Mental Health Services Act

FY 2023/2024 - 2025/2026 Three Year Plan

(FY 2021/2022 Evaluation)

PREPARED WITH

EVALCORP

Measuring What Matters

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INTRODUCTION

Mental Health Services Act

The Mental Health Services Act (MHSA) was approved in 2004 through the passage of California's Proposition 63 and was enacted in 2005, placing a 1% personal tax on incomes over $1 million. The goal of MHSA is to transform the mental health system while improving the quality of life for those living with a mental illness. The MHSA represented a statewide movement to provide a better coordinated and more comprehensive system of care for those with serious mental illness.

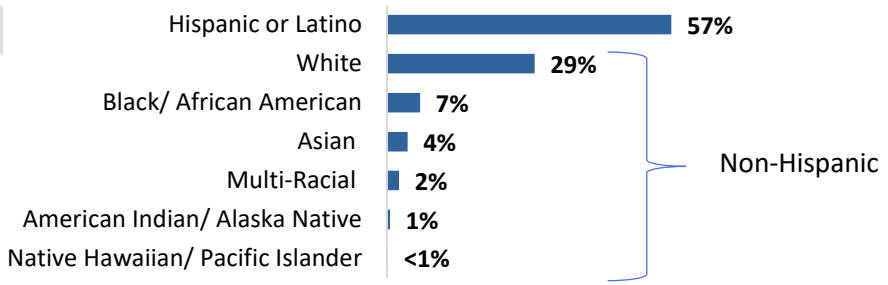
Shortly after passage of the MHSA, Kings County Behavioral Health (KCBH) was formed. KCBH's mission -- "to promote, support, and invest in the wellness and recovery of individuals living in the communities of Kings County by creating opportunities to contribute, learn, work, and find hope in each day" -- was designed to be in alignment with MHSA principals.

About Kings County

KCBH serves a geographic region covering 1,391 square miles and has a population of over 150,000 residents. The county is comprised of 11 incorporated cities, the Santa Rosa Rancheria, and the Lemoore Naval Air Station. Kings County is also home to two state prisons (Avenal State Prison and Corcoran State Prison) and the California Substance Abuse Treatment Facility (also located in Corcoran). The county seat is Hanford where 37% of the population resides[1].

More than half of the residents are Hispanic/Latino (See **Figure 1**). Other race categories may be slightly underestimated in the figure below, as Hispanic/Latino residents may report being of any race using U.S. Census categories. Additionally, a little over 40% of adults speak a language other than English at home.

Figure 1. Race/Ethnicity



Military-affiliated persons comprise an important segment of the population in Kings County given their specific mental and behavioral health needs. The Lemoore Naval Air Station is located in Kings County, and employs 7,500 active-duty military personnel, 820 reservists, and 1,800 civilians.[2] Additionally, roughly 6.5% of the county's population consists of veterans.

[1] Unless noted otherwise, all demographic data are from the American Community Survey 1-year estimates (2021)
[2] Military Installations. Naval Air Station Lemoore. https://installations.militaryonesource.mil/in-depth-overview/naval-air-station-lemoore

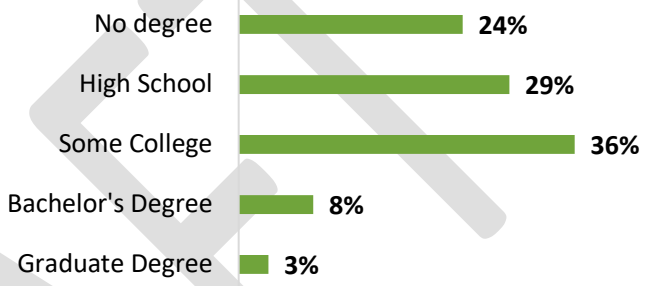
Another important segment of the population is the local Native American population. The Santa Rosa Rancheria has an estimated population of 887 individuals from the Tachi Yokut Tribe. Of those living on the Rancheria, more than 25% live below the Federal Poverty Level which is higher than the county overall.

Kings County is relatively low income compared to other counties in the state. Of households in the county, 18% live below the Federal Poverty Level (compared to 12% in California overall).

Additional county demographics are summarized below:

- Roughly 75% of residents aged 25+ have a high school degree higher educational attainment (See **Figure 2**).
- Median household income ($62,155) is about 25% less than the State median household income of $84,907.
- Unemployment rate[3] (9.6%) is higher than the state average (7.3%).

Figure 2. Educational Attainment for Residents 25+



[3] Bureau of Labor Statistics, Annual Average 2021

LOCAL STAKEHOLDER PROCESS

LOCAL STAKEHOLDER PROCESS

In accordance with California Welfare and Institutions Code (WIC) § 5848, KCBH conducted a Community Program Planning (CPP) process to engage stakeholders and gather information to support decision-making for the Annual Update. KCBH commissioned EVALCORP Research & Consulting to facilitate the CPP process activities, analyze data gathered from the community, and summarize key findings.

Methods

A mixed-methods approach was used to meaningfully involve stakeholders (including clients and their family members) in all aspects of the CPP process through a series of engagement opportunities:

- Community Focus Groups
- Community Survey
- Key Stakeholder Interviews
- Public Comments
- Behavioral Health Advisory Board Public Hearings

Collectively, these CPP activities gathered stakeholder input on mental health policy, program planning, implementation, monitoring, quality improvement, evaluation, and budget allocations in accordance with WIC § 5848.

KCBH invited participation from, and included, the following stakeholder groups in accordance with WIC § 5848 and California Code of Regulations (CCR) § 3300:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations
- Stakeholders that reflect the diversity of the demographics of the county including, but not limited to geographic location, age, gender, and race/ethnicity
- Adults and older adults with severe mental illness and/or serious emotional disturbance
- Families of children, adults, and older adults with severe mental illness and/or serious emotional disturbance
- Service providers
- Law enforcement agencies
- Educators and educational agencies
- Social services agencies
- Veterans and representatives from veteran organizations
- Providers of alcohol and drug treatment services
- Health care organizations

Each CPP activity was designed to engage stakeholders in planning, implementing, and evaluating programs using the following standards in accordance with CCR § 3320:

- Community collaboration
- Cultural competence
- Client driven
- Family driven
- Wellness, recovery, and resilience focused
- Integrated service experiences for clients and their families

The sections that follow describe each CPP activity in more detail.

Community Focus Groups

Twelve focus groups were conducted (with a total of 90 participants) in order to assess the current needs for mental and behavioral health services by community members, and how KCBH can better address needs within the county. All focus groups used a semi-structured protocol (see **Appendix**). Focus groups were purposively sampled to represent a variety of ages from youth to older adult, race/ethnicities, and regions of the county. **Table 1** provides further details about each of the focus groups.

Table 1. Summary of Focus Groups

Focus Group Type	# Participants
Adults with Serious Mental Illness	12
Older Adults	12
LGBTQ+	3
African American	7
Spanish Speakers	6
Veterans	17
Native American	6
LGBTQ+ Youth	9
Black Youth	9
Unhoused	3
Rural Residents (Corcoran)	6
Family Members of Individuals with Mental Illness	9
Total	**90**

Community Survey

The Community Survey was developed and administered online by EVALCORP in both English and Spanish from late November through December 2022. Surveys were distributed via:

- Kings County Behavioral Health website
- Kings Partnership for Prevention listserv
- Radio and social media advertisements created and promoted through iHeartMedia.

A total of 412 completed surveys were collected and used for analysis. The Community Survey is available in the **Appendix** .

Key Stakeholder Interviews

Key Stakeholder Interviews (KSIs) were conducted to gather information about the mental and behavioral health needs of Kings County residents from a systems-level perspective. Interviewees were selected in collaboration with the KCBH staff. In total, 14 interviews were conducted. Participating interviewees primarily consisted of providers that offered one or more of the following services:

- Counselling
- Crisis services
- Mental health diagnoses
- Medication
- Placement and release of 5150s
- Outreach and education
- Outpatient or inpatient services
- Referrals
- School-based services
- Support groups/programs
- Substance use/prevention services
- Housing assistance/shelters

Interviewees provided information about: (1) mental and behavioral health priorities; (2) unmet mental and behavioral health needs; (3) gaps in access to, and availability of, service provision; (4) current efforts to address these priorities and challenges; and (5) recommendations and strategies for improving the mental and behavioral health of Kings County residents. The Key Stakeholder Interview Protocol is available in the **Appendix**.

Limitations

Community engagement efforts were conducted in a purposeful way to invite input from diverse perspectives. However, feedback from the aforementioned CPP activities are not intended to be representative of all stakeholders. Qualitative data gathered through interviews and focus groups represent a sample of the lived experiences of those both providing and receiving mental and behavioral health resources within Kings County.

Additionally, COVID-19 has imposed unique challenges to data collection and community engagement. In March 2020, the global COVID-19 pandemic shut down in-person services across the nation when stay-at-home and social distancing mandates were implemented. Due to intermittent spikes of cases, virtual community engagement strategies have been relied upon to reduce opportunities for COVID-19 variants to spread. Virtual community engagement has increased access to participate in data collection activities for some who could not take time off work or travel to specified locations while reducing it for others due to barriers such as access to technology and reliable internet.

Stakeholder Participation Demographics

In total, CPP activities included more than 500 participants. **Table 2** shows the number of participants by activity. Some participants may have engaged in multiple activities.

Table 2. Participants by CPP Activity Type

Data Collection Activity	# Participants
Community Focus Groups	90
Community Survey	412
Key Stakeholder Interviews	14
Behavioral Health Advisory Board Public Hearing	TBD
Total	**516**

The data summarized in Tables 4-8 reflect the demographic profile of participants from the Community Survey. Note that demographic data was not explicitly collected from participants in the public hearing, focus groups, or interviews.

Table 3. Participants by Gender (n=397)

	%
Male	17%
Female	82%
Transgender	1%
Questioning	1%
A different gender identity	0%

Compared to County demographics (Female 44%, Male 56%), women were over-represented in community engagement efforts.

Table 4. Participants by Race/Ethnicity* (n=395)

	%
Asian	3%
Black/African American	7%
Hispanic/Latino	56%
Native American/Alaska Native	4%
Native Hawaiian/Pacific Islander	0%
White	38%
Multiracial	4%
Another	2%
*Percentages add to more than 100% as respondents could select more than one response option	

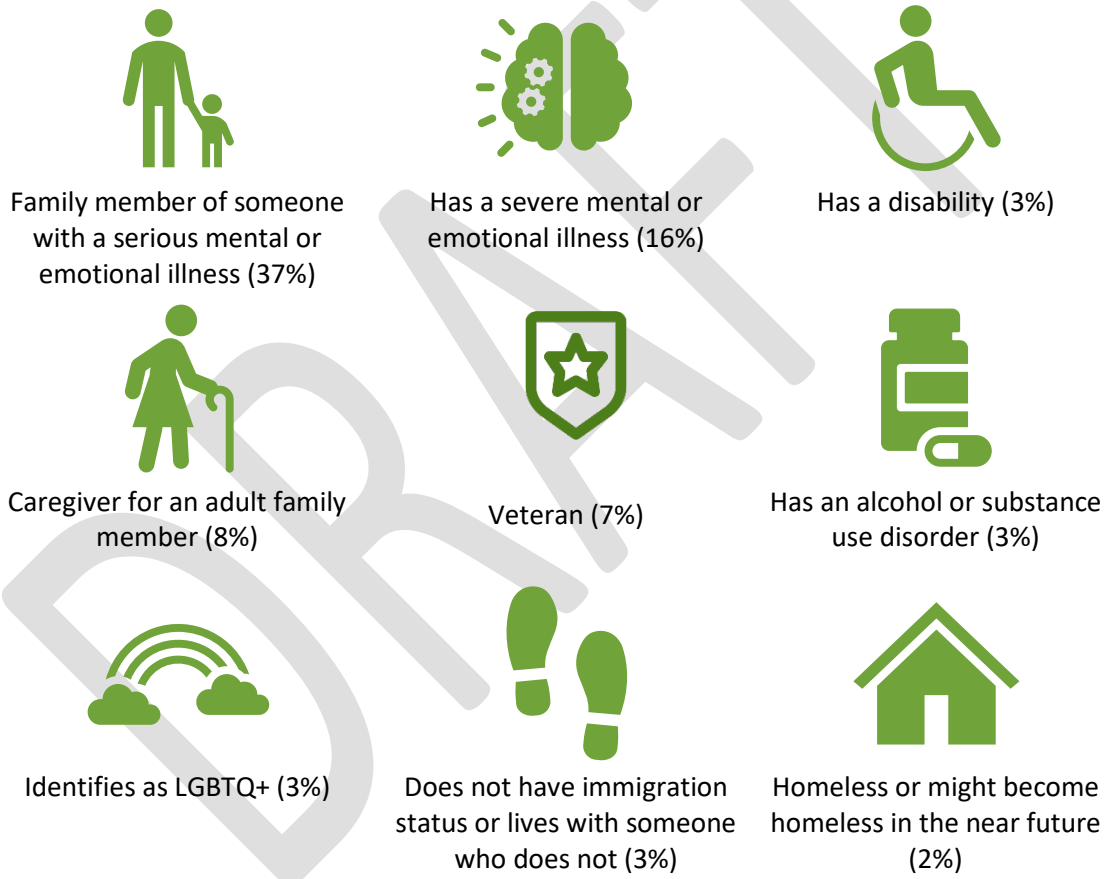
The distribution of racial and ethnic representation among participants in the community engagement process is close to that of the County overall.

Table 5. Participants by Age (n=391)

	%
18-25	5%
26-35	35%
36-45	35%
46-55	17%
55 and older	8%

Figure 3. Additional Respondent Characteristics

Of participants to this question (n=376), more than half of the respondents (77%) reported being the parent or guardian of a child under 18. Additional characteristics are visualized in the graphic below.



Key Findings

This section summarizes the top mental and behavioral health needs, causes and contributing factors to poor mental and behavioral health, barriers to accessing care, and recommended strategies that were identified in the CPP process.

Priority Mental and Behavioral Health Needs

Below are the top identified priority mental/behavioral health concerns by data collection activity.

- **Focus Groups**
  - Stress, suicidal ideation, isolation, and anger
  - Depression and anxiety
  - Substance use/misuse
- **Community Survey**
  - Alcoholism/Substance Use
  - Trauma
  - Depression
- **Interviews**
  - Assistance with basic needs (e.g. rent, electricity, food, housing)
  - Anxiety and depression
  - Aggression among school children
  - Crisis situations/hospitalizations

Causes and Contributing Factors

Below are the top identified causes and contributing factors to poor mental/behavioral health by data collection activity. This data was not collected on the Community Survey and therefore not available.

- **Focus Groups**
  - COVID-19/Post-COVID impacts (i.e. increases in anxiety, isolation, depression)
  - Economic insecurity (e.g. unemployment and homelessness)
  - Limited Support for Vulnerable Youth (i.e. those at risk for gang involvement, substance use, school suspension, suicidal ideation)
- **Interviews**
  - Financial struggles (i.e. unemployment and inflation)
  - Lack of access to services (i.e. long wait times, no drop-in clinics, limited transportation, not knowing where to go)
  - Isolation/disconnection from support systems

Barriers to Accessing Mental and Behavioral Health Care

Community engagement efforts revealed that there were barriers and/or major gaps in services that prevent residents from accessing services in the county. Below are the top identified barriers to mental/behavioral health services by data collection activity.

- **Focus Groups**
  - Limited accessibility of existing services (due to i.e. sense of unease from providers not being representative of population, long waitlists, staff turnover, costly services, location restrictions)
  - Lack of services for specific needs (i.e. topic-specific support groups, local community warm line, physical spaces for social gatherings, assistance with funeral planning or budgeting)

    - Limited knowledge of available services (i.e. uncertainty of where to go, outdated online resources, limited resources for Spanish speakers)
- **Community Survey**
    - Lack of information about where to get help
    - Stigma (against seeking help for a mental illness)
    - Limited appointment availability
- **Interviews**
    - Limited knowledge of services
    - Long wait times and limited availability
    - Difficulty navigating the health care system

Recommendations

Recommendations were provided by participants contributing to the needs assessment to address identified needs and gaps. The recommendations below are intended to inform services for all agencies county-wide and are not referring to any specific agency or service. Please note that some suggested strategies may already be implemented by one or more individuals/organizations, but additional resources may be required to adequately address the need.

Top recommended strategies to address mental and behavioral health needs in the county by data collection activity are listed below:

- **Focus Groups**
    - Expand additional specific services (i.e. home-based and onsite activities, support groups, expanded telehealth services)
    - Improve community outreach efforts (i.e. collaboration of crisis teams with law enforcement, expand outreach to younger populations at schools, improved awareness of services for needs that are "not severe" per insurance requirements)
- **Community Survey**
    - Improve access to services (i.e. increase staffing, geographic reach, and appointment flexibility)
    - Improve community outreach (i.e. inform about available services, reduce stigma)
    - Expand service options (i.e. youth-specific therapy, on-site counseling for unhoused individuals, residential substance use treatment programs)
- **Interviews**
    - Increase accessibility of services (i.e. mobile unit(s), having crisis teams in schools, having some mental health presence 24/7)
    - Expand types of services (i.e. stabilization program, crisis services, prevention services)
    - For providers and staff: increase cultural competence and knowledge of available services

The findings and recommendations suggest that, while Kings County is providing important and needed mental and behavioral health services to residents, there are unmet needs that could be addressed through further improvements to the network of county and non-county providers of mental and behavioral health services. It is clear from the recommendations provided by participants across data collection activities that these improvements should focus on ***improving accessibility of services*** (in particular, by offering on-site, home-based, and/or mobile services with flexible scheduling) and ***expanding services that support specific needs*** (i.e. substance use services, crisis services, population-

specific services or groups, employment and/or housing assistance, and wellness or prevention services).

For additional information about each data collection activity and their associated findings please refer to each activity's respective Summary of Findings (**Appendix D-F**).

Plan Proposed Modifications and Use of Community Feedback

Below is the manner in which Kings County Behavioral Health has used the valuable feedback from the community heard through various community outreach and engagement efforts throughout 2022-2023 and through the robust feedback obtain through the MHSA Community Planning Process. All proposed plan modifications for the 2023-2024 Three-Year Plan are outlined below and further expanded upon within the plan where the program may be associated.

Per California Code of Regulations, Title 9, Section 3745, a plan modification is defined as substantial change to the essential elements of a Program or Strategy or change(s) to the intended outcomes or target population.

While this is a three-year plan covering July 1, 2023 through June 30, 2026, it is noted that during 2022-2023 the Governor of California released the Mental Health Services Act Reform for voter ballot on March 2024. This Reform, if approved, could begin to impact counties and communities as early as January 2025, and will reshape MHSA Plans and eliminate the MHSA components as they are setup today which is:

- 76% of MHSA funds are to be used towards CSS programs of which a majority (51%+) are to go towards FSP-type services;
- 19% of MHSA funds are to be used towards PEI programs of which a majority (51%+) are to go towards services for those 25 years of age and younger; and
- 5% of MHSA funds are to be used towards Innovation.

The Reform revises this structure (as last released, contingent upon any amendments by the Governor or State) as:

- Housing Interventions –30%
- Full Services Partnerships (FSP) –35%
- Behavioral Health Services and Supports (BHSS) –35%
    - Includes: Early Intervention, Workforce Education and Training, Capital Facilities and Technology Needs, Innovative Behavioral Health Pilots and Projects, & Prudent Reserve
    - Outreach and engagement is an allowable service
    - At least 51% of BHSS shall be used for Early Intervention
        - At least 51% of Early Intervention shall be used to serve individuals who are 25 years of age or younger.

Therefore, the department would be remiss to not take into consideration these significant future changes and their impact to sustainability of decisions within this plan.

Expanded Hours

Based on the recommendations gleaned from the Community Planning Process related to improving accessibility of services through varied services delivery methods and flexible scheduling, Kings County Behavioral Health is reviewing the capacity of the State's new CalAIM Payment Reform initiative (was effective July 1, 2023) and its ability to potentially fiscally accommodate service delivery in the earlier morning hours, later into the evening hours, and possibly during weekend hours. However, this possible expansion of service hours does not necessarily apply to the MHSA-funded programs, because the three direct mental health treatment programs within this plan (Assertive Community Treatment Team and Adult and Children's Full Service Partnership programs) are already primarily field-based services which have the ability to provide their enrolled clients with after-hours support as needed and as applicable.

The programs in which Payment Reform may be able to allow for the fiscal ability to expand hours are the Adult Recovery Oriented Services Program (adult outpatient mental health) and the Children's Recovery Oriented Services Program (children's outpatient mental health) provided through The KIND Center. These two programs are the two primary access points for the community when initially accessing county mental health services and serve the majority of the clients receiving mental health services. Therefore, while these efforts may not impact the three MHSA-funded programs, they may inform county-review of the potential flexible scheduling among these other two primary service programs.

Expanded Community Locations and Services

As mentioned above, the three MHSA-funded programs are primarily field-based services, serving individuals at Family Engagement/Resource Centers, schools, homes, via telehealth, and other community-based locations. The KIND Center and the Adult Recovery Oriented Services Program currently offer the ability for clients to be served at locations other than their Hanford Clinic, by appointment only. However, through community feedback and this community planning process, the community would like this to be expanded to not just be by appointment only (allow a place for walk-in request for services).

Kings County Behavioral Health is in the process of a request for proposal to be released in the coming months for the Adult System of Care Programs, including, but not limited to, the Recovery Oriented Services Program (not MHSA-funded currently), the Assertive Community Treatment (ACT) Team Program (MHSA funded), the Adult Full Service Partnership (FSP) Program, the Crisis Program (not MHSA-funded), and the Adult Outpatient and Intensive Outpatient (ODF and IOT) Substance Use Disorder Services (not MHSA funded) . Within the RFPs, among the various requirement, applicants will be asked to demonstrate how they will accommodate this within Hanford, Avenal, and Corcoran, based on the varying size and needs of the communities. As well as demonstrate or speak to flexible scheduling outside of regular business hours, ability to assess and host community support groups based on community need and accessibility, and employment of providers who are culturally and linguistically diverse and representative of the community composition.

Among the various requirements within the Crisis Program RFP, will be the requirement for the program to provide call center triage and support and crisis mobile response, 24 hours a day, 7 days a week, 365 days a year..

Expanded Support Groups

Through this community planning process and during ongoing community engagement, the county recognizes the request for the county to review expansion of the support groups to communities in addition to Hanford. The possible expansion of the support groups is noted as a potential program modification to the Prevention and Wellness Program.

Wellness or Prevention Program and Population-Specific Supports

In addition to exploring the possible expansion of the Prevention and Wellness Services program listed within (Support Groups) as outlined above, based on the community feedback from the Community Planning Process on expansion of services, population-specific services or groups, post-COVID supports, and anxiety and depression especially among students, Kings County Behavioral Health proposes two other program modifications:

- Modification for the School Based Services program which has had overwhelming demand and success since first being implemented in January 2022. The program is now fully booked for fiscal year 2023-2024 due to the requests of the myriad of schools throughout the County. Therefore, expansion of and budget modification for the School Based Services is proposed to meet the demand, and provide the expanded post-pandemic adjustment and student mental health supports especially related to anxiety and depression.
- Addition of a new program targeted towards the active duty population in the area and their dependents and post-9/11 veteran population. This program would provide the privacy and to some degree anonymity this population needs to safely reach out and connect to services without fear of stigma and discrimination nor the concern of occupational impact. The goal of services would be to reduce risk factors for developing a potentially serious mental illness and help build protective factors to reduce the applicable negative outcomes as a result of untreated mental illness.

Public Review and Comments

(to be completed after public hearing)

COMMUNITY SERVICES AND SUPPORTS (CSS) PROGRAMS

FULL SERVICE PARTNERSHIP (FSP)

Assertive Community Treatment (ACT)

Status:	☐ New	☒ Continuing	☐ Modification	
Target Population:	☐ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group:	N/A	5	63	11
Total Served: 79 **Cost per person served:** $22,552				

Program Description

Assertive Community Treatment (ACT) is a multidisciplinary intensive treatment team approach which includes dedicated psychiatric care, psychotherapy, and intensive case management with connection to the community. ACT treatment reliably decreases hospitalization and incarceration while improving quality of life. The purpose of ACT is to provide individuals, who have had difficulty successfully engaging in lower-level outpatient services, with an intensive, evidence-based program, with low staff to client ratio, that decreases hospitalizations, incarcerations, and homelessness, and increases recovery, quality of life, and other psychosocial outcomes.

ACT provides the full range of treatment services in the community, including:

- Clinical mental health services including psychiatry and medication support
- Individual and group psychotherapy
- Intensive case management
- Treatment for co-occurring disorders
- Vocational/educational services
- Peer support
- Any other support the individual may need to promote their recovery using a "whatever it takes" approach

The ACT model is characterized by: Low client to staff ratios; dedicated, individualized psychiatric care, providing services in the community rather than in the office; shared caseloads among team members; 24-hour staff availability; direct provision of all services by the team (rather than referring clients to other agencies); peer support and time-unlimited services.

Population Served: ACT serves adults 18 years of age and older with serious mental illness and the highest level of need due to their risk or experience of frequent and repetitive hospitalizations and/or incarcerations, homelessness, or co-occurring disorders. ACT serves Full Service Partnership (FSP) consumers at the highest level of need.

Program Updates

<u>Activities and Outcomes in FY 2021 – 2022</u>

Referrals and/or coordination of care continue to be provided between the ACT program, Kings County Behavioral Health, the Adult Recovery Oriented and Full Service Partnership program provider - Kings

View, the Health Provider within the County Jail - Wellpath, the Probation Department, the Adult Substance Use Disorder Services Provider - Champions, Shelters, Board & Care and Room & Board facilities, and the Public Guardian's Office. Additionally, the ACT Program continue to attend the Kings County Behavioral Health Acute Care Coordination meetings every Tuesday and Thursday where case staffings are held between provider and County related to coordination of care for clients with acute care or complex care needs.

ACT served a total of seventy-nine (79) unduplicated clients for fiscal year 2021-2022, of which thirty-two (32) were referred during fiscal year 2021-2022 and forty-seven (47) were active clients enrolled during prior fiscal years. A total of twenty-eight (28) clients were discharged from the ACT program for the fiscal year, due to reasons including, but not limited to: transitioning to a lower level of care, moving out of county, and no contact/lack of engagement. On average per month, the ACT Program served fifty-three (53) clients.

The ACT program also provided housing services utilizing master leases, board & cares, room & boards, and motels for fifty-three (53) clients for fiscal year 2021-2022. During the COVID 19 pandemic, the ACT office remained opened and conducted face-to-face and telehealth services, with face-to-face sessions increasing throughout the fiscal year as the COVID-19 pandemic policies and procedures were understood to ensure safety of all. Safety plans were developed and utilized by staff.

The ACT Team received specialized training in Dialectical Behavioral Therapy (DBT) to continue to enhance their ability to serve the treatment needs of clients. Staff continued to utilize the Columbia Suicide Severity Rating Scale (C-SSRS) to preventatively respond to a client in crisis. ACT also organized a food pantry and prepared hygiene packets to provide to clients in need of hygiene products, food, and water. The program's Registered Nurse supported clients with medication management services including providing linkages to medical, dental, and psychiatric appointments.

Goals and Objectives

1) Provide treatment and care that promotes wellness, recovery, and independent living, 2) Reduce hospitalization, homelessness, and incarceration for adults with serious mental illness, and 3) Support the recovery of individuals and the development of life skills and psychosocial outcomes, including social, educational, and vocational rehabilitative outcomes.

Key Successes

The ACT referrals process was streamlined to ensure a timelier and more coordinated referral route. Programs with those who may meet the criteria for ACT services, make the referral to KCBH who then schedules the referral to be reviewed at the upcoming bi-weekly Acute Care Coordination meeting to be reviewed for appropriateness of referral, service fit for client need, and if approved, warm linking into service.

The ACT program provided housing services utilizing master leases, board & care, room and boards, and motels for fifty-three (53) clients for fiscal year 2021-2022.

Food pantry was available for clients in need of food and water, and hygiene packets were provided to clients in need of hygiene items. ACT utilized C-SSRS tool to ensure safety of a client in crisis, and provided intensive case management and support services to clients in order to reduce hospitalizations.

Program Challenges

The ACT program experienced high turnover of key staffing positions including the Program Manager, Clinical Supervisor, and Mental Health Clinicians. Additional challenges were related to the COVID-19 pandemic and the impact to the program which resulted in difficulties with engaging clients for individual treatment sessions via telephone. The COVID-19 pandemic prevented the program from offering group sessions, to ensure staff and clients' safety and wellbeing. Clients had limited access to telehealth platforms such as Microsoft Teams to engage in video/telehealth groups due to poor connection, no Wi-Fi access, and/or telephone capabilities. The COVID-19 pandemic also resulted in intermittent staff shortages due to staff and providers being sent home and/or taking extended sick leave due to exposure or illness. Limited housing resources constrained by the COVID-19 pandemic made it difficult to rapidly house clients upon their enrollment in the program.

Proposed Activities for FY 2023-2024

The ACT program will work toward the following goals and objectives for FY 2023-2024:

- Provide treatment services that promote and enhance whole person wellness and recovery.
- Provide Group Therapy and Group Rehab services to all ACT clients focused on reducing functional impairment.
- Recruit and retain quality staff including a Program Manager and Clinical Supervisor.
- Empower ACT clients through educational and vocational rehabilitation services that result in increased independent living skills.
- Continue to provide intensive, community-based services through multiple weekly contacts.
- Develop a discharge plan template to assess and effectively step clients down to lower level of care when treatment plan goals are met.
- Develop an Individualized Service Plan (ISP) template and utilize with clients to assess current needs.
- Continue to onboard student interns to increase staff recruitment and retention.
- Add additional Master Leases to ensure adequate housing capacity for clients in need.

Children's Full Service Partnership (FSP)

Status:	☐ New	☒ Continuing	☐ Modification	
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☐ Adult Ages 26 – 59	☐ Older Adult Ages 60+
Number Served by Age Group	48	52	N/A	N/A
Total served: 100 **Cost per person served:** $21,748				

Program Description

The Children's Full-Service Partnership (FSP) program offers wraparound-type services that provide an individualized, family-centered, and team-based approach to care aimed at keeping children and families together. FSP provides a coordinated range of services to support children and youth to stay on track developmentally and improve educational/academic performance, social and emotional skills, parent and family skills, and launch into adulthood.

FSP is a team-based planning process intended to provide individualized and coordinated family-driven care to increase the "natural support" (as they define it) available to a family by strengthening interpersonal relationships and utilizing other resources that are available in the family's network of social and community relationships. FSP requires that family, providers, and key members of the child or youth's social support network collaborate to build a creative plan that responds to the particular needs of the child/youth and their support system. FSP services should build on the strengths of each child/youth and their support system and be tailored to address their unique and changing needs.

Services may include:

- Mental health treatment, including individual and family/group therapy
- Alternative treatment and culturally-specific treatment approaches
- Family support including respite care and transportation to children/youth for their mental health appointments

Population Served: FSP serves children and transitional age youth (TAY) ages 6 to 21 years old with severe emotional disturbance or serious mental illness. Children and youth may be at risk of or are transitioning from out-of-home placement, are engaged with child welfare, and/or juvenile justice, or are at risk of homelessness, incarceration, or hospitalization as they transition into adulthood.

Program Updates

<u>Activities and Outcomes in FY 2021 – 2022</u>

- Increase in services; clients are being seen 2-4 times weekly by staff.
- Use of a "Whatever it takes" approach to assist families in preserving child stability in the home while working collaboratively with family
- Increased Child Family Therapy (CFT) meetings and services in the community or home to increase service connectedness for those enrolled

- Continued 24-hour on-call support and FSP services provided based upon the Pathways to Mental Health Services Core Practice Model (CPM) to assist in goals and objectives of program

Goals and Objectives

1) Reduce out-of-home placements for FSP enrolled children/TAY, 2) Increase service connectedness for FSP enrolled children/TAY, and 3) Reduce involvement in child welfare and juvenile justice.

Key Successes

- Hired 2 bilingual Support Counselors, 2 Parent Partners, 2 Clinicians, and 1 Compliance Specialist
- Program Manager position was filled for FSP as of March 2022
- Participated in monthly Quality Assurance Committee meetings
- Participated in Kings Partnership for Prosperity outreach video
- Participated in the Kings County Resource Fair
- Referrals have increased from last reporting period: Forty-nine (49) client referrals received with no referrals declined.
- One hundred (100) unduplicated clients served in fiscal year 2021-2022.
- Fifty-seven (57) youth/TAY successfully completed their goals and transitioned to a lower of care (The KIND Center)
- Participated in transition (step down to lower level of care) meetings to increase warm linkages between youth/TAY and new Recovery-Oriented Services provider, The KIND Center
- 83% of clients discharged maintained/decreased their level of placement and decreased their level of safety risk. This is consistent with the previous fiscal year findings
- Parent Cafes were hosted monthly, as two additional parent partners were hired during this time period
- Increased number of CFTs due to the provision of Intensive Case Coordination (ICC) Services and the increase in census: over 153 CFTs were facilitated by FSP
- Implemented the use of the Praed Foundation's Child and Adolescent Needs and Strengths (CANS) functional assessment tools
- All clients received CFTs at intake, discharge, and at important events in treatment
- FSP provided services at Red Ribbon Week for elementary and middle schools in Kings County
- FSP services are provided 100% outside of the clinic, in the home, school, or community setting
- All schools areas in Kings County are being served. Areas included: Corcoran, Lemoore, Hanford, Armona, Kettleman, Avenal, Stratford, Shelley Baird, Learn 4Life and community day schools.

Program Challenges

- Lower referral rate during change in Recovery-Oriented Services Children's provider in January 2022
- Youth/TAY needing to remain enrolled in FSP once goals have been met, due to delay in ability to transition medication services

Proposed Activities for FY 2023 – 2024

- Increase linkage and consultation amongst FSP providers
- Continue to implement the use of CANS with CFTS, Mental Assessments, and Plans of Care
- Identify youth/TAY who qualify for Intensive Home-Based Services (IHBS) for consideration of enrollment into services.

Adult Full Service Partnership

Status:	☐ New	☒ Continuing	☐ Modification	
Target Population:	☐ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group	N/A	10	99	21
Total served: 130 **Cost per person served:** $33,910				

Program Description

The Adult Full-Service Partnership (FSP) program engages individuals 18 years of age and older with serious mental illness (SMI) into intensive, team-based, and culturally appropriate services in the community with a low staff to consumer ratio. FSP provides a "whatever it takes" approach to promote recovery and increased quality of life, decrease negative outcomes such as hospitalization, incarceration, and homelessness, and increase positive outcomes such as increased life skills, access to benefits and income, involvement with meaningful activities such as education and employment, and socialization and psychosocial supports.

FSP provides a full range of clinical and non-clinical services, including:

Clinical Services

- Mental health treatment, including individual and family/group therapy
- Alternative treatment and culturally specific treatment approaches
- Peer support: Incorporating people with lived experience into a person's treatment plan
- Full spectrum of community services to aid the client in attainment of goals as identified in a Plan of Care (POC)
- Crisis intervention/stabilization services

Non-clinical services and supports:

- Supportive services to obtain, where needed, employment, housing, education, and health care including, but not limited to, primary care and substance use disorder services
- Referrals and linkages to community-based providers for other needed social services, including, but not limited to, housing and primary care
- Family education services
- Respite care

Population Served: The Adult FSP program serves adults (18) years of age and older with serious mental illness who are unserved or underserved and at risk of or experiencing homelessness, incarceration, or hospitalization.

Program Updates

<u>Activities and Outcomes in FY 2021-2022</u>

The Adult Recovery Oriented Services (lower level of care than FSP) provider, Kings View, identified clients who met FSP criteria during the course of Recovery Oriented Services wherein the client may have demonstrated a higher level of care need, or as a client was assessed at entry into Recovery

Oriented Services and had treatment needs that were more appropriate for a higher level of care program. These clients were referred to the Kings View FSP Team. Focus by the FSP program geared towards engagement, commitment strategies, collaboration with support systems and community partners to assist client in acquiring the appropriate level of care. Individual and group services are provided to clients by working with a treatment team involving a therapist, case manager, peer support specialist, and medical providers to assist client in stabilization efforts and management of their mental health symptoms.

- Weekly case staffing occurred at minimum twice weekly to help with supporting treatment team and ensure quality clinical services were being provided.
- Resumed in-person services that also included providing hybrid model, integrating telehealth and field visits based on consumer needs amidst ongoing COVID-19 pandemic.

Goals and Objectives

1) Continue to screen and refer clients to FSP program, as appropriate, 2) Develop an informational handout for staff to use with clients and their support systems for engagement/commitment with the FSP program, and 3) provide an increase in telehealth services, including group services via HIPAA-compliant platforms in response to the pandemic.

Key Successes

- Launched of an introductory engagement group to strengthen commitment amongst clients, including providing psychoeducation regarding Full-Service Partnership approach.
- Hiring of a Peer Support Specialist to enhance the treatment team capacity and client service experience.
- Supported Dialectical Behavior Therapy (DBT) training in May 2022 to further assist with staff development.
- Revitalized DBT Friends & Family skills group to help provide support with additional resource for a client's support system as well as community partners.
- The FSP Program attended partnership community meetings, and provided community education at events to promote mental health awareness.
- Increased program to over targeted goal of 100 as seen in number of consumers served (130) this fiscal year (July 1, 2021-June 30, 2022).

Program Challenges

Housing and residential facilities to assist with the housing needs of clients is an ongoing challenge due to limited options in the County.

As is common with higher level of care programs due to the complex needs of clients and the intensity of services, provider burnout and shortages are a challenge, and with shortages come higher caseloads. These challenges were experienced during 2021-2022 at times. As program grew, the total number of staff was not able to also increase at the same rate due to budget limitations.

Proposed Activities for FY 2023-2024

- Continue to provide staff trainings to increase skills set: Trauma and Psychosis related training

- Continue to expand the availability of virtual groups, in-person groups, and services in the outlying areas of the County
- Work on creating homeless packages to be able to distribute to those the program serves who are unhoused
- Add additional Consultation Meeting weekly for Licensed Clinicians ("Licensing Corner") to provide further support to help with reducing burnout and compassion fatigue due to not having an outlet for the peer support as a clinical supervision setting does for our non-licensed staff.
- Peer Support State Certification and Training for Peer Support Specialist staff.

GENERAL SYSTEMS DEVELOPMENT

Collaborative Justice Treatment Court (CJTC)

Status:	☐ New	☒ Continuing		☐ Modification
Target Population:	☐ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group	N/A	3	12	0
Total served: 15 **Cost per person served:** $17,863				

Program Description

Collaborative Justice Treatment Court (CJTC) aims to divert consumers with mental health and co-occurring disorders from incarceration into treatment by engaging and connecting participants to the services and support they need thereby reducing the likelihood of future offenses. CJTC provides for four specialty court calendars, including Behavioral Health, Co-occurring Disorders, Drug, and Veterans.

CJTC uses the drug court model with an integrated trauma-informed approach that provides clients with access to a continuum of alcohol and other drug services and mental health treatment. Collaborative courts operate under a collaborative model in which the judiciary, prosecution, defense, probation, law enforcement, mental health, and treatment communities work together to assist individuals so they can recover and go on to live productive lives. Collaborative court offers an alternative to incarceration, while addressing the underlying causes of criminality through providing programming and services that appropriately address the needs of individuals with mental health, substance use, and co-occurring disorders. In recently published literature, drug courts are developing a solid evidence base, demonstrating their effectiveness in reducing crime, combating substance use addictions, preserving families, and saving taxpayers money.

CJTC services are provided through the Adult Full Services Partnership program, which offer CJTC clients the following services:

- Substance use and mental health treatment
- Transportation support
- Employment services and job training
- Case management
- Housing support
- Peer-to-peer support services

Population Served: CJTC serves individuals whose mental health and/or substance use has led to criminal justice involvement and whose offenses and level of risk are eligible for participation in a specialty court program.

Program Updates

<u>Activities and Outcomes in FY 2021 – 2022</u>

Participants participate in regular court appearances before the judge. Treatment includes weekly individual or group counseling sessions, probation check-ins, random drug and alcohol testing, and weekly attendance at recovery support/self-help meetings. During the second half of the fiscal year (January 2022-June 2022), the number of clients screened and referred to the CJTC program increased from 2-4 per month to 8-10 per month. The redesign of the CJTC program was completed and implemented during 2021-2022 wherein the length of the program was changed from 18 months to 52 weeks. The revisions to the CJTC handbook have been an easy transition for the CJTC treatment team and the clients.

Goals and Objectives

1) Assist individuals with mental health needs as well as total abstinence from alcohol and illegal drugs to live a clean and sober lifestyle, 2) Provide the resources needed for a successful reentry into the community, 3) Provide money management education to help participants budget their funds for food, clothing, shelter, and personal needs, 4) Offer employment and educational tools and resources to help with resume building, job seeking, and links to community education resources

Key Successes

- The ability to connect with participants via telehealth for the delivery of case management, groups, and therapy services during the COVID-19 pandemic.
- Some participants were accepted and completed residential/inpatient programs.
- CJTC personnel were able to drug test participants to assist with compliance in the program.
- CJTC personnel had participants successfully complete the program even through the pandemic.
    - Graduated four (4) clients in the Collaborative Justice Treatment Court (CJTC) program
    - A graduation ceremony was held in the fall of 2021 via Zoom for participants that completed the program.
    - One successful graduate was able to take over the family business, purchase his own vehicle, and purchase a home.
    - Another graduate secured full-time employment and experienced family reunification.
    - Clients continued to utilize mental health services after graduation from the program.

Program Challenges

The COVID-19 pandemic impacted the delivery of services, including not being able to see clients in person. Some clients did not have access to the internet or a reliable internet connection. During the first half of the fiscal year (July 2021-December 2021), the number of referrals to the program were impacted by the challenges of the pandemic, which contributed to low enrollment in the program during this time.

Proposed Activities for FY 2023-2024

For the coming fiscal year 2023-2024, CJTC plans to host a graduation ceremony that is scheduled for the fall of 2023 for participants who have successfully completed the program.

Mental Health Services for Domestic Violence Survivors (Barbara Saville)

Status:	☐ New	☒ Continuing	☐ Modification	
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served in FY 2021-2022 by Age Group	43	20	37	6
Number of individuals served in FY 2021-2022: 106 **Cost per person served in FY 2021-2022:** $1,052				

Program Description

The Barbara Saville Shelter (BSS) provides a safe and secure living environment for individuals seeking refuge from domestic violence and/or homelessness due to unforeseen circumstances and situations. The Shelter provides case management and linkage services for individuals experiencing mental health challenges and are residents of the Barbara Saville Shelter.

The program provides case management services and linkage to other supports to address issues related to trauma, domestic violence, and homelessness.

Population Served: Barbara Saville Shelter serves individuals seeking refuge from domestic violence and/or, who are homeless due to unforeseen circumstances and situations. Case management and linkage services are provided for anyone (adult or their child(ren)) experiencing mental health challenges and are current shelter residents.

Program Updates

Activities and Outcomes in FY 2021 – 2022

- BSS provided Adult Case Management to over fifty-three (53) clients in FY 2021-2022.
- BSS was able to implement movie nights on a monthly basis, therapeutic painting, continue celebrating client birthdays and spend one-on-one time with children in order to provide respite to the parent.
- In October of 2021, Rainscape was able to complete landscape at BSS both inside and outside of the shelter. Many trees and plants were planted and a water drip system was installed.
- Due to continuous attention to sanitization of all areas of the shelter on a regular basis, none of the children and adults housed at the BSS during FY 2021-2022 were contracted COVID-19.

Goals and Objectives

1) Identify and engage individuals and families in mental health services, 2) Connect victims of domestic violence to mental health services, and 3) Increase self-sufficiency among residents with the goal of moving individuals to permanent, independent housing.

Key Successes

- Case Managers continued establishing working relationships with partnering support programs and community-based organizations, such as Champions, Centro La Familia, CSET and Victim Witness.
- Clients were assisted in establishing care at local primary care and were supported in scheduling medical, dental and vision visits on a regular basis for their children and themselves. Approximately 95% of clients who entered the shelter attended their scheduled visits.
- Eighteen (18) families/single families who were homeless and eleven (11) families/single families who were survivors of domestic violence were able to reestablish relationships with close relatives and friends. Through this reconnection, they were able to exit the shelter and into their friend's or family homes.
- One (1) client was linked to Supportive Services for Veteran Families (SSVF) in Kings and Tulare Counties provided through WestCare Foundation. As a result, this client was able to establish an income, apply for housing, terminate their BSS housing, and rent an apartment using a Veterans Affairs Supportive Housing (VASH) rental subsidy.
- Four (4) families moved into their own apartment utilizing the public housing program, two (2) families moved into their own apartment utilizing other housing subsidies, and one (1) family moved into their own apartment without any rental subsidy.
- BSS assisted over five (5) clients with first month's rent and deposit for their apartments.

Program Challenges

- Due to the COVID-19 pandemic, regular monthly budgeting classes, facilitated by Wells Fargo and West America Bank, were put on hold. These classes helped clients manage their money, work on their credit, and learn how to save money.
- As the COVID-19 pandemic impacted the availability of rental properties, apartment waitlists increased causing rental properties to be available in 18 months as opposed to a previous three month waitlist
- As the COVID-19 pandemic prevention and control efforts were underway in which businesses began reopening, there was an influx of employment hiring opportunities. Clients were able to more aptly find employment, but struggled securing childcare due to the increase in the number of individuals throughout the community becoming eligible for childcare assistance programs as a result of lost or reduced wages from COVID-19 impact.
- While clients are informed of the hope to make three times the rent, most clients reported an income that was just enough to pay their bills and rent and lived from paycheck to paycheck. Since low-income housing and apartments are scarce, clients had to result to locating housing that was more expensive and thus made it difficult to save or pay other bills.

Proposed Activities for FY 2023-2024

- BSS will implement a sensory room
- BSS will implement sensory items for adults and children during case management meetings.
- BSS will renovate their donation clothing room.
- BSS will continue to celebrate clients birthdays on an individualized manner
- BSS will renovate the kitchen and dining area.
- BSS will continue the renovation of rooms installing new beds and closets.

OUTREACH AND ENGAGEMENT

Warm Line

Status:	☐ New	☒ Continuing		☐ Modification
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group:	2	15	828	6
Total served: 859 **Cost per person served:** $232				

Program Description

The Kings/Tulare Warm Line Program, operated by Kings View, is a 24 hours a day/7 days a week (24/7) non-emergency, peer-run phone line that is available for all residents of the County of Kings and Tulare seeking mental health support. The Warm Line assists those experiencing difficult times who call-in for needed emotional support and specific information about mental health resources in Kings County. When more intensive services are needed, the program refers calls to the appropriate community agency(ies) within the county.

The Warm Line is staffed by peers who have lived experience of mental health struggles themselves and who are open to sharing their stories of challenging situations, recovery, and perseverance. Moreover, they listen to callers share their own struggles, with the goal of supporting the caller who may be in emotional distress before they reach a crisis point. Services are offered in English & Spanish. All call sessions are confidential.

Population Served: While the Kings/Tulare Warm Line serves all residents of the County of Kings and Tulare, Kings County Behavioral Health Mental Health Services Act funding and reporting only includes costs and information pertaining to the County of Kings.

Program Updates

Activities and Outcomes in FY 2021 – 2022

The Warm Line received and interacted with 859 callers, attended and participated in 23 outreach events, and presented to a total of 2,436 individuals collectively putting the total number of individuals reached at 3,295 individuals. The program also referred 38 individuals to behavioral health services.

Goals and Objectives

1) Increase outreach and engagement for individuals in need of mental health services, and 2) Increase access and linkage to mental health services via outreach & engagement.

Key Successes

The Warm Line program collaborated with other county and community agencies to promote and raise awareness among county departments and county residents of the existing peer-to-peer non-crisis services. The program helped increase mental health awareness and collaboration with rural county school districts. The program offered 24/7 services in both English & Spanish, making services more accessible and attainable. The program also took steps to state certify all their peer support staff needed to officially become State Certified Peer Support Specialists. All staff are currently following through with this process and are either pending approval or are waiting for their certification test date. As the COVID-19 pandemic unexpectedly took effect, the program successfully transitioned and utilized social media and zoom platforms for outreach purposes.

Program Challenges

The Warm Line program faced COVID-19 pandemic challenges for most of the fiscal year (2021-2022). While the program utilized social media and zoom platforms to conduct virtual outreach, numerous targeted rural communities lacked adequate technological means and did not benefit from this alternate outreach delivery. Due to the COVID-19 pandemic, in-person community outreach and presentation opportunities were limited. Warm Line callers expressed specific concerns regarding COVID-19 anxiety and uncertainty. Callers also expressed needs regarding community resources that were minimal in rural areas of the county including access and linkage to support groups, housing assistance, gambling addiction, and mental health workshops.

Proposed Activities for FY 2023 – 2024

The Warm Line program hopes to achieve the following:

- Increase call volume
- Exceed 50 calls per month
- Attend more community outreach events
- Conduct more Warm Line Program presentations
- Attend more and available program-pertinent staff development trainings
- Update equipment
- Ensure all peer support staff attain state recognized certification becoming Certified Peer Support Specialists

Housing Programs

Status:	☐ New	☒ Continuing	☐ Modification	
Target Population:	☐ Children Ages 0 – 15	☐ Transitional Age Youth Ages 16 – 25	☐ Adult Ages 26 – 59	☐ Older Adult Ages 60+
Number Served by Age Group:	0	0	0	0
Total Served: 0 **Cost per person served:** $0				

Program Description

This program was initially listed within the Kings County Mental Health Services Act Plan to develop and fund Housing Programs specifically Board and Care Programs to meet the needs of Kings County residents in regard to augmented and specialized Board and Care housing. The population proposed to be served were adult mental health consumers with severe and persistent mental health conditions, and adult consumers requiring residential and mental health services with a community-based alternative to institutional placements.

However, these activities and cost fall within the Assertive Community Treatment (ACT) and Full Service Partnership (FSP) programs listed earlier in this plan, because the housing is associate with individuals connected with these programs. As such, no activities nor funding is associate with this program, as they are participant and program activities and costs within ACT and FSP programs.

No funds expended in this program due to the above.

PREVENTION AND EARLY INTERVENTION (PEI) PROGRAMS

PREVENTION

School Based Services

Status:	☐ New		☒ Continuing	☒ Modification
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☐ Older Adult Ages 60+
Number Served by Age Group:	1656	18	55	N/A
Total served: 1729 **Cost per person served:** $346				

Program Description

School Based Services are designed to provide students with skills and tools to promote increased mental health, school performance, and healthy relationships and communication.

- **Mindful Classrooms-**The K-12 Mindfulness Schools curriculum in elementary school classrooms across Kings County. Utilizing the Mindful School K-12 Curriculum, 5 foundational mindfulness lessons and 15 supplemental lessons are offered to students to deepen understanding of techniques to nurture social-emotional well-being. Each lesson lasts approximately 15-20 minutes and supports students in cultivating emotion and attention regulation. In addition, the project supports the development of mindfulness/self-regulation corners to provide safe, constructive places for students to practice mindfulness techniques and self-regulation in their classroom.
- **Mindfulness and Resiliency Assemblies-**School-wide assemblies and summits designed to promote mental health supports, mindfulness and enhance student resiliency. Each assembly is age and developmentally appropriate for the following groups of students - K-6th grade and 7th-12th grade. The 7th-12th grade summit is developed in collaboration with middle and high school youth who will identify key topics, activities, and guest speakers.
- **Pro-Social Skill Groups – Elementary-** Pro-social skill groups are for students in 4th-6th grade who may be experiencing behavioral issues as identified as needing additional pro-social skill supports.
- **Coping, Social support and life still groups (Middle school and High School)-**The Coping and Support Training (CAST) is an evidence-based curriculum designed to build coping skills, increase time spent in healthy activities, and enhance social support resources. The curriculum is effective in decreasing suicide risk behaviors (i.e., decreased depression, anger/aggression, increased school achievement).
- **WHY TRY-**The Why Try curriculum is an evidence-based curriculum designed to support life skills and increase social and emotional learning. The curriculum has evidence towards improving locus of control, improving attendance, and academic performance.
- **Trauma-Informed School Workshops-** In-service trainings to school staff designed to provide trauma-informed and healing-centered approaches to working with youth who have been exposed to Adverse Childhood Experiences (ACEs) and increase knowledge on buffering supports to reduce toxic stress and enhance resiliency in students.

- **Parent Engagement and Family Strengthening-** The Family Strengthening Curriculum is implemented as a healing centered approach for parents in the community. The curriculum is implemented once per year and rotates to different communities each year. Parents may stay involved after the implementation of the curriculum through monthly circles to provide support and continued implementation of the learnings.

Population Served: The target population of this program is children and youth who are at risk of developing a mental health problem.

Program Updates

Activities and Outcomes in FY 2021 – 2022

Kings County Behavioral Health released a request for proposal (RFP) in fiscal year 2020/2021 for the school-based services program for which California Health Collaborative (CHC) was awarded.. The contract was executed on December 21, 2021. CHC created the Young Minds Kings County Project in January 2022. The Young Minds Project was created as a school-based approach to providing youth development resources and mental wellness activities for youth in TK-12th grade residing in various Kings County communities. During its first six months, the Young Minds Project exceeded multiple goals and reached a broad range of youth in TK-12th grades. The relationships built with schools and communities yielded promising results and led to the team establishing services for the next fiscal year.

Goals and Objectives

1) Increase student connectedness and relationship building skills, 2) Increase student coping mechanisms skills, 3) Increase student capacity for seeking help, and 4) Decrease depression and anxiety among students.

Key Successes

- CHC reached 371 youth for reoccurring evidence -based curriculum and 1708 youth, families and school staff through outreach activities, assemblies, and in-service training.
- Through direct curriculum services with youth, survey data found 92% of youth reported having learned new tools and techniques to reduce stress and anxiety and 68% reported experiencing a reduction in stress and anxiety.
- As a result of direct services, 73% of students reported having new skills to regulate their emotions.
- As a result of the teacher in-service training, 74% of teachers reported having learned new skills to support self-regulation in their classrooms.
- School relationships were established quickly which allowed for rapid uptake of program services for the following school year
- Program staff received an overwhelming amount of interest for services taking place in the 2022-2023 school year that allowed staff to begin building out the next school year calendar of services fairly quickly.
- Provided In-service trainings to 32 teachers.
- Outreach in the communities of Hanford, Lemoore, Armona, Corcoran, and Avenal reaching the following school districts in the first six months:
    - Lemoore Unified School District
    - Corcoran Unified School District
    - Hanford Joint Union High School District
    - Armona Elementary School District

    - Reef Sunset Unified School District
- Participated in youth wellness fairs on high school campuses in Hanford to promote resources and services on school campuses throughout the district. Events took place at Hanford High, Hanford West, Earl F. Johnson HS, Community Day Continuation HS, and Sierra Pacific HS.
- School-wide Mental Health assemblies were also provided to Armona Elementary School and Parkview Middle School in Armona, bringing in guest speakers and engaging activities which included:
    - May 20th (Armona Elementary School): 510 students in attendance. In collaboration with the Fresno African Drumming Inc., CHC hosted a drumming presentation and spoke on coping and mental health.
    - May 25th (Parkview Middle School): 400 students in attendance. In collaboration with a local radio DJ, DJ Kay Rich, spoke to youth about mental health and engaged them in music and movement activities.
- Implemented the following school-based services beginning in April and ending in June:
    - Armona Elementary: School-wide mindfulness sessions across 29 classrooms (Number of participants varied due to attendance each week. The team engaged approximately 500 students in TK-4th grade.
    - Parkview Middle School hosted mindfulness sessions on three (3) dates. Between 15-38 students participated on each date.
    - Hanford High School hosted mindfulness sessions on four (4) dates. Between 14-18 students participated on each date.
- In June 2022, Young Minds staff delivered four (4) weekly Why Try sessions to Parkview Middle School students. Between 5-13 students participated in each session.
- May 13th Corcoran Family Summit: Spring into Wellness – The California Health Collaborative hosted a community event for youth and their families to engage in wellness activities. A total of 64 participants from the community came to the event and engaged in wellness activities. Program staff presented to parents on mental health and other health-related topics. Community vendors attended to provide information to families about local services and resources.
- June 30th Avenal: Community Health & Wellness Fair- The California Health Collaborative hosted a Wellness Fair which was attended by approximately 279 participants attended this event. Families and community members engaged in various activities including art, music, and movement. The event included a performance from a local folklorico dance troupe and a local DJ. Program staff presented to participants on the importance of caring for our mental well-being.
- Armona Elementary School: 32 school staff including classroom teachers, para-educators, and school administrators participated in the staff in-service which provided staff with training on the science of ACEs (Adverse Childhood Experiences) and toxic stress, trauma-sensitive practices, and the importance of self-care. As a result of this event, Armona Elementary School staff requested that CHC return and provide a second in-service next year.

<u>Program Challenges</u>

The California Health Collaborative encountered challenges in launching the program mid-school year and recruiting qualified personnel in the midst of launching program services. Due to the January 1st start date, the school year had already commenced which made building relationships with school sites and at the same time recruiting and training staff to implement services challenges. Nonetheless,

through these challenges, staff continued to outreach and promote services and provided resources available at the time, given the staffing levels of the project, resulting in some great partnerships for the next school year and surpassing the number of youths proposed to be served in only six months.

Proposed Activities for FY 2023 – 2024

Once program services commenced and schools became aware of the resources available with enough time to incorporate into the school year, CHC began booking services with schools and the Independent Living Program (ILP) foster youth program for the 2022-2023 fiscal year. For the 2022-2023 school year, Young Minds focused on increasing outreach and networking efforts to schools and communities and leveraging relationships with existing school partners to increase outreach to other school communities. Increasing the project's participation in community events to elevate the community's awareness of our program and services was also a priority for the 2022-2023 school year. The team also began working on developing a second in-service to continue supporting schools in increasing their capacity to support the social and emotional well-being of students. Additionally, the team increased outreach to communities to determine a collaborative partner and location for a Youth Summit event.

CHC continued to experience overwhelming interest and requests from schools for these services, and is unfortunately booked through the 2023-2024 fiscal year. Due to the overwhelming demand by schools causing service bookings to become 1 school year in advance, it is proposed to increase funding to support services for children and youth, particularly student mental health. This increased funding will assist with services targeted at reducing anxiety among students especially post-pandemic adjustment support, and expanding services to better serve the high demand among the number of schools throughout the County of Kings.

However, with the Mental Health Services Act Reform looming, Kings County Behavioral Health is undergoing fiscal modeling to project the impact the Reform may have to current Mental Health Services Act programs and funding structure (funding allowed for each component). Therefore, it is unknown the amount of funding increase that can be allocated at this time, rather funding may be increased based on fiscal ability and component funding allocation limitations.

Prevention and Wellness

Status:	☐ New	☒ Continuing	☒ Modification	
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group:	15/50	38/250	58/250	13/50
Total Served: 724 (124: Support Groups/600 Cohen Clinic) **Cost per person served:** $1,200				

Program Description

Prevention and Wellness services provides quality and culturally competent support to targeted populations to reduce risk factors for developing a potentially serious mental illness and help build protective factors to reduce the negative outcomes as a result of untreated mental illness. Activities promote positive approaches to mental health and aid in reducing serious mental health crises. This program includes, but is not limited to, Support Groups and the Veteran Prevention and Early Intervention Services particularly the Cohen Clinic.

Within the Support Group portion of this program: The Support Groups program offers several support groups that meet regularly to provide opportunities for connection, discussion, education about mental health and other resources, and other services through a peer-to-peer model.

The program also offers several support groups for different target populations:

- The Sisters Speak Support Group (Sisters Speak) is a forum that meets to discuss, answer questions, provide presentations on mental health, prevention, wellness, stressors and other life issues, challenges and barriers that prevent African American Women from accessing programs and services. The forum also educates attendees on what can be done as a community to eliminate identified challenges and barriers as they pertain to African American Women.
- The Family Support Group is a non-structured, family/participant driven group for family members of individuals who struggle with mental health challenges. The groups' participants identify themes, topics, and utilize a peer-to-peer support model.
- The Veteran Support Group provides the opportunity for veterans to meet for establishing camaraderie and to increase connectedness to outside services and linkages regarding available veteran and mental health services. Groups include guest speakers on subjects and topics of interest identified by veterans (guided by the group's facilitator) to which services are ensured by the facilitator to be client-centered and client-driven.
- The Source LGBTQ+ Support Group holds "Pop Up" group meetings for all who identify as a part of the LGBTQ+ community to which allies are included. Meetings often include conducted activities and have a brief theme offering information and resources on topics that affect the LGBTQ+ community, as well as offering a safe environment for the LGBTQ+ community to communicate freely.

NEW Within the Veteran Prevention and Early Intervention Services (Cohen Clinic): The Cohen Clinic uses evidence-based practices with a holistic and when possible, peer-based (veteran) approach to improve the quality of life for people with military backgrounds and their families. Services are specialized and confidential targeted at preventing, identifying, and treating mental health and life

challenges to include, but not limited to, depression, anxiety, post-traumatic stress disorder, adjustment issues, anger, grief and loss, transition challenges.
In addition to prevention and early intervention services for individualized mental health challenges, the Cohen Clinic can offer marriage counseling, relationship counseling, and help with children's behavioral issues. These services are not meant to replace or duplicate those offered through specialty mental health services or private insurance, rather are offered as a safe, confidential access point for which individuals can be further warmly linked with more sustainable long-term services as needed as applicable.

Population Served: The target population for Prevention and Wellness services are individuals who are unlikely to receive services in a traditional environment.

Program Updates

Activities and Outcomes in FY 2021 – 2022

During this fiscal year, support group facilitation continued in the slow transition of shifting from meeting virtually to meeting in-person due to ongoing COVID-19 pandemic response efforts. As a result, three out of the four support groups resumed holding in-person meetings at Kings County Behavioral Health (KCBH) in which COVID-19 safety measures were carried out to promote and ensure the continuous ability to meet in-person. The Family Support Group served 21 unduplicated individuals. Sisters Speak served 12 unduplicated individuals. The Source LGBTQ+ Support Group served 81 unduplicated individuals. The Veterans Group served 10 unduplicated individuals.

Goals and Objectives

1) Increase service connectedness to outside agencies and 2) Increase linkages to mental health services for children, youth, adults, and older adults in Kings County.

Key Successes

The Veterans Support Group successfully resumed their in-person meetings after pausing groups altogether due to issues preventing virtual meetings from taking course (since COVID-19's inception). Sisters Speak continued to hold virtual meetings and retained most of their regular group attendees since transitioning from in-person meetings to virtual meetings (due to the COVID-19 pandemic). The Family Support Group (also affected by COVID-19) was successful in transitioning back to in-person groups from virtual meetings in addition to slowly building support group attendance over the course of subsequent meetings.

The Source LGBTQ+ Support Group was successful at fully transitioning from virtual to in-person support groups and was nominated for and won a community positive impact award that recognized the valuable contributions of the support group in Kings County. Through the support of The Source LGBTQ+ Support Group, one group attendee was nominated for and won an individual community positive impact award for their community contributions.

Numerous support group attendees reported on their appreciation for the return of in-person groups from virtual meetings, expressing this need and desire to return to a more cohesive element of group dynamics. Kings County Behavioral Health (KCBH) continued to work with the support group members to ensure successful transition from referral to behavioral health services or appropriate community

agency linkages. KCBH was able to update the department website keeping the community informed of current and relevant support group information related to in-person and teleconference capabilities.

Program Challenges

Although in-person support group meetings eventually resumed their course, all the support group facilitators/administrators reported the loss of several group attendees and needing to rebuild group attendance. Since the COVID-19 pandemic created the challenge of meeting in-person thus forcing the transition to virtual meetings, this created a challenge for individuals who were not tech savvy, did not have the technological means to attend virtual groups, or who simply preferred to attend in-person. As a result of these, numerous group attendees stopped attending.

The Veterans Support Group, who had stopped meeting altogether since the inception of the COVID-19 pandemic, struggled with low group attendance once in-person meetings resumed. Although Sisters Speak retained most of their group attendees via virtual group means, the group facilitator/administrator indicated that more women were interested in attending the group if meeting holdings were in-person. However, the support group was unable to identify an available KCBH Conference Room time opening due to the conflicting schedules of other support groups who were already meeting in-person at KCBH.

The lack of adequate transportation affected numerous group members of The Source LGBTQ+ Support Group who desired to attend group. However, they were unable to at times in which public transportation caused hesitancy due to the fear of transgender, nonbinary, and feminine individuals receiving public harassment.

As COVID-19 response efforts enabled the Family Support Group to transition from virtual meetings to in-person meetings, rebuilding group attendance was initially an issue. Due to unforeseen circumstances in which the group had to return to meeting virtually for a two-month span, group attendance was very low as technology access was a barrier.

Proposed Activities FY 2023 – 2024

For the Support Group portion of this program: Support groups will utilize an in-person model of service delivery which will include virtual conferencing capabilities only if needed. Support groups will be afforded the opportunity to contribute to the MHSA Annual Update Community Program and Planning Process (CPPP) via scheduled focus groups. Support group outreach and awareness raising efforts will be assisted by the Kings County Mental Health Task Force members and network of community partners. All support groups will meet with KCBH leadership on a quarterly basis to maintain a working relationship and contractual oversight.

The Veterans Support Group facilitator/administrator will continue to network and collaborate with other veteran providers to increase the group numbers in which there will be a heightened focus on increasing female veteran attendance. Activities for this group will include offering supportive resources (i.e., exercise classes, crafting, alternative healing), establish partnerships with other veteran resources to support community rapport, and offer veterans outside (pre-approved) activities to build self-esteem, engagement, and confidence. In addition, this group will strive to offer more support to outside resources to build connections for veterans within their own community and give opportunities to connect with each other in-between KCBH groups.

The Source LGBTQ+ Support Group will continue and strive to build group attendance by participating in all opportune community outreaching efforts to spread both LGBTQ+ awareness and pertinent resources. The group facilitator/administrator will enhance group experiences by collaborating with

other organizations who will provide artistic expressive and fulfilling learning opportunities. The Family Support Group hopes to build group attendance through means of word of mouth, the dissemination of group program flyer, and KCBH's informing of the program to community agencies via regular meeting round tabling. The support group will look to have quarterly presentations from community healthcare providers, law enforcement, and mental health providers.

Sisters Speak will continue to build group attendance by participating in community outreaching events and by visiting and informing churches and community agencies about the group. The support group will also create a new vision framework, develop a greater focus on mental health, engage in more mental health wellness activities, and partner with community speakers who will educate group attendees on mental health relevant topics and provide more information about available community resources.

For the Veteran Prevention and Early Intervention Services (Cohen Clinic): Development of a new program targeted towards the active-duty population in the area and their dependents and post-9/11 veteran population for launch by end of 2023-2024 or calendar year 2024, with the goal of services to reduce risk factors for developing a potentially serious mental illness and help build protective factors to reduce the negative outcomes as a result of untreated mental illness.

EARLY INTERVENTION

Early Intervention Clinical Services (EICS)

Status:	☐ New	☒ Continuing		☐ Modification
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☐ Adult Ages 26 – 59	☐ Older Adult Ages 60+
Number Served by Age Group:	0	48		
Total Served: 48 Cost per person served: $4,583				

Program Description

Early Intervention Clinical Services (EICS) seeks to engage youth early in the development of a serious mental illness to decrease the severity of symptoms, increase recovery and help youth stay on track developmentally. Services provided include home, community, and office-based clinical services, case management, and other supportive services for the youth and their family.

Population Served: The target population of EICS is Transitional Age Youth identified by parents, providers, schools, emergency rooms, primary care physicians, child welfare, law enforcement, and juvenile probation that have experienced a first episode of psychosis, mania, depression, or other mental health disorder or are beginning to show signs of developing a serious mental health problem.

Program Updates

Activities and Outcomes in FY 2021 – 2022

- A designated case manager was added to the EICS Team to help with increasing outreach and engagement.
- Increased in engagement of youth and family in services.
- Provided direct services to 48 consumers
- Increased psychosocial outcomes, including education and academic and family involvement.
- Increased the number of participants that either attended college, found paid or volunteer employment, or are actively working with the Department of Rehab.
- Decreased in the Beck Cognitive Insight Scale (BCIS) composite index: Self-Reflectiveness minus Self-Certainty.
- Increased the number of clients that had one or more family members participate (whether client is present) in at least one session provided by the clinician in the program.

Goals and Objectives

1) Identify and engage youth and family in services, 2) Increase psychosocial outcomes, including education and academic and family involvement, and 3) Decrease hospitalizations, involvement with the criminal justice system, truancy, and substance use.

Key Successes

Number of Clients

Total Clients	Number of Clients Currently Enrolled	Number of Client Discharged	Target Goal (25 Clients)
48	27	21	27 Client **(Goal >=25)**

Employment Status

Type of Employment	Number of Clients	Percentage
Attend College, Volunteer, Paid Employment or Department Rehab	15	36.59% **(Goal >= 20%)**
Unemployed	26	63.41%
Total	**41**	**100%**

Supporting Systems

Type of Supporting Systems	Number of Clients	Percentage
Family Member(s)	38	97.44%
Friend(s)	1	2.56%
Total	**39**	**100% (Goal >=20%)**

Living Arrangement Status

Type of Living Arrangements	Number of Clients	Percentage
Apartment/House	35	72.92%
Family	5	10.42%
Homeless	5	10.42%

Program Challenges

- Staffing changes and ongoing pandemic-related limitations in the State of California
- Need more early intervention training for staff, limited options

Proposed Activities for FY 2023 – 2024

- Increase outreach to provide education to the community including community outreach with community partners (i.e., Primary Care Providers, Hospitals, Law Enforcement/Probation, etc.), and participate in college site events or other areas that would provide education.
- Launch a TAY-focused group in conjunction with the Wellness Center to help develop and promote social interactions/skills.

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Community Wide Outreach and Engagement Education/Training

Status:	☐ New		☒ Continuing	☐ Modification
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group:	10	30	140	20
Total Served: 200 **Cost per person served:** $230				

Program Description

Community-Wide Education works to improve the community's ability to recognize and respond to early signs and symptoms of mental illness. The focus of KCBH's community wide education and training strategies include keeping people healthy and getting people the treatment, they need early on to prevent worsening symptoms that can occur when mental illness is undiagnosed and/or untreated. Key activities include:

- **Mental Health First Aid (MHFA):** Mental Health First Aid teaches how to identify, understand, and respond to signs of mental health and substance use challenges among adults. It builds skills and confidence needed to reach out and provide initial support to those who are struggling. You will also learn how to help connect them to appropriate support.

- **Applied Suicide Intervention Skills Training (ASIST):** ASIST is a two-day interactive workshop in suicide first-aid. ASIST teaches participants to recognize when someone may have thoughts of suicide and work with them to create a plan that will support their immediate safety. Although ASIST is widely used by healthcare providers, participants do not need any formal training to attend the workshop—ASIST can be learned and used by anyone.

- **Safe TALK:** SafeTALK is a half-day training in suicide alertness. It helps participants recognize a person with thoughts of suicide and connect them with resources who can help them in choosing to live. Participants do not need any formal preparation to attend the training—anyone age 15 or older who wants to make a difference can learn the safeTALK steps.

Population Served: The above mentioned have an age minimum for participants to be able to attend. The age minimum are as follows:

- **Mental Health First Aid** – 18 years and older
- **ASIST** – 16 years and older
- **SafeTALK** – 15 years and older

However, the community members, family, and friends that they can be helped with the skills learned at the training can be of any age.

Program Updates

Activities and Outcomes in FY 2021 – 2022

Due to the COVID-19 pandemic, all in-person community wide outreach and engagement trainings were suspended.

Goals and Objectives

1. Re-establish these trainings on a regular basis in the community.
2. Facilitate the first Spanish Mental Health First Aid
3. Build up the training pool to ensure that demand for these trainings is being met and to build sustainability in the future.

Key Successes

Incoming mental health illness/wellness training requests were successfully diverted to online virtual trainings offered by the Living Works training provider and Kognito at www.livingworks.net and www.Kognito.com

Program Challenges

Due to the COVID-19 pandemic, all in-person community wide outreach and engagement trainings were suspended. The existing KCBH staff qualified to facilitate the trainings worked within Public Health Department to increase capacity for addressing the public health crisis.

Proposed Activities for FY 2023 – 2024

Reestablish community training capacity to include expand number of Trainers within Kings County to expand capacity to provide community trainings and trainings to the public entities throughout Kings County. The goal is to increase community members' knowledge and capacity to recognize and respond to various mental health needs. Where possible, offer the trainings in Spanish to serve that Spanish speaking only population of the county.

STIGMA AND DISCRIMINATION REDUCTION

Community Wide Stigma and Discrimination Reduction

Status:	☐ New		☒ Continuing	☐ Modification
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group:	0	0	0	0
Total Served: Given the nature of this program and the widely distributed outreach efforts, KCBH is unable to track the exact number of individuals impacted by this program. **Cost per person served:** N/A				

Program Description

Kings County utilizes a number of efforts to reduce stigma, increase cultural competency, and increase service connectedness. These efforts include:

- **Community Outreach:** Use of various mediums and methods by which to share information to raise awareness of mental illness to reduce stigma and promote services and programs to reduce the discouragement of seeking services associated with stigma. While in prior years this was listed as media/social media, that failed to fully encapsulate the various mediums and methods outreach is conducting, such as presentation to teachers regarding children's system of care and access, hosting a booth to disseminate various program and services materials and promotional items, partnering with community-based organizations on community events targeting topics and services related to behavioral health, placing signage through the communities via mediums like billboards, bus wraps, digital displays, bus shelter posters, flyers, magnets, etc.
- **The Kings Partnership for Prosperity (KPFP)** is a coalition in Kings County that works to create an environment of wellness throughout the community through community outreach and prevention education, and by facilitating the Kings County Mental Health Taskforce (MHTF) in partnership with KCBH. The MHTF mission is to strive to increase mental wellness by decreasing suffering and creating a climate of hope. The Taskforce focuses on reducing stigma and promoting prevention, decreasing suicide and suicidal behavior, and increasing engagement and early intervention.
- **The Kings County Cultural Humility Task Force (CHTF)** is made up of community members and partnering agency staff who oversee the completion of the required State Cultural Competency Plan, annual updates to that plan, setting the training agenda for the year, and promoting culturally appropriate services throughout Kings County. This effort is accomplished through initiatives to include, but not limited to, identification and recommendation of community provider training needs, identifying and developing activities to reduce stigma and increase access among underserved or traditionally underserved populations in Kings County, and the promotion of CLAS standards through the behavioral health systems of care. The Task Force meets monthly and is open to all community members, organizations, and service providers.

Population Served: Stigma and Discrimination Reduction is a community-wide effort across the County.

Program Updates

Activities and Outcomes in FY 2021 – 2022

Community Outreach (through Media/Social Media)

KCBH released radio and social media outreach for which radio commercials were aired on both English and Spanish Radio stations and social media outreach was through Facebook and Instagram directing viewers to the KCBH web site where stigma reduction, cultural competency, and service connectedness were promoted.

The Kings Partnership for Prevention (KPFP)

KPFP hosted a Suicide Prevention panel during the September 2021 general meeting. To participate in Mental Health Awareness Month activities, the MHTF developed a training titled "Understanding Mental Health & YOU," in May 2022. The training brought together mental health service professionals around Kings County and presented information on the who, what, when, where, & why of mental health, self-care, how to support others and community resources. The MHTF continued meeting monthly and assisted in creating a collaborative Maternal Wellness toolkit. To increase awareness, engagement, and community impact of the MHTF, KPFP began hosting MHTF leadership meetings in which the taskforce leads would meet to discuss strategy for the taskforce.

The Kings County Cultural Humility Task Force (CHTF)

During FY 2020/2021, the Cultural Humility Consumer/Staff surveys were administered to contracted providers, beneficiaries of the Mental Health Plan, CHTF members, and KCBH staff to help determine the cultural competency needs within the behavioral health system of care per beneficiaries, providers, and staff. The results from the survey were reviewed at a CHTF meeting and provided in the Kings County FY 2021/2022 Cultural Competence Plan Annual Update found on the KCBH.org website. Additionally, the CHTF focused outreach efforts for increasing awareness and access among the Hispanic/Latino population.

Goals and Objectives

1) Increase the prevalence of social media to share information and reduce stigma on mental health, 2) Increase knowledge and awareness of mental health and mental health services, 3) Reduce stigma regarding mental health, 4) Increase cultural competency, and 5) Increase access to mental health services for the Latino community.

Key Successes

Community Outreach (through Media/Social Media)

Stigma & Discrimination Reduction Radio ads increased in frequency in the Fiscal Year on English and Spanish radio. This was the first year that social media outreach and promotion was utilized which successfully generated a (0.24) Click Through Rate (CTR) and (559) specific KCBH web site clicks directly stemming from social media outreach.

The Kings County Cultural Humility Task Force (CHTF)

In 2021, from August to October, KCBH ran a Cultural Humility Taskforce media campaign with iHeart Media targeting the Hispanic/Latino population to raise awareness of mental health services available.

During the campaign radio ads were played on two iHeart radio stations (B95 and La Preciosa) as well as ads on the two stations' Facebook and Instagram pages. The social media campaign generated 416,899 Social Impressions, 3,309 Social Clicks, and a 0.79% Social Click Through Rate (CTR).

The Kings Partnership for Prevention (KPFP)
KPFP expanded the community engagement of the MHTF through its "Understanding Mental Health & YOU" training, with over 60 participants attending the event on May 11, 2022. Additionally, the Suicide Prevention Panel in September 2021 promoted suicide prevention information to community stakeholders during the KPFP General Meeting. In partnership with California Health Collaborative, the MHTF assisted in creating a Maternal Wellness Toolkit, which in addition to providing health resources, also included mental health resources. Additionally, KPFP maintains the Kings County Mental Health Taskforce website, which hosts the MHTF meeting notes and mental health, self-care, and suicide prevention resources. KPFP continues to serve as a catalyst for sharing mental health information and resources with county stakeholders via its extensive network of community contacts and acting as a community advocate. Kings Partnership additionally formalized the MHT into the KPFP Bylaws and developed a charter, allowing the opportunity to request workgroup funding from KPFP.

Program Challenges

Community Outreach (through Media/Social Media)
Many Kings County residents that live in rural areas of the county have limited or no access to internet services.

The Kings Partnership for Prevention (KPFP)
MHTF meetings continued to be held virtually due to the convenience of attendees who work throughout Kings County and the greater Central Valley region. However, despite continuing the meeting and becoming more accessible to community members, the taskforce experienced decreased engagement and interaction due to a lack of clear taskforce strategy.

The Kings County Cultural Humility Task Force (CHTF)
The taskforce had challenges with attendance. Even with changing the time to 5pm so more community members could attend, the attendance numbers decreased. A survey was conducted, and the taskforce took a vote to change the meeting time back to 10am. Due to the COVID-19 pandemic, the taskforce transition to virtual meeting and continue to convene monthly virtually.

Proposed Activities for FY 2023 – 2024

Community Outreach

KCBH intends to continue to build on the success of constituent community event outreach, as well as, review the ability to conduct a marketing analysis to best understand the medium and methods best suited for outreach to the diverse areas and populations through the community and the messages being delivered (i.e. anti-stigma, suicide prevention, behavioral health services awareness, etc.). From the results of this analysis, KCBH will tailor efforts to maximize reach and impact.

The Kings Partnership for Prevention (KPFP)

KPFP will be holding a Suicide Prevention panel in September 2023. KPFP will expand the MHTF by integrating the taskforce with the Suicide Prevention Strategic Plan. KPFP will continue to recruit members of MHSA-designated target populations and stakeholders to be contributing members of the MHTF. KPFP will contribute to statewide mental health wellness initiatives, including planning and facilitating county-wide activities relative to mental health awareness month. KPFP will act as a community advocate and leader in distributing mental health-related training information, resources, and community mental health needs assessments. KPFP and the MHTF will also be collaborating with the City of Avenal to put together a suicide prevention community walk to bring together community members to remember those who have passed by suicide, support survivors of suicide loss, and raise awareness of the stigmatized issues of mental health and suicide.

The Kings County Cultural Humility Task Force (CHTF)

The Ethnic Service Coordinator will continue to provide access and track culturally specific trainings through the Cultural Humility Taskforce, and continue to work on increasing attendance at the monthly CHTF meetings by focusing on the recruitment of members that are not currently represented such as persons with lived experience.

SUICIDE PREVENTION

Suicide Prevention

Status:	☐ New		☒ Continuing	☐ Modification	
Target Population	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+	Undisclosed (LOSS)
Number Served by Age Group: DRAW	0	131	0	0	0
LOSS	0				8
CVSPH	66	27	58	5	0
Total Served: Given the nature of this program and the widely distributed outreach efforts, KCBH is unable to track the exact number of individuals impacted by this program. **Cost per person served:** N/A					

Program Description

Suicide Prevention activities promotes public awareness of suicide prevention resources, improves and expands suicide reporting systems, and promotes effective clinical and professional practices. Key Services/Activities of suicide prevention include, but are not limited to:

- **The Depression Reduction Achieving Wellness (DRAW)** program is a campus-linked project that addresses the first onset of a psychiatric illness in students through collaboration with an institution of higher education. DRAW provides students with education regarding both the cultivation of wellness approaches and the identification of signs and symptoms of mental illness, short-term low-intensity intervention services, referrals to community-based agencies for more extended or intensive services when needed, and training for college staff on the signs and symptoms of depression.

- **Local Outreach to Suicide Survivors (LOSS)** is a program that provides a delayed response to friends and family members of the suicide victim. The purpose of this visit is to provide some comfort to the mourning individuals, provide them with resources and offer counseling services.

- **Central Valley Suicide Prevention Hotline (CVSPH)** is an immediate and consistent support for individuals in crisis or experiencing a suicidal crisis. The hotline is available 24 hours a day, 365 days a year, and is confidential and cost free. The trained staff and volunteers conduct the following: Save the caller and offers immediate support, develop a safety plan for the caller, reach out to callers with post crisis follow-up to ensure that they are safe and getting the help the caller may need.

Population Served: Kings County residents and their family members experiencing a mental health crisis, junior college students, family, and friends of those who died by suicide and anyone that accessed the suicide prevention hotline due to a suicide related issue.

Program Updates

Activities and Outcomes in FY 2021 – 2022

DRAW: The DRAW program provided 40 direct counseling services to students with an average session rate of (.9 sessions. One hundred and sixty-six (166) students received in-person DRAW mental health awareness presentations, workshops, and outreach. Twenty (20) students were linked to continuing care behavioral health services. Two (2) online outreach events were facilitated reaching 200 school administration/faculty members and 7 students.

LOSS: The LOSS team consisted of Kings County Behavioral Health Adult System of Care divisional staff for follow-up calls. Contracted clinician with KCBH provided therapeutic services in a telehealth setting due to the COVID-19 pandemic. In total 8 families were contacted to offer counseling services with 3 referrals for counseling were made. Information regarding the number of sessions and who accessed them is not available.

CVSPH: The Central Valley Suicide Prevention Hotline received a total of 649 calls from Kings County residents and continued to offer the crisis response services 24 hours a day 7 days a week. A crisis call is defined as a caller that experiences any kind of crisis including suicidal ideation/intent and emotional crisis. Calls broken down by concern were: (28%) for mental health, (23%) suicidal content (22%) social issues, (13%) general needs, (8%) basic needs, (3%) physical health, (3%) abuse& violence.

Goals and Objectives

1) Increase knowledge and awareness amongst Kings County residents of mental health wellness and suicide prevention, 2) Increase service linkages to mental health services for residents at risk of suicide, and 3) Connect friends and family members of suicide victims to resources and support services.

Key Successes in FY 2021-22

DRAW: Despite the COVID-19 pandemic, the DRAW Program continued to provide services via telehealth to students continuously without any break or disruption of services. Telehealth services offered an easy-to-use HIPAA-compliant platform which made it very feasible for students that would not have been able to access services traditionally due to lack of transportation, childcare, etc. Additionally, students that struggled with accessing mental health services found it more comforting to have a telehealth session at home. Due to the elimination of travel time for the DRAW therapist in commuting to various campuses to provide services, there were more hours spent providing clinical services. Various communities experienced an increase in mental health problems, and it became more acceptable for students to access mental health services. The DRAW Program was able to provide students with a counseling appointment within 1-2 weeks from the first point of contact.

LOSS: The LOSS program maintained a strong working relationship with the Kings County Coroner's Office to ensure an expedited linkage to mental health services for clients that were interested. Clients that requested therapeutic services were seen in a telehealth setting (e.g., phone/video call). Clients that requested more therapy sessions and if the contracted clinician determined the client needed more sessions, did not have any gap in services. The Kings County Behavioral Health Adult System of Care (ASOC) Program Manager and Unit Supervisor provided linkage to the LOSS program for Kings County Human Services Agency and ASOC providers when clients and or staff were impacted by a death by suicide.

CVSPH: The hotline was successful at managing 257 crisis calls, six (6) of which were Suicide Ideation Talk Downs, and four (4) Active Rescues. A Talk Down means the caller is at immediate risk of committing suicide, has the means readily available, and is planning on immediately acting on their suicidal thoughts. The caller is then de-escalated without the use of emergency services. An Active Rescue means the caller is at imminent risk and is unable to be talked down or is already in the process of acting on suicidal behavior. With this type of call, emergency services have been activated.

Program Challenges in FY 20201-22

DRAW: In-person sessions were suspended due to the COVID-19 pandemic. In-person outreach events decreased and were eventually suspended. Many students did not follow through with referrals to continuing care mental health services after receiving short term intervention.

LOSS: In-person LOSS services were not done this year due to the pandemic. The LOSS team consisted of follow-ups by the KCBH ASOC divisional staff for calls from the Kings County Coroner's Office. This affected the assigned duties of the divisional staff, who maintain caseloads and other duties as assigned for the division. Referrals for therapy services were referred to an outside contractor, while ASOC Program Manager recruited a licensed mental health clinician in the interim. ASOC Program Manager carried a small caseload of clients when necessary to maintain a suitable caseload.

CVSPH : Program challenges included reaching all unserved and underserved populations of Kings County due to the COVID-19 pandemic and transitioning to a hybrid model of service and working remotely. Complex calls including social & community anxiety and fear-based unrest calls were received which subsequently resulted in increased call handle time. Veterans, senior citizens, and the LGBTQ+ population were reported to be the highest risk target populations.

Proposed Activities for FY 2023 – 2024

DRAW: The DRAW program will continue to promote and facilitate services. Outreach and mental health awareness events will be facilitated via video. Additional program marketing will be targeted towards specific populations that are not utilizing or underutilizing the program services (e.g., Southeast Asian & Spanish Speaking students).

LOSS: KCBH ASOC division will continue to maintain the direct follow-up for individuals impacted by a death of someone that died by suicide and are seeking therapy. LOSS calls are to be done in-person. LOSS Team will recruit other members, get them trained and ride along with experienced members. If

there is enough interest, a LOSS Support Group will be explored. Potential ASOC licensed clinician will provide therapeutic services for individuals, reducing and or eliminating the need for an outside contractor for therapeutic services.

CVSPH: Continued drive through and virtual outreach events will be scheduled at multiple cities within the County. The program will collaborate with the Kings County Mental Health Task Force in attempts to increase promotion of the service to underserved populations within the county. Promote suicide prevention efforts via increased social media platforms and collaboration with other community-based organizations. Provide suicide prevention trainings including Suicide Prevention 101, Non-Suicidal Self Injurious Behavior, Suicide Prevention After a Disaster, and ASIST 101.

ACCESS AND LINKAGE TO TREATMENT

Senior Access for Engagement (SAFE)

Status:	☐ New		☒ Continuing	☐ Modification
Target Population:	☐ Children Ages 0 – 15	☐ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+
Number Served by Age Group:	N/A	N/a	42	263
Total served: 305 **Cost per person served:** $1,371				

Program Description

The Senior Access for Engagement (SAFE) Program provides supportive services to older adults in their home, senior centers, nursing homes, and assisted living facilities. SAFE providers promote psychosocial supports and identify possible signs and symptoms of mental illness assisting older adults with appropriate referral linkage to mental health treatment. Specific SAFE services include:

- Visitation to older adults in the home or community to provide social support
- Caregiver support group
- Linkages to Respite for Caregivers
- Referral and linkage to other community-based providers for other needed social services and primary care
- Wellness and socialization engagement via event and activity opportunities for the seniors/older adults population and caregivers

Respite for Caregivers aids caregivers needing periodic relief from their supervision and caregiving duties of older adults. Respite for Caregivers also gives caregivers the opportunity to engage in activities and to utilize social supports needed to alleviate their stress and promote wellbeing. Services are intended to complement existing family structures to allow older adults to remain in the community as long as possible and avoid unnecessary nursing home and other out-of-home placements. The program also provides some assistance to primary caregivers on the supervision/caregiving of his/her family member

Population Served: SAFE serves isolated older adults ages 60 and older at-risk of or beginning to experience mental health problems, such as depression, related to aging and isolation. SAFE also serves primary caregivers of older adults with mental illness. Caregivers accessing this service must live in a non-licensed setting and not be paid for caregiving.

Program Updates

<u>Activities and Outcomes in FY 2021 – 2022</u>

The Kings County Commission on Aging (KCCOA) SAFE Program continued to actively collaborate with other community based social service agencies as the need for services increased due to the COVID-19 pandemic. Mental Health linkage services were promoted via Caregiver Support Groups. Mental Health Awareness outreach was conducted continuously during weekly Meals on Wheels Distributions to

seniors, monthly food bank drives, senior home-visits, office contacts, and via COVID-19 Quarantine Assistance Program.

Goals and the Objectives

1) Reduce out of home placements for seniors/older adults, 2) Increase service connectedness, 3) Increase socialization and reduce isolation among senior population, and 4) Reduce caregiver stress.

Key Successes

Continued mental health awareness on a weekly basis during KCCOA program activities such as Caregiver Support Group meetings, home-visits, and safety checks by distributing literature about mental health services, food, personal protective equipment (PPE) supplies, etc. Participated in the Hope Fest Kings County event that created a unique opportunity for seniors to get together and bond with the community through music while having access to haircuts, groceries, clothing, and other essential resources. The community was able to attain valuable information that advanced elder abuse awareness, mental health services, and KCCOA programs through the event.

Participated in the Youth Spring Fest in which youth were educated in an innovative, lively way about senior abuse and senior resources. Held the Worldwide Elder Abuse Awareness Day Event in which KCCOA and multiple other social service agencies collaborated to promote elder abuse awareness and available community resources. The supportive event also provided seniors/older adults with the opportunity to have an entertaining, socializing, and community connectedness time amongst one another.

The Safety Bar Program enabled seniors/older adults to improve their at-home safety efforts needed to decrease anxiety and provide comfortability. Additional staff were hired to meet the needs of the growing senior/older adult population. Successfully assisted a senior/older adult in urgent need of prompt and comprehensive services (i.e., financial, legal, and mental health support) due to unforeseen events that brought extreme anxiety.

Program Challenges

Program seniors/older adults experienced increased rates of anxiety stemming from fear of contracting COVID-19 infection. As a result of the pandemic, many scheduled senior/older adult events were postponed due to COVID-19 restrictions. Many seniors/older adults expressed their frustrations in having difficulty utilizing or not having the technology to engage in virtual-based services and activities. The lack of needed volunteers and workers created issues regarding meeting the needs of the growing senior/older adult community.

Proposed Activities for FY 2023 – 2024

- Host the Annual Friendship Day event to further increase access to information and resources while eliminating sense of hopelessness and loneliness amongst the senior/older adult Population.
- Participate in the Mooney Grove Park event and conduct outreach for mental health services, caregiver support group, and other available services according to senior needs
- Conduct monthly educational presentations in both English and Spanish for seniors by having presenters from different community agencies present on topics, services, and available resources (physical health, elder abuse, self-care, etc.)

- Conduct frequent mental health presentations to bring awareness and decrease stigma by having mental health specialists present on the reality of mental health disorders and the symptoms to look out for
- Conduct frequent mental health-based presentations having speakers with lived mental health disorder experience discussing their challenges to further reduce stigma and bring mental health awareness
- Conduct monthly outreach and provide assistance to seniors/older adults at the re-opened senior nutrition sites
- Conduct art classes at senior nutrition sites to enable seniors to experience mental stimulation and socialization in a creative manner
- Host educational stress relief workshops to promote self-care and healthy ways to reduce stress
- Conduct outreach to LGBTQ+ community members by attending Kings County community events providing information about The SAFE Program services and available resources.

Access and Linkage

Status:	☐ New		☒ Continuing	☐ Modification	
Target Population:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+	Decline to state/unable to obtain
Number Served by Age Group:	2	97	887	427	1425
Total Served: 2,838 **Cost per person served FY 2021-2022:** $70					

Program Description

Access and Linkage can be defined as a set of related means to connect children & adults with potential and existing behavioral health needs to identified resources and programs for screening, assessment, and treatment. The purpose of Access and Linkage is to review and ensure linkage to treatment and other resources for individuals that are seeking linkage to services.

2-1-1 Kings County is a service provided by Kings United Way (KUW) that serves as a telephonic, text, and electronic device app informational tool to assist in linking community members to local public resources provided by government, community, and non-profit entities, including behavioral health services.

Population Served: All of Kings County residents are served by the 2-1-1 Kings County program.

Program Updates

Activities and Outcomes in FY 2021 – 2022

Kings County Behavioral Health (KCBH) provided county residents with current and available resource information and access to behavioral health referrals via the 2-1-1 Kings County platforms. 2-1-1 Kings County received a total of 2,838 calls during the reporting period. There were 1,635 active users on the 2-1-1 mobile app and 161 referrals made to KCBH. 2-1-1 Kings County also recorded 14,775 total behavioral health unduplicated website views which includes hotlines, treatment, counseling, support groups, and more.

Goals and Objectives

1) Increase the number of referrals to existing services, 2) Connect community members to various social services with an emphasis on behavioral health, and 3) Create support services to assist community members with various concerns.

Key Successes

2-1-1 continues to be a vital resource to community members and service providers reaching all residents within Kings County, especially those in rural, outlying areas. 2-1-1 received a total of 2,838

calls consisting of both 2,459 English callers and 379 Spanish callers, had 14,775 unduplicated website views, and had 161 referrals made to KCBH for mental health services.

Through targeted outreach and focus group hosting, 2-1-1 consistently received between 20%-25% calls from mono-lingual Spanish speakers. Kings United Way became one of the few agencies in California to translate all resources within the 2-1-1 database into Spanish. All updates to the database were completed in both English and Spanish.

Despite the COVID-19 pandemic, Kings United Way 2-1-1 staff participated in over thirty 30 tabling events throughout Kings County to market and educate the community on 2-1-1 functionalities. The 2-1-1 team participated in several outreach opportunities to the Kings County Spanish speaking population living in rural areas. In addition to tabling events, 2-1-1 staff conducted presentations in both English and Spanish.

Program Challenges

2-1-1 continued to navigate through the challenges that the COVID-19 pandemic created in which the conducting of presentations, focus group holdings, and participating in outreach events started off slow due to suggested safety precautions. Shifting the conducting of these activities back to in-person from virtual hosting was a process in terms of making the community aware of the services delivery format change. The COVID-19 pandemic made it difficult to conduct focus groups despite incentives for participation being put in place to garner feedback from users of 2-1-1. Several attempts were made through the year to provide focus groups with community members. While many signed up to participate in the groups, there were many no-shows on the day of the events.

There tends to be a community misperception where it is assumed that Kings United Way/2-1-1 provides services such as housing, mental health services, utility assistance, etc. when in all actuality the Kings United Way/2-1-1 provider only links/refers community members to these services. This misunderstanding may frustrate the public and dissuade community members from following up with services on their own. Since Kings United Way/2-1-1 relies on providers to provide updates for their programs to ensure resources within the 2-1-1-database are current and accurate for users, the 2-1-1-database may consist of outdated program resource information, at times, if providers delay in 2-1-1's requests for program updates.

Proposed Activities for FY 2023 – 2024

2-1-1 will continue to conduct outreach to all Kings County populations through community events and presentations. 2-1-1 Kings County will continue to educate the community on all 2-1-1 Kings County functionalities such as Dial 2-1-1, visiting 211kingscounty.org or using Live Chat, downloading the 2-1-1 Intelliful mobile app and/or texting zip code to 989211. 2-1-1 staff will continue to attend numerous and regular community committees and meetings to stay connected to and familiar with available resources in Kings County. 2-1-1 staff will continue to maintain a current, comprehensive, and computerized inventory of community resources in English and Spanish languages. 2-1-1 will conduct follow-ups and provide additional resources as needed within the Referral Exchange network.

INNOVATION

INNOVATION

Multiple-Organization Shared Telepsychiatry (MOST)

Program Description
View full approved Innovation Plan here: http://www.kcbh.org/plans--documents.html
This project concluded its term as an Innovation Program in 2022-2023

Kings County adopted the Multiple Organization Shared Telepsychiatry (MOST) Project as its Innovation Plan as approved by the Kings County Board of Supervisors in June 2018, which was the catalyst to change an existing practice. The MOST project is seeking to expand much needed psychiatric services by establishing Multiple Organization Shared Telepsychiatry suites that will be accessed by multiple providers. Additionally, the MOST program seeks to use these shared services to improve care coordination and to infuse the lived experience of peers into the provision of psychiatric services. The MOST Project was approved by the Mental Health Services Oversight & Accountability Commission (MHSOAC) in September 2018.

The MOST Project goes far beyond addressing a serious psychiatric shortage in a small and rural community and does more than just build capacity or improve access to care. Its focus moves Telepsychiatry from a medical model of care to one that is based on wellness and recovery, thus improving the overall coordination of care and the clinets' experience. The goal for this project was to increase access to timely care, create paid peer roles in the system of care, and increase the number of individuals receiving care in the community instead of jails, hospitals, and emergency departments.

The Kings County stakeholders identified a need in years prior to 2018, for additional psychiatric services that would allow for greater access, timely access, and to allow consumers to be served in the community. Having teams who could specialize with populations, such as children, were seen as critical in improving engagement, care, and outcomes. The County could operate these Telepsychiatry suites in various locations, but share the resources with our children and adult services providers. Designated days for each population and provider shall be established, ensuring appropriate staff are scheduled for those populations (i.e., child psychiatrist for children).

Sustainability was a focus for the program from its on-set. The MOST Project was designed in a manner which allowed it to transition to a fully sustainable service at the conclusion of the Innovation plan term (June 30, 2023). It will allow for other public funding, specifically Medi-Cal reimbursement, to carry the program forward. The ability to provide access to psychiatric care in a more timely and coordinated manner reduces the number of consumers who are hospitalized, incarcerated, or admitted into the emergency room, yielding significant cost savings that will also support the program's continuing sustainability.

Program Updates

- The 2021-2022 Multiple-Organization Shared Telepsychiatry (MOST) Annual Innovation Project Report can be found in the appendix of this plan and details program updates
- This Innovation Project concluded in FY 2022-2023; therefore, there are no proposed activities for FY 2023-2024

Semi-Statewide Enterprise Health Record (EHR) Innovation

Program Description
View full approved Innovation Plan here: http://www.kcbh.org/plans--documents.html

This project makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population, and it's primary purpose is to Increases the quality of mental health services, including measured outcomes, and promote interagency and community collaboration related to Mental Health services or supports or outcomes. This project is unique in that it engages counties to collaboratively design a lean and modern EHR to meet the needs of counties and the communities they serve both now and into the intermediate future.

Kings County adopted the Semi-Statewide Enterprise Health Record (EHR) Project as its Innovation Plan as approved by the Behavioral Health Advisory Board on September 26, 2022 and the Board of Supervisors on October 18, 2022. The Semi-Statewide Enterprise Health Record Project was approved by the Mental Health Services Oversight & Accountability Commission (MHSOAC) January 25, 2023, and the EHR went live in Kings County on July 1, 2023.

California counties have joined together to envision an enterprise solution where the EHR goes far beyond its origins to provide a tool that helps counties manage the diverse needs of their population. The counties participating in the Semi-Statewide EHR have reimagined what is possible from the typical EHR system. We have identified three key aims:

1. Reduce documentation burden by 30% to increase the time our scarce workforce has to provide treatment services to our client population.
2. Facilitate cross county learning by standardizing data collection and outcomes comparisons so best practices can be scaled quickly.
3. Form a greater economy of scale so counties are able to test and adopt innovative practices with reduced administrative burden.

KCBH conducted a community planning survey to assess the perspective of stakeholders utilizing the current EHR system and addressed the following domains:

- Frequency of EHR usage
- Role with EHR system
- Primary use of EHR system
- Identified challenges of utilizing the existing EHR system
- Proposed changes, revisions, and improvements to the EHR system
- Patient Portal priorities and needs

As with many counties across California, Kings County Behavioral Health (KCBH) and Community Partners are uniquely situated to participate in this Multi-County INN project. Stakeholders across our system have expressed deep concern on the volatile and antiquated EHR system that is currently utilized. Stakeholders have prioritized this project to improve and enhance the EHR system to meet the needs of the provider and consumer community alike. With this unique multi-county collaborative, Kings County will gain an opportunity to provide continuous feedback through system end-users, providers, contractors, consumer/family member staff and recipients of care. This broad stakeholder group will serve as an essential feedback loop to program design, system design and evaluation alike

The California Advancing and Innovating Medi-Cal (CalAIM) initiatives that were impacting counties and providers started in 2022 are requiring swift adoption of highly technical changes and transformation of County BH service delivery systems. Clinical documentation redesign, payment reform and data

exchange requirements to bring California Behavioral Health (BH) requirements into greater alignment with national physical healthcare standards, thereby creating a lower-barrier entry to EHR vendors seeking to serve California. At the same time, the COVID-19 pandemic has increased the demand for behavioral health services, has disproportionately impacted communities of color, and has factored into the staggering workforce shortages faced by counties throughout California. Behavioral Health Plans (BHPs) need to foundationally revamp their primary service tool to meet the challenges and opportunities of this moment. BHPs, in partnership with CalMHSA are positioned to do just that through the Semi-Statewide Enterprise Health Record initiative.

CalMHSA will serve as the Administrative Entity and Project Manager. Counties have previously participated in and provided robust input to CalMHSA during the collaborative learning phase that culminated in the Request for Proposal (RFP) seeking a new EHR vendor. Counties have prioritized this project in light of the severe behavioral workforce challenge that counties are facing and leaning into this multi-county innovation opportunity to preserve local workforce and allow their skills and energy to be focused on service provision during a time of rising need for mental health treatment services..

Activities during this project are:

FY 22/23	**EHR INN Project Plan**	**EHR Project Plan: Phase I**
Q1: July-Aug	Landscape Analysis	Requirements Gathering
Q2: Sept-Dec	Landscape Analysis	Requirements Gathering
Q3: Jan-March	Human-Centered Design Process	Analysis and Design
Q4: April-June	Human-Centered Design Process	Development/Configuration/ Testing/Training
FY 23/24		
Q1: July-Aug	Design Optimization	Phase I Go Live
Q2: Sept-Dec	Design Optimization	Optimization
Q3: Jan-March	Post-Go Live Survey Period (Summative Assessment)	Monitoring/Controlling
Q4: April-June	Evaluation, Learnings, and Recommendations	Monitoring/Controlling

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WORKFORCE EDUCATION AND TRAINING (WET) PROGRAMS

WORKFORCE EDUCATION AND TRAINING (WET)

The Central Region Partnership 2020-2025 MHSA WET Five-Year Plan (WET Plan) provides Regional Partnerships the opportunity to design and implement their chosen WET programs in the counties of their respective regions through a contract with Office of Statewide Health Planning and Development (OSHPD). The programs under the domain of the Regional Partnerships include pipeline development, scholarships, stipends, loan repayment, and retention strategies, with the ability to link programs across the workforce pipeline spectrum (from pipeline to scholarship and stipends to loan repayment and retention). The Central Region Partnership (CRP) appreciates this opportunity to further its workforce by attracting culturally diverse individuals to behavioral health careers and support them along each step in their educational and training career pathway within the public mental health system.

Kings County intends to utilize the guidance and supports of the Central Region Partnership WET Plan and programs within, as they are most appropriate in Kings County.

No activities to report ni FY 2021-2022, as the program did not launch until FY 2022-2023.

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN) PROGRAMS

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS (CFTN)

Program Description

Capital Facilities and Technology Needs (CFTN) is infrastructure development to support the implementation of the technological infrastructure and appropriate facilities to provide mental health services. The Purpose of CFTN is to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with serious mental illness or that provide administrative support to MHSA funded programs. Funding for technological needs is to be used to fund county technology projects with the goal of improving access to and delivery of mental health services. There were no CFTN expenditures during the FY 2021-2022. This one-time allocation is fully expended with no proposal to transfer funds from CSS for future use.

FUNDING AND EXPENDITURES BUDGET

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: KINGS

Date: 8/25/23

	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 2023/24 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	1,944,940	1,953,758	1,310,591			
2. Estimated New FY2023/24 Funding	11,834,606	2,958,651	778,592			
3. Transfer in FY203/24[a/]	(686,115)					
4. Access Local Prudent Reserve in FY2023/24	0					
5. Estimated Available Funding for FY2023/24	13,779,546	4,912,410	2,089,184			
B. Estimated FY2023/24 MHSA Expenditures		8,340,469	3,458,597	1,575,060		
C. Estimated FY2024/25 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	4,752,961	1,453,812	514,124			
2. Estimated New FY2024/25 Funding	6,968,185	1,742,046	458,433			
3. Transfer in FY2024/25[a/]	(94,511)					
4. Access Local Prudent Reserve in FY2024/25	0					78,802
5. Estimated Available Funding for FY2024/25	11,721,146	3,195,858	972,557			
D. Estimated FY2024/25 Expenditures		8,697,364	3,195,858	972,556		
E. Estimated FY2025/26 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,944,979	0	0			
2. Estimated New FY2025/26 Funding	7,665,004	1,916,251	504,277			
3. Transfer in FY2025/26[a/]	0					
4. Access Local Prudent Reserve in FY2025/26	15,709					
5. Estimated Available Funding for FY2025/26	10,609,983	1,916,251	504,276			
F. Estimated FY2025/26 Expenditures	9,066,091	1,916,251	504,276			
G. Estimated FY2025/2620 Unspent Fund Balance	1,543,892	0	0			

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2023	1,184,797
2. Contributions to the Local Prudent Reserve in FY 2023/24	686,115
3. Distributions from the Local Prudent Reserve in FY 2023/24	0
4. Estimated Local Prudent Reserve Balance on June 30, 2024	1,870,912
5. Contributions to the Local Prudent Reserve in FY 2024/25	94,511
6. Distributions from the Local Prudent Reserve in FY 2024/25	0
7. Estimated Local Prudent Reserve Balance on June 30, 2025	1,965,423
8. Contributions to the Local Prudent Reserve in FY 2025/26	0
9. Distributions from the Local Prudent Reserve in FY 2025/26	15,709
10. Estimated Local Prudent Reserve Balance on June 30, 2026	1,949,715

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 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: KINGS

Date: 8/25/23

	Fiscal Year 2023/24					
	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. Assertive Community Treatment (ACT)	2,532,005	1,880,322	651,683			
2. Children's Full Service Partnership (FSP)	2,477,199	2,425,747	51,452			
3. Adult Full Services Partnership (FSP)	1,852,961	1,353,525	499,437			
Non-FSP Programs						
1. Collaborative Justice Treatment Court (CJTC)	224,059	224,059				
2. Mental Health Services for Domestic Violence Survivors (Barbara Saville)	108,652	108,652				
3. Warm Line	210,560	210,560				
4. Housing Programs						
CSS Administration	1,383,610	1,383,610				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	9,543,041	7,646,142	1,202,572			
FSP Programs as Percent of Total	92.7%					

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Assertive Community Treatment (ACT)	2,658,605	1,941,754	716,851			
2. Children's Full Service Partnership (FSP)	2,601,059	2,544,462	56,597			
3. Adult Full Services Partnership (FSP)	1,945,609	1,396,229	549,381			

4. Assertive Community Treatment (ACT)						
Non-FSP Programs						
1. Collaborative Justice Treatment Court (CJTC)	235,262	235,262				
2. Mental Health Services for Domestic Violence Survivors (Barbara Saville)	114,085	114,085				
3. Warm Line	221,088	221,088				
4. Housing Programs						
5. Collaborative Justice Treatment Court (CJTC)						
CSS Administration	1,452,790	1,452,790				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	10,020,193	9,460,360	1,322,829			
FSP Programs as Percent of Total	92.7%					

	Fiscal Year 2025/26					
	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. Assertive Community Treatment (ACT)	2,791,536	2,002,999	788,537			
2. Children's Full Service Partnership (FSP)	2,731,112	2,668,855	62,257			
3. Adult Full Services Partnership (FSP)	2,042,890	1,438,571	604,319			
4. Assertive Community Treatment (ACT)						
Non-FSP Programs						
1. Collaborative Justice Treatment Court (CJTC)	247,025	247,025				
2. Mental Health Services for Domestic Violence Survivors (Barbara Saville)	119,789	119,789				
3. Warm Line	232,142	232,142				
4. Housing Programs						
5. Collaborative Justice Treatment Court (CJTC)						
CSS Administration	1,525,430	1,525,430				
CSS MHSA Housing Program Assigned Funds						
Total CSS Program Estimated Expenditures	10,521,203	8,300,595	1,455,112			
FSP Programs as Percent of Total	92.7%					

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: KINGS

Date: 8/25/23

	Fiscal Year 2023/24					
	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 - Prevention						
1. School Based Services	630,551	630,551				
2. Prevention and Wellness	147,317	147,317				
PEI Programs - Early Intervention						
3 Early Intervention Clinical Services (EICS)						
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
4. Community-Wide Outreach and Engagement Education/Training	84,176	84,176				
PEI Programs - Stigma and Discrimination Reduction						
5. Community-Wide Stigma and Discrimination Reduction	1,112,196	1,112,196				
PEI Programs - Access and Linkage to Treatment						
6.. Senior Access for Engagement (SAFE)	353,468	353,468				
7. Access and Linkage	161,702	161,702				
PEI Programs - Suicide Prevention						
8. Suicide Prevention	217,359	217,359				
PEI Administration	802,248	802,248				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	3,458,597	3,458,597				
	Fiscal Year 2024/25					
	A	B	C	D	E	F

	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. School Based Services	662,078	662,078				
2. Prevention and Wellness	154,683	154,683				
PEI Programs - Early Intervention						
3 Early Intervention Clinical Services (EICS)						
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
4. Community-Wide Outreach and Engagement Education/Training	88,385	88,385				
PEI Programs - Stigma and Discrimination Reduction						
5. Community-Wide Stigma and Discrimination Reduction	1,167,806	1,167,806				
PEI Programs - Access and Linkage to Treatment						
6.. Senior Access for Engagement (SAFE)	371,142	371,142				
7. Access and Linkage	169,787	169,787				
PEI Programs - Suicide Prevention						
8. Suicide Prevention	175,288	175,288				
PEI Administration	842,360	842,360				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	3,631,527	3,631,527				

	Fiscal Year 2025/26					
	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 - Prevention						
1. School Based Services	695,182	695,182				
2. Prevention and Wellness	162,417	162,417				
PEI Programs - Early Intervention						

3 Early Intervention Clinical Services (EICS)						
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
4. Community-Wide Outreach and Engagement Education/Training	92,804	92,804				
PEI Programs - Stigma and Discrimination Reduction						
5. Community-Wide Stigma and Discrimination Reduction	1,226,196	1,226,196				
PEI Programs - Access and Linkage to Treatment						
6.. Senior Access for Engagement (SAFE)	389,699	389,699				
7. Access and Linkage	178,276	178,276				
PEI Programs - Suicide Prevention						
8. Suicide Prevention	184,052	184,052				
PEI Administration	884,478	884,478				
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	3,813,104	3,813,104				

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: KINGS

Date: 8/25/23

	Fiscal Year 2023/24					
	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. Semi-Statewide Enterprise Health Record	1,353,324	1,353,324				
INN Administration	378,371	378,371				
Total INN Program Estimated Expenditures	1,801,695	1,801,695	0	0	0	0

	Fiscal Year 2024/259					
	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. Semi-Statewide Enterprise Health Record	1,494,490	1,420,990				
INN Administration	397,290	397,290				
Total INN Program Estimated Expenditures	1,891,780	1,891,780	0	0	0	0

	Fiscal Year 2025/26					
	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. Semi-Statewide Enterprise Health Record	1,492,039	1,492,039				
INN Administration	417,154	417,154				
Total INN Program Estimated Expenditures	1,986,369	1,986,369	0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Workforce Education and Training (WET) Component Worksheet

County: KINGS

Date: 8/25/23

	Fiscal Year 2023/24					
	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
WET Programs 1.						
WET Administration						
Total WET Program Estimated Expenditures			0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs 1.						
WET Administration	0					
Total WET Program Estimated Expenditures			0	0	0	0

	Fiscal Year 2025/26					
	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
WET Programs 1.						
WET Administration						
Total WET Program Estimated Expenditures			0	0	0	0

FY 2023-24 Through FY 2025-26 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: KINGS

Date: 8/25/23

	Fiscal Year 2023/24					
	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.						
CFTN Administration						
Total CFTN Program Estimated Expenditures			0	0	0	0

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects 1.						
CFTN Administration	0					
Total CFTN Program Estimated Expenditures			0	0	0	0

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects 1.						
CFTN Administration						
Total CFTN Program Estimated Expenditures			0	0	0	0

APPENDIX – DETAILED CPPP RESULTS

COMMUNITY SURVEY RESULTS

Introduction

As part of the Mental and Behavioral Health Needs Assessment, Kings County Behavioral Health partnered with EVALCORP to conduct a County-wide Community Survey to identify priority mental and behavioral health concerns, barriers to accessing care, and recommendations for improving mental and behavioral health services in Kings County. The purpose of the Community Survey is to collect primary data from community members about the current mental and behavioral health issues in Kings County. This information will help the County better understand and address barriers to mental and behavioral health services while capitalizing on the strengths of the current system within the County.

Methods

The Community Survey was developed by EVALCORP and distributed online from late November through December 2022 to community members via:

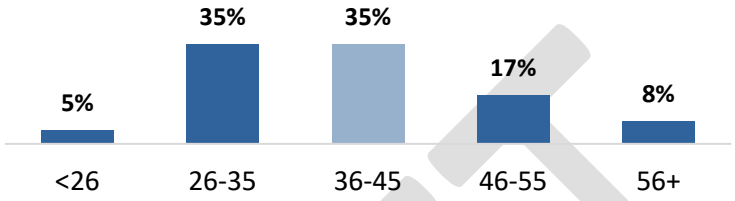
- Kings County Behavioral Health website
- Kings Partnership for Prevention listserv
- Radio and social media advertisements created and promoted through iHeartMedia.

During the survey administration timeframe, a total of 412 responses were collected and findings from these responses are summarized below.

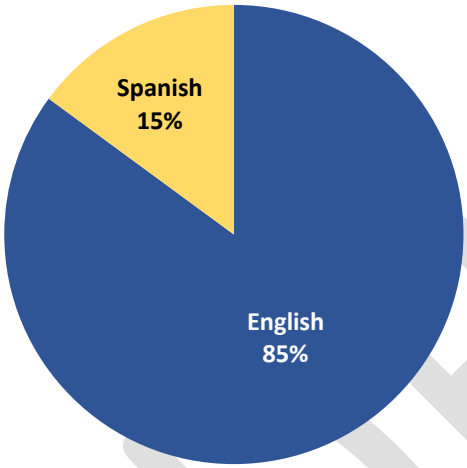
Respondent Profile

Demographic information and other characteristics were elicited from Community Member Survey respondents to provide context for their responses. Questions included age, gender identity, primary language, and race/ethnicity and city of residence.

Age (n=391)



Primary Language (n=402)

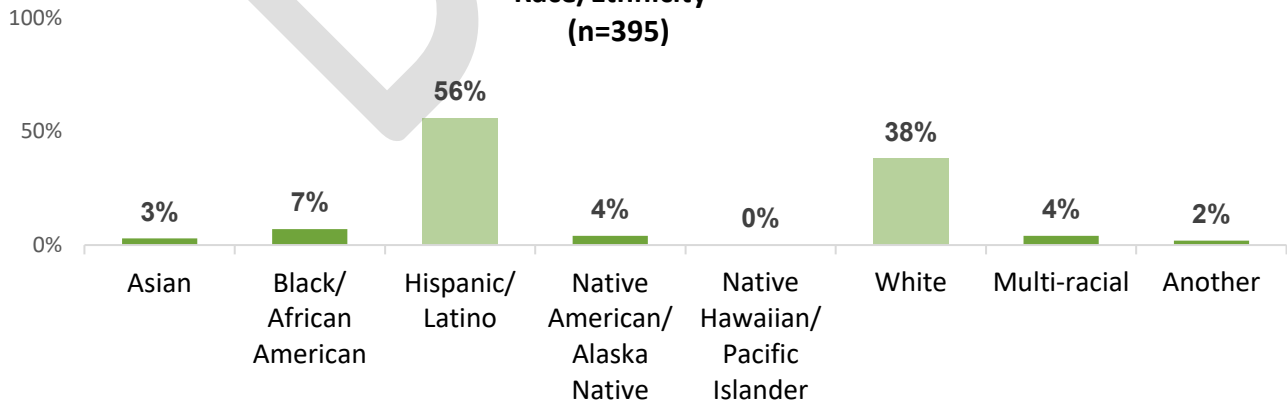


76% of respondents live in the city of Hanford (n=400)
11% live in Corcoran
7% live in Lemoore
1% live in Visalia
1% live in Avenal
4% live across 14 other ZIP codes

Gender Identity (n=397)

Female	82%
Male	17%
Transgender	1%
Genderqueer	0%
Questioning	1%
A different identity	0%

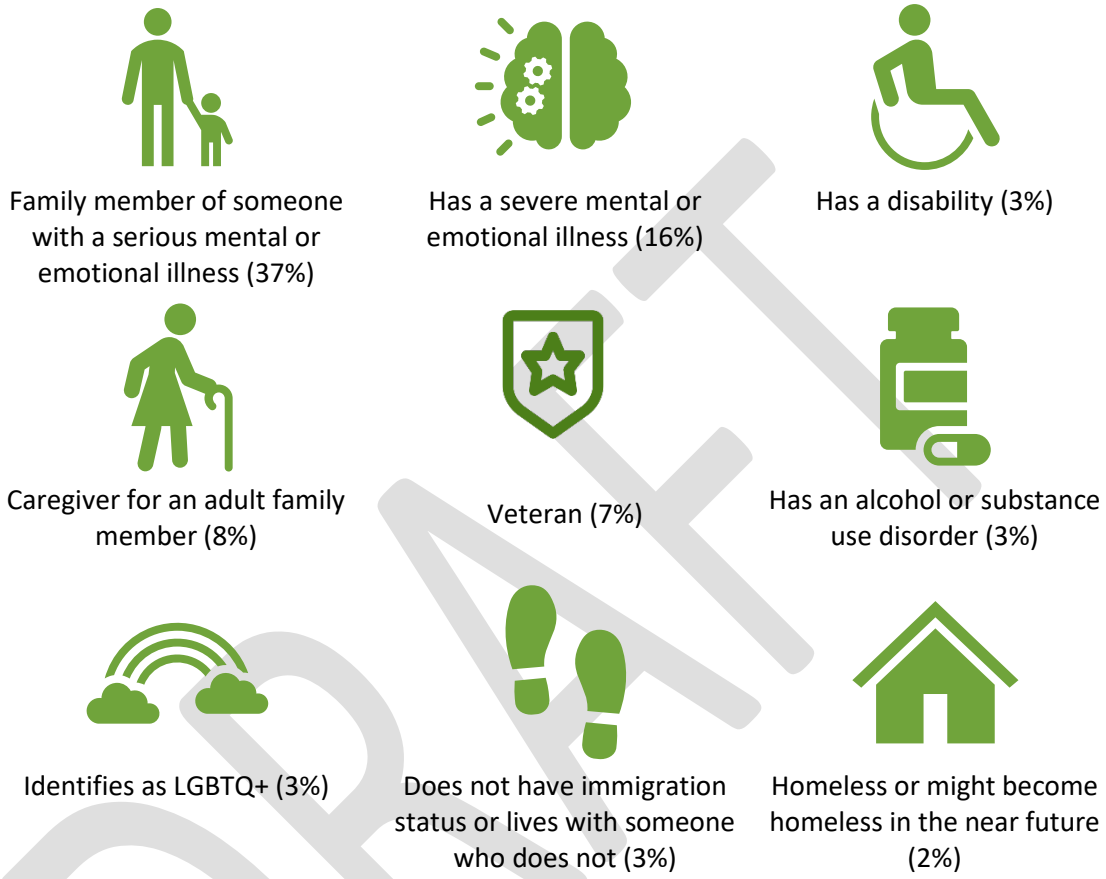
Race/Ethnicity* **(n=395)**



*Respondents could select more than one response option therefore the total percentage may exceed 100%

Survey respondents were also asked if they identified with any specific sub populations from a provided list so their feedback could be better understood in context. Of respondents to this question (n=376), more than half of the respondents (77%) reported being the parent or guardian of a child under 18.

Additional characteristics are visualized in the graphic below.



Additionally, respondents who indicated “other” (n=45) shared that they identify as family members of someone with a non-severe mental/behavioral health issue (n=8), providers of mental health services in Kings County (n=7), medical providers (n=4), school-based professionals (n=4), individuals with a history of or are recovering from substance use (n=4), and retirees (n=2).

Identified Mental and Behavioral Health Needs

The community member respondents were asked to identify King County's top needs for mental and behavioral health. Respondents selected from a list of provided options and were instructed to select up to three areas. Issues of alcohol and substance use (n=292), trauma (n=281), and depression (n=237) were the most frequently identified areas in 2022. Results from the prior three years are also included for comparison.

The findings are outlined in **Table 1** below. Values at or above 50% are **bolded** to facilitate interpretation.

Table 1. Pressing Mental & Behavioral Health Needs

	2019 (n=143)	**2020** (n=123)	**2021** (n=158)	**2022** (n=411)
Alcoholism/Substance Use	**75%**	**74%**	**73%**	**71%**
Depression	**64%**	**68%**	**66%**	**68%**
Anxiety	45%	**50%**	**54%**	**58%**
Trauma	26%	45%	49%	46%
Suicide or thoughts of suicide	30%	42%	26%	36%
Chronic Stress	19%	27%	33%	31%
Other*	6%	7%	8%	6%

*Other responses in 2022 included bipolar disorder (n=1), feelings of isolation (n=2), and homelessness/poverty (n=8).

Disparities

The most commonly identified mental and behavioral health needs varied slightly across demographic subgroups, although all subgroups examined (n's > 20) identified either alcoholism/substance or depression as the top need.

Most Commonly Identified Mental and Behavioral Health Needs by Subgroup

Gender

Male	Alcohol/SU	72%
Female	Depression	72%

Race/Ethnicity

Hispanic/Latino	Depression	74%
White	Alcohol/SU	77%
Black/AA	Alcohol/SU	77%

Misc.

Mental illness	Alcohol/SU	70%
Family member	Alcohol/SU	69%

Primary Language

Spanish	Depression	63%
English	Alcohol/SU	73%

Age

<26	Depression	85%
26-35	Depression	74%
36-45	Alcohol/SU	72%
46-55	Alcohol/SU	69%
56+	Alcohol/SU	76%

Impact of COVID-19

Respondents were asked how the COVID-19 pandemic has impacted the mental health of themselves or their family. Of those who responded (n=321), sixty (19%) indicated that the pandemic had not affected them. The most common theme in responses was related to changes in specific mental health symptoms, which was shared by one hundred forty five respondents (45%), and is explored in further detail below, along with other commonly reported themes. Note that answers to open-ended responses could contain more than one theme.

Change in mental health symptoms (45%, n=145)

Increased feelings of:

- Anxiety (n=79)
- Depression (n=46)
- Stress (n=42)
- Fear (n=10)
- Paranoia (n=2)

Decreased Feelings of:

- Motivation (n=3)

"My daughters have missed out on two years of socialization during critical, formative years. They both struggle with anxiety in social situations and neither did prior to COVID-19."

"I have watched my family's motivation and excitement for the future disappear, at times, completely. My children do not have the desire to conquer or even set goals any longer. Anxiety levels have shot through the roof in our home as well."

In general, community members reported increased levels of anxiety, stress, fear, and depression for themselves and/or their families, a result that was also described by community members last year. Specific fears or anxieties reported included fear of contracting COVID-19, fear of getting others/loved ones sick, and concerns about the COVID-19 vaccine.

The next few most commonly reported themes after changes in mental health symptoms that were reported were:

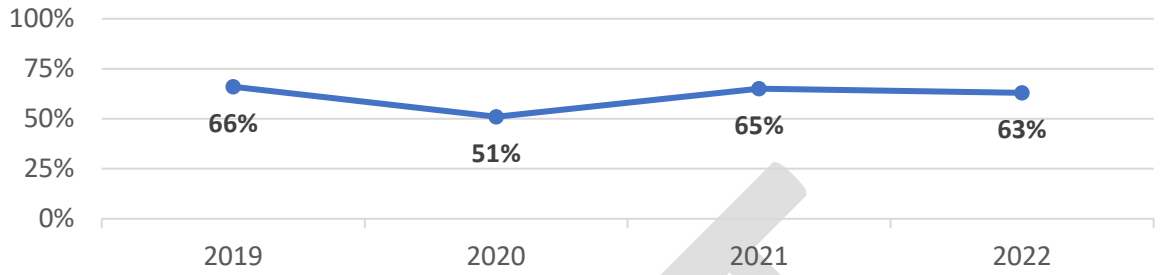
- Pandemic had not affected them (19%, n=60)
- Lack of social interaction with others (17%, n=54)
- Basic needs not being met (e.g. housing, employment) (8%, n=26)
- Impacted accessibility to services (5%, n=17)
- Difficulties with remote learning (3%, n=10)

Access to Care

Survey respondents were also asked to share their perception of access to mental and behavioral health services in Kings County. When asked whether people with mental and behavioral health needs can get

help in the community, 63% (of 410) of respondents agreed or strongly agreed (**Figure 1**). This result is a 2% decrease in agreement over last year's findings.

Figure 1. Agreement that Services are Accessible



Disparities

The percent of agreement that mental and behavioral health services were accessible varied slightly across most demographic subgroups. However, Black or African American participants were much less likely to agree that services are accessible (46%, n = 26).

Agreement that Services are Accessible by Subgroup

Gender	
Male	63%
Female	63%
Race/Ethnicity	
Hispanic/Latino	65%
White	64%
Black/AA	46%
Misc.	
Mental illness	56%
Family member	58%

Primary Language	
Spanish	75%
English	61%
Age	
<26	60%
26-35	64%
36-45	60%
46-55	69%
56+	67%

Barriers to Accessing Care

From a list of provided options, respondents were asked to identify three top barriers to accessing mental and behavioral health services in Kings County. Lack of information about where to get help (n=248), stigma about mental illness (n=223) and appointment availability (n=217) were the most frequently identified barriers to accessing services. The findings are outlined in **Table 2** below. Values at or above 50% are **bolded** to facilitate interpretation.

Table 2. Barriers to Accessing Services

	2019 (n=146)	**2020** (n=124)	**2021** (n=156)	**2022** (n=409)
Lack of information about where to get help	40%	**57%**	**63%**	**61%**
Stigma against mental illness	45%	**59%**	**56%**	**55%**
Appointment availability	38%	49%	**54%**	**53%**
Cost of services	35%	29%	42%	**52%**
Lack of health insurance	25%	34%	38%	40%
Lack of childcare	16%	23%	30%	31%
Distance to available services	22%	43%	34%	29%
Lack of transportation	33%	41%	32%	25%
Staff don't understand different cultures or backgrounds	6%	12%	15%	15%
Staff don't speak my language or have translation available	3%	6%	12%	9%

Note that the top three barriers reported last year remain consistent with this year. Other barriers themed from write-in responses included:

- Limited staff and services to meet high need (4%, n=17)
- Navigation and support while accessing services (1%, n=5)
- Appointment flexibility and wait times (1%, n=4)

Disparities

Most Commonly Experienced Barriers to Accessing Services by Subgroup

Gender

Male	Lack of info	63%
Female	Lack of info	60%

Race/Ethnicity

Hispanic/Latino	Lack of info	61%
White	Lack of info	58%
Black/AA	Lack of info	65%

Misc.

Mental illness	Stigma	67%
Family member	Lack of info	68%

Primary Language

Spanish	Lack of info	67%
English	Lack of info	59%

Age

<26	Cost	85%
26-35	Lack of info	68%
36-45	Cost	58%
46-55	Lack of info/Stigma	62%
56+	Lack of info	58%

Most Useful Services

Respondents were asked to describe the mental and behavioral health services they find most useful to themselves or to their family members. Of respondents (n=285), common themes emerged in the responses that are shown below. Note that answers to open-ended responses could contribute to more than one theme.

- Impactful individual and group therapy services (n=98)
- Addressing a variety of mental/behavioral health conditions (n=44)
- Practical child and adolescent therapy (n=35)
- Quality medication services (n=18)
- More opportunities for parenting and family support (n=15)
- Availability of therapists and clinicians (n=14)
- Helpful school-based services (n=10)
- Increased number of support groups (n=7)
- Providing virtual and in-person therapy (n=4)
- Informed case management (n=3)

"The school counselor really helped my son work through depression and make friends."

Respondents expressed how important and meaningful therapy is for community members and/or their families. It is most useful for community members to have readily available services addressing specific mental and/or behavioral health conditions and youth-specific therapy that addresses challenges children and adolescents encounter. Mental health conditions described included depression (n=17), stress (n=12), anxiety (n=16), and addiction (n=1).

When asked about County strengths, some respondents decided to talk about services they felt the County needed. Needs conveyed through these responses include:

- Improved access to services (n=27)
  Respondents described that access to services needs to be improved by offering services for community members with private insurance, reducing the cost of services so that it is more affordable, reducing wait times so that services can be accessed in a timely manner, and having services within the community so providers are closer to where community members live.

- Specific services needed (n=26)
  Services mentioned by respondents included substance use disorder services, suicide prevention services, crisis-related services, and services for those experiencing serious mental illnesses.

- Culturally diverse and empathetic staff (n=3)
  Respondents described the need for providers to hire empathetic staff who speak the language of the community as well as train staff to be culturally competent and sensitive.

Recommendations

Survey respondents were asked to provide recommendations for how the County can better support and address the mental and behavioral needs in the county. From all respondents who provided recommendations (n=302), specific strategies and illustrative quotes are provided respondents below.

Recommendation 1: Improving access to services	Respondents (n=302) recommended improving access to services to better meet the mental and behavioral health needs of the county. The top three ways respondents expressed to improve access included:	
 Increasing the number of counselors/staff/clinicians (n=43)	 Expanding the reach of services (n=40)	 Offering appointment flexibility (n=34)
Concerns over speaking with someone in a timely manner or finding a clinician who is currently accepting new patients led respondents to discuss the need for more counselors/staff/clinicians to meet the needs of the community. "Recognizing when we have a problem is the first and most difficult step, but to look for help only to find that there are no appointments with a psychologist or counselor due to staffing shortages is disheartening. In our clinic, there is only one psychologist, and during the pandemic, she was always so busy that appointments were once a month."	Respondents expressed a need for services to be expanded to improve access for community members. The top reported location where respondents would like to see expanded services is in the school setting, with respondents describing the need for counseling services to be provided within the school during school hours to eliminate the need to leave school for an appointment and transportation complications. Respondents also identified other ways in which services should be expanded including, a mobile crisis unit and more services to be offered via telehealth.	Respondents expressed that if providers offered appointment flexibility, this would help improve their access to services. Respondents suggested for providers to offer weekend and evening services for families who work, and 24/7 in-person facilities for services. "It's hard to get into therapy when we work the same hours as the providers or have children but no sitter so we can go to these appointments."

Other methods to improve access to services as described by respondents included offering services for community members with private insurance and lowering the cost of services.

Recommendation 2: Improving outreach to inform the community of available resources and reduce stigma of mental illnesses	Respondents (n=80) expressed a need for more outreach to inform the community of the services that are available in the county, the benefit of those services, and how to access those services. Respondents also expressed the importance of informing the community of signs and symptoms of mental health issues, destigmatizing mental illnesses so individuals seek the help they need, and providing information on the steps involved in receiving mental health services.

"Increase advertising of mental health services, offer 'guides' to getting a therapist/counselor..."

Recommendation 3: Increase providers/service options	Survey respondents (n=72) indicated that there is a need for wider variety of service types and options in the county, such as: • Youth-specific therapy • On-site counseling (for homeless individuals) • Residential substance abuse treatment programs • Residential psychiatric care • Mobile crisis units • School-based services • Support groups • Housing programs

"Make mental health services easily accessible. Have open conversations at schools about mental health and how to cope…A psychiatric hospital in Hanford would be wonderful as well."

Recommendation 4: Improving the quality of services received	Respondents (n=43) recommended providers improve the quality of services to better meet the needs of community members. Respondents described the need for services to be in-person and virtual to provide more flexibility for clients, especially those whose work hours conflict with appointment times or who have children. Lastly, respondents highlighted a need for expanded staff capacity and training, with respondents asking for staff that is bilingual, culturally competent, and compassionate and understanding towards clients.

"…my husband did not feel comfortable with her [his therapist] because she seemed disinterested and so he stopped treatment…"

COMMUNITY SURVEY ITEMS

1. **What do you think are the most important behavioral health issues in your community?** (please choose up to three)
   - ❑ Alcoholism/Substance Use
   - ❑ Chronic Stress
   - ❑ Suicide or thoughts of suicide
   - ❑ Anxiety
   - ❑ Depression
   - ❑ Trauma
   - ❑ Other (please specify): _____

2. **What are the barriers to accessing mental and behavioral health care in Kings County?** (select all that apply)
   - ❑ Appointment availability
   - ❑ Distance to available services
   - ❑ Lack of health insurance
   - ❑ Lack of transportation
   - ❑ Staff don't speak my language or have translation available
   - ❑ Cost of services
   - ❑ Lack of childcare/caregiver relief
   - ❑ Lack of information about where to get help
   - ❑ Stigma against mental illness or getting help
   - ❑ Staff don't understand different cultures or backgrounds
   - ❑ Other (please specify): _____

3. **How much do you agree or disagree with the following statement?**
   People with mental and behavioral health needs can get help in my community.

   ❑ Strongly Agree ❑ Agree ❑ Disagree ❑ Strongly Disagree

4. **What are the mental and behavioral health services that are most useful to you and your family?**

5. **How has COVID-19 impacted the mental and behavioral health of your or your family??**

6. **What recommendations do you have to better meet the mental and behavioral health needs in Kings County?**

Please tell us about yourself.

7. **What is the zip code where you currently live? ___ ___ ___ ___ ___**

8. **How old are you? _____** years old

9. **What racial/ethnic categories do you identify with?** (check all that apply)
   - ❑ American Indian or Alaska Native
   - ❑ Asian
   - ❑ Black or African American
   - ❑ Hispanic or Latino
   - ❑ Native Hawaiian or Pacific Islander
   - ❑ White
   - ❑ Multiracial
   - ❑ Another race/ethnicity (please specify):_____

10. **What language do you speak <u>most</u> at home?**
    - ❑ English
    - ❑ Spanish
    - ❑ Another language (please specify): _____

11. **How do you describe your gender?**
    - ❑ Male
    - ❑ Female
    - ❑ Transgender
    - ❑ Genderqueer
    - ❑ Questioning/unsure of gender identity
    - ❑ A different identity (please specify): _____

12. **Please tell us anything else about yourself that would help us understand your feedback.** (check all that apply)
    - ❑ I am a parent/caretaker of a child under 18
    - ❑ I identify as LGBTQ+ (please specify): _____
    - ❑ I am a veteran
    - ❑ I have a severe mental or emotional illness
    - ❑ I am a family member of someone with a serious mental or emotional illness
    - ❑ I have an alcohol or substance use disorder
    - ❑ I have a disability (please specify): _____
    - ❑ I am a caregiver for an adult family member
    - ❑ I do not have immigration status or live with someone who does not have immigration status
    - ❑ I am homeless or might become homeless in the near future
    - ❑ Other (please specify): _____

FOCUS GROUP RESULTS

Introduction

As part of the Community Program Planning Process (CPPP) for the FY 22-23 Annual Update and 3-Year Plan beginning FY 23-24, Kings County Behavioral Health (KCBH) partnered with EVALCORP Research & Consulting to conduct a series of focus groups.

The goal of the focus groups was to collect primary data from community members of diverse subpopulations about the mental and behavioral health issues in Kings County to help support the planning process for mental and behavioral services. In particular, the focus group questions analyses were designed to (1) assess the current needs for mental and behavioral health services by community members, and (2) identify how KCBH might better address these needs within the county.

Methods

Focus group participants were recruited through partner organizations and intended to be inclusive of individuals from vulnerable as well as minoritized populations within the county. All focus groups used a semi-structured protocol and were facilitated in English or Spanish. Twelve focus groups were successfully conducted with a total of 90 participants. **Table 1** provides further details about each of the focus groups.

Table 1. Focus Groups Completed

Focus Group Type	# Participants
SMI Adults	12
Older Adults	12
LGBTQ+	3
African American	7
Spanish Speakers	6
Veterans	17
Native American	6
LGBTQ+ Youth	9
Black Youth	9
Unhoused	3
Rural Residents (Corcoran)	6
Family Members of Individuals with Mental Illness	9

Data Analysis and Results

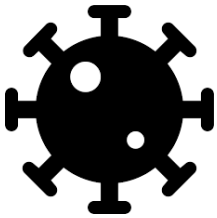
Notes taken during the focus groups were analyzed using a form of qualitative content analysis. This approach used an interpretive frame to identify commonalities and meaning across groups related to the purpose of the focus groups (i.e. (1) an assessment of the need for services, as shared by community members, and (2) to identify how KCBH might address these needs).

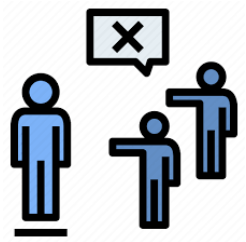
Note that throughout the results, sample sizes ("n=…") are provided to contextualize the frequency with which the topic was independently discussed across all groups, regardless of the prompt to which it was responded. Because of this, these values may exceed the total number of groups (i.e. 12).

Results

Broader Social Issues Affecting Mental Health Needs

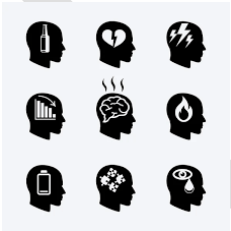
This section includes topics discussed by focus group participants that described as contributing to the severity and/or nature of mental health needs in the community, although they are not necessarily directly related to mental health services. Each topic is followed by additional context and examples of how the issue was discussed, and how it affects mental health needs in the county.

	Post-COVID Impacts (n=8) As a result of the COVID-19 pandemic, along with the broader societal response to the pandemic (e.g. lockdowns, mask mandates, school closures, etc.), participants reported experiencing spikes in anxiety and depression, which led to an increased demand for mental health services. Additionally, increases in nervousness and a general fear of leaving home were discussed in this context.
 	Economic Insecurity (n=5) Concerns related to economic insecurity, including high unemployment and prevalent homelessness were described as contributing to the nature and extent of the community's need for mental health services. For example, participants explicitly noted how being unemployed and experiencing homelessness triggered mental health issues. A lack of, or limited sense of, broader social and economic support was also discussed and limiting the potential positive impact of mental health services for those already engaged in treatment.
	Limited Support for Vulnerable Youth (n=3) Participants described how limited social support systems for vulnerable youth contributed to the severity and prevalence of mental health needs in the community. For example, the limited nature of social and mental/behavioral support for youth experiencing difficulties likely contributes to the increased engagement of these youth with gangs and/or drug use as alternative coping strategies. Similarly, a lack of support systems likely contributes to increased feelings of hopelessness and suicidal ideation, as well as an increased prevalence of "acting out," resulting in suspensions from school.

	Experiences of Discrimination (n=2) Historical distrust of health care and government systems, as well as experiences of racial profiling, were expressed as common issues that contributed to poor mental health, particularly among Black and Native American populations. These experiences create an additional barrier for members of these populations to seeking or receiving care, and contribute to the severity and prevalence of mental illness. This is not only because of untreated mental illness, but also because of a feeling of hopelessness due to the lack of appropriate and effective care by the available systems.
	Limited Coordination Between Mental Health Services and the Criminal Justice System (n=2) Participants shared that those most affected by law enforcement and the criminal justice system also tended to be those with untreated mental health issues, including individuals in gangs and incarcerated individuals. Additionally, youth, young adults and older males tend to experience a disproportionate amount of engagement with law enforcement, and it was shared that law enforcement did not understand the mental health needs of these populations.

Common Individual/Behavioral Concerns

This section describes topics discussed by participants that more directly reflect commonly reported or experienced mental health issues among community members. Each topic is followed by additional context and examples of how it was discussed.

	Stress, Suicidal Ideation, Isolation and Anger (n=11) Experiences of stress, suicidal ideation, isolation, and anger were frequently shared by participants, as well as their family members. Note that these are not technically mental health disorders, but when frequently experienced, can contribute to the onset of mental health conditions. These experiences were shared across a broad variety of contexts, including as a response to each of the broader social issues mentioned above, as well as in the context of encountering barriers to care described further below.
	Depression and Anxiety (n=10) Services for treating depression and anxiety were the most frequently discussed needs for formal mental health conditions described throughout the focus group sessions. However, participants also mentioned how alcohol and drug use (the next topic) were used to cope with depression and anxiety, so these topics are somewhat interrelated.
	Substance Use (n=5) Individuals reported engaging in substance use as a coping mechanism for other needs not being met, and shared that this needs to be understood by those offering services for substance use. For example, LGBTQ+ individuals expressed not being validated by their sexuality, which led to a lack of belonging and feelings of isolation, which in some individuals, contributed to substance use as a coping mechanism. Similarly, among Black men, it was voiced that it was more normalized to drink alcohol rather than access mental health services to cope with depression.
	Severe Mental Health Disorders (n=4) Improved services for, and a better understanding of, individuals with severe mental health disorders, including schizophrenia, bipolar, and PTSD were discussed among participants. For example, hallucinations were noted as a behavioral issue prevalent among participants, as well as other individuals in the community, and may be more common than many people realize. Additionally, a lack of a broader health support system (beyond direct treatment for mental health conditions), particularly for unhoused individuals, was mentioned as a leading contributor to the increased prevalence and/or exacerbation of severe mental health disorders.

Accessibility of Existing Mental and Behavioral Health Services

This section summarizes needs related to the accessibility of mental and behavioral health services that were shared by participants. The first subsection describes *barriers* that limit the community's access to effective care, while the second section summarizes more explicit *needs* that were shared.

Barriers Limiting Access

(n=23)

- *Not having mental health providers representing the population* was reported to make it more challenging to seek mental health services. For example, Veteran and African American participants noted that the lack of representation made them feel uneasy, given they questioned whether they were provided with the same level of care as others. Participants described that having mental health providers of color would be helpful in being able to relate to them and feel comfortable expressing themselves.

- Across focus group sessions it was also voiced how *long waitlists*, which sometimes could take up to three months, made it difficult to access mental health services.

- *Therapists not lasting* due to relocation or staff turnover was an additional need mentioned by some of the focus groups.

- *Costly services* also made it difficult for some individuals to access services. This includes not having funds to pay for internet and cellphone services required for telehealth care.

- *Location restrictions* were also described as service needs among several individuals. Participants shared that services in rural regions were either limited or nonexistent, which made it challenging to access services for individuals without reliable transportation.

- *Stigma associated with seeking services* was commonly discussed by participants as a reason contributing to a lack of access to mental health services. This stigma was particularly prevalent among men, the LGBTQ+ population, and Native Americans. Harassment and poor treatment were also expressed as additional concerns for why individuals chose to not seek mental health services.

The following are the primary needs related to access to mental and behavioral health services, as shared by participants.

Need for Additional Specific Support Services (n=13)	Requests for access to specific support services and programming were voiced by participants, and included topic specific support groups, a community warmline, and additional places for social gatherings. For example, it was discussed how having a place for social gatherings would help them feel validated, as would having a Warmline specific to their community. Additionally, participants mentioned having an in-person site and peer advocates at the colleges would also be beneficial. Finally, having support services that could help individuals that were hard of hearing during their therapy sessions, help individuals provide funeral planning guidance, and services that could give advice on budgeting were also mentioned as being helpful.
Need for Improved Awareness of Existing Services (n=9)	Participants share that there was very little to no awareness of the mental health resources available to the community. In particular, uncertainty about where and how to seek mental health services was frequently noted. Outdated online resources were another barrier to finding out about resources. Spanish-speaking monolingual individuals also mentioned the challenges they had in learning about mental health resources in the broader community.
Need for Additional Information Sources (n=8)	Several existing resources to access mental health resources were mentioned, including the library, Veterans' Corner, as well as the LGBTQ+ warmline. However, participants also noted how having more resource sites and resources was needed. Additionally, it was shared that having a downtown site, a county warmline, and peer advocates would be helpful in improving awareness about what resources are available and how community members can access them.

Strengths of Existing Services

Two primary strengths of the existing mental and behavioral health services were shared by participants and are summarized below.

Existing Services are Beneficial and Coordinated (n=5)

In general, participants shared that their experience with the services available were beneficial and coordinated. For example, it was expressed that Kingsview therapists were knowledgeable and the services at KCAO were helpful. More specifically, participants appreciated how their mental health providers were in constant communication with each other and resourceful, especially during times of limited availability of resources. Participants described how providers work effectively and ethically with clients' family members, and how providers have offered useful and effective resources to navigate additional community resources.

Additionally, participants appreciated the expansion of telehealth and telepsychiatry since the onset of the COVID-19 pandemic, as well as the campaigns to destigmatize seeking help for mental illness. Both of these examples served as additional ways of improving local mental health services within a limited budget and capacity.

Use of Knowledge Facilitators (n=5)

Participants generally shared the utility of the available resources they have used to access or learn about available mental health resources. These effective "knowledge facilitators" included an online newsletter, the Family Health Network, KCAO, social media, therapists, ACT Program, Kings View, MHS Kind, AspireNet, Champions, Westcare, and knowing someone affiliated with community events. As discussed earlier, it was noted that although these resources themselves were useful, they were sometimes difficult to learn about.

Recommendations to Improve Services

Finally, two broad categories of explicit and specific recommendations were shared by participants across groups and are summarized below.

Expand or Improve Specific Support Services

Participants shared many specific requests for improvement or expansion of particular service needs, including many associated with a broader conception of mental wellness and prevention. These included:

- Offering additional home-based and onsite activities for youth and adults, including classes for learning English, cooking, driving, Zumba, swimming, and how to apply to college. It was also noted that if these activities were on-site, offering scheduling flexibility (e.g., evenings and weekends) would be helpful.

- Expanding the availability of existing programs, including telehealth services, services for the unhoused, warmline access, drop-in centers, support groups, and the capacity for crisis services.

- Prioritize and expand improving awareness and treatment of mental health among younger populations, particularly at schools.

- Identify, expand and share ways to access mental health services for situations that are not considered as severe per insurance requirements.

Improve Community Outreach Efforts

Additionally, participants shared several specific suggestions related to improving the accessibility of existing services, as well as improving community engagement more broadly:

- Promote the current locations of mental health services through the hospital district advertising, and coordinate this messaging between physicians, mental health professionals, and families to facilitate ease of navigating resources and insurance requirements.

- Offer courses to board members, caregivers and social workers on mental health triggers and working with special populations. These include Spanish-speaking students, unhoused individuals, youth and their families, and trauma survivors. Additionally, offer onsite health education resources in locations familiar to the broader community on these or other topics.

- Improve collaboration of mental health services with the police department as they are often the first responder to come in contact with someone experiencing severe mental illness.

- Improve the accessibility of the current county website and 211 mental health line, and make these resources available in languages other than English.

FOCUS GROUP ITEMS

Mental/Behavioral Health Needs

Let's begin by discussing mental and behavioral health issues in your community.

1. In your opinion, what are the most important mental and behavioral health concerns in your community?
    a. Are there certain groups or populations more affected than others?
2. What changes have you seen in the needs of community members as a result of COVID-19?
3. What do you think contributes the most to poor mental and behavioral health in your community?

Available Resources and Ideas for Increasing Access

Now we are going to talk about resources for help with mental and behavioral health needs.

1. What resources or services are available in the community in to help address mental and behavioral health needs?
    a. How did you learn about them?
2. How easy or hard it is to get help for mental/behavioral health issues in your community?
3. What are the current strengths of the County's mental and behavioral health system?
4. What prevents people from getting mental and behavioral health help or support?
5. How can mental/behavioral health services be made more accessible?
6. What additional mental and behavioral services do you think would benefit the community?

Closing Question(s)

1. Is there anything else you would like to share with us about mental/behavioral health issues within your communities?

KEY STAKEHOLDER RESULTS

Introduction

As part of the Community Program Planning Process (CPPP) for the FY 22-23 Annual Update and 3-Year Plan beginning FY 23-24, Kings County Behavioral Health (KCBH) partnered with EVALCORP Research & Consulting to conduct a series of Key Stakeholder Interviews.

The goal of the interviews was to collect primary data from mental health providers throughout Kings County to help support the planning process for mental and behavioral services.

About the Interviewees

Mental and behavioral health providers were interviewed about the ways in which their agencies engage in/with mental and behavioral health service provisions, and the populations they serve. Four-fifths of interviewees (80%) stated that their agencies serve all of Kings County. The remainder provide services for specific school districts, multiple counties, and statewide. All interviewees (n=14) except one provide a form of mental/behavioral health service, either directly through their staff or through their agency. These services included:

- **Counseling**
- **Crisis services**
- **Mental health diagnoses**
- **Medication**
- **Placement and release of 5150s**
- **Outreach and education**
- **Outpatient/Inpatient services**
- **Referrals**
- **School-based services**
- **Support groups/Programs**
- **Substance misuse and prevention services**
- **Housing/shelters**

The other agency acquires and distributes funding for services.

When asked which populations were served by their agency or organization, interviewees were quick to share specific subgroups from a wide array of populations including:

- **Adults**
- **Veterans**
- **Refugees**
- **Children and teens**
- **Unhoused**
- **Youth involved in the justice system**
- **Foster youth**
- **LGBTQ+**
- **Low-income families**
- **Probationers**
- **Severely mentally ill individuals**
- **Victims of crime**

Results

Mental & Behavioral Health Needs

To explore the most pressing mental/behavioral health needs in Kings County, interviewees discussed specific mental health conditions and mental health system-level needs. An important note about the following mental health conditions and system-level needs presented is that certain subpopulations were impacted to a greater degree than others, as expressed by interviewees. The populations most frequently stated included residents in rural communities (n=9), children and teens (n=6), people without homes (n=5), and poor communities (including low-income families) (n=5). Other groups mentioned included minorities, LGBTQ+, individuals with severe mental illness, active military, veterans, parents, those recovering from trauma, and foster youth.

Pressing Mental Health Conditions

Of the mental or behavioral health conditions identified by interviewees, depression, substance misuse, self-harm, post-traumatic stress disorder, eating disorders, severe mental illness (e.g., paranoia), and suicide ideation were discussed. Increases in depression, stress, social anxiety, and suicide ideation was noted and could be due to changes in daily living as a result of the COVID-19 pandemic and financial strains due to inflation. Interviewees also noted the impact that COVID-19 has had on the community, as they have seen increases in stress, anxiety, isolation, not wanting to return to work, school absenteeism and bullying, domestic violence, child abuse, and grief.

System Needs

Lack of mental health services and providers (n=15)
Respondents noted a lack of services in the County such as family counseling, services for the LGBTQ+ community, people with eating disorders, rural residents, older adults, and 5150 beds for the gravely disabled. Interviewees discussed a need for providers to reduce wait lists and have access to care on evenings and weekends.

Improvements needed amongst providers (n=10)
Interviewees indicated improvements needed include more providers with an understanding of the LGBTQ+ and indigenous communities, mid-level providers, and an increase in the number who accept private insurance.

Lack of easily accessible services (n=9)
Respondents expressed a need for making services more easily accessible such as having mental health workers in the community, bringing resources to clients (including having services in the schools), reducing wait times for services, and establishing a mobile clinic.

Other critical gaps shared by interviewees include a lack of resources for residents including basic needs (i.e., food, shelter) and access to medication, as well as assistance with/in addressing transportation difficulties to services such as traveling to Kings View from outlying communities. Interviewees also

expressed concern about the lack of internet access for telehealth appointments, services for active military and their families (especially prior to deployment), fear of rejection by members of the LGBTQ+ community looking for help, an eating disorder provider, and education on how to navigate through the system. In addition, a place for domestic violence victims to house their pets while in the shelter and more housing facilities that accept emotional support animals was mentioned. Trauma-informed instruction for teachers and more school-based care was recommended.

It was noted by several interviewees that people with private insurance have more difficulty accessing counseling services. The reasons are threefold (1) affording the co-pays, (2) most private insurance providers are cash pay and then patient bills insurance, and (3) Medi-Cal has requirement to see patient within 10 days so they have better access than people with private insurance.

COVID-19 Impact

Since March 2020, the COVID-19 pandemic has presented a globally significant social, economic and health crisis. In Kings County, recommendations to shelter-in-place and self-isolate have had notable implications for the needs of community members. To understand the impact of COVID-19 on county residents, interviewees were asked what changes they have observed in community members' needs as a result of the COVID-19 pandemic. Respondents discussed a range of issues including an increase in mental and behavioral health conditions, increased levels of service needs, and new or emerging barriers to services.

COVID-19-Induced Mental and Behavioral Health Conditions

- **Mental health symptoms**
  - Anxiety
  - Depression
  - Grief
  - Paranoia
  - Psychosis
  - Suicide
  - Overall mental health issues
  - Substance misuse
  - Isolation
  - Eating disorders
- **Aggression (amongst school children)**
- **Crisis situations/hospitalizations**

Interviewees attributed the above mental and behavioral health conditions to either an increase in need for services or the effect of the pandemic. For example, respondents expressed that the COVID-19 pandemic led to increased needs for assistance with basic needs (n=9) such as rent, electricity, food, and housing which were tied to increased anxiety for residents. Most interviewees shared that COVID-19-induced mental and behavioral health conditions (i.e., anxiety, depression, grief, overall mental health

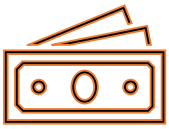
issues) had led to a need for greater capacity for mental health providers to respond to the increased demand within the County, as well as for services to meet a wider range of pressing needs.

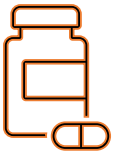
Interviewees also brought up an escalation of barriers to accessing County services. Specifically, interviewees felt that mental and behavioral health services have been more difficult to access because services are not provided nearby, difficulties accessing virtual/telecommunication platforms, and decreased rates of clients following up with or seeking services since the pandemic began.

"[I] *Saw a small reduction of homelessness in the county, which had to do with an abundance of new resources due to COVID, such as Project Room Key, which is ending. I am concerned about the aftermath as COVID programs as beginning to stop e.g., rental protections."*

Contributing Factors

Interviewees also provided information about causes and contributors to the poor mental and behavioral health of Kings County residents which are summarized below.

	**Financial Struggles** Respondents conveyed that unemployment and inflation affected individuals' mental health. It was stated that basic needs must be met before mental health services are pursued.
	**Lack of Resources/Flexibility and Communication** Interviewees expressed that Kings County residents are not able to receive the care they need due to a lack of access to mental health services, high turnover rates for health providers in the behavioral health field, long wait times, no drop-in clinics, limited resources for the evening times when a crisis occurs, not having necessary transportation, as well as lack of communication about where to start/next steps to accessing needed resources.
	**Negative Experiences/No Support System** Respondents described that individuals who have experienced trauma in the past or individuals who feel isolated from their support systems do not seek the help they need. One interviewee explained that foster youth move from home to home often because foster parents do not have the education and support they need.

	**Substance Misuse** Interviewees suggested that an increase in individuals with substance misuse disorders are leading to a higher number of individuals experiencing poor mental/behavioral health.

An important shared understanding from interviewees was how the lack of education on mental health contributes to increased levels of stigma-related mental health issues. Stigma concerns, such as "people who seek services are 'crazy' and weak," are specifically caused by a lack of information, cultural differences in the perception of mental health, and religious beliefs.

Barriers to Services

Interviewees were asked about their perceptions of barriers that Kings County residents experience when trying to access mental and behavioral health services, and their recommendations to improve access to services. The top barrier areas are presented below.

Knowledge (n=9)
For some community members, there is lack of knowledge about accessing services, such as knowing where and how to find services, finding service providers, knowing which providers are LGBTQ+ friendly, and understanding referral processes.

Time and Availability (n=7)
Long wait times for services, the need for more timely services, and adjusting to (or meeting) individual agency appointment schedules so that services are available on evenings and weekends, have been challenges for Kings County residents when trying to access services.

Navigating Care (n=5)
Community members have challenges in navigating the health care system including lack of availability in facilities and difficulties in accessing services. For community members, knowing what insurance is accepted, languages spoken, and if new patients are being accepted would be helpful. They are uncertain about the pathway to care and what to expect when care is provided.

Other barriers and/or lack of supports mentioned by stakeholders included transportation to care (n=2), cultural bias and stigma (n=7), instability in the home (n=7), service or provider limitations (n=3), access to technology (n=4), and health and digital literacy (n=3).

Recommendations

Interviewees additionally provided recommendations on how to overcome the barriers identified and improve access to mental and behavioral health services for Kings County residents. The top three ways shared by interviewees to improve access are described below.

Provide Easily Accessible Services (n=13)

Almost all of the interviewees expressed that having more easily accessible services would give residents more flexibility. One way specifically described to make services more accessible is to increase presence in the community including having a mobile unit to provide medical services such as signing up for Medi-Cal or a crisis team, having a crisis team in the schools, increasing the number of providers in the area, and having mental health workers in the community 24/7.

Increase Services and Resources (n=12)

Interviewees recommended increasing the types of programs/services in the area such as a stabilization program. Recommendations also include increasing the number of programs/services, such as more crises-oriented and prevention services. Lastly, interviewees suggested increasing access to resources for residents would improve access to services for Kings County residents. Resources suggested by interviewees include having drop-in centers, providing hotline services, a mobile clinic, and having services in rural regions.

Increase Knowledge (n=8)

Respondents suggested that increasing cultural competency amongst providers and knowledge of services within the community would help improve access to services. As explained by interviewees, possible ways to increase community knowledge include conducting community outreach, advertising in schools and on social media, and providing cultural training to mental health staff so they can learn how to talk to people with different cultural backgrounds and know what is important within that community.

Interviewees expressed other ways to improve service access such as improved inter-disciplinary care, providing support for transportation, and hiring more clinicians and mid-level providers. Interviewees also conveyed a need for expanded facilities to handle the increased County demands and suggested a psychiatry ward, more mental health clinics, a residential care program where men and their children can go, more parenting groups, and education for parents and teens about self-harm.

Additional Services Requested

Interviewees were asked if there were any additional services that KCBH can provide that would benefit the community. Services mentioned included:

Educational Resources	Mental Health Services In Schools	Case Management	Improved Interdisciplinary Care
Domestic Violence Program	Preventative Programs	Specialized Services for Adults, Children, and Individuals Facing Substance Misuse	Crisis Mobile Unit
24-Hour Mental Health Services	Transportation Services	Inpatient Facilities	Outreach
Patient Navigators	A Wellness Center for Children	More Services by Psychologists	Pop-Up Clinics

Strengths

Interviewees were asked about the current strengths of the County's behavioral health system and additional services that would benefit Kings County. The most commonly mentioned strengths are listed below.

Increased Collaboration and Communication Between Providers and Clients (n=15)

All of the interviewees expressed gratitude for the shared collaboration between KCBH and local stakeholders. This ensures that clients get the services they need. Additionally, it was noted that there is a high amount of communication and collaboration between KCBH and providers of mental and behavioral health supports as seen through the integration of clinical expertise across providers and the provider/care coordination meetings.

Trained Staff that Provides Excellent Care (n=13)

Respondents described the staff at KCBH as caring, friendly, approachable, accessible, strength-based, involved, and responsive.

"I love the direction that the county is headed".

Tailored Services and Specialized Programs that Align with the Needs of the Individual (n=12)

More than half of the interviewees expressed appreciation for the new programs coming through KCBH, due in part by taking local stakeholder input on how to utilize funds to address the needs of community members. KCBH's responsivity to levels of care are tailored to the individual (e.g., number of services per week, types of interventions/ programs), ensuring that those assessed get proper treatment and are offered personable services.

Expanded Accessibility of Health Services/Resources (n=5)

Interviewees mentioned that services have been made more accessible for community members (although there is still room for improvement) through the KIND and ACT programs and collaboration with the California Health Collaborative. The additional support groups were also mentioned.

KEY STAKEHOLDER INTERVIEW ITEMS

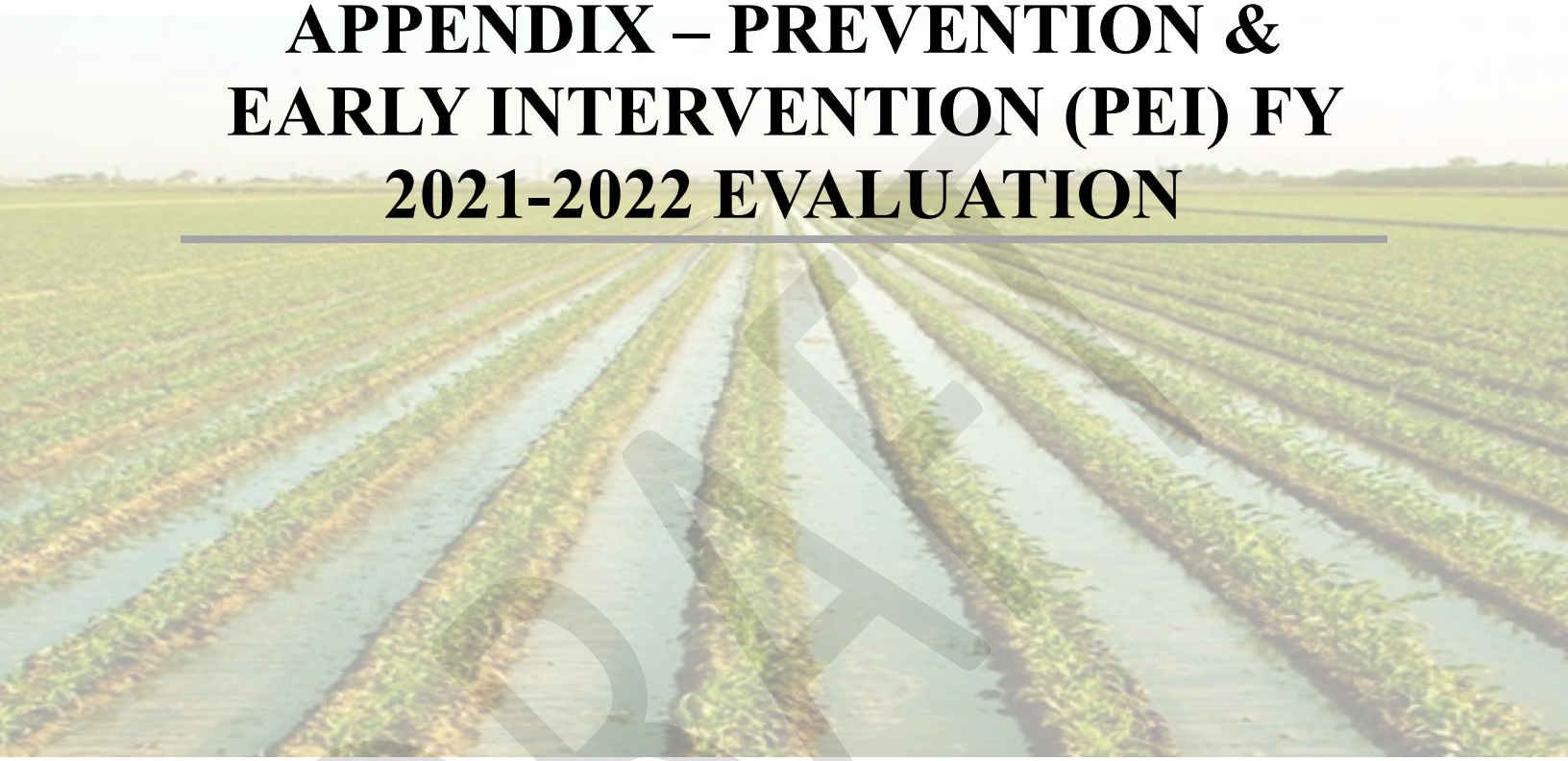
Respondent Background Information

1. What is your current role at [Agency]?
    a. How long have you been in this role?
2. Please briefly describe the work that [Agency] conducts/engages in with mental/behavioral health service provision.
3. Which populations do you work with most?
4. Which geographic areas does your agency serve?

Mental Health in Kings County

5. What are the most pressing mental/behavioral health-related concerns or needs you're seeing in the communities you work in?
    a. Why?
    b. Which populations/communities are most affected by these?
6. What changes have you seen in the needs of community members as a result of COVID-19?
7. What are some factors that contribute to poor mental/behavioral health in the communities you work in?
    a. Do these factors vary by population or region?
8. What are the biggest challenges community members face when trying to access mental/behavioral health services?
9. How can access to mental/behavioral health services be improved in the communities you work in?
10. What are the current strengths of the County's mental and behavioral health system?
11. What additional mental and behavioral services do you think would benefit the community?
12. Is there anything else you would like to share with us that we haven't already talked about that would be helpful for understanding the mental/behavioral health needs in the communities you work in?

APPENDIX – PREVENTION & EARLY INTERVENTION (PEI) FY 2021-2022 EVALUATION



KINGS COUNTY
MENTAL HEALTH SERVICES ACT

FY 2021-2022
Annual Prevention and Early Intervention (PEI) Report

Prepared for:

Prepared by:

OVERVIEW OF PEI PROGRAMS

The following table lists the PEI Programs for FY 21-22, organized by program classification.

Program Type	Program Name
Prevention	Young Minds Family Support Group LGBTQ+ Support Group Veterans Support Group
Early Intervention	Early Intervention Clinical Services (EICS)
Access and Linkage to Treatment	2-1-1 Kings County Senior Access for Engagement (SAFE)
Outreach for Increasing Early Recognition of Early Signs of Mental Illness	Applied Suicide Intervention Skills Training (ASIST) Safe TALK Mental Health First Aid (MHFA) Youth Mental Health First Aid (YMHFA)
Stigma and Discrimination Reduction	Kings Partnership for Prevention (KPFP) Cultural Humility Taskforce Radio and Billboards
Suicide Prevention	Central Valley Suicide Prevention Hotline (CVSH) Depression Reduction Achieving Wellness (DRAW) Local Outreach to Suicide Survivors (LOSS)

The remainder of the report includes additional descriptions of each of the above programs, along with a summary of any available activity, demographic, referral, and outcome data for that program for the 21-22 fiscal year.

A final section of the report (**Appendix**) includes a list of events at which KCBH services, including PEI programs, were promoted during the 21-22 fiscal year. The goal of these events was to connect with hard-to-reach communities/populations.

PREVENTION

Young Minds

Numbers Served[1]**:** 1,716 students/youth; 331 family members; 32 teachers/staff

Program Description

Young Minds is a school-based program designed to provide students with skills and tools to promote mental health, school performance, and healthy relationships and communication. Young Minds started operating in Kings County in January 2022. Examples of mental health prevention services offered through this program include several curricula, as well as single-event activities such as school-wide assemblies.

Activities

One type of activity or event conducted by Young Minds consists of **curricula or recurring activities**. Some additional information about these activities is provided below.

Name	Events	Participants	Intended Population
Mindful Schools	14	358	Students/Youth
Middle/High School Groups	5	13	Students/Youth

- *Mindful Schools* utilizes a curriculum that teaches mindfulness to K-12 students with the purpose of increasing attention, self-regulation, and empathy. The research-based program allows behavioral health staff to teach and implement mindfulness activities and practices in classrooms, after-school programs, or other settings. The program seeks to improve the student's emotional regulation, focus, and engagement, as well as improve connections with other students. This is a cost-effective way to help students develop skills to decrease stress and anxiety.

A second type of activity or event conducted by Young Minds consists of **single-event activities**. Some additional information about these activities is provided in the table below.

Name	Events	Participants	Intended Population
Teacher In-service Training	1	32	Teachers/Staff
Youth Health Fair	5	435	Students/Youth
Mental Health Assembly	2	910	Students/Youth
Family Engagement Events	2	331	Family Members

Demographics[2]

The following tables include available demographics for some student curricula (i.e. Mindful Schools for middle school students, and Why Try recurring group for middle school students) and family engagement events. Note that these tables only reflect total survey responses, so the counts may be less than the total number of participants listed in the tables above.

[1] May be duplicated

[2] Demographic and outcome data for this program are adapted from reports by LPC Consulting Associates, Inc.

Students/Youth (n = 59)

Race	Count	Percent
White	10	20%
American Indian	9	18%
Pacific Islander	2	5%
More than one	12	24%
Other	16	33%
Decline to state	10	-

Ethnicity	Count	Percent
African	3	6%
Japanese	2	4%
Other – Non-Hispanic	7	14%
Mexican/Mex.-Am./Chicano	33	62%
Central American	1	1%
South American	1	1%
Other – Hispanic/Latino	6	11%
More than one	1	1%
Decline to state	8	-

Primary Language	Count	Percent
English	49	88%
Spanish	4	7%
Other	3	5%
Decline to state	3	-

Disability	Count	Percent
Yes	9	17%
No	45	83%
Decline to state	5	-

Families[3] (n = 84)

Race	Count	Percent
White	18	43%
Black or African American	4	10%
American Indian	2	5%
More than one	3	9%
Other	14	33%
Decline to state	42	-

Primary Language	Count	Percent
Spanish	57	68%
English	27	32%

Outcomes

The following outcomes reproduced below are from a program summary document for Young Minds activities conducted during January – June 2022 and are based on surveys of students and teachers who attended events.

Outcome	Reported Value	Goal
Students report having new tools or techniques to reduce stress and anxiety.	92%	70%
Students report a reduction in stress and anxiety.	68%	60%
Students report having new skills to regulate their emotions.	73%	60%
Teachers report having tools to support self-regulation of students in the classroom.	74%	70%

[3] Unit of analysis for these demographics is family, not individual

Family Support Group

Number Served: 18 unique individuals (>101 attendees)

Program Description
The Family Support Group offers a high quality and culturally competent support group that provides opportunities for connection, discussion, education about mental health, and living with individuals who live with a mental health diagnosis. The group uses a peer-to-peer approach and is facilitated by a licensed clinician. There is an emphasis on community resources, referrals, and linkages. The group is an open group, meaning that there is no ongoing curriculum or roster of individuals.

Activities
The Family Support Group **meets** twice a month (on the first and third Tuesday). The table below lists the dates and recorded attendance (per sign-in sheets) for groups held during the 21-22 fiscal year.

Group Date	Attendance
8/3/2021	2
8/17/2021	8
9/7/2021	6
9/21/2021	8
10/5/2021	9
10/19/2021	7
11/2/2021	8
11/16/2021	8
January through March – Zoom only	(unspecified)
4/5/2022	9
4/19/2022	8
5/3/2022	6
5/17/2022	8
6/7/2022	6
6/21/2022	8

The Family Support Group is **promoted** through the distribution of postcards through the community at locations such as hospitals, the court, schools, and to providers.

LGBTQ+ Support Group

Number Served: 257[4]

Program Description
The Source's LGBTQ+ Support group meets regularly to provide opportunities for connection, discussion, education about mental health and other resources, and other services through a peer-to-peer model.

Activities
The LGBTQ+ Support Group has four variations that each **meet** once per month:

- Youth Night: The purpose of this group is to build a sense of belonging, share resources, and have fun. This group is open to individuals ages 12-18.

- Kings County Pop-Up (first): This group is focused on education and support, and is open to everyone, including allies.

- Transgender Support Night: The purpose of this group is to provide support and resources, and to provide an opportunity for peer-to-peer sharing of experiences. This group focuses on trans and non-binary issues, and is open to all trans and gender-diverse individuals.

- Kings County Pop-Up (second): This group is similar to the other Pop-Up group, in that it is focused on support, sharing resources, and building community. It is also provides a safe place to be one's self, and is open to everyone, including allies.

Through PEI, the Source also participates in **outreach events** such as red-ribbon weeks and wellness fairs. It also visits high schools and collaborates with other organizations to host smaller events that primarily focus on youth.

[4] Duplicated counts

Veterans Support Group

Number Served: 28 unique individuals[5]

Program Description
The Veterans Support Group meets regularly to provide opportunities for connection, discussion, education about mental health and other resources, and other services through a peer-to-peer model. The goals of the group are to decrease isolation and provide peer support. This group began offering services in March 2022.

Activities
The Veterans Support Group **meets** twice a month: on the second and fourth Tuesday from 5:30pm – 7:30pm. Topics include PTSD, emotional regulation, anxiety, depression, wellness, and becoming one's own advocate. Often, guest speakers from the community are brought in to facilitate discussion around a particular topic.

The group facilitator also provides verbal **referrals** to community services, including to e.g. private providers, utility assistance, and rental assistance.

The Veterans Support Group is **promoted** at the Veterans Coalition (meets monthly), and occasionally at larger events with filers or speaking engagements. The group facilitator also represents veterans on the Mental Health Task Force, which meets monthly.

[5] Estimated

EARLY INTERVENTION

Early Intervention Clinical Services (EICS)

Number Served: 540 unique individuals

Program Description

The Early Intervention Clinical Services (EICS) program at Kings View seeks to engage youth early on in the development of a serious mental illness to decrease the severity of symptoms, increase recovery, and help youth stay on track developmentally. Services provided include home, community, and office-based clinical services, case management, and other supportive services for youth and their family.

The target population of EICS is Transitional Age Youth (aged 18-25) that have experienced a first episode of psychosis, mania, depression, or other mental health disorder or are beginning to show signs of developing a serious mental health problem. Program clients are identified and referred by parents, providers, schools, emergency rooms, primary care physicians, child welfare, law enforcement, and juvenile probation staff.

Activities

EICS provides **outpatient services** (Specialty Mental Health Services) for individuals aged 18-25 years. Individuals are given **assessments** using the Burns Anxiety Inventory, Burns Depression Inventory, and Adults Needs and Strengths Assessment. Individuals are **referred** to additional services or higher levels of care, as appropriate.

Demographics

The following tables summarize the available demographics of the individuals who received outpatient services.

Gender Identity	Count	Percent
Female	287	53%
Male	252	47%
Another	1	<1%

Age	Count	Percent
0 to 15	-	-
16 to 25	540	100%
26 to 59	-	-
60+	-	-

Veteran Status	Count	Percent
No	483	90%
Yes	53	10%
Decline to state	4	-

Primary Language	Count	Percent
English	527	98%
Spanish	11	2%
Vietnamese	1	<1%
Not reported	1	-

Disability	Count	Percent
Hearing/Speech	14	3%
Mental Domain	9	2%
Vision	6	1%
Physical/Mobility	3	<1%
Other	22	4%
None (inc. mental health)	505	90%
Decline to state	6	-

Race	Count	Percent
White/Caucasian	184	36%
Black/African American	75	15%
Asian	14	3%
Native American	10	2%
Pacific Islander	2	<1%
Other	222	44%
Not reported	33	-

Ethnicity – Hispanic/Latino	Count	Percent
Mexican/Mex.-Am./Chicano	133	44%
Puerto Rican	3	1%
Cuban	1	<1%
Other	162	55%
Not reported	20	-

Ethnicity – Non-Hispanic/Latino	Count	Percent
Filipino	6	3%
Asian Indian	2	1%
Korean	1	<1%
Other (Asian)	5	2%
Other (Non-Hispanic)	207	94%

ACCESS AND LINKAGE TO TREATMENT

2-1-1 Kings County

Number Served: 3,217[6] calls received

Program Description

2-1-1 Kings County serves as a telephonic, text, website, live chat, and mobile app informational tool to assist in linking community members to local, regional or national public resources provided by the government, community, and non-profit entities, including behavioral health services.

Activities

Program staff receive a **call, text, or chat** directly from a community member (available 24-7). A live specialist will respond and conduct an initial screening to drill down (triage). Call specialists will identify a minimum of three community resources and provide resource information to them (text preferred to ensure a record of the referral is captured). If they agree to a follow-up call, a specialist will reach out within 72 hours of the original call. Three attempts are made. The purpose is to ensure that the resource information provided helped them with their needs. If not, additional resource information will be provided. If they have additional needs, they are identified and provided with additional resource information. The tables below include summary information about calls, chats, and texts received.

Activity	Frequency
Number of calls (English)	2,838
Number of calls (Spanish)	379
Number of texts	>123
Number of live chat	>216

Additionally, **website links** and **app downloads** are also tracked. The tables below include summary information about the usage of these services.

Activity	Frequency
Unique website visits	14,775
App downloads	1,635
Active app users	437

Finally, program staff engage in **resource promotion** by attending community events to provide information.

Demographics

The following tables include available demographics for some services (i.e. calls, live chat, and texts). Note that these tables only reflect total responses, so the counts may be less than the total number of individuals served.

[6] May be duplicated

Calls received

Gender Identity	Count	Percent
Female	1,699	72%
Male	663	28%
Another	3	<1%
Prefer not to answer	17	-

Age	Count	Percent
0 to 15	2	<1%
16 to 25	108	7%
26 to 59	964	62%
60+	472	31%
Prefer not to answer	712	-

Race	Count	Percent
White	335	20%
Hispanic	948	55%
African-American	170	10%
Asian	8	<1%
American Indian	18	1%
Other	238	14%
Prefer not to answer	550	-

Ethnicity	Count	Percent
Caucasian	343	20%
Hispanic	952	55%
African-American	171	10%
Asian	9	1%
Other	248	14%
Prefer not to answer	544	-

Primary Language	Count	Percent
English	1,640	79%
Spanish	410	20%
Other	15	1%
Prefer not to answer	211	-

Veteran Status	Count	Percent
Yes	57	3%
No	1,817	97%
Prefer not to answer	391	-

Texts received

Gender Identity	Count	Percent
Female	75	82%
Male	12	13%
Another	5	5%
Prefer not to answer	28	-

Age	Count	Percent
0 to 15	2	2%
16 to 25	13	17%
26 to 59	55	71%
60+	8	10%
Prefer not to answer	41	-

Language	Count	Percent
English	109	89%
Spanish	3	2%
Other	11	9%

Live chat

Gender Identity	Count	Percent
Female	138	66%
Male	68	33%
Another	2	1%
Prefer not to answer	8	-

Age	Count	Percent
0 to 15	3	1%
16 to 25	33	16%
26 to 59	153	72%
60+	23	11%
Prefer not to answer	4	-

Ethnicity	Count	Percent
Hispanic or Latino	107	57%
Not Hispanic or Latino	80	43%
Prefer not to answer	29	-

Referrals

976 (45%) of individuals who called agreed to follow-up calls by a 2-1-1 call specialist to verify linkage to services. The most common resources referred to or accessed (based on available data) are summarized in the tables below.

Most Common Referral (Calls)	Count	Percent
Substance Use Service Related	47	29%
Mental Health Crisis Resource	28	18%
General Counseling Services	20	13%
Other	65	41%

Most Common Resource Clicked (Website)	Count	Percent
Mental Health Hotlines	210	15%
Bereavement Support Groups	133	9%
Anger Management	122	8%
Other	976	68%

Most Common Resource Clicked (App)	Count	Percent
Drug Dependency Support Groups	19	8%
Domestic Violence Hotline	19	8%
Drug Detoxification	18	8%
Other	179	76%

Senior Access for Engagement (SAFE)

Number Served: 363

Program Description
Senior Access for Engagement (SAFE) provides services and referrals to seniors/older adults in the home, at senior centers, nursing homes, assisted living facilities, and at other events. SAFE providers promote psychosocial support, identify possible signs and symptoms of mental illness, and assist seniors into the appropriate referral for mental health treatment. Additional SAFE services include:

- Visitation to older adults in the home or community to provide social support
- Caregiver support group
- Linkages to Respite for Caregivers
- Referral and linkage to other community-based providers for other needed social services and primary care

SAFE primarily serves isolated older adults (ages 60 and older) at risk of or beginning to experience mental health problems, such as depression, related to aging and isolation. SAFE also serves primary caregivers of older adults with mental illness. Caregivers accessing this service must not be paid for caregiving and must live in a non-licensed setting.

Activities
SAFE providers conduct **home visits** to assess/ensure mental state, conduct assessments for elder abuse, and provide help with everyday services or activities (e.g. heating, shopping/groceries, wheelchair/mobility services, transportation, Medi-Cal applications, rent/mortgage paperwork).

SAFE providers also conduct **facility visits** to assess behavioral concerns, connect with social workers, help staff with care plans and doctor appointments, and to help coordinate with family and visitors.

Staff also engage in **program promotion**, including through distributing materials at a monthly food bank, yearly picnic, farmer's market, and other community events.

Demographics

The following tables include available demographics for individuals who were referred to SAFE and received some form of service and/or linkage.

Sex	Count	Percent
Female	239	72%
Male	91	28%
Not reported	33	-

Gender Identity	Count	Percent
Female	241	73%
Male	89	27%
Not reported	33	-

Age	Count	Percent
0 to 15	-	-
16 to 25	-	-
26 to 59	-	-
60+	326	100%
Not reported	-	-

Sexual Orientation	Count	Percent
Heterosexual or Straight	152	46%
Prefer not to answer	177	54%
Not reported	34	-

Veteran Status	Count	Percent
No	275	95%
Yes	15	5%
Not reported	73	-

Primary Language	Count	Percent
English	218	67%
Spanish	107	33%
Japanese	1	<1%
Not reported	37	-

Disability	Count	Percent
Chronic Health Condition	8	5%
Physical/Mobility	49	29%
Mental Domain	2	1%
Hearing/speech	2	1%
Vision	1	1%
Other	16	9%
None	92	54%
Prefer not to answer	2	-
Not reported	191	-

Race	Count	Percent
White	234	90%
Black or African American	17	7%
Asian	1	<1%
American Indian	2	<1%
More than one	1	<1%
Other	5	2%
Not reported	103	-

Ethnicity	Count	Percent
Hispanic/Latino	159	65%
Non-Hispanic	87	35%
Not specified	117	-

Referrals

351 (97%) individuals referred from SAFE to another service/program were verified to have engaged with that program (i.e. confirmed linkage). Twenty-five (7%) of the confirmed linkages were to mental health counselling (i.e. support groups). The remaining 326 (93%) confirmed linkages were to general supportive services (e.g. food assistance, mobility assistance, housing/rental assistance).

OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

Program Descriptions

Four trainings for potential responders are offered periodically by Kings County Behavioral Health staff as Outreach for Increasing Recognition of Early Signs of Mental Illness Programs. A brief description of each training is provided below.

The **Applied Suicide Intervention Skills Training (ASIST)** workshop is a two-day, highly interactive, practice-oriented workshop for caregivers who want to feel more comfortable, confident and competent in helping to prevent the immediate risk of suicide.

Safe TALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide.

Mental Health First Aid (MHFA) is a course that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives participants the skills to reach out and provide initial help to support someone who may be developing a mental health or substance use problem, or experiencing a crisis.

Youth Mental Health First Aid (YMHFA) is a course designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, and others how to help an adolescent (age 12-18) who is experiencing a mental health or addictions challenge, or is in crisis. The course is primarily designed for adults who regularly interact with young people.

Activities

No outreach training sessions were offered during the fiscal year because of COVID restrictions and a lack of staff to offer trainings. All trainings will begin being offered again during FY 2022-2023.

STIGMA AND DISCRIMINATION REDUCTION

Kings Partnership for Prevention (KPFP)

Program Description

The Kings Partnership for Prevention (KPFP) is a coalition in Kings County that works to create an environment of wellness throughout the community. Members come from throughout the county representing a wide variety of interests. KPFP participates in and leads collaborative processes on behalf of KCBH to improve the overall wellness of the community. These wellness efforts are conducted through community-wide prevention efforts that include mental health outreach, suicide prevention awareness, and substance use prevention activities.

Activities

One regularly meeting group organized through KPFP is the **Substance Use Prevention Workgroup.** This group meets once a month to plan community events. Meetings and attendance for this group are listed in the table below.

Event Date	Event Description	Attendance
8/9/2021	Workgroup	9
8/11/2021	Back to School Meeting Logistics	7
9/1/2021	Workgroup	17
10/6/2021	Workgroup	13
11/10/2021	Workgroup	12
1/5/2022	Workgroup	14
2/6/2022	Workgroup	22
3/2/2022	Workgroup	0
4/6/2022	Workgroup	17
5/4/2022	Workgroup	20
6/1/2022	Workgroup	22

Another regularly meeting group organized through KPFP is the **Mental Health Taskforce**. This group also meets once a month to plan community events. Meetings and attendance for this group are listed in the table below.

Event Date	Event Description	Attendance
8/26/2021	Taskforce Meeting	21
9/23/2021	Taskforce Meeting	12
10/28/2021	Taskforce Meeting	14
11/30/2021	Taskforce Meeting	15
1/27/2022	Taskforce Meeting	18
2/24/2022	Taskforce Meeting	21
3/24/2022	Taskforce Meeting	17
4/28/2022	Taskforce Meeting	25
5/11/2022	Understanding Mental Health	83
5/26/2022	Taskforce Meeting	29
6/23/2022	Taskforce Meeting	15

Additionally, KPFP organizes additional **community events** that are not necessarily affiliated with the above groups. These include setting up booths at events, offering trainings, and running social media campaigns.

The table below includes some metrics related to a social media campaign that was conducted on Facebook and Instagram during Mental Health Awareness month (May 2022). Topics posted during this time include "Motivation Monday," "Take Action 4 Mental Health," "Teens Guide to Self-Care," "Self-Compassion for Parents," "Mental Health Tip for Kiddos," and "Mental Health Tips for Seniors."

Indicator	Value
Number of Posts	45
Number of People Reached (Facebook)	5,170
Number of People Reached (Instagram)	2,612
Number of Likes (Facebook)	94
Number of Likes (Instagram)	203
Number of Shares (Facebook)	24
Number of Shares (Instagram)	46

Cultural Humility Task Force

Program Description

The Kings County Cultural Humility Task Force (CHTF) is made up of community members and partnering agency staff who oversee the completion of the required State Cultural Competency Plan. This includes annual updates to that plan, setting the training agenda for the year, and promoting culturally appropriate services throughout Kings County. This effort is accomplished through identification of some of our community provider training needs, recommending trainings, working on anti-stigma and stigma reduction, focusing on underserved or inappropriately served populations in Kings County (e.g. LGBTQ Youth, Latinos, Veterans, seniors, Native Americans, ex-offenders, and those living with a mental illness) as well as promotion of CLAS standards. The Task Force meets monthly and is open to all community members, organizations, and service providers.

Activities

In addition to **monthly task force meetings** that are open to the public, CHTF participates in **community outreach events**, such as those listed in the Appendix to this report.

Additionally, CHTF collaborated with iHeartMedia to conduct a **radio and social media campaign** to raise awareness about, and acceptance of, seeking help for a mental illness. This campaign was conducted between August and October 2021. The following table includes indicators related to the impact of this radio and social media campaign.

Indicator	Value
Number of mentions (radio)	334
Impressions (radio)	1,302,195
Audience with most radio impressions (Age)	25-34 years
Impressions (social media)	416,899
Clicks (social media)	3,309
Reach (Facebook)	19,604

iHeart Media Radio and Billboards

Program Description

Kings County partners with iHeart Media to share information and educate the public about mental illness. This program shares messaging across multiple local media, including through radio ads, billboards, and/or social media posts. The intended population for these messages are individuals and communities who may view mental health as a stigma as well as minorities who would benefit from tailored and culturally appropriate services.

Activities

During the 2021-2022 fiscal year, three **campaigns** were conducted through radio and social media. The following table summarizes these campaigns.

Campaign Start Date	Campaign End Date	Content Description
Aug 2021	Oct 2021	Cultural Humility Task Force Campaign
12/6/2021	1/2/2022	KCBH & Suicide Prevention
1/3/2022	4/3/2022	KCBH & Suicide Prevention

The following tables include indicators related to the impact of the later two campaigns. Additional indicators about the CHTF campaign can be found in the corresponding program section of this report.

December '21 – January '22 Campaign

Indicator	Value
Number of commercials (radio)	260
Impressions (radio)	1,266,526
Audience with most radio impressions (Age)	25-34 years
Impressions (social media)	250,012
Clicks (social media)	694
Reach (Instagram)	18,253
Reach (Facebook)	14,346

January '22 – April '22 Campaign

Indicator	Value
Number of commercials (radio)	357
Impressions (radio)	661,251
Audience with most impressions (Age)	18-24 years

SUICIDE PREVENTION

Central Valley Suicide Prevention Hotline (CVSPH)

Number Served: 884[7]

Program Description

Central Valley Suicide Prevention Hotline (CVSPH) is an immediate and consistent support for individuals in crisis or experiencing a suicidal crisis. The hotline is available 24 hours a day, 365 days a year, and is confidential and cost-free. The trained staff and volunteers conduct the following: offer immediate support, develop a safety plan for the caller, and reach out to callers with post-crisis follow-up to ensure that they are safe and getting the help they may need.

Activities

During the fiscal year, CVSPH **received calls** from 884 Kings County residents, whose concerns were classified into the following categories.

Caller Concern	Count	Percent
Mental Health	254	41%
Social Issues	168	26%
Suicidal Content	166	26%
General Needs	20	3%
Abuse/Violence	8	1%
Homicidal Content	8	1%
Physical Health	7	1%
Basic Needs	6	1%
Unspecified	247	-

Demographics

The following tables summarize the available demographics of the individuals whose calls were received.

Sex	Count	Percent
Female	314	67%
Male	157	33%
Decline to state	51	-
Unknown	364	-

Gender Identity	Count	Percent
Female	306	66%
Male	151	32%
Gender-queer	8	2%
Decline to state	7	-
Unknown	412	-

[7] May be duplicated

Central Valley Suicide Prevention Hotline (CVSPH)

Age	Count	Percent
0 to 15	29	6%
16 to 25	136	28%
26 to 59	301	61%
60+	26	5%
Decline to state	19	-
Unknown	373	-

Sexual Orientation	Count	Percent
Heterosexual or Straight	518	97%
Gay/Lesbian	15	3%
Another	2	<1%
Decline to state	21	-
Unknown	328	-

Veteran Status	Count	Percent
No	22	-
Yes	16	-
Decline to state	9	-
Unknown	837	-

Primary Language	Count	Percent
English	695	97%
Spanish	21	3%
Another	1	<1%
Decline to state	10	-
Unknown	157	-

Disability	Count	Percent
Chronic Health Condition	30	-
Physical/Mobility	22	-
Mental Domain	10	-
None	8	-
Decline to state	26	-
Unknown	788	-

Race	Count	Percent
White/Caucasian	67	85%
Asian	4	5%
Other	6	8%
More than one	2	2%
Decline to state	132	-
Unknown	673	-

Ethnicity – Hispanic/Latino	Count	Percent
Mexican/Mex.-Am./Chicano	103	-
Puerto Rican	1	-
None	8	-
Decline to state	65	-
Unknown	707	-

Ethnicity – Non-Hispanic/Latino	Count	Percent
None	5	-
Other	6	-
Decline to state	25	-
Unknown	848	-

Outcomes

Among all 884 calls received, 480 calls were classified as “Crisis Calls.” An additional 16 were determined to be “Active Rescues” and 18 were determined to be “Talk Downs.”

Depression Reduction Achieving Wellness (DRAW)

Number Served: 49

Program Description
The Depression Reduction Achieving Wellness (DRAW) program is a campus-linked project that addresses the first onset of a psychiatric illness in students through collaboration with an institution of higher education. DRAW provides students with education regarding both the cultivation of wellness approaches and the identification of signs and symptoms of mental illness, short-term low-intensity intervention services, referrals to community-based agencies for more extended or intensive services when needed, and training for college staff on the signs and symptoms of depression.

Activities
The DRAW program primarily offers **individual counseling** for students at a college. These consist of up to six psychotherapy sessions and include an intake assessment and development of a treatment plan.

Upon request, **presentations** are also offered to college faculty and staff on a variety of mental health-related topics. These presentations are generally in-person and are often 60-90 minutes in length. Example topics include Assisting Students in Distress and Mental Health First Aid training.

The DRAW program is **promoted** through fairs, tabling at local events, and distribution of promotional items through other agencies or organizations.

Demographics

The following are the available demographics are for 49 individuals who at least received an intake assessment for individual counseling through the DRAW program.

Age	Count	Percent
0 to 15	-	-
16 to 25	36	73%
26 to 59	13	27%
60+	-	-
Decline to state	-	-

Referrals

Referral information is available for 46 of the 49 individuals who received at least received an intake assessment for individual counseling through the DRAW program. These are summarized in the table on the following page.

Referral & Linkage Status	Count	Percent	Notes
Unknown	3	-	-
In program as of late June 2022, not yet referred	3	7%	-
Not linked to continuing behavioral health care services	13	28%	Most common reason: Unable to make contact with clients
Linked to additional county mental health services	11	24%	Services include Kings View Counseling Services and Warm Line
Linked to non-county mental health services	19	41%	Linked to providers through private health insurance

Outcomes

The BURNS Depression and Anxiety scales are used as screening instruments for those receiving individual counseling, and each consists of a pre-test (given during initial session) and a post-test (given during the final session). The score of the BURNS Depression checklist ranges from 0 (minimal or no depression) to 45 (severe depression). The score of the BURNS Anxiety checklist ranges from 0 (minimal or no anxiety) to 99 (extreme anxiety or panic).

Average changes (i.e. post-test minus pre-test) in depression and anxiety scores for 21 of the 49 individuals who engaged in individual counseling are summarized below.

BURNS Depression	
Average change	-22.81
Number (percent) of individuals with a lower score at time of post test	20 (95%)

BURNS Anxiety	
Average change	-19.19
Number (percent) of individuals with a lower score at time of post test	19 (90%)

Local Outreach to Suicide Survivors (LOSS)

Number of families served: 8

Program Description

Local Outreach to Suicide Survivors (LOSS) is a program that dispatches support teams to the location of a suicide to provide resources, support, and hope to friends and family members of the suicide victim. The counseling services generally consist of six to eight therapy sessions, including an intake and a treatment plan.

Activities

There were a total of eight suicides during this fiscal period, in which three families sought bereavement counseling services, and five were solely provided resources and information.

Additional data for this program for this fiscal period were unavailable.

APPENDIX – OUTREACH EVENTS

The following is a list of community events at which KCBH services, including PEI programs, were promoted during the 21-22 fiscal year. One goal of these events was to connect with harder-to-reach communities/populations.

Event Date	Event Description
8/13/2021	Corcoran Farmers Market
8/17/2021	John Muir Middle School Back to School Night (Corcoran)
8/18/2021	Corcoran High School Back to School Night
9/10/2021	Corcoran Farmers Market
9/10/2021	Avenal Flea Market
9/11/2021	First Responders Event (Hanford)
9/16/2021	Hanford Thursday Night Farmers Market
9/22/2021	Reef-Sunset Suicide Prevention Week (Avenal)
9/23/2021	Hanford Thursday Night Farmers Market
9/23/2021	Reef-Sunset Suicide Prevention Week (Avenal)
9/24/2021	Reef-Sunset Suicide Prevention Week (Avenal)
10/5/2021	West Hills Community College Mental Health Awareness Event
10/7/2021	Hanford Flea Market
10/8/2021	Avenal Flea Market
10/28/2021	West Hills Community College Operation Awareness Event
5/1/2022	Dia de los Ninos @ My Corazon Store (Hanford)
5/5/2022	Hanford Thursday Night Market
5/10/2022	Oak Wellness Mental Health Awareness Event/Walk
5/12/2022	Hanford Thursday Night Market
5/19/2022	Hanford Thursday Night Market
5/21/2022	7th Annual Taco Truck Throwdown (Hanford)
5/26/2022	Hanford Thursday Night Market

APPENDIX – MOST INNOVATION FY 2021-2022 EVALUATION

Kings County

Annual Innovation Project Report

FY 2021/2022

Welfare & Institutions Code (WIC) 3850

Title 09, California Code of Regulations (CCR)

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Kings County Behavioral Health
Innovation Plan: Multiple Organization Shared Telepsychiatry (MOST) Project

January 2023

KINGS COUNTY
behavioral health
kcbh.org

Kings County Behavioral Health
MHSA Annual Innovation Project Report FY 2021/2022
Multiple Organization Shared Telepsychiatry (MOST) Project

Table of Contents

Executive Summary

The Mental Health Services Act (MHSA) three year planning process for 2017-2020 identified the need for additional psychiatric services within Kings County. These additional services would increase access to mental health services for underserved populations, reduce long wait times, and allow for services to be accessed at the community level. To address this need, Kings County Behavioral Health (KCBH) securing Innovation funding from MHSA to implement the Multiple Organization Shared Telepsychiatry (MOST) program. The MOST program was designed to integrate peer and family support within a shared telepsychiatric program across several partner organizations, while promoting a wellness and recovery-based model of care.

Kings County Behavioral Health (KCBH) contracted with Evalcorp, a professional evaluation company, to support an assessment of the Multiple Organization Shared Telepsychiatry (MOST) Program. Evaluation strategies focused on assessing the value of peer involvement for beneficiaries. From July 1, 2021 through June 30, 2022, surveys, focus groups, and interviews were utilized for data collection to assess progress of the MOST program toward the following outcomes:

Learning Goal 1: Can a shared telepsychiatry program that includes peer and family member as part of the treatment team help transform psychiatric services to a wellness and recovery-based system of care with improved outcomes for beneficiaries?

Outcomes:

- Improved perceived value of peer involvement
- Beneficiaries are meeting wellness and recovery goals
- Reduce no-show rate
- Transform telepsychiatric services from medical to wellness and recovery-based model of care

Learning Goal 2: Can sharing telepsychiatric services with multiple service providers (including community-based providers) improve coordination of care and outcomes of program participants?

Outcomes:

- Transitions to lower level of care
- Reduced wait times for initial and follow-up appointments
- Reduced hospitalizations for mental health crisis
- Reduced number of individuals seen by emergency room for mental illness
- Reduced recidivism for individuals with mental illness

Methodology

Two surveys, the Adult Baseline Survey (n = 13) and the Adult Follow-up Survey (n = 31) were administered directly to adult beneficiaries while the Family Survey (n = 9) was administered to

the parents or caregivers of child beneficiaries. Each instrument was designed to gather perspectives about particular outcomes that the MOST program was designed to achieve. In addition to surveys, interviews were conducted with MOST program staff (n = 6) as well as staff from partner agencies (n =3). A final primary data collection effort was a focus group that was facilitated with MOST program beneficiaries (n = 7) to better understand their experiences participating in the MOST program. To round out data collection efforts of anticipated outcomes, secondary and administrative data was collected via a tracking log.

Due to many factors, noted in the Program Changes section below, a shared telepsychiatric suite was not developed with partner agencies and other setbacks put a damper on the anticipated evaluation of the MOST program. Despite the setbacks with full implementation, primary, secondary, and administrative data collected provides valuable insights on MOST program outcomes. Results shared below are organized by learning goal and outcome and reflect the assessment of peer involvement in psychiatric services.

Findings

Learning Goal 1, Outcome 1: Improved perceived value of peer involvement

There is a high level of perceived value of the peer support that was provided to MOST beneficiaries among staff, stakeholders, and beneficiaries. Staff and partner agency interviews shared how peer support fosters an open-environment that allows for better communication between beneficiary and psychiatrist. When beneficiaries were asked whether peer support would make them more comfortable prior to receiving MOST services, only 62% agreed. However, on the follow up survey, 93% agreed. During the focus group, beneficiaries recounted stories of how the peer support specialist made them feel comfortable during appointments.

Learning Goal 1, Outcome 2: Beneficiaries are meeting wellness and recovery goals

Evaluation strategies sought to understand whether the involvement of a peer support specialist leads to greater achievement of wellness and recovery goals. Program and partner agency staff shared how the involvement with a peer support specialist leads to benefits they would, without the involvement, not experience. For example, peer involvement supports the goal setting environment and leads to more realistic goals and the co-creation of strategies. The personalized support helps with monitoring progress toward goals and adapting goals or strategies when needed. These additional benefits lead to greater levels of progress toward wellness and recovery goals. When beneficiaries were asked whether the peer support specialist helped them meet their goals, 93% of beneficiaries agreed.

Learning Goal 1, Outcome 3: Reduce no-show rate

Results of evaluation suggest that the involvement of a peer support specialist reduce no-show rate. Primarily, the effort that the peer support provides in making reminder calls was identified as a primary support, followed by transportation assistance. Additionally, both partner agency staff and beneficiaries noted that participation of peer support eases negativity and discomfort

at initial appointments, making it easier for beneficiaries to attend. When asked if peer support helped beneficiaries keep their mental health appointments, 86% of respondents agreed on the Adult Follow Up Survey and 75% of respondents agreed on the Family Survey.

Through administrative data collected on appointment attendance, 73% of appointments were attended by adult beneficiaries. This is a 3% increase in the attendance rate from the prior fiscal year. While 53% of appoints were attended by child beneficiaries, FY 21/22 represented the first year that services were provided to child beneficiaries.

Learning Goal 1, Outcome 4: Transform telepsychiatric services from medical to wellness and recovery-based model of care

Findings suggest that the involvement of a peer specialist has supported a shift toward a wellness and recovery model and away from the medical model of care. Interviews with MOST program staff revealed a strong connection between beneficiaries and the peer support specialist that they described as a healthy friendship that help beneficiaries feel understood. As noted above, this increases the participation of beneficiaries in the development and progress monitoring of goals.

The adult beneficiary perspective reflects a similar finding. When asked if they participate in the making of their own goals, 50% of respondents agreed at baseline and 89% agreed at follow-up. Additionally, when adult beneficiaries were asked about their involvement in working toward achieving goals, only 16% of respondents selected “Most of the time” or “All of the time” at baseline. This number grew to 74% at follow-up. These results suggest that beneficiaries are more involved in both the creation of goals as well as the process of achieving their goals, both hallmarks of the wellness and recovery model, because of the MOST program.

Family members or guardians of child beneficiaries were asked about how involved the child was in working toward their wellness and recovery goals. All responses to the Family Member Survey indicate that the child was actively involved in the decision-making process about their wellness and recovery and reflect agreement that the MOST program helps with more than just medical needs.

Learning Goal 2, Outcome 1: Transitions to lower level of care

Information about beneficiary transitions to different levels of care is collected using the MOST Program Tracking Log. During FY 2021/2022, 18 beneficiaries were discharged from the program, six of whom were transitioned to a lower level of care (33%). Nine beneficiaries were discharged for other reasons including:

- Non-compliance
- Administrative reasons
- Relocation
- Incarceration

- Death

Learning Goal 2, Outcome 2: Reduced wait times for initial and follow-up appointments
Information about wait times from referral to initial appointment and from discharge from the hospital for a mental health crisis to follow-up appointment is collected using the MOST Program Tracking Log. All 63 adult and 44 child beneficiaries had a documented referral source and date from Mental Health Services (MHS), Inspiring Pathways, or Aspiranet, along with the date of their first schedule appointment. For adult beneficiaries, almost half (46%) of referred individuals were able to be seen by MOST program staff the same day as the referral was made. However, due to interruptions with the hiring and onboarding of a child clinician, wait times were higher for children who were referred to the MOST program in FY 21/22. More than half of child referrals (63%) did not have an appointment scheduled within 15 days of the referral date.

Learning Goal 2, Outcome 3: Reduced hospitalizations for mental health crisis
Beneficiaries were asked whether they recall being hospitalized (admitted) for mental health crisis in the past three years on the Baseline Survey and since being enrolled in MOST program on the Follow-up Survey. While 69% of respondents of the Adult Baseline Survey (n = 13) indicated that they had been hospitalized for mental illness in the past three years, only 16% of respondents of the Follow Up Survey (n-31) indicated that they had been hospitalized for mental illness since enrolling in the MOST program.

The number of hospitalizations for mental health crisis before and during enrollment in the MOST program can also be determined by accessing the county's Electronic Health Record (EHR) system. Hospitalization rates were calculated as annual rates. While the average annualized number of hospitalizations increased from the three years before enrollment to their time as beneficiaries in the MOST program beneficiaries, fewer beneficiaries were hospitalized. Prior to MOST program enrollment, 42 of 97 beneficiaries (43%) were hospitalized for a mental health crisis. Since enrollment, 30 of 97 (31%) were hospitalized (decrease by 12%). This suggests that individuals are less likely to require hospitalization after enrolling in the MOST program.

Learning Goal 2, Outcome 4: Reduced number of individuals seen by emergency room for mental illness
Beneficiaries were asked to self-report whether they recall being evaluated for a mental health crisis at the emergency room since being enrolled in MOST program on the Adult Baseline and Follow-up surveys. The number of individuals who, on the Follow Up Survey (n = 31) self-reported an emergency department crisis evaluation visit since MOST program enrollment is 34% lower than those who reported an emergency department crisis evaluation prior to MOST program enrollment on the Adult Baseline Survey (n = 13).

The number of ER visits that resulted in a mental health crisis evaluation before enrollment in the MOST program and during participation in the MOST program can also be determined by accessing the county's Electronic Health Record (EHR) system. While the average annualized number of crisis evaluations increased for MOST program beneficiaries from the three years before their enrollment to during MOST enrollment, fewer individuals were seeking crisis evaluations. Prior to MOST program enrollment, 63 of the 97 beneficiaries (65%) needed a crisis evaluation. Since enrollment, 42 of the 97 (43%) beneficiaries needed a crisis evaluation (decrease by 22%). This suggests that individuals are less likely to need a crisis evaluation while enrolled in the MOST program.

Learning Goal 2, Outcome 5: Reduced recidivism for individuals with mental illness
Beneficiaries were asked whether they recall being arrested and booked into county jail in the past three years on the Baseline Survey and since enrolling in the MOST program on the Follow-up Survey. The percentage of individuals reporting an arrest since enrolling in the MOST program on the Follow Up Survey (16%) is 38% lower than those who reported an arrest in the three years prior to MOST program enrollment on the Adult Baseline Survey (54%).

Discussion

KCBH is providing an important service to individuals with serious mental illness by combining medication services with the care of a peer support specialist. The additional peer support component is a key contributor to the health of beneficiaries and to the achievement of health and wellness goals. County health records are showing that fewer individuals are requiring hospitalizations for mental illness and crisis evaluations during MOST enrollment, compared to three years prior to enrollment. However, the annualized average of hospitalizations and crisis evaluations is higher during enrollment than prior to enrollment. Further conversation or investigation could look at this phenomenon more closely.

Introduction

At Kings County Behavioral Health (KCBH), we believe peers and family members are the heart and soul of recovery. Without them we lose the joy of community and the wisdom of those who have walked the road to wellness before. Working with peers and family members, KCBH is pursuing a wellness and recovery model of treatment and is striving to spread this approach to all aspects of behavioral health care in our county.

As we strive to move our system of care to a wellness and recovery model, it has become clear that one of the last vestiges of a medical model that remains is traditional psychiatric care. Prior to the implementation of the Multiple Organization Shared Telepsychiatry (MOST) program, all psychiatric care in our system was provided using the medical model, without a wellness and recovery approach supported by peers and family members. KCBH identified the need for more psychiatric care in Kings County and the need to align these expanded services with the wellness and recovery model of care.

Kings County is a small rural county with a population of nearly 150,000 people. Our county has a challenging combination of a high poverty rate and a high rate of serious mental illness (SMI). Of Kings County residents, 19% live in poverty and 38% are Medi-Cal eligible. The estimated need for serious mental illness (SMI) mental health services is the fourth highest in California for adults (6.9%) and the thirteenth highest for children (8%).[1] The rates of serious mental illness among adults and children in households with incomes below 200% of the poverty level are higher, at 8% and 9%, respectively.[2] In addition, despite having one of the highest rates of serious mental illness, Kings County, like other rural California counties, has a shortage of psychiatrists. This shortage contributes to an average wait time for an initial appointment with a psychiatrist of 25.6 business days.

These challenges are exacerbated in the more remote areas of Kings County, such as the community of Avenal, which is a 37-mile drive or a daylong round-trip bus ride to available psychiatric services in Hanford. The dearth of psychiatric treatment hours and the fact that they were supplied by a single provider (Kings View) poses an ongoing structural challenge to offering mental health services to residents of the county. We have found that this lack of psychiatric services has led many people with serious mental illness to seek treatment at local hospitals and emergency departments or become incarcerated in the county jail.

Additionally, the Mental Health Services Act (MHSA) three-year planning process 2017-2020 for Kings County identified the need for additional psychiatric services which would increase access

[1] California Mental Health Prevalence Estimates (2012). Retrieved from: https://www.dhcs.ca.gov/Documents/California%20Prevalence%20Estimates.pdf
[2] Ibid.

for underserved populations, reduce long wait times, and allow for services to be accessed at the community level. The limited access to timely care and the prior medical model, which excludes vital peer and family support, hinders the effectiveness of psychiatric care and is a barrier to full engagement in services. A well-known solution for expansion of psychiatric services in areas with too few psychiatrists is telepsychiatry; a secure two-way audiovisual communication between a psychiatrist in a distant location and a local beneficiary in a designated private space, supported by staff on site. In fiscal year (FY) 2018/2019, KCBH began implementing the MOST program, which integrates peer and family member support while following a wellness and recovery model. Through this program, KCBH seeks to explore two significant issues as we strive to change the model of telepsychiatry through this innovation project.

> **One**: Can a shared telepsychiatry program that includes peer and family member as part of the treatment team help transform psychiatric services to a wellness and recovery-based system of care with improved outcomes for beneficiaries?
>
> **Two**: Can sharing telepsychiatric services with multiple service providers (including community-based providers) improve coordination of care and outcomes of program participants?

Project Description

Kings County developed the MOST Program under its Innovation Plan. The MOST Program will make changes to an existing practice in the field of mental health as required in California Code of Regulations, Title 9, Section 3910(a).

In fiscal year 2018-2019, KCBH began the process of creating a shared telepsychiatric suite within Kings County to improve quality of care and timely service delivery. These service providers include the following providers in Kings County: the Department of Public Health, Mental Health Systems, Inc., Aspiranet, Inc., Kings View Counseling Services, and the KCBH Department. With the implementation of the MOST program, we sought to transform the traditional medical model of our system of care into one that is wellness and recovery oriented by providing peer and family staffed telepsychiatric services available to multiple service providers.

We began offering telepsychiatry in July of 2019 and continue to work toward establishing a program that will enable other mental health service providers and county departments to offer telepsychiatry services to their beneficiaries in the shared facilities managed and staffed by the county behavioral health department. At the onset of this program, we had found that there were no psychiatric telepsychiatry services that 1) are accessible to multiple county

departments and contracted mental health providers; and 2) are staffed by peers and family members who are employed by the county in the state of California.

Over the course of the project, KCBH planned to establish telepsychiatry suites in three cities (Hanford, Avenal, and Corcoran) and will serve over 250 more Kings County residents. Only Full-Service Partnership contracted providers, Aspiranet and Mental Health Services (MHS), can provide referrals to the MOST program for telepsychiatric services for their enrolled clients. The only exception is for those with urgent conditions; this includes individuals who have been released from custody and require same-day psychiatric care. KCBH provides on-site staff support for the telepsychiatrist. Paid, trained peer support specialists will also be located within telepsychiatry suites and will provide beneficiaries with transportation and other support, as needed. Peer support specialists assist beneficiaries by navigating psychiatric care, teaching beneficiaries how to advocate for themselves, and advocating on behalf of beneficiaries. Trained peer support specialists meet with each beneficiary prior to their psychiatric appointment to ensure that they can express any concerns, challenges, or issues with their treatment plan or care providers. If necessary, with the beneficiary's consent, a peer support specialist will sit in sessions with the beneficiary to provide support and language interpretation as necessary.

An additional benefit of this project is that it is simple and highly replicable for other California counties. We believe that this model will likely improve beneficiary outcomes, reduce stigma around psychiatric services, increase engagement, and assist with retention of participants. The model goes beyond counties sharing resources: in this case, severe limitations of cost, capacity, and geography are addressed by both counties and their local providers while promoting a recovery and wellness based model of care.

This Annual Innovation Report will reflect the following information in accordance with Welfare & Institutions Code (WIC) 5830 and 9 CCR § 3580.010:

Reporting Period FY 2021 – 2022 (July 1, 2021 – June 30, 2022)

- Changes that were made to the Innovation Project during the reporting period & reasons for the changes.
- Available evaluation data, including outcomes of the Innovation Project and which elements of the program are contributing to outcomes.
- Program information collected during the reporting period for applicable Innovative Projects that serve individuals, including number of participants served by: age, race, ethnicity, primary language, sexual orientation, and disability.

Changes made to the Innovation Project

Pursuant to the Welfare & Institutions Code (WIC) 5830 and 9 CCR § 3580.010, changes made to the Innovation Project during FY 2020/2021 and the reason for these changes are detailed below.

Change One

Original Plan:

The original Innovation Plan stated that the MOST program at the Hanford site was to serve 128 unduplicated individuals in its first year, with half of those being children/youth.

Changes to the Plan:

The MOST program was not able to serve any children in FY 2019/2020.

Reasons why the changes were made:

Kings County Behavioral Health experienced difficulty recruiting and attracting a child psychiatrist to the Kings County area to perform services. Further, due to COVID-19 pandemic the recruiting of a child psychiatrist was delayed, with expected contract negotiations pending in Fall of 2020.

As of June 2021, the county has contracted with a child psychiatry group and began services for children.

Change Two

Original Plan:
The original Innovation Plan stated that the MOST program would hire a Parent Peer Support Specialist.

Changes to the Plan:
The MOST program did not seek to hire a Parent Peer Support Specialist in FY 2019/2020.

Reasons why the changes were made:
Due to not having started the child psychiatric services, the MOST program did not hire the Parent Support Specialist in FY 2019/2020 and discussed the option of having the Peer Support Specialist fulfill this role due to initial lower child psychiatrist caseload.

Change Three

Original Plan:
The original Innovation Plan stated that the MOST program would start providing psychiatric services at a satellite location in Avenal in FY 2019/2020.

Changes to the Plan:
The MOST program was not able to provide psychiatric services at a satellite location in Avenal during FY 2019/2020.

Reasons why the changes were made:
Kings County Behavioral Health experienced difficulty recruiting and attracting adult and children psychiatrists to the Kings County area to perform services. Dr. Arieh Whisenhunt began his first day as a contracted adult psychiatrist with Kings County on June 6, 2019, which caused an overall delay in the start of services. The MOST program is currently working on recruiting a child psychiatrist. In addition, the COVID-19 Pandemic delayed program progress towards this goal.

Change Four

Original Plan:
The original Innovation Plan stated that the MOST program would start providing community outreach and education to Avenal residents.

Changes to the Plan:
The MOST program was not able to provide community outreach and education to Avenal residents.

Reasons why the changes were made:
Due to delay in starting child psychiatric services and overall program delay caused by the COVID-19 Pandemic, the projected Avenal site service start date was initially pushed back and has been postponed indefinitely.

Change Five

Original Plan:
The original Innovation Plan stated that the MOST program would transition towards being fully Medi-Cal billable and bill during FY 2019/2020.

Changes to the Plan:
The MOST program was not ready to bill Medi-Cal until FY 2020/2021 as training was postponed due to COVID-19. The MOST program will start billing Medi-Cal in Quarter 1 of FY 2020/2021 and will retroactively bill for FY 2019/2020 services.

Reasons why the changes were made:
The Kings County Behavioral Health MOST program site was certified for Medi-Cal in late February of 2020 but was unable to start billing Medi-Cal because KCBH staff required training. Additionally, the COVID-19 pandemic further delayed the program's ability to begin the billing process.

Change Six

Original Plan:
The original Innovation Plan stated that the evaluation/learning component of the MOST program would utilize a comparison or control group to determine program impact on the following learning goals and outcomes: Learning Goal 1, Outcome 3, and Learning Goal 2, Outcomes 1 to 5.

Changes to the Plan:
After contracting with an external evaluator, it was determined that a control group would not be feasible. To determine program impact on the affected learning goals and outcomes, baseline and follow-up data will be collected and analyzed for individuals receiving MOST program services.

Reasons why the changes were made:

KCBH had developed the MOST Project's Innovation Plan without consultation with an external evaluator regarding the feasibility of the evaluation components outlined in the plan.

Change Seven

Original Plan:

The original Innovation Plan stated that the paid, trained peer support specialist will provide beneficiaries with transportation, as needed.

Changes to the Plan:

Due to the COVID-19 pandemic, the peer support specialist is no longer providing transportation to beneficiaries. We plan to resume services post-COVID.

Reasons why the changes were made:

State and local public health mandates, such as social distancing and stay-at-home orders, required that staff begin working remotely.

Change Eight

Original Plan:

The original Innovation Plan stated that the evaluation/learning component of the MOST program would work with the Kings County Sheriff's Department to access beneficiaries' incarceration records to determine the program impact on recidivism (Learning Goal 2, Outcome 5).

Changes to the Plan:

After contracting with an external evaluator, it was determined that accessing historical incarceration records for individuals receiving MOST program services would not be possible. To determine program impact on the affected outcome, incarceration data will be collected and analyzed on an ongoing basis to determine if the program has an impact over time on an individual's recidivism while enrolled in the MOST program.

Reasons why the changes were made:

KCBH had developed the MOST Project's Innovation Plan without consultation with an external evaluator regarding the feasibility of the evaluation components outlined in the plan.

Change Nine

Original Plan:

The original Innovation Plan stated that the program would add an estimated 192 individuals for the second year with the site expansion and an additional 64 individuals in the third year with an additional expansion site. This would bring the program to an estimated total of 256 served clients over the three-year period.

Changes to the Plan:
The MOST program did not expand to additional proposed sites. The program was able to coordinate efficient ways to collaborate with referring programs on service provision, consultations and access to services for both adults and children making the difficult remote operations smoother and providing area coverage.

Reasons why the changes were made:
Due to COVID-19 the site expansion to Avenal and Corcoran were postponed as the program operated remotely. This would lead to indefinitely postponing the site expansions proposed for years 2019 and 2020.

Change Ten

Original Plan:
The original Innovation Plan indicated the program would start child psychiatric services in 2019.

Changes to the Plan:
The program secured a contract with Precision Psychiatry in the first quarter of 2021 and started services June of 2021.

Reasons why the changes were made:
Due to previous delays in program operation and COVID-19 the timelines for the program operation were delayed. Further, due to COVID-19 the completion and execution of the contract for child psychiatric services took longer than projected.

Evaluation Data

Available evaluation data for the 107 beneficiaries (63 adult and 44 children) served during FY 2021/2022 are outlined below, including outcomes of the Innovation Project and which elements of the program are contributing to outcomes.

Methods

KCBH contracted with EVALCORP Research & Consulting, an independent evaluation consulting firm, to develop and implement an evaluation framework for the MOST program, design data collection tools, collect and analyze data, report on outcomes, and provide ongoing technical assistance and support.

Working in collaboration with KCBH, EVALCORP developed and employed a mixed-methods approach, utilizing quantitative and qualitative data collection methodologies to obtain information on program activities and outcomes. During FY 2021/2022, four primary types of data collection strategies were implemented.

Surveys.

Adult Baseline Survey. Baseline surveys were developed to collect baseline data for each beneficiary for multiple outcomes; specifically, these surveys are intended to measure:

- the perceived value of peer support specialist involvement (Learning Goal 1, Outcome 1),
- whether beneficiaries are meeting their wellness and recovery goals (Learning Goal 1, Outcome 2),
- if services are based on a wellness and recovery model of care (Learning Goal 1, Outcome 4), and
- past three-year hospitalization, incarceration, and Emergency visits for mental health (Learning Goal 2, Outcomes 3, 4, & 5).

Adult Follow-up Survey. Follow-up surveys are distributed to all beneficiaries after 90 days in the program or upon program completion/when transitioning to a lower level of care. Follow-up surveys are intended to measure:

- changes in the perceived value of peer support specialist involvement in psychiatric care (Learning Goal 1, Outcome 1),
- whether beneficiaries are meeting their wellness and recovery goals (Learning Goal 1, Outcome 2),
- the effect of peer support specialist involvement in the reduction of the appointment no-show rate (Learning Goal 1, Outcome 3), and
- whether services are based on a wellness and recovery model of care (Learning Goal 1, Outcome 4).

Family Member Surveys. Family members of children receiving MOST program services were asked to fill out the Family Member Survey after 90 days in the program. The Family Member Survey is intended to measure:

- the value of peer support specialist support as a component of mental health services for children (Learning Goal 1, Outcome 1),
- the effect of peer support specialist involvement in the reduction of the appointment no-show rate (Learning Goal 1, Outcome 3), and
- whether the model of care being implemented by the MOST program is consistent with a wellness and recovery-based model of care (Learning Goal 1, Outcome 4).

Key Stakeholder Interviews.

Program Staff Interviews. During Spring 2022, EVALCORP facilitated semi-structured interviews with all current MOST program staff (i.e., Program Manager, Psychiatric Technician, Psychiatrist, Office Assistant, and Peer Support Specialist). Interviews were conducted to gain an understanding of how MOST program staff define and implement a wellness and recovery model of care, perceptions of the value peer support specialist involvement bring to psychiatric treatment, the development and use of wellness and recovery goals, overall program benefits and challenges, and recommendations for program improvement. Findings are detailed below, along with illustrative quotes shared during the interviews with program staff.

Partner Agency Interviews. Structured interviews were conducted with program staff from external providers/referring agencies to measure:

- their perceptions of peer involvement in psychiatric services (Learning Goal 1, Outcome 1),
- whether peer involvement supports beneficiaries in meeting wellness and recovery goals (Learning Goal 1, Outcome 2), and
- their perceptions on whether peer support specialist involvement reduces no-show rate (Learning Goal 1, Outcome 3).

Beneficiary Focus Groups.

A focus group was conducted with program beneficiaries in the Fall of 2021. Information collected from the focus group was intended to measure:

- perceived value of peer support specialist involvement in psychiatric care (Learning Goal 1, Outcome 1),
- progress made toward wellness and recovery goals (Learning Goal 1, Outcome 2),
- effect of the involvement of peer support specialist in the reduction of appointment no-show rate (Learning Goal 1, Outcome 3), and

- whether services are based on a wellness and recovery model of care (Learning Goal 1, Outcome 4).

MOST Program Tracking Log.

EVALCORP developed a comprehensive spreadsheet to collect program implementation data and process metrics such as the wait time between their referral and first appointment (Learning Goal 2, Outcome 2), number of appointments attended, and the number of appointments missed (Learning Goal 1, Outcome 3).

EVALCORP has continued to refine the template in order to meet the needs of MOST program staff, to increase data adherence to MHSA regulations, and to accurately document progress made toward program outcomes. To analyze data collected in the template, the spreadsheet was first reviewed and cleaned. Frequencies were then run for each item to determine progress toward program activities.

Findings

Learning Goal 1: Can a telepsychiatry program that includes a peer and family component as part of the treatment team help to transform psychiatric services that are based on a medical model to a wellness and recovery model?

Outcome 1: Improved perceived value of peer involvement

Interviews provide insight into how patient care has improved through the involvement of peers and how their perception of having peer support as a component of psychiatric care has changed over time.

Improved Patient Care as a Result of Peer Involvement

MOST Program Staff Perceptions of Peer Involvement

When asked how beneficiaries' experiences have changed with the involvement of peers, interview respondents agreed that peer support specialists help beneficiaries keep their appointments by providing reminders, transportation, and moral support and encouragement with their physical presence at appointments. More notably, peers foster a friendship with the beneficiaries they support. With peers, beneficiaries have the opportunity to freely express their daily struggles and possible frustrations they may have with their therapist in a safe environment. Peers also take on the role of being thought partners when individuals contemplate committing crimes or self-harm and provide them with healthy ways of redirecting negative thoughts and feelings. They work together to cocreate strategies for healthy decisions and coping skills to handle daily struggles and, importantly, the more difficult and sensitive topics. Further, peers act as a middle person between beneficiaries and clinicians, they maintain open communication and advocate for beneficiaries' needs which has led to further enhancing the help individuals receive.

"Last year until now, peer support has been able to minimize incarceration and hospitalization… talk them out of committing a crime or before they get to the point of having to go to the emergency room."

MOST Program Partner Agency Perceptions of Peer Involvement

Interviewees were asked if it was helpful for beneficiaries to have a peer support specialist present with them at mental health appointments. Interview respondents shared how peer support enables individualization of clinical support. Interviewees conveyed an appreciation for how peer support can foster open communication between clinicians and beneficiaries by bringing attention to specific needs of beneficiaries that would have otherwise not been shared. This greater transparency then allows clinicians to hone in toward deeper levels of specificity in treatment plans while making real-time adjustments for clients.

As I saw her interact with the patients, I could see it was a lot more. My appreciation for this service grew. When it came to talking to us…, she was always advocating for the patients.

Attitudes about Peer Involvement Over Time

MOST Program Staff Perceptions of Peer Involvement

Interview respondents were asked if their attitudes regarding peer involvement in beneficiaries' wellness and recovery process have changed over time. Respondents held positive views prior to working in the MOST program and expressed that their expectations and preconceptions were surpassed. Respondents initially thought that peer support had similar responsibilities as social workers and case managers, such as appointment reminders, transportation assistance, and check-ins. Respondents found that the way peers interact with beneficiaries is unique in that they don't treat beneficiaries as their medical condition, but as individuals who need support and care. Peers play a role in elevating the quality of care and personalizing how beneficiaries experience medical help; in turn, the medical team is better able to understand beneficiaries' needs.

MOST Program Beneficiary Perceptions of the Value of Peer Involvement

Baseline beneficiary perceptions of the value of peer involvement were also measured through the Baseline Survey (see below). Results reflect an initially positive outlook on peer involvement. About a third of beneficiaries did not anticipate the involvement of peer support would help them feel more comfortable at mental health appointments.

Table 1. Beneficiary Perceptions of Anticipated Peer Involvement (n=11-12)

	Baseline Survey	
	Agree	Disagree
I think it will be helpful to have a peer support specialist with me when I have mental health appointments.	92%	8%
I believe having peer support will be helpful for meeting my mental health and wellness recovery goals.	91%	9%
I think having peer support will help me feel more comfortable at my mental health appointments.	64%	36%
I think having peer support will help me to feel more understood during my mental health recovery.	91%	9%
I think having peer support will help me advocate for myself.	83%	17%

Follow-up Surveys investigated beneficiary perception of peer involvement after participating in services. Results show a continued positive outlook through services. While Baseline Surveys showed a less positive outlook regarding how comfortable beneficiaries would be with peer support involved in mental health appointments, 93% of Follow-up Survey respondents shared that peer involvement in mental health appointments helped them feel more comfortable.

Table 2. Beneficiary Perceptions of Peer Involvement (n=26-29)		
	Follow-up Survey	
	Agree	Disagree
It has been helpful to have a peer support specialist with me when I have mental health appointment	92%	8%
Having a peer support specialist has been helpful for making progress on my mental health and wellness recovery goals	93%	7%
Peer support helps me feel more comfortable at my mental health appointments	93%	7%
Peer support helps me to feel more understood during my mental health recovery	89%	11%
Having peer support has helped me advocate for myself	90%	10%

In the Fall of 2021, seven beneficiaries of the MOST program participated in a focus group to discuss their experiences with the program. One purpose of the focus group was to understand the perceived value of peer involvement in psychiatric care from the perspective of beneficiaries.

When speaking to MOST program beneficiaries about their peer support specialist, beneficiaries expressed deep appreciation of their peer support specialist through not only the services that the peer support specialist provides, but also how those services are provided. Beneficiaries expressed that their peer support specialist is helpful with things such as, providing reminder calls about their appointments, helping with counseling, and offering rides for those who need it. Beneficiaries described the peer support specialist as respectful; one beneficiary recounted an instance where the peer support specialist was thoughtful when starting their relationship by asking her how often the peer support specialist could call her. The peer support specialist was also described as being kind-hearted, understanding, and considerate of all individuals. Descriptions from beneficiaries illustrated these characteristics through stories of the peer support specialist making efforts to ensure that beneficiaries were comfortable with treatment and making them feel that they were not alone. It was also mentioned that the peer support specialist will call after their appointment to check in on how their appointment went, confirming their genuine care. The impact of the peer support specialist on MOST program beneficiaries is so profound that two individuals from the group

expressed their desire to speak with their peer support specialist more regularly. Altogether, beneficiaries viewed their peer support specialist as a benefit to the MOST program.

"Makes me feel wanted. She's very kind."- When speaking about their peer support

"Everyone has been caring and always open to listen."

Family Perceptions of the Value of Peer Involvement

Perceptions of the value of peer involvement in their children's mental health appointments were measured through the Family Member Survey (see below). Table 3 displays results from the Family Member Survey and reflect a favorable perception of peer involvement across several indicators.

Table 3. Beneficiary Perceptions of Peer Involvement (n=9)			
	Agree	Disagree	n/a
It has been helpful to have a peer support specialist with my family member when they have mental health appointments	67%	0%	33%
Having a peer support specialist has been helpful for my family member in making progress toward their mental health and wellness recovery goals	89%	0%	11%
Peer support helps my family member feel more comfortable at their mental health appointments	78%	0%	22%
Peer support helps my family member feel more understood during their mental health recovery	78%	0%	22%
Having peer support has helped my family member advocate for themselves	67%	11%	22%

Outcome 2: Beneficiaries are meeting wellness and recovery goals

Interviews sought to gain an understanding of how clients experience the development of wellness and recovery goals as well as how clients make progress toward achieving them.

MOST Program Staff Perceptions of Developing Wellness and Recovery Goals

Developing Wellness & Recovery Goals

Interview respondents were asked if having peer support for beneficiaries helped in developing beneficiaries' wellness and recovery goals. Respondents expressed that peers play a role in helping beneficiaries develop their own wellness and recovery goals by being someone beneficiaries can talk to about struggles, whether it is about arranging transportation to an appointment, figuring out who their support system is at home, or needing to generate

solutions to everyday problems. Together peers and beneficiaries cocreate daily solutions and goals that are tailored and focused on meeting beneficiaries where they are in their lives. In planning and strategizing, beneficiaries are able to talk through pros, cons, and what it is beneficiaries want to achieve. The support results in helping beneficiaries resolve everyday struggles and worries; in turn, it allows beneficiaries the ability to shift their focus toward taking steps to improve their mental wellness.

"They are the experts in what will improve their mental health."

Progressing Toward Wellness & Recovery Goals

While respondents don't have first-hand experience with the process peers and beneficiaries go through to make progress toward achieving beneficiaries' wellness and recovery goals, respondents believe and are hopeful of the impact of having peer support. Respondents express that peers and beneficiaries have one-on-one conversations in confidential settings; thus, beneficiaries can freely express what is on their mind and communicate the progress they are making toward their wellness goals. Additionally, beneficiaries have peers to check-in on them, where the action of checking in both keeps beneficiaries on track and shows them that they have a support system to fall back on if they need help. Through check-ins peers are able to identify if something is wrong and work with beneficiaries to readjust their pathway toward achieving goals, as many times as necessary, as wellness and recovery looks different for each beneficiary.

MOST Program Partner Agency Perceptions of Reaching Wellness and Recovery Goals

Interview respondents were also asked whether peer support helps beneficiaries make progress toward their wellness and recovery goals. Individuals interviewed expressed a shared perspective on the beneficial role a peer support specialist can have in the recovery process. Interviewees felt that beneficiaries who have access to a peer support specialist are able to gain a more personalized type of guidance, thus better situating them to make progress toward wellness and recovery goals. Peer support specialist have also provided a greater level of support by making frequent calls to clients to check in on their progress. This has provided an avenue for clients to hear and practice emotional and behavioral coping skills more regularly.

MOST Program Beneficiary Perceptions of Wellness and Recovery Goals

The Follow-up Survey is intended to measure whether beneficiaries are meeting their wellness and recovery goals. As shown in Table 2, 93% of Follow-up Survey respondents shared that peer support has been helpful for making progress on mental health and wellness recovery goals.

Focus Group participants were also asked to describe the progress they feel like they are making toward their wellness and recovery goals. Beneficiaries expressed that while it is

difficult to discuss goals in therapy, working with their therapist and the peer support helps with meeting goals.

Outcome 3: Reduce no-show rate

Perceptions of whether the involvement of peers reduces the appointment no-show rate is measured through the Partner Agency Interviews, Follow-up Survey, and Beneficiary Focus Groups.

Interviews sought to understand how the inclusion of peer support specialists in psychiatric services impacts beneficiaries' reservations with mental health appointments (e.g., beneficiaries keeping their mental health appointments).

MOST Program Partner Agency Perceptions on Attendance of Appointments

Influencing Attendance of Mental Health Appointments

Interviewees expressed that peer support specialists were only able to encourage clients to keep their appointments; they are not able to make clients go to their appointments. However, they also shared that peer support specialists have a unique position where they are able to ease any negative feelings beneficiaries may have associated with going to a mental health appointment. This, they felt, would decrease a beneficiary's no-show rate over time.

"Patients get to have a peer with them at the psychiatrist's office for comfort. Sometimes she [the peer support] will go and pick them up for their appointments."

MOST Program Beneficiary Perceptions of Attendance of Appointments

During the Fall of 2021, EVALCORP conducted a Beneficiary Focus Group with beneficiaries of the MOST program. A third purpose of the focus group was to understand the impact of peer involvement in the reduction of appointment no-show rate.

Beneficiaries stated that they were grateful for the involvement of their peer support specialist and the MOST program staff in ensuring that beneficiaries attend their appointments. As a group, beneficiaries agreed that they are more likely to attend their appointments at MOST program because they identify with the peer support specialist; knowing they also have lived experience with mental and behavioral health issues.

There was strong agreement among beneficiaries that peer support is helpful in attending scheduled appointments. Beneficiaries conveyed several ways in which all staff of the MOST program worked in tandem with the peer support specialist to ensure appointments were kept. Beneficiaries acknowledged that a primary support provided to help them keep their appointments was the peer support specialist calling to remind them of their appointments. Additionally, some beneficiaries mentioned it was easier to attend their appointments because

of the rides offered by the peer support specialist. Beneficiaries also expressed an appreciation for the flexibility of MOST program staff and willingness to schedule around beneficiaries' schedules. Altogether, beneficiaries value the support offered by the peer support specialist and the MOST program staff in ensuring beneficiaries attend their appointments.

Additionally, beneficiaries were asked on the Follow-up Survey whether having peer support helps them keep their mental health appointments. Out of 28 responses on the Follow-up Survey, 86% of respondents agreed that peer involvement helped them keep their appointments.

Family Perceptions of the Value of Peer Involvement in Keeping Mental Health Appointments
Families were invited to share their perception of how having peer support specialists can help their family member keep their mental health appointments. Of the eight family members who responded, six agreed that peer support helped their child keep their mental health appointments. Two remaining responses selected "I don't know or Not Applicable."

Secondary Data Analysis of Appointment Attendance
For the 63 adult beneficiaries that were enrolled in services between July 1, 2021 and June 30, 2022, 1,279 appointments were scheduled. Of those scheduled appointments, 73% were attended. This is a 3% increase in the attendance rate that was seen by the MOST program in the prior fiscal year. On average, beneficiaries attended 15 appointments. The number of appointments attended by beneficiaries ranged from 1 to 67. Adult beneficiaries missed an average of six appointments. Overall, approximately 27% of appointments were missed.

In the first year of children receiving services from the MOST program, 44 child beneficiaries were enrolled in services between July 1, 2021 and June 30, 2022. Of the 579 appointments that were scheduled, 53% were attended. On average, beneficiaries attended 7 appointments. The number of appointments attended by beneficiaries ranged from 1 to 20 appointments. Child beneficiaries missed an average of six appointments. Overall, approximately 46% of appointments were missed.

Outcome 4: Transform telepsychiatric services from medical to wellness and recovery-based model of care
With a focus on shifting to a wellness and recovery-based model of care that is centered around individual beneficiaries, interview respondents were asked whether support provided by peers improves telepsychiatry services.

MOST Program Partner Agency Perceptions on Shifting to a Wellness and Recovery-based Approach
Impacts of a Wellness and Recovery-based Model of Care
Respondents shared that the peer support specialist' lived experience and their attentiveness had positive effects on beneficiaries. Having the opportunity to foster a healthy friendship with

a peer support specialist who has lived experience, along with the peer's attentiveness, helped beneficiaries feel that they are genuinely being understood. The inclusion of peer support specialists led beneficiaries to feel safe and know that they are not alone in the steps they take toward improving their mental health.

MOST Program Beneficiary Perceptions on Transforming the Approach to Mental Health Services

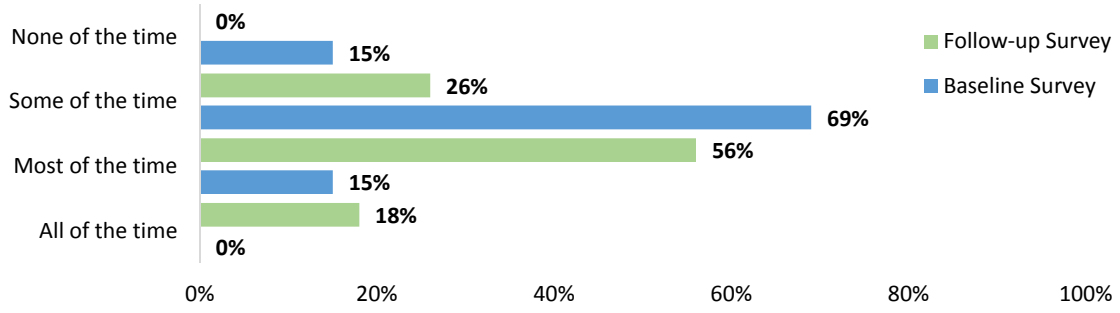
Only 50% of those who have completed the Baseline Survey indicated that they played an active role in the development of personal goals. Follow-up survey respondents indicated a stronger level of participation, with 89% of individuals indicating that they set their own mental health goals (Table 4). Other indicators reflect an experience in the MOST program that aligns with the wellness and recovery model.

Table 4. Personal Development of Wellness and Recovery Goals

	Baseline Survey (n=12)		Follow-up Survey (n=31)	
	Yes	No	Agree	Disagree
I make my own wellness and recovery goals for my mental health. (n=12, 27)	50%	50%	89%	11%
I have wellness and recovery goals for my mental health. (n=27)	-	-	100%	0%
In this program, I help make decisions about my mental health recovery. (n=27)	-	-	89%	11%
This program helps me with more than just my medical needs. (n=29)	-	-	86%	14%
This program helped me rely on myself to improve my well-being. (n=6)	-	-	83%	17%

Responses from the Follow-up Survey show greater involvement than Baseline Survey responses, suggesting participants in the MOST program play a more active role in working toward personal goals than they had prior to involvement with the Program.

Figure 1: Adult Beneficiary Involvement in Working toward Goals



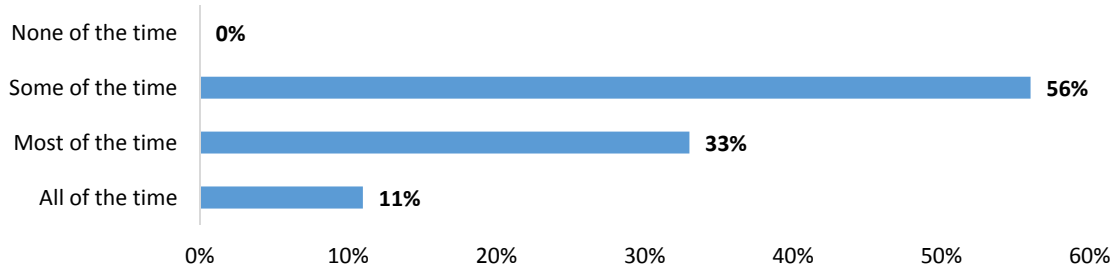
During the Fall of 2021 Beneficiary Focus Group, beneficiaries were asked whether they experienced services that are based on a wellness and recovery model of care.

When discussing the services received in the MOST program, beneficiaries expressed a variety of ways in which the peer support specialist reflects a wellness and recovery model of care. Beneficiaries spoke of a relationship with the peer support specialist that was distinctly tailored to their specific situation in life and considered beneficiaries' social, mental, and physical needs. This tailored approach reflects the patient-driven approach of a wellness and recovery model of care. In addition to this tailored approach to support, beneficiaries expressed appreciation for how the peer support specialist helped them monitor their progress toward achieving goals with regular check-ins before, between, and after appointments. This additional support that the peer support specialist provides enhances the delivery of a wellness and recovery model of care by ensuring that beneficiaries are heard and feel valued.

Family Member Perceptions on Transforming the Approach to Mental Health Services

Family members of child beneficiaries were asked about how involved the child was in working toward their wellness and recovery goals. Responses from the Family Member Survey indicate beneficiary participation in working toward goals, a hallmark of the wellness and recovery model of mental health care. Additionally, 100% of responses to the Family Member Survey indicate that the child was actively involved in the decision-making process about their wellness and recovery (n=9) and reflect agreement that the MOST program helps with more than just medical needs (n=8).

Figure 2. Child Beneficiary Involvement in Working toward Goals



Learning Goal 2: Can sharing of telepsychiatry services with other local service providers (including community-based providers) improve coordination of care and outcomes of program participants?

Outcome 1: Transitions to lower level of care

Information about beneficiary transitions to different levels of care is collected using the MOST Program Tracking Log.

During FY 2021/2022, 18 beneficiaries were discharged from the program, six of whom were transitioned to a lower level of care (33%). Nine beneficiaries were discharged for other reasons including:

- Non-compliance
- Administrative reasons
- Relocation
- Incarceration
- Death

Outcome 2: Reduced wait times for initial and follow-up appointments

Information about wait times from referral to initial appointment and from discharge from the hospital for a mental health crisis to follow-up appointment is collected using the MOST Program Tracking Log. All 63 adult and 44 child beneficiaries had a documented referral source and date from Mental Health Services (MHS), Inspiring Pathways, or Aspiranet, along with the date of their first schedule appointment. Figure 3 shows that almost half referred were able to be seen by MOST program staff the same day.

Figure 3. Adult Beneficiary Wait Times

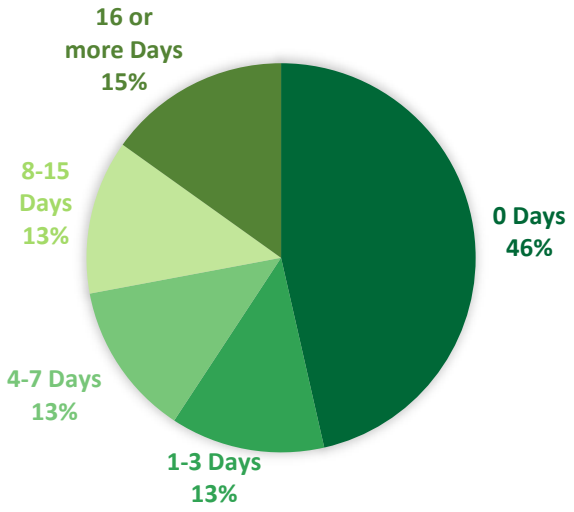


Figure 4. Child Beneficiary Wait Times

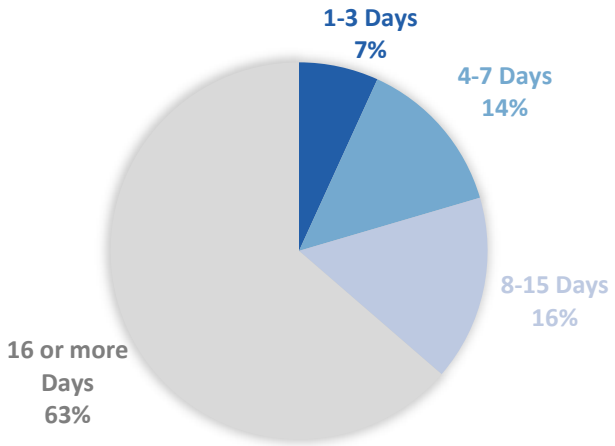


Figure 4 reflects the wait times of child beneficiaries. Due to interruptions with the hiring and onboarding of a child clinician, wait times are high for those who have received services this fiscal year; however, it is anticipated that average wait times decrease significantly for those who enroll in FY 2022/2023.

Information about appointment wait times from discharge (from hospitalizations for mental health crisis) to follow-up for MOST program beneficiaries is not currently available.

Outcome 3: Reduced hospitalizations for mental health crisis

The reduction of hospitalizations for mental health crisis is documented using the MOST Program Tracking Log. The number of hospitalizations for mental health crisis before enrollment in the MOST program and during participation in the MOST program is determined by accessing the county's Electronic Health Record (EHR) system.

Information about hospitalizations for a mental health crisis is reported below for 97 unduplicated beneficiaries. Only beneficiaries that had been enrolled in the MOST program for at least a month were included. Hospitalization rates were calculated as annual rates. Across

the 97 beneficiaries, 63 of them had a total of 91 hospitalizations prior to their enrollment in the MOST program. Reducing the number of individuals requiring hospitalizations for a mental health crisis in Kings County could lessen the strain on the healthcare system within the county.

Table 5. Average Annualized Hospitalizations			
	3 Years Prior to Enrollment	During Enrollment	% Change
Average # of Hospitalizations prior to MOST Program Enrollment (Annualized)	0.3 per year	0.6 per year	+ 80%

While the average annualized number of hospitalizations increased for MOST program beneficiaries, fewer beneficiaries were hospitalized. Prior to MOST program enrollment, 42 of 97 beneficiaries (43%) were hospitalized. Since enrollment, 30 of 97 (31%) were hospitalized for a mental health crisis (decrease by 12%). This suggests that individuals are less likely to require hospitalization after enrolling in the MOST program.

Beneficiaries were also asked whether they recall being hospitalized (admitted) for mental health crisis in the past three years on the Baseline Survey and since being enrolled in MOST program on the Follow-up Survey. Responses for beneficiaries that completed the surveys and were enrolled in MOST program in FY 2021/2022 are in Table 6 below.

Table 6. Past Hospitalization for Mental Health			
	Yes	No	Don't Know
Have you been hospitalized for mental illness in the past 3 years? (n=13)	69%	8%	14%
Have you been hospitalized for mental illness since enrolling in the MOST program? (n=31)	16%	81%	3%

Outcome 4: Reduced number of individuals seen by emergency room for mental illness
The reduction of Emergency Room (ER) visits for mental health crisis is documented using the MOST Program Tracking Log. The number of ER visits that resulted in a mental health crisis evaluation before enrollment in the MOST program and during participation in the MOST program is determined by accessing the county's Electronic Health Record (EHR) system.

Information about crisis evaluations for 97 beneficiaries is reported below. Only beneficiaries that had been enrolled in the MOST program for at least a month were included. Crisis evaluation rates were calculated as annual rates. Across the 97 beneficiaries, 63 of them had a total of 184 crisis evaluations at the emergency department prior to their enrollment in the

MOST program. Reducing the number of individuals seeking crisis evaluations in Kings County could also lessen the strain on the healthcare system within the County.

Table 7. Average Annualized Crisis Evaluations			
	3 Years Prior to Enrollment	During Enrollment	% Change
Average # of Crisis Evaluations prior to MOST Program Enrollment (Annualized)	0.6 per year	1.4 per year	+ 129%

While the average annualized number of crisis evaluations increased for MOST program beneficiaries, fewer individuals were seeking crisis evaluations. Prior to MOST program enrollment, 63 of the 97 beneficiaries (65%) needed a crisis evaluation. Since enrollment, 42 of the 97 (43%) beneficiaries needed a crisis evaluation (decrease by 22%). This suggests that individuals are less likely to receive crisis evaluations after enrolling in the MOST program.

Beneficiaries were asked to self-report whether they recall being evaluated for a mental health crisis at the emergency room since being enrolled in MOST program on the Follow-up Survey. Responses for beneficiaries that completed the surveys and were enrolled in MOST program in FY 2021/2022 are in Table 8 below. The number of individuals who self-reported an emergency department crisis evaluation visit since MOST program enrollment is 34% lower than those who reported an emergency department crisis evaluation prior to MOST program enrollment.

Table 8. Past Emergency Department Mental Health Crisis Evaluations			
	Yes	No	Don't Know
Have you had a mental health crisis evaluation at the emergency department in the past 3 years? (n=13)	66%	15%	23%
Have you had a mental health crisis evaluation at the emergency department since enrolling in the MOST program? (n=31)	32%	55%	13%

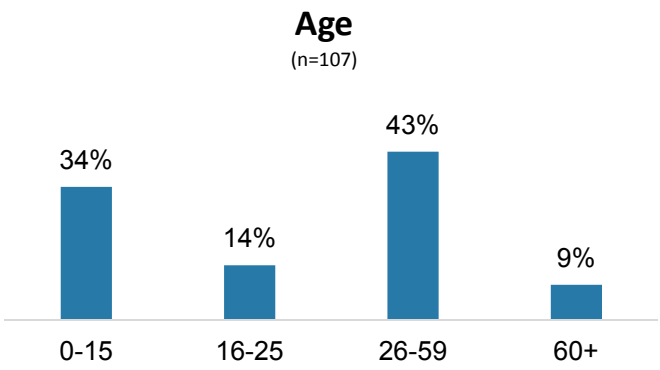
Outcome 5: Reduced recidivism for individuals with mental illness

Beneficiaries are asked whether they recall being arrested and booked into county jail in the past three years on the Baseline Survey and since enrolling in the MOST program on the Follow-up Survey. Responses for beneficiaries that completed the surveys in FY 2021/2022 are in Table 9 below. The percentage of individuals reporting an arrest since enrolling in the MOST program dropped 38% from those who reported an arrest prior to MOST program enrollment.

Table 9. Arrest/Jail Incarceration (n=9)			
	Yes	No	Don't Know
Have you been arrested or booked into jail in the past 3 years? (n=9)	54%	38%	8%
Have you been arrested or booked into jail since enrolling in the MOST program? (n=31)	16%	71%	13%

Program Information

During FY 2021/2022, a total of 107 beneficiaries were provided telepsychiatry services. Demographic information for both child and adult beneficiaries served is displayed below.



Primary Language
(n=106)

93% English

7% Spanish

Gender Identity
(n=105)

Female	54%
Male	45%
Transgender[3]	0%
Genderqueer	0%
Questioning	0%
Another Gender Identity	1%

Sexual Orientation
(n=60)

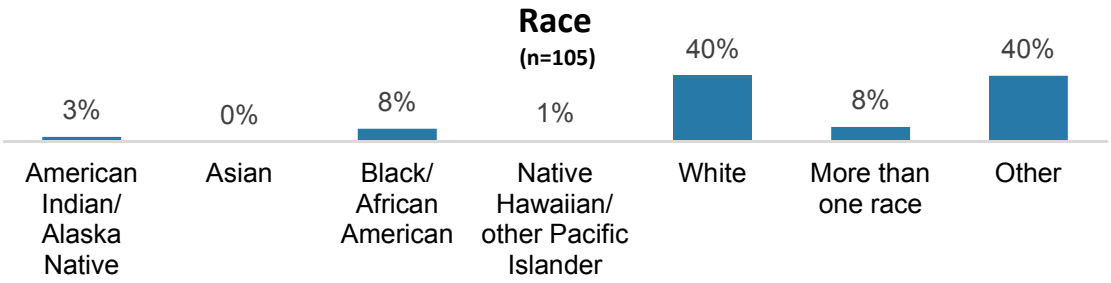
Bisexual	2%
Gay or Lesbian	6%
Heterosexual or Straight	92%
Queer	0%
Questioning	0%
Another Sexual Orientation	2%

Sex at Birth
(n=106)

57% Female

43% Male

Four beneficiaries identified as a veteran

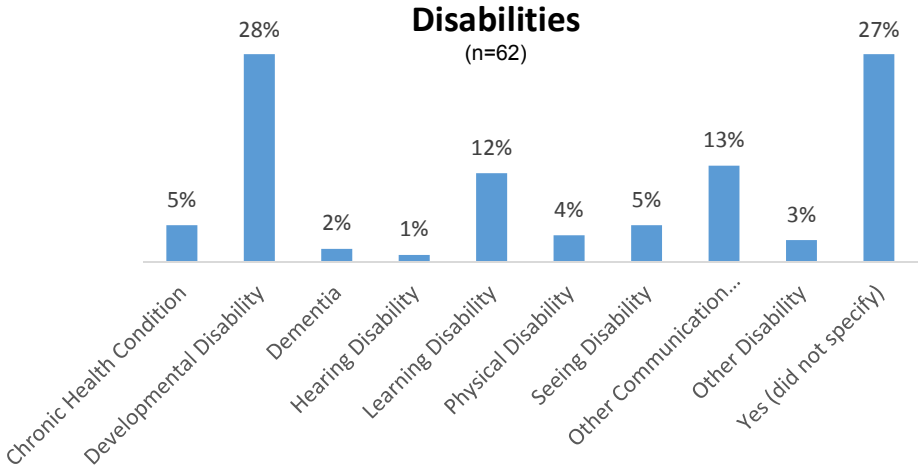


Ethnicity*
(n=105)

Hispanic/Latino	
Caribbean	0%
Central American	3%
Mexican/Mexican American/Chicano	39%
Puerto Rican	0%
South American	0%
Other	20%
Multiple	1%

Non-Hispanic/Latino			
African	4%	Filipino	3%
Asian Indian/South Asian	0%	Japanese	0%
Cambodian	0%	Korean	0%
Chinese	0%	Middle Eastern	0%
Eastern European	0%	Vietnamese	0%
European	3%	Other	47%
Multiple	3%		

*Percentages may add up to more than 100% as individuals were able to select more than one ethnicity



Conclusion

The MOST program was able to make progress toward defined learning goals and associated outcomes. In addition, 97% of MOST program beneficiaries who completed a follow-up survey noted that they felt respected by staff and 100% of respondents indicated that the services were useful for them.

- Program staff and beneficiaries both reported positive value of peer involvement in psychiatric care.
- Wait times were shorter for adult beneficiaries than the county average of 26 days. Just under half of the beneficiaries seen during FY 2021/2022 (46%) had no wait between their referral and first appointment.
- Among beneficiaries with a history of mental health hospitalizations, there was a clear reduction with fewer than 22% being hospitalized for mental health crisis after their enrollment in the MOST program.
- MOST program staff reported that through peer involvement beneficiaries have an individual whom they trust and can freely express their challenges with, allowing for a supportive and safe environment for beneficiaries to focus on their well-being and reach their clinical goals.

<u>Areas of Improvement</u>

Even with the extraordinary circumstances posed by the pandemic, there are a few areas of improvement, particularly related to the implementation and documentation of evaluation activities, recommended for program staff.

- *Survey Distribution and Completion.* The majority of adult participants served in FY 2021/2022 (about 84%) did not complete the Adult Baseline Survey.
- *Consistent/Systematic Use of Peer Support.* All focus group participants found value in having peer support. However, some participants disclosed a desire for more frequent contact while others reported high levels of contact. Systematic assessment and documentation of which beneficiaries want to be contacted and how often would provide an additional layer of information regarding the degree of treatment related to peer support.