San Diego Health and Human Services Agency (HHSA) Behavioral Health Services contracted with Southern Caregiver Resource Center (SCRC) to implement the REACHing Out program, as part of the Prevention and Early Intervention (PEI) Plan.

Research has demonstrated that the health outcomes for Hispanic caregivers are worse than other groups. These poor health outcomes are attributed to the disproportionate share of AD care performed by family members, and a reluctance to utilize formal care. Since San Diego County has a large Hispanic population, SCRC tailored the program to address the specific needs of this population. Behavior management, communication, stress management, and relaxation techniques are emphasized.

REACHing Out is among many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

*Source: Alzheimer's Association (2011). Alzheimer's Disease Facts and Figures, Alzheimer's & Dementia, Volume 7, Issue 2.

Southern Caregiver Resource Center

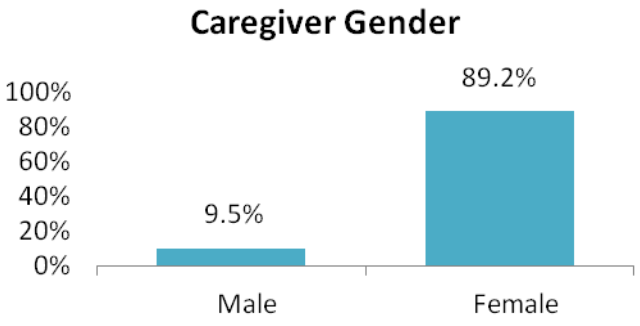
SCRC is a private, independent non-profit organization that helps families and caregivers by providing services that are inclusive of all issues related to caring for adults with chronic and/or disabling conditions.

SCRC offers two levels of REACH intervention. The first is a small group psychoeducational intervention, which consists of four two-hour program sessions. Group sessions address the stigma associated with mental health, and use instruction and practical exercises to teach specific cognitive and behavioral skills.

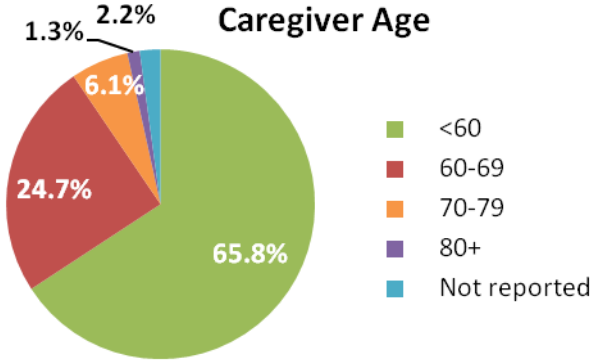
The second type of intervention is home based, and is available to family caregivers who would benefit more from a one-on-one intervention. This intervention consists of four 2-hour, in-home psychoeducational sessions, and three additional telephone follow up contacts, with the topics customized based on a caregiver assessment.

Demographics of Caregivers (REACH Clients)

During Fiscal Year (FY) 2012-13, SCRC enrolled 231 Hispanic caregivers into the REACHing Out program. The majority of participants in the program are Female (89.2%), of Mexican origin (89.8%), and under 60 years old (65.8%).



Three caregivers (1.3%) did not report gender.

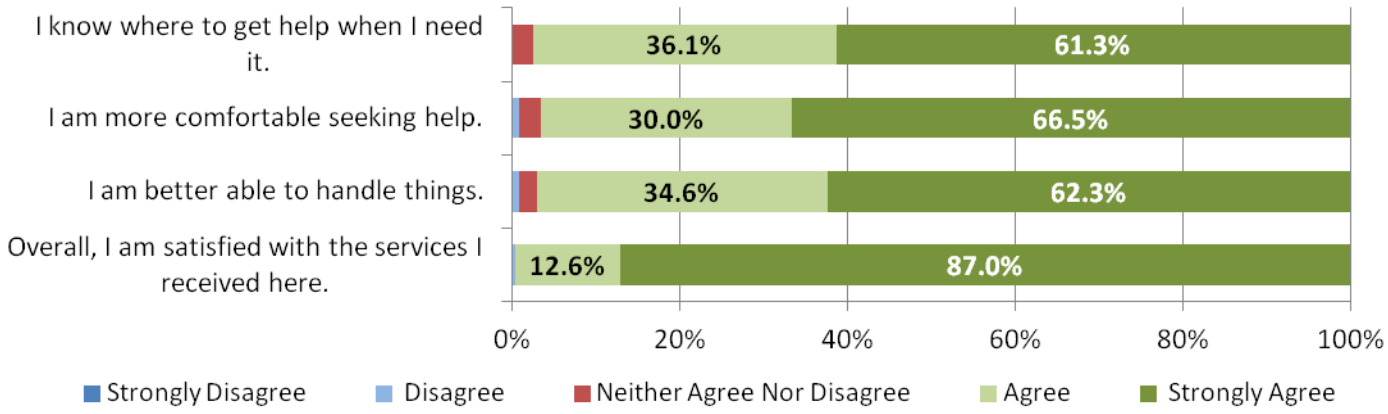


Health conditions such as high blood pressure and diabetes, lower levels of education and other differences in socioeconomic characteristics that are risk factors for AD are more common in older African-American and Hispanics than in older whites.

Alzheimer's Association, 2011 Alzheimer's Disease Facts and Figures, *Alzheimer's & Dementia,* Volume 7, Issue 2.

Program Satisfaction

Caregivers were asked to complete several items to assess the perceived benefits of the REACH intervention. Almost all of the caregivers "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (97.4%), "I am more comfortable seeking help" (96.5%), "I am better able to handle things" (97.0%), and "Overall, I am satisfied with the services I received here" (99.6%).



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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Salud

OA05 – South, N. Coastal, and N. Inland Regions, Districts 1, 5
N. County Health Services (NCHS), San Ysidro Health Center (SYHC), and UCSD

The Prevention and Early Intervention (PEI) Salud program targets the high prevalence of comorbid diabetes and depression evident among Hispanic elderly through a partnership between the County of San Diego Behavioral Health Services, San Ysidro Health Center (SYHC), North County Health Services (NCHS), and the University of California, San Diego (UCSD).

The Salud program targets unserved or underserved Hispanic older adults, 60 years of age and over with a diagnosis of diabetes and with symptoms of depression and/or at risk of developing depressive symptoms. Early Intervention includes integrated diabetes/depression care management including both diabetes care and depression care. Intervention is delivered in primary care settings.

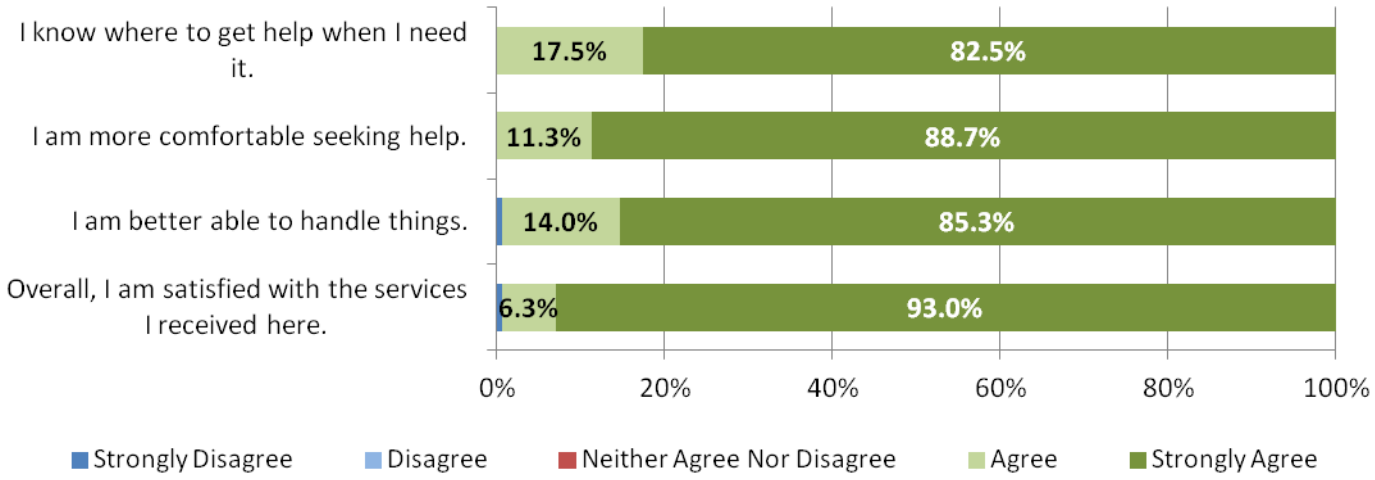
All Salud program participants take part in the Diabetes Self-Management Program (DSMP), an evidence-based practice treatment approach designed to provide patients with the knowledge and skills needed to better manage their diabetes through six weekly group workshops. Participants make weekly action plans, share experiences, and help each other solve problems they encounter in creating and carrying out their self-management program.

In addition, patients from SYHC have access to a care coordinator who monitors their diabetes and mental health concerns and engages them in Problem Solving Therapy (PST) to help treat their depressive symptoms. The program design supports the development of integrated care for diabetic participants experiencing depression by assigning responsibility for mental health and medical care to one single care provider.

Salud is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

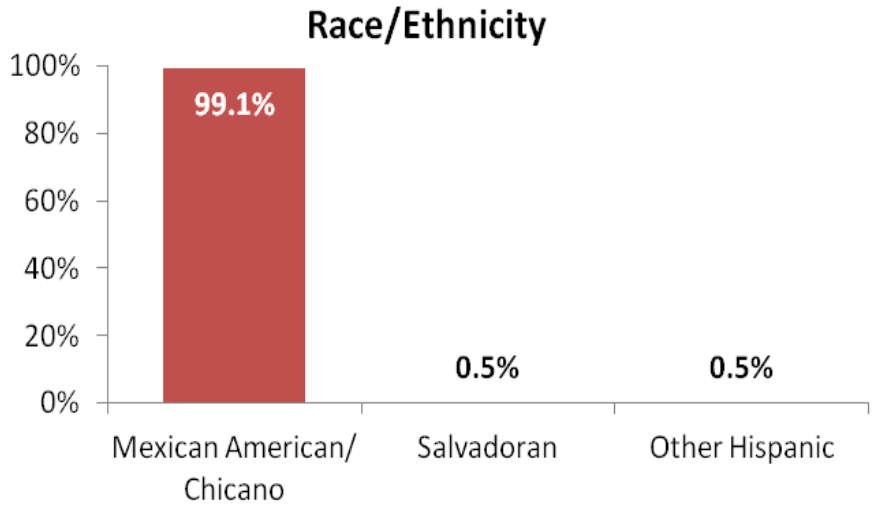
Program Satisfaction

Upon completing the Salud program, participants are asked to assess the perceived benefits of the program. Of the 221 enrolled participants, 143 have completed the program and the assessment. A majority of these participants "Agreed" or "Strongly Agreed" that because of the intervention, "I am better able to handle things" (99.3%), and "Overall, I am satisfied with the services I received here," (99.3%). All of the participants "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it," and "I am more comfortable seeking help," (both 100.0%).

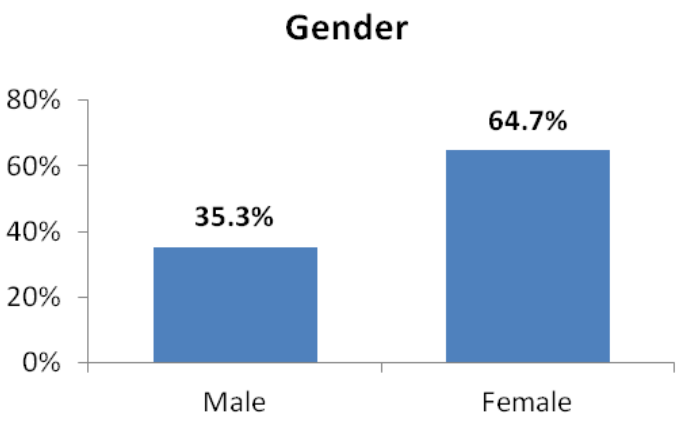


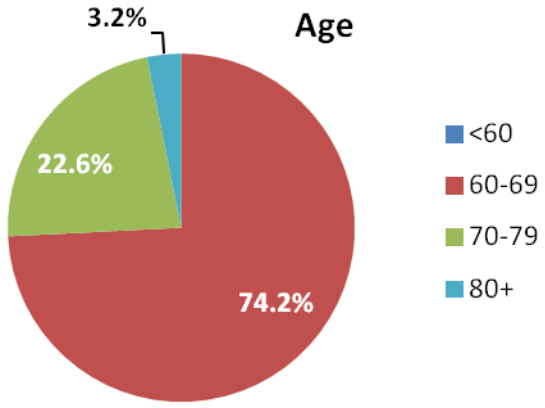
Participant Demographics

During Fiscal Year (FY) 2012-13, San Ysidro Health Center, North County Health Services, and the University of California, San Diego provided services to 221 participants through the Salud program. The Salud program is designed to target the Hispanic population in San Diego County. All but 1 of the participants (95.5%) identified themselves as Hispanic. The one person who did not identify themselves as Hispanic identified themselves as Native American. Almost all of the participants were Mexican American/Chicano (99.1%), and 1.0% were Salvadorian or other Hispanic.



The majority of the participants in the program were female (64.7%), and aged 60-69 (74.2%). The mean age of the participants was 65.9. A small proportion of the participants had served in the military (0.9%).





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PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Breaking Down Barriers

PS01C – Central, East, South, North Coastal, North Inland, North Central Regions, All Districts Mental Health Association

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

The Prevention and Early Intervention (PEI) Breaking Down Barriers program uses a Cultural Broker outreach model to create effective collaborations with various agencies, community groups, participant and family member organizations, and other stakeholders to reduce mental health stigma and increase access to mental health services by unserved and underserved culturally-diverse communities.

A Cultural Broker is a person known in the local community, engaged to provide outreach and engagement support with existing agencies.

The term "culturally diverse" refers to both racial/ethnic and non-racial/ethnic groups. The former includes Latinos, Native Americans, Asian Americans, African Americans, and people from the Pacific Islands. The latter includes—but is not limited to—those with disabilities (blind and vision impaired, deaf and hard of hearing, or persons who are otherwise physically challenged), gay, lesbian, bisexual, and transgendered persons, transition age youth and older adults.

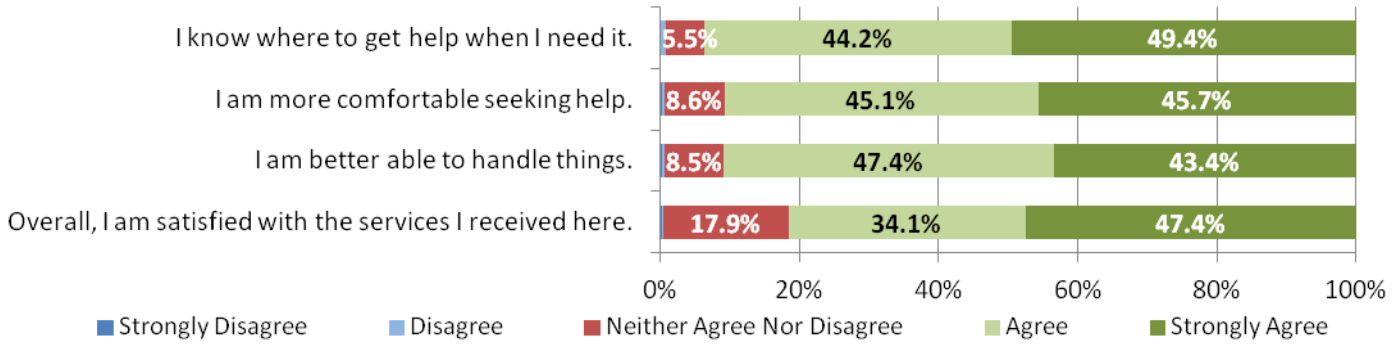
The Breaking Down Barriers Program provides prevention and early intervention services through the efforts of Cultural Brokers to:

- Provide mental health outreach, engagement and education to persons in the Latino, Native American (Rural and Urban), Lesbian/Gay/Bisexual/Transgender/Queer, African, and African American communities;
- Implement and evaluate strategies to reduce mental health stigma; and
- Create effective collaborations with other agencies, community groups, participants, and family member organizations.

The program provides information on various topics related to mental health (for example, depression, teen stress, and bereavement). Topics presented are dependent upon and modified to best fit the needs of each individual community.

Breaking Down Barriers is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

PEI Outcomes and Satisfaction



n varied from 1404-1408

Participants were asked to assess their improvement in several areas of interest, and their satisfaction with the Breaking Down Barriers intervention. These items were only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of the participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (93.7%), "I am more comfortable seeking help" (90.8%), "I am better able to handle things" (90.8%), and "Overall, I am satisfied with the services I received here" (81.5%).

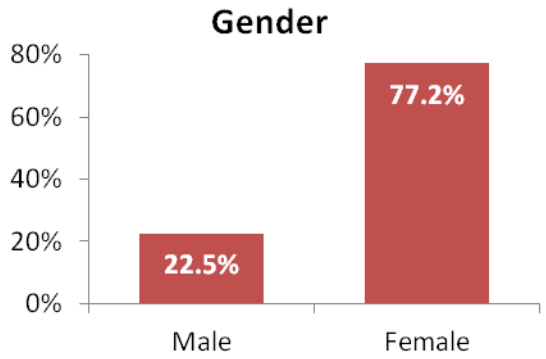
Program Specific Outcomes

Participants who participated in Breaking Down Barriers presentations assessed the effectiveness of the program's presentations. These items were also only given to participants who completed the intervention, and the number of respondents varied for each item. A majority of the participants either "Agreed" or "Strongly Agreed" with the statements, "After the presentation, I feel more knowledgeable about resources available for individuals" (95.7%), "After the presentation, I feel more comfortable dealing with today's topic" (94.9%), "The materials given out were helpful" (97.3%), and, "I feel my questions were answered" (95.8%).

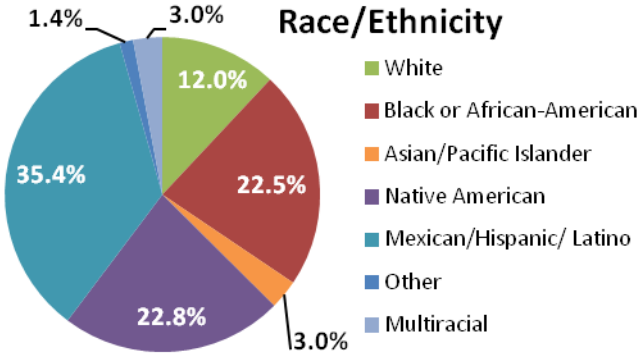
n varied from 1423-1430

Participant Demographics

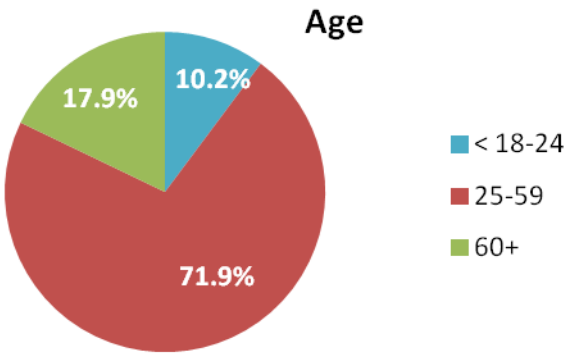
During Fiscal Year (FY) 2012-13, Breaking Down Barriers provided services to 1,472 participants. The majority of the participants who received services were female (77.2%). Hispanic or Latino (35.4%), Black or African American (22.5%) and Native American (22.8%) made up the largest racial/ethnic groups receiving services. Of Hispanic and Latino participants, a majority were Mexican American/Chicano (76.1%). About a third of all participants (30.0%) did not report their age. Of those who did, the majority were 25-29 years old (71.9%). A smaller percentage of participants was 60 and above (17.9%). A very small percentage of participants had served in the military (5.0%).



4 (0.3%) reported gender as "other"
23 did not report gender and were excluded



35 did not report race/ethnicity and were excluded



442 did not provide age and were excluded

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HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Project Enable

PS01E—Central Region, District 4
Neighborhood House Association

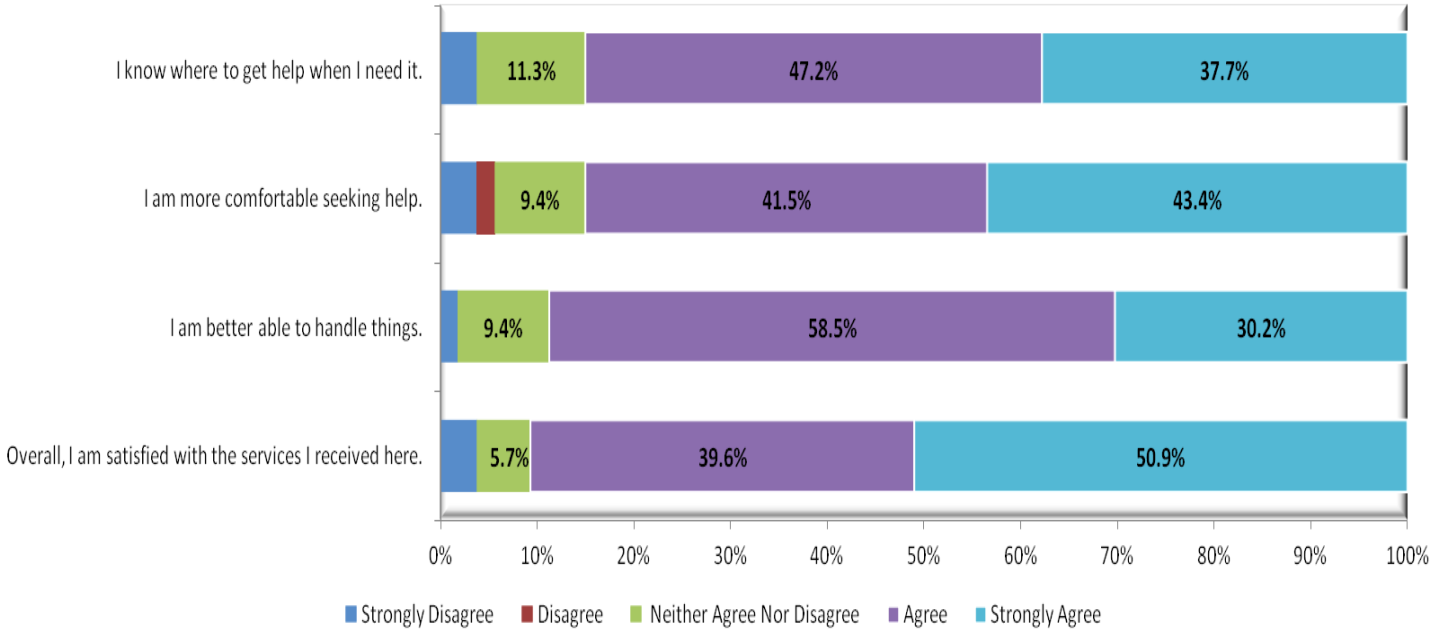
COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

Neighborhood House Association via Project Enable provides MHSA Prevention and Early Intervention (PEI) funded services via In-Reach Services primarily to at risk African-American and Latino citizens who are residents of San Diego County and who are incarcerated adults or transitional-age youth (TAY) at designated detention centers. Services include in-reach, engagement; education; peer support; follow-up after release from detention centers and linkages to services that improve participant's quality of life; diminish risk of recidivism; and diminish impact of untreated health, mental health and/or substance abuse issues.

A Bio-Psychosocial Rehabilitation (BPSR) Wellness and Recovery Center provides time-limited outpatient specialty mental health services to adults 18 years of age and older who are affected by serious and persistent mental illness and/or co-occurring disorders that interfere with their ability to function in key life roles, as parents, students, spouses and employees. The program strives to reduce psychiatric symptoms and the need for hospitalization while rehabilitating clients to their highest level of functioning.

Project Enable is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

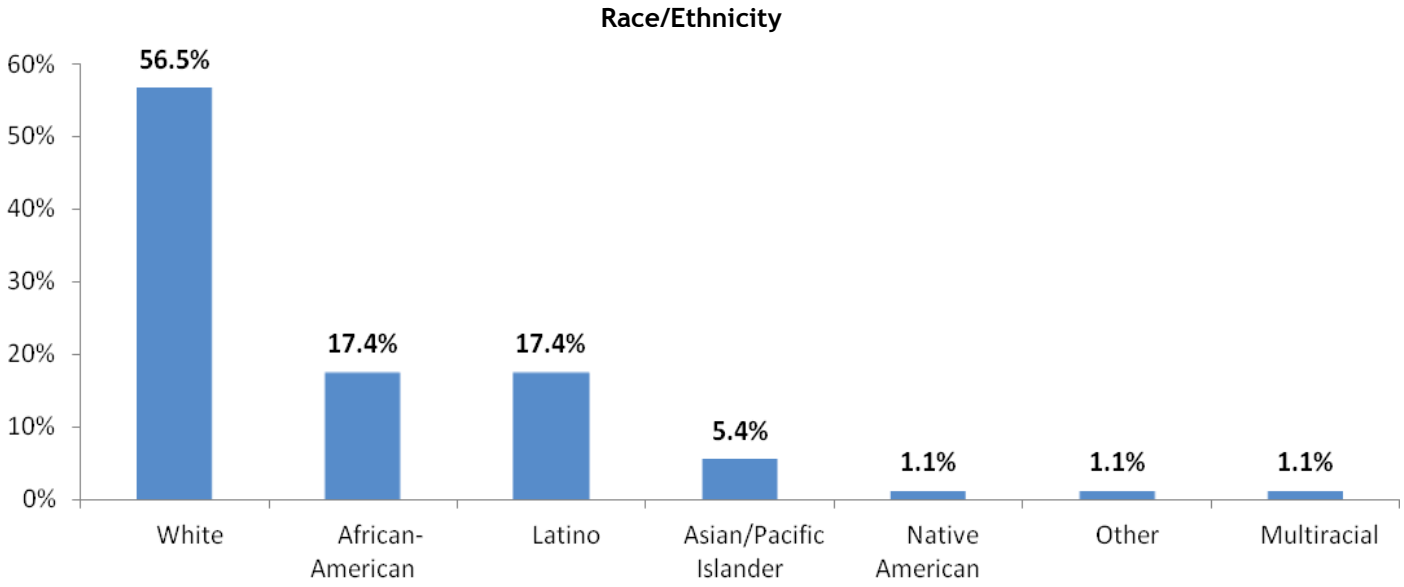
Program Satisfaction



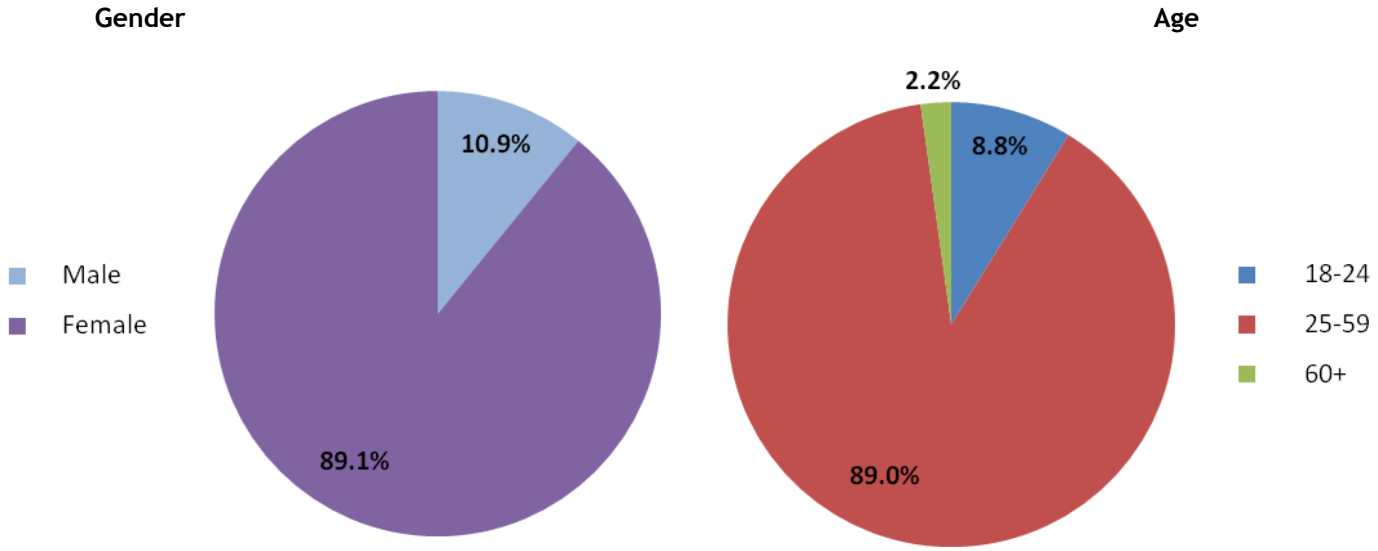
Participants were asked to assess the perceived benefits and their overall satisfaction with the Project Enable/In-Reach program. Of the 92 participants enrolled in the program, 53 participants completed the satisfaction survey. A majority of participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (84.9%), "I am more comfortable seeking help" (84.9%), "I am better able to handle things" (88.7%), and "Overall, I am satisfied with the services I received here" (90.5%).

Participant Demographics

During Fiscal Year (FY) 2012-13, Neighborhood House Association provided services to 92 participants through Project Enable. One of the goals of Project Enable is to provide services primarily to at-risk African-American and Latino adults incarcerated in San Diego County. Most participants were either White (56.5%), African-American (17.4%), or Latino (17.4%). Of those participants who reported Latino origin, the majority (82.4%) were Mexican-American or Chicano.



The majority of the participants in the program were female (89.1%), and aged 25-59 (89.0%). The mean age of the participants was 38.5. A small proportion of the participants reported military service (3.3%).



This report was prepared by the HEALTH SERVICES RESEARCH CENTER at University of California, San Diego, a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Behavioral Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data used to help improve the behavioral health care system and, ultimately, to improve client quality of life. For more information about HSRC please contact Andrew Sarkin, PhD at 858-622-1771.

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Adult/Family Peer Support Line

PS01G – Central, East, South, N. Coastal, N. Inland, N. Central Regions, Districts 1-5

National Alliance of Mental Illness (NAMI)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

The goal of the Primary and Secondary Prevention (PS01) portion of the Prevention and Early Intervention (PEI) plan is to increase public awareness and understanding of mental illness through media-based outreach and education campaigns. This two-pronged approach also seeks to provide outreach and education to targeted underserved and un-served populations.

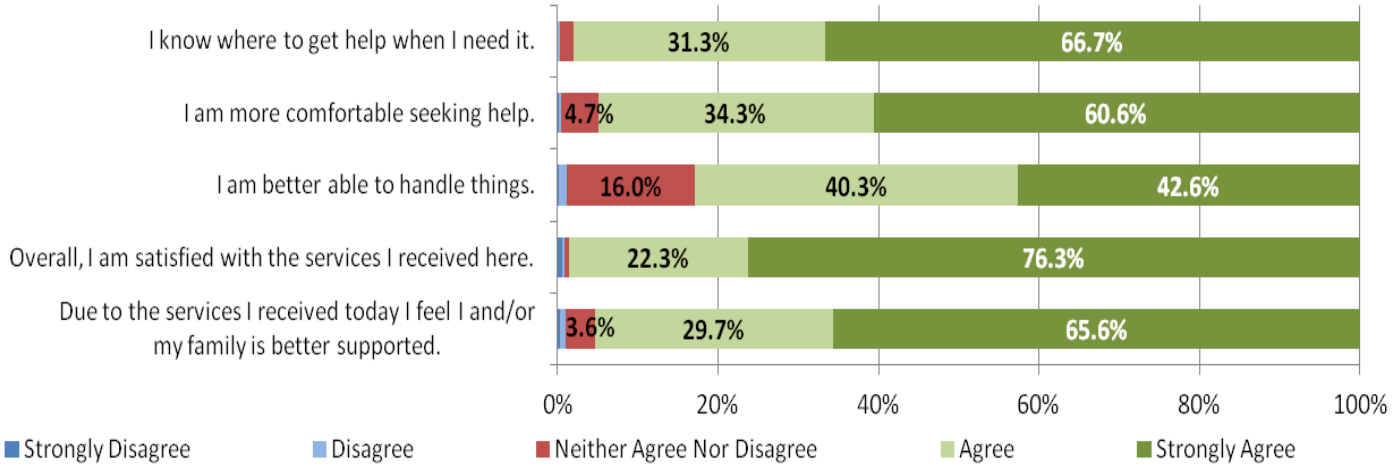
A means of providing outreach and education for PEI occurs via the confidential Adult/Family Peer Support Line supported by the National Alliance on Mental Illness (NAMI) San Diego. NAMI San Diego is part of the grass-roots, non-profit, national NAMI organization founded in 1979 by family members of people with mental illness. This Family Peer Support Line was established to provide countywide non-crisis support, mental health education, and referral services for families, friends and those affected by serious mental illness.

The support line is staffed by family members of individuals affected by mental illness who are trained to provide culturally competent support and resources. Individuals calling the NAMI helpline receive information about classes and support groups offered, as well as additional information about mental health related resources. **The NAMI Support line can be reached at (619) 543-1434**.

The Adult/Family Peer Support Line is one of many programs implemented as a result of the Mental Health Services Act (MHSA). Originally passed by voters as Proposition 63, the MHSA became state law, effective January 1, 2005. MHSA funding gives counties a unique opportunity to implement programs to prevent the onset of mental illness or to provide early intervention to help decrease severity.

After providing individuals with the information they need, support line staff asked callers several questions including demographics and their satisfaction with the Adult/ Family Peer Support Line services. Data presented in this report include information about the individual who made the call to the support line, the 'caller,' and information about the individual who will be receiving the mental health services, the 'consumer.' In some cases, the caller may request information for themselves, whereas in other cases the caller may request information for a family member or friend in need.

PEI Outcomes and Satisfaction



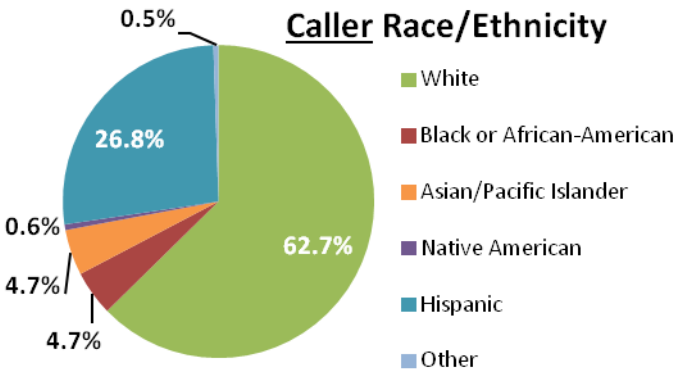
n = 939

Participants were asked to assess their improvement in several areas of interest, and their satisfaction with the Adult/Family Peer Support Line. The number of respondents varied for each item. A majority of participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (98.0%), "I am more comfortable seeking help" (94.9%), "I am better able to handle things" (82.9%) and, "Overall, I am satisfied with the services I received here" (98.5%). A majority of participants either "Agreed" or "Strongly Agreed" that, "Due to the services I received today, I feel I and/or my family is better supported" (95.3%).

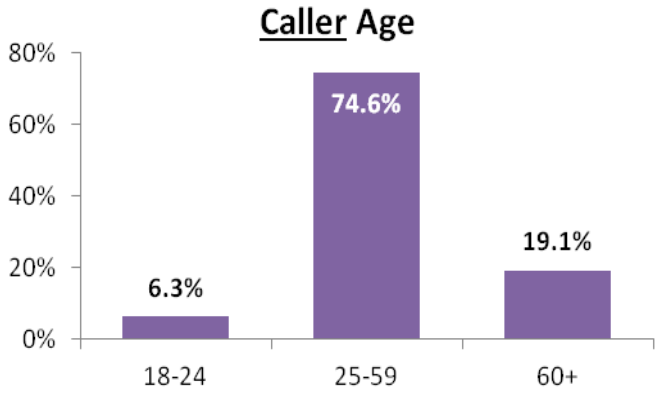
Participant Demographics

During Fiscal Year (FY) 2012-13, Adult/Family Peer Support Line provided services to 4,410 callers. Of those callers who reported their information*, the majority were female (73.3%), white (62.7%), and between 25 and 59 years old (74.6%). A very small percentage of callers had served in the military (2.9%). Of those consumers for whom data were available*, the majority were between 25 and 59 years old (68.0%). White consumers were the largest racial/ethnic group served (67.5%). There was approximately an equal proportion of male and female consumers (50.7% and 49.3%, respectively). Data on specific Hispanic origin, consumer military service or service branch were not collected for this program.

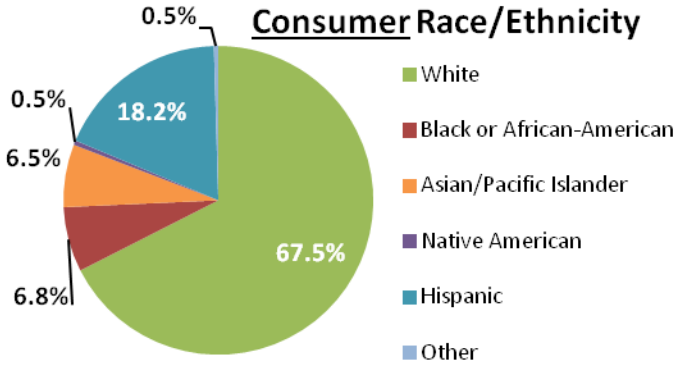
* Gender data were not reported for 1,154 callers and 3,343 consumers. Information on non-reported data for race/ethnicity and age for callers and consumers is provided in the charts below.



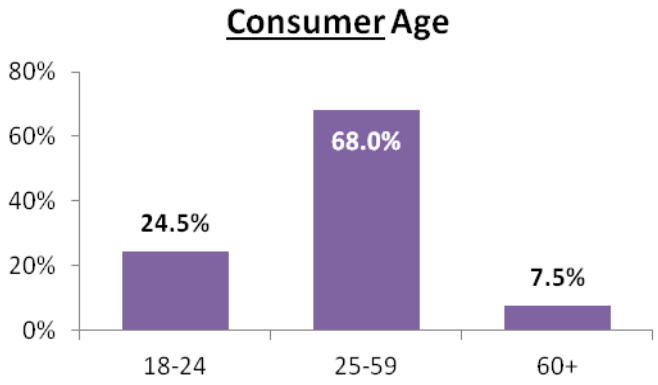
2,889 did not provide race/ethnicity and were excluded



2,394 did not provide age and were excluded



3,982 did not provide race/ethnicity and were excluded



3,798 did not provide age and were excluded

This report was prepared by the HEALTH SERVICES RESEARCH CENTER at University of California, San Diego, a non-profit research organization within the Department of Family and Preventive Medicine. HSRC works in collaboration with the Performance Outcomes and Quality Improvement Unit of San Diego County Behavioral Health Services to evaluate and improve mental health outcomes for County residents. Our research team specializes in the measurement, collection and analysis of health outcomes data used to help improve the behavioral health care system and, ultimately, to improve client quality of life. For more information about HSRC please contact Andrew Sarkin, PhD at 858-622-1771.

HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

PREVENTION AND EARLY INTERVENTION
FISCAL YEAR 2012-13 REPORT

Courage to Call

VF01—Central, East, South, North Coastal, North Inland, and North Central Regions, Districts 1-5
National Alliance of Mental Illness (NAMI)

COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

The Veterans, Active Duty Military, Reservists, National Guard and their Families (VMRGF) population in San Diego County is increasing annually with the return of troops from Operation Enduring Freedom (OEF; Afghanistan) and Operation Iraqi Freedom (OIF; Iraq). The percentage of military personnel returning from Afghanistan and Iraq with mental health concerns and PTSD ranges from 17-27% and 15-24%, respectively. Additionally, the suicide rate for those returning from deployment is 49% above the national average. Although the incidence of mental health issues is high in the VMRGF population, 58% returning from war with mental health concerns do not seek treatment (National Center for PTSD, Department of Veterans Affairs, 2011). Aside from the direct impact of mental illness on the individual, the impact on familial relationships may extend the consequences of combat-related mental health problems across generations.

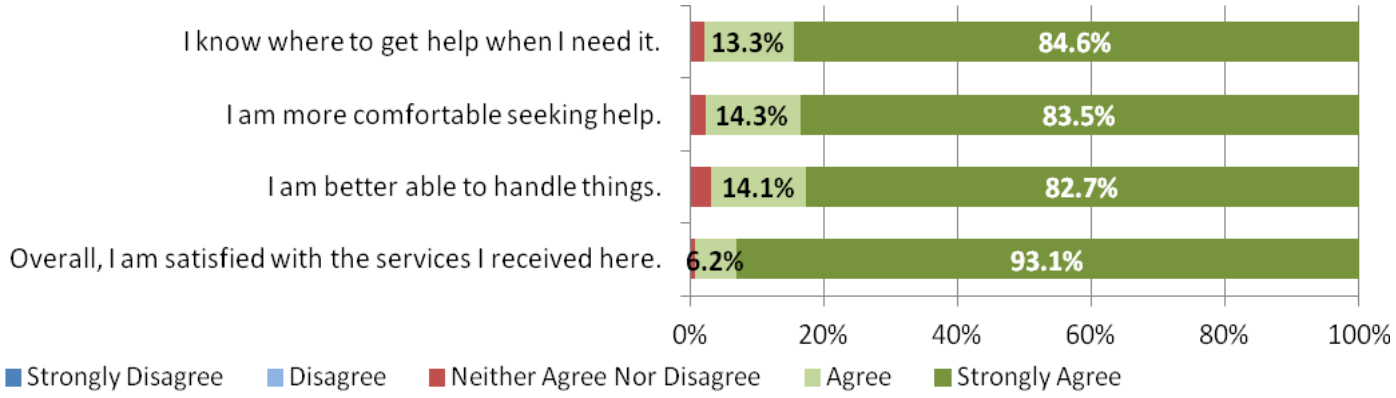
The Prevention and Early Intervention (PEI) Veterans and their Families program (VF01) focuses on populations not served, or whose needs are not met by traditional veteran and active duty military service providers. The potential target population of this PEI program is in excess of 1,000,000, roughly 1/3 of San Diego County (San Diego MHSA PEI Plan, 2008). Specifically, the VF01 program provides education to VMRGF on relevant mental health topics, and peer counseling to reduce mental health risk factors or stressors. Education and training is also offered to providers serving the VMRGF community (behavioral and primary health care providers, businesses, faith-based organizations, schools and colleges/universities, law enforcement, and justice system) to improve understanding of the military culture and improve recognition of mental health issues unique or relevant to the VMRGF.

The VF01 program also provides free comprehensive information 24 hours a day, 7 days a week to VMRGF, outside of military channels, via the Courage to Call telephone helpline. The helpline is staffed with veterans who provide mental health information, self screening tools and appropriate resources, as well as help with establishing linkages to mental health services.

Courage to Call staff follow up with all callers to ensure that individuals are able to access the services they need. During the follow-up call, individuals are asked to participate in a short survey regarding their satisfaction with the Courage to Call helpline. The data presented in this report reflect only those 780 callers who agreed to participate in the survey during Fiscal Year (FY) 2012-13.

The Courage to Call helpline can be reached at 2-1-1.

PEI Outcomes and Satisfaction

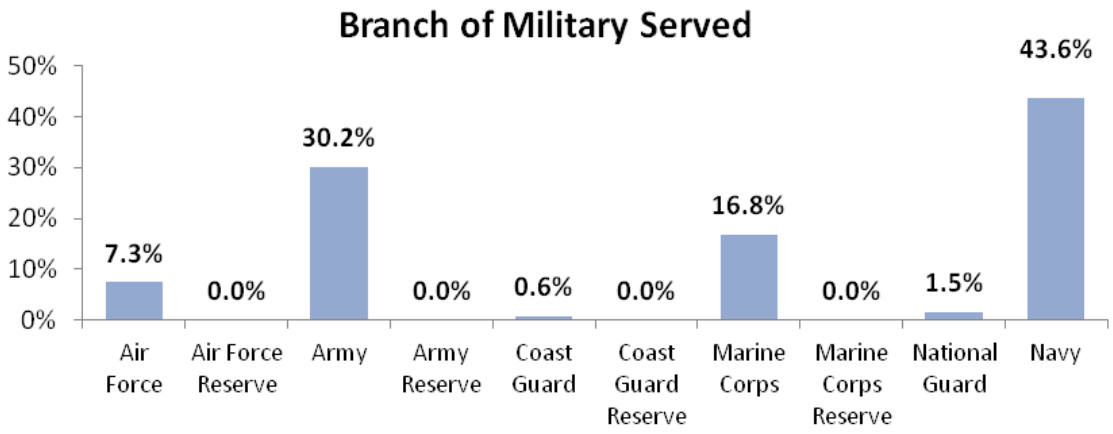


n varied from 140-141

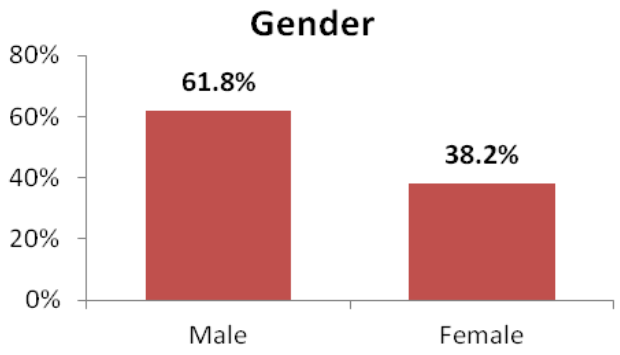
Participants were asked to assess both their improvement in several areas and their satisfaction with the Courage to Call program. These items include participants who agreed to complete the survey and the number of respondents varied for each item. A majority of participants either "Agreed" or "Strongly Agreed" that because of the intervention, "I know where to get help when I need it" (97.9%), "I am more comfortable seeking help" (97.8%), "I am better able to handle things" (96.8%), and "Overall, I am satisfied with the services I received here" (99.3%).

Participant Demographics

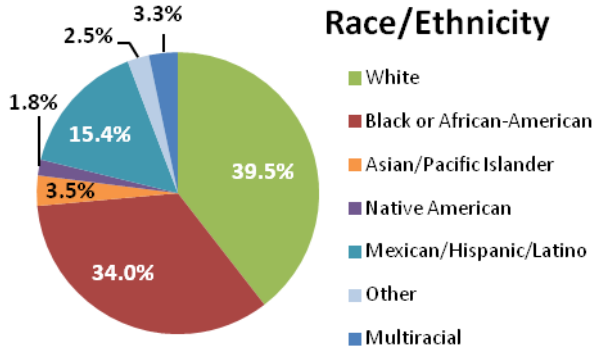
The majority of Courage to Call participants (n= 780) in FY 2012-13 who responded to the survey were male (61.8%), white (39.5%), and between 40 and 70 years old (69.6%). The vast majority of callers served in the military (61.7%), with most serving in the Navy (43.6%), the Army (30.2%), or the Marine Corps (16.8%).



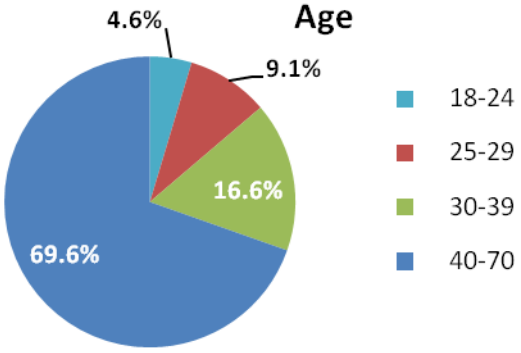
4 did not provide branch of military and were excluded



26 did not provide race/ethnicity and were excluded



175 did not provide race/ethnicity and were excluded



155 did not provide race/ethnicity and were excluded

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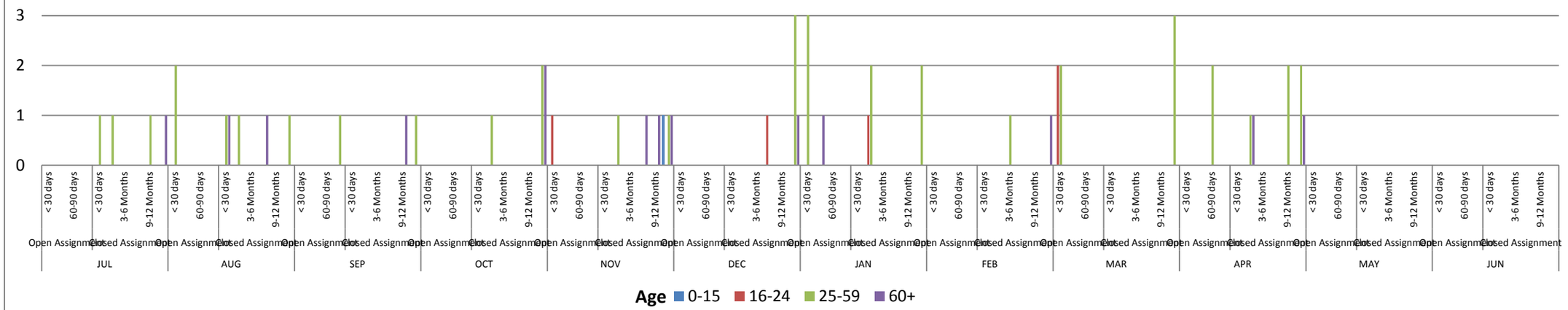
HEALTH SERVICES RESEARCH CENTER
UNIVERSITY OF CALIFORNIA, SAN DIEGO

San Diego County Suicide Report Dashboard
April 2014

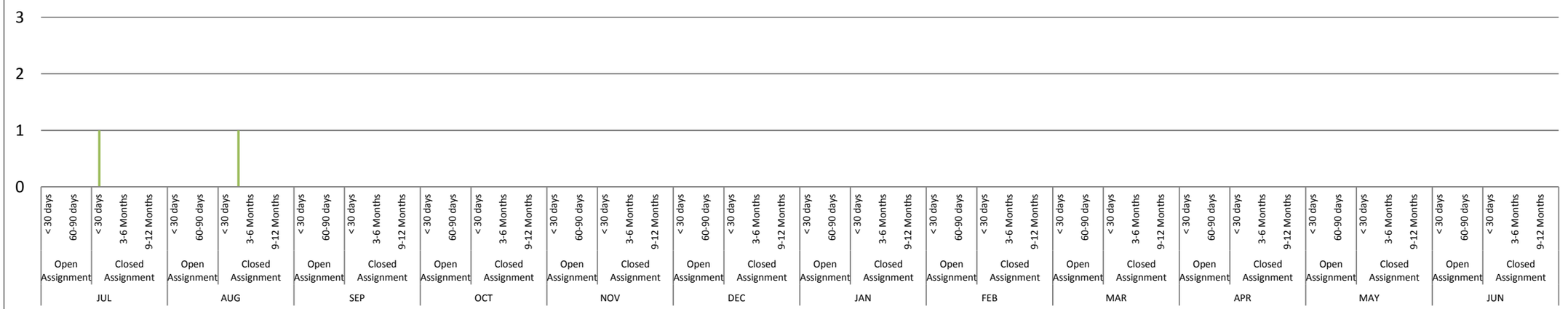
Fiscal Year 2013 - 2014

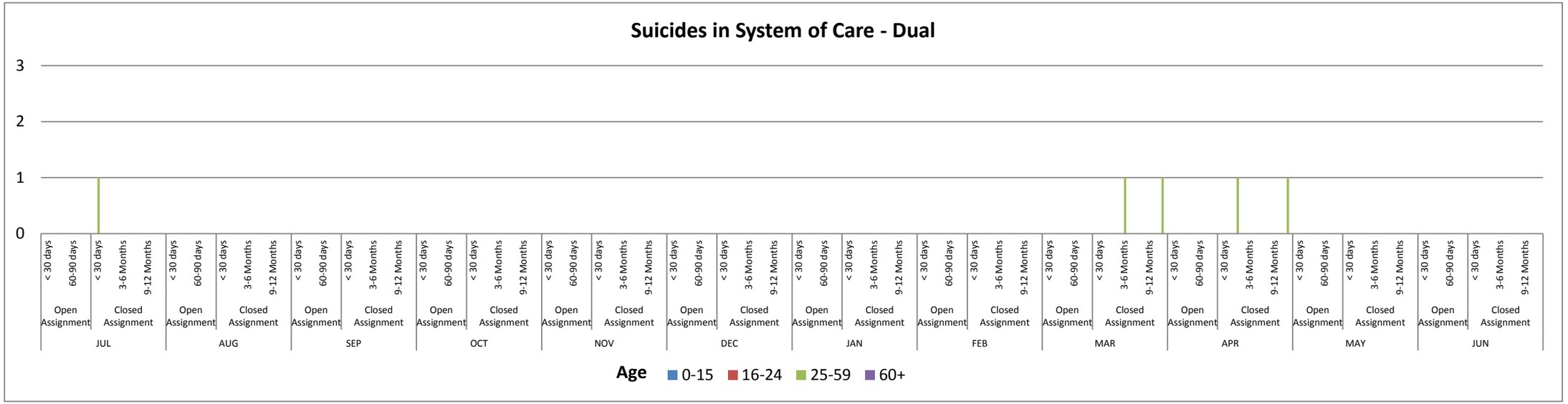
COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

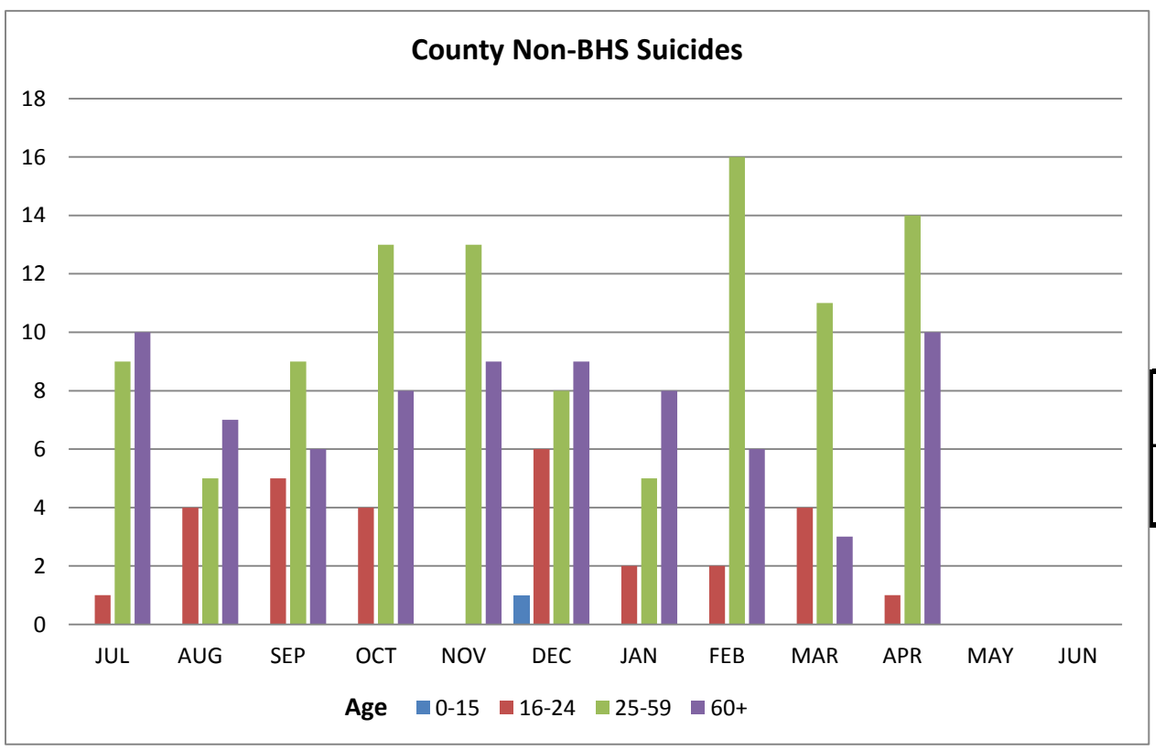
Suicides in System of Care - Mental Health



Suicides in System of Care - Alcohol and Drug Services

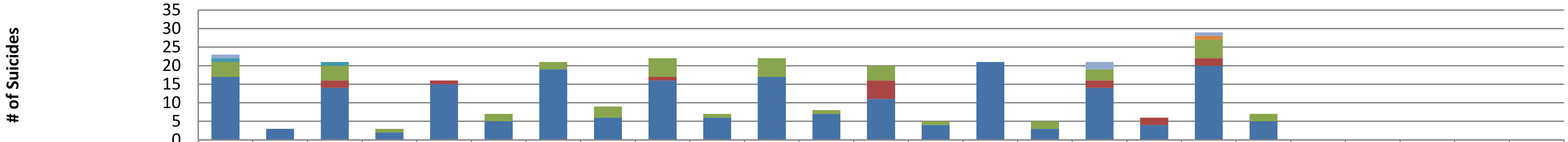






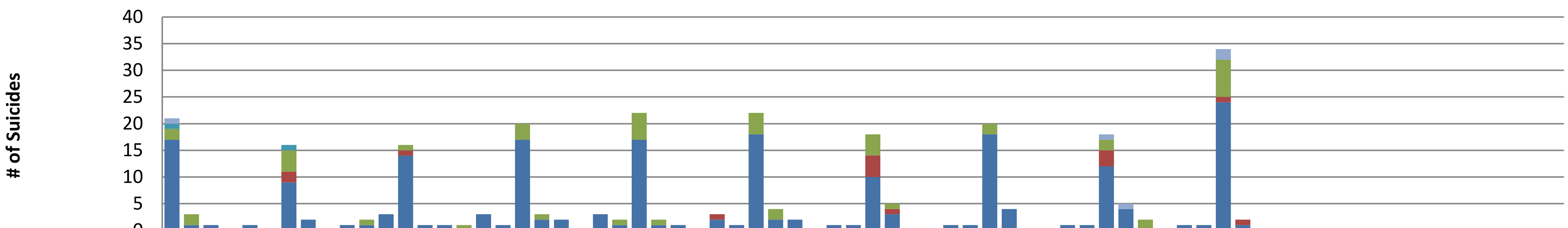
	FY2011/12	FY2012/13	Current YTD FY2013/2014
Countywide Sucides - CME Report	320	332	276
System of Care Sucides - CME Report	84	71	67

Suicides by Gender



	JUL		AUG		SEP		OCT		NOV		DEC		JAN		FEB		MAR		APR		MAY		JUNE		Total
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Total	23	3	21	3	16	7	21	9	22	7	22	8	20	5	21	5	21	6	29	7	0	0	0	0	276
Dual Closed	1																2		1						4
Dual Open																			1						1
Alcohol/Drug Closed	1		1																						2
Alcohol/Drug Open																									0
Mental Health Closed	4		4	1		2	2	3	5	1	5	1	4	1		2	3		5	2					45
Mental Health Open			2		1				1				5				2	2	2						15
County Non-BHS	17	3	14	2	15	5	19	6	16	6	17	7	11	4	21	3	14	4	20	5					209

Suicides by Race/Ethnicity



	JUL						AUG						SEP					
	W	H	B	AI	AP	O	W	H	B	AI	AP	O	W	H	B	AI	AP	O
Dual Closed	1																	
Dual Open																		
Alcohol/Drug Closed	1						1											
Alcohol/Drug Open																		
Mental Health Closed	2	2					4				1		1			1		
Mental Health Open							2						1					
County Non-BHS	17	1	1		1		9	2		1	1	3	14	1	1		3	1

	OCT						NOV						DEC					
	W	H	B	AI	AP	O	W	H	B	AI	AP	O	W	H	B	AI	AP	O
Dual Closed																		
Dual Open																		
Alcohol/Drug Closed																		
Alcohol/Drug Open																		
Mental Health Closed	3	1				1	5	1					4	2				
Mental Health Open											1							
County Non-BHS	17	2	2		3	1	17	1	1		2	1	18	2	2		1	1

	JAN						FEB						MAR					
	W	H	B	AI	AP	O	W	H	B	AI	AP	O	W	H	B	AI	AP	O
Dual Closed													1	1				
Dual Open																		
Alcohol/Drug Closed																		
Alcohol/Drug Open																		
Mental Health Closed	4	1					2						2		2			
Mental Health Open	4	1											3					
County Non-BHS	10	3			1	1	18	4			1	1	12	4			1	1

	APR						MAY						JUN					
	W	H	B	AI	AP	O	W	H	B	AI	AP	O	W	H	B	AI	AP	O
Dual Closed	2																	
Dual Open																		
Alcohol/Drug Closed																		
Alcohol/Drug Open																		
Mental Health Closed	7																	
Mental Health Open	1	1																
County Non-BHS	24	1																

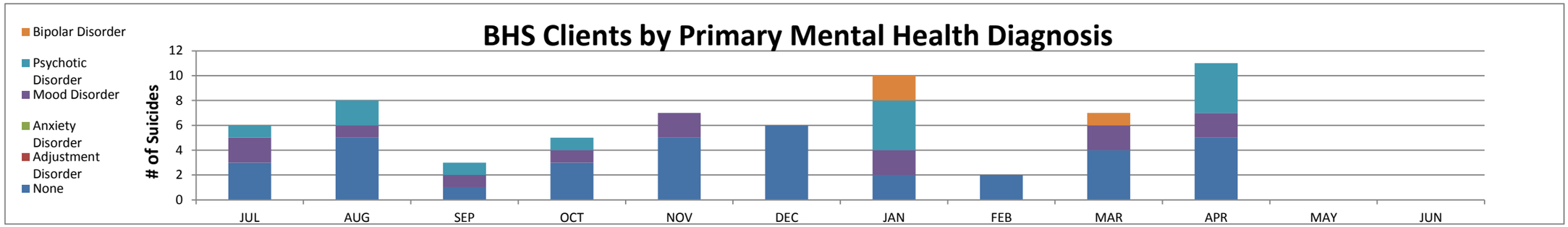
Race/Ethnicity	
W	White
H	Hispanic
B	Black
AI	American Indian/Alaskan Native
AP	Asian/Pacific Islander
O	Other/ Unknown

Suicides By Method - System of Care

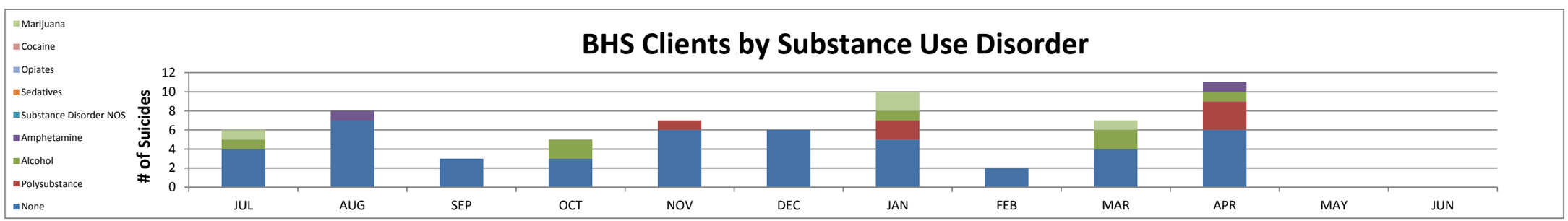
	Blunt Force/Other	Cutting/ Stabbing	Hanging	Gun (Firearm)	Jumping	Asphyxiation	Drowning	OD Medication	Train	Carbon Monoxide	Poison	Undeter mined	Total
JUL			3	1	2								6
AUG			4	1	2	1							8
SEP			2	1									3
OCT			3					1		1			5
NOV			4	2	1								7
DEC			3	2	1								6
JAN		1	3	2	3				1				10
FEB	1		1										2
MAR			5		2	1						1	9
APR			4	1	1	3		2					11
MAY													0
JUN													0
TOTAL	1	1	32	10	12	5	0	3	1	1	0	1	67

Suicides By Method - County Non-BHS

	Blunt Force/Other	Cutting/ Stabbing	Hanging	Gun (Firearm)	Jumping	Asphyxiation	Drowning	OD Medication	Train	Carbon Monoxide	Poison	Undeter mined	Total
JUL			3	14	1			1	1				20
AUG			7	6	2	1							16
SEP			8	8	3				1				20
OCT			3	16	1	1		2	1		1		25
NOV			6	11	3	1		1					22
DEC			7	10	2	5							24
JAN			2	10	3								15
FEB		1	12	7	2	2							24
MAR			6	6	3	1				1		1	18
APR		1	9	11	2	2							25
MAY													0
JUN													0
TOTAL	0	2	63	99	22	13	0	4	3	1	1	1	209



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	Total
None	3	5	1	3	5	6	2	2	4	5			36
Adjustment Disorder													0
Anxiety Disorder													0
Mood Disorder	2	1	1	1	2		2		2	2			13
Psychotic Disorder	1	2	1	1			4			4			13
Bipolar Disorder							2		1				3
Total	6	8	3	5	7	6	10	2	7	11	0	0	65



	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	Total
None	4	7	3	3	6	6	5	2	4	6			46
Polysubstance					1		2			3			6
Alcohol	1			2			1		2	1			7
Amphetamine		1								1			2
Substance Disorder NOS													0
Sedatives													0
Opiates													0
Cocaine													0
Marijuana	1						2		1				4
Total	6	8	3	5	7	6	10	2	7	11	0	0	65

COUNTY OF SAN DIEGO – HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

Mental Health Services Act Innovation Projects

Evaluation 2013

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

Innovation Project Evaluation
Developed by the County of San Diego Behavioral Health Services,
Behavioral Health Division, Quality Improvement Unit

If more information is desired, please email your request to the
QI Performance Improvement Team at
BHSQIPOG@sdcounty.ca.gov

TABLE OF CONTENTS

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Introduction

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. The MHSA provides funding for expansion of mental health services in California. As required by the law, the County of San Diego, through the Health and Human Services Agency (HHSA) Mental Health Services Division, has completed the MHSA Innovation Program and Expenditure Plan. The MHSA Innovation Plan outlines proposed MHSA-funded programs and services to be provided locally. Innovation programs provide services that are novel, creative and/or ingenious mental health practices/approaches that are expected to contribute to learning, which are developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.

The County's MHSA Innovation Plan will be updated annually based on funding revisions and other program considerations. New programs will be added based on funding availability. The MHSA provides access to services for identified unserved/underserved clients in new or expanded programs, but may not replace or supplant existing services. Services provided through MHSA support the County's adopted Live Well, San Diego! initiative by enabling participants with behavioral health needs and the general public to access necessary resources and thereby lead healthy and productive lives.

In accordance with the MHSA ***Vision Statement*** and ***Guiding Principles***, services are designed to adhere to the following principles:

- Cultural and linguistic competency
- Promotion of resiliency in children and their families, and recovery/wellness for adults and their families
- Increased access to services, including timely access and more convenient geographic locations for services
- Services that are more effective, including evidence-based or best practices
- Reduced need for out-of-home and institutional care, maintaining clients in their communities
- Reduced stigma towards mental illness
- Consumer and Family participation and involvement
- Increased array and intensity of services
- Screening and treatment for persons with dual diagnoses
- Improved collaboration between mental health and other systems (education, law enforcement, child welfare, etc.)
- Services tailored to age-specific needs
- Address eligibility gaps by serving the uninsured and unserved

HHSA and BHS Vision, Mission, and Guiding Principles

All Innovation Projects are in alignment with the HHSA and Behavioral Health Services' vision, mission, and strategy/guiding principles.

County of San Diego, Health and Human Services Agency

Vision: Healthy, Safe, and Thriving San Diego Communities
Mission: To make people's lives healthier, safer, and self-sufficient by delivering essential services.

Strategy:

1. **Building a Better System** focuses on how the County delivers services and how it can further strengthen partnerships to support health. An example is putting physical and mental health together so that they are easier to access.
2. **Supporting Healthy Choices** provides information and educates residents so they are aware of how choices they make affect their health. The plan highlights chronic diseases because these are largely preventable and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within**. As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk." Simply said, change starts with the County.

Behavioral Health Services

Vision: Safe, mentally healthy, addiction-free communities
Mission: In partnership with our communities, work to make people's lives safe, healthy and self-sufficient by providing quality behavioral health services.

Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery and client/family centered, and innovative and creative.
3. Foster continuous improvement to maximize efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees in reaching their full potential.

Mental Health Services Act Innovations Projects
INN-01 Wellness and Self-Regulation for Children and Youth Evaluation 2013

Program Name: **Wellness and Self-Regulation for Children and Youth**
Program Start Date: **October 15, 2010**
Program End Date: **October 14, 2013**

Purpose

1. **Purpose:**
   The Wellness and Self-Regulation for Children and Youth Innovations Project is an MHSA funded program. It was awarded to both New Alternatives Inc. for adolescents, ages 12 to 18 in the Rate Classification Levels (RCL) 12 and 14, and to San Diego Center for Children for children ages 6 to 13 in RCL 12. The goal of this program was to address the specific physical, emotional, and relational challenges faced by these children and youth. Given their circumstances, these children and youth are more likely to face health challenges such as obesity, diabetes, depression, anxiety, post-traumatic stress, and other life challenges.

2. **Explanation of Purpose:**
   The Wellness and Self-Regulation Program offered these youth an array of alternative, holistic interventions to produce a positive impact on their mental and physical health. These alternative treatment strategies focused on teaching youth multiple ways to reregulate functioning in areas such as arousal level, mood, physical health, mental health, social functioning, sleeping patterns, eating habits, family wellness, frustration management, and sense of self.

Learning Objectives

1. **Learning Objective (#1): Nutrition**

What We Hoped to Learn: The impact of nutrition on health, weight, and behaviors.

What We Learned: Much was learned throughout this process. First, this program highlighted the importance of a proper nutritional base. The first change implemented to one of the campuses was the menu. It went from a standard school lunch to a menu based on the Mediterranean diet created by the Kitchen Manager and a consulting Clinical Nutritionist. This diet maximized nutrition while minimizing sugar intake. The food was so important that it became predictable when one might see an increase in behaviors. For example, the school staff knew when the teens did not eat the full available breakfast and instead ate only the sweet foods (only the pancakes and syrup when there were pancakes, eggs, and sausage). Individuals were more likely to exhibit negative behaviors after the insufficient breakfast due to a drop in blood sugar levels after breakfast. Furthermore, the staff noticed a decrease in weight management and behavior improvement with an increase in junk food during certain holidays or times of year when there were parties, on-campus visitors, and off-campus visits.

2. **Learning Objective (#2): Motivational Interviewing**

What We Hoped to Learn: The impact of incorporating motivational interviewing during staff's interactions with the youth.

What We Learned: As part of the wellness and self-regulation program, the staff learned Motivational Interviewing. This technique was also supported by the socialization program, WhyTry. Staff was trained and encouraged to interact with the youth in a more effective way. Power struggles were avoided and the youth were empowered. This was both more effective with the youth and more encouraging for the staff. This change in approach is one reason for the change in campus culture.

3. Learning Objective (#3): Medication Tracking

What We Hoped to Learn: By tracking the youth's medication to see if there was a decrease in medication after involvement in the program.

What We Learned: Tracking medication in order to measure effectiveness of this program was not significant. The percentage of discharged teens who experienced a decrease in medication per diagnostic category was an average of 15.6 percent. Because medication use is a complex and multifaceted issue, different methods for tracking medications were discussed prior to implementation. Different medications are successful for treating different symptoms for different people. Also, teenagers are in a state of development with their bodies changing. Changes in dosages of medications are common based on their growth. In addition, RCL 12 and 14 programs are designed to treat children and youth with more severe diagnoses and symptoms. Medication use is more prevalent among this population. It was agreed to track number of medication per category, such as antidepressants and antipsychotics. Dosage and frequency were not tracked.

Though there was no significant decrease in psychotropic medication use, there was an observable decrease in the need for the regularly prescribed stool softener. Chronic constipation is often the side effect of psychotropic medications, not to mention the result of a poor diet. The teens had become familiar with constipation and taking the stool softener. After the wellness program began, they were amazed at how this changed when the new menu was implemented.

4. Learning Objective (#4): Mood Surveys

What We Hoped to Learn: By tracking the youth's moods to see if there was an increase or decrease in the youth's mood during their involvement in the program.

What We Learned: Mood surveys were administered to measure feeling happy, sad, calm, or angry. Originally these were to be administered daily and it was changed to weekly to avoid the youths' frustration with the survey frequency. Despite this change in frequency of administering the survey, the youth still became frustrated. Efforts were made to make it more fun, interesting, and less bothersome. However, the youth began to refuse, purposefully score the same every time, or simply scribble on the paper. It was concluded that mood surveys do not offer valuable information. Perhaps if they were administered monthly, there may have been more compliance. In addition, the psychological assessments provided a valid and reliable method for measuring psychological health. Thus, the mood surveys may not be necessary in future wellness programs.

5. Learning Objective (#5): Cholesterol, Blood Sugar, Blood Pressure

What We Hoped to Learn: To determine if there is a change in cholesterol, blood sugar, and blood pressure as a result of wellness interventions.

What We Learned: The large majority of youth measured normal cholesterol, blood sugar, and blood pressure levels, thus there was no significant change observed. However, few teens (average of 10 throughout the program) with high cholesterol or who were pre-diabetic or diabetic experienced improvements in these areas. In the future, these measurements can be reserved for the youth who specifically experience or express concerns with cholesterol, blood sugar, or blood pressure. These measurements could be obtained at intake or if concern arises, and then monitored quarterly. This approach would be less intrusive and more cost-effective.

6. Learning Objective (#6): Heart Rate

What We Hoped to Learn: To determine if there is a change in heart rate as a result of involvement in wellness interventions.

What We Learned: The Wellness Licensed Vocational Nurse (LVN) obtained heart rate measurements weekly. Heart rate changes showed insignificant results. It was very difficult to obtain this measurement at the same time each week, and many teens refused, thus creating fluctuation in readings and deeming data invalid. Heart rate did not prove to be necessary for tracking physical health improvements.

Analysis of Program Effectiveness

1. Changes or Modifications during Implementation:

The Wellness and Self-Regulation contract required some modifications to its required elements in order to improve its effectiveness, efficiency, and to more easily coordinate with programs already in place such as mental health clinics and schools.

Initially, the contract required five wellness activities to be offered per day. At New Alternatives Inc. wellness activities were between 45 and 60 minutes in duration, thus, to add five hours of wellness activities to the time between school, clinical hours, dinner, and bedtime was not feasible. There simply was not enough time in the day. Thus, the requirement for daily wellness activities was adjusted to three to five activities per day. This allowed flexibility to schedule activities within the schedule.

Next, mood surveys were intended to be administered to the youth daily. The mood surveys were a Likert scale survey measuring a continuum between happy and sad, and angry and calm. However, experience informed the program directors that the youth would not comply with completing the surveys daily. The mood survey administration was changed from daily to weekly.

In order to take a deeper look at the psychological impact of the wellness and self-regulation program, the directors suggested adding valid and reliable psychological assessments to the outcome data. Administration of psychological assessments was conducted upon intake and discharge, and sometimes at six-month intervals to ensure a pre and post score. Three assessments used widely in psychological research were chosen to measure anxiety, depression, and post-traumatic stress (RCMAS, CDI, UCLA-PTSD Index).

2. Impact on Participants: The program indicated to have positive results on the participants due to the change of nutrition resulting in effective weight management and a reduction of negative behaviors. The training and implementation of staff in motivational interviewing also resulted in a change in campus culture as it empowered the youth and encouraged the staff in their work.

3. **What Was Learned:** Nutrition was deemed extremely important to the youth's physical and mental health. In addition, the staff's implementation of motivational interviewing stressed the youth's resilience and empowered them in decision making. The tracking of mood, cholesterol, blood sugar, blood pressure, heart rate, and medication proved to be more of a stressor on staff and the youth and will not be recommended for continued program management or future program implementation.

4. **Recommended for Replication? YES**

   Although the MHSA wellness and self-regulation contract ended October 14, 2013, the wellness program at New Alternatives, Inc. continues as the program had a built-in sustainability plan. The Wellness Director assembled a team of Wellness Leaders to assume the responsibilities of the wellness program. Together they lead daily wellness activities, provide nutrition education, facilitate WhyTry socialization groups, role model healthy behaviors, and educate the youth and staff about wellness issues.

   Each unit on campus designed their own unique schedule based on the interests of the teens, which include activities in the five areas of wellness including, but not limited to drumming, fitness, dance, art and culture, creative writing, food preparation, nutrition education.

   The Wellness Leaders participated in transition activities to signify transition of the wellness program from the consultants to the new leaders. These activities involved a mural including every teens' and staff's wellness statement and a special ceremony to "pass the wellness torch" for every wellness consultant.

   In addition, the implementation of sensory integration and a sensory room began. The use of sensory integration to promote healthy self-regulation in teens has been effective and congruent with the trauma-focused nature of the wellness program. Sensory integration education allows teens and staff to identify warning signs and initiate sensory interventions and coping skills to prevent escalation of behaviors.

5. **Lessons Learned in Implementation:**

   This experience determined what elements would be beneficial for future wellness programs and what elements are not necessary. The following is a list of elements that are not necessary for the success of future wellness programs.

   - Weekly mood surveys – eliminate completely.
   - Quarterly blood draws – reserve for specific youth with health concerns.
   - Heart rate and blood pressure measurements – reserve for specific youth with health concerns.
   - Medication tracking – this is a difficult category to track for an age group who is growing and who experiences a particular high level of trauma and diagnoses. Specific medication tracking measures identifying type, dose, and times per day, may be helpful in gaining more insight into the wellness program's effect on medication use. This would require adequate staffing.

6. Program Cost-Effectiveness:

In order to cut costs, the number of wellness consultants can be integrated into each facility. Professional wellness consultants were an integral part of this contract and their expertise in wellness benefitted all involved. Wellness activities that require professional certificates or intensive training such as nutrition, yoga, meditation, or martial arts would benefit the most with help from a professional consultant. However, staff with experience in particular wellness areas such as cooking, fitness, gardening, music, relaxation, and art can lead these activities.

Next Steps/Recommendations

Program has been discontinued; however, effective elements have been incorporated into existing programs since the philosophy of the program is well aligned with *Live Well! San Diego*.

Mental Health Services Act Innovations Projects
INN-02 HOPE Connections Evaluation 2013

Program Name: **HOPE Connections Peer and Family Engagement Project**
Program Start Date: **July 1, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   HOPE Connections offers support to persons experiencing mental health challenges and/or their family members from the unique perspective of "someone who has been there." HOPE Connections utilizes peers, staff, and family members to assist clients in navigating the County of San Diego's behavioral health system, particularly during significant life transitions such as the initial engagement with behavioral health services. Additionally, HOPE Connections aims to reduce the need for hospitalization, reduce stigma, and foster independence in clients while they navigate behavioral health services.

2. **Explanation of Purpose:**
   HOPE Connections offers peer support and family engagement to clients and their families in three levels of care throughout San Diego County's Behavioral Health Services: 1). The County's Emergency Psychiatric Unit (EPU); 2). San Diego County Psychiatric Hospital (SDCPH); and 3). Designated Outpatient clinics. Culturally and linguistically competent support staff offers referrals, side-by-side coaching, assistance with reintegration into the community, linking clients to appropriate mental health services, and help with navigating both behavioral and primary health care systems in an effort to encourage service utilization and recovery. HOPE Connections has developed an education curriculum to train peer specialists and family members to serve as an effective bridge between primary health and behavioral health care.

Learning Objectives

1. **Learning Objective (#1): Peer Engagement**

What We Hoped to Learn: Does having peer specialists at the clinic site produce better client recovery outcomes?

What We Learned: Hope contacts are defined as those who engaged with Hope Connections in the EPU, SDCPH, and/or designated OP clinics but did not enroll in the program for various reasons. Hope enrolled clients are defined as those who engaged with Hope Connections and chose to continue with the peer and/or family support by enrolling in the Hope Connections program. Analysis of recovery measures such as employment status and living situation look promising for those clients enrolled in the Hope Connections program. For example, a greater percentage of Hope enrolled clients are seeking work when compared to the Hope contacts group. Also, a greater percentage of the Hope enrolled clients are living independently when compared to the Hope contacts group.

2. Learning Objective (#2): Building Trusting Relationships with Clients and Family

What We Hoped to Learn: Are peer specialists able to build trust with clients and families and make them feel less overwhelmed?

What We Learned: HOPE Peer specialists built trust with clients and families, utilizing personal experiences. They were able to relate to the participants, having personally been through the same processes and learnings.

3. Learning Objective (#3): Service Pattern of Clients Engaged at EPU

What We Hoped to Learn: Does initial client engagement at the EPU by peers and family lead to improved access and utilization of behavioral health services?

What We Learned: Having peer specialists increased the utilization of Outpatient services. The HOPE enrolled group, which includes persons who chose to continue with the peer and/or family support provided by Hope Connections by enrolling in the Hope Connections program, went from 28 percent at pre-enrollment to 60 percent at post-enrollment, an increase of 32 percent enrollment in the Outpatient services. The HOPE contact group, which includes persons who were contacted by Hope Connections staff in the EPU, San Diego County Psychiatric Hospital (SDCPH), and/or designated Outpatient clinics but chose not to enroll in the Hope Connections program for various reasons, started at 25 percent at pre-enrollment and increased to 40 percent at post-enrollment, an increase of 15 percent enrollment in the outpatient services, based on data from "Anasazi", the Mental Health Management Information System.

4. Learning Objective (#4): Role of Family Involvement in EPU Outcomes

What We Hoped to Learn: Does an effort to include the family members of clients contribute to better outcomes in the EPU?

What We Learned: Increased family involvement served as an alternate source to connect with clients post discharge and an important tool in utilizing the clients' natural resources in the community, thus contributing to reduction in utilization of EPU services.

5. Learning Objective (#5): Relationships Between EPU Engagement and Client Retention

What We Hoped to Learn: Does effective engagement and linkage by the EPU HOPE Connections team result in greater client retention in behavioral health services?

What We Learned: A reduction in EPU utilization was observed in both the HOPE contacts group and the HOPE enrolled group. HOPE contacts decreased from 92 percent at pre-enrollment to 33 percent at post-enrollment, a 59 percent reduction in utilization of EPU services. The EPU utilization among the HOPE enrolled group members decreased from 86 percent at pre-enrollment to 28 percent at post-enrollment, a 58 percent reduction in utilization. The apparent high pre-enrollment EPU utilization rates for both groups are due to the fact that enrollment or contact with HOPE Connections often takes place at the EPU.

6. **Learning Objective (#6): Relationships Between Peer/Family Support and Long-Term Recovery**

What We Hoped to Learn: Do peer and family support result in long-term recovery outcomes for clients?

What We Learned: The program provides Peer and Family Engagement and Support services while assuring a strong peer model with an emphasis on cultural inclusion. The results of the unique expertise of the partner-agencies has provided resources necessary to reduce the stigma related to mental illness lowering barriers to recovery. The data does indicate a reduction in the need for hospitalization, while providing ongoing educating and support of clients, their families, and the community in accessing resources.

7. **Learning Objective (#7): Effectiveness of Client-Center, Recovery-Oriented Services within the EPU & Outpatient Clinics**

What We Hoped to Learn: Can voluntary, recovery-oriented, client-driven services be successful and change staff attitudes toward recovery within the EPU and outpatient clinic environments?

What We Learned: Through the use of peers and family, HOPE Connections has been able to educate and support clients, their families, and the community in accessing resources while they navigate mental health services. As indicated by the program data, it resulted in a reduction in the need for client hospitalization.

"I simply love this program – and combined with Bridges – the experience of our patients in the EPU has improved immeasurably. Thank you for your vision – and for broadening mine as well – I never knew what we were missing." – Dr. Michael Krelstein about HOPE Connections

"Just wanted to send you a message recognizing Ms. Julie Nicholas for her great work this evening with a challenging patient. She volunteered to help with an appropriate intervention and facilitated a successful outcome with the patient for all of us here at the EPU. I sincerely appreciate her assistance." – Dr. Carl Taswell about HOPE Connections

8. **Learning Objective (#8): Effectiveness of Peer Engagement Strategies within Age, Ethnic, and Cultural Groups**

What We Hoped to Learn: Are peer engagement strategies effective with certain age, ethnic, and cultural groups? Are these results strong enough to inform practice for this program and other programs in San Diego County?

What We Learned: HOPE enrolled clients were less likely to be African American, and more likely to be White. HOPE contacts clients were more likely to be Hispanic and African American than either the HOPE enrolled group or the comparison group. The data indicated that peer engagement strategies were effective with the HOPE contact participants although more research is be needed to determine why this was the case.

9. **Learning Objective (#9): Generalizability of Program Model for other San Diego Emergency Departments**

What We Hoped to Learn: Can this program model be generalized to other emergency departments in San Diego County hospitals to provide support and linkage to clients and families?

What We Learned: It appears, with adequate funding, that this model could easily be generalized to other emergency departments in San Diego hospitals. Preliminary evaluation results demonstrate that providing support and linkage to clients and families by peer specialists and family specialists are promising practices that lead to increased utilization of outpatient treatment and a reduction in unnecessary hospitalizations.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**

   On June 30, 2013, the .5 full-time equivalent (FTE) community-registered nurse (RN) position was increased to 1.0 FTE to better meet the needs of the clients.

2. **Impact on Participants:**

   "I can't thank you enough for nudging me into the right directions and bringing these helpful people into my life. Since I've met you, you've made the biggest difference on my recovery more than anyone else. It seems as though you have the power to open these doors leading to my better life. Sincerely I appreciate your wise guidance, gentle encouragement, and strong support. I have begun to HOPE." – Client about HOPE Connections Peer Support Specialists

   "HOPE Connections, several messages of thank you are due. Thank you, Fay, for seeing me yesterday at the office and adjusting the topic according to a pressing need that has arisen. I look forward to our next meeting. You showed compassion and concern, as did Anita, who kindly contributed worthwhile information and guidance." – Client about HOPE Connections Peer Support Specialists

3. **What Was Learned:**

   The increase in RN hours to the HOPE Connections team enhanced effectiveness by providing additional support that other members could not provide. The community RN assists in connecting clients that were not accepted into mental health clinics by linking them to Primary Care Physicians (PCP) that can prescribe psychiatric medications, or linking them to a primary care clinic with a psychiatrist on staff that can prescribe psychiatric medications.

4. **Recommended for Replication? YES**

   The HOPE Connections program has shown to provide Peer and Family Engagement and Support services to clients, their families, and the community in accessing resources while they navigate mental health services. The program is operated in partnership with quality community agencies that have assured a strong peer model with an emphasis on cultural inclusion and resulted in a reduction in the need for client hospitalization. The unique expertise of each partner-agency has

provided access to the resources necessary to reduce the stigma related to mental illness that can create barriers to recovery.

The RN position was instrumental in linking lower-level mental health clients to PCPs and primary care clinics when they were found to be ineligible for admission to outpatient mental health specialty clinics.

5. Lessons Learned in Implementation:

The following variables positively contribute to successful outcomes of HOPE Connections:

- Implementation of "warm hand-offs" wherein Community Specialists who will be working with clients post-discharge meet with patients and engage prior to their discharge from the hospital.
- Use of Community Specialists to drive patients to their initial clinic appointment immediately after discharge while ensuring that Hope Connections establishes other transportation options and resources with them so they can maintain future appointments.
- Matching of patient with assignments to Community Specialists who have similarities in regards to culture and age.
- Increased coordination with Crisis House to facilitate clinic appointments.
- Increased family involvement as they also serve as an alternate source to connect with clients post-discharge.
- Length of time that the HOPE Connections staff works with clients on the inpatient units prior to discharge.
- Coordination and communication with assigned Social Worker on the inpatient units prior to discharge.
- Establishing relationships with staff at mental health clinics and attending monthly meetings at mental health clinics to follow up on status of clients that were referred to the clinic.
- Assigning Community Specialists to be present at clinics during walk-in hours at four different mental health clinics. This allows the Community Specialist an opportunity to set up meetings during walk-in hours with clients that were referred to that clinic and establish relationships with clinic staff.
- Assigning clients to Community Specialists that are present during walk-in hours at the client's assigned mental health clinic to assist in the walk-in process and ensure acceptance to the clinic and provide referrals, if needed.
- Understanding the nuances of each mental health clinic site operations is vital in maximizing our assistance to clients in navigating the system. HOPE conducted research on these unique aspects and developed a spreadsheet for use with clients in successfully facilitating the timeliness of their appointments at the clinics, and to identify other activities/groups, etc. that might motivate clients to connect to their clinic.
- Informing mental health clinics of the services offered by the HOPE Connections Community RN that will assist clients with physical health problems and referrals to PCP. The community RN can also assist in connecting clients that were not accepted into the Mental Health clinic to a PCP that will prescribe psychiatric medications or another clinic that has a psychiatrist.

6. Program Cost-Effectiveness:

There was a decrease in the utilization of EPU services, (62 percent) and an increase in connecting clients to outpatient services for mental health needs (32 percent). The program did demonstrate savings as both groups, the enrolled and the contact groups showed expense reduction of 61 percent (401,000 dollars) and 27 percent (1,345,800 dollars) respectively as a result of decreased hospital/EPU days. Staffing ratios are estimated at one staff member to ten clients on average. The average hourly rate for HOPE Connections is 26 dollars per day. The average hourly rate for County Case Management is 122 dollars per day and for County Clinics – 189 dollars per day. The average daily rate for fee-for-service providers is 57 dollars per day. Based on these figures, the HOPE Connections program offers substantial savings as compared to similar programs.

Next Steps/Recommendations

Program is to be modified and continued within system of care with alternate funding source, to be determined.

Mental Health Services Act Innovations Projects
INN-03 Physical Health Integration Project Evaluation 2013

Program Name: **Physical Health Integration Project/ICARE**
Program Start Date: **January 10, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   ICARE (Integrated Care Resources) is an innovation pilot designed to create person-centered medical homes for individuals with serious mental illness (SMI) in a primary care setting.

2. **Explanation of Purpose:**
   ICARE is one of five MHSA components designed to foster new approaches to increasing knowledge about serving the mental health needs of San Diego County communities. The goals of all innovation projects are to use novel approaches to increase service access to underserved groups, increase quality of services, promote interagency collaboration and increase service access for the mental health community. The focus of the ICARE program is to enhance mental and physical wellness through a holistic and collaborative continuum of care across primary care and mental health clinics.

Learning Objectives

1. **Learning Objective (#1): Interagency Collaboration between Community Health Centers and Mental Health Providers**

What We Hoped to Learn: Whether such a transition can promote interagency collaboration between community health centers and Mental Health service providers and if it will increase access and quality of services for those individuals with acute illness who we are currently unable to be served adequately due to an overburdened Mental Health system. We hoped to see an increase in access and quality for clients with SMI.

What We Learned: The program is still ongoing but preliminary data from patients, Federally Qualified Health Centers (FQHC) and mental health clinics indicate that the interagency collaboration has increased and has promoted both access and quality. Overall satisfaction scores from clients increased by 13 percent between baseline and at 6 months, and were 3.6 percent higher when compared with the aggregate scores of other County mental health programs.

2. **Learning Objective (#2): Improvement in Overall Outcomes for Older Adult Population**

What We Hoped to Learn: Does this approach benefit and meet the mental health and physical health needs, and improves the overall outcomes of the older adult population. We hope to see an improvement in both physical health and mental health outcomes in the older adult population.

What We Learned: The program is still ongoing, but it appears as though there are very few older adults represented in the stable clinic population who meet the criteria for this project. Data from January 2013 indicates that only 12 individuals over the age of 50 were represented in the group,

accounting for less than 10 percent of the total sample. Implications for the older adult population are not immediately clear and will be reviewed in further detail when the next evaluation period begins in December 2013.

3. Learning Objective (#3): Underserved/Refugee Community Outcomes

What We Hoped to Learn: Does this approach benefit and meet the mental health needs of those in the underserved and refugee communities who typically present in primary care settings with physical complaints? We hoped to learn whether individuals who present in a primary care setting with physical health complaints, but who were actually in need of a higher level of mental health care, would be connected with mental health clinics as they were identified.

What We Learned: To date, no referrals have been made from the FQHC to the mental health clinics for refugees or any other patients. This may be because this program and the SmartCare psychiatric consultation program have provided a great deal of support to primary care to treat individuals with higher level mental health needs. It may also be because ICARE had a contractor that specifically treats mental health for refugee populations and they are not part of this project. Therefore, if refugees were identified and referred, it may have occurred outside this project.

4. Learning Objective (#4): Increase in Recognition, Referral, and/or Treatment of Poorly Served Communities

What We Hoped to Learn: If a systematic investment in the competence of primary care providers, to recognize and manage mental health needs, will increase their recognition, and referral or treatment of this otherwise poorly served community. We hoped to determine whether providing Behavioral Health Consultants (BHC) and other support staff would increase the primary care providers' ability to recognize, refer, and/or treat the SMI population.

What We Learned: Preliminary data indicate that providers feel positive about the program. *"[Providers] have enjoyed it…the opportunity to expand their skill set and also to be able to see these patients holistically…"* Data from the psychiatric consultation program (separate from this program) indicate that the clinics that participated in ICARE were some of the more frequent users of the service, which may indicate an increased awareness and willingness to serve the SMI population. Data will continue to be evaluated and reviewed to track this objective.

5. Learning Objective (#5): Improvement in Mental Health Outcomes when Clients Receive Physical Health Services

What We Hoped to Learn: Is there an improvement in mental health outcomes when clients with SMI receive ongoing physical health care services and/or treatment in a primary care setting? We hoped to see participants' scores on Illness Management and Recovery questionnaire and Recovery Markers questionnaire improve.

What We Learned: The program continues to collect data, but preliminary finding show that those participants in the project for six months showed greater mental health recovery improvements as indicated by data from the client and the BHC. This objective will continue to be tracked and evaluated as the project continues.

6. **Learning Objective (#6): Reducing Stigmatization of SMI Clients with Primary Care Physicians/Staff**

What We Hoped to Learn: If the BHC model, which has proven effective for less serious mental illness, can be adapted to assist primary care providers in serving the behavioral health needs of their patients with stable SMI. Can this role also help reduce stigmatization of SMI clients with Primary Care staff? We hoped to see a decrease in the amount of stigma experienced by the clients and to see an increased capacity on the part of the primary care providers to serve clients with stable SMI.

What We Have Learned: From baseline to the six-month follow up, clients' average stigma score decreased from 2.73 to 2.39, showing marked improvement. However, a few measures worsened including one where clients indicate that they feel they have been talked down to due to their mental health problems. We will continue to follow these measures and will combine with our key informant interview data to determine why this may be.

7. **Learning Objective (#7): Meeting the Needs of Refugee and Immigrant Populations in Primary Care Setting**

What We Hoped to Learn: If this behavioral health integrated approach meets the mental health needs of refugee and immigrant populations at the primary care setting. We hoped to learn how refugees and immigrants respond to this model of treatment.

What We Have Learned: Data that differentiate immigrants and refugees from other participants in the project are not available at this time. Staff will work with Health Services Research Center to determine whether this is possible.

8. **Learning Objective (#8): Reduction in Emergency Department Visits**

What We Hoped to Learn: If emergency department (ED) visits are reduced for individuals with SMI who are receiving ongoing physical health care compared to the current rate for clients in the Mental Health system. We hoped to see a reduction in ED visits for those with SMI who were engaged in this project.

What we have learned? Data from baseline to six months indicate that ED visits for any health reason decreased from 30.2 percent to 21.2 percent. This appears to be a significant improvement and ICARE will continue to monitor to determine whether this is maintained throughout the project.

9. **Learning Objective (#9): Transferring Clients with SMI from Mental Health Clinics to Primary Care Provider Settings**

What We Hoped to Learn: If the transfer of stable SMI clients from the health clinic into the primary care setting helps the county serve more severe SMI clients. We hoped to see an increase in access for less stable SMI clients into the County Mental Health System.

What We Have Learned: Data are still being gathered and evaluated to determine whether this project has improved access for individuals with severe SMI.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**

   During the course of implementation, project staff discussed the possibility of expanding the site where the program was offered to include the south region because there were many clients in this area who would meet the criteria for participation and a health clinic was located nearby. An exam room was built at the South Bay Guidance Center to accommodate the nurses' physical exams for clients, and Family Health Centers' Chula Vista site was added to the list of participating locations for the ICARE program.

   Secondly, the staff explored the idea of utilizing the LVN as the Nurse Care Coordinator instead of an RN. It was determined that the LVN would be more cost-efficient and would provide the health information and scheduling assistance that was needed to continue to make the project successful.

2. **Impact on Participants:**

   The addition of the South region site has had a positive impact on the program and its participants. The site has become a steady source of referrals. Participants at both mental health sites are now able to choose to receive their healthcare at Family Health Centers, Chula Vista if that location better meets their needs. Other choices include Logan Heights, North Park and the Downtown clinics. The clients who now have access to this program receive all of the services available for the ICARE participants at the Areta Crowell Center: physical health screenings and on-site scheduling assistance; substance abuse screening and counseling; peer assistance in transitioning to the Family Health Centers' services; and support from BHCs during the process.

3. **What Was Learned:**

   In addition to providing services in an area where the ICARE program was clearly needed, the ICARE expansion showed us how participants in different regions respond to the model. Staff found that while clients from Areta Crowell, who are a more transient population, were relatively amenable to the idea of needing to access their mental and physical health care at a new location, the clients in Chula Vista were more resistant. Staff noted that there is a much higher population of Latino clients in South Bay; they value a sense of family with the staff and with other clients. The idea of transferring to another location was challenging for many of these clients.

   To meet this challenge, BHCs began to spend more time at the mental health site so that clients would meet them and get to know them better before they would be asked to transition to the health clinic for their services. Because this relationship was built on the front end, clients were then greeted by a familiar face when they made their first appointment at the new clinic. The BHCs provided the clients with more detail regarding the building and the process at the new clinic, which made the transition smoother.

4. **Recommended for Replication? YES**

   Yes, this project is recommended for replication. While the program could be run successfully as is, the County has chosen to use elements from this program in combination with other projects to create a new program.

5. **Lessons Learned in Implementation:**

   The program is set to end June 30, 2014. In addition to the lessons learned above, we will have data regarding health indicators for the project participants available after program completion.

6. **Program Cost-Effectiveness:**
   There was an increase in services because the funding provided additional services that were previously unavailable. ICARE supplies a Nurse Care Coordinator onsite at the mental health clinic that performs physical health screenings and direct appointment scheduling at FHC. An Alcohol and Other Drugs (AOD) counselor is also available for screenings, groups, and follow-up support. Peers help transition clients to the new health center, provide follow-up with clients regarding appointments and also help clients obtain necessary eligibility paperwork. BHCs provide necessary, therapeutic support as client's transition from the mental health clinics to the FHC sites.

Next Steps/Recommendations

Program to be modified and continued within system of care with alternate funding source, to be determined.

Mental Health Services Act Innovations Projects
INN-04 Mobility Management in North San Diego County Evaluation 2013

Program Name: **North County Transit District: Mobility Management Program**
Program Start Date**: August 1, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   Increase access to underserved groups. The Mobility Management Program (MMP) is a peer-based transportation program designed to improve the availability, quality and efficient delivery of transportation services as well as increase participant access to services and activities. It is also meant to minimize barriers to transportation for seniors, people with disabilities, and low-income residents in North County. The primary components of the program include travel training and transportation coordination.

   Transportation Coordinator
   Transportation Coordinators educate service providers and consumers on transportation resources in the North San Diego County region. Mental health consumers who preferred to receive training in a group format were able to participate in group travel training courses facilitated by the Transportation Coordinator. Similarly to the one-on-one mentoring provided via a Travel Trainer, group classes focus on educating consumers on how to navigate the transit system safely and confidently throughout the local community. Consumers learn how to use the Rider's Guide to map routes to and from their desired destinations, transit fares using the ticket vending machines, safety, problem solving, on-line resources, transit center locations and amenities, and more. The final component of the group training process included planning and implementing a field trip, by utilizing public transportation, to a location selected by the class members.

   The Transportation Coordinator also assisted in problem solving various transportation needs consumers or service providers may encounter. Consumers with unique transportation needs due to language barriers, geographic barriers and age, were assisted to develop customized transportation strategies.

2. **Explanation of Purpose:**
   It is a well-established fact that current systems of transportation in San Diego County do not meet the needs of the people who must rely on public transit or private transportation (Full Access & Coordinated Transportation, Inc.). Numerous stakeholders have expressed this need throughout the MHSA Community Planning Process.

   Stakeholders stated that a peer-based transportation program could "increase self-sufficiency," provide "more access to patient services", and lead to "a lot less appointments missed". Other benefits that the stakeholders identified were the opportunity to "build relationships with peers while sharing rides", the reduction of "family's stress because they will know that transportation assistance is available", and the reduction of "isolation because clients will need to get out and talk with peers in order to get to their appointments".

Studies clearly demonstrate that older adults are underserved by community mental health systems for a number of reasons. One significant cause is the inability for individuals to access adequate services. In addition, changes in regional demographics and land use patterns require new approaches for providing transportation services, particularly for underserved adults and older adults in North San Diego County. North San Diego County consists of a geographic region larger than the state of Rhode Island, and over half of the area is rural. Historically, due to low population numbers, these areas consistently struggle with securing adequate resources to provide comprehensive health and social services to community residents.

According to findings of the study, "Transportation Concerns and Needs of Mental Health Client Populations in North San Diego County" (A-Menninger-Mayeda-Alternative Transit Planning), residents have limited knowledge of available transportation resources. Evidence suggests that some consumers are reaching out and effectively connecting with public transit options; however, it is not the majority.

Transportation plays a critical role in providing access to employment, health care, education, community services, and activities necessary for daily living. The importance is underscored by the variety of transportation programs created in conjunction with health and human services programs and the significant federal investment in accessible public transportation systems, United We Ride.

Learning Objectives

1. Learning Objective (#1): Utilizing Transit

What We Hoped to Learn: With the skills and confidence gained by participating in the MMP, participants will utilize transit more frequently, relying less upon family and friends. By reducing various barriers to utilizing public transportation, participants will become more confident and independent, thus improving their overall social functioning and satisfaction.

What We Learned:

- 70 percent (75 of 107) of travel trainees reported utilizing transit more often than they did prior to participating in the travel training program.
- 58 percent (68 of 116) reported receiving rides less frequently from friends/family for the purpose of attending appointments/activities.

2. Learning Objective (#2): Scheduling and Attending Health/Medical Appointments

What We Hoped to Learn: With the ability to comfortably utilize the transit system, participants will be more apt to schedule and attend health and medical appointments. When consumers/participants are comfortable with their mode of transportation, they are more likely to schedule and attend events in the community, including appointments related to health and healthy living, which will enhance the participants' overall health and well-being.

What We Learned:

- 69 percent of participants (63 of 91) who reported on the pre-test that they avoided scheduling health/medical appointments due to transportation barriers reported an increase in the number of appointments they now schedule.
- 77 percent of participants (67 of 87) who reported on the pre-test the inability to attend health/medical appointments due to transportation barriers reported an increase in the number of appointments they now attend.
- 83 percent of consumers (89 of 107) who completed travel training reported on the post-test that they use public transit to participate in social activities.

3. Learning Objective (#3): Outcomes for Peer Volunteers and Participants

What We Hoped to Learn: By recruiting peers as volunteer drivers for the Ride Share component of the program, both the volunteer and participant would enhance their social skills, the participant would experience increased mobility, and the family members would be allowed some respite from the responsibility of transporting the participant. The objective of the Ride Share program was to reduce barriers and increase mobility for the targeted population. Some of the expected benefits that derived from ride sharing would include increased mobility for the rider, an opportunity for both the volunteer driver and the rider to enhance existing social skills, relieve family members of the responsibility of transporting their loved ones, and provide an added degree of safety/security for the rider. Ride sharing could be used to attend social events, receive medical and mental health services and/or participate in leisurely activities such as shopping and recreational activities, which may otherwise go unattended.

What We Learned:

- Though well received and desired, the Ride Share component was discontinued for the following reasons:
  - Difficulty recruiting a sufficient number of volunteer drivers. The potential liability for the driver was also a deterrent.
  - Most consumers preferred the advantages of Ride Share services over using transit, even if they possessed transit skills, which was perceived by the program as something not sustainable due to lack of volunteer drivers.
  - Information provided by applicants' references was not always reliable.
  - High administrative requirements were necessary to provide services responsibly and safely.

Analysis of Program Effectiveness

1. Changes or Modifications During Implementation:

The Ride Share component was discontinued.

2. Impact on Participants:

Those who were receiving rides no longer had that option available. All other components remained.

3. What Was Learned:

What Worked:

- 463 individuals engaged in services which exceeds the contract goal.
- Developed and strengthened partnerships with Clubhouses, hospitals and many of the mental health provider agencies.
- The benefits gained by the volunteers (social connection, sense of worth and independence) were evident in participants.
- Offering incentives to encourage program participation (compass cards, transit passes, gift cards, etc.).
- Consumers developed social relationships with one another as a result of program participation.
- Consumer engagement increased access to services and activities; and program volunteers were very committed. Several consumers were very active in encouraging their peers to enroll.
- Providing group travel training services.
- Marketing on the BREEZE Buses (Bus Placards).
- Peer-based service model.

Challenges Faced:

- Difficulty recruiting a sufficient number of volunteer drivers. The potential liability for the driver was also a deterrent.
- Most consumers preferred the advantages of Ride Share services over using transit, even if they possessed transit skills.
- Information provided by applicants' references was not always reliable.
- High administrative requirements needed to provide services responsibly and safely.
- Most mental health service providers have heavy workloads. This makes it difficult for many of them to dedicate time/effort needed to facilitate consumer access to the MMP.
- Private practitioners were difficult to engage.
- The stigma associated with mental illness was a barrier to enrollment for many, particularly older adults.
- Consumers were not able to readily identify "recovery skills".
- Transportation options in rural communities are very limited.

4. Recommended for Replication? NO

While the program has had some success with some mental health clients, it is not recommended for replication due to its low priority for the limited funding resources available. Transportation issues in the North County Regions, particularly in the rural areas and for adults with mobility issues, cannot be significantly improved by this program.

5. Lessons Learned in Implementation:

Lessons learned are detailed below each Learning Objective in the above narrative.

6. Program Cost-Effectiveness:

There was an increase in the number of participants who were able to utilize the transit system to increase both social and health-related interactions. This program utilized Volunteer Travel Trainers and volunteer drivers, which improved the cost-effectiveness of the program.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-05 Positive Parenting for Men in Recovery Evaluation 2013

Program Name: **Positive Parenting for Men in Recovery**
Program Start Date: **July 1, 2010**
Program End Date: **June 30, 2013**

Purpose

1. **Purpose:**
   A 13-session group program with four objectives:
   i. Increase Positive Parenting skills and model with children
   ii. Improve Mental Health Wellness
   iii. Reduce substance abuse risk factors and/or stressors
   iv. Reduce/prevent violence and trauma (directed at children or self and others)

2. **Explanation of Purpose:**
   This was a voluntary group program for men in the following target population:
   i. Transition age youth (TAY) , ages 18-25
   ii. Enrolled in non-residential AOD treatment programs at six Regional Recovery Centers (RRCs)

   Six Regional Recovery Centers had equal funding and objectives, noted in the table below:

Contract	Contractor	RRC	3-Year Funding	3=Year Caseload Objective	Documented Graduates	Pre- and Post-Tests	Surveys	Comments
534111	MITE	SOUTH	$105,000	75	16	8	17	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534112	MITE	EAST	$105,000	75	41	20	27	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534113	MHS Inc.	CENTRAL	$105,000	75	66	51	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534154	MHS Inc.	NORTH INLAND	$105,000	75	17	0	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534155	MHS Inc.	MID-COAST	$105,000	75	0	35	24	REPORTED 32% AVERAGE INCREASE IN POST-TEST SCORES
534156	MITE	NORTH COASTAL	$105,000	75	49	23	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
TOTALS			$630,000	450	189	137	68	

Learning Objectives

1. Learning Objective (#1): Increase Positive Parenting Skills

What We Hoped to Learn: These groups would produce measureable improvement in positive parenting skills as measured by pre- vs. post-test improvement.

What We Learned: Non-clinical therapy in a relaxed group setting, incorporating approved parenting curriculum and led by experienced clinicians, may be helpful in improving parenting skills for a minority percentage of motivated or court-ordered clients, including those already receiving mental health services. Pre- vs. post-test improvement was not measured formally in all cases.

2. Learning Objective (#2): Improve Mental Health Wellness

What We Hoped to Learn: This program component was a voluntary counseling/education opportunity for male clients to learn more about mental health wellness and additional treatment resources as well as child and family trauma/violence prevention issues.

What We Learned:

- A relaxed "non-clinical" tone or setting allowed the participants the time and encouragement to engage in the group, bond with other members, be open in a safe place, and be receptive to the instructor and curriculum.
- Topics included mental health resources in the community, self-monitoring and awareness for signs of mental health problems, and where to go for medication management support.
- Providing refreshments (snacks and soft drinks) for the male TAY population is highly recommended to encourage participation and retention.

3. Learning Objective (#3): Reducing Substance Abuse Risk Factors and/or Stressors

What We Hoped to Learn: This program component would help clients identify life stressors related to parenting issues and provide additional tools for reducing risk factors for relapse and inadequate or inappropriate parenting, while supporting the primary substance abuse treatment.

What We Learned: As tools, effective approaches for this population include:

- Redirection of anger by acknowledgment and adoption of positive parenting behaviors which are "best for the child".
- Meditation and visualization techniques were taught as stress reduction tools.
- Clients in the SBRRC who benefitted from the group chose to continue the group outside the contract setting, and were to be joined by the instructor.

4. Learning Objective (#4): Violence and Trauma Prevention

What We Hoped to Learn: Contractor's use of "trauma-informed" approaches would recognize the vulnerabilities of trauma survivors, including these male adult clients, and avoid inadvertently re-traumatizing clients, while also facilitating client participation in treatment.

What We Learned

- A large majority of TAY fathers in AOD programs (clients) have experienced some form of trauma, neglect and/or abuse as children.
- Clients benefited from increased knowledge about trauma and how it impacts negative and positive approaches to parenting.
- Role play and discussion of modeling healthy parenting was perceived as being beneficial to most clients in a group setting.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**

   None

2. **Impact on Participants:**

   Of 189 documented program graduates:
   - 68 clients completed satisfaction surveys.
     - 70 percent of surveys were rated positively.
   - 137 clients completed both the pre-and post-program tests.
     - An average of 49 percent of post-tests showed improvement, below the benchmark expected outcome of 70 percent discussed with providers.

3. **What Was Learned:**

   - Creating age-based parenting sub-groups with some level of shared experience fosters comfort and openness in clients.
   - Sub-groups of differing perspectives and cultural backgrounds can learn improved parenting skills from each other by dialogue in the group setting and sharing successful strategies.
   - Improving parenting skills appears anecdotally to promote increased sobriety and social competence of formerly substance-abusing, male parents.

4. **Recommended for Replication? NO**

   The cost per client was a main contributing factor to discontinuing the program; however, components and aspects of this model can be incorporated into existing AOD services or Prevention and Early Intervention programs with similar benefits to the client population and their children.

5. **Lessons Learned in Implementation:**

   - Positive parenting resources for men in AOD treatment are in a supply deficit. This target population will benefit from the curriculum ["A Nurturing Father's Journal" Developing Attitudes and Skills for Male Nurturance Workbook. Mark Perlman, MA 1998] in group sessions, within established contracts and using existing staff.
   - Providing separate, non-treatment oriented parenting groups allows clients to focus on parenting skills taught by the instructor and curriculum, yet supports AOD treatment goals.
   - Providing snacks and soft drinks for the male TAY group is highly recommended to increase participation and retention.

- It is recommended that TAY treatment participants be screened to see whether they need anger management services as a companion to substance abuse treatment.

6. Program Cost Effectiveness:

630,000-dollar budget total per 189 graduates = 3,807 dollars per person at budget, but actual cost was less due to some contractor underspending. There was an increase in level of services as these services formerly did not exist. The staff-to client ratio was 1:7.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-06 After-School Inclusion Program Evaluation 2013

Program Name: **MHSA Innovations After-School Inclusion Program**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   The purpose of the MHSA Innovations After-School Inclusion Program is to increase access to after-school programs for youth with social-emotional/behavioral issues. The program provides opportunities for students, previously stigmatized and/or precluded from participating, to be integrated with their peers by utilizing Inclusion Aides to provide behavioral support and teach them pro-social and functional skills. The program introduces to the behavioral health system a community defined approach that has been successful in a non-mental health context. Additionally, the Inclusion Program educates after-school staff, families, and other community members on how to help youth with behavioral issues thrive in their environment with the intent of building in sustainability of concepts in after school programs. The Inclusion Program measures the impact of the benefit derived from behavior interventions and access to after-school programs on youth with behavioral issues and their families with the goal of leading happier, healthier, less stigmatized lives and the potential to reduce need for future behavioral health services.

2. **Explanation of Purpose:**
   Research has shown a need in the community for services that provide interventions for youth who are exhibiting social-emotional/behavioral issues while in the care of after-school providers who are not equipped with the knowledge and/or training to work with these youth. Therefore, these youth are at risk of being precluded or discharged from the after-school program. When youth do not have the opportunity to participate in after-school programming, stressors may occur in the family which can lead to further issues in the community. Often, families do not have the resources and/or knowledge to access available services for their children. Inclusion Program staff that are working with these youth are able to provide appropriate support aligning with the behavioral health system in a nontraditional mental health setting. Inclusion Program staff offer one staff-per-client behavioral support to the youth and teach the after-school staff how to work with these youth through both formal and informal training.

Learning Objectives

1. **Learning Objective (#1): Through behavior intervention, the Inclusion Program will be able to provide improvements in students' self-esteem, social competence, and healthy behavior.**

What We Hoped to Learn: Inclusion Aides are able to assess each referral and identify the problematic behaviors that are precluding the participant from fully participating in the after-school program. Inclusion Aide would be able to distinguish between self-esteem, social competence, and healthy behaviors in order to accurately assess each behavior and what it correlates with. Program

would be able to see a positive change in each of the three areas: self-esteem, social competence, and healthy behavior.

What We Learned: Participants' behavior issues stem from mental health issues, environmental stressors, trauma, educational difficulties, etc. The program may see a positive change in one area, (e.g., self-esteem), but not in all three areas at once, and/or the participant may only struggle in one area. Inclusion aides prioritize the area of need and due to the limited time for services the participants' plan may only focus on one area of need. The participants' behaviors may be reflective of causes that are not measured through self-esteem, social competence, and/or healthy behavior. The program learned that with the difficult and complex issues that our participants face, there is a benefit for on-going system support.

2. **Learning Objective (#2): Inclusion Program participants will increase their social connectedness and will live happier, healthier, less stigmatized lives while experiencing success and normalcy.**

What We Hoped to Learn: Inclusion Program participants will be included and will participate in the after-school program with the same success and normalcy as all after-school program participants. Participants will not be excluded from certain activities or stigmatized for limitations. Participants will be successful and learn ways in which they can manage their own behavior in the context of the program. Participants will carry this success on through all areas of their life.

What We Learned: Inclusion Program participants are able to be integrated into their peer group with the right tools and interventions provided by the Inclusion Aide as well as the after-school program staff. Success in the program is not only measured by the success of the participant, but the success of the after-school staff and their ability to understand the behaviors and effectively implement interventions. Inclusion has learned that each participant is different and success may look different for each one of them, requiring individualized services. A small improvement in one area may have a significant impact on the participants' self-esteem and/or behavior. This improvement can help the participants integrate into their peer group with more success. Inclusion has learned that interventions provided by Inclusion Aides in the after-school program are often helpful in the classroom as well, and teachers are open to implementing different strategies when able.

3. **Learning Objective (#3): Parents/Guardians will be satisfied with the services provided for their youth and their stress level will decrease.**

What We Hoped to Learn: Parents will receive fewer phone calls from the after-school program and/or teachers regarding their child's behavior. Parents will decrease their stress level and learn how to implement interventions to help their child in the home. Parents will take all the information and resources given to them and put them into place for both the participant and family. Parents will participate in services with the Inclusion program on a consistent/regular basis. Parents will recommend the Inclusion Program to other parents that face similar struggles with their children.

What We Learned: Parents are extremely busy and have many demands for their time. Parents are interested in the program but do not always have the time needed to implement interventions for their children in the home. The program has learned that measuring stress is complex. Parent stress

level is based on a number of things going on in their life; therefore, the way a parent measures stress can be very different on any given day. Parent stress level can have a high correlation to a child's behavior, but it also may have a low correlation to the behavior.

Parents often have different definitions of stress and base stress on several different factors. Parents are limited with their resources and do not always qualify for the most appropriate services and/or have the time to connect with community resources. However, we have learned that many parents go the extra mile for their child and are willing to help in any way they are able to.

We have learned through Parent Advisory Group meetings that Inclusion Aide services work, and parents are pleased with the improvements that they see in their child. Parents would like to see services run longer and follow their children to different schools.

4. **Learning Objective (#4): Gatekeepers will increase awareness of how to identify and work with at-risk youth and refer them to appropriate services.**

What We Hoped to Learn: After-school program staff will embrace the Inclusion Program model. After-school program staff will take the interventions and strategies provided by the Inclusion Aides and continue to implement them after the participant is discharged from the Inclusion Program. After-school staff will understand the causes of different types of behaviors and issues the participants face. After-school staff will have an increased awareness of how to identify what factors play into the behavior. After-school staff will obtain the knowledge needed to identify and work with these participants on their own, and, ultimately, the after-school program would be better positioned to support youth with social-emotional and behavioral challenges.

What We Learned: The Inclusion Program has learned that there is a constant turnover rate with after-school staff, which makes sustainability of program knowledge challenging. After-school staff often view Inclusion Aides as the "fixers" and, therefore, do not try to implement interventions on their own. After-school staff are open to training and learning about behaviors but are consumed with the large ratio of youth they are working with so they often do not have the time needed for these particular participants. Inclusion has learned that some after-school programs are more open to interventions offered by Inclusion Aides than others. The Inclusion Program (Inclusion) also learned that there are site supervisors and staff that utilize all the interventions and strategies given to them by Inclusion Aides. These after-school program sites and staff have more participant success and less behavior issues.

5. **Learning Objective (#5): All program participants are evaluated and referred to external services, as needed.**

What We Hoped to Learn: All program participants and families that are in need of external resources will be successfully connected to community resources.

What We Learned: Not all families are interested in receiving information about other programs and services at the time of intake. Many families are in need of extra resources, but may feel ashamed to ask. Often times there are services our participants may need but do not have access to due to lack of transportation and/or income. Inclusion has learned that Inclusion Aides often have more success with providing referrals during the course of services rather than at the beginning or end. There are

families that have taken advantage of the external resource given to them. When families are able to connect with resources and outside referrals, we tend to see more change within the family system.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**
   During the course of the programs first year, Inclusion has made modifications programmatically, administratively, and fiscally.

   Programmatic changes:
   Inclusion has had several changes in staff due to a high rate of turnover. Over the course of the program, staff members were obtaining high qualifications in order to work with this population of youth and, therefore, are now looking to obtain full-time positions in which they can grow.

   Inclusion developed standardized training curriculums on a wide variety of topics that fit the need of the after-school program and participant issues. We changed our delivery model and decided to implement these standardized trainings quarterly at after-school program staff meetings. Inclusion has also implemented training at camp site facilities, while providing support for participants at camp.

   Inclusion set standards for productivity, such as requiring Inclusion Aides to meet with after-school staff for at least 30 minutes per week, meeting with school staff monthly, working with participants at a high rate, and meeting with families regularly.

   Inclusion continues to work with participants for three months, but has broken it down to 60 school days so holidays do not play into a decrease in service time.

   Full-time program staff meet regularly with the branch coordinators and directors to discuss program challenges and successes.

   Inclusion has added an additional component of supervision where the Lead Inclusion Aides provide individual and group supervision as well as go out and monitor school sites.

   Inclusion increased the number of training opportunities given to the Inclusion Aides, including but not limited to:
   - Yoga in the Raw
   - Behavior Management 101
   - Positive discipline

   Inclusion Aides were given the opportunity to pick one to two trainings to attend that were specific to issues at their site and the participants' behaviors.

   Inclusion purchased additional supplies that were put into the KITS and specific to certain school sites and participant needs.

   Administrative Changes:
   Inclusion hired a 5th Lead Inclusion Aide to help facilitate the training process and develop training curricula, as well as monitor school sites. Inclusion hired an Advocacy Coordinator to help with community outreach, recruitment, and program development.

Fiscal Changes:
Fifteen additional Inclusion Aides, two Data Entry staff and one Receptionist were added to the program's staff on a temporary basis.

The program Research Associate started as a part-time position then was able to become full-time for the remainder of the fiscal year. Beginning July 1, 2013, the position went back to part-time and as of October, has been eliminated and replaced with an Independent Subcontractor for the outcome analysis.

Inclusion is contracting with Harder & Company to do data analysis.

The program Office Administrator started as a 30-hour/week position and is now a full-time position.

Inclusion changed our expectations in staff travel mileage as the program requires more travel than expected.

2. Impact on Participants:

Inclusion has been able to implement a positive change model for working with youth. We have effectively enhanced staff's ability to deliver services to participants and their families.

3. What Was Learned:

During the implementation of the program's first year, Inclusion learned the following:

- It is critical to consistently reach out to school districts to ensure collaboration.
- Having a tiered system of supervision is important. Lead Inclusion Aides provide a wealth of knowledge and guidance to Inclusion Aides in their region.
- The addition of a 5th Lead Inclusion Aide helped improve program development and sustainability.
- The best way to train the after-school staff is to have standardized training curricula that can be used across the county to educate staff on a wide range of topics and behaviors.
- There are different types of after-school programs, such as non-licensed programs (free) vs. licensed programs (parents pay for services). There are different regulations and requirements for each program.
- It is integral for Inclusion to have constant communication with the YMCA branches to ensure collaboration and increased referral numbers.
- It takes not only a large amount of money, but a large amount of time, effort, collaboration, drive, and passion to set up the infrastructure of a brand new program, as well.
- Staff is attracted to the Inclusion Aide position as a stepping stone to other professions within the field of mental/behavioral health. Part-time staff report that this program provides exceptional training, guidance, support, and supervision; however, the need for them to obtain a full-time position outweighs their experience with the Inclusion program. Having the ability to retain staff and keep continuity within the after-school program would make the program more effective. It takes an immense amount of time to train new staff coming in at such a high rate.
- It is harder to find bilingual staff.
- In order to produce quality data, a specialized evaluator and system is critical.

- Inclusion learned through trauma-informed care that the majority of our participants have mental health issues and/or experience trauma in some way. More participants than the program originally thought have been or are involved with the child welfare system, are exposed to substance abuse, have or have had incarcerated parents, and exhibit different mental health diagnosis.
- Many of our participants come from single-parent households and/or are being raised by a relative or guardian.

4. Recommended for Replication? YES

Explain:
The Inclusion Program has been very successful throughout its first year. Inclusion has learned what our limitations, challenges, and capabilities are. The biggest difficulty for the program has been sustaining staff for part-time positions. Staff has the qualifications and is looking for full-time work. For the continuity and stability of the program, it would be helpful to have the Inclusion Aide position be full-time, but due to after-school program hours, having full-time Aide positions is not practical or cost-effective.

5. Lessons Learned in Implementation:

While implementing the Inclusion Program we have learned about all the available resources in the community, and the best practices for reaching out and linking participants and families to appropriate services and resources.

Inclusion has learned that staff consistency is very important and integral to the success of the youth and families.

Inclusion has learned that youth are in the after school program until 6:00 p.m., Monday through Friday, and on the weekend parents don't have resources to get the participants involved in recreational activities and sports. Sports are not offered in all after-school programs.

Inclusion has learned that not all after-school programs and/or districts are run the same; therefore, it is hard to make staff aware of all the differences and hold them accountable to the same standards.

Inclusion has learned that the background and experience level within the after-school staff is very different and often limited.

6. Program Cost-Effectiveness:

Throughout the first year of programming, there was an increase in the amount of schools and participants. Inclusion was able to provide service due to the budget and ability to hire 15 additional Inclusion Aides on a temporary basis. This gave Inclusion the capability of working with more participants, families, and training more after-school staff.

Actual cost per client for the fiscal year 2012-2013 was 4,700 dollars; however, this was during the start-up year, and traditionally program's cost per client is higher during start-up periods.

This compares to an estimated target cost per client of 3,000 dollars in the Children's outpatient system; however, the premise is that if you can do preventive work on the front end, there are savings not only in dollar terms, but also in the long-term impact of preventing youth from

entering the behavioral health system. Youth who have higher mental health needs can exceed costs of 10,000 dollars per year if they need ancillary or day program services.

A potential one-staff-per-client behavior coaching service comparison could be made with Therapeutic Behavioral Services, which has an average cost per client of 5,000 dollars.

Next Steps/Recommendations

Yet to be determined as the program began July 1, 2012, so only the first year data of a three-year contract is available.

Mental Health Services Act Innovations Projects
INN 07 Transition Age and Foster Care Evaluation 2013

Program Name: **TAY Academy**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   a. Increase access to underserved groups by:
      - Providing solutions to the challenges, problems, and barriers identified by the community for Transition Age Youth (TAY) and Foster Youth.
      - Establishing five regionally-based TAY Academy Centers that integrate coaching, mentoring and teaching strategies resulting in a successful transition to independent living and an increase in the number of youth/TAY who transition out of the Children's and Adult Behavioral Health Systems of Care.

2. **Explanation of Purpose:**
   a. TAY and a prominent subset of current and former Foster Youth often have difficulty in transitioning from the Children's to the Adult System of Care and often struggle with a lack of overall support and access to care. Subsequently, these TAY are at an elevated risk for mental illness compared to their same age peers.

Learning Objectives

1. **Learning Objective (#1): Individualized goals and activity modules that address goals and reduce the problems and barriers, including:**

   a. TAY lacking self-identity, sense of purpose, and passion for future:
      - 144 out of 818 youth (18 percent) who received services, created individualized vision plans to address their needs/goals and reduce their problems and barriers. Connections coaches and Youth Support Partners (YSP) then assisted youth in making community connections and accessing resources. Examples include: transport to appointments and teaching them to use public transportation; navigating applying for resources; developing stress tolerance skills and healthy/safe coping skills; linkage to resources and appointments for housing, education, and employment; and assisting youth in developing skills to maintain stability.
      - 21 of the 144 youth (15 percent) demonstrated intensive engagement for a period of at least six months by accessing Connections coaching and Seeking Safety curricula, vocational training, and/or short-term stabilization housing.

   b. Foster/at-risk youth non-engaged TAY are at an elevated risk for mental illness compared to their age peers:
      - 18 youth out of 100 (18 percent) who showed improvement in areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care behaviors, Healthy Development, Protective Mechanisms and Resiliency.
      - 18 youth out of 100 (18 percent) showed improvement in five relational competency areas including empathy, social conduct, expression of emotion, impulse control and insight.

c. TAY do not effectively engage in available resources:
   - 29 youth out of 150 (19 percent) demonstrated sustained or increased productivity by enrollment in school, college, training program, community service program or employment.
   - 18 youth out of 100 (18 percent) showed improvement in five relational areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care behaviors, Healthy Development, Protective Mechanisms and Resiliency.

d. There is a lack of coaching, mentoring and teaching TAY on identifying goals that directly connected to their passion and motivators:
   - 52 youth out of 150 (35percent) demonstrated progress towards meeting one or more life plan goals in the areas of Safety, Health and Wellness, Education, Employment, Self-Sufficiency, and Stability.
   - 21 youth out of 100 (21percent) demonstrated intensive engagement for a period of at least six months who accessed connection coaching and either Seeking Safety curricula, vocational training, and/or short-term stabilization housing.
   - While required to engage a minimum of 40 youth, 168 youth participated in leadership and development activities.
   - 1,424 duplicated youth attended skill-development workshops, classes, or support groups at the TAY Academy Centers.

e. There are insufficient support resources for at-risk, non-engaged youth and Foster TAY.
   - 29 youth out of 150 (19 percent) demonstrated sustained or increased productivity by enrollment in school, college, training program, community service program or employment.
   - 18 youth out of 100 (18 percent) showed improvement in five relational areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care behaviors, Healthy Development, Protective Mechanisms and Resiliency.

2. Learning Objective (#2): We sought out to learn whether this type of community integration program improves TAY outcomes by:

a. Increasing the engagement and retention rates of foster youth in supportive transitional activities:
   - 75 former foster youth created vision plans, accessed connection coaching, and increased their engagement in supportive transitional activities. (Creating vision plans is a requirement of the State of Work (SOW), although there was no minimum expectation.)
   - 34 youth out of 818 (4 percent) were current or transitioning foster youth transitioning out of the foster care system.

b. Assisting TAY youth in developing goals and life plans; reducing the number of youth/TAY that would need to transition to Adult specialty mental health services:
   - 96 TAY Academy youth, per SOW, were to be assisted in developing life plans that may have reduced the number of TAY that would transition into Adult Mental Health Services. (This number is out of the total number of youth who accessed connection coaching who demonstrated need for vision planning and had their needs met through that Connection Coaching and did not require additional referral to the Behavioral Health System of Care.)

- 52 youth out of 150 (35 percent) demonstrated progress towards meeting one or more life plan goals in the areas of Safety, Health and Wellness, Education, Employment, Self- Sufficiency and Stability.
- 18 youth out of 100 (18 percent) showed improvement in areas that support reduced engagement in the Children or Adult Mental Health Systems of Care such as: Self Care Behaviors, Healthy Development, Protective Mechanisms and Resiliency.

c. Increasing the number of youth/TAY that transition out of the Children's and Adult Systems of Care that participate in transitional activities:
   - TAY Academy reported 18 out of 21 youth (86 percent) who engaged for at least six months with a Connections Coach, showed improvements in areas that support reduced engagement in the Children's or Adult Mental Health System of Care, including self-care, healthy development, positive mechanisms and resiliency.

d. Providing the support that TAY need to navigate resources; increasing youth/TAY participation in school and/or employment:
   - 29 youth out of 150 (19 percent) demonstrated sustained or increased productivity by enrollment in school, college, training program, community service program or employment.
   - 24 youth out of 50 (48 percent) were accepted into the Eco-Eventerprise or NAVSUP Programs. Of the 24 youth, nine (38 percent) completed initial training for Eco-Eventerprise or NAVSUP Programs. No youth were employed after six months; including employment by Eco-Eventerprise or NAVSUP.
   - Twenty seven (27) youth who received vocational training, including those participating in Eco-Eventerprise and NAVSUP programs.

e. Reducing re-hospitalizations, legal system involvement, incarceration and homelessness:
   - 5 youth out of 100 (5 percent) who had prior legal system involvement demonstrated reduced criminal activity.
   - 30 youth out of 30 (100 percent) received stabilization housing.
   - 91 youth obtained housing other than TAY Academy stabilization housing.

f. Increasing healthy behaviors:
   - 28 youth were connected to a medical home and received medical check-ups and/or physicals. In addition, numerous youth engaged in classes/groups/programming that actively engaged youth to increase healthy behaviors.
   - Healthy behaviors can be documented in acquisition of housing, employment, and through participating in leadership.
     - Housing – 91.
     - Employment – 27 youth out of 75 (36 percent) received vocational training
     - Leadership – 168 youth, while only 40 were required, participated in leadership and youth development activities.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**
   The program did not expend their full start-up budget, and, as a result, funding was reduced during the first fiscal year in the amount of 207,607 dollars. This changed the program's annual contract amount from 1,812,706 dollars to 1,605,029 dollars.

2. **Impact on Participants:**
   The youth who were surveyed noted that they strongly agreed or agreed with the statement that "TAY Academy staff understands how to work with youth". Youth are heard, respected and valued, involved in making decisions about activities, feel free to share their opinions and ideas about the Academy with staff, and there is a culture of acceptance for differences at TAY Academy.

3. **What Was Learned:**
   - Current and former foster youth gained support through the Extended Foster Care (AB 12) Units (HHSA Child Welfare)
   - Leading from behind and allowing the youth to be the expert of their own experience was successful.
   - That a drop-in model appears to not lend itself to support a consistent and sustained impact over time. The model does not have the capability to track the TAY life goals/needs and long-term well-being.

   Year 2: Fiscal Year 2013-2014
   - Reduce housing funding by 50 percent due to decreased utilization.
   - Redirect Eco-Eventerpsise (vocational training) component to another model (to be determined).
   - Consolidate sites.
   - Change service delivery model to more effectively engage Extended Foster Care (EFC) youth.
   - Ensure that the tracking system is gathering needed learning information and/or contract with another evaluator.

4. **Recommended for Replication? YES**
   This program structure has been successful for engaging homeless TAY for a short period of time. The recommendation would be to replicate the program with the addition of a housing support specialist to effectively link homeless youth to housing and community resources over a longer period of time to track effectiveness. In addition, the recommendation is to provide services that target high risk EFC youth, to prevent homelessness, and a successful transition to adulthood.

5. **Lessons Learned in Implementation:**

   a. Housing was a barrier and did not get implemented until four months into the program issues included:
      - Gaining acceptance from the renting agency.
      - Identifying youth.
      - Difficulty in monitoring housing.
      - Housing utilization rate was approximately 53 percent.

b. The employment component (Eco-Eventerpize) experienced several unanticipated challenges
   - Youth could not access the training /classes due to transportation issues.
   - Youth tended drop from the program after first paycheck.
   - Youth did not attend the program if they didn't feel they were doing well.
   - Youth did not consistently access all programs at the expected volume and, consequently, the outcomes were difficult to achieve.

c. Measuring outcomes/performance was an issue:
   - Database was not operational until six months into the first year of contract.
   - Data were tracked inconsistently and did not produce the consistent measurements or results.

6. Program Cost Effectiveness:

TAY Academy had a total of 818 unduplicated youth attend five TAY Academy sites and 17.5 direct-staff positions which is a direct staff-to-TAY ratio of 1 to 47. It should be noted that the unduplicated youth goal for the fiscal year 2012-2013 was 200, which would have been a direct staff-to-client ratio of 1 to 11. Cost per client was 1,962.14 dollars (1,605,030.52 dollars for 818 youth).

Next Steps/Recommendations

Program evaluation outlined the need for additional learning with modifications to the current program design.

Mental Health Services Act Innovations Projects
INN-08 Independent Living Facilities Evaluation 2013

Program Name: **Community Health Improvement Partners – Independent Living Facilities**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   a. To promote the highest quality Independent Living (IL) home environment for adults with severe mental illness, and to promote support, wellness, and recovery to IL residents.
   b. The Independent Living Association (ILA) represents the core of the Independent Living Facilities (ILF) Project. The ILA includes criteria for membership, rating levels for facilities based on adherence to ILA quality standards, education for IL owners and residents, membership development, and a focus on sustainability.

2. **Explanation of Purpose:**
   The ILA is a free, voluntary membership organization for IL owners with membership benefits.

Learning Objectives

1. **Learning Objective (#1): Create a set of quality standards for IL homes.**

What We Hoped to Learn: IL owners would be open to ILA membership and thereby adopt a baseline level of quality standards that all IL members would adhere to in order to create a better standard of living for IL residents.

What We Learned: To date, there are 24 active members and several more that are still going through the membership process. IL owners have worked or learned to successfully collaborate with other community organizations, law enforcement partners, hospitals and behavioral health partners. Having established standards has been critical to program success.

2. **Learning Objective (#2): Create an ILA Online Directory to include an online database of ILA-approved homes, and to provide exclusive tools and resources to IL owners to help them improve the quality of their business.**

What We Hoped to Learn: Behavioral health consumers, family members and the larger community would utilize a searchable online database that would provide a centralized resource to help consumers, family members, and the larger community to find information about the quality of the IL options in the county. ILA members would utilize the online directory to provide marketing opportunities and referral sources for owners.

What We Learned: The online directory is successfully being utilized according to its design. According to the Google Analytics data cited from the ILA's term one evaluation report, the results thus far have been promising. According to the data, the site has had 3,400 visits: 58.7 percent were first-time visitors and 41.3 percent were returning visitors.

3. **Learning Objective (#3): Create a Quality Measures and Peer Review Accountability Team (PRAT)**

What We Hoped to Learn: The ILA quality standards (developed by the ILA work team) would create a foundation for ensuring transparency and consistency in the process of determining which IL homes qualify to be ILA members. Through these quality standards, the ILA hopes to improve outcomes for IL residents and help residents, their families, and service providers choose the most appropriate and acceptable housing option. PRAT is made up of owners and residents, and serves to ensure that all ILA members adhere to the quality standards and provide ongoing feedback.

What We Learned: Since the program's inception, there have been 20 PRAT inspections. Sixteen homes met the quality standards on the first inspection and four were advised to make changes to meet the standards. PRAT is able to provide support to the homes that do not meet the standards. Constant review and comparison of inspections has helped PRAT standardize inspections and make improvements on the current inspection process.

4. **Learning Objective (#4): Provide ongoing education and training for IL owners and residents.**

What We Hoped to Learn: Providing education and training on an ongoing basis for both IL owners and residents will help improve the standards of IL homes and promote high quality facilities. The training programs are designed to increase knowledge about IL homes, ILA Quality Standards, and other topics that contribute to increasing the quality of IL operations for owners and residents.

What We Learned: Since the program's inception, the ILA has conducted 32 training courses for participants, including: 104 owners, 167 residents, 51 trainers, and 217 community members. Results from the pre- and post-tests indicate positive results and exceed the contract's outcome objectives. Based on evaluations, training participants indicated that they were very satisfied with the course content and trainers.

5. **Learning Objective (#5): Advocacy and Systems Change**

What We Hoped to Learn: An advocacy and systems change component will focus on educating policy makers and community members in order to reduce discrimination and ensure that the rights of IL owners and IL residents are protected.

What We Learned: To be determined as this will be more of a focus in term two.

Analysis of Program Effectiveness

This program has an end date of June 30, 2015; an analysis of program effectiveness will be conducted upon the conclusion of the program.

Next Steps/Recommendations

Yet to be determined as program continues through the fiscal year 2014-2015.

Mental Health Services Act Innovations Projects
INN-09 Health Literacy Evaluation 2013

Program Name: **Health Literacy- Implementation on Hold**
Program Start Date: **N/A**
Program End Date: **N/A**

Mental Health Services Innovations Projects
INN-10 In-Home Outreach Teams (IHOT) Evaluation 2013

Program Name: **In-Home Outreach Team Program**
Program Start Date: **January 2, 2012**
Program End Date: **December 31, 2014**

Purpose

1. **Purpose:**
   The purpose of the mobile In-Home Outreach Teams (IHOT) is to provide in-home outreach and engagement services to individuals with Severe Mental Illness (SMI) who are reluctant to seek outpatient mental health services, and to their family members or caretakers.

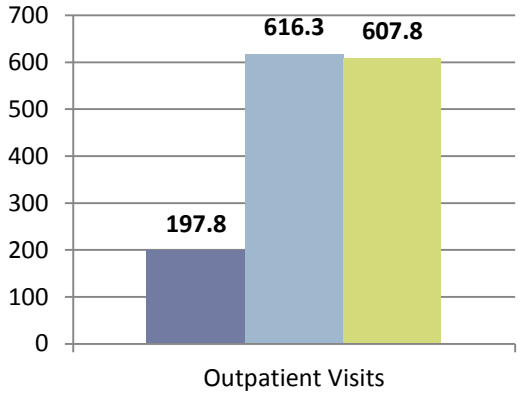
2. **Explanation of Purpose:**
   IHOT teams will provide in-home assessment, crisis intervention, short-term case management, and support services (including information and education about mental health services and community resources; linkages to access outpatient mental health care; and rehabilitation and recovery services among others) to individuals with SMI and their family or caretaker, as necessary. These services are expected to increase family member satisfaction with the Mental Health System of Care, as well as to reduce the effects of untreated mental illness in individuals with SMI and their families.

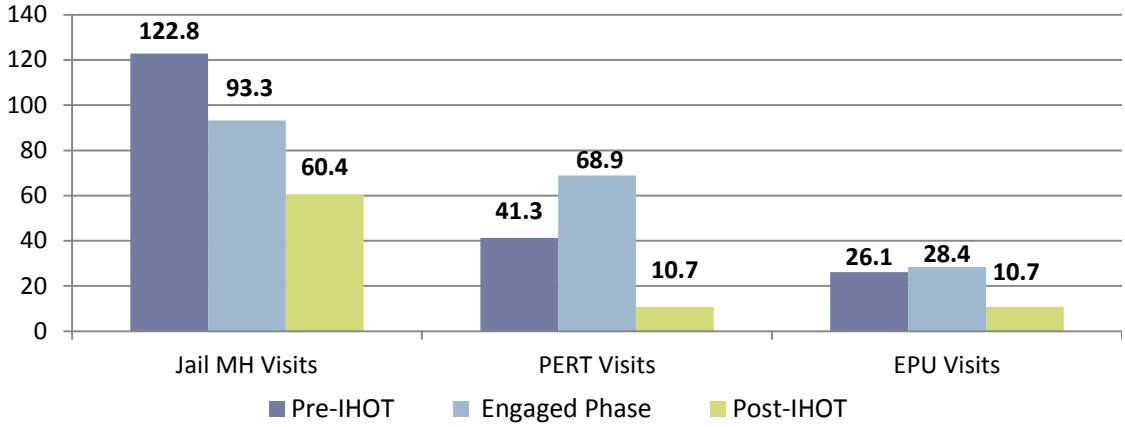
Learning Objectives

1. **Learning Objective (#1): Providing an in-home outreach and engagement service will allow individuals with SMI, who have resisted traditional means of accessing services, a greater knowledge of the system and be more comfortable accessing or accepting outpatient mental health services.**

What We Hoped to Learn: By providing this service, individuals with SMI would be more likely to access or accept outpatient mental health services, thus reducing unnecessary hospitalization and/or criminal justice interaction, and would reduce the instances of individuals with SMI "falling through the cracks".

What We Learned: The service utilization patterns suggest that participation in IHOT is associated with the desired trends of increased outpatient mental health treatment and reduced utilization of the high severity, high need services such as PERT, EPU, and hospitalization as noted in the charts below.





2. **Learning Objective (#2): Bringing services to the participant and family will increase family member knowledge of and enhanced satisfaction with the mental health system of care.**

What We Hoped to Learn: By providing these outreach and education services, families will have a better understanding of the mental health system and how best to approach acquiring needed services for their loved one as well as experiencing a sense of support and encouragement.

What We Learned: Results of the received satisfaction surveys indicate that out of 9 family members who completed the satisfaction question, 100 percent agreed with the statement, "Overall, I/we are satisfied with the services my/our family member received here", with 66.7 percent strongly agreeing. Out of 7 participants/family members who completed the satisfaction question, (100 percent) agreed with the statement, "Overall, I am satisfied with the services I received here", with 85.7 percent strongly agreeing. In addition, the program has received numerous letters from family members thanking the program for the assistance received by IHOT.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**
   According to the workloads, it was determined that an additional 1.0 full-time equivalent (FTE) data analyst would be needed to track the data provided by the field staff.

Demographics of IHOT participants: males comprised the majority of persons accepted into IHOT (58.6 percent). Caucasian was the most common racial/ethnic category (62.1 percent). Approximately three quarters (75.6 percent) of the IHOT participants were between 25-59 years old, with some representation among both TAY and older adults. Schizophrenia/Schizoaffective Disorder represented the most common diagnosis for the IHOT participants (52.3 percent), followed by Bipolar Disorder (17.2 percent). Slightly over a third (36.8 percent) were identified as likely having a substance abuse related disorder. Referrals came from many sources, but referrals from family members were most common (54.6 percent).

2. **Impact on Participants:**
   With the addition of a data analyst, staff time was freed up to allow more time in the field interacting with participants, and clinical staff had more time for necessary case consultation and supervision with staff about participant and family situations.

3. **What Was Learned:**
   The program services have been very well received in each of the regional catchment areas. Knowledge of the IHOT services has become widespread, with over 30 percent of incoming referrals coming from outside of the program's catchment areas. It is evident that there is a need for these services to be available in all County regions.

4. **Recommended for Replication? YES**
   The program would benefit from an additional 1.0 FTE licensed clinician to be available for face-to-face screening should a participant be eligible and amenable to receiving services. Services should also be available Countywide.

5. **Lessons Learned in Implementation:**
   See narrative above.

6. **<u>Program Cost-Effectiveness</u>:**

   It was determined that additional data staff was needed to maintain the expected scope. In addition to administrative staff, three IHOT teams each consist of a case worker, a peer staff, and a family coach. Moving forward, there will be an additional licensed clinician to provide the face-to-face screening of those deemed eligible. Unfortunately, the number of **family** members served was not tracked in the initial year of the program, only the identified participants who were referred, accepted for outreach, and engaged. Therefore, the metric for the initial year of the program (dividing budget/participants) is not inclusive of everyone served. For year one of the program, 174 participants were accepted into the program. Budget for year one (less startup costs) = 1,109,097 dollars/174 = 6,374 dollars per participant on average.

Next Steps/Recommendations

Program evaluation outlined need for additional learning through a continuance of current program for a designated time period.

APPENDIX E – EXCERPT FROM County of San Diego Health and Human Services Agency Adult/Older Adult Behavioral Health Services Five Year Strategic Housing Plan FY 2013-14.pdf)

County of San Diego
Health and Human Services Agency
Adult/Older Adult Behavioral Health Services

Five Year
Strategic Housing Plan
FY 2013-14

Table of Contents

Executive Summary

Housing is a critical resource for achieving health and wellness, particularly for people with limited means who struggle with behavioral health issues. This Five Year Strategic Behavioral Health Strategic Housing Plan outlines a planning process, and the local needs and resources that contributed toward the development of Five Year Goals that will maximize housing options for people with behavioral health issues in San Diego County.

This Plan was developed through a robust stakeholder process that included input from consumers, service providers, housing developers and operators, and funders of housing and services. Throughout the plan we analyze the importance of housing in achieving recovery, while mapping out local housing needs as well as the resources and tools available to meet those needs. This Plan also specifically recognizes the importance of the Mental Health Services Act in transforming the range of housing and services options to those who were previously unserved or under-served in our communities. The specific Five Year Goals are to:

1. Expand Inventory of Affordable and Supportive Housing
2. Increase Access to Independent Living Options
3. Provide Opportunities to "Move On" To More Independent Housing Options
4. Expand Opportunities to Increase Income (Employment and Benefits)
5. Lessen Isolation and Keep People Connected to Their Communities
6. Develop Improved Data Collection and Analysis Capacity

The Plan then defines the key strategies and activities to undertake over a five year period in order to achieve these goals, as well as a process to evaluate and update the Plan on an annual basis, creating a living document that reflects and responds to the changing housing and services environment in San Diego.

Chapter 5: Mental Health Services Act Housing Program

The Mental Health Services Act (MHSA) Housing Program has transformed the range of housing options for people with serious mental illness in San Diego County. MHSA is funded through a 1% income tax on personal income over $1 million to be used for mental health care in California. MHSA's goal has been to transform the mental health system in California so that those who are unserved or under-served can access responsive client- and family-centered care that is oriented toward wellness and recovery. In addition, MHSA explicitly recognizes that a lack of housing for individuals with mental health issues is a barrier to wellness and recovery, and in San Diego $33 million was dedicated to the creation of new supportive housing units. The resources of the MHSA Housing Program have brought many new housing and services partners together to create unprecedented integrated affordable and supportive housing options across the County. Since the implementation of the program in San Diego, the following results have been achieved:

- **241 units of MHSA Developed Housing:** 101 units of MHSA housing are currently open and leased up in seven housing developments across the County, with an additional 359 units of affordable housing that are integrated with these MHSA developments. The $22 million in MHSA Housing Program capital funds is leveraging over $450 million in other funding including Low Income Housing Tax Credits, State funding (SHP, TOD, Infill, etc.) and local funding (Civic San Diego, San Diego Housing Commission, Carlsbad, Lemon Grove, San Marcos) for the development of 241 MHSA units and 1,127 other affordable housing units. A map of these developments can be found in Appendix C. In addition, Civic San Diego has adopted a requirement that a minimum of 15% of units in new affordable housing developments receiving agency funding be set aside for homeless or at-risk populations. Project based Section 8 vouchers have also been leveraged in four MHSA Housing developments.

- **237 Partnership Units across the County:** Partnering with the San Diego Housing Commission, the County has leveraged its services funding to secure 135 sponsor-based vouchers (95 for persons with serious mental illness and 40 for persons with substance use issues). In addition, in partnership with the local Continuum of Care which oversees San Diego's application for federal Housing and Urban Development (HUD) Homelessness funding, 102 Shelter Plus Care vouchers provide housing subsidies for people served by County Behavioral Health Services.

- **Importance of Housing in Recovery:** Since FY 08-09, the County and their technical housing consultant, CSH, have conducted 30 focus groups with 365 MHSA FSP-enrolled clients to assess their experiences with housing and services. In addition, in FY 09-10, conducted comprehensive survey of 633 MHSA FSP-enrolled clients. Consumers consistently rate quality affordable housing as one of their greatest needs. They report that housing is the foundation to live a healthy lifestyle and achieve recovery goals. Through the annual focus groups, FSP enrollees have consistently indicated that housing has helped them achieve personal goals such as working to achieve recovery, having a sense of security, the ability to work and/or go to school, and the opportunity to take care of health issues.

- **Housing MHSA FSP Clients:** The County's goal is to have at least 85% of MHSA Full Service Partnership clients living in housing. As of December 1, 2013, the FSPs had 97% of

their clients housed with 74% of clients living in permanent housing, an increase over the previous year in which 71% of clients were living in permanent housing[12]. To make this possible BHS has integrated on an ongoing basis over $3.1 M in Community Supports and Services (CSS) funding exclusively for housing support among the Full Service Partnership. Today we have over 1,100 clients in an array of housing options.

Table 1: FSP Clients Housing Situation as of December 1, 2013

Permanent Housing	**Number**	**Percent of Total FSP clients**
Developed MHSA Units	**115**	**10%**
MHSA Leased Units	**274**	**23%**
Shelter Plus Care	**102**	**8.5%**
Clients with Project-Based Section 8	**63**	**5%**
Clients with Tenant-Based Section 8	**43**	**3.5%**
Clients in Other Affordable housing[13]	**22**	**2%**
Clients without Subsidy	**185**	**16%**
Sponsor Based Vouchers	**69**	**6%**
Total Clients in Permanent Housing	**873**	**74%**
Other Housing		
Clients living w/ Family/Friends	**45**	**4%**
Clients living in Emergency Housing	**7**	**0.5%**
Clients living in Transitional Housing	**56**	**4.5%**
Clients living in Licensed Facilities (Board and Care, Long-Term Care Hospital, Assisted Living, etc.)	**152**	**13%**
Other (streets, unknown living situation, etc.)	**51**	**4%**
Total Clients in Other Housing	**311**	**26%**
Total FSP Clients	**1184**	**100%**

[12] Housing is defined as emergency housing, transitional housing, permanent housing, skilled nursing facility, board and care, assisted living, and living with family/friends.

[13] In this table, affordable housing is permanent housing where the rents are subsidized to make them affordable to the tenant.

Continuing the MHSA Housing Program

As developers continue to apply for MHSA Housing Program funds in San Diego, the County has developed and updates annually the MHSA Housing Program Guidelines and Recommendations (found in Appendix D). These Guidelines and Recommendations outline the criteria and priorities in creating new MHSA Housing in the County.

It is important to note that the County of San Diego has committed virtually all of the $33 million of the initial allocation of MHSA Housing funds and has the option to continue to assign monies as they become available to the California Housing Finance Agency (CalHFA) to administer on their behalf. These monies can be derived from a number of sources:

- Any MHSA Housing development that has a current commitment of Capitalized Operating Subsidy Reserve (COSR) that receives a subsequent commitment of operating funds (such as Project Based Section 8 or Shelter Plus Care), will have the portion of COSR that is no longer needed for the project returned to San Diego's MHSA Housing Program fund account that is administered by CalHFA. There are several projects in San Diego that could potentially receive Project Based Section 8 in the future, depending on the availability of vouchers particularly through the San Diego Housing Commission and County Housing and Community Development

- The Housing Council has identified a goal of assigning $3 to $5 million/year to the MHSA Housing Program depending on availability of MHSA funds locally. When funds are available to assign to CalHFA, this would provide a powerful ongoing source to create additional MHSA Housing units across the county.

APPENDIX F – NON-BINDING LETTER OF ACKNOWLEDGEMENT TO CLMHSA

LETTER OF ACKNOWLEDGMENT

(Response Due by May 1, 2014)

California Mental Health Services Authority (CalMHSA)

SUSTAINABILITY FUNDING COMMITMENT BY COUNTY FOR FY 2014/15

COUNTY: County of San Diego, Health and Human Services Agency, Behavioral Health Division
ADDRESS: 3851 Camino del Rio South, San Diego, CA 92108

With this letter, the above County provides CalMHSA notice of its recommendation for funding towards Statewide PEI Projects, to be conducted in accordance with regulations and statutes that govern the Mental Health Services Act (MHSA). CalMHSA acknowledges that the submission of this Letter serves solely as notice to CalMHSA of the County's present objective and is not binding on the County, which must comply with its own procedures before providing such funding. The Letter will be reviewed by CalMHSA's Finance Committee in conjunction with development of CalMHSA's annual budget, which is recommended to the CalMHSA Board each June.

Amount of Funding by Dollar	**Amount of Funding by Percentage** (See Table 1, Annual Funding Breakdown by Percentage)
$650,000	**3%** (depending on actual revenue)

Comments regarding funding exceptions should be noted here:

The County of San Diego would like $530,000 of our contribution to be allocated to School Mental Health activities, and the remaining amount towards Suicide Prevention activities, specifically those supporting the use of "live chat" functionality at local helplines.

Comments regarding funding estimate:
(Please indicate the method by which the county determined amount in the box above)

- Estimated amount above based on **Table 1 - Annual Funding Breakdown by Percentage** table
- Amount above is inclusive of Admin, Planning, Evaluation, Program/Direct and Reserve funds

Name: Alfredo Aguirre Title: Behavioral Health Services Director
Phone Number: 619-563-2766 Email Address: Alfredo.Aguiree@sdcounty.ca.gov

TO BE CONSIDERED, THIS LETTER OF ACKNOWLEDGMENT MUST BE RECEIVED BY MAY 1, 2014.

Email To: Kim Santin, Finance Director at Kim.santin@calmhsa.org
Email Subject Line: CalMHSA Letter of Acknowledgement

APPENDIX G – STAKEHOLDER INPUT

30-Day Input

MHSA Three-Year Program and Expenditure Plan: FY 2014-15 through FY 2016-17 Stakeholder Input

	DATE	COMMENT	RESPONSE
1.	6/23/14	My only suggestions are to 1) encourage more collaboration and 2) mobility of all programs to the street level. Many agencies have their own perspective of "outreach". One of the main ones still needed is walking the streets side by side with a housing the homeless agency like PATH paired with Mental Health services. This is definitely a way to reach those who often are the most resistant, hidden from typical methods of outreach, and the most in need.	Noted. May be considered for future funding in alignment with other HHSA priorities as appropriate.
2.	6/23/14	Focus on the needs of families in the alcohol and drug treatment programs with co-occurring needs. There is a real need for more mental health counselors in the alcohol and drug treatment programs. Also there is a strong need for therapeutic sober living for families that includes mental health services for the whole family	Noted.
3.	6/25/14	Need more mental health counselors in the drug & alcohol treatment programs please.	Noted.
4.	7/15/14	Currently there are between 34-37 BHC participants, though we have had as many as 41 in recent months. We average about 9.5 referrals to BHC per month. We have to be picky about who we take because we are limited by resources. If we are above capacity, we cannot take someone who might otherwise be qualified. Additionally, there are other populations we could be providing with mental health treatment, such as higher risk offenders or lower level repeat offenders. By expanding the program, we could service a larger population and provide alternatives to custody for more people with mental illnesses. Currently we have resources to meet only once a month. An expansion of the program to include more days appearing in court before the judge would provide a firmer handle on the participants and reduce recidivism. A defendant in jail who is not assessed in time for the monthly calendar has to wait another entire month for acceptance to BHC – that's another month spent in jail instead of getting treatment. The first BHC participants became eligible to graduate in February 2013. Since then, out of 20 graduates, only 2 have recidivated (10% rate). BHC has helped dozens of transient defendants find places to live, unemployed defendants get jobs, and broken families be reunited. BHC has reduced recidivism for its participant population, thereby increasing the safety of the community and reducing costs associated with jail housing. We are requesting additional resources: • To treat more defendants • To provide an alternative to jail • To hold court more frequently • To sustain an appropriate treatment-provider-to-client ratio	The input provided is related to FSPs within the MHS component of CSS. FSPs are listed as priorities within the current Three-Year Plan. Behavioral Health Services will consider the input when planning future FSPs.
5.	7/18/14	Provide funding for the Virtual Senior Center pilot program.	Noted.
6.	7/21/14	The San Diego Housing Commission (SDHC) urges the County of San Diego to allocate Mental Health Services Act (MHSA) funds for the development of permanent supportive housing in San Diego in the next three years. The SDHC is concerned that funds have not been committed to the Community Services and Supports MHSA Housing Program in the MHSA Three-Year Program and Expenditure Plan that has been distributed for public comment.	A brief overview of Housing Program is included on page 30 of the Draft MHSA Three-Year Program and Expenditure Plan: Fiscal Year 2014-15 through Fiscal Year 2016-17. The Five-Year Housing Plan will also be included as an appendix. There are no additional funds assigned to CalHFA at this time.
7.	7/21/14	This is my personal answer to what is lacking still in our 3 Year Plan: A solution to the overlapping jurisdictions of Protection and Advocacy for Individuals with Mental Illness and privacy laws…. Maybe we should consider treating family members who are out of control with a family ACT model to give them the basic underlying structure and meds which they are missing?	Noted.

APPENDIX H - ACRONYMS

ACS – American Community Survey
ADC – Admissions and Discharge Census
ADS – Alcohol Drug and Services
API – Asian/Pacific Islander
A/OA – Adult/Older Adult
BHS – Behavioral Health Services
BOS – Board of Supervisors
CalMHSA – California Mental Health Services Authority
CBO(s) – Community Based Organization(s)
CEO – Chief Executive Officer
CFTN – Capital Facilities and Technological Needs
CMHDA – California Mental Health Directors Association
CPP – Community Program and Planning
CRU – Crisis Recovery Unit
CSS – Community Services and Supports
CYF – Children, Youth, and Families
EPU –Emergency Psychiatric Unit
FSP – Full Service Partnership
FY – Fiscal Year
HHSA – Health and Human Services Agency
IHOT – In-Home Outreach Team
INN – Innovation
KIP – Knowledge Integration Project
LWSD – Live Well San Diego
MH – Mental Health
MHSA – Mental Health Services Act
MHSOAC – Mental Health Services Oversight and Accountability Commission
MIS – Management Information System
OA – Older Adult
P3 – Policy, practice, and people
PEI – Prevention and Early Intervention
SANDAG – San Diego Association of Governments
SDCPH – San Diego County Psychiatric Hospital
SED – Serious Emotional Disturbance
SMI – Serious Mental Illness
SOC – System of Care
SSI - Supplemental Security Income
TAY – Transition Age Youth
WET – Workforce Education and Training
WIC – California Welfare and Institutions Code