Mental Health Services Act

FY 2024-2025

Annual Update

(June 2024)

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.

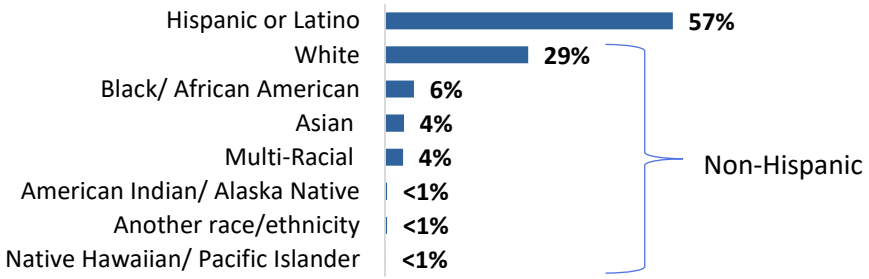
Kings County Behavioral Health's (KCBH) mission -- "to promote, support, and invest in the wellness and recovery of individuals living in the communities of Kings County by creating opportunities to contribute, learn, work, and find hope in each day" -- was designed to be in alignment with MHSA principals.

About Kings County

Kings County covers 1,391 square miles and has a population of over 150,000 residents. The county includes 4 incorporated cities (Hanford, Lemoore, Corcoran, Avenal), 7 Census-designated places, the Santa Rosa Rancheria (a federal reservation for the Tachi Yokut), 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 38% of the population resides[1].

Forty-two percent of households primarily speak a language other than English at home. Additionally, more than half of the residents are Hispanic/Latino (See **Figure 1**).

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 nearly 8,500 individuals.[2] Additionally, roughly 7.8% of the county's population consists of veterans.

Another important segment of the population is the local Native American population. The Santa Rosa Rancheria has an estimated population of 870 individuals from the Tachi Yokut Tribe.

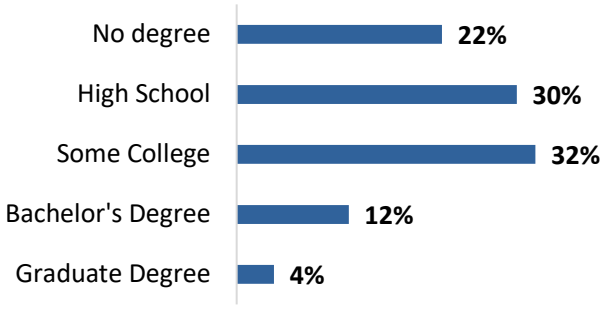
[1] Unless noted otherwise, all demographic data are from the American Community Survey 1-year estimates (2022)
[2] Military Installations. Naval Air Station Lemoore. https://cnrsw.cnic.navy.mil/Installations/NAS-Lemoore/

Kings County is relatively low income compared to other counties in the state. Of households in the county, 18.8% live below the Federal Poverty Level (compared to 12.2% in California overall).

Additional county demographics are summarized below:

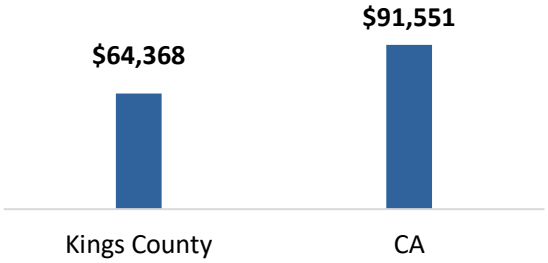
- Roughly 78% of residents aged 25+ have a high school degree higher educational attainment (See **Figure 2**).

Figure 2. Educational Attainment for Residents 25+



- Median household income ($64,368) is about 30% less than the State median household income of $91,551 (see **Figure 3**).

Figure 3. Median Household Income



- Unemployment rate[3] (7.0%) is higher than the state average (4.3%) (see **Figure 4**).

Figure 4. Unemployment Rate

[3] Bureau of Labor Statistics, Annual Average 2022

COMMUNITY PROGRAM PLANNING PROCESS

COMMUNITY PROGRAM PLANNING 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

Four focus groups were conducted in January 2024 (with a total of 38 participants) 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 races/ethnicities, language proficiencies, and regions of the county. **Table 1** provides further details about each of the focus groups.

Table 1. Focus Group Summary

Region/Subpopulation	# Participants
Veterans	21
Corcoran (Bilingual)	8
Avenal	7
Spanish Speaking Parents (Corcoran)	2
Total	38

Community Survey

The Community Survey was developed and administered online by EVALCORP in both English and Spanish from January through February 2024. Surveys were distributed via:

- Kings County Behavioral Health website
- Kings Partnership for Prevention listserv
- Local mental health outreach events

A total of 244 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 in January – February 2024 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, six interviews were conducted with eight individuals interviewed, where an interview could have more than one interviewee.

Participating interviewees primarily consisted of providers that offered one or more of the following services:

- Case management
- Counselling
- Crisis services
- Full-Service Partnership programs
- Housing assistance/shelters
- Medication
- Mental health diagnoses
- Outpatient/Inpatient services
- Outreach and education
- Placement and release of 5150s
- Psychiatric services
- Psychoeducation
- Referrals
- Substance misuse and prevention services
- Support groups/programs
- Wraparound services
- Wellness center services

Interviewees provided information about mental and behavioral health services in Kings County, focusing on (1) service accessibility, (2) peer services, and (3) support groups. The Key Stakeholder Interview Protocol is available in the **Appendix**.

Training

Training on the CPP process and methods was provided to three groups of stakeholders during the 2023-2024 fiscal year:

- Kings County Behavioral Health Advisory Board — November 2023
- Kings County Mental Health Task Force — November 2023
- Mental Health Services Act Team at KCBH — April 2024

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.

Stakeholder Participation Demographics

In total, CPP activities included more than 250 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	38
Community Survey	244
Key Stakeholder Interviews	8
Total	**290**

The data summarized in Tables 3-5 reflect the demographic profile of participants from the Community Survey. Note that demographic data was not explicitly collected from participants in the focus groups, or interviews.

Table 3. Participants by Gender (n=204)

	%
Female	81%
Male	18%
Transgender	1%

Compared to County demographics (Female 45%, Male 55%), women were over-represented in community engagement efforts.

Table 4. Participants by Race/Ethnicity (n=203)

	%
Hispanic/Latino	52%
White	23%
Black/African American	16%
Asian	3%
American Indian/Alaska Native	2%
Multiracial	2%
Native Hawaiian/Pacific Islander	1%
Another	1%

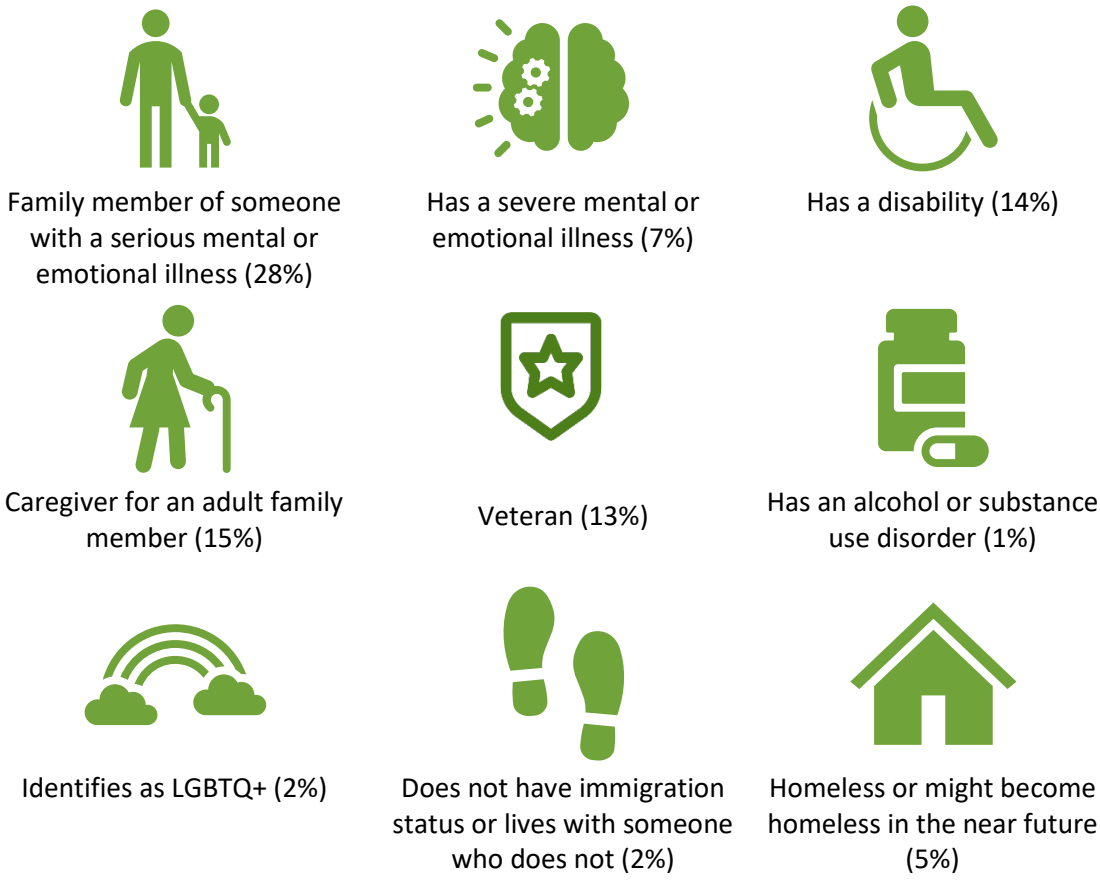
The distribution of racial and ethnic representation among participants in the community engagement process is close to that of the County overall. The age ranges of participants is provided below.

Table 5. Participants by Age (n=202)

	%
Under 18	1%
18-24	4%
25-39	40%
40-59	24%
60-69	19%
70 and older	12%

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=148), more than half of the respondents (59%) reported being the parent or guardian of a child under 18. Additional characteristics are visualized in the graphic below.

Figure 5. Additional Respondent Characteristics



Additionally, respondents who indicated “other” (n=23) shared that they identify as a behavioral health provider (3) or as someone who potentially has a demand for behavioral health services (7).

Key Findings

This section summarizes the findings related to the topics addressed during the 2023-2024 CPP process, organized by method. Additional details about the methods and results can be found in the **Appendix**.

Expanding Service Hours

Below is a summary of feedback received related to the topic of expanding mental health service hours, organized by data collection activity.

- **Community Survey**
  - Nearly 1/3 (29%) of respondents preferred engaging in mental health services during regular business hours.
  - Nearly 1/3 (29%) of respondents preferred to engage in mental health services during Saturday mornings (8am-noon)
  - Nearly 1/4 (22%) of respondents preferred to engage with mental health services between 5pm and 7pm on weekdays.
- **Interviews**
  - Additional clarity was requested for providers and contractors regarding county approval processes for changes in hours
  - It was shared that individual therapy would be feasible to extend hours for, however this would likely not be possible for psychiatric services
  - The willingness of clinicians to work outside of traditional hours was reported as the biggest factor affecting the implementation of extended service hours

Telehealth

A summary of feedback related to telehealth is provided below, grouped by data collection activity.

- **Focus Groups**
  - Participants shared concerns related to technological literacy and a lack of privacy related to telehealth services, in addition to an overall preference for in-person services. Additionally, a lack of consistent internet and it being more difficult to take the provider seriously were shared as additional barriers to telehealth in rural areas.
  - Participants shared that telehealth can be a good alternative when in-person services are not available. Additionally, veterans shared that they appreciated the additional privacy and convenience of telehealth.
- **Community Survey**
  - Nearly 3/4 (73%) of respondents indicated that they ***do not*** currently use telehealth to access mental health or substance use services.
  - By far, the most common reason (67% of responses) was that they “prefer in-person appointments.”
- **Interviews**
  - Only two of six interviews recommended telehealth as an alternative to meeting clients in person, but even then, this was noted as “not ideal”

Support Groups

A summary of feedback received related to the implementation of support groups is provided below, grouped by data collection activity.

- **Focus Groups**
  - Participants shared several positive experiences with support groups in the past, both in-person and virtual.
  - Barriers to participation in support groups that were shared were mostly related to logistics such as finding good facilitators, the group being at inconvenient hours, or a lack of consistent attendance at virtual groups.
- **Community Survey**
  - Nearly half (45%) of respondents reported that a Stress Management support group would be helpful for them or their family. The next most common topic of interest was Depression – Adults (40%), followed by Depression – Teens (23%) and Anxiety – Adults (23%).
  - Forty-one percent of respondents would be interested in participating in a virtual support group (an additional 29% were "not sure"), and seventy-one percent of respondents indicated that they were able to connect to a virtual support group.
  - The most common barriers reported to attending a support group of interest to them were limited transportation (28%), unable to take time off work (25%), and caregiving responsibilities (24%).
- **Interviews**
  - Interviewees shared that the implementation of support groups requires a specific contract, advertising for the group, a willing facilitator, and consideration of community feedback.
  - Interviewees shared that remote support groups have privacy and safety advantages for participants (if they have a safe space), and no need for transportation, however this is not an ideal mode of service delivery.

Improving Trust

A summary of additional feedback received, related to improving trust between mental health providers and community members, is summarized below.

- **Focus Groups**
  - Focus group participants shared a need for culturally responsive services for Latino/a communities, including a desire for services to be more social/less formal.
  - Specific subpopulations within Latino/a communities with unique challenges or barriers include recent immigrants needing help transitioning to American culture, and older generations overcoming the idea that addressing behavioral health issues without help "is a sign of toughness."
  - Participants from Avenal and Corcoran shared a need for adult and child services locally, and that the presence of a county vehicle outside someone's home (i.e. during a home visit) would bring stigma
  - Some individuals shared a concern about misdiagnosis, and that first impressions from providers make a big difference.

- **Interviews**
    - Five of the six interviews expressed a need to meet clients out in their community or in their home
    - Four of the six interviews identified a need for additional and intentional outreach regarding available services and/or how to navigate them
    - Improving trust between the community and providers was considered "an all-around issue," with specific suggestions for improving trust including creating a physical presence in rural communities, hiring bilingual (English/Spanish) clinicians and staff, conducting additional outreach, and improving the quality and consistency of services

Summary and Recommendations

The findings summarized above suggest that ***there is strong support for additional or expanded support groups***, including informal and virtual groups. The most requested topics for groups were Stress Management and Depression, although there was also interest in a more informal/social model of support group, particularly for Latino(a)s in rural areas.

The most reported barriers to accessing support groups included limited transportation (which would not be an issue for virtual groups), an inability to take time off work (which could be mitigated by offering the groups outside of traditional hours, such as Saturday mornings or weekday evenings), and caregiving responsibilities.

The findings also suggest that ***there is limited interest in telehealth as a replacement for in-person mental and behavioral health services***. When possible, telehealth should be limited to follow-up appointments or as an option for clients, rather than the sole means of service delivery. For rural areas in particular, a physical space/presence for mental and behavioral health services is recommended where possible, particularly for initial appointments/intakes.

For additional information about each data collection activity and their associated findings please refer to each activity's respective Summary of Findings in the **Appendix**.

Public Review and Comments

[to be updated after public review]

Plan Proposed Plan Modifications and Application of Community Feedback

Within the Kings County Behavioral Health 2023-2026 Three-Year Mental Health Services Act Plan which can be found at the KCBH.org website, starting on page 9, are the details related to the comprehensive Community Planning Process that occurred to help set direction for the 2023-2026 period. To assist with better understanding the results as it relates to such items as what topics for support group consideration, what hours and locations for service expansion, etc., Kings County Behavioral Health focused the community planning for the 2024/2025 Plan Update towards these details. The application of the results of this feedback will be shared with applicable providers and programs to discuss how best to use for service and program enhancement and expansion, where applicable and feasible.

As a start, the following has taken place:

- Within this 2024/2025 Plan, the Department is proposing a modification to expand the number of certified trainers under the Community Wide Outreach and Engagement Education/Training PEI Program through the Mental Health Task Force, as well as to expand the capacity of the School-based Prevention and Early Intervention Program to serve more schools/students.

- While not funded through the Mental Health Services Act, the Department is using the feedback for the desire of expanded services to request current mental health and substance use disorder service providers expand their clinic operations to be physically in the outlying communities most specifically in Avenal and Corcoran. This request is being done through the 2023 and 2024 adult outpatient Request for Proposals. The substance use disorder adult outpatient Request for Proposal concluded and resulted in the expansion of available providers as well as the expansion to Avenal and Corcoran. These expansions are anticipated to begin in the fall/winter 2024.

- While also not funded through the Mental Health Services Act, the Department is launching a 24/7 call center and mobile crisis response program to serve all communities within the County. This is anticipated to begin in the fall/winter 2024.

Kings County Behavioral Health will continue to apply the community feedback from the 2023-2026 Three-Year Plan and the 2024/2025 Annual Update to inform and guide Mental Health Services Act and other County Behavioral Health funding and programs.

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	3	80	9
Total Served: 77 **Cost per person served:** $22,552				
Number to be Served by Age Group:	N/A	5	80	10
Total to be Served: 95 **Cost per person to be served:** $35,287				

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. Psychiatry and telepsychiatry will be offered through the Multiple Organization Shared Telepsychiatry (MOST) unit.

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.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022 – 2023

Referrals and/or coordination of care continues to be provided between MHS, Kings County Behavioral Health (KCBH), Kings View, Wellpath, Probation Department, Champions, Shelters, Board & Care, Room & Board facilities, and the Public Guardian Office. MHS Kings County ACT staff attend the Acute Care Coordination meetings every Tuesday and Thursday, to share updates and/or concerns, to coordinate client care, and to discuss incoming referrals. ACT served a total of ninety-two (92) unduplicated Partners for the fiscal year 2022-2023. ACT received a total of forty-two (42) referrals for fiscal year 2022-2023 and all clients were enrolled in the MHS ACT Program. A total of thirty-nine (39) clients were dis-enrolled from MHS Kings County ACT, for the fiscal year, due to moving out of county, conservatorship, no engagement, or contact made, deaths, or referral to lower level of care. ACT Program served an average of fifty-six (56) clients monthly. ACT program provided housing services utilizing a variety of master leases, board & care, room and boards, and motels for fifty-four (54) unduplicated clients for fiscal year 2022-2023.

Staff received specialized training to address the needs of the Seriously Mentally Ill (SMI) including Dialectical Behavioral Therapy (DBT). Staff continued to utilize the Columbia Suicide Severity Rating Scale (C-SSRS) to preventatively respond to a client in crisis. MHS organized a food pantry and prepared hygiene packets to provide 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 for clients.

Key Successes (Overall Accomplishments and Highlights)

The ACT referral process was made directly from KCBH, which streamlines referrals from Kingsview FSP program, Kings View Crisis Program, Champions, and Wellpath in the Kings County Jail contracted provider, to successfully link clients to the ACT program. ACT program provided housing services utilizing master leases, board & care, room and boards, rental assistance, and motels for fifty-four (54) clients for fiscal year 2022-2023. MHS Kings County ACT was able to secure an additional master lease during this fiscal year to increase capacity for housing clients that experience significant barriers to other forms of supportive housing. The food pantry was available for clients in immediate need of food and water. Hygiene packets were provided to clients when unable to access community resources due to barriers associated with mental health impairments and/or insufficient financial means. C-SSRS forms are being utilized to ensure the safety of a client in crisis. ACT program provided targeted case management and support services to clients to reduce hospitalizations. In addition to this, the ACT program increased the utilization of group therapy and psychosocial rehabilitation services which resulted in significant increases in participation by partners.

Overcoming Challenges

MHS ACT program experienced high turnover of a key staffing position for a Clinical Supervisor. This was alleviated by flexibility in recruiting a virtual Clinical Supervisor and this role has since been filled. 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 phone capabilities. COVID-19 resulted in shortage of staff

for multiple two-week periods due to being sent home and/or taking extended sick leave to recover from infections. COVID-19 also impacted the health and availability of clients to meet with program staff. Telehealth audio and video services were utilized when appropriate to maintain contact, connection, and progress toward treatment goals. Limited housing resources within the county presented barriers to accessing stabilization and treatment for clients newly referred. MHS ACT program did have to utilize increased motel stays, to assist newly referred clients in maintaining safety, as housing plans of care were created to identify and meet their needs.

2024-2025 Goals and Proposed Activities

Goals and Objectives for 2024-2025

1) Provide assertive community 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.

Proposed Activities for FY 2024-2025

MHS ACT program will work toward the following goals and objectives for FY 2024-2025:

- Provide treatment services that promote and enhance the whole person's wellness and recovery.
- Provide Group Therapy, Group Rehab, and Group Peer Support services to all ACT Partners focused on reducing functional impairment and building coping skills.
- Recruit and retain quality staff including within positions such as Clinical Supervisor and Clinicians. Both positions are fully staffed currently.
- Empower ACT clients through educational and vocational rehabilitation services that result in increased independent living skills. ACT will seek out community connections to assist clients in developing educational and/or vocational skills that will serve them in their wellness and recovery.
- ACT program will continue to provide intensive, community-based services through multiple weekly contacts.
- Continue to track progress of clients toward reaching their treatment plan goals to provide smooth transition upon discharge planning to lower level of care.
- Continued use of Individualized Service Plan (ISP) template for Targeted Case Management services to focus collaborative care upon the client's goals.
- Continue to onboard student interns to increase staff recruitment and retention.
- Maintain current Master Lease units to provide immediate assistance to clients experiencing barriers to other options for housing in the community.
- Focus upon supporting clients to be document ready for permanent supportive housing as it becomes available.

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	23	8	0	0
Total served: 31 **Cost per person served:** $21,748				
Number to be Served by Age Group	Children 34	TAY 10	Older 0	Older Adult 0
Total To Be Served in FY 2024-2025: 44 **Cost Per Person to be Served:** $47,354				

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 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. Psychiatry and telepsychiatry will be offered through the Multiple Organization Shared Telepsychiatry (MOST) unit.

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.

2022-2023 Program Updates, Outcomes, and Challenges

Overall Activities and Outcomes for FY 2022-2023 (July 1, 2022-June 30, 2023):

Aspiranet (FSP Provider) encountered an approximate 54.5% success rate, according to data reporting. Routine parent cafes, 3-person team configurations, proficiency in communicating with other systems of care, and dedication to clients attributed to this rating.

Overall Project Strengths for FY 2022-2023 (July 1, 2022-June 30, 2023):

The Aspiranet FSP Program offered individual, rehab, and peer support services providing these directly to clients and families within the community. Aspiranet provided coordination of care to other child systems of care to support achievement of client and family goals. Aspiranet provided 24/7 crisis support to all clients involved in the program and supported the families of Aspiranet clients by hosting events specific for them.

Overall Accomplishments and Highlights:

With Aspiranet's treatment support, fifteen (15) clients graduated from the program and three (3) clients transferred to programs outside of Aspiranet (Step Down and The Kind Center). Nineteen (19) clients reached goals (fifteen (15) reached them in full while four (4) partially reached them). The structure of Aspiranet's services contributed to the success of the program. This entailed designating a Clinician who was responsible for providing Intensive Care Coordination and individual therapy, designating a Support Counselor whose responsibility was to provide social, coping, and life skills; and designating a Peer Support Specialist to provide support for parents who needed assistance managing client's needs and providing parents resources. Lastly, Aspiranet also has dedicated staff who are committed to serving and meeting the needs of our clients.

Overcoming Challenges:

Aspiranet encountered multiple transitions which included a change in EHR system and personnel changes at Kings County Behavioral Health (KCBH). Aspiranet had to develop procedures for Streamline and develop creative ways to provide services. Aspiranet also was tasked with creating spaces with KCBH to enhance procedures and protocols.

2024-2025 Goals and Proposed Activities

Program Goals and Objectives for 2024-2025 (July 1, 2024-June 30, 2025):

- Training to assist with working with consumers who have Psychotic related symptoms as well as Trauma.
- Provide a licensed consultation group to support our licensed clinicians to help with increasing staff retention.
- Developing a resource cabinet to help with immediate needs that our consumers face (i.e., hygiene kits, snack packs).
- Working with the County to identify additional housing resources that include residential placements.

Proposed Activities for 2024-2025 (July 1, 2024-June 30, 2025):

- Having workshops quarterly to focus on areas that could be helpful at the OWC to host: Job skills/interviewing skills-inviting JTO or other type of employment partners to do a presentation, having fashion show of how to dress for employment seeking; Life Skills-cooking demos, Public Health presentation on nutrition. Things like that where we can invite our FSP consumers.

- Increasing relationships with community partners by inviting them to our dept meetings or "field trips" for our staff (FSP team) to go to their locations to learn more about local resources and how to navigate their systems to help when they are working with their own clients.

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 for FY 2022-2024: 130 **Cost per person served:** $33,910				
Number to be Served by Age Group	N/A	10	100	20
Total To Be Served in FY 2024-2025: 130 **Cost Per Person to be Served**: $14,597				

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
- Psychiatry and telepsychiatry will be offered through the Multiple Organization Shared Telepsychiatry (MOST) unit.

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.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022-2023

The Adult Recovery Oriented Services (lower level of care than FSP) provider, Kings View, identified clients who met FSP criteria during 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

- Launch of an introductory engagement group to strengthen commitment amongst clients, including providing psychoeducation regarding a 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 resources 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, 2022-June 30, 2023).

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.

Due to the complex needs of clients and the intensity of services in high level care programs, provider burnout and shortages are a challenge, and with shortages come higher caseloads. These challenges were experienced during 2022-2023 at times. As program grew, the total number of staff was not able to also increase at the same rate due to budget limitations.

2024-2025 Goals and Proposed Activities

Proposed Activities for FY 2024-2025

- Continue to provide staff training 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	1	20	0
Total served FY 2022-2023: 21 **Cost per person served:** $17,863				
Number to be Served by Age Group	0	2	19	1
Total To Be Served in FY 2024-2025: 22 **Cost Per Person to be Served:** $22,287				

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 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.

2022-2023 Program Updates, Outcomes, and Challenges

Overall Activities and Outcomes for FY 2022-2023 (July 1, 2022-June 30, 2023): Participants participate in regular court appearances before the judge. Treatment includes weekly individual or group sessions, probation check-ins, random drug and alcohol testing, and weekly attendance at recovery support/self-help meetings. During court appearances, weekly raffles are conducted to incentivize compliance and provide positive reinforcement to participants in their programs. During the fall of 2022, a holiday event was organized for participants. The event featured food, raffle prizes, and swag bags distributed to all participants who actively participated. Some members of the treatment team, including the judge, attended the California Association of Collaborative Courts 2023 Conference in February.

Overall Project Strengths for FY 2022-2023 (July 1, 2022-June 30, 2023): Several participants successfully completed the program**.** The consistent retention of staff within the treatment team, including the judge, provider, same probation officer, has fostered a strong environment of collaboration and teamwork. This continuity enables effective support for clients and enhances the overall effectiveness of our efforts. Our program has reached its 10-year anniversary during this time, signifying a significant milestone. Its longevity since its pilot version back in 2013 is remarkable, highlighting a decade of continuous success.

Overall Accomplishments and Highlights: Some participants were accepted and completed residential/inpatient programs. Several participants have successfully improved their relationships with their families. One successful graduate was working towards obtaining a professional certification. A few graduates have actively worked towards family reunification. When participants successfully complete the program, they become eligible for a reduction in court fines and fees.

Overcoming Challenges: Limited availability of residential facilities in our area, which requires the need to search outside of the county. There is limited housing placement for long-term sober living once some of our participants complete inpatient or residential facilities. Seeking comprehensive training for our entire team, which is crucial for maintaining effective treatment court programs and staying updated on best practices.

2024-2025 Goals and Proposed Activities

Program Goals and Objectives for 2024-2025 (July 1, 2024-June 30, 2025): Provide services and treatment to participants living with a mental illness or substance use disorder to improve their quality of life. Support participants successful reentry to society and address substance abuse that may have contributed to their criminal justice involvement. Expand training opportunities for the entire CJTC treatment team to ensure we stay current with best practices.

Proposed Activities for 2024-2025 (July 1, 2024-June 30, 2025): Participants who successfully complete the program are recognized during court by both the judge and treatment team. They receive a certificate of completion, a medallion, and other incentives. We plan to host workshops for participants, focusing on job searching, interview skills, health, and nutrition, among other activities. Enhance training for treatment team members, including attendance at the national Conference for treatment court professionals.

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 FY 2022-2023: 106 **Cost per person served in FY 2022-2023:** $1,052				
Number to be Served by Age Group	53	15	43	4
Total To Be Served in FY 2024-2025: 115 **Cost Per Person to be Served:** $1,110				

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 support 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.

Target Population:

Our target population is serving individuals who are experiencing domestic violence, human sex trafficking, sexual assault, and elder abuse of all genders. We also provide support to unhoused single women and unhoused women with children.

A. Continue to retain a Licensed Marriage and Family Therapist for the benefit of the clients.
B. Strive to complete at least 95% Vulnerability Index- Service Prioritization Decision Assistance Prescreen Tool (VI-SPDAT) with clients to increase their chances of being housed with a program.
C. Maintain and attend meetings with Kings County Executive Advisory Council to stay up to date with all educational events that can benefit the families we serve.

2022-2023 Program Updates, Outcomes, and Challenges

Overall Activities and Outcomes for FY 2022-2023 (July 1, 2022-June 30, 2023):

Barbara Saville Shelter was able to obtain a grant from CalViva in the amount of $10,000. This funding allowed BSS to purchase egg chairs, sensory mat massage game mats, weighted blankets, kids table and chair set, ball pits, star projector, non-slip plastic balance stepping stones, autism tap LED lights, cushioned movable couches and sensory foam crash pads.

The BSS staff has continued to celebrate birthdays individually by asking each client with an upcoming birthday the type of cake they would like to have and their dinner preference. A birthday gift is provided to the client by BSS.

During case management meetings case managers set out bins with sensory item toys, that can be used throughout the meeting. Clients meet with case managers 1-2x a week.

In addition, closet rods and brackets were purchased to switch the donation room from storing clothes in bins to hangers. The appearance of the donation room appears as if you would if you went to a clothing shop. BSS was able to complete a shelter renovation in April 2023, this included new cabinets in the kitchen, new countertops, new sink, a new stove and hood range, new refrigerator and freezers, new paint on walls in the kitchen and dining room, new lighting, and tables and chairs. The shelter also replaced bed frames in June 2023, going from wood frames to all metal frames. New mattresses were provided for each bed and new closets have been installed.

Overall Project Strengths for FY 2022-2023 (July 1, 2022-June 30, 2023):

- The Program Manager was able to present to 9 different organizations and agencies regarding shelter services and operations to raise awareness in the community.
- Shelter advocates, case managers, shelter coordinator and crisis support services staff, were all able to participate and complete the Mental Health 1st Aid Training at Kings County Behavioral Health.
- Shelter advocates, case managers, shelter coordinator and crisis support services staff were all able to participate and complete the Family Violence Appellate Project (FVAP) Survivors & Housing Rights Training

Overall Accomplishments and Highlights:

- Assisted 82 clients during the 2022/2023 program year.
- Provided support to 3 unhoused families who exited the shelter by obtaining a rental on their own without a housing subsidy.
- Provided support to 5 unhoused families reconnecting with family and being able to exit BSS to stay with them on a temporary or permanent tenure.
- Provided support and assistance to 3 males fleeing from a domestic violence situation.
- Provided support and assistance to 1 transgender individual fleeing from a domestic violence situation.
- Provided support to 2 Domestic Violence families who exited the shelter by obtaining a rental on their own. One client was able to rent without ongoing housing subsidy. One client was able to rent with her section 8 assistance.

- Provided support to 8 Domestic Violence families reconnecting with family and being able to exit BSS to stay with them on a temporary or permanent tenure.
- Provided support to 4 Domestic Violence Families reconnecting with friends and being able to exit BSS to stay with them on a temporary tenure.

Overcoming Challenges:

- Low inventory on homes and apartments for rent to refer our clients to and have had to work closely with private landlords to consider our applicants at BSS.
- Increase in need for mental health services to obtain for clients. This led our director to consider hiring a Licensed Marriage and Family Therapist for shelter clients that can meet clients where they are at.
- Increase in not only domestic violence, but domestic violence case w/firearms involved.
- Increase in men seeking domestic violence services. This was a challenge for other residents to understand and accept people who identify with other genders can and are survivors of domestic violence and have rights to services.

2024-2025 Goals and Proposed Activities

Proposed Activities for 2024-2025 (July 1, 2024-June 30, 2025):

- BSS hopes to create a learning center at the shelter for individuals of all ages through applying for the Leprino Foods Grant.
- BSS hopes to replace and repair the dining room roof using CalViva funds.
- BSS hopes with funds granted by Leprino Foods in 2023 to create a murphy table in the dining room and install an AC unit in the kitchen.

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:	1	213	866	178
Total served FY 2022-2023: 1,258 **Cost per person served:** $134				
Number to be Served by Age Group	25	300	1000	300
Total To Be Served in FY 2024-2025: 1,625 **Cost Per Person to be Served:** $120				

Program Description

The Kings/Tulare Warm Line Program, operated by Kings View, is 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.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022-2023

The Warm Line met their contractual goal of providing service to over 3,318 Kings County and exceeded the year goal of facilitating 50 calls per month in Kings County by answering 859 calls this year. 49 community events were attended, and presentations conducted regarding outreach and engagement.

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 was successful in facilitating outreach and engagement within Kings County resulting in the increasing of calls being received by The Warm Line. Two Peer Support Specialists (one full-time and one part-time) were hired to assist with increased phone calls and outreach coverage. The hiring of the Peer Support Specialists greatly contributed to Warm Line's success of conducting outreach in Kings County. 80% of callers responded "yes" when asked if they would call-in again and 75% of callers reported that they felt better after their phone call. Three Peer Support Specialists passed the California Peer Certification Examination and are now California state certified.

Program Challenges

Prior to the hiring of the Peer Support Specialists, the Warm Line program needed serious help to accommodate the growing call volume. While the Warm Line offered services in both English & Spanish 24 hours a day and 7 days a week, there was a significant (28%) increase in call volume from the previous year. Consequently, the Warm Line team had to adjust to the increased call volume in which the new Peer Support Specialists helped rectify the concern. The Warm Line had some challenges contacting and touching bases with KCBH due to county staff changes. There were also initial difficulties processing the Peer Certification Test for the Warm Line Peer Support Specialists which was later worked out.

2024-2025 Goals and Proposed Activities

Proposed Activities for FY 2024-2025

The Warm Line program hopes to achieve the following:

- Administer surveys during calls to continue engaging and improving services.
- Continue promoting the Warm Line Program throughout the Bi-County to increase the volume of callers and meet and/or exceed contractual obligations.
- Continue attending Community Events throughout Tulare and Kings County to build relationships and expand program awareness.
- Schedule regular meetings with Kings County to receive their support for the program's Peer Support Specialists as it applied to receiving state certification.
- Will advertise to increase community awareness and continue marketing the Warm Line Program with Facebook and other community resources.
- Will continue scheduling trainings for all staff to enrich their expertise in dealing with various level of difficulties from callers.
- Continue providing exceptional service to all callers and be recognized as a reliable and beneficial consumer resource for Kings County residents.
- Provide added training to embrace self-care and wellness with staff. Add staff development days to the schedule for teambuilding purposes.
- Attend more community outreach events.

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 FY 2022-2023: 0 **Cost per person served:** $0				
Number to be Served by Age Group	0	50	300	5
Total To Be Served in FY 2024-2025: 355 **Cost Per Person to be Served:** $77				

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 about 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 associated with individuals connected with these programs.

Additionally, Kings County Behavioral Health works to support initiatives and activities that help address the housing needs of clients and those within the community at risk of or experiencing homelessness. This work is done through housing support provided within the ACT and FSP programs, through the collaborative efforts of the Kings County Homeless Collaborative, which the Department is a member, Point in Time Survey participation, and other such efforts. Currently the Department has two permanent supportive housing programs: A 5-unit (10-bed) permanent supportive housing project titled Anchors, and a 72-unit project anticipated to open in the Summer of 2024 of which 22-units are No Place Like Home Permanent Supportive Housing. Kings County Behavioral Health Provides supportive services at both locations.

Lastly, the Kings County Homeless Collaborative has identified the need for a housing coordinator position to assist with the coordination of the efforts spanning across the county and community providers, and as such the position will be funded through blended funds across such entities as, but not limited to, Kings County Behavioral Health, Human Services Agency, and County Administration.

Activities and Outcomes in FY 2022-2023

No funds were expended in this program due to the above in FY 22/23.

Proposed Activities for FY 2024-2025

Due to increased need for housing and housing supports, there will be a position created to support permanent supportive housing as well as and support services provided for FSP and ACT program clients, such as housing programs to include but not limited to the No Place Like Home and Anchors projects.

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:	1,716	228	439	N/A
Total served: 2,383 **Cost per person served:** $201				
Number to be Served by Age Group	1,800	300	500	N/A
Total To Be Served in FY 2024-2025: 2,600 **Cost Per Person to be Served:** $137				

Program Description

The California Health Collaborative Young Minds Kings County program utilizes evidence-based and promising practice approaches to increase protective factors and reduce risk factors among youth in support of 1) Reducing stress and anxiety among students, 2) Decreasing risk for school failure, 3) Increasing emotional self-regulation skills, 4) Support sustainability in the communities.

Utilizing a trauma-informed and healing-centered approach, program efforts will also focus on enhancing resilience and buffering toxic stress through student and adult-targeted activities. Programs will deliver educational and practical applications designed to be developmentally appropriate for the ages and stages of the individuals served with a skill-building focus. To promote sustainability, the project includes education to parents, families, and school staff to engage them in supporting the efforts to interrupt toxic stress and promote protective factors among youth.

School Based Services

These evidence-based and promising practice skill building services are designed to provide students with skills and tools to promote increased mental health wellness, improved school performance, healthy interpersonal relationships, and overall communication.

- **Mindfulness Lessons (TK-12th Grades) -** Utilizing the Mindful Schools K-12th Curriculum, five (5) foundational mindfulness lessons and fifteen (15) supplemental lessons are offered to students in elementary school classrooms across Kings County 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.
- **Mental Health and Resiliency Assemblies/Events (TK-12th Grades)-** 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 - TK-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 (1st-3rd Grades)-** 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.
- **Leadership, Resiliency & Coping Skills Groups (4th-12th Grades) -** 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.
- **County School Staff Trauma-Informed Care Training -** 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.
- **Peaceful Spaces Consulting and Technical Support -** 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.
- **Family Engagement Events -** The Young Minds program provides annual family engagement activities in at least 4 communities each year. Activities are hosted at schools, local parks or involve field trips to outdoor spaces throughout California to encourage family and community cohesion, and support increase access to buffering supports (physical activity, balanced nutrition, mindfulness, creative expression, and/or supportive relationships). These family engagement activities are designed to enhance community resiliency and promote opportunities for youth PreK-12 and Transitional Aged Youth to access stress busting activities designed to interrupt the toxic stress response. Activities may include opportunities for families to cook healthy meals together, mindfulness activities like Yoga in the park, or engaging in art activities, physical activities (i.e. family outdoor activities or youth sports). All activities will be enhanced by establishing opportunities for participants to build community relationships with one another.

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

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022 – 2023

The subcontracted agency, California Health Collaborative (CHC) has led a trauma-informed and healing centered project known as Young Minds Kings County Project serving all Kings County communities. 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. The Young Minds Kings County Project continues to exceed multiple goals and reach 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 quickly on several Kings County school campuses.

(Outreach) The Young Minds team engaged in outreach in the communities of Hanford, Lemoore, Armona, Corcoran, Stratford, Kettleman City, and Avenal reaching the following school districts throughout the year:

- Armona Union Elementary School District
- Corcoran Unified School District
- Hanford Joint Union High School District
- Reef Sunset Unified School District
- Pioneer Union Elementary School District
- Hanford Elementary School District
- Lemoore Union High School District
- ILP Lab KCBH- Provider Night

(Youth Engagement) The California Health Collaborative participated in youth wellness fairs on high school campuses in Hanford, Corcoran, to promote resources and services on school campuses in relation to suicide prevention and mental wellness.

The 2023 Kings County Youth Summit engaged middle and High School youth in a variety of workshops and activities to promote youth development and mental wellness at West Hills Community College in Lemoore, drawing youth from communities of Avenal, Kettleman City, Corcoran, Stratford, Lemoore, and Hanford. A School-wide Mental Health assembly was also provided to Frontier Elementary School in Hanford, CA bringing in guest speakers and engaging activities which included:

- May 13th Youth Summit: 80 students in attendance. In collaboration with SOL Youth, and drawing on other CHC program and community organizations, a full day youth mental health and wellness summit was implemented on a Saturday where youth could learn and engage in positive coping strategies and gain insight into youth topics of interest.
- May 15th (Frontier Elementary School): Approximately 475 students and 30 staff in attendance. In collaboration with African Drumming Interactive California Health Collaborative hosted a school-wide assembly on mental wellness, highlighting how music, rhythm, and cultural practices can support mental well-being.

(School-based services) Young Minds implemented the following school-based services in July 2022 and ending in June 2023.

Mindful Schools Curriculum

- Independent Living Program (ILP) Hanford: 17 foster youth participated in weekly art and mindfulness sessions (4 sessions) using the Mindful Schools Curriculum during the month of July.
- Armona Elementary School: The California Health Collaborative commenced Mindful Schools lessons at Armona Elementary in September 2023. Program staff delivered 8 weekly sessions to 29 classrooms serving 520 students in TK-4th grade, including 2 SDC-special education classrooms serving TK-2nd Grade and 3rd-4th grade classroom.
- John Muir Middle School: John Muir Middle School serving 117 6-8th grade students and 5 school staff participants. Across the second and third quarters 8 sessions were delivered.
- Sunrise High School: mindfulness services with the students and staff at Sunrise High School totaling 9 sessions across the 3rd and 4th quarters. 12 students and 3 staff received these sessions.
- Secondary Community Day School: Young Minds Staff provided mindfulness services to the students and staff at Secondary Community Day School in Avenal totaling 5 sessions across the 3rd and 4th quarters. 5 students and 2 staff received these sessions.

- Washington Elementary School: Young Minds Staff concluded mindfulness services with the students and staff at Washington Elementary School totaling 6 sessions. 372 tk-6th grade students and 19 staff attended these sessions.
- Earl F. Johnson High School: Young Minds Staff concluded mindfulness services with the students and staff at Earl F. Johnson High School totaling 4 sessions. As these sessions were held during the lunch period, participation varied among students and staff with 17 9th-12th grade students and 5 staff participating in at least one session.
- Avenal Parks and Recreation Summer Kids program: In June of 2023 Young Minds staff began providing Mindfulness lessons to a group of approximately 12 youth ages 8 to 18. This service will continue through July 2023.

(Pro-Social Groups)

- Parkview Middle School: During December and November 2022, the Young Minds team conducted eight sessions of WhyTry at Parkview Middle School. During this time, we had three groups with students from 8th, 7th, 6th, and 5th grade. The curriculum used was WhyTry with the 8th and 7th-grade groups. The curriculum Zones of Regulation was used with the 6th and 5th-grade groups. The students were pulled out to meet for the groups during the morning Physical education period. The groups met twice a week for a total of four weeks. Group 1 consisted of seven (7) 7th grade students, group 2 consisted of five (5) 8th grade students, and group 3 consisted of three (3) 6th grade students and two (2) 5th grade students.
- Avenal Elementary School: In January 2023, Young Minds staff began two (2) pro-social groups at Avenal Elementary School. Zones of Regulation curriculum was implemented with one group of eight (8) boys in grades TK-1st once weekly for 8 sessions. Girasol curriculum was implemented with six (6) 3rd and 4th grade girls meeting once weekly for 10 sessions.
- Kettleman City Elementary School –In February, Young Minds staff began three (3) pro-social groups at Kettleman City Elementary School utilizing the ZONEs of Regulation across all three groups. Group 1 consisted of six (6) 1st-2nd grade students, group 2 consisted of eight (8) 3rd-4th grade students, and group 3 consisted of seven (7) 5th-6th grade students.

(Coping Skills Groups)

- Hanford High School: Young Minds team conducted ten sessions of Coping skills while using the curriculum CAST to five (5) participating students, all from 10th to 12th grade. The sessions were held near the end of the day, altering between the sixth and seventh periods once a week.

(Family Engagement)

- Parkview Parent Night: Young Minds and SOL Youth collaborated to provide a presentation to parents at Parkview Middle School on the relationship between mental health and SUD, how to support their youth, and an overview of program services being offered to the community. One (1) adult and two (2) youth attended.
- Armona Cara y Corazón Cohort: In February, the Young Minds team began implementing the Cara y Corazon curriculum with Families in the Community of Armona. While it took time to get a solid group of returning participants, the team provided 4 Spanish sessions to 5 families (9 individuals) while also providing child-care to support the accessibility of the service. The sessions took place once a week every other week on Saturday mornings.
- Aria Health First Annual Spring Wellness Fair: In April at St. Joseph Church in Stratford Young Minds staff engaged approximately 150 individuals while sharing information on program services

and the upcoming youth summit. We also engaged families in conversations about how they like to deal with stress.

- Avenal Elementary Mental Health Fair: May 17, 2023. Young Minds staff engaged approximately 50 students and their families and 10 school staff in an art activity while engaging participants in conversation about how they deal with emotions, stress, and challenges in their lives.
- ARCH Health Event occurred on May 18th, 2023, at United Health Corcoran Health Center. Young Minds staff engaged approximately 15 youth and their families and shared information on program services. Through art activities, staff engaged youth in conversations about stress and dealing with emotions.
- KPFP/CHC Mental Health Fair May 27, 2023. The young Minds team provided a mindful grounding activity for families and participated in a panel discussion on mental health. Young Minds staff participated on a panel of speakers on the importance of supporting mental wellness. Approximately
- Avenal Elementary School's family trip occurred on June 4, 2023. Young Minds partnered with the Kings Costal Experience for Youth Program to provide a free family trip. Thirty-six (36) individuals (4th grade students and parent chaperones) participated on the day of the event. Families were invited to the Morro Bay State Parks and Museum of Natural History. The families broke into three groups, and the park rangers provided an interactive educational experience.
- Family trip to Monterey Bay occurred on June 25, 2023. Young Minds, in collaboration with Kings Coastal Experience for Youth Program, provided transportation, meals, and activities to forty-eight (48) youth and families from Kings County communities including Hanford, Kettleman, Corcoran, and Avenal. This day trip to the coast included play time at the beach where Young Minds provided sand toys and other outdoor games for participants to engage in together and bond over their experience in nature. Participants were then given the opportunity to tour the Monterey Bay Aquarium for the afternoon. Breakfast, lunch, and dinner were provided to participants, along with transportation. Among those surveyed 74% reported that the trip helped them feel less stressed or worried about things going on in their lives, 81% reported feeling more connected to nature, 97% reported feeling included and comfortable, 69% reported feeling more connected to their community.

(School Staff In-Services) The "Resilient Schools" trauma-informed in-service training has been instrumental to support administrators and educators in schools with tools and resources necessary to support youth with self-regulation tools and reducing stigma regarding behavioral challenges of students impacted by adversity and/or trauma. This year the Young Minds team developed a part 2 training to expand on healing centered strategies for the schools that requested more training. Young Minds provided 9 school staff in-services this year reaching 263 school staff across Kings County including the following schools:

Part 1 "Resilient Schools" in-service training

- Parkview (23 staff)
- John Muir (40 staff)
- Avenal Elementary (32 staff)
- Kettleman City Elementary (18 staff)
- Washington Elementary (27 staff)
- Frontier Elementary (30 staff)
- 2023 Annual Central California Truancy Summit (50 staff)

Part 2 “Healing-Centered Approaches” in-service training

- John Muir (33 staff)

Kettleman City Elementary (16 staff)

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.

Annual Process Goals for the program included:

- Serving a minimum of 500 youth annually – The California Health Collaborative surpassed this goal by serving a total of 1716 children and 228 transitional age youth with reoccurring and one-time mental wellness activities.
- Serving 12 school sites annually – The California Health Collaborative met this goal serving 12 school sites with a wide range of activities and services.
- Hosting Teacher Trainings for 20 school staff – 17 school staff completed the Mindful Schools interest form, 5 responded to follow up outreach and were enrolled in the Mindful Schools 101 training for the month of August 2023.
- 263 school staff received trauma-informed in-service training.

Annual Outcome Goals for the program included:

- Goal: 70% of students surveyed during program activities reporting having new tools or techniques to reduce stress and anxiety; Actual: 62% of students surveyed reported having new tools or techniques to reduce stress and anxiety.
- Goal: 60% of Students surveyed during program activities reporting a reduction in stress and anxiety; Actual: 66% of students surveyed reported having a reduction in stress and anxiety.
- Goal: 60% of Students surveyed during program activities reporting having new skills to regulate their emotions; Actual: 71% of students surveyed reported having new skills to regulate their emotions.
- Goal: 70% of parents who participate in family strengthening sessions reporting increased parenting techniques to support their child(ren); Actual 100% parents surveyed reported having new parenting techniques to support their child(ren)
- Goal: 70% of Teachers who participate in trainings reporting having tools to support self-regulation of students in the classroom; Actual: 85% of teachers who participated in Inservice trainings reported having tools to support self-regulation in the classroom.

Key Successes

The top strengths of this program center around the relationships built and maintained through program services and the trauma-informed and healing-centered approach taken in building those relationships. The result of this intentional approach to relationships is in the program outcomes and the booking of services for the next fiscal year. More importantly, there was a lasting impact of the services implemented.

- In response to family engagement events, families report having learned ways to support their family’s well-being, increased knowledge in positive parenting practices, and increases in connection to their community.

- School staff reported the lingering results as seen in changes in student behavior and school success.
- Additionally, the Young Minds program developed peace corner (self-regulation spaces) intended for classroom/school settings as non-stigmatizing spaces for students to practice self-regulation and mindfulness skills, reduce stress and anxiety, and promote positive classroom climates.
- Another top strength is the effort the Young Minds Team has put into educating the primary adults in the lives of young people (parents and educators). Through non-stigmatizing, culturally tailored, family strengthening program and trauma-informed school staff in-services, Young Minds has supported adults in their understanding of the impact of trauma and adversity on the developing bodies and minds of youth, strategies to support the metal wellness, resilience, and healing of youth, and effectively reducing the stigma around accessing mental health support and intervention services. By providing this essential education to adults in the community, Young Minds is laying the groundwork of developing the infostructure to support the sustainability of community resilience, reducing the harmful effects of adversity on youth now and for generations to come. Another top strength of this program is in its practice of leveraging relationships with other key stakeholders in the community including CBO's and county agencies, collaborating with these stakeholders in a variety of ways to foster a greater awareness and access to the existing toxic stress buffering supports for youth and families in Kings County.

The key successes of this program in its second year is the number of youth served and 6 out of 7 program goals reached or exceeded. In its first full year, California Health Collaborative was able to reach 1119 youth in reoccurring evidence-based curriculum services and 2111 youth, families, and school staff through outreach activities, assemblies, and in-service trainings. Through direct curriculum services with youth, survey data found 66% reported experiencing a reduction in stress and anxiety, exceeding the initial goal of 60%. As a result of direct services, 71% of students reported having new skills to regulate their emotions, exceeding the initial goal of 60%. As a result of the teacher in-service training, 85% of teachers reported having learned new skills to support self-regulation in their classrooms. As a result of family strengthening groups 100% of participants surveyed reported having new parenting techniques to support their child(ren), exceeding the initial goal of 70%.

Another program success was the continued development of relationships with youth, families, communities, and schools. These relationships have led to an increase in services booked at schools, an abundance of invitations to participate in community events, and most invaluable is the trust that is being built with families and communities in more remote and marginalized areas of Kings County. The following anecdotal examples demonstrate the power of these relationships built because of services and interactions with program staff.

(Family) A family who had participated in the program's family trips to the ocean joined the program at the Avenal Family Picnic later that week and reported to staff just how meaningful the experience had been for them and how eager they were to participate in future events provided by the California Health Collaborative.

(School Based Services) In an email received from the Principal at Tamarack Elementary, formerly Assistant Principal at Kettleman City Elementary: "I would like to thank the team at Young Minds who provide a valuable and much needed service to students. At KCES, their work with small groups of students noticeably changed the amount of behavior and discipline referrals I saw. I know behavior issues are a form of communication that an underlying problem exists. As groups progressed, I saw students from the groups less and less for behavior referrals. I appreciated the support and look forward to continuing to work with them through my new position as Principal of Tamarack Elementary. "

(Staff In-Services) In a follow-up meeting with the principal at Washington Elementary, she reported to staff that in the weeks following the staff in-service, she noticed a marked reduction in behavioral referrals form teachers who previously sent students to the office frequently for behavior. The principal also reported that the teachers were now viewing behavior differently and addressing it in the classroom rather than sending students to the office for behavioral referrals.

Program Challenges

The California Health Collaborative encountered challenges in recruiting personnel throughout the year while keeping up with the high needs of local schools. While the shortage of staffing did not prevent the existing program staff from reaching and even exceeding program goals, the workload left staff feeling depleted by the end of the school year and certain program events, such as the Youth Summit, could have benefited from a larger team while program services on school sites were continuing. The team was able to secure a third qualified staff member by the fourth quarter and is already securing plans to establish sustainable practices program wide, so staff do not become overwhelmed by the requirements of the program and the needs of the communities.

2024-2025 Goals and Proposed Activities

Goals and Objectives for FY 2024-2025

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.

Proposed Activities for FY 2024-2025

In the 2024-2025 fiscal year, the Young Minds program plans to provide a variety of activities and events to support the mental wellness and resilience of youth between the ages of 4 and 18. Activities may include small and whole group lessons for youth utilizing research-based and promising practice curriculums, youth and family events and activities that support mental wellness and access to mental health resources, and county school staff education and resources to support the sustainability of emotionally safe environments in school settings.

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:	25	44	105	34
Total Served in FY 2022-2023: 208 **Cost per person served:** $460				
Number to be Served by Age Group:	26	54	129	50
Total to be Served in FY 2024-2025: 259 **Cost Per Person to be Served:** $412				

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 because 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.

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.

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

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022 – 2023

During this fiscal year, support group facilitation continued in the transition from meeting virtually to meeting in-person due to ongoing COVID-19 pandemic response efforts. As a result, three out of four support groups held in-person meetings at Kings County Behavioral Health (KCBH) (with Sisters Speak continuing to hold virtual meetings) 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 61 unduplicated individuals. Sisters Speak served 14 unduplicated individuals. The Source LGBTQ+ Support Group served 94 unduplicated individuals. The Veterans Support Group served 39 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 numbers continued to rise and met the need for social connectedness with a means to decrease suicide and mental illness amongst the veteran population. More veterans were vocalizing their desire to attend groups so that they could connect with their newfound friends and receive support with mental health wellness. Veterans expressed an appreciation for the consistency of the group's meetings, the ability to socialize with their comrades consistently, and the extracurricular activities that were facilitated within the group.

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). Through ongoing group connectedness, group attendance remained consistent and group participants communicated their appreciation for the opportunity to meet regularly and utilize the platform to promote mental health wellness as it related to African American contexts. Group members reported how the group has provided them an ongoing support system and sisterhood.

The Family Support Group maintained consistent meeting attendance since transitioning back to in-person meetings from virtual meetings (caused by the occurrence of the COVID-19 pandemic). Families were served while they navigated their first encounter with a mental health crisis (as it related to a family member having a mental health concern) and were provided ongoing support to those families who had sustained mental health challenges within their family.

The Source LGBTQ+ Support Group continues to serve as the sole general Kings County LGBTQ+ support and resources establishment thus allowing for individuals with intersecting identities to be able to attend more than one group a month. The group continues to boost their Kings County outreach efforts reaching over 1,900 individuals and participated in outreach opportunities for the first time at the Naval Air Station (Lemoore, CA.), Lemoore High School (Lemoore, CA.) and the Hanford Joint Union High School District Suicide Prevention Week event. As result, these entities continue to send invitations for outreach opportunities at scheduled community and school events.

A youth-designated Kings County Pop-Up support group meeting night was developed (by The Source LGBTQ+ Support Group) to accommodate the growing youth population that identify as a part of the

LGBTQ+ community. Over 70% of the group participants agreed that The Source LGBTQ+ Support Group increased their feelings of social connectedness. The group collaborated with Kings Partnership for Prevention (a Kings County community-based agency) to host their first ever "Paint for Pride" event in Kings County in which several supports group members and allies attended. A survey was conducted in which 85% of the support group's individuals reported that they felt less isolated after attending groups.

Program Challenges

Although in-person support group meetings eventually resumed their course, all the support group facilitators/administrators reported the ongoing rebuilding of group attendance. Three out of the four support groups officially transitioned back to holding in-person meetings while the Sisters Speak Support Group resumed the holding of virtual meetings (resulting in irregular attendance as Sister Speak group members preferred to meet in-person).

As Kings County Behavioral Health (KCBH) moved their operations office (of which the Veterans Support Group held their meetings in), numerous support groups members expressed concerns regarding the smaller size of the new meeting location as with having issues with the change in location. Consequently, the group facilitator/administrator and two support group members worked to move the group meetings to a Veteran-affiliated and group members endorsed building.

Sisters Speak reported the desire to begin meeting in-person to establish stronger bonds and fellowship. Group members felt that group attendance could expand if in-person meetings were held but were under the impression that this could not occur due to regulations of the COVID-19 pandemic.

Again, and as KCBH moved their operations office, the Family Support Group's attendance was briefly affected by this change in locations. However, and with time, group attendance resumed to normal course through internal group outreach and engagement.

During promotion for The Source LGBTQ+ Support Group's Paint for Pride event, the group received push back from the Anti-LGBTQ+ community as members of the Anti-LGBTQ+ community threatened to protest the event. One individual of the Anti-LGBTQ+ community also made complaints to Kings County officials regarding the celebration of the event in hopes to prevent it from occurring.

2024-2025 Goals and Proposed Activities

Proposed Activities FY 2024-2025

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 will meet twice a month and provide veteran group members mental health, camaraderie, well-being support and community resources (i.e., Equine therapy, painting class, pottery making), and other nontraditional therapeutic activities during FY 2023-2024. The group will also host a veteran event specifically for women veterans on a quarterly basis.

The Sisters Speak Support Group will celebrate events and commemorate holidays/societal acknowledgement days specific to women and African American culture (I.e. Black History Month, International Women's Day, Juneteenth, Juneteenth, Kwanzaa, etc.). Sister Speak will host outside group speakers to educate and train group members. The group will hold two to four outside group social activities.

The Family Support Group hopes to have at least four presentations regarding mental health services and access to care. The group also seeks to increase attendance (via targeted outreach and engagement) and promote and advertise the group to community partners and providers.

The Source LGBTQ+ Support Group hopes to increase group attendance by 5%. The group hopes to host one free event (expenses covered by the group) for LGBTQ+ individuals and their families. The group will hold a Pride Night event in collaboration with a Kings County community-based organization. The Source LGBTQ+ Support Group hopes to establish a stronger social media presence and conduct stronger community outreach efforts in hopes of building group attendance.

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	330	0	0
Total Served: 330 **Cost per person served:** $0				
Number to be Served by Age Group	0	350	0	0
Total To Be Served in FY 2024-2025: 350 **Cost Per Person to be Served:** $0				

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.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022-2023

The BURNS Depression and Anxiety scales serve as screening tools for individuals receiving individual counseling. Everyone takes a pre-test in the initial session and a post-test in the final session. The BURNS Depression score can be anywhere from 0 (meaning very little or no depression) to 45 (indicating severe depression). Meanwhile, the BURNS Anxiety score can range from 0 (meaning minimal or no anxiety) to 99 (indicating extreme anxiety or panic).

Percent changes (i.e. post-test minus pre-test) in depression and anxiety scores for 19 to 20 individuals who engaged in individual counseling are summarized below:

BURNS Depression: Percent change from Pre-to-Post -26.32%

BURNS Anxiety: Percent change from Pre-to-Post -17.61%

Key Successes

- Ran Transitional Age Youth-focused sessions at a wellness center.
- Implemented a secure electronic system for tracking the status of individuals referred to, and participating in, the program.
- Worked on outreach and advertised Transitional Age Youth population events to increase engagement.
- Recruited and trained staff to work in the First Episode Psychosis (FEP) program.
- Worked with UC Davis Consultation Team and county leadership to structure programs.

Program Challenges

The program, like many others, grappled with industry-wide employment challenges exacerbated by the impact of COVID. These challenges significantly hindered the ability to fill open positions, particularly given the high demand for clinical talent in the designated HRSA area. Also, the new Electronic Health Record system took priority when it came to staffing focus, as implementation was to take effect on July 1, 2023.

The program confronted the challenge of securing clinicians for the First Episode Psychosis program (18-25 y/o). Unfortunately, many clinicians were reluctant to specialize in working with this specific age group, creating difficulties in building a specialized team.

There has been minimal attendance at the Oak Wellness Center, despite our engagement efforts. We continue to learn how to identify what could help increase this by linking with current TAY members and using a survey for feedback.

2024-2025 Goals and Proposed Activities

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.

Proposed Activities for FY 2024-2025

- 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 Oak 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:	0	0	147	0
Total Served: 147 **Cost per person served:** $176				
Number to be Served by Age Group	0	0	200	0
Total To Be Served in FY 2024-2025: 100 **Cost Per Person to be Served:** $82				

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 can be assisted and impacted by the skills learned in these trainings, can be of any age.

Activities and Outcomes in FY 2022 – 2023

In person training was able to resume during fiscal year 2022-2023. The following number of MHFA, ASIST, and SafeTALK trainings were all facilitated during the fiscal year:

- **MHFA:** 3 trainings and 49 trained
- **Safe TALK:** 3 trainings and 42 trained
- **ASIST:** 3 trainings and 47 trained

Goals and Objectives

1. Facilitate 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 this training is being met and to build sustainability in the future.

Key Successes

Two (2) additional trainers were acquired, and we are working towards moving from provisional to certified trainers. Demand for training was higher than in previous years.

Program Challenges

As a result of not having enough trainers, the amount of training that could be offered was limited. The following number of trainers were certified during FY 2022-2023:

ASIST (1), Safe TALK (1) and MHFA (1)

2024-2025 Goals and Proposed Activities

Proposed Activities for FY 2024-2025

Training is in high demand after the pandemic and specifically since in person training resumed. There is a need to continue to recruit new trainers to meet the demand for mental health trainings. Also, to be able to facilitate mental health trainings in Spanish and to train high school students to help with their peers.

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:	N/A	N/A	N/A	N/A
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				
Number to be Served by Age Group	N/A	N/A	N/A	N/A
Total To Be Served in FY 2024-2025: 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 to be Served:** N/A				

Program Description

Kings County utilizes several 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 Prevention (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 that impacts everyone in the county.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022-2023

Community Outreach: In 2023, KCBH ran multiple ad campaigns via radio/social media with iHeart Media, Kings Area Rapid Transit (KART), and through the KCBH Billboard to raise awareness of mental health services available and promote the 9-8-8 Suicide Lifeline launch. The KART ad campaign includes two bus ads, one English and one Spanish (the busses rotate through the Kings County routes), both English and Spanish ads rotate through the media screens on all buses. The ads are displayed on a KART shelter in Avenal, in both English and Spanish. In addition, KCBH has added three additional shelter spaces to include a space in front of the Home Garden Clinic, College of the Sequoias, and the Remington, which is also near the new Northstar Apartments in Hanford. The 9-8-8 Suicide Lifeline was also promoted in the November 2022 Kings County Voter Information Guide, there were also coffee sleeves handed out by a couple coffee shops in Kings County. KCBH was also able to attend 63 different community events throughout Kings County.

The Kings Partnership for Prevention (KPFP): The Mental Health Taskforce collaborated with the Suicide Prevention Taskforce to develop a Suicide Prevention Plan specifically tailored for Kings County. The MHTF contributed valuable insights on addressing suicide within the community and worked alongside other organizations to craft a strategic plan. In organizing the "Mental Health Matters" event for the community, the Taskforce organized resource tables, a mental health panel, engaging activities, and more. Additionally, the MHTF organized its inaugural Suicide Prevention Walk in the city of Avenal, drawing support from community members to stand in solidarity with those grappling with suicide ideation and in memory of those lost to suicide. Furthermore, the Taskforce created a resource flier featuring mental health providers for outreach events and actively participated in over 50 outreach initiatives aimed at promoting overall well-being.

- Suicide Prevention Walk: Over 30 people participated, 5 resource tables, and resources were provided.
- Mental Health Matters: Over 10 resource tables, a panel discussion, and food boxes were available.
- Suicide Prevention Panel: 5 panelists provided insight on suicide in the community. Over 30 community members attended the panel discussion.

The Kings County Cultural Humility Task Force (CHTF): The 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.

Overall Project Strengths for FY 2022-2023

Community Outreach: KCBH has about tripled the outreach events attended in FY 2022-2023. Of the 63 events that KCBH attended, 21 of the events were in Avenal where the Hispanic/Latino population was targeted to raise awareness of mental health services available.

Kings Partnership for Prevention (KPFP): The Mental Health Taskforce benefits from diverse stakeholder participation in its meetings, offers county-wide training sessions, aligns with the goals and objectives, and actively engages in community events. Over 30 individuals participated in the Suicide Prevention Walk in Avenal, alongside 5 resource tables, marking a successful inaugural year.

The Kings County Cultural Humility Task Force (CHTF): During FY 2022-2023, the Cultural Humility Consumer/Staff surveys were administered to contracted providers, beneficiaries, 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 2023-2024 Cultural Competence Plan Annual Update found on the KCBH.org website.

Overall Accomplishments and Highlights

Community Outreach: KCBH had two employees (Community Outreach Specialist & Prevention Coordinator) who were finalists in the Striving for Zero Suicide Prevention Excellence Awards for Outreach, Media & Communications, and Innovative Partnerships. The nominations were for the "Be Here Tomorrow" campaign that was developed to promote the 9-8-8 Suicide Lifeline and "Go Lime Athletics" which promoted Mental Health Awareness month with the help of Kings County softball and baseball teams.

Kings Partnership for Prevention (KPFP):

1. The Substance Use Response Group had a successful Red Ribbon Week at Kings County middle schools.
2. The Kings County Mental Health Taskforce facilitated its first event of the fiscal year 'Mental Health Matters' on Saturday, May 27, 2023, in Corcoran.
3. The Substance Use Response Group collaborated to create a Social Media Campaign for National Prevention Week in May that was shared amongst a variety of platforms by organizations who are a part of the Substance Use Response Group.
4. The Substance Use Response Group facilitated Health & Wellness Week at Kings County high schools that included Avenal High School, Lemoore High School, Jamison High School, and Corcoran High School.

The Cultural Humility Task Force (CHTF): During FY 2022-2023, the Cultural Humility Consumer/Staff surveys were administered to contracted providers, beneficiaries, 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 2023-2024 Cultural Competence Plan Annual Update found on the KCBH.org website.

Overcoming Challenges

Community Outreach: Since KCBH has started attending community outreach events, the requests have almost tripled. The community outreach specialist must at times turn down some events due to staffing or no volunteers.

Kings Partnership for Prevention (KPFP): This year presented challenges, notably the low attendance at the Mental Health Matters event. The MHTF acknowledges the need to enhance outreach, promotion, and event marketing. Collaborative efforts with other organizations will be pursued to incorporate additional resource tables, raffle prizes, and more.

Ways we will be solving any challenges this upcoming year:

1. Engage additional stakeholders that are currently not on the Mental Health Taskforce
2. Meet with the Kings County Behavioral Health team to collaborate on problem solving.
3. Create additional plans in case we have barriers arise.
4. Promote the Kings County Mental Health to community members and the services that will be provided.

The Cultural Humility Task Force (CHTF): The taskforce has had challenges with attendance. Even with changing the time back to 10am per survey results, the attendance numbers continued to be low.

2024-2025 Goals and Proposed Activities

Program Goals and Objectives for 2024-2025

Community Outreach: The use of various mediums and methods by which to share information to raise awareness of mental illness to reduce stigma, promote services and programs to reduce the discouragement of seeking services associated with stigma, and raise suicide prevention awareness, such as 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. 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 goals and objectives for FY 2024-2025 are as follows:

- Increase knowledge and awareness of mental health, mental health services, and suicide prevention.
- Reduce the stigma regarding mental health.

Kings Partnership for Prevention (KPFP): The goals of the Mental Health Taskforce for FY 24/25 include diminishing the stigma surrounding mental health in Kings County through the promotion of information, educating the community about mental illness, including substance use disorders, fostering awareness of attitudes and behaviors towards individuals with mental illness, and cultivating an environment where discussing mental health is comfortable.

Throughout the year, the Mental Health Taskforce will host various trainings, such as "Why Mental Health Matters," "How to Reduce Stigma," and "How to Seek Help," among others. Additionally, the Taskforce will engage in county-wide outreach initiatives to highlight available mental health resources and utilize social media platforms to disseminate information on suicide prevention efforts and stigma reduction.

- Community Discussion on Mental Health & Anxiety Cards
- Mental Health Matters Event
- Summer Kids Program Spot Program in Avenal
- Suicide Prevention Walk

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. The goals and objectives for FY 2024-2025 are the following:

- Increase cultural competency within agency and contracted providers.
- Increase cultural competency training.

Proposed Activities for 2024-2025

Community Outreach: The Community Outreach Specialist intends to continue to build on community outreach events but will also be looking into different methods to outreach to the community focusing on diverse areas and populations.

Kings Partnership for Prevention (KPFP):

1. Mental Wellbeing Workshops: Host workshops covering topics such as stress management, mindfulness, resilience building, and coping strategies.
2. Self-Care Seminars: Offer seminars that teach self-care techniques, including relaxation exercises, healthy lifestyle habits, and emotional regulation techniques.
3. Mental Health Awareness Campaigns: Organize campaigns to raise awareness about mental health issues, reduce stigma, and promote help-seeking behaviors.
4. Nature Walks and Outdoor Activities: Arrange nature walks, hikes, or outdoor yoga sessions to encourage physical activity, connection with nature, and relaxation.
5. Mindfulness Meditation Classes: Offer regular mindfulness meditation classes to promote present-moment awareness, stress reduction, and overall mental wellness at the Children Storybook Garden.
6. Journaling and Expressive Writing Workshops: Organize workshops on journaling and expressive writing as tools for self-reflection, emotional processing, and personal growth.
7. Work-Life Balance Workshops: Provide workshops addressing work-life balance issues, time management, setting boundaries, and prioritizing self-care.
8. Cultural Competency Training: Provide training sessions on cultural competency and diversity awareness to ensure inclusivity and sensitivity in mental health support services.
9. Community Wellness events: Organize community wellness fairs featuring mental health resources, interactive booths, wellness screenings, and informational sessions.

The Cultural Humility Task Force (CHTF): The task force is currently undergoing a restructuring phase, to gain more consistent participation and to give the task force members a better understanding of the purpose of the task force. The CHTF conducted a survey regarding meeting occurrences and with the results given the Chair and Co-Chair decided on keeping the meeting time the same (10am – 11:30pm) but the taskforce would meet quarterly instead of monthly.

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	67	69	124	5	1
Total served in FY 22-23: 266 **Cost per person served:** $ 585					
Number to be Served by Age Group:	70	70	150	5	1
Total to be served in FY 24-25: 296 **Cost per person to be served:** **$** 724					

Program Description

Suicide Prevention activities promote public awareness of suicide prevention resources, improve, and expand suicide reporting systems, and promote 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 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.

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.
3. Connect friends and family members of suicide victims to resources and support services.

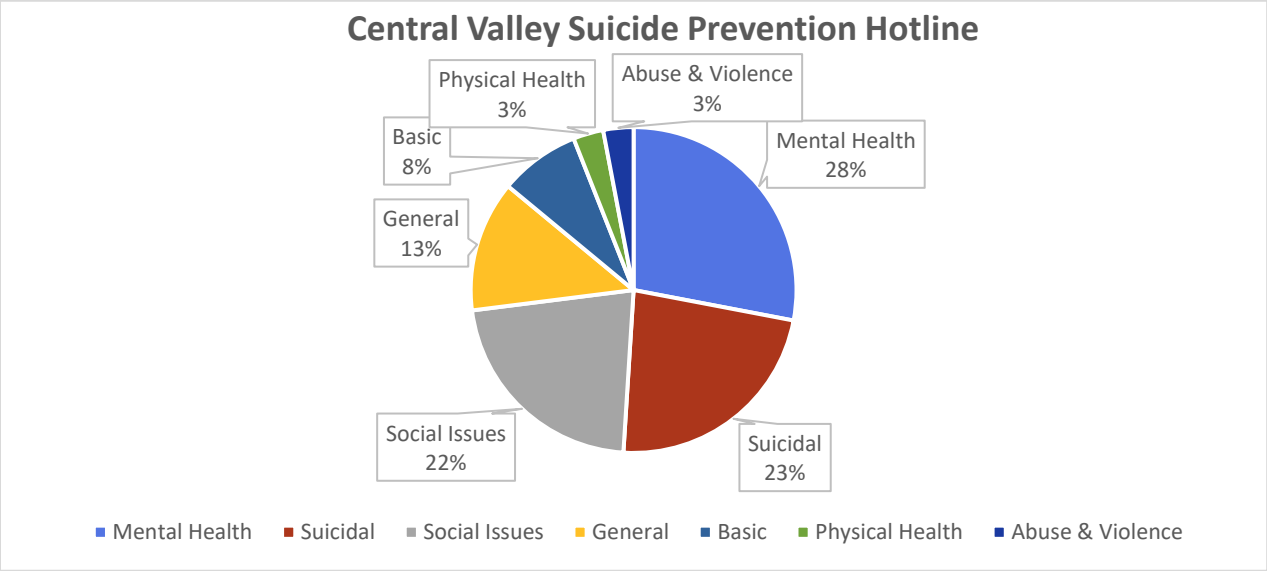
2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022 – 2023

DRAW: The DRAW program provided 57 direct counseling services to students for at least one session. One hundred and sixty-four (164) students and thirty-seven (37) faculty/staff received in-person DRAW mental health awareness presentations, workshops, and outreach.

LOSS: The LOSS team consisted of Kings County Behavioral Health Adult System of Care divisional staff for follow-up calls. There was a contracted clinician with KCBH that 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 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.



Key Successes in FY 2022-23

DRAW: Program continued to provide services to students continuously. 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: In-person LOSS calls were resumed for the fiscal year. 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 where the clinician determined the client needed more sessions, did not experience a 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 2022-23

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: More outreach efforts are needed to get more volunteers (specifically clinicians and those with life experience) so that the LOSS team can resemble best practice. Despite efforts there was still no LOSS support group available in the county.

CVSPH : Program challenges included complex calls about social & community anxiety and fear-based unrest calls, which subsequently resulted in increased call handling time. Veterans, senior citizens, and the LGBTQ+ population were reported to be the highest risk target populations.

2024-2025 Goals and Proposed Activities

Proposed Activities for FY 2024-2025

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 made in-person. The LOSS Team will recruit other members, get them trained, and have them ride along with experienced members. If there is enough interest, a LOSS Support Group will be explored. Ideally, a licensed clinician will be staffed or contracted, to provide therapeutic services for individuals.

CVSPH: 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. There will also be increased promotion of suicide prevention efforts, via social media platforms and through collaboration with other community-based organizations. CVSPH will provide suicide prevention resources such as, 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	N/A	623
Total Served in FY 2022-2023: 623 **Cost per person served:** $412				
Number to be Served by Age Group:	☐Children Ages 0 – 15	☐ Transitional Age Youth Ages 16 – 25	☐ Adult Ages 26 – 59	☒ Older Adults Ages 60+ 670
Total To Be Served in FY 2024-2025: 670 **Cost Per Person to be Served:** $394				

Program Description

The Senior Access for Engagement (SAFE) Program provides supportive services to older adults in their homes, 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 support 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 homes 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.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022 – 2023

The Kings County Commission on Aging (KCCOA) SAFE Program continues to actively collaborate with other community based social service agencies. The program is engaged in activities that impact older adults their families in the community. There were two weekly support groups available for family members who specifically cared for seniors. The attendees were educated on mental health disorders, managing difficult scenarios, managing challenges they may face with their loved ones, and learning how to advocate for seniors and their providers.

The Safety Bar Program was a service that was provided to enhance the senior population's homes to establish safe environments. Seniors that were supplied with safety equipment (provided by this program) were satisfied and appreciative of the services. Program staff conducted weekly wellness check phone calls to stay engaged with homebound seniors resulting in the seniors reporting of their gratefulness for these. Program staff continued to conduct home visits and check on home bound seniors thus allowing for information on local resources to be provided to these seniors.

The Meals on Wheels and Senior Nutrition Centers Programs provided nutritional meals to help improve the diet and mental alertness of the seniors and presented them with another opportunity to convene. Mental health and behavioral health resources and information were continuously provided to the older adults and their families through the Senior Nutrition programs, monthly food drives, senior home-visits, office contacts, outreach, and the agency social media account.

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

Representatives from various community agencies such as the Adventist Health Hospice and the Alzheimer's Association informed attendees about mental health services and educated caregivers about mental health disorders. Central California Legal Services presented information about estate planning. Kings County Behavioral Health (KCBH) and Kings View Counseling Services for Kings County representatives presented on the importance for support group attendees to reach out to mental health professionals to receive additional services.

The SAFE Program hosted and participated in events such as the Senior Picnic in the Park, the Senior Health Fair, and the World Elder Abuse Awareness campaign which the seniors and their families reported their approval and appreciation for the events. Seniors were provided the opportunity to visit and socialize with one another while enjoying live music, entertainment, and delicious meals. Homebound seniors who lacked transportation were provided with gas cards to attend the events and the program was successful in their outreach and education efforts as community-based agencies serviced as vendors for the older adults and their families.

The Angel Tree project was another achievement that helped in need seniors during the holiday season. Homebound seniors were provided with Christmas gifts of their choice. The project was a success in which generous donations from local human service agencies were given. Lastly, the opening of all Senior Nutrition Centers was a success due to the older adults receiving and enjoying a nutritious hot meal that was appropriate for their diet needs. The nutrition centers had active attendees who engaged in daily activities and games that promoted mental health wellness and socialization. The Senior Nutrition

Centers' offering of meals assisted in the reduction of depression and anxiety stressors as seniors reported the opportunity to eat healthy meals without the worry of repercussions. Program staff conducted monthly senior assistance visits which helped educate seniors about available services, resources, and becoming familiar with KCCOA staff. The Meals on Wheels program exceeded serving over 400 seniors and served over 2000 home delivered meals a week.

Program Challenges

Due to the lack of respite resources for those who did not qualify for In-Home Supportive Services because of not meeting the criteria to hold Medi-Cal insurance, the SAFE Program worked through this challenge by continuously seeking resources for these specific clients. Another challenge the program had to navigate through was supporting seniors who were affected by the increased costs of senior safety items such as commodes, wheelchairs, and shower chairs as the result of societal financial inflation. To address this concern, the program supported clients and their families by purchasing items that could be loaned. A final challenge entailed meeting the increased demand for incontinence items (adult briefs, bed liners, etc.) and the lack of personal hygiene (shampoo, conditioner, etc.) items that seniors both requested and needed. The SAFE Program addressed this concern by accepting generous donations from the community and providing clients with gift cards/vouchers to purchase the items.

2024-2025 Goals and Proposed Activities

Proposed Activities for FY 2024-2025

- Host the Senior Picnic in the Park event and the World Elder Abuse Awareness 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 Master Plan & Resource Fair event to 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 (i.e. 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 share symptom indicators of the mental health disorders.
- Conduct frequent mental health-based presentations by having speakers of those who have mental health disorder experience, discussing their challenges to further reduce stigma, and bring mental health awareness.
- Conduct monthly outreach and education to aid seniors/older adults at the senior nutrition sites.
- Conduct daily activities at senior nutrition sites to enable seniors to experience mental stimulation and socialization in a creative manner (i.e. Bingo, meditation, exercise, etc.)
- Host educational stress relief workshops to promote self-care and healthy ways to reduce stress.
- Conduct outreach to LGBTQIA+ community members by attending Kings County community events providing information about the SAFE Program services and available resources.
- Promote the availability of support group for seniors and their families in Kings County
- Continue providing seniors with as many resources as possible and conducting home visits.
- Continue bringing services to seniors who have difficulty accessing services.

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:	Children Calls:1 Text:1 Live Chat:1	TAY Calls: 129 Text: 21 Live Chat: 40	Adult Calls: 1,113 Text: 78 Live Chat: 153	Older Adult Calls: 359 Text: 7 Live Chat: 16	665
Total Served in FY 2022-2023: 2,584 **Cost per person served FY 2022-2023:** $52					
Number to be Served by Age Group:	☒ Children Ages 0 – 15	☒ Transitional Age Youth Ages 16 – 25	☒ Adult Ages 26 – 59	☒ Older Adult Ages 60+	
2,700	5	300	2,000	500	
Total To Be Served in FY 2024-2025: 2,805 **Cost Per Person to be Served:** $35					

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.

2022-2023 Program Updates, Outcomes, and Challenges

Activities and Outcomes in FY 2022 – 2023

211 Database Specialist and Program Specialist worked hard throughout the year to maintain the database with current, comprehensive, computerized inventory of community resources in both English and Spanish. There were 3 new agencies and 99 new programs added. Programs were updated regularly due to constant changes such as food distribution dates or COVID-19 testing locations.

There were 342 program updates. Verification of program information was navigated by contacting the agency to review program information listed in 2-1-1. This involved going over any changes to program description, verifying phone numbers were operating, checking if the website was active, location and

program hours. All program delivery details were reviewed such as eligibility, languages offered, application process, payment methods and documents required. Any changes made were also translated into Spanish.

One hundred three (103) community surveys were conducted throughout Kings County. Fifty-six (56) percent responded and stated that they had never heard of 2-1-1 prior to the outreach while forty-four (44) percent conveyed their knowledge of and had used 2-1-1 in the past. The surveys also showed that fifty-four (54) percent preferred using the Dial 2-1-1 method, thirty-five (35) percent preferring using mobile methods such as texting and/or downloading the Intelliful™ app. Ten (10) percent preferred using the website and one (1) percent did not provide a response. Respondents answered the final survey question approving of their support for and recommending 2-1-1 services to others. All survey responses were reviewed by the Executive Director to evaluate whether changes were needed within the 2-1-1 service delivery model.

A focus group was conducted at the Kettleman City Family Resource Center. The 2-1-1 Coordinator and Database Specialist were present with a small group of families from the center. The attendees were all residents of the Kettleman City community. The focus of the group was to understand the needs and access to resources. The feedback received shows a high need for services and limited access to resources in the surrounding areas. After the 2-1-1 presentations, the group shared this was their first-time hearing of 2-1-1 and are grateful to know of such a wonderful service.

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 Kings County Call Center handled 2,740 calls. Data collected shown 81% were English calls and 19% were Spanish calls. They received and handled 214 Live Chat conversations and responded to 213 text messages. The Executive Director and 2-1-1 Coordinator maintain constant communication with the call center through bi-monthly check-ins to discuss recruitment and staffing of the call center, review call data, number of call types, percentage of handled and abandoned calls, average handle and average wait times.

2-1-1 staff at Kings United Way participated in over sixty (60) tabling events throughout Kings County to market and educate on 2-1-1 functionalities. The team conducted extensive outreach to Spanish speaking residents in the rural areas. In addition to tabling events, 2-1-1 staff conducted 8 presentations in both English and Spanish.

Program Challenges

Kings United Way had some unexpected hurdles with social media platforms. Platforms like Facebook placed Kings United Way's page under review placing it under suspension and from new posts being made until the review was over. Kings United Way is currently working on resolving these issues and in the process of utilizing other social media outlets available (i.e. Instagram and X – formerly Twitter) to promote 2-1-1 services.

2024-2025 Goals and Proposed Activities

Proposed Activities for FY 2024-2025

Kings United Way (2-1-1) hopes to achieve the following activities in FY 2024-2025:

- Continue using SMS Text and Live Chat for Kings County residents.
- Maintain a current, comprehensive, computerized inventory of community resources in both English and Spanish.
- Conduct eight (8) presentations (including virtual), throughout Kings County, to promote 2-1-1 platforms.
- Complete one hundred (100) surveys from Kings County residents regarding their knowledge and usage of 2-1-1 services.
- Review survey responses and evaluate whether changes are needed within the 2-1-1-service delivery model.
- Complete monthly social media posts to promote access to community resources through 2-1-1 platforms.
- Conduct focus group with Kings County residents to gather feedback regarding 2-1-1 functionality and resources within the database.
- Maintain the availability of 2-1-1 services 24 hours per day, 365 days per year.
- Distribute 2-1-1 information and collateral to shut-in seniors through partnership with the Kings County Commission On Aging Council (KCCOA).
- Include 2-1-1 information/collateral in summer and winter survival kits for homeless.

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 clients' 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, was 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 help carry the program forward. The ability to provide access to psychiatric care in a timelier 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 and was found to be an effective psychiatry and telepsychiatry model and will therefore be sustained under Community Services and Supports for ACT and FSP program clients.

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 its 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) on 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 must 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 can 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 about 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 considering 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 support of the Central Region Partnership WET Plan and programs within, as they are most appropriate in Kings County.

On April 12, 2022, Kings County Behavioral Health executed a contract with the Central Region Partnership's identified third-party Grant Administrator, CalMHSA, retroactively covering the 5-Year Central Region WET Plan 2020-2025, for the provision of opting into the WET programs for application to the workforce within Kings County Behavioral Health, county and contracted. To opt in, Kings County Behavioral Health paid a required County match of $61,472.02 for which the total funds available for Kings County Behavioral Health WET Programs $247,750.86. The County match was paid to CalMHSA in FY 2021/2022 through alternate funding than MHSA; however, the Department would like to note the activities that occurred here within the Mental Health Services Act Plan.

County Share of OSHPD Regional Grant Award	$186,178.84
County Match Funds	$61,472.02
Total County Grant Funds	**$247,750.86**

The initial roll-out of WET Programs by Kings County Behavioral Health was through a Loan Repayment Opportunity. Through this Program, qualified Kings County Behavioral Health County and contracted providers within the Region's Behavioral Health care provider networks that commit to a 12-month service obligation in a recognized hard-to-fill or hard-to-retain position could apply for up to $10,000.00 in student loan repayment.

Kings County Behavioral Health advertised this opportunity on its website and through flyers and correspondence with its county and contracted programs applicable between October 1, 2022, and November 15, 2022. Four applications were received by CalMHSA of which one was approved and was undergoing the 12-month commitment period during FY 22/23 through 23/24. Among the other three applicants, one was not from a Kings County programs, another had resigned, a third withdrew.

Kings County Behavioral Health will proceed with the Retention Strategies Opportunity in FY 24/25 for the completion of use of the total County grant funds overseen by CalMHSA.

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 2022-2023. This one-time allocation is fully expended with no proposal to transfer funds from CSS for future use.

FUNDING AND EXPENDITURES BUDGET

Funding Summary

FY 2024/25 Mental Health Services Act Annual Update
Funding Summary

County: Kings County

Date: 04/18/24

	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. FY 2024-2025 Funding						
1. Unspent Funds from Prior Fiscal Years*	3,342,764	2,683,987	277,275	0	0	0
2. New FY 2024/25 Funding	6,378,784	1,594,696	419,656	0	0	0
3. Transfer in FY 2024/25						
4. Access Local Prudent Reserve in FY 2024/25						
5. Available Funding for FY 2024/25						
B FY 2024/25 MHSA Expenditures	10,591,570	1,761,870	626,303	0	0	
C FY 2024/25 Unspent Fund Balance	(870,021)	2,516,813	70,629	0	0	

D. Local Prudent Reserve Balance**	
1. Local Prudent Reserve Balance on June 30, 2024	1,184,797
2. Contributions to the Local Prudent Reserve in FY 2024/25	0
3. Distributions from the Local Prudent Reserve in FY 2024/25	0
4. Local Prudent Reserve Balance on June 30, 2025	1,184,797

*Based on Reversion Tables issued 3/28/20 and projected FY20-21 spending as of 2/20/21
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.

** Pursuant to SB192 and DHCS IN 19-017, each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS component in FY 2014-15, FY 2015-16, FY 2016-17, FY 2017-18, and FY 2018-19.

Community Services and Supports (CSS) Component Worksheet

FY 2024/25Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: Kings County

Date: 4/18/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CSS Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
FSP Programs						
1. Full Service Partnership/Wraparound Services for Children/TAY	2,939,106	2,083,611	855,495			
2. Full Service Partnership for Adults/Older Adults	2,158,051	1,897,675	260,375			
3. Assertive Community Treatment	4,648,406	3,352,346	1,296,060			
4.						
5.						
6.						
Non-FSP Programs						
1. Warm Line (Kings-Tulare Warm Line Kingsview)	195,769	195,769				
2. Intensive Case Management/Intensive Outpatient Program						
3. Collaborative Justice Treatment Court (CJTC)	505,965	490,333	15,632			
4. Mental Health Services for Domestic Violence Survivors	116,111	116,111				
5. Whole Person Care	0	0	0			
6. Multiple-Organization Shared telepsychiatry (MOST)	942,385	527,698	414,687			
7.						
8.						
9.						
10.						
CSS Administration*	1,900,461	1,900,461				
CSS MHSA Housing Program Assigned Funds	27,565.06					
Total CSS Program Expenditures	13,433,820					
FSP Programs as Percent of Total	73%					

Prevention and Early Intervention (PEI) Component Worksheet

FY 2024/25 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: Kings County

Date: 4/18/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Total Mental Health Expenditures	PEI Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
Access and Linkage						
1. Senior Access for Engagement	263,957	263,957				
2. Kings United Way 2-1-1	100,443	100,443				
3.						
Early Intervention						
5. Early Intervention Clinical Services	0	0				
6.						
Prevention						
8. School Based Services	355,975	355,975				
9. Prevention and Wellness Support Groups	106,940	106,940				
10. Suicide Prevention (DRAW-LOSS-CVSPH)	214,454	214,454				
11.						
Outreach for Increasing Recognition of Early Signs of Mental Illness						
12. Outreach and Engagement Training (MHFA-ASIST-SAFE Talk)	8,244	8,244				
13.						
14.						
Stigma and Discrimination Reduction						
15. Stigma and Discrimination Reduction (Media-KPFP-CCTF)	233,906	233,906				
16.						
PEI Administration	471,787	471,7867				
PEI Assigned Funds	51%					
Total PEI Program Estimated Expenditures	1,761,870	1,761,870				

Capital Facilities/Technological Needs (CFTN) Component Worksheet

FY 2024/25 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: Kings County

Date: 4/18/24

	Fiscal Year 2024/25					
	A	B	C	D	E	F
	Total Mental Health Expenditures	CFTN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
CFTN Programs - Capital Facilities Projects						
1.						
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
CFTN Programs - Technological Needs Projects						
1.						
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
CFTN Administration	0					
Total CFTN Program Expenditures			0	0	0	0

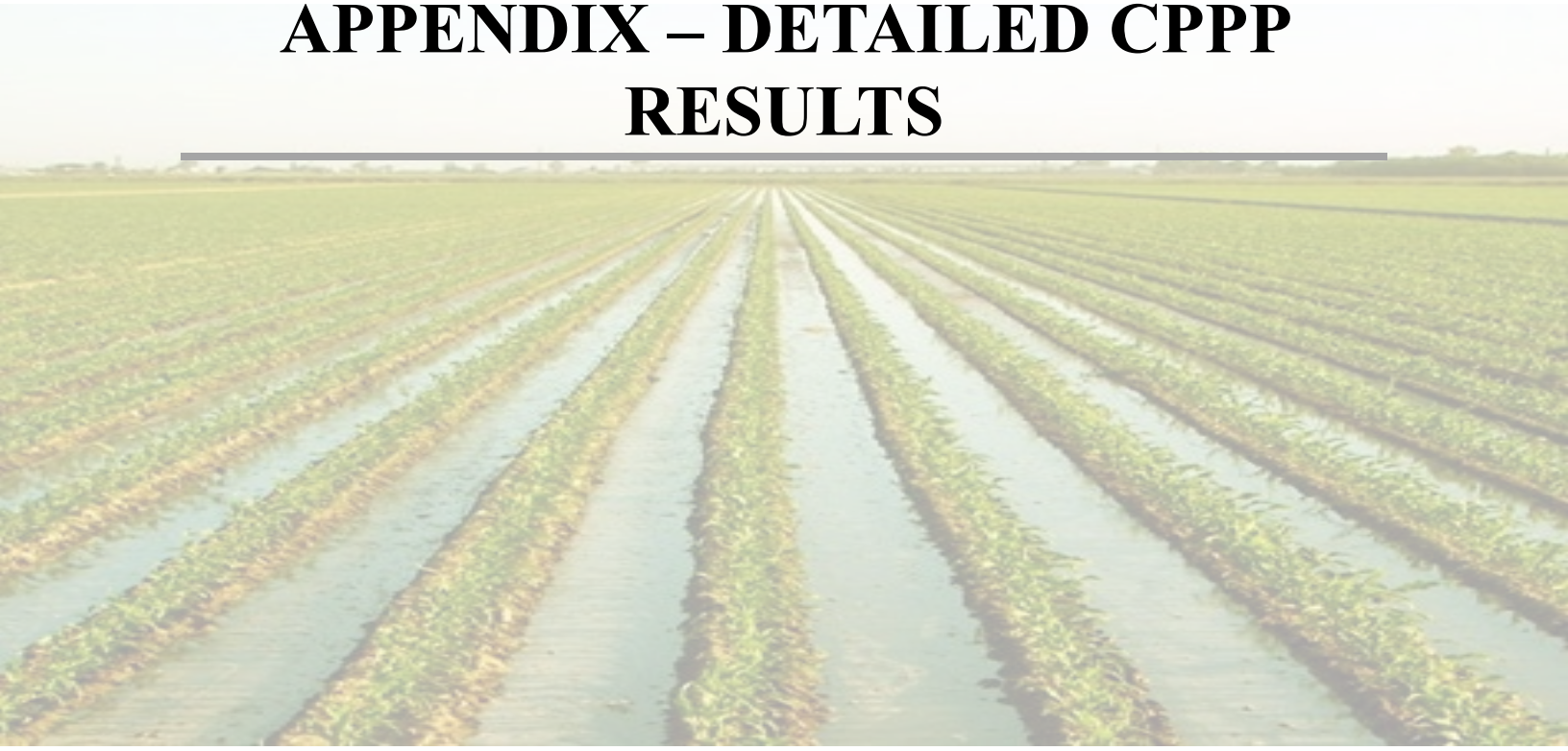
Innovation Program (INN) Component Worksheet

FY 2024/25 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: Kings County Date: 4/18/24

	Fiscal Year 2022024/25					
	A	B	C	D	E	F
	Total Mental Health Expenditures	INN Funding	Medi-Cal FFP	1991 Realignment	Behavioral Health Subaccount	Other Funding
INN Programs						
1. Semi-Statewide Enterprise Health Record	513,568	513,568				
2.						
3.						
4.						
5.						
6.						
INN Administration	112,735	112,735				
Total INN Program Expenditures	626,303	626,303	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 is intended to 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 both online and on paper from January 2024 through February 2024 to community members via:

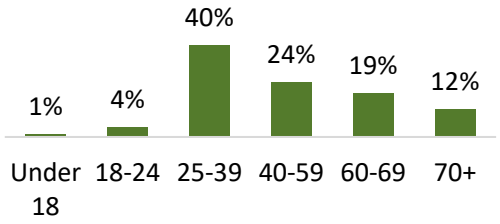
- Kings County Behavioral Health website
- Kings Partnership for Prevention listserv
- Local mental health outreach events

During the survey administration timeframe, a total of 244 responses were collected and findings from these responses are summarized below.

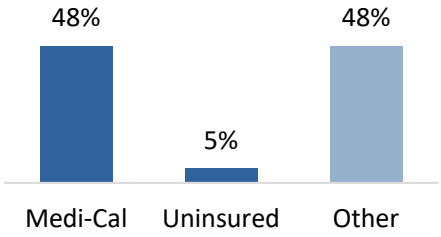
Respondent Profile

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, race/ethnicity, and city of residence.

Age
(n=202)

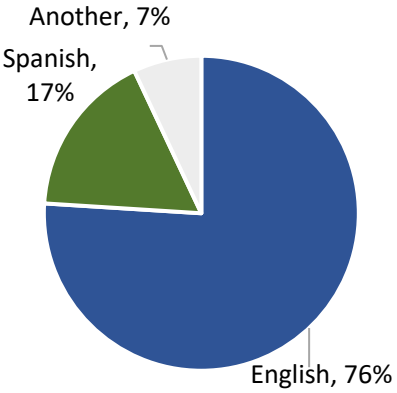


Health Insurance
(n=196)



Participants could select more than one option. Percentages may exceed 100%.

Langauge Spoken at Home (n=204)



53% of respondents live in the city of Hanford

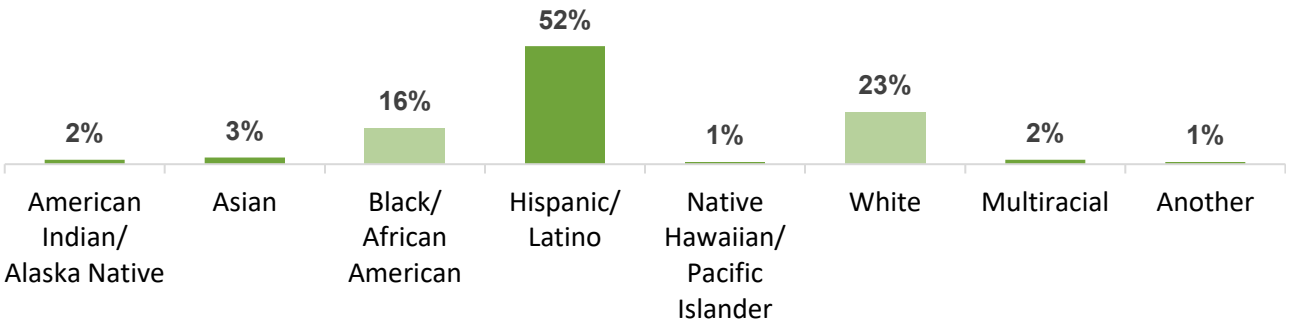
20% live in Lemoore
9% live in Avenal
7% live in Corcoran
6% live in Armona
3% live in Kettleman City
2% live across other areas of the county

(n= 201)

Gender Identity
(n=204)

Female	81%
Male	18%
Transgender	1%

Race/Ethnicity
(n=203)



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=148), more than half of the respondents (59%) reported being the parent or guardian of a child under 18. Additional characteristics are visualized in the graphic below.

Family member of someone with a serious mental or emotional illness (28%)

Has a severe mental or emotional illness (7%)

Has a disability (14%)

Caregiver for an adult family member (15%)

Veteran (13%)

Has an alcohol or substance use disorder (1%)

Identifies as LGBTQ+ (2%)

Does not have immigration status or lives with someone who does not (2%)

Homeless or might become homeless in the near future (5%)

Additionally, respondents who indicated “other” (n=23) shared that they identify as a behavioral health provider (3) or as someone who potentially has a demand for behavioral health services (7).

Overview of Topics

The survey requested feedback on the following topics, results from which are further summarized below:

- Expanded Service Hours
- Support Groups
    - Helpful topics for community-based groups
    - Barriers to attending groups
    - Interest in participating in virtual groups
    - Ability to connect to virtual groups
- Telehealth
    - Current use of telehealth
    - Reason for not using telehealth

Expanded Service Hours

Survey participants were asked whether offering mental and behavioral health service hours outside of traditional service hours (i.e. Monday through Friday, from 8am to 5pm) would be useful for them or their families. Respondents selected one option from a list of provided options. However, seven respondents selected more than one option on a paper version of the survey; thus, the total percentage for Table 1 exceeds 100%. The most frequently selected options were: None of the above – I am satisfied or prefer engaging in mental health services during regular business hours (n=70), open Saturday mornings (8 am-noon) (n=68), and open until 7pm on weekdays (n=53).

Table 1. Useful Times for Expanding Mental and Behavioral Health Service Hours

None of the above – I am satisfied or prefer engaging in mental health services during regular business hours	**29%**
Open Saturday mornings (8am-noon)	**29%**
Open until 7pm on weekdays	**22%**
Open Saturday afternoons (1pm-4pm)	11%
Open at 7am on weekdays	10%
Open Sunday mornings (8am-noon)	3%
Open Sunday afternoons (1pm-4pm)	3%
Other*	1%

Question 1. If expanded hours (beyond Monday – Friday, 8am – 5pm) were available, which one of the following would you or your family find most useful? [please select one]
*Other responses included holidays (n=1), and some early days and some late days (n=1).

Disparities

Across demographic subgroups (n's > 20), community member respondents reported similar preferences. The most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below.

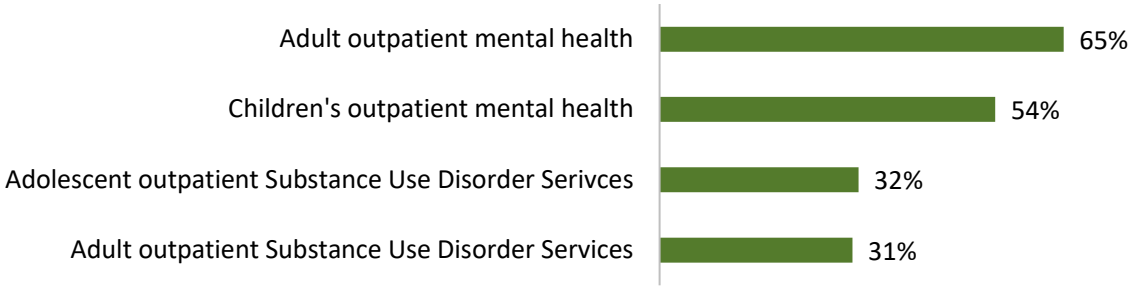
Useful Times for Expanding Mental and Behavioral Health Service Hours by Subgroup

Gender			**Primary Language**		
Male	None of the above	43%	Spanish	None of the above	36%
Female	Saturday mornings	30%	English	Saturday mornings	32%
Race/Ethnicity			**Age**		
Hispanic/Latino	None of the above	33%	25-39	Saturday mornings	27%
White	None of the above	33%	40-59	Saturday mornings	46%
Black/AA	Saturday mornings	45%	60-69	None of the above	33%
			70+	None of the above	59%
Location			**Misc.**		
Avenal & Corcoran	None of the above	53%	Parent/caretaker	Saturday mornings	28%
			Family member	Saturday mornings	39%
			Disability	Saturday mornings	48%
			Survivor of domestic violence	Saturday afternoons & None of the above	29% (tie)

Type of Service for Expanded Hours

Respondents were asked about the types of programs for which expanded hours would be most beneficial, either for themselves or their families. Among respondents (n=145), the most frequently selected type of program is adult outpatient mental health services (n=94), followed by children's outpatient mental health services (n=79), adolescent outpatient substance use disorder services (n=47), and adult outpatient substance use disorder services (n=45).

Figure 1. Helpful Programs to have Expanded Hours



Question 2. Which of the following programs would be helpful (for you or your family) to have the expanded hours? [please select all that apply]

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below. The subgroups of residents of Avenal and Corcoran are not reported due to the insufficient number of respondents (less than 20) who answered the question within those particular subgroups.

Helpful Programs to have Expanded Hours for by Subgroup

Gender			**Primary Language**		
Male	Adult Mental Health	63%	Spanish	Adult Mental Health	70%
Female	Adult Mental Health	67%	English	Adult Mental Health	65%
Race/Ethnicity			**Age**		
Hispanic/Latino	Adult Mental Health	70%	25-39	Adult Mental Health	74%
White	Adult Mental Health	65%	40-59	Children Mental Health	63%
Black/AA	Children Mental Health	68%	60-69	Adult Mental Health	59%
			Misc.		
			Parent/caretaker	Children Mental Health	69%
			Family member	Adult Mental Health	77%

Support Groups - Topics

Table 2 presents results on the support group topics that would be most helpful to members of the community. Among respondents (n=196), the top five most frequently chosen topics were Stress Management (45%), Depression-Adults (40%), Depression-Teens (23%), Anxiety-Adults (23%), and Anxiety-Teens (20%).

Table 2. Helpful Topics for Community-Based Support Groups

Stress Management	**45%**	Men – adult	5%
Depression – Adults	**40%**	Women – adult	5%
Depression – Teens	**23%**	Veterans	5%
Anxiety – Adults	**23%**	Boys/Men – teen/young adult	4%
Anxiety - Teens	**20%**	Girls/Women – teen/young adult	4%
Grief/bereavement	16%	Survivors of Sexual Violence: Adult	4%
Older adults	12%	Current or formerly homeless	4%
Caregivers	11%	New/Expecting Parents	4%
Trauma	9%	Foster/Adoption Support: Parents	4%
Divorce – Adults	8%	Other	4%
Survivors of Domestic Violence: Adult	7%	LGBTQIA+ - teen/young adult	3%
Women's Health (perimenopause, menopause, etc.)	7%	Divorce – Teens	3%
Survivors of Domestic Violence: Youth	5%	Formerly incarcerated	3%
Survivors of Sexual Violence: Youth	5%	LGBTQIA+ - adult	2%
Survivors of Suicide	5%	Foster/Adoption Support: Youth	1%

Question 3. What topic or community-based support groups for mental health/wellness would be most helpful to you and/or your family in Kings County? Please select up to three.
Participants could select more than one option. Percentages may exceed 100%.

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below.

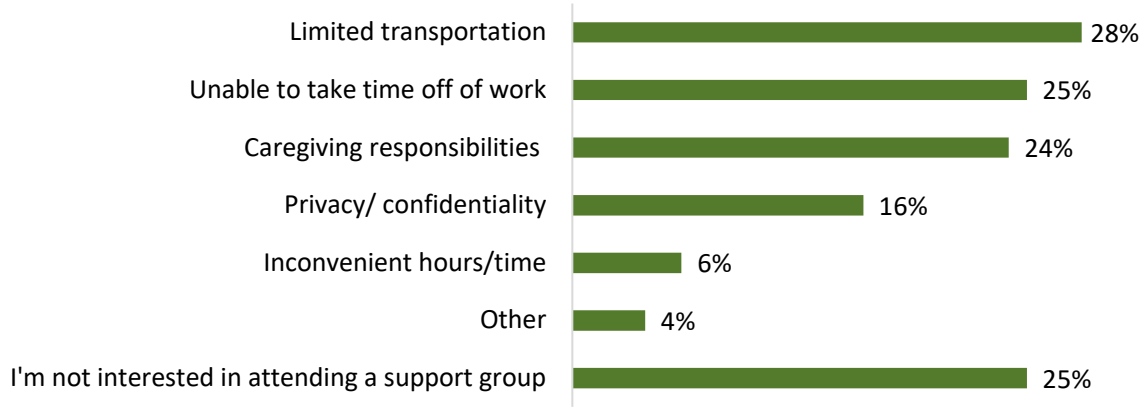
Helpful Topics for Community-Based Support Groups by Subgroup

Gender			**Primary Language**		
Male	Depression – Adults	53%	Spanish	Depression – Adults	55%
Female	Stress Management	47%	English	Stress Management	46%
Race/Ethnicity			**Age**		
Hispanic/Latino	Depression – Adults	46%	25-39	Stress Management	57%
White	Stress Management	47%	40-59	Stress Management	35%
Black/AA	Stress Management	52%	60-69	Depression – Adults	46%
Location			**Misc.**		
Avenal & Corcoran	Stress Management & Depression-Adults	44% (tie)	Parent/caretaker	Stress Management	56%
			Family member	Stress Management	40%
			Survivor of domestic violence	Stress Management	41%
			Caregiver of adult family member	Stress Management	64%

Support Groups – Barriers

As shown in Figure 2, among respondents (n=197), limited transportation (28%) was cited most frequently as a barrier to attending support groups. Other common responses were being unable to take time off of work (25%) and caregiving responsibilities (e.g. lack of child or elder care) (24%). A quarter of the respondents (25%) also indicated that they were not interested in attending a support group.

Figure 2. Barriers to Attending Support Groups



Question 4. Would any of the following prevent you from attending a support group on a topic of interest to you? Participants could select more than one option. Percentages may exceed 100%.

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below.

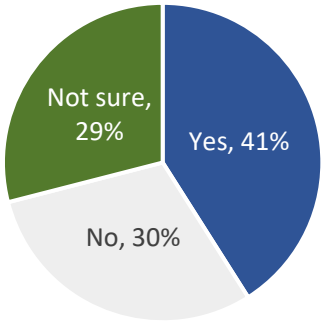
Barriers to Attending Support Groups by Subgroup

Gender			**Primary Language**		
Male	Limited Transportation	28%	Spanish	Limited Transportation	41%
Female	Limited Transportation	21%	English	Not interested	21%
Race/Ethnicity			**Age**		
Hispanic/ Latino	Limited Transportation	26%	25-39	Caregiving Responsibilities	25%
White	Not interested	31%	40-59	Unable to take time off work	26%
Black/AA	Unable to take time off work	29%	60-69	Limited Transportation	36%
			70+	Not interested	50%
Location			**Misc.**		
Avenal & Corcoran	Limited Transportation	33%	Parent/ caretaker	Caregiving Responsibilities	27%

Support Groups – Interest in Virtual Groups

Respondents (n=167) were asked if they would be interested in participating in a virtual support group on a topic that interested them. Of the respondents, 68 (41%) expressed interest, while 50 (30%) indicated they were not interested, and 49 (29%) were not sure.

Figure 3. Interest in Virtual Support Groups



Question 5. Would you be interested in participating in a virtual support group on a topic of interest to you?

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below.

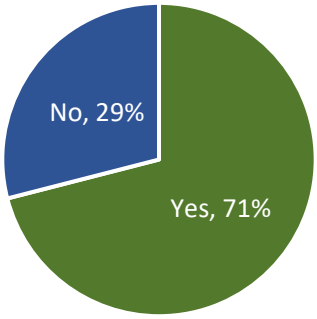
Interest in Virtual Support Groups by Subgroup

Gender			**Primary Language**		
Male	Not sure	43%	Spanish	Yes	41%
Female	Yes	46%	English	Yes	45%
Race/Ethnicity			**Age**		
Hispanic/Latino	Yes	41%	25-39	Yes	56%
White	No	38%	40-59	Yes	45%
Black/AA	Yes	69%	60-69	No	36%
Location			**Misc.**		
Avenal & Corcoran	Yes	39%	Parent/caretaker	Yes	55%
			Family member	Yes	58%
			Survivor of domestic violence	Yes	43%

Support Groups – Able to Connect Virtually

Community member respondents were asked if they would be able to connect to a support group if it was virtual. Among respondents (n=129), 92 (71%) indicated that they have the resources they need to connect to virtual support groups.

Figure 4. Ability to Connect to Virtual Support Groups



Question 6. Would you *be able to* connect to a virtual support group? (i.e. have internet access, know how to join, etc.)

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below. The subgroups of males and residents of Avenal and Corcoran are not reported due to the insufficient number of respondents (less than 20) who answered this question.

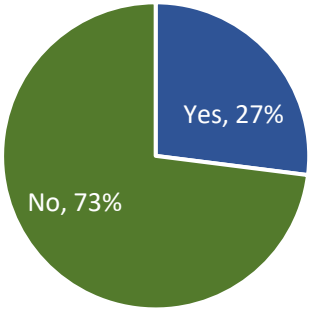
Ability to Connect to a Virtual Group by Subgroup

Gender			**Primary Language**		
Female	Yes	74%	Spanish	Yes	52%
			English	Yes	78%
Race/Ethnicity			**Age**		
Hispanic/Latino	Yes	69%	25-39	Yes	88%
White	Yes	67%	40-59	Yes	81%
Black/AA	Yes	87%	60-69	No	54%
			Misc.		
			Parent/caretaker	Yes	89%
			Family member	Yes	79%

Telehealth – Current Use

As shown in Figure 5, just under three-quarters (73%) of respondents (n=193) said that they did not use telehealth for mental health or substance use services.

Figure 5. Current Use of Telehealth



Question 7. Do you use telehealth to access any type of mental health or substance use services?
NOTE: *Telehealth refers to phone or video appointments that can be done from home or a location other than a traditional doctor's office or clinic*

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below.

Current Use of Telehealth by Subgroup

Gender			**Primary Language**		
Male	No	77%	Spanish	No	90%
Female	No	72%	English	No	70%
Race/Ethnicity			**Age**		
Hispanic/Latino	No	78%	25-39	No	61%
White	No	72%	40-59	No	80%
Black/AA	No	53%	60-69	No	76%
			70+	No	90%
Location			**Misc.**		
Avenal & Corcoran	No	67%	Parent/caretaker	No	65%

Telehealth – Reasons for Not Using

As shown in Table 3, by far the most commonly selected reason for not using telehealth among respondents (n=141) was that respondents preferred in-person appointments (67%).

Table 3. Reasons for Not Using Telehealth

Prefer in-person appointments	**67%**
Do not have a private space for the visit	14%
Do not have internet service	12%
Do not know how to access telehealth visits	11%
Do not have a device I can use (e.g., tablet, laptop)	11%
Not covered by my insurance	8%
There are no local spaces that I can use to connect me to telehealth services (e.g., senior centers, libraries, schools, colleges)	2%
Other	13%
Question 8. What are the reasons why you do not use telehealth? Please check all that apply Participants could select more than one option. Percentages may exceed 100%.	

Disparities

Across demographic subgroups (n's > 20), the most common responses, along with the percentage of responses from that subgroup who selected that option, are provided below. The subgroups of Black or African American and ages 70+ are not reported due to the insufficient number of respondents (less than 20) who answered this question.

Reasons for Not Using Telehealth by Subgroup

Gender			**Primary Language**		
Male	Prefer in-person appointments	69%	Spanish	Prefer in-person appointments	71%
Female	Prefer in-person appointments	65%	English	Prefer in-person appointments	67%
Race/Ethnicity			**Age**		
Hispanic/Latino	Prefer in-person appointments	66%	25-39	Prefer in-person appointments	64%
White	Prefer in-person appointments	70%	40-59	Prefer in-person appointments	76%
			60-69	Prefer in-person appointments	69%
Location			**Misc.**		
Avenal & Corcoran	Prefer in-person appointments	76%	Parent/caretaker	Prefer in-person appointments	65%
			Family member	Prefer in-person appointments	80%

Community Survey

Kings County Behavioral Health

Thank you for taking the time to share your feedback today. We are asking community members to complete this brief survey to provide feedback on behavioral health needs in Kings County. Your individual responses will be kept confidential and the results will only be reported in aggregate.

1. If expanded hours (beyond Monday – Friday, 8am – 5pm) were available, which one of the following would you or your family find *most* useful? [please select one]

- ❑ Open until 7pm on weekdays
- ❑ Open at 7am on weekdays
- ❑ Open Saturday mornings (8am – noon)
- ❑ Open Saturday afternoons (1pm – 4pm)
- ❑ Open Sunday mornings (8am – noon)
- ❑ Open Sunday afternoons (1pm – 4pm)
- ❑ None of the above – I am satisfied or prefer engaging in mental health services during regular business hours *[skip to question 3]*
- ❑ Other (please specify): _____

2. Which of the following programs would be helpful (for you or your family) to have the expanded hours? [please select all that apply]

- ❑ Adult outpatient mental health
- ❑ Adult outpatient Substance Use Disorder Services
- ❑ Children's outpatient mental health
- ❑ Adolescent outpatient Substance Use Disorder Services

3. What topic or community-based support groups for mental health/wellness would be most helpful to you and/or your family in Kings County? Please select up to three.

- ❑ Stress Management
- ❑ Survivors of Suicide
- ❑ Depression – Adults
- ❑ Depression – Teens
- ❑ Grief/bereavement
- ❑ Older adults
- ❑ Anxiety – Adults
- ❑ Anxiety - Teens
- ❑ Trauma
- ❑ Divorce - Adults
- ❑ Divorce – Teens
- ❑ Survivors of Domestic Violence: Adult
- ❑ Survivors of Domestic Violence: Youth
- ❑ Survivors of Sexual Violence: Adult
- ❑ Survivors of Sexual Violence: Youth
- ❑ LGBTQIA+ - adult
- ❑ LGBTQIA+ - teen/young adult
- ❑ Men – adult
- ❑ Boys/Men – teen/young adult
- ❑ Women – adult
- ❑ Girls/Women – teen/young adult
- ❑ Women's Health (perimenopause, menopause, etc.)
- ❑ Veterans
- ❑ Current or formerly homeless
- ❑ New/Expecting Parents
- ❑ Caregivers
- ❑ Foster/Adoption Support: Parents
- ❑ Foster/Adoption Support: Youth
- ❑ Formerly incarcerated
- ❑ Other (please specify): _____

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Please note that the following support groups are currently offered through Kings County Behavioral Health:

- Family Support Group (family members of individuals with mental illness)
- Veterans Support Group
- LGBTQ+ Support Group
- Sisters Speak (African American Women support group)

For information on dates/times and other services offered, visit http://www.kcbh.org/services.html

4. Would any of the following prevent you from attending a support group on a topic of interest to you?

- ❑ Limited transportation
- ❑ Privacy/confidentiality
- ❑ Caregiving responsibilities (e.g. lack of child or elder care)
- ❑ Unable to take time off of work
- ❑ Inconvenient hours/time [if selected, specify preferred time]: _____
- ❑ Other: _____
- ❑ I'm not interested in attending a support group *[skip to question 7]*

5. Would you be interested in participating in a virtual support group on a topic of interest to you?

- ○ Yes
- ○ No *[skip to question 7]*
- ○ Not sure

6. Would you *be able to* connect to a virtual support group? (i.e. have internet access, know how to join, etc.)

- ○ Yes
- ○ No

7. Do you use telehealth to access any type of mental health or substance use services?
NOTE: ***Telehealth*** *refers to phone or video appointments that can be done from home or a location other than a traditional doctor's office or clinic*

a. Yes *[skip to question 9]*
b. No

8. What are the reasons why you do not use telehealth? Please check all that apply.

- ❑ Prefer in-person appointments
- ❑ Not covered by my insurance
- ❑ Do not know how to access telehealth visits
- ❑ Do not have a device I can use (e.g., tablet, laptop)
- ❑ Do not have internet service
- ❑ There are no local spaces that I can use to connect me to telehealth services (e.g., senior centers, libraries, schools, colleges)
- ❑ Do not have a private space for the visit
- ❑ Other (please specify): _____

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Please tell us about yourself.

9. Where do you live?

- ○ Armona
- ○ Avenal
- ○ Corcoran
- ○ Hanford
- ○ Kettleman City
- ○ Lemoore
- ○ Stratford
- ○ Other:

_____

10. How old are you?

- ○ Under 18
- ○ 18-24
- ○ 25-39
- ○ 40-59
- ○ 60-69
- ○ 70+

11. What kind of health insurance do you have?

- ○ Medi-Cal
- ○ Uninsured
- ○ Other

12. Which of the following *best* represents your race or ethnicity?

- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Hispanic or Latino
- ○ Native Hawaiian or Pacific Islander
- ○ White
- ○ Multiracial (specify):

  _____
- ○ Another race/ethnicity (please specify):

  _____

13. What language do you speak most at home?

- ○ English
- ○ Spanish
- ○ Another language (please specify):

  _____

14. Which of the following *best* describes your sex/gender?

- ○ Male
- ○ Female
- ○ Transgender
- ○ Genderqueer
- ○ Questioning/unsure of gender identity
- ○ A different identity (please specify):

  _____

15. 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 am a member of the LGBTQ+ community
- ❑ 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 (cognitive or physical)
- ❑ 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 a survivor of domestic violence
- ❑ I am a survivor of sexual violence
- ❑ I am a current or former foster youth
- ❑ I am formerly or currently justice-involved
- ❑ I am formerly or currently homeless, or might become homeless in the near future
- ❑ Other (please specify):

  _____

Thank you for your time and feedback.

FOCUS GROUP RESULTS

Introduction

As part of the Community Program Planning Process (CPPP) for the Annual Update to the 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 purpose 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 were designed to collect data on community members' understanding of 1) Mental Health and Substance Use Disorders, 2) Accessibility of Services, 3) Peer Supported and Group Services, and 4) Wellness or Mental Health Messaging.

Methods

Focus group participants were recruited through partner organizations and intended to be inclusive of individuals from vulnerable populations within the county. All focus groups used a semi-structured protocol and were facilitated in English and/or Spanish. Four focus groups were successfully conducted with a total of 38 participants. **Table 4** provides further details about each of the focus groups.

Table 4. Focus Groups Conducted (n=38)

Focus Group Participants	# Participants
Veterans (Hanford)	21
Corcoran (English/Spanish)	8
Avenal	7
Parents (Spanish; Corcoran)	2

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. Themes in the focus group discussions were identified for each topic. Each theme was contextualized, and an example of how the theme was discussed was provided, along with an analysis of how the County can use the findings. Illustrative quotes are also included. For some topics, tables are also provided that summarize the similarities and differences across focus group discussions.

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. 4).

Overview of Topics

Topics discussed by interviewees and presented in the results are organized into the following categories:

- Accessing Services
- Culturally Responsive Services for Latino(a) Communities
- Group Services
- Behavioral Health Messaging

Accessing Services

This section includes topics discussed by focus group participants related to the accessibility of services, including:

- Barriers and Strengths of Telehealth
- Preferences Regarding Extended Service Hours
- Service Utilization Preferences and Perceptions

Barriers and Strengths of Telehealth

Participants discussed the barriers and strengths of telehealth. Table 9 compares these barriers and strengths identified or discussed across the four focus groups. Green shaded boxes indicate that the barrier or strength was discussed in the particular group.

Table 9. Barriers and Strengths of Telehealth

Barriers and Strengths	Parents (Spanish; Corcoran)	Corcoran	Avenal	Veterans (Hanford)
Barriers				
Technological Literacy (N=6)			■	■
Lack of Privacy (N=3)	■		■	
Prefer In-Person (N=3)	■			
Limited Internet Service (N=2)		■	■	
Lacks Gravity of Medical Office (N=2)		■	■	
Excludes Unhoused (N=1)				■
Lack of Awareness of Service (N=1)				■
Strengths				
Alternative if In-Person is Not Available (N=4)		■		
Provides Privacy (N=1)				■
Option for Follow-Up Appointments (N=1)		■		
Convenient (N=1)				■

Above are the barriers and strengths that participants across all focus groups discussed for telehealth. The most commonly mentioned concerns were technological literacy, lack of privacy, and a preference for in-person services. These barriers were each discussed in more than one focus group. Rural area focus groups also expressed concerns about a lack of consistent internet service and not being able to take telehealth as seriously as when they are in a medical office.

The biggest strength of telehealth was that it was seen as a good alternative if in-person services were not available. Veterans also expressed a desire for telehealth because it provided privacy and was convenient. The biggest opportunity for telehealth according to the data is with Veterans, who discussed as many strengths of telehealth as all the other focus groups combined.

Preferences Regarding Extended Hours

Participants were asked about different options for extended KCBH's service hours. Participants wanted to see hours extended to:

- Weeknights (N=5)
- 24/7 Emergency Services (N=2)

- Saturdays (N=1)
- Sundays (N=1)

The data above provide the most support for extending services to weeknights, as well as for 24/7 emergency services.

Service Utilization Preferences and Perceptions

Three subthemes related to Preferences and Perceptions of Service Utilziation emerged from participants' feedback:

- Location
- Awareness
- Trust

Table 10 provides summaries of responses associated with these themes, along with illustrative quotes as examples.

Table 10. Service Utilization Preferences and Perceptions

Location (N=10)	Participants shared their thoughts on the location of services provided. They emphasized the need for services in rural locations both for adults and for children. Community members also mentioned that services were needed in schools. Finally, participants discussed how local spaces were available in Avenal for a full-time satellite branch. For example, community members lamented how there used to be a KCBH therapist in Avenal, but that these services were no longer provided. The findings suggest that there is a demand for services in rural areas, as well as space in some communities to locate satellite branches.
	"No [client] wants to drive to Hanford to get treated. Kids need a lot of support. We need local psychiatrists." -Avenal Focus Group Participant
Awareness (N=3)	Participants also discussed their awareness of behavioral health services. Here, community members showed that there was a divide. Participants from the Spanish Speaking Parents focus group described how they knew what services were available. However, the same participants also described how they were still learning the system and adapting. The findings suggest that inroads have been made in terms of raising awareness in the Spanish-speaking community but that more outreach and education can be done.
	"We don't access services but we know where to get them. We're in good hands." -Spanish Speaking Parents Focus Group Participant
Trust (N=2)	Participants described issues with trust that impeded access to services. When asked about home visits, participants balked because they said that the presence of a county vehicle outside of someone's house would bring stigma. Community members also emphasized how the first impressions that providers made mattered for the community and affected the trust that the community had.

	The findings here suggest that home visits should be approached with caution and that community members are reluctant to continue services if they have a negative first experience. These findings can be used to inform service providers.
	"[Service providers] need to understand that first impressions matter." -Avenal Focus Group Participant

Culturally Responsive Services for Latino(a) Communities

This section includes topics discussed by focus group participants concerning Culturally Responsive Services for Latino(a) Communities. Two subthemes emerged:

- Social Expectations
- Communication Patterns

Table 8 provides summaries of responses associated with these themes, along with illustrative quotes as examples.

Table 8. Culturally Responsive Services for Latino(a) Communities

Social Expectations (N=17)	Latino(a) participants discussed social norms and shared some insights into how they would like to receive messaging concerning social expectations. First, some participants highlighted their desire to fight against normalizing or romanticizing alcoholism and binge drinking as coping mechanisms. They further emphasized the importance of social support by discussing the need for parents to take time to connect and foster trust with their children. Recent migrants discussed how they needed help making the transition to American culture and norms. Other participants shared their deep desire for behavioral health services to be more social. For example, participants discussed how they would like services to be less formal and potentially allow participants to bring food to share. Finally, participants discussed the importance of combating the expectation by older generations that overcoming behavioral health issues without any help was a sign of toughness. Here the data provide evidence of the importance of social connections and social support for Latino(a) participants across focus groups. However, these findings show that Latino(a)s cannot be thought of as one population because those who recently migrated expressed clear differences regarding social expectations from those whose parents had migrated. This would then entail outreach efforts and services that are tailored to different generations and different immigration experiences.
	"We recently came from Mexico and my kids are struggling to adapt a little bit. We're taking the good with the bad, and I'm always checking in with my kids." -Spanish Speaking Parents Focus Group Participant *"Our parents who are migrants weren't given the space to recognize those emotions and we're more privileged than they were. We have the space to recognize those emotions but now it's hard for them to honor that we have the space they didn't."* -Avenal Focus Group Participant

Communication Patterns (N=9)	Latino(a) participants described the communication patterns around behavioral health in their communities. Across focus groups, participants mentioned that they rarely used behavioral health language with friends and family. However, they did emphasize that they understand behavioral health language when it is used but lamented that in some situations there is a lack of information about behavioral health for older generations. Finally, participants emphasized the need for services in Spanish. Once again, there is evidence of a generational divide and a divide in terms of experiences with immigration for Latino(a)s. These findings indicate the opportunity to create outreach and education campaigns for older generations and for recent migrants.
	"It's pretty rare for us to use mental health language with our family and friends but we understand this language." -Spanish Speaking Parents Focus Group Participant *"It is also generational. Our parents will say 'why do you need help? Why do you need medication? Like no, be strong.' Because our parents never saw it in their generation growing up. I see my kids, I see that [behavioral health] is getting introduced to them at an early age"* -Corcoran Focus Group Participant

Group Services

Two subthemes related to Group Services emerged from participants' feedback:

- Barriers
- Strengths

Table 11 provides summaries of responses associated with these themes, along with illustrative quotes as examples.

Table 11. Group Services

Barriers (N=7)	Participants described the barriers that they faced to accessing group services. Community members mentioned issues such as challenges with logistics, finding good facilitators, having group services at convenient hours, and consistent attendance at virtual focus groups. Other participants discussed more complicated issues, such as needing to select peers who participate in peer support services carefully because they could be a bad influence, as well as the stigma against behavioral health as a barrier to broader participation. For example, in the Veterans focus group, one participant described the stigma that they faced when they tried to recruit other veterans to attend a support group. Findings suggest that barriers fall into two primary categories for community members: 1. Logistics and 2. Stigma. Stigma can be addressed through outreach and education programs, while logistics can be addressed through careful organization and funding.
	"There are assumptions about what a support group is. When I try to recruit vets to come in, their response is 'I don't want to go to therapy.'" - Veterans Focus Group Participant

Successes (N=6)	Community members also discussed the successes of group services. Across focus groups, participants described liking in-person support groups. Participants also mentioned liking virtual support groups. Crucially, while logistics and stigma were framed as barriers by some participants, others emphasized that they had extremely positive experiences with facilitators, as well as that support groups were an important resource. For example, a participant in the Veterans focus group described the Veterans support group as a "family" that played an important role in the participant's life. These findings demonstrate the positive experiences that participants have with group services. This is especially true for veterans. These data provide evidence that there is support among focus group members for group services. Based on these data, group services could potentially be expanded.
	"I look forward to the comradery [at my veterans support group]. It happens two times a month and I wish it could happen more often. This is family for me and it's all I've got. You have to be able to talk without feeling like someone is assessing you." -Veterans Focus Group Participant

Behavioral Health Messaging

This section includes topics discussed by focus group participants concerning Behavioral Health Messaging, including:

- Behavioral Health Messaging Content
- Modes of Messaging
- Strategies for Effective Messaging

Behavioral Health Messaging Content

Three subthemes related to messaging content emerged from participants' feedback:

- Engaging with behavioral health language
- Positive behavioral health language
- Behavioral health as stigmatized

Table 5 provides summaries of responses associated with these themes, along with illustrative quotes as examples.

Table 5. Behavioral Health Messaging Content

	Participants shared how they engaged with the behavioral health system's language. First, some participants confirmed that they understood behavioral health language. Participants then described how they engage with behavioral health services by using this language in two ways that affirmed the behavioral health system and in one way that was skeptical of behavioral health services. In terms of affirmative uses, participants discussed the need to think about mental illness and substance use disorder differently from one another. They also discussed serious mental illness and substance use disorder as clinical issues that needed to be addressed by professionals.

Engaging with Behavioral Health Language (N=22)	Some, however, described behavioral health issues skeptically, as they expressed their concerns about misdiagnoses. One participant even went so far as to claim that everyone had some sort of behavioral health issue. This evidence reveals that many participants actively engage with the behavioral health system and are in a dialogue with themselves and their communities about behavioral health. This shows that outreach and education efforts have been effective for many participants and supports efforts to continue to provide community members with the tools to understand and apply behavioral health concepts in their own lives.
	"Taking medication doesn't mean something is wrong with you, it is just giving your body something it is not able to produce on its own." -Avenal Focus Group Participant
Positive Behavioral Health Language (N=22)	Participants provided insight into positive behavioral health messaging that is used by community members. For participants who had recently arrived in the United States, their positive language focused on parenting techniques for managing the stress and anxiety that comes with immigration. Community members also shared positive messages during the focus group, like explaining that if you do not reach out for help then you cannot receive help, that they understood mental health in terms of support, and that they thought about mental health as self-care. The most common positive message shared in the focus groups was that the participants were trying to destigmatize behavioral health issues and services in their own communities by raising awareness and listening to others. For example, a participant discussed how their child had a serious mental illness and that the participant tried to talk about behavioral health issues as much as they could in order to destigmatize the topic. These findings provide evidence of behavioral health messaging in the community around support. From supporting children, to reaching out for help, to self-care, to outreach, participants understood behavioral health in a positive light in terms of different forms of support. These findings could inform outreach campaigns and provide evidence of the inroads that have been made in the community in terms of behavioral health messaging.
	"Mental health to me is identity. How I navigate within myself…It is just a balance." -Veterans Focus Group Participant *"If you don't ask for help, you can't get help"* -Spanish Speaking Parents Focus Group Participant
	Some participants held a stigmatized view of behavioral health. The theme that emerged was that those who had a mental illness or a substance use disorder were "dangerous" or "crazy." One participant characterized both "mental health" and "mental health disorder" as referring to people who were "dangerous."

Behavioral Health as Stigmatized (N=5)	These findings can inform education efforts to combat this stigma. Particularly, an effective strategy could be to combat this stigma by relying on the previous findings and framing behavioral health issues as requiring support rather than providing a reason to isolate affected individuals.
	"That goes back to how some people just go straight to the word crazy. 'Oh, they're just crazy.' They call those people experiencing mental illness crazy." -Corcoran Focus Group Participant

Suggested Modes of Messaging

Participants discussed suggested modes of messaging. Table 6 compares and contrasts these suggestions across focus groups, with green shading indicating that the mode of messaging was mentioned in that particular group. Note that this topic was not explicitly discussed in the Spanish-Speaking Parents group.

Table 6. Suggested Modes of Messaging

Mode of Messaging	Corcoran	Avenal	Veterans
Local Shops (N=2)			
TV (N=1)			
In-Person Events (N=3)			
Brochures and Flyers in English (N=2)			
Brochures and Flyers in Spanish (N=1)			
Word of Mouth (N=3)			
Social Services (N=2)			
Hospital (N=1)			
Social Media (N=1)			

Above are the modes of messaging suggested by participants. Many modes were unique to each focus group. However, there were two exceptions. First, participants in Corcoran and the Veterans focus group agreed on the importance of advertising at in-person events. Second, participants in the Veterans focus group and the Avenal focus group agreed on the importance of brochures and flyers. An approach based on these data could then develop brochures and flyers to distribute widely, with special attention given to distribution at in-person events.

Effective Messaging

Participants discussed suggested effective styles of messaging. Table 7 compares and contrasts these suggestions across focus groups, with green shading indicating that the style of messaging was recommended in that particular group. Note that this topic was not explicitly discussed in the Spanish-Speaking Parents group or the Veterans group.

Table 7. Effective Messaging

Style of Messaging	Corcoran	Avenal
Clear (N=5)		
Simple (N=4)		
Relatable (N=3)		
Partnering with Successful Events (N=1)		

Above are suggestions by participants for how to communicate with the community effectively. Focus groups from the rural areas (Corcoran and Avenal) strongly valued clear, simple, and relatable messaging. Especially when messaging rural communities, emphasis can be placed on being clear, simple, and relatable.

FOCUS GROUP ITEMS

Understanding Mental Health and Substance Use Disorders

Let's begin by discussing the meaning of some terms

1. Can you please share what you think of when you hear the term mental health?

2. Is this different from "mental health disorder"?
   [***Mental health*** *is a general term for psychological well-being that refers to social and emotional needs common to everyone*]

3. What about substance use disorder?
   a. Optional follow-up questions:
      i. What are some alternative ways to describe these ideas?
      ii. How do you talk about these ideas with close friends or family?
      iii. What are ways to achieve or improve mental health (or another more meaningful term for this concept)?

The following questions are related to specific service needs identified from recent community feedback.

Accessibility of Services

4. If mental health service hours could be extended, what would be the best time? For example, open late on weeknights, early on weekdays, Saturday mornings.

5. Does this depend on the type of service (e.g. substance use vs. mental health)?
   a. Optional follow-up question:
      i. If specialized services could be offered *locally* when would be the best time to provide those?

6. **Telehealth** refers to phone or video appointments that can be done from home or a location other than a traditional doctor's office or clinic. What have your experiences been with using telehealth for mental health or substance use services?

7. Would you use telehealth services if they were available?
   a. Optional follow-up question: Are there any barriers you have encountered when using telehealth? If so, what are they?
   b. Optional follow-up question: Are there services you would only attend in person? Why or why not?
   c. Optional follow-up question: Would you use a local community site to use for a telehealth session?

8. (Optional) Are there (mental health or substance use disorder) services that you would like to have available more locally? What types of services in particular?
   a. Optional follow-up question: If a full-time location couldn't be set up locally, would home visits be an acceptable alternative? Why or why not?

b. Optional follow-up question: If a full-time location couldn't be set up locally, what would be a good local site that could potentially be used to *also* provide mental health or substance use services? (e.g. school, library, community center).

Peer-Supported and Group Services

9. A peer is someone with lived experience with a mental health or substance use disorder who assists with providing services in some way but does not directly provide treatment. What have your experiences been with mental health or substance use disorder services that have had a peer component to them (i.e. "peer-led" or "navigator")?
    a. Optional follow-up question: Is this something that you would find helpful? Why or why not? What concerns would you have?

10. What have your experiences been with support groups?
    a. Optional follow-up question: How would you define a successful support group?
    b. Optional follow-up question: What are some barriers to attending support groups?
    c. Optional follow-up question: Would you be interested in attending support groups virtually?
        i. Why or why not?

Wellness or Mental Health Messaging

11. Have you ever seen any mental health messages or advertisements that you have found to be particularly informative or useful?

12. What was useful/what do you like about them?

13. Where did you see them? (i.e. billboards, radio ad, Facebook ad/post, etc.)
    a. Optional follow-up question: Are there certain types of information that you would appreciate being shared this way? If so, what type of platform would be most likely to see and find useful?

Closing Question(s)

14. Is there anything else you would like to share with us about any of the topics we have discussed today?

KEY STAKEHOLDER INTERVIEW 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 and implementation for mental and behavioral services.

Methods

Six interviews were conducted, where an interview could have more than one interviewee. The results indicate the number of interviews where the interviewee(s)' responses aligned with a specific theme, denoted by "n."

Eight individuals who primarily work either directly for KCBH or through agencies partnered with KCBH to provide mental and behavioral health services to communities in Kings County were interviewed between January and February 2024. These interviewees included a vice president, directors, program managers, and a psychiatrist. Among the interviewees, they had an average of approximately 3 years (range: 7 months to 6.5 years) of experience in their current roles. All interviewees provide a form of mental and/or behavioral health service, either directly through their staff or their agency.

Overview of Topics

Topics discussed by interviewees included:

- Service Accessibility
- Peer Services
- Support Groups

Service Accessibility

This section includes topics and subtopics discussed by interviewees regarding service accessibility, including:

- Meeting the Desire for Local Services
  - Use of telehealth
  - Use of outreach
- Extending Mental Health Service Hours
  - Timing of services
  - Type of service and staffing
- Barriers to Improving Service Accessibility
  - Limited trust
  - Limited funding

Meeting the Desire for Local Services

An interviewee indicated that often clients do not have a form of transportation to and from main city centers, such as Hanford, where a majority of mental and behavioral services are typically located. Interviewees in five interviews expressed that providers need to physically "meet the clients out in the community, out in their home." Potential ways to meet individuals' needs for locally accessible services

may resemble having a physical building in rural communities, co-locating with another agency or organization, having stable clinicians, a mobile clinic van, transportation to and from services, and telehealth.

***Use of Telehealth*.** Among the six interviews, in two interviews it was shared that telehealth was an alternative way for individuals to receive services if they were not able to make it to in-person appointments, but it is not ideal; ideally, individuals would be able to receive services in person. Additionally, an interviewee indicated that telehealth may not make services locally accessible for all populations. Individuals from specific subpopulations, such as unhoused individuals, individuals with low socioeconomic status, and individuals residing in rural communities, may not be familiar with how to navigate technology, have unreliable access to technology, or have unstable broadband access and connection. Additionally, there are individuals who are in crisis who would need to be helped in person (n=1).

***Use of Outreach*.** In addition to providing services in local communities, interviewees expressed that there needs to be additional and intentional outreach to increase awareness of the types of services available (n=2), how to navigate the different services (n=2), and for which languages they are available (n=1).

Extending Mental Health Service Hours

***Timing of services*.** Interviewees indicated that it would be helpful to extend mental health service hours to evenings after the workday ends (n=4), the weekends (n=3), or mornings before the workday (n=2),

> "If they [KCBH] were open on Saturdays, it would be very busy."
> – Program Director

> "In rural communities, especially where we have people who are working in fields, it would be late, but it would also be on the weekends."
> – Director

***Type of service and staffing*.** In three interviews, interviewees noted that the feasibility of providing services outside traditional hours varies by service type. While individual therapy and counseling currently accommodate non-traditional hours, psychiatric services may not. In two interviews, it was suggested that the willingness of clinicians and staff to work outside traditional hours, rather than service type, would determine the ability to provide non-traditional hours of service. Another interviewee emphasized the need for clarity regarding county approval for changes in operating hours.

Barriers to Improving Service Accessibility

***Limited Trust*.** An interviewee noted that trust as a barrier "is an all-around issue." Some suggestions from the interviewees on how to build and improve trust include improving the quality of services and

> "It in the small communities, it's often challenging for the community to trust the provider. They really want somebody they know well and that stays and doesn't turn over."
> – Director

the consistency in the timing of services (n=3), doing more outreach to increase awareness of what clients can expect from services and their rights as patients (n=3), having a bilingual clinician/staff who speaks Spanish (n=2), and building rapport with the client (n=1). In rural communities, establishing a physical presence not only addresses the need for locally accessible services but also fosters trust among potential and current clients by offering consistency and familiarity with clinicians or providers (n=1). However, one interviewee noted that a substantial number of participants would be necessary to justify establishing service facilities.

Limited Funding. Three interviewees highlighted the necessity for additional funding to offer local services. In one of the three interviews, an interviewee emphasized that hiring clinicians alone isn't sufficient; support staff are also required for clinic operations, further adding to the cost of services. Another funding-related challenge raised was compensating for travel to rural communities, particularly with CalAIM changes eliminating reimbursement, leading to increased service costs (n=1). However, one interviewee stated their current ability to meet clients' service needs promptly improved recently as a result of their agency reallocating funds and resources.

Peer Services

This section includes topics discussed by interviewees about peer services, including:

- Defining the Role of Peers
- Implementation of Peers
- Incorporating Peers

Defining the Role of Peers

In four of the interviews, interviewees shared that a peer is someone with lived experience, who can connect with families more deeply and in a different way because they have had similar experiences. Additionally, peers can help clients and families navigate services because they have had experiences with navigating mental/behavioral health services themselves.

> "A peer is someone with lived experience who has come to the other side and can help navigate the system, which can be difficult to do. Someone who has been there and done it. Someone not giving you clinical terms, sitting there trying to give you therapy but is just there to listen is the difference."
>
> – Regional Clinical Director

Concretely, peers conduct case management activities (appointment reminder calls, transportation, navigate care, are a confidant) (n=3), and facilitate peer-led groups (n=2).

Implementation of Peers

An interviewee shared that there was initial hesitation surrounding whether it would be feasible to hire a peer who was also a former service recipient of the agency. In two interviews, it was expressed that implementing peers in programs is possible with good ethical standards, privacy and confidentiality of patient information, and training. Conversely, another interviewee noted the inability to implement a peer into their programs due to contractual constraints.

Incorporating Peers

Throughout all interviews, interviewees expressed that all programs could benefit from having a peer. In two interviews, it was indicated that peers are especially needed in schools for kids and their parents, older adults, and individuals receiving psychiatric services. From four interviews, it was indicated that programs lacking a peer component would require funding to implement the position; one interviewee mentioned that their agency recently received grant funding and would be hiring a peer soon.

> "Yes, if I had the money, I would love to incorporate [peers] in every program we have. It's shown to be super beneficial even just as a buffer between appointments regardless of what level of acuity [a client] is at."
>
> – Regional Clinical Director

Support Groups

This section includes topics discussed by interviewees encompassing support groups, including:

- Defining the Role of Support Groups
- Implementing Support Groups
- Remote Support Groups

Defining the Role of Support Groups

During two of the six interviews, it was emphasized that support groups provide individuals with a sense of camaraderie and understanding, as they offer connection with others facing similar challenges, while also serving as environments where individuals can learn new skills. Through their agencies, a variety of support groups are provided:

- **African-American**
- **Anger management**
- **Anxiety skills**
- **Co-occurring Mental Health and Substance Use Disorders**
- **Depression skills**
- **Dialectical behavioral therapy**
- **Family support**
- **Friends and family**
- **Grief**
- **LGBTQ+**
- **Parenting**
- **Parent support**
- **Psychoeducational**
- **Recovery**
- **Rehabilitative service group**
- **Veterans**
- **Victims of violence**

Implementing Support Groups

The implementation of support groups entails various activities, including contracting (n=1), advertising the support group (n=1), appointing a liaison to develop support groups in community spaces (n=1), and gathering consumer feedback for new and existing support groups (n=1). Additionally, an interview underscored that the ease of implementing a support group is influenced by its topic (n=1).

In five of the six interviews, interviewees shared that it would be possible to provide additional support groups and expand existing ones. However, it would depend on which ones the communities need and their feedback on existing ones (n=3), if there is a big enough number of participants attending the

groups (n=2), whether there is an individual willing to facilitate the group (n=1), and if there is a contract for it (n=1).

Remote Support Groups

Across all interviews, participants emphasized that support groups could be offered remotely. One interviewee shared that they currently offer five remote support groups based on clients' feedback. Two interviews highlighted the privacy benefits of remote support groups for clients discussing personal issues (n=1) and ensuring client safety (n=1).

While acknowledging the feasibility of remote groups, interviewees in three interviews expressed clients' preferences for in-person support groups. Additionally, while having a remote option is an alternative for individuals without transportation or who live in rural communities where support group attendance is low, it is not an ideal mode of service delivery (n=1). Furthermore, to be able to offer remote support groups, agencies would need dedicated facilitators (n=1) and the inclusion of remote support groups in their contracts (n=1).

> "I recommend face-to-face because I don't know if the client is in a safe space…I don't know who else is in the room…We do deal with a lot of trauma and lots of the trauma occurs in the family."
>
> – Program Manager

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 does the agency primarily work with?

4. Which geographic areas does your agency serve?

The following questions are related to specific service needs identified from recent community feedback.

Service Accessibility

5. From your perspective, how can mental health providers best meet the community's desire for locally accessible services?
    a. What additional services/resources would you need to do that?
    b. What are some barriers to expanding services to rural communities?

6. If mental health service hours could be extended, what would be the best time? For example, open late on weeknights, early on weekdays, Saturday mornings.
    a. Does this depend on the program or type of service (e.g. substance use vs. mental health)?
    b. Is it currently possible for at least some providers at your organization to work outside of the traditional workday to expand access to care? Why or why not?

7. Is trust a barrier to some communities seeking services? How can trust be improved?

Peer services

8. What does the phrase “peer supported” or “peer provider” mean to you in the context of mental health or substance use services?
    *[a **peer** is someone with lived experience with a mental health or substance use disorder who assists with providing services in some way but does not directly provide treatment]*

9. Does your program currently provide any peer services?
    a. If so, what are they and what has been your experience in implementing these services?
    b. If not, why not?

10. Of the services that do not have a peer component, would it be feasible to incorporate a peer component into any of these? Why or why not?

Support Groups

NOTE: the following questions are about support groups, not clinical groups/group therapy

11. Does your program currently provide any support groups?
    a. If so, what are they and what has been your experience in implementing these groups?

b. If not, why not?

12. Would your program be able to provide additional (or expand existing) support groups?
    a. If so, what would be needed?
    b. If not, why not?

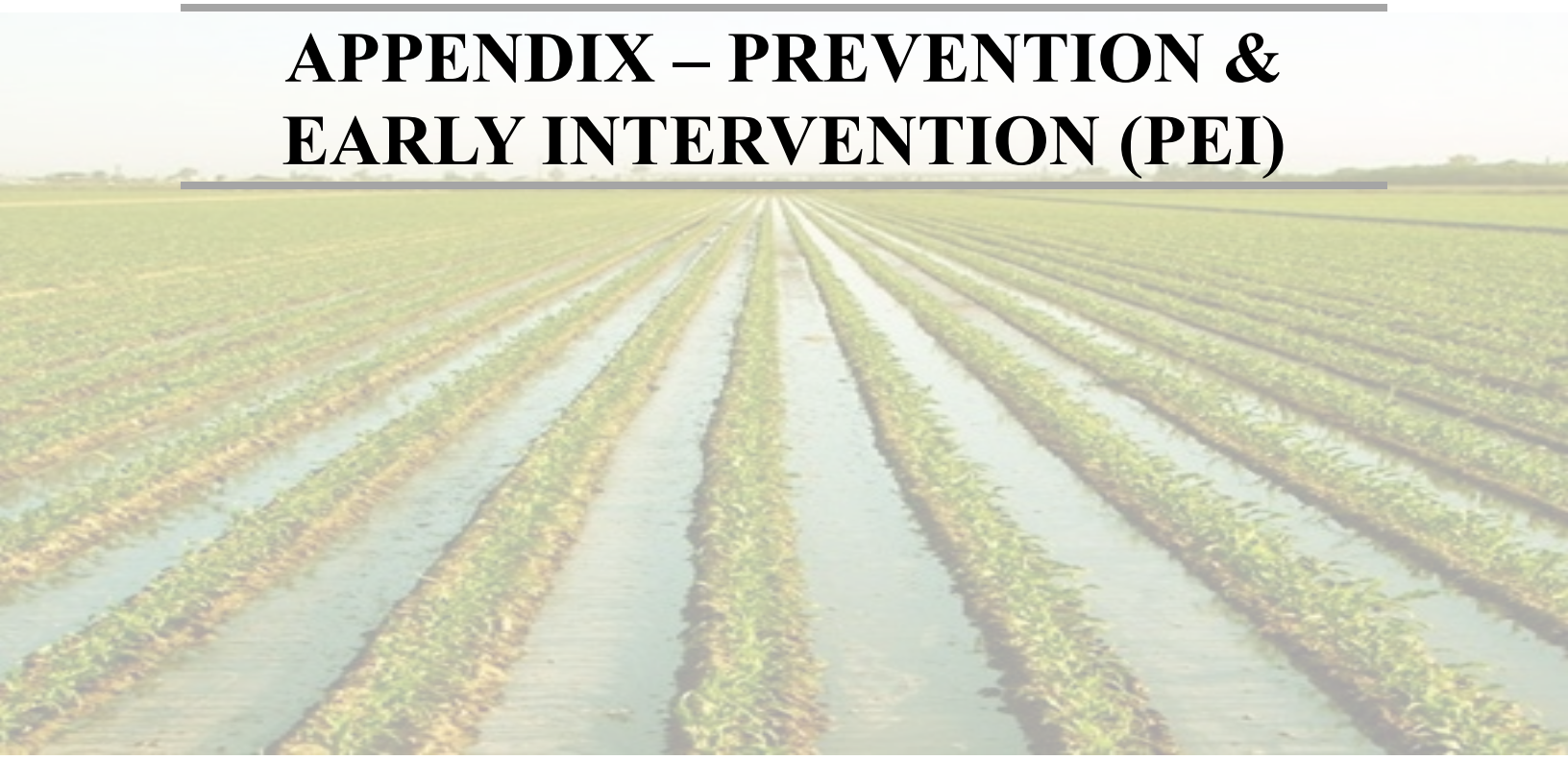
13. Of the groups you do or could offer, are these groups able to be offered remotely? Why or why not?

Conclusion

14. 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?

Thank you again for your participation. Your feedback is extremely helpful.

APPENDIX – PREVENTION & EARLY INTERVENTION (PEI)



Mental Health Services Act

ANNUAL PREVENTION & EARLY INTERVENTION REPORT

FY 2022-2023

Prepared by

EVALCORP

Measuring What Matters

TABLE OF CONTENTS

INTRODUCTION

OVERVIEW

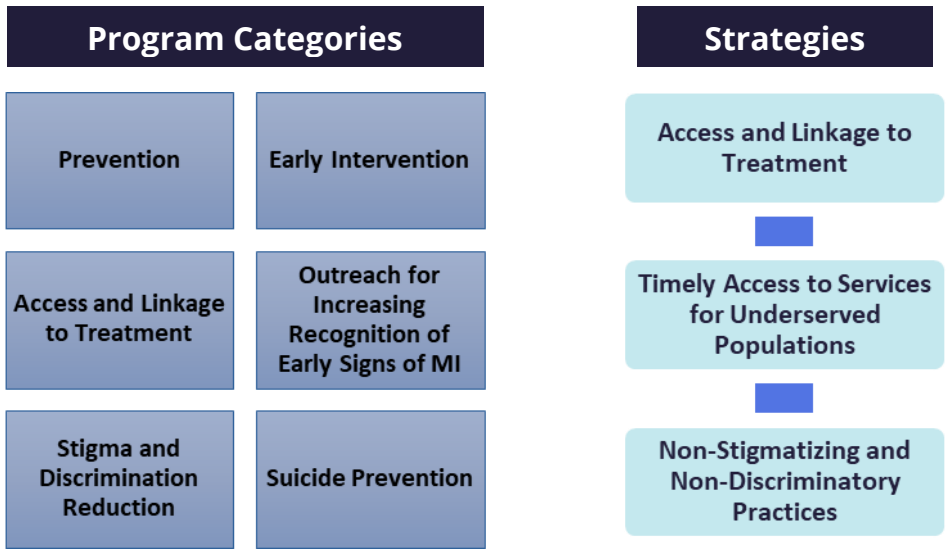
The Mental Health Services Act (MHSA) was passed by California voters in 2004 through Proposition 63, which designated funding to improve mental health service systems throughout the state. MHSA has several funded components, including Prevention and Early Intervention (PEI), which is intended to support programs that prevent mental illnesses from becoming severe and disabling.

Through MHSA funds, Kings County Behavioral Health Bureau (KCBH) supports PEI programs that address the mental health prevention and early intervention needs of the county's culturally and regionally diverse communities. In fiscal year (FY) 22–24, KCBH funded 17 programs, administered by both KCBH and contracted community service providers.

MHSA PEI REGULATIONS

Each of Kings County's PEI programs are organized into one of six categories, as defined by state regulations. Additionally, each program must employ PEI strategies within the PEI activities they provide.

A list of funded KCBH PEI programs by category is included in the Overview of PEI Programs section later in this report, along with a description of how the strategies were met.



State regulations also require specific process and outcome evaluation metrics to be reported on an annual and three-year basis. Outcomes for each program, when available, are specified and included in this report. Additional data collection tools have been developed are currently being implemented for FY 23-24.

PRIORITY/UNDERSERVED POPULATIONS

Additionally, state regulations require the specification of priority/underserved populations for the county. Referrals for these populations are to be tracked and reported separately, and a required strategy for all PEI programs is to prioritize facilitating timely access to services for these populations.

The priority populations specified for FY 22-23 for Kings County Prevention Programs were identified and are listed below, along with a brief explanation as to as to why they were specified:

- 6-17 year olds
    - This group has low penetration rate in comparison to the state and other small counties
- Hispanic/Latino population
    - This group has low penetration rate in comparison to state and other small counties
- Residents from outlying communities to include Avenal, Corcoran, Stratford, and Kettleman City
    - These populations were identified through community feedback
- Persons experiencing homelessness
    - This is a national, state, and local priority

METHODOLOGY

An overview of the data collection tools and processes used to generate the data summarized in this report is included below. Note that not all programs engage in all data collection methods, and not all methods are necessarily uniform across programs.

DATA SOURCES

Data sources compiled to develop the fiscal year 2022–2023 report fall into four general categories:

1. **Quarterly Report Forms and Activity Tracking**: Most programs complete a Quarterly Report. This is a Word document completed by a program staff member that is submitted every 3 months. The report includes: number and types of events/activities (including core program activities/services and outreach/awareness raising activities), number of individuals reached by these activities, and narrative information summarizing program successes and/or challenges.

2. **Demographic Forms/Trackers:** Several programs use standardized forms/surveys (paper or digital) that were developed to collect demographic information required by MHSA PEI regulations (e.g., age group, race, ethnicity, primary language, sexual orientation, disability, veteran status, assigned sex at birth, current gender identity). Other programs have pre-existing processes or systems for collecting service recipient demographic data, and these are used for reporting when possible. When possible, modifications to existing demographic tracking processes were implemented to more closely match the information required by PEI regulations.

3. **Referral tracking**: Several providers used a template (spreadsheet) to report the referrals made to MHSA-funded services by type, such as referral to mental/behavioral health treatment and referral to support services. Some programs had existing processes for tracking referrals, and these were used, or adapted, when possible.

4. **Outcome Surveys/Reports:** Most programs have unique outcomes, related to the type of service provided, and these indicators were used or adapted where available. Changes in BURNS Anxiety and Depression scores are used as outcomes for two programs, and post-training and/or satisfaction surveys are used for several other programs.

LIMITATIONS

Some considerations to keep in mind while reviewing this report are detailed below.

- Unduplicated data: all are duplicated unless otherwise specified
    - Tracking unique individuals across multiple service uses was not always feasible, so counts should generally be interpreted as “events” rather than “unique individuals receiving services”, although there are some exceptions (noted throughout the report)
- Completeness of demographic and outcome data: the number of demographic and outcome responses may be much lower than the total number of participants.

- Skipped questions or declined to take surveys - program participants are free to skip any question or decline to complete surveys at their discretion.
- Generally, when the rate of unanswered questions is high for a given program, data should be interpreted with caution, as they may not be representative of all individuals served by the program.
- Differences in response options to demographic questions. As mentioned above, some providers had pre-existing demographic tracking forms/processes, which may not have been alterable (practically) to completely match those specified in MHSA PEI regulations

OVERVIEW OF PEI PROGRAMS

PROGRAMS

The following table lists the PEI Programs for FY 22-23, organized by program classification.

Program Type	Program Name
Prevention	• Young Minds - School Based Services • Family Support Group • LGBTQ+ Support Group • Veterans Support Group • Sister Speak
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) • Mental Health First Aid • Safe TALK
Stigma and Discrimination Reduction	• Kings Partnership for Prevention (KPFP) • Cultural Humility Taskforce • Community Outreach: iHeart Media
Suicide Prevention	• Central Valley Suicide Prevention Hotline (CVSPH) • Depression Reduction Achieving Wellness (DRAW) • Local Outreach to Suicide Survivors (LOSS)

STRATEGIES

Three strategies (Access and Linkage to Treatment, Timely Access to Services for Underserved Populations, and Non-Stigmatizing and Non-Discriminatory Practices) are required as part of each Prevention and Early Intervention Program (Title 9 CCR § 3735). Examples of how these strategies are implemented are included in the table below.

Strategy	Implementation
Access and Linkage to Treatment	• Conducting follow up call(s) conducted after providing referral(s) • Sharing information and resources at community events, including opportunities for 1-on-1 interactions • Providing screenings, referrals during trainings or other activities
Timely Access to Services for Underserved Populations	• Provide services outside "traditional" business hours • Provide services available in Spanish • Conduct outreach/service promotion using messaging specific for intended population(s) • Offer modified version of services specific to intended population(s)' experience • Bring service to location of underserved population(s)
Non-Stigmatizing and Non Discriminatory Practices	• Requiring training for staff on trauma-informed practices, harm reduction • Providing psychoeducation with opportunities for direct feedback and question-answering • Updating materials to remove stigmatizing language, use empowering language (e.g. person-first), and include culturally-specific examples

OUTREACH

PEI program staff participated in dozens of community outreach events during the fiscal year to raise awareness about available services, share resources, and coordinate with other organizations and service providers. This is in addition to the 63 mental health-related outreach events organized or attended by Kings County Behavioral Health. These events often engaged hundreds of community members. Example outreach events that program staff participated in include:

- Resource fairs (at e.g. community colleges, schools, farmers markets, etc.)
- Red Ribbon week activities
- Parent nights

- Pride events
- Suicide Prevention Events
- Food banks
- Health fairs
- Awareness events

The remainder of the report includes additional descriptions of each of the PEI programs, along with a summary of any available activity, demographic, referral, and outcome data for that program for the ’22-‘23 fiscal year.

PREVENTION PROGRAMS

YOUNG MINDS - SCHOOL BASED SERVICES

Number Served: 1,774 youth/students participated in mental health and wellness activities.
263 teachers received in-service training.
433 families participated in Family Engagement events.

Intended Population: K-12 students at risk of developing a mental health problem, their families and teachers

Program Description

Young Minds is designed to provide students with skills and tools to promote increased mental health, school performance, and healthy relationships and communication. The program began offering services in January 2022. Mental health prevention services offered through Young Minds include curricula (recurring activities) and single-event activities.

Program Activities

Young Minds conducted recurring activities (e.g. curricula, support groups) and single-event activities (e.g. trainings), with events available for students/youth, teachers/staff and families. The following is a list of activities Young Minds conducted during fiscal year 2022-2023.

Recurring Activities	Events	Participants
Mindful Schools	48	1685
Middle/High School Groups	26	31
Social and Coping Skills Group	25	53
Family Strengthening	8	5

Single Event Activities	Events	Participants
Teacher In-Service Training	10	263
Mental Health Assembly	1	505
Family Engagement	8	428
Other (prevention events)	915	17

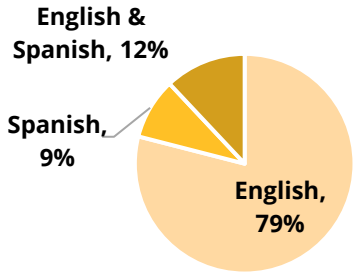
Demographics[1]

Race

Latino or Hispanic	48%
More than one race	26%
White	11%
Black / African American	6%
American Indian / Alaskan Native	4%
Other	4%
Asian	1%

n=164
18 individuals declined to state.

Primary Language



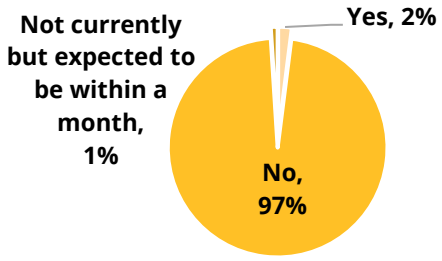
n = 194
4 individuals declined to state.

Ethnicity

Hispanic	
Mexican/Mexican American/Chicano	74%
Other Hispanic/Latino	5%
Central American	2%
South American	1%
Non-Hispanic	
Other Non-Hispanic/Latino	6%
More than one ethnicity	5%
African	4%
Eastern European	1%
Filipino	1%
Middle Eastern	1%

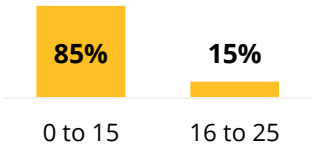
n = 219
34 individuals declined to state.

Unhoused?



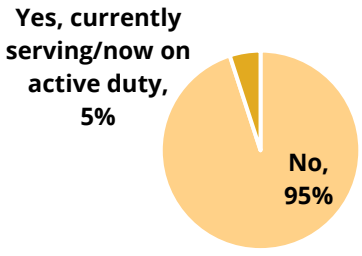
n = 122
14 individuals declined to state.

Age



n = 156
35 individuals declined to state or their age is unknown.

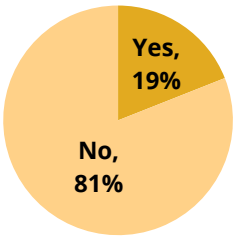
Veteran Status



n = 84
2 individuals declined to state.

[1] Demographics are from student participants

Has a Disability?



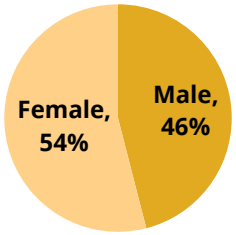
n = 172
3 individuals declined to state.

Disability Type[2]

Difficulty Seeing	41%
Another disability	25%
Anxiety Disorder	12%
Learning Disability	10%
Difficulty Hearing / Having Speech Understood	6%
Bipolar Disorder	3%
Physical / Mobility	1%
Post Traumatic Stress Disorder	1%
Major Depressive Disorder	1%

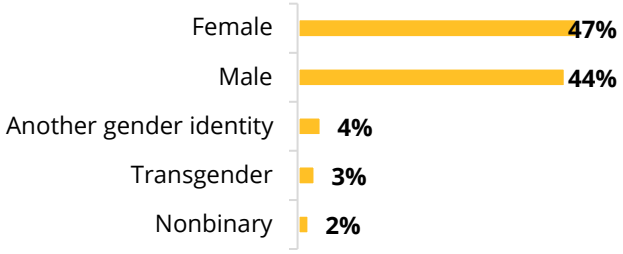
n=68
13 individuals declined to state.

Assigned Sex at Birth



n = 110
1 individual declined to state.

Gender Identity



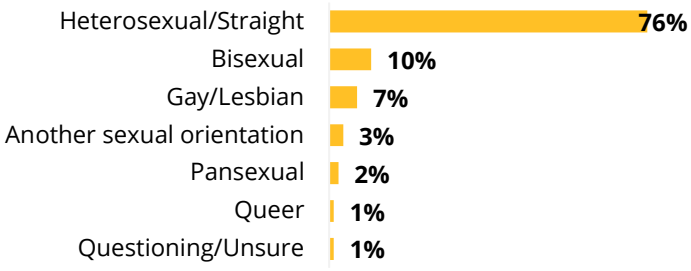
n = 113
2 individuals declined to state.

Home Residence

Corcoran	74%
Hanford	15%
Armona	7%
Lemoore	4%

n=136

Sexual Orientation



n = 90
14 individuals declined to state.

[2] If individuals indicated they have a disability.

Referrals

Individuals were referred to county mental or behavioral health services provided by the KIND center. Program staff were unable to determine if individuals were able to successfully access the services they were referred to.

Outcomes

The following outcomes reproduced below are from quarterly program summary documents for Young Minds activities conducted during fiscal year 2022-2023. The results are from surveys of students, teachers, or parents who attended events.

Population	Outcome	Reported Value (% agree - self-report)	Dates of Reported Values
Students	Have new tools or techniques to reduce stress and anxiety.	61%	Quarter 2
		100%	Quarter 1
Students	Have new skills to regulate their emotions.	71%	Quarter 1
Students	Decreased behavioral referrals	80%	Quarter 2
Teachers	Have tools to support self-regulation of students in the classroom.	76%	Quarter 1
		91%	Quarter 4
Parents	Increased parenting techniques to support your child.	100%	Quarter 3

Program Accomplishments & Challenges

Accomplishments & Successes

- The program creates safe and inclusive spaces for students with diverse needs, including special needs youth, second language learners, and LGBTQ+ youth. Staff ensure comfort and safety, modify lessons when needed, use inclusive language, and provide resources in both English and Spanish.
- The program organized significant youth engagement events, including the Kings County Youth summit and a school-wide assembly at Frontier Elementary School, promoting youth development and cultural practices that support mental health.

Challenges

- The program experienced staffing turnover, resulting in a vacancy and limitations in capacity. Recruitment and cross-training of existing staff are ongoing to address this challenge.
- While the program was successful in implementing one pro-social skills group, challenges with scheduling and solidifying services persisted in some elementary schools. Efforts to meet with school leadership have led to opportunities for program services in the future.

Case Narrative

During our Zones of Regulation sessions with a combination of fifth and sixth-grade students, the principal noticed a significant improvement in one of the 6th grade participants. The principal shared that this student had a challenging history and has had negative encounters with other students and adults on campus in the past. Young Minds staff noted that this student had been highly involved in most of the group conversations and even drew from personal experiences to help other students grasp some concepts during group sessions. The principal shared that this student has shown significant improvements with others on campus and the student reported they enjoyed attending Zones of Regulation sessions.

SISTER SPEAK

Number Served: >29 group attendees (5 – 10 attendees per group)

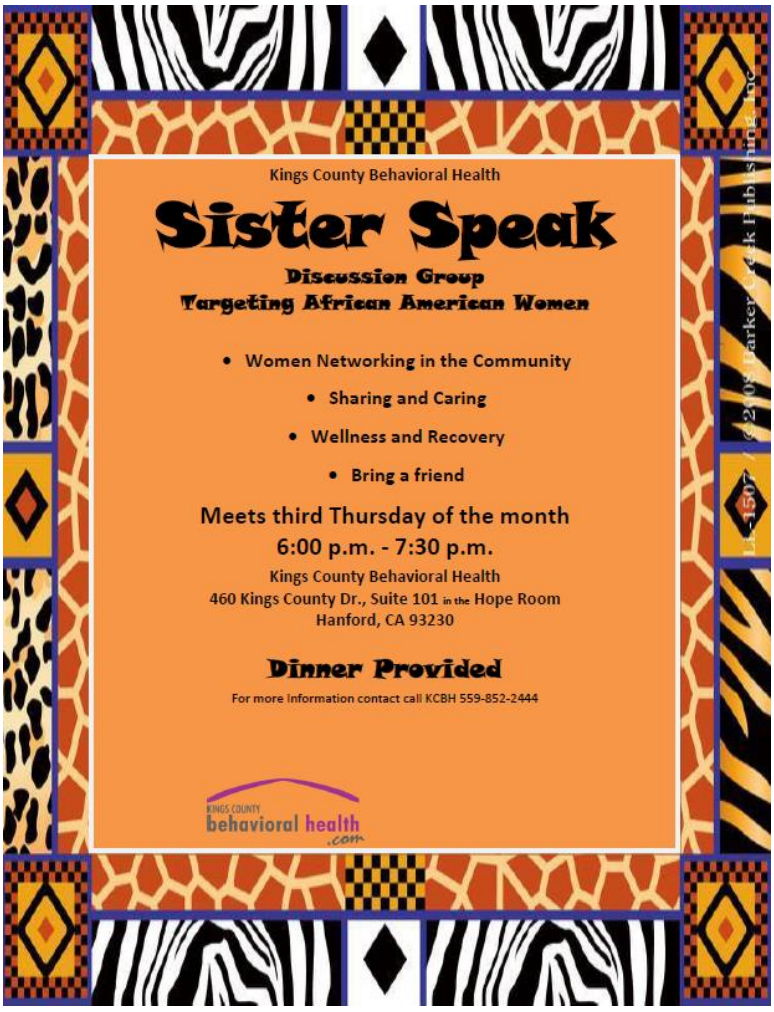
Intended Population: African American Women

Program Description

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.

Program Activities

- Support Group: Meets once a month (see flier below)



FAMILY SUPPORT GROUP

Number Served: 26 unduplicated individuals served.

Intended Population: Individuals living with, or supporting, someone with a serious mental illness.

Program Description

Family Support Group provides quality and culturally competent support groups that foster opportunities for connection, discussion, and education about mental health and living with individuals who have 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.

Program Activities

- Support Group: Meets twice a month (on the first and third Tuesday of every month). Open group with no ongoing curriculum or roster. Participants are free to come and go as they please.
    - 24 family support groups held in FY 22-23

- Promotion/Outreach: These efforts include Postcards—which are the main outreach method. Postcards are distributed throughout the community (e.g. hospitals, court, schools, providers, etc.). Participants also engage in outreach through word of mouth.

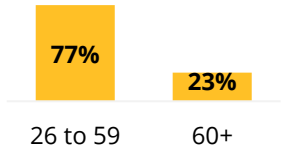
Demographics

Race

White	50%
Hispanic or Latino	38%
More than One Race	8%
Black or African American	4%

n=26

Age



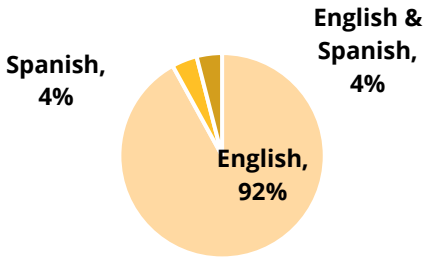
n = 26

Ethnicity – Hispanic/Latino

Mexican	47%
Another Hispanic/Latino Ethnicity	5%
European	24%
Another Non-Hispanic/Latino Ethnicity	24%

n=10
1 individual declined to state.
Data were not reported for 4 individuals.

Primary Language



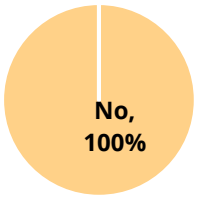
n = 26

Disability Type

Difficulty Hearing or Understanding Speech	29%
Mental Disability	29%
Mental Health Disorder	29%
Chronic Health Condition	13%

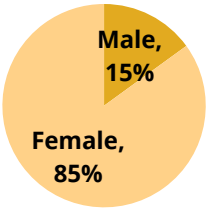
n=10
3 individuals declined to state.
Data were not reported for 16 individuals.

Veteran Status



n = 24
Data were not reported for 2 individuals.

Assigned Sex at Birth

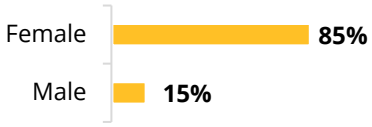


n = 26

Sexual Orientation

n = 23
Data were not reported for 3 individuals.

Gender Identity



n = 26

Program Accomplishments & Challenges

Accomplishments & Successes

- Providing a safe, non-judgmental space for those who live with or support individuals with mental illness.
- Offering access to resources, experience validation, hope, connection, and support for participants.
- Group members brought family and friends to attend.
- Increased outreach efforts through postcard distribution and participants' word of mouth.

Challenges

Lack of access to regular Spanish language translators.

Case Narrative

We were able to support the mother of a transgender youth who experienced a mental health crisis.

We were able to provide support to a family navigating the loss of a loved one's stability after discontinuing medication. The list is long, and I am very proud of the incredible prevention work being done.

LGBTQ+ SUPPORT GROUP

Number Served: 143 unduplicated support group participants served.

Intended Population: LGBTQ+ individuals, with focuses on youth, trans, and non-binary individuals

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.

Program Activities

Support Groups

36 support groups held in FY 2022-23, with rotating themes:

- Youth Night: Build a sense of belonging, share resources, have fun. For individuals ages 12-18.
- Kings County Pop-Up: Focused on education and support. Open to all, including allies.
- Transgender Support Night: Support and resources, peer to peer sharing of experiences, focused on trans and non-binary issues. Open to trans and gender diverse individuals.
- Kings County Pop-Up: Support, sharing resources, and building community. Have a safe place to be one's self. Open to all, including allies.

Community Events

Focused on outreach (like red-ribbon week or a wellness fair). Will visit high schools. Collaborates with other organizations to host smaller events (mostly focused on youth). Have partnered with KCAO. Typically smaller events and in collaboration with other organizations.

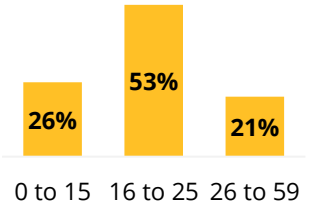
Demographics

Race

White	61%
Latino or Hispanic	21%
More than one race	10%
Black or African American	5%
Native American	3%

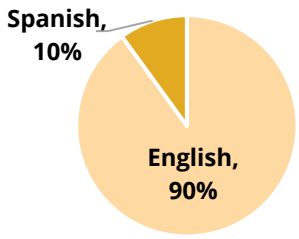
n=39

Age



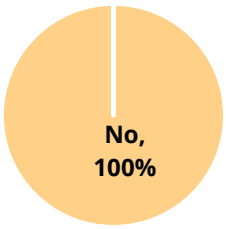
n = 38
1 individual declined to state.

Primary Language



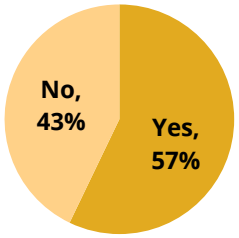
n = 39

Veteran Status



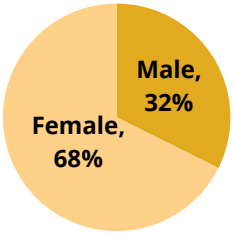
n = 38
1 individual declined to state.

Disability Status



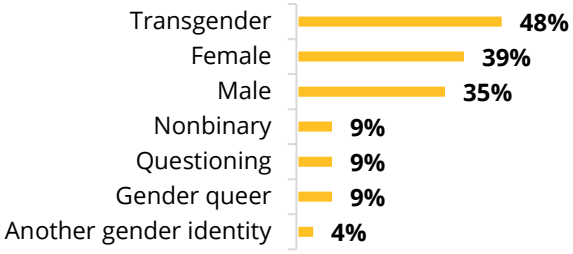
n = 35
4 individuals declined to state.

Assigned Sex at Birth



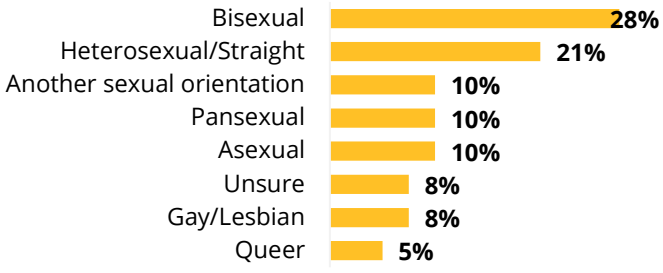
n = 34
5 individuals declined to state.

Gender Identity



n = 35
4 individuals declined to state.

Sexual Orientation



n = 39

Referrals

1 referral was made to mental/behavioral health treatment without a confirmed linkage.

Program Accomplishments & Challenges

Accomplishments & Successes

- Creating a safe space for the LGBTQ+ community.
- High recruitment of new members through outreach.
- Participants feel safe in support groups.
- Outreach efforts make participants feel like they belong.
- Employing an Outreach Coordinator who recruits in Kings County.
- Hosting a monthly youth night for youth to come together and feel validated.
- High degree of collaboration with CBOs.

Challenges

- Homophobic backlash from some community members.
- Low participation in new youth nights.

Case Narrative

We gained a new member who was very nervous about coming to the group. We made sure to make them feel welcome and it was an amazing surprise to see them come out all the way to our Visalia campus for another support group. The new member also checked out the resources on the main campus.

VETERANS SUPPORT GROUP

Number Served: 24 unique individuals

Intended Population: Veterans

Program Description

The Veterans Support Group 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. An explicit goal of the program is to decrease isolation and provide peer support.

Program Activities

The Veterans Support Group meets twice a month. 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 private providers, utility assistance, and rental assistance.

Demographics

Race

White	44%
Black / African American	28%
Latino or Hispanic	16%
American Indian / Alaskan Native	8%
Another race	8%
Asian	4%
Native Hawaiian / Pacific Islander	4%

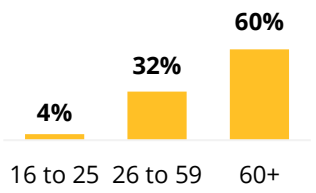
n=25
Another includes Portuguese.

Ethnicity

Hispanic	
Mexican/Mexican American/Chicano	19%
Another Hispanic/Latino ethnicity	6%
Central American	6%
Non-Hispanic	
More than one ethnicity	25%
African	25%
European	13%
Filipino	13%
Chinese	6%
Asian Indian/South Asian	6%
Another Non-Hispanic/Latino ethnicity	6%

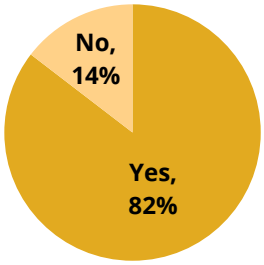
n = 16

Age



n = 25

Disability Status



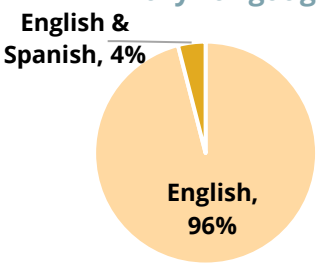
n = 22
3 individuals did not answer the question.
1 individual declined to answer.

Disability Type[3]

PTSD	81%
Anxiety disorder	44%
Difficulty hearing or having speech understood	38%
Chronic health condition/chronic pain	38%
Major depressive disorder	25%
A physical disability	25%
Mental disability	13%
Difficulty seeing	13%
Bipolar disorder	6%
Another disability	6%

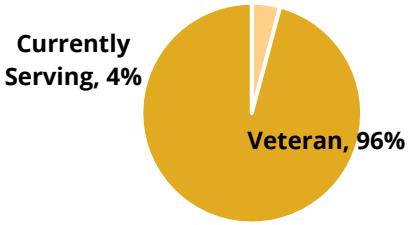
n=16
Another disability includes hard of hearing and slight cognitive decline.
1 individual declined to state.

Primary Language



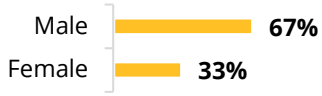
n = 25

Veteran Status



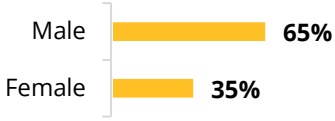
n = 24
1 individual did not answer the question.

Gender Identity



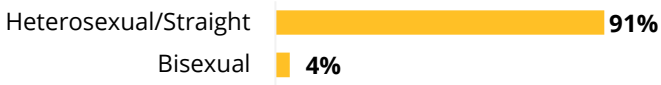
n = 24
1 individual did not answer the question.

Sex Assigned at Birth



n = 23
2 individuals did not answer the question.

Sexual Orientation



n = 22
1 individual declined to state.
2 individuals did not answer the question.

[3] If individuals indicated that they had a disability.

Program Accomplishments & Challenges

Accomplishments & Successes

- On December 1, 2022, the veterans support group received the Lifetime Achievement Award, reflecting the community's recognition of its value. Attendance has quadrupled compared to previous years, with approximately 22-25 veterans, including females, actively participating.
- Veterans share the group within their personal and professional networks, actively engage in open discussions about mental health, and have contributed valuable information to KCBH for their mobile unit.

Challenges

- Historically, the group faced attendance challenges, which are being overcome through active networking within the community and consistent promotion.
- The ongoing learning opportunity is to maintain consistent outreach efforts to capture and retain this population.

Case Narrative

Through networking and collaborations with other community providers to enhance support for veterans, including arranging guest speakers, peer speakers, food distribution, and coordinating cooking classes, there has been success in attracting and retaining veterans. The impact is evident in the positive responses from veterans and the continuous growth of the group. Veterans have expressed feeling valued, a sentiment that was lacking during the pandemic. The group goes beyond addressing their mental health needs by connecting veterans to essential resources, highlighting veteran-only assistance programs (rent/utilities support, etc.), and providing volunteering opportunities.

EARLY INTERVENTION PROGRAM

EARLY INTERVENTION CLINICAL SERVICES (EICS)

Number Served: 9,297 outpatient service provisions
1,322 unique individuals ages 18-25 years served

Intended Population

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 Description

Early Intervention Clinical Services (EICS) 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 the youth and their family.

Program Activities

Early Intervention Clinical Services (EICS) engages in a number of program activities, which include:

- Outpatient services for individuals age 18-25 years
- Transitional Age Youth-focused sessions at a wellness center

Demographics

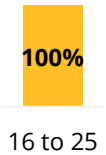
The following tables summarize the available demographics of the individuals who received outpatient services.

Race

Other	43%
White/Caucasian	38%
Black/African American	14%
Native American	2%
Pacific Islander	2%
Asian	2%

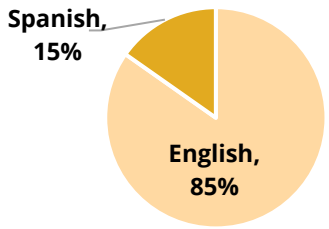
n=389
Data for 55 individuals were not reported.

Age



n = 444

Primary Language



n = 164
Data for 280 individuals were not reported.
Data for Vietnamese as a primary language was not available.

Ethnicity

Hispanic	
Other Hispanic/Latino	76%
Mexican/Mex.-Am./Chicano	23%
Puerto Rican	1%

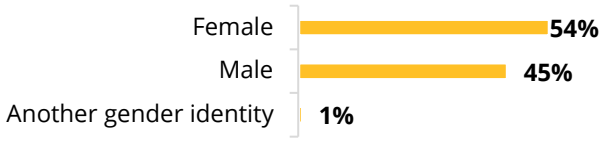
n = 402
Data for 42 individuals were not reported.
Data for Cuban was not available.

Disability

None (including mental health)	91%
Other	5%
Vision	1%
Mental Domain	1%
Hearing/Speech	1%
Physical/Mobility	1%

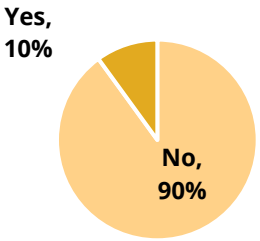
n=428
16 individuals declined to state.

Gender Identity



n =444

Veteran Status



n = 444

Referrals

12 referrals were made to FSP and 3 were listed as authorized for enrollment.

Outcomes

The BURNS Depression and Anxiety scales serve as screening tools for individuals receiving individual counseling. Each individual takes a pre-test in the initial session and a post-test in the final session. The BURNS Depression score can be anywhere from 0 (meaning very little or no depression) to 45 (indicating severe depression). Meanwhile, the BURNS Anxiety score can range from 0 (meaning minimal or no anxiety) to 99 (indicating extreme anxiety or panic).

Percent changes (i.e. post-test minus pre-test) in depression and anxiety scores for 19 to 20 individuals who engaged in individual counseling are summarized below.

BURNS Depression

Percent change from Pre-to-Post **-26.32%**

BURNS Anxiety

Percent change from Pre-to-Post **-17.61%**

Program Accomplishments & Challenges

Accomplishments & Successes

- Ran Transitional Age Youth-focused sessions at a wellness center.
- Implemented a secure electronic system for tracking the status of individuals referred to, and participating in, the program.
- Worked on outreach and advertised Transitional Age Youth population events to increase engagement.
- Recruited and trained staff to work in the First Episode Psychosis (FEP) program.
- Worked with UC Davis Consultation Team and county leadership to structure programs.

Challenges

- The program, like many others, grappled with industry-wide employment challenges exacerbated by the impact of COVID. These challenges significantly hindered the ability to fill open positions, particularly given the high demand for clinical talent in the designated HRSA area.
- The program confronted the challenge of securing clinicians for the First Episode Psychosis program (18-25 y/o). Unfortunately, many clinicians were reluctant to specialize in working with this specific age group, creating difficulties in building a specialized team.

Case Narrative

A challenge we experienced was low attendance this last quarter at Transition Age Youth-focused wellness groups. We learned that when we have created monthly events that centered around an activity that focused on wellness (Example: Pizza and Painting) there was a higher turnout—which resulted in a scheduled ice cream social that will be occurring July 27, 2023. Discussions were held about extending a calendar of 6 months of such monthly events to help with building excitement about attending events that focus on wellness and recovery.

ACCESS AND LINKAGE TO TREATMENT PROGRAMS

2-1-1 KINGS COUNTY

Number Served: 3 direct referral services (calls, texts, live chat)
3,080 individuals served

Intended Population: All of Kings County residents are served by this program.

Program Description

2-1-1 Kings County 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.

Program Activities

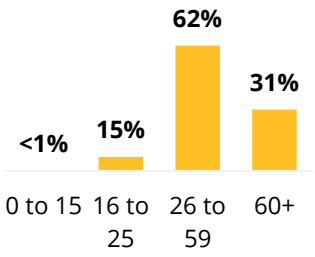
- The 2-1-1 hotline received 2,675 calls
- The 2-1-1 text service received 198 messages
- The 2-1-1 live chat service answered 207 individual responses
- The 2-1-1 website received 17,210 unique visitors
- The 2-1-1 app had 452 active users

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.

Calls received

Age



n = 1,546
712 individuals declined to state.

Ethnicity

Hispanic	55%
Caucasian	20%
Other	14%
African-American	10%
Asian	1%

n = 1,723
544 individuals declined to state.

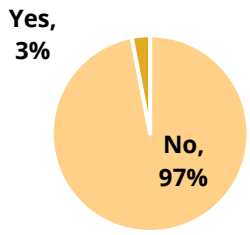
Race

Hispanic	55%
White	20%
Other	14%
African American	10%
American Indian	1%

n=1,717
550 individuals declined to state.

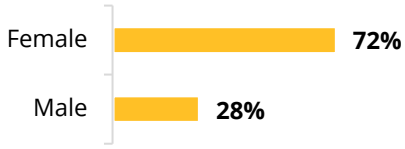
2-1-1 KINGS COUNTY

Veteran Status



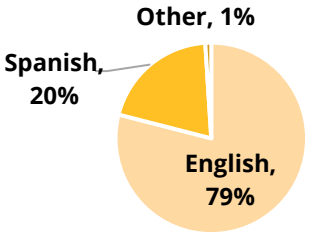
n = 1,874
391 individuals declined to state.

Gender Identity



n = 2,365
17 individuals declined to state.

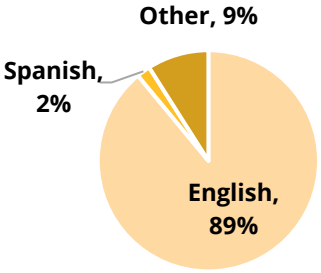
Primary Language



n = 2,065
211 individuals declined to state.

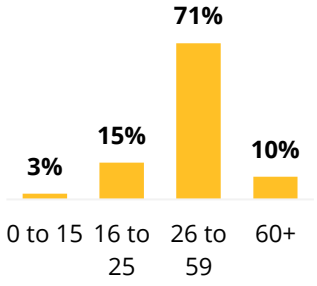
Texts received

Primary Language



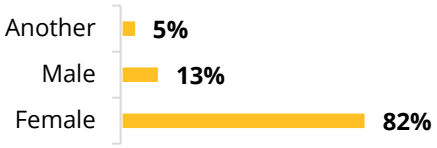
n = 123

Age



n = 78
41 individuals declined to state.

Gender Identity



n = 92
28 individuals declined to state.

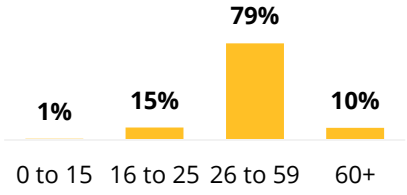
Live chat

Ethnicity

Hispanic or Latino	51%
Not Hispanic or Latino	49%

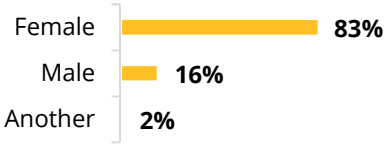
n = 207
18 individuals declined to state.

Age



n = 207
3 individuals declined to state.

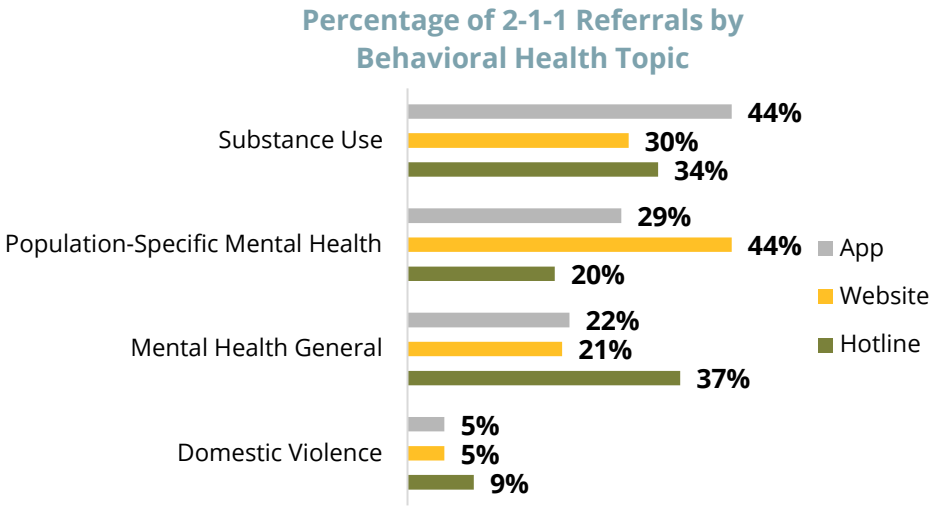
Gender Identity



n = 207
7 individuals declined to state.

Referrals

Individuals were referred to county mental or behavioral health services provided by 2-1-1 services. These services included a hotline, a website, and an app. Below are the referral sources given by each service (hotline, website, app).



Hotline N=131, Website N=1,534, App N=172

SENIOR ACCESS FOR ENGAGEMENT (SAFE)

Number Served: 627 individuals connected to services

Intended Population

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 not be paid for caregiving and must live in a non-licensed setting.

Program Description

SAFE provides services and referrals to seniors/older adults in the home, at senior centers, nursing homes, assisted living facilities, and other events for older adults. SAFE providers promote psychosocial supports and identify possible signs and symptoms of mental illness and assist them into the appropriate referral for 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

Program Activities

SAFE made 60 home visits (serving 64 individuals) and 67 facility visits (serving 280 individuals) to older adults to provide social support.

Demographics

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

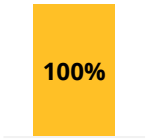
Race	
White	90%
Black or African American	6%
Asian	2%
American Indian	1%
Other	1%

n=618
7 individuals declined to state.

Ethnicity	
Hispanic	55%
Non-Hispanic	45%

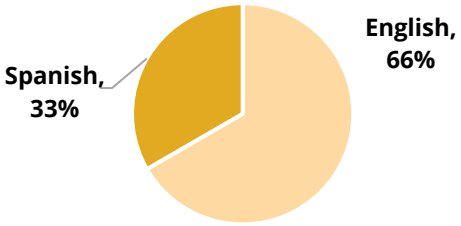
n =615
5 individuals declined to state.

Age



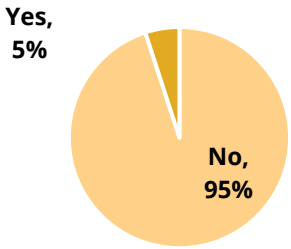
n = 627

Primary Language



n = 622

Veteran Status



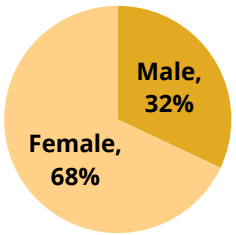
n = 627

Disability Type

None	66%
A physical disability or mobility challenge	17%
Chronic Health Condition	7%
Other	6%
Cognitive challenges	2%
Difficulty hearing or having speech understood	1%

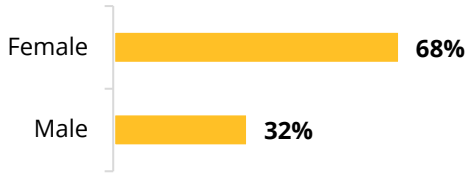
n=624
1 individual declined to state.

Assigned Sex at Birth



n = 625

Gender Identity



n = 625

Sexual Orientation

n = 626

Referrals

602 (96%) individuals referred from SAFE to another service/program were verified to have engaged with that program (i.e. confirmed linkage). 76 (13%) of the confirmed linkages were to mental health counselling (i.e. support groups). The remaining 526 (87%) confirmed linkages were to general supportive services (e.g. food assistance, mobility assistance, housing/rental assistance).

Program Accomplishments & Challenges

Accomplishments & Successes

- Continuing growth of the English and Spanish Caregiver Support Groups. This part of the program helps caregivers prevent and reduce mental health issues that commonly arise when caregiving.
- Free Senior Picnic in the Park event. This particular event created a great opportunity for our seniors to get out of their homes, reintroduce them to socialization, and enjoy the company of the community through participation in various fun activities.

Challenges

- There is the lack of respite resources for those who are unable to qualify for In-Home Supportive Services due to not qualifying for Medi-Cal. These individuals are unable to pay out-of-pocket for a caregiver.
- Due to reduced COVID-19 funds, the program had to remove a substantial number of clients from the Meals on Wheels Program. Consequently, there was a notable increase in clients' need for food resources, which has been addressed through the distribution of food vouchers. Ongoing efforts involve actively seeking diverse food bank resources for these clients. One positive outcome is the financial relief provided to seniors as a result of these measures.

Case Narrative

One particular client was struggling to ask for help with her spouse that was recently diagnosed with dementia. She came to her first group session in tears about her situation. It did not take long to take a liking to other attendees and found herself relying on the support group for advice. She was educated by a presenter from the Alzheimer's Association about dementia and Alzheimer's disease, services, and a multitude of self-care tips. She is now a regular attendee, enjoys the company, and frequently engages in our services.

OUTREACH FOR INCREASING EARLY RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS

APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST)

Number of potential responders: 74 individuals were trained through 5 trainings.

Intended Population

The intended population is caregivers who want to feel more comfortable, confident, and competent in helping to prevent the immediate risk of suicide. Over one million caregivers have participated in this two-day, highly interactive, practical, practice-oriented workshop.

Program Description

Applied Suicide Intervention Skills Training (ASIST) workshop is a two-day, highly interactive, practice-oriented workshop. Participation includes small group discussions and skills practice that are based upon adult learning principles. Participants experience powerful videos on suicide intervention and learn suicide first aid.

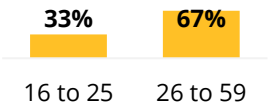
Demographics

Race

Latino or Hispanic	67%
White	33%

n=3
1 individual declined to state.

Age



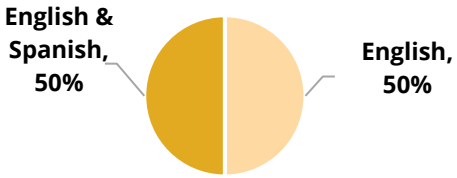
n = 3
1 individual declined to state or their age is unknown.

Ethnicity

Hispanic	
Mexican/Mexican American/Chicano	67%
Non-Hispanic	
European	33%

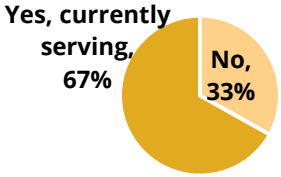
n = 3
1 individual declined to state.

Primary Language



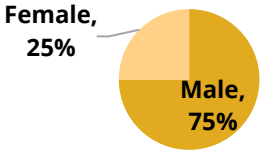
n = 4

Veteran Status



n = 3
1 individual declined to state.

Assigned Sex at Birth



n = 4

Outcomes

100% of individuals who received training from the ASIST workshop liked it a lot.

n=64; 1 individual declined to state.

100% of individuals would recommend the ASIST workshop.

n=64; 1 individual declined to state.

	% Agreed	
	Before	After
I feel prepared to help a person at risk of suicide.	32%	100%
If someone told me he or she were thinking of suicide, I would do a suicide intervention.	48%	98%

n=65

Program Accomplishments & Challenges

Accomplishments & Successes

- Continuing to help service providers and community members become comfortable with suicide interventions.
- Helping participants become more aware of the community resources available and how to access them.
- Working to certify two new trainers.
- Taking steps to avoid staff burnout and increase trainings.

Challenges

- Interest in ASIST training has been suboptimal from the community and partnering agencies.
- Expanding training to the Naval base has faced delays.

Case Narrative

We worked to get new staff to be certified as trainers.

MENTAL HEALTH FIRST AID

Number of potential responders: 46 individuals participated in 3 Adult Mental Health First Aid trainings.

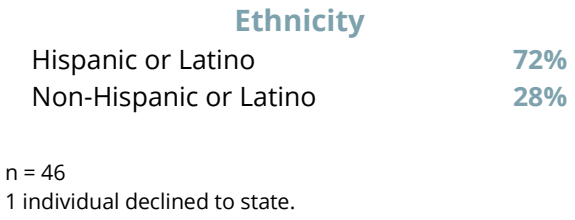
Intended Population

The Mental Health First Aid USA course has benefited a variety of audiences and key professions, including: primary care professionals, employers and business leaders, faith communities, school personnel and educators, state police and corrections officers, first responders, nursing home staff, mental health authorities, ER Staff, state policymakers, volunteers, young people, families, and the general public.

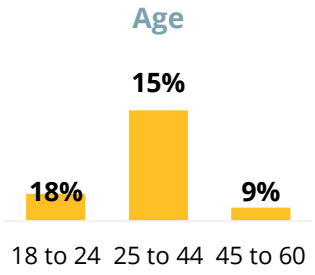
Program Description

Mental Health First Aid is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and overviews common treatments. Those who complete the 8 hours to certify as Mental Health First Aiders learn a 5-step action encompassing the skills, resources, and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

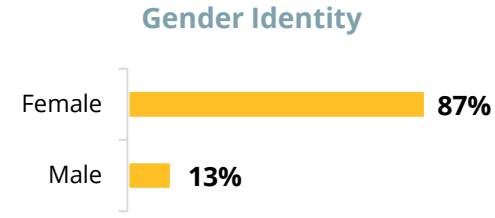
Demographics



n = 46
1 individual declined to state.



n = 44
2 individuals declined to state.



n = 45
1 individual declined to state.

Outcomes

The outcome data for the Mental Health First Aid course are from individuals who attended courses facilitated on June 8, 2023 and June 12, 2023 and completed the Adult Mental Health First Aid Post-Evaluation survey.

100% of individuals who participated in the Mental Health First Aid course would recommend the course.

n=26

Program Accomplishments & Challenges

Accomplishments & Successes

- Providing training on how to recognize early and worsening symptoms of mental illness and substance abuse.
- Teaching community participants how to intervene in mental health crises.
- Partnering with the County of Sacramento's Department of Behavioral Health to develop trainers.
- Facilitated 3 MHFA Trainings this quarter after a hiatus where no MHFA Trainings were facilitated for approximately two years.

Challenges

New trainers were unable to be fully certified until April 2023.

Case Narrative

No MHFA Trainings were facilitated during the first two quarters.

SAFE TALK

Number of potential responders: 42 potential responders trained through 3 trainings.

Intended Population: Potential responders to a mental health crisis.

Program Description

Safe TALK is a half-day training program that teaches participants to recognize and engage persons who might be having thoughts of suicide. It is designed to help participants monitor the effect of false societal beliefs that can cause otherwise caring and helpful people to miss, dismiss, or avoid suicide alerts and to practice the TALK step actions to move past these barriers.

Program Activities

Safe TALK facilitated three trainings, for Kings Partnership, NAS - Lemoore, and Corcoran School District, to community partners, officers, and school counselors during the fiscal year.

Demographics

Race

Latino or Hispanic	57%
White	36%
Black / African American	7%

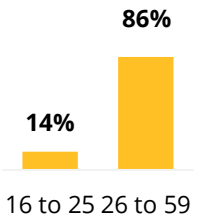
n=14

Ethnicity

Hispanic	
Mexican/Mexican American/Chicano	83%
Non-Hispanic	
European	8%
Another Non-Hispanic/Latino	8%

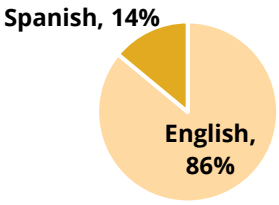
n = 12
2 individuals declined to state.

Age



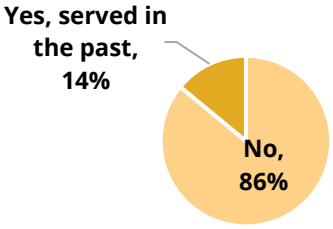
n = 14

Primary Language



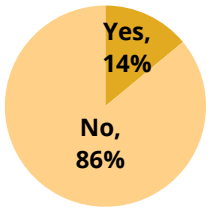
n = 14

Veteran Status



n = 14

Disability Status



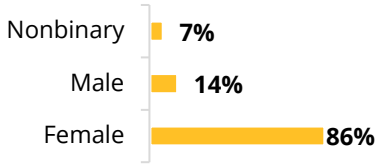
n = 14

Disability Type

Physical/Mobility Disability	40%
Post Traumatic Stress Disorder	20%
Difficulty Hearing / Having Speech Understood	20%
Chronic Health Condition/Chronic Pain	20%

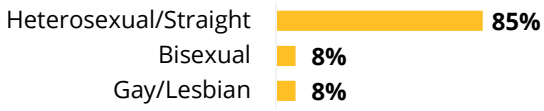
n=5
9 individuals declined to state.

Gender Identity



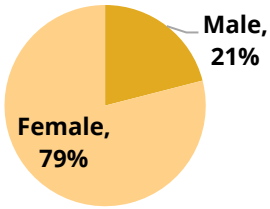
n = 14

Sexual Orientation



n = 13
1 individual declined to state.

Assigned Sex at Birth



n = 14

Outcomes

98% feel prepared to talk directly and openly to a person about their thoughts of suicide.

n=40

100% intend to tell others that they will benefit from this training.

n=40

100% of individuals trained in the workshop felt that the training they received was very good.

n=40

Program Accomplishments & Challenges

Accomplishments & Successes

- One SafeTALK training was facilitated during the fourth quarter.
- 13 service providers were trained.
- Continuing to help various types of caregivers to be suicide alert.
- Spreading awareness of the available local resources.
- Connecting the community to suicide intervention tools.

Challenges

- Agency relocation made it difficult to facilitate trainings due to time limitations.
- Agency relocation made it difficult to find conference rooms for trainings.

Case Narrative

Evaluations of the training held were very positive. However, the county does need to have more trainers. As of now, there is only one certified trainer for SafeTALK.

STIGMA AND DISCRIMINATION REDUCTION PROGRAMS

KINGS PARTNERSHIP FOR PREVENTION (KPFP)

Number Served: 567 Individuals Participated across 21 Activities

Intended Population

The target population for these services 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. Stigma and Discrimination Reduction is a community-wide effort across the County.

Program Description

The Kings Partnership for Prevention (KPFP) is a coalition in Kings County that works to create an environment of wellness throughout our 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 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.

Program Activities

The Kings Partnership for Prevention (KPFP) leads a number of program activities that include:

- Kings County Mental Health Taskforce
    - 7 taskforce meetings took place
- Substance Use Prevention Workgroup
    - 4 workgroups took place
- Red Ribbon Week Committee
    - 3 committee meeting took place
- Substance Use Prevention Learning Session
    - 1 session was held
- Substance Use Response Group
    - 3 meeting took place
- MHT & Kings Suicide Prevention Strategic Plan
    - 1 meeting took place

Program Accomplishments & Challenges

Accomplishments & Successes

- Providing resources for those struggling with addiction and mental health issues in all parts of Kings County and on social media.
- Kings County Mental Health Taskforce facilitated its first event of the fiscal year called “Mental Health Matters.”
- The Substance Use Response Group collaborated to create a social media campaign for National Prevention Week in May.
- The Substance Use Response Group facilitated Health & Wellness Week at Kings County high schools.

Challenges

- Little or no participation in some workgroups.
- Transitioning to in-person and Zoom meetings.

Case Narrative

In this last quarter, the Substance Use Response Group and the Mental Health Taskforce achieved collaboration and commitment to our community. The National Prevention Week Campaign reached around 1,300 members on our social media accounts and was shared on various organizations’ social media platforms. The Mental Taskforce’s Mental Health Matters event attracted about 30-40 community members who interacted with 13 booths and a mental health panel. The Substance Use Response Group participated in Health & Wellness Week in Avenal, Corcoran, and Lemoore high schools to provide Substance Use Prevention programs and education to students and staff.

CULTURAL HUMILITY TASK FORCE

Program Description

KCBH facilitates a Cultural Humility Task Force (CHTF) which evolved in late 2010. The Task Force is made up of community members and partnering agency staff who oversee the completion of the required State Cultural Competency Plans, annual updates to that plan, setting the training agenda for the year, and promoting culturally appropriate services throughout Kings County.

Program Accomplishments & Challenges

Accomplishments & Successes

- Of KCBH beneficiaries surveyed, 87% were satisfied overall.
- Of KCBH staff and contracted providers surveyed, 88% were satisfied overall.
- Oversaw the completion of the required State Cultural Competency Plans and annual updates to that plan.
- Set the training agenda for the year.
- Promoted culturally appropriate services throughout Kings County.
- Identified community provider training needs.

Challenges

- Maintaining consistent attendance at the monthly Cultural Humility Taskforce meeting by committee members.
- Limited representation on the Task Force by persons with lived experience.

Case Narrative

In 2022, KCBH ran multiple ad campaigns via radio/social media with iHeart Media, and Kings Area Rapid Transit (KART) to raise awareness of mental health services available and promote the new 9-8-8 Suicide Lifeline launch. The KART ad campaign includes two bus ads (the busses rotate through the Kings County routes). Both English and Spanish ads rotate through the media screens on all busses and are displayed on the only KART shelter in Avenal in both English and Spanish.

COMMUNITY OUTREACH: IHEART MEDIA

Intended Population

The target population for these services 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. Stigma and Discrimination Reduction is a community-wide effort across the County.

Program Description

Kings County utilized two main efforts to reduce stigma, increase cultural competency, and increase service connectedness in the community through media outreach campaigns via the iHeart Radio broadcasting network.

Program Activities

During fiscal year 2022-2023, there were 2 outreach campaigns, with 4,867,178 impressions.

Broadcast Campaign: Use of radio broadcasting to share information and educate the public about mental illness in English and Spanish.

1,497 Radio Commercials made 3,877,128 impressions.
These efforts include:

- B95 (KBOS-FM) – iHeart Fresno: Outreach in English on a Hip Hop FM radio station.
- Power Talk Fresno Visalia FM 96.7 and AM 1400 (KALZ-FM) – iHeart Fresno: Outreach in English on a politically conservative radio station that broadcast in both FM and AM.
- La Precisoa 92.9 FM (KFSO-FM) – iHeart Fresno: Outreach in Spanish on a Latin music FM radio station.

Digital Campaign: Use of digital marketing tools to share information and educate the public about mental illness in English and Spanish.

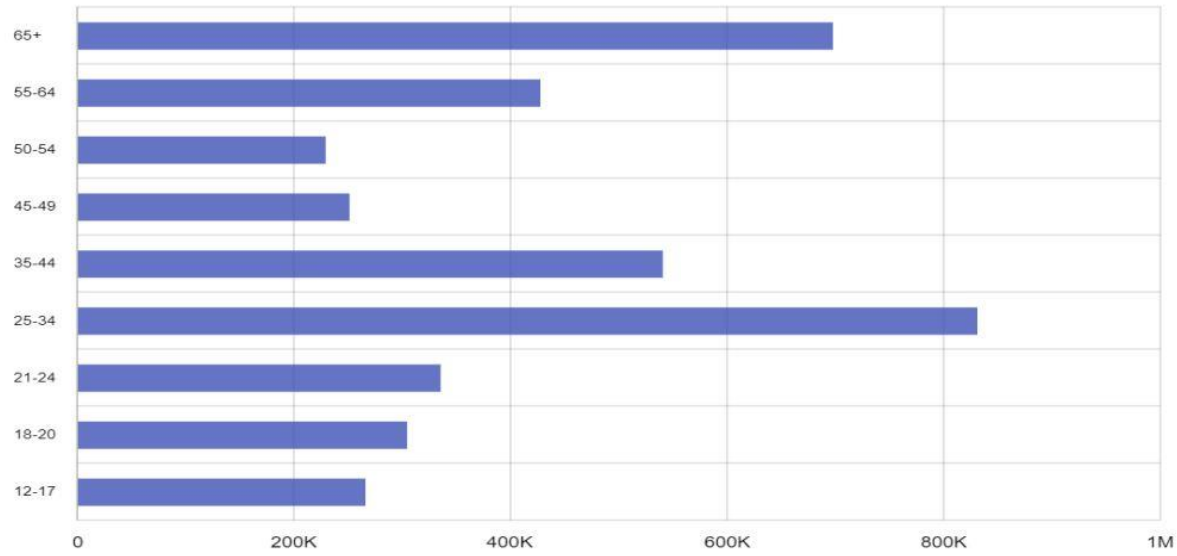
Multimedia Digital Campaign made 990,505 impressions. 801,139 impressions were made via devices and 188,911 impressions were made via digital audio played.
These efforts include:

- Smart Phone: Digital outreach to the community via Smart Phone devices.
- Media Players: Digital outreach to the community via Media Players.
- Desktop: Digital outreach to the community via Desktop Computers.
- Tablet: Digital outreach to the community via Tablets.
- Streaming Device: Digital outreach to the community via Streaming Devices.
- Smart TV: Digital outreach to the community via Smart TVs.
- Game Console: Digital outreach to the community via Gaming Consoles.

Demographics

The following figures summarize the available demographics of the individuals reached by the two campaigns. Specifically, there are data available on audience by age and audience by gender.

Audience by Age (Source: Nielsen Media Research)



Audience by Gender (Source: Nielsen Media Research)

SUICIDE PREVENTION PROGRAMS

CENTRAL VALLEY SUICIDE PREVENTION HOTLINE (CVSPH)

Number Served: 694 calls received from Kings County residents

Intended Population: Kings County residents and their family members experiencing a mental health crisis.

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: 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.

Demographics

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

Race

White / Caucasian	70%
Other	27%
American Indian or Alaska Native	1%
Black / African American	1%
More than one race	1%

n=73
Data for 621 individuals were not reported/unknown.

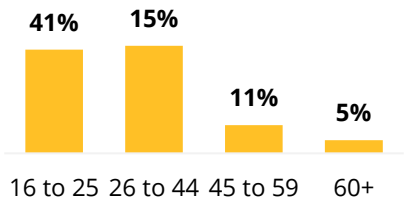
Ethnicity

Hispanic	
Mexican/Mexican American/Chicano	39%
Other Hispanic/Latino	33%
None	28%
Non-Hispanic	
Other Non-Hispanic/Latino	58%
None	35%
African	2%
Filipino	2%
Cambodian	2%
Middle Eastern	2%

Hispanic percentages:
n = 58
Data for 636 individuals were not reported/unknown.

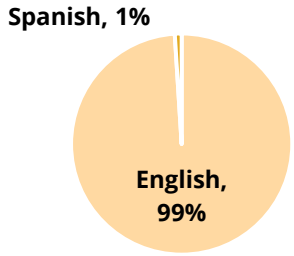
Non-Hispanic percentages:
n = 53
Data for 641 individuals were not reported/unknown.

Age



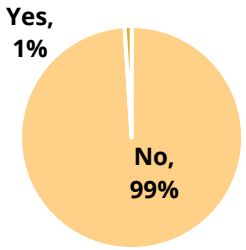
n = 148
Data for 546 were not report/unknown.

Primary Language



n = 694

Veteran Status



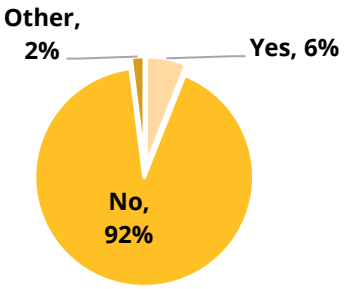
n = 146
Data for 548 individuals were not reported/unknown.

Disability Type

None	77%
Chronic Health Condition	9%
Physical/Mobility	5%
Other	5%
Mental Domain-Learning, Developmental, Dementia	4%

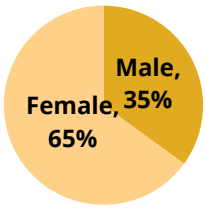
n=129
Data for 565 individuals were not reported/unknown.

Unhoused?



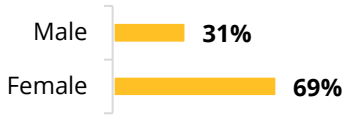
n =225
Data for 469 individuals were not reported/unknown.

Assigned Sex at Birth



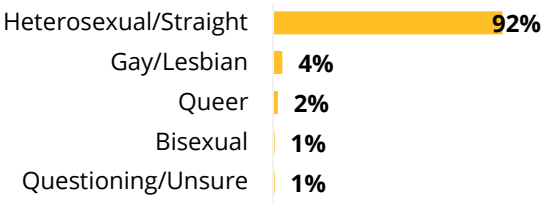
n = 355
Data for 339 individuals were not reported/unknown.

Gender Identity



n = 223
Data for 471 individuals were not reported/unknown.

Sexual Orientation



n = 157
Data for 537 were not reported or unknown.

Outcomes

Of the 197 Crisis Calls, 4 were classified as Active Rescues and 3 as Talk Downs.

DEPRESSION REDUCTION ACHIEVING WELLNESS (DRAW)

Number Served: 314 individuals served

Intended Population: College students experiencing first onset of psychiatric illness

Program Description

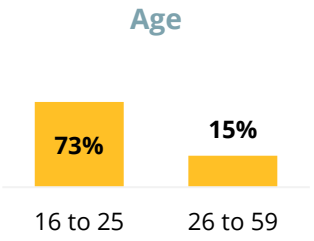
The Depression Reduction Achieving Wellness (DRAW) program is a campus-linked project that addresses the first onset of a psychiatric illness in students through collaboration with an institution of higher education. DRAW provides students with education regarding both the cultivation of wellness approaches 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.

Program Activities

- 3 presentations in Quarters 3 and 4 were given to 61 individuals
- 662 counseling sessions were given to 253 individuals

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.



n = 49

Referrals

- 102 individuals were referred by DRAW to mental health-related referrals
- 106 individuals were confirmed as linked to behavioral health services by DRAW

Non-Mental Health-Related Referrals Destinations

Destination	Count
211	58
Warmline	25
KCAO	8
Crisis hotline	2

Referrals

Total number of referral destinations does not equal the total number of individuals referred because not all individuals referred to mental health services were also referred to non-mental health-related services

Outcomes

- Individuals who completed the program decreased their burns depression score (indicating reduced depression symptoms) by an average of 23.6 points
- Individuals who completed the program decreased their burns anxiety score (indicating reduced anxiety symptoms) by an average of 18.1 points

N=70	% Agree
The counseling I received in this program helped me with my mental health problem or problems.	79%
This program helped me learn more about depression.	67%

N=70	% Unlikely
If DRAW Program counseling had not been available to you, how likely is it that you would have accessed mental health services elsewhere?	61%

Program Accomplishments & Challenges

Accomplishments & Successes

- Students have easy access to mental health services without needing to qualify for medical necessity.
- Students are offered services free of charge—which is vital, given the high number of uninsured students.
- Students can be seen within 1-2 weeks.
- Removes barriers to mental health access for students.
- Provides education via mental health and wellness presentations.

Challenges

Minimizing mental health stigma.

Case Narrative

A nursing student decided to seek DRAW services—as they were highly promoted in the nursing program. She was experiencing significant family stressors and was exhibiting anxiety and depressive symptoms. The student noticed it was negatively impacting her academics. In addition to lessening her Burns anxiety and depression scores by more than half, she was able to learn skills and techniques to help manage her mental health symptoms and was provided psychoeducation to help her have a better understanding of herself and her family dynamics. The student provided positive feedback on her experience with DRAW—as it was her first time seeking mental health services.

LOCAL OUTREACH TO SUICIDE SURVIVORS (LOSS)

Number Served: 7 unduplicated individuals and 2 unduplicated families received counseling.

Intended Population: Friends and family members of suicide victims experiencing a mental health crisis.

Program Description

Local Outreach to Suicide Survivors (LOSS), 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.

Program Activities

LOSS facilitated 21 counseling sessions in fiscal year 2022-2023.

Program Accomplishments & Challenges

Accomplishments & Successes

LOSS team prepared packets to provide to families.

Challenges

Mental health therapist position has been vacant since November 2022.

Kings County

Semi-Statewide Enterprise Health Record

Multi-County Collaborative INN Project

Annual Innovative Project Report

Reporting Period: July 1, 2022 – June 30, 2023

Project Period: January 25, 2023-January 25, 2028

KINGS COUNTY
BEHAVIORAL HEALTH

In partnership with

CalMHSA
California Mental Health Services Authority

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Project Overview and Local Need

1. Please describe this Innovation project and its purpose.

This is a multi-county, scalable INN project that stems from a larger Semi-Statewide Enterprise Health Record (EHR) project CalMHSA is concurrently leading (the EHR Project). CalMHSA is partnering with 23 California counties – collectively responsible for 27% of the state's Medi-Cal beneficiaries – on the Semi-Statewide Enterprise Health Record project.

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 in the future.

The key principles of the EHR project include:

- **Enterprise Solution:** Acquisition of an EHR that supports the entirety of the complex business needs (the entire "enterprise") of county behavioral health plans. This approach also facilitates data sharing between counties for patient treatment and payment purposes as patients move from one county to another.
- **Collective Learning and Scalable Solutions:** Moving from solutions developed within individual counties to a semi-statewide cohort allows counties to achieve alignment, pool resources and bring forward scaled solutions to current problems, thus reducing waste, mitigating risk and improving quality.
- **Leveraging CalAIM:** CalAIM implementation represents a transformative moment when primary components within the EHR are being re-designed (e.g., clinical documentation and Medi-Cal claiming), while data exchange and interoperability with physical health care — toward improving care coordination and client outcomes — are being both required and supported by the State.
- **Lean and Human-Centered**: Engaging with experts in human-centered design to reimagine the clinical workflow in a way that reduces "clicks" (the documentation burden), increases client safety and natively collects outcomes.
- **Interoperable**: Typically, county behavioral health has, in response to state regulations, developed documentation that is out of alignment with data exchange standards. We are reimagining the clinical workflow so critical information about the people we serve is formatted in a way that will be interoperable (standardized and ready to participate in key initiatives like health information exchanges).

2. Please describe how 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.

This project will meet the general requirements by making a change to an existing practice in the field of mental health, specifically, the practice of documentation of care provision in an EHR that meets the needs of the county's workforce and the clients they serve.

3. Please describe how this project impacts your County's local need(s):

Kings County Behavioral Health (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

The results of the surveys are attached; however, in summary, the stakeholders expressed the challenges with our current EHR system and opportunities with a semi-statewide multi-county EHR and patient portal:

Some of the challenges expressed (details in attached survey summary):

1. “Pulling data specific to the reports I need is very difficult.”
2. “The system is not easy to navigate, and it does not flow well.”
3. “It's too outdated and it can make doing a simple task less timely and tedious than that of a more modernized EHR.”

Client and Provider Impact:

1. When asked if the challenges expressed if applicable could cause or caused user/provider burnout, sixty-eight (68) percent (twenty-one (21) of the thirty-one (31) respondents) indicated yes.
2. When asked if the challenges experienced with the EHR detracts from direct service time with clients/family members, sixty-one (61) percent (nineteen (19) of the thirty-one (31) respondents) indicated yes.

Opportunities with new semi-statewide multi-county EHR:

1. Better reporting specifically for outcome measures, more intuitive
2. Smoother more streamlined documentation process and administrative workflows
3. One place where clinicians can see their schedule (including travel time and service location) as well as documenting the progress note to a particular appointment. In other words, if clinician’s homepage and scheduler were combined, that would be very helpful

When respondents were asked what they would hope to be achieved with the adoption of a new EHR using the following items to select from (being able to select more than one), below were the results:

1. Ninety-three (93) percent of respondents selected 'Less time spent navigating (less mouse clicks)'

2. Seventy-seven (77) percent of respondents 'More interoperability with data collected (easier to extract information)'

3. Seventy (70) percent of respondents selected 'More system direction such as flags/reminders'

4. Sixty-eight (68) percent of respondents selected 'Built in analytics (ability to query information for real-time reporting)'

5. Three (3) respondents selected 'Other' indicating:

    a. More template forms especially around assessments

    b. Intuitive system

    c. Dashboards for workflow management

    d. Patient Portal

KCBH presented this INN Project to receive feedback receive feedback at the August 24, 2022, KCBH Quality Improvement Committee (QIC) which is comprised of contracted service providers and County staff that directly utilize the Electronic Health Records system.

Progress Update and Identified Changes

1. Please describe your project progress from the date of approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC) through June 30, 2023.

KCBH has made the following project progress since the January 25, 2023 date of approval from the MHSOAC, to date:

- KCBH worked with CalMHSA on baseline data gathering for purposes of Innovation Evaluation.
- KCBH worked with CalMHSA and other transitioning Anasazi-to-SmartCare EHR counties (peer counties) on the conversion from the existing Anasazi EHR to the new SmartCare EHR, which included but was limited to, transitioning the Anasazi programs and forms structure to the SmartCare structure, exporting and importing medical record data for active clients, and inputting and training all users.
    - This conversion occurred most substantially from March 2023 through Une 2023.
- KCBH went live with the new SmartCare EHR on July 1, 2023.
- KCBH has been working during the first 6 months post-go live with addressing conversion issues, supporting and retraining users as they learn and use the new EHR, and working

with fiscal staff to ensure billing processes occurs successfully through the new EHR especially since the new CalAIM Payment Reform also took effect July 1, 2023.

2. Has your county experienced any changes in project implementation and/or local need since the submission of your Appendix for MHSOAC approval? What is/are the reason(s) for this/these change(s)?

KCBH has not experienced any changes in project implementation and/or local need since the submission of the project to the MHSOAC. However, the conversion from one EHR to another with over 20 counties and to a newly developed records system encompassing the new CalAIM Payment Reform rates, CPT codes, etc. has proven to be far more technically complex task than originally anticipated, and as such, the technical support in addressing initial issues and supporting users during this transition has dominated the first six months post-go live. It was initially anticipated the transition would be most predominate the first three-month post go-live with the subsequent quarters focused on dashboard and report generation as well as personal health record development. Dashboard and report generation is now anticipated for January-June 2024 and the personal health record is anticipated during fiscal year 24/25. While the project is proving to be far more complex, KCBH has anecdotal began to hear from local users their ability to see the benefits this new EHR will provide to clients, providers, and administration once outside of the transition period.

3. How does this change/these changes noted in #2 above impact or modify your project plan and/or timeline?

N/A, no changes.

CalMHSA's Internal Evaluation and Qualitative Analysis of the State of Electronic Health Records Across California Counties

During this project period, CalMHSA partnered with IDEO, a global design and research company with over 40 years of consulting experience working in social and government sectors. IDEO was uniquely positioned to assist CalMHSA based on their strong focus on capacity building and creating new, strategized approaches to previously unsolved problems. CalMHSA, at the request of participating counties, sought to create a semi-statewide EHR system, built according to the needs of the user, that not only meets documentation and regulatory requirements, but also integrates provider needs for transparent communication, augments support for decision-making and best practices and, through increased efficiency, reduces staff burnout and improves workforce retention.

IDEO conducted interviews with county staff from participating county agencies, primarily focused on outpatient psychiatry services, to better understand different users' interactions and needs within an EHR. The staff interviewed included doctors, nurses, social workers and peer counselors. Forty-four Kings County Behavioral Health staff and providers participated in these interviews. IDEO also met with EHR experts and analogous experts, such as digital storytellers, data visualization scientists, and behavioral scientists to draw inspiration for what was possible for this future EHR vision. They also conducted an in-depth analysis of the transitional EHR, SmartCare, to better understand what could be leveraged versus what would need to be customized to achieve the goals as stated above.

Some key needs identified from these interviews included:

- An improved EHR design that allows for a holistic view of patient data rather than siloed across different areas of the software
- Better facilitation of record keeping and sharing across the platform
- Improved utilization of automaticity and intentional pauses as moments to accurately capture structured data to reduce redundancy, disseminate key information and promote best practices while maintaining flexibility and trust amongst users
- Transparent dialogue and a disruption of bias patterns in the software so the data entered can promote equitable outcomes and care

Evaluation Data/Learning Goals/Project Aims

CalMHSA contracted with the RAND Corporation during this project period to conduct a comprehensive evaluation of the project. To ensure a systematic evaluation of the migration to the new EHR platform, RAND is employing two measurement approaches: 1) a pre-post user survey, 2) pre-post task-based usability testing. RAND selected evidence-based EHR metrics grounded in measurement science that are precise, reliable and valid.

The goal of the pre-post user survey is to measure user experience and satisfaction of existing EHRs and the new EHR across all participating counties. This pre-phase of the survey was administered during this project period and prior to the "go-live" implementation of the new EHR system. It was sent to all EHR users in participating counties (see Exhibit 1 for Pre-Survey User Data). The survey (see Exhibit 2) included outcome measures such as the Post-Study System Usability Questionnaire (PSSUQ), satisfaction with EHR attributes, satisfaction with specific tasks in the EHR, and likelihood of recommending the EHR. The PSSUQ is a 16-item standardized questionnaire that originated from the IBM project called System Usability Metrics in 1988. This standardized tool allows for a single metric to be calculated as an average of the 16 items, which provides a reliable measure that can be compared to other studies that have used the tool. The tasks included in the survey were also based on the most common use cases across different role types (e.g., prescribers, medical staff, licensed clinicians, non-licensed providers and administrators).

The goal of the pre-post task-based usability testing is to obtain objective measures of EHR usage and burden (as measured by the length of time required to complete specific, common tasks in the EHR) before and after the migration to the new EHR. The pre-phase of this usability testing was conducted from May 30, 2023, to June 30, 2023, and included 30 prescribers and licensed clinicians in the select counties who opted to participate. The usability tests asked each participant to complete three tasks in a simulated EHR environment with simulated client scenarios. Tasks included creating an assessment/evaluation and progress note for a new client visit, reviewing a chart for an existing client and creating a progress note for a return client visit. The outcome metrics included task completion rate, time on task, errors and post-task satisfaction. These usability tests complement the user survey to provide objective measures of the EHRs in a controlled environment.

The post-phase of the survey and task-based usability testing will likely occur in approximately January/February 2024 to allow users to become accustomed to the new EHR platform. The optimal time to conduct a post-migration assessment is when users have established stable and sustainable behaviors, which has typically been three to six months after implementation. The post-survey will also address the original learning goals and project aims regarding quality, safety/privacy, satisfaction and outcomes.

Overall, the evaluation will eventually allow for an assessment of how the transition to the new EHR resulted in changes to usability and user satisfaction.

Learning Goals/Project Aims

Quality

- Comprehensiveness of client care
- Efficiency of clinical practice
- Interactions within the health care team
- Clinician access to up-to-date knowledge

Safety/Privacy

- Avoiding errors (i.e., drug interaction)
- Ability to use clinical data for safety
- Personal and professional privacy

Satisfaction

- Ease of use
- Clinician's stress level
- Rapport between clinicians and clients
- Client's satisfaction with the quality of care they receive
- Interface quality

Outcomes

- Communication between clinicians and staff
- Analyzing outcomes of care
- System usefulness
- Information quality

Future annual reports will include status updates on the above learning goals and project aims.

Program Information for Individuals Served

This project focuses on transforming current EHR systems and processes counties use for the provision of behavioral health services. Accordingly, we have not estimated the number of individuals expected to be served annually. As noted previously, the participating counties in the Semi-Statewide Enterprise Health Record project are collectively responsible for serving the population of Medi-Cal beneficiaries who need specialty mental health and/or substance use disorder treatment services among approximately 27% California's Medi-Cal beneficiaries, or among approximately 4,000,000 people.

Regarding specific project information on individuals to served, this project focuses on transforming the current EHR system and the processes California counties use for the provision of behavioral health services rather than directly testing an innovative approach to service delivery.

Budget and Annual Expenditures

REPORTING PERIOD: *7/1/2022 - 6/30/2023*	BUDGET	INNOVATIVE PROJECT	ADMINISTRATION	EVALUATION	
INNOVATION FUNDS	763,061	768,669	645,422		
MEDI-CAL FEDERAL FINANCIAL PARTICIPATION		0	0	0	
1991 REALIGNMENT		0	0	0	
BEHAVIORAL HEALTH SUBACCOUNT		0	0	0	
ANY OTHER FUNDING		357,631			
TOTALS		1,126,300	645,422	-	1,771,722

Exhibit 1 – Pre-Survey User Data

1. **User Roles**
    a. 96 prescribers
    b. 121 prescriber med staff
    c. 730 clinician LPHA
    d. 723 non-LPHA
    e. 1081 admin
    f. 17 other
    g. 157 no response

2. **Users by County (Please note: Counties participating in the Multi-County INN project are noted with an "*" below)**
    a. Colusa - 5
    b. Contra Costa - 6
    c. Fresno - 290
    d. Glenn - 29
    e. Humbolt* - 67
    f. Imperial* - 189
    g. Kern - 585
    h. Kings* - 44
    i. Lake - 74

j. Marin - 29
k. Mono* - 16
l. Placer* - 103
m. Sacramento - 303
n. San Benito* - 20
o. San Joaquin* - 165
p. San Luis Obispo - 119
q. Siskiyou* - 27
r. Sonoma* - 101
s. Stanislaus - 104
t. Tulare* - 232
u. Ventura* - 299
v. Other - 9
w. Did not respond - 89

Exhibit 2 – Pre-Survey Questions

Usability and Satisfaction Metrics

A. PSSUQ: On a scale between "Strongly Disagree" and "Strongly Agree," please rate the following statements (1 - Strongly Disagree to 7 - Strongly Agree).

1. Overall, I am satisfied with how easy it is to use this system.
2. It was simple to use this system.
3. I was able to complete the tasks and scenarios quickly using this system.
4. I felt comfortable using this system.
5. It was easy to learn to use this system.
6. I believe I could become productive quickly using this system.
7. The system gave error messages that clearly told me how to fix the problems.
8. Whenever I made a mistake using the system, I could recover easily and quickly.
9. The information provided with this system was clear.
10. It was easy to find the information I needed.
11. The information was effective in helping me complete the tasks and scenarios.
12. The organization of information on the system screens was clear.
13. The interface of this system was pleasant.
14. I liked using the interface of this system.
15. The system has all the functions and capabilities I expect it to have.
16. Overall, I am satisfied with this system.

B. Based on your experience, please indicate how satisfied you are with the way your EHR performs on the following items (1 - Very Dissatisfied to 5 - Very Satisfied, NA).

1. Ability to use the EHR without needing IT or additional support
2. Supports delivery of quality healthcare
3. Interactions within the care team
4. Amount of time spent in the EHR
5. Your stress level

6. Rapport between providers and clients
7. Data privacy and security
8. Access to up-to-date information
9. Usefulness of alerts
10. Comprehensiveness of client care
11. Efficiency of clinical practice
12. Avoiding errors (such as overlooking a drug interaction, selecting the wrong intervention or scheduling the wrong service time)
13. Amount of information presented on each screen
14. Amount of data entry required
15. Response time (i.e., speed of system response or loading time)
16. Reliability (i.e., system performs correctly every time)
17. Costs of providing care
18. Inclusivity or adequacy of demographic data fields

C. Based on your experience, how satisfied are you with the way your EHR allows you to perform the following tasks? (1 - Very Dissatisfied to 5 - Very Satisfied, NA)

1. Review progress notes
2. Obtain and review lab results
3. Obtain and review imaging or test results
4. Review past and current medications or prescriptions
5. Identify allergies
6. Update medication lists
7. Enter a progress note with all relevant service indicators (e.g., person contacted, contact type, place of service, service intensity, etc.)
8. Create and maintain problem lists
9. Customize templates
10. Prevent providers from signing a document if required fields are not complete
11. Link a new episode or admission record to previous care coordination activities
12. Enable documentation of social determinants of health (SDOH) or Z-codes
13. Bill for services in a timely manner
14. Complete a psychosocial assessment or screening
15. Enter new outpatient lab orders
16. Enter orders for other tests
17. Add/renew/discontinue prescriptions
18. Receive drug interaction or dosage error alerts when writing prescriptions
19. Receive drug allergy alerts when writing prescriptions
20. Prevent other adverse events
21. Schedule appointments
22. Manage a closed-loop referral process (i.e., make a referral to an outside entity and track if the referral was completed)
23. Manage client caseload (e.g., identify people at risk or those who have not engaged in services in the last 60 days)
24. Run reports on metrics across your client network (e.g., number of clients dealing with homelessness, timeliness to treatment, number of referrals, etc.)
25. Analyze outcomes of care

26. Send quality measures to other entities (e.g., preventive screening rates)
27. Facilitate continuity of care and follow-up across organizations or providers
28. Communicate with clients electronically
29. Generate documents in my client's preferred language

D. How likely are you to recommend this EHR to a colleague? (0-to-10-point scale)

Kings County Behavioral Health
MHSA Annual Innovation Project Final Evaluation Report
Multiple Organization Shared Telepsychiatry (MOST) Project

Kings County

Final Innovation Project Report

Welfare & Institutions Code (WIC) 3850

Title 09, California Code of Regulations (CCR)

_____

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

December 2023

Kings County Behavioral Health
MHSA Annual Innovation Project Final Evaluation Report
Multiple Organization Shared Telepsychiatry (MOST) Project

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Kings County Behavioral Health
MHSA Annual Innovation Project Final Evaluation Report
Multiple Organization Shared Telepsychiatry (MOST) Project

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) secured 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.

Methodology

Kings County Behavioral Health (KCBH) contracted with Evalcorp, a professional evaluation company, to support an assessment of the Multiple Organization Shared Telepsychiatry (MOST) Program. The program sought to answer two questions.

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?

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

Across the project term (July 1, 2019 through June 30, 2023), EVALCORP developed and employed a mixed-methods approach, utilizing quantitative and qualitative data collection methodologies to obtain information on program activities and outcomes. During the reporting period, four primary types of data collection strategies were implemented including:

- Adult Baseline Survey (n=21-22). Distributed to all adult participants upon entry to the program.
- Adult Follow-up Survey (n=30-33). Distributed to all adult participants after 90 days in the program or upon program completion/when transitioning to a lower level of care.
- Family Member Survey (n=11). Distributed to all guardians of youth participants after 90 days in the program
- Key Stakeholder Interviews (program staff and partner agency staff). Conducted twice during the project term with a total of X participants.
- Participant Focus Group. Conducted with 7 adult program participants.

EVALCORP also developed a comprehensive spreadsheet to collect program implementation data and process metrics.

Limitations

Due to many factors, not the least being the COVID-19 pandemic, the county was unable to implement the original vision of the MOST program. A shared telepsychiatric suite was not developed with partner agencies, additional sites in Avenal and Corcoran, and children's services were delayed.

Despite the setbacks with full implementation, the program has had a positive impact on intended beneficiaries.

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. In the survey, beneficiaries were asked whether peer support would make them more comfortable, be helpful, improve understanding with the Psychiatrist, and improve self-advocacy. There were marked improvements in responses to these questions between the baseline and follow-up survey. For example, only 71% of survey respondents on the baseline survey indicated that they believed peer support would make them more comfortable, but at follow-up this increased to 90% of respondents. 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 involvement with a peer support specialist leads to benefits they would otherwise not experience. For example, peer involvement supports the goal setting environment and leads to more realistic goals and the co-creation of strategies. 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, 94% of beneficiaries agreed.

Learning Goal 1, Outcome 3: Reduce No-show Rate

Results of evaluation suggest that the involvement of a peer support specialist reduces no-show rates. 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, 84% of respondents agreed on the Adult Follow Up Survey.

Through administrative data collected on appointment attendance, 85% of appointments were attended by adult beneficiaries. This is a 12% increase in the attendance rate from the prior fiscal year. While 57% of appointments were attended by child beneficiaries. This is a 4% increase in the attendance rate from the prior fiscal year.

Learning Goal 1, Outcome 4: Transform Telepsychiatric Services from a Medical to a 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 helps 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, 65% 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 13% 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 nearly all agree that the MOST program helps with more than just medical needs.

Learning Goal 2, Outcome 1: Transitions to Lower Levels of Care

Information about beneficiary transitions to different levels of care is collected using the MOST Program Tracking Log. Across the project term, 69 beneficiaries were discharged from the

program, 13 of whom were transitioned to a lower level of care (19%). Nine beneficiaries were discharged for other reasons including: non-compliance, administrative reasons, relocation, incarceration, and death.

Learning Goal 2, Outcome 2: Reduced Wait Times for Initial and Follow-up Appointments

For adult beneficiaries, more than a third (41%) 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. Nearly half of child referrals (49%) 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 crises in the past three years on the Baseline Survey and since being enrolled in the MOST program on the Follow-up Survey. While 50% of respondents of the Adult Baseline Survey (n= 24) indicated that they had been hospitalized for mental illness in the past three years, only 17% 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 crises 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. Due to program staff turnover, this data was not available for beneficiaries from the 2022-2023 fiscal year. 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 the MOST program on the Adult Baseline and Follow-up surveys. The number of individuals who, on the Follow Up Survey (31%, n=31), self-reported an emergency department crisis evaluation visit since MOST program enrollment is lower than those who reported an emergency department crisis evaluation prior to MOST program enrollment on the Adult Baseline Survey (54%; 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 (14%) is lower than those who reported an arrest in the three years prior to MOST program enrollment on the Adult Baseline Survey (42%).

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. Additionally, more information will be required to fully understand the program's impact on youth beneficiaries and their families.

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. 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 supported by peers and family.

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 SMI among adults and children in households with incomes below 200% of the Federal Poverty Level are higher, at 8% and 9%, respectively.[2] In addition, despite having one of the highest rates of SMI, Kings County, like other rural California counties, has a shortage of psychiatrists.

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 historically 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 SMI to seek treatment at local hospitals and emergency departments or go untreated which can often result in incarceration 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 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

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

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 a peer 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 in the state of California 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 a county agency.

Over the course of the project, KCBH planned to establish telepsychiatry suites in three cities (Hanford, Avenal, and Corcoran) and serve over 250 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. One exception is for those with urgent conditions; this includes individuals who have been released from Sheriff's Department custody and require same-day psychiatric care.

Since June 2019, KCBH has provided on-site staff support for a contracted remote psychiatrist. Paid, trained peer support specialists have provided 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. When necessary, and with the beneficiary's consent, a peer support specialist has attended sessions with the beneficiary to provide support and language interpretation.

An additional benefit of this project is that it is simple and highly replicable for other California counties.

Overall, this model improved beneficiary outcomes, reduced stigma around psychiatric services, increased engagement, and assisted with retention of participants.

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 2019 – 2020 through FY 2022-2023

- 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 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 the 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 was 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 started billing Medi-Cal in Quarter 1 of FY 2020/2021 and billed retroactively 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 suspended transportation support to beneficiaries.

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. Transportation support resumed XX.

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 remote operations smoother and increasing 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 led to indefinitely postponing the site expansions proposed for 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 163 beneficiaries (105 adult and 58 children) served during the reporting period 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 the reporting period, 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.

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),
- their perceptions on whether peer support specialist involvement reduces 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).

Beneficiary Focus Groups.

A focus group was conducted with program beneficiaries in the Spring of 2023. 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.

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, surveys and focus groups were utilized to investigate how the MOST Program improved the perceived value of peer involvement. Findings from each evaluation strategy are presented below.

MOST Program Staff Perceptions of Peer Involvement

Program staff highlighted the profound impact peer support specialists have by advocating for beneficiaries who struggle with self-advocacy. They can ask questions that the beneficiaries may find difficult or uncomfortable to articulate themselves, ensuring that their concerns are heard and addressed. Furthermore, during appointments, peer support specialists provide invaluable support, particularly when beneficiaries feel intimidated or have complaints. By serving as a constant presence and a reminder that the treatment team is on their side, peer support specialists create an environment of trust and teamwork. This fosters a sense of empowerment for beneficiaries, making them feel less alone in their journey toward wellness and recovery.

Additionally, the presence of a peer support specialist is perceived by program staff as beneficial for providing moral support and a sense of comfort to beneficiaries. Program staff expressed that peer support specialists spend more time with beneficiaries than clinicians do, leading to a stronger rapport and a deeper understanding of beneficiaries' needs and experiences. The familiarity and trust developed between beneficiaries and peer support specialists contribute to the effectiveness of the support provided. When beneficiaries are going through a tough time or may not be comfortable sharing with the clinician, having a peer support specialist present allows beneficiaries to express themselves fully.

Partner Agency Staff Perceptions of Peer Involvement

Agency staff responses indicated having limited experience with peer support specialists in mental health appointments because they are not present during appointments. Agency staff acknowledge the potential benefit of having a peer support specialist for beneficiaries who struggle with advocating for themselves. These individuals may rely on peer support specialists to help them communicate their needs and concerns effectively, bridging the gap between the beneficiary and the clinician. The support provided by peer support specialists is perceived as valuable by agency staff in these cases.

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.

MOST Program Beneficiary Perceptions of the Value of Peer Involvement

Table 1. Beneficiary Perceptions of Anticipated Peer Involvement (n=21-22)		
	Baseline Survey	
	Agree	Disagree
I think it will be helpful to have a peer support specialist with me when I have mental health appointments.	82%	18%
I believe having peer support will be helpful for meeting my mental health and wellness recovery goals.	95%	5%
I think having peer support will help me feel more comfortable at my mental health appointments.	71%	29%
I think having peer support will help me to feel more understood during my mental health recovery.	90%	10%
I think having peer support will help me advocate for myself.	86%	14%

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 2. Beneficiary Perceptions of Peer Involvement (n=30-33)		
	Follow-up Survey	
	Agree	Disagree
It has been helpful to have a peer support specialist with me when I have mental health appointment	93%	7%
Having a peer support specialist has been helpful for making progress on my mental health and wellness recovery goals	94%	6%
Peer support helps me feel more comfortable at my mental health appointments	90%	10%
Peer support helps me to feel more understood during my mental health recovery	87%	13%
Having peer support has helped me advocate for myself	88%	12%

Results indicate a positive experience throughout services. While Baseline Surveys showed a less positive outlook regarding how comfortable beneficiaries would be with peer support involved in mental health appointments, 90% of Follow-up Survey respondents shared that peer involvement in mental health appointments helped them feel more comfortable.

In the Spring of 2023, 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.

Responses from MOST beneficiaries reflect a high level of perceived value of the peer support specialist and program. Positive themes were represented across responses including advocacy, general support, social support, comfort, and a sense of reliability and satisfaction with the peer support specialist.

Client advocacy and general support were recurrent themes in beneficiaries' responses. These responses reflect that the peer support specialist often assisted with tasks and issues outside of what beneficiaries consider typical mental health treatment. Multiple responses mentioned the peer specialist assisting with finding housing or helping with meals and supplies when unhoused. Beneficiaries also reported help with utilities, chores, obtaining transportation for errands outside of medical and mental health appointments, and arranging and confirming medical and mental health appointments. These additional services were highly appreciated by beneficiaries.

Additional themes in beneficiaries' responses reflected softer forms of support. Beneficiaries expressed value in the comfort with, perceived social support from, and sense of reliability and dependability that all came from interactions with the peer support specialist. Multiple responses mentioned that they felt the peer specialist cared about them, even when their familial ties had been lost as a result of their mental health. Feelings of being cared for often appeared to stem from the reliability of the peer specialist when beneficiaries would reach out of assistance. These positive overall impressions of the MOST program mitigated reports that beneficiaries sometimes felt the program was lacking staffing resources, resulting in some missed appointments or inability to get help in some instances.

The examples shared above reflect experiences with a peer support specialist where the beneficiary was in or close to being in a crisis situation. Observing the peer support specialist recognize their situation and act in ways to prevent or lessen the severity of the situation, resulted in beneficiaries expressing very close connections and strong bonds of trust with the peer specialist.

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 Table 3).

Table 3. Beneficiary Perceptions of Peer Involvement (n=11)			
	Agree	Disagree	n/a
It has been helpful to have a peer support specialist with my family member when they have mental health appointments	64%	0%	36%
Having a peer support specialist has been helpful for my family member in making progress toward their mental health and wellness recovery goals	82%	0%	18%
Peer support helps my family member feel more comfortable at their mental health appointments	73%	0%	27%
Peer support helps my family member feel more understood during their mental health recovery	73%	0%	27%
Having peer support has helped my family member advocate for themselves	64%	9%	27%

Results from the Family Member Survey reflect a favorable perception of peer involvement across several indicators. It is notable that several responses suggest that there was no peer involvement.

Outcome 2: Beneficiaries are Meeting Wellness and Recovery Goals

Interviews, surveys and focus groups were utilized to investigate how peer involvement in the MOST Program supported beneficiaries in meeting wellness and recovery goals. Findings from each evaluation strategy are presented below.

MOST Program Staff Perceptions of Peers' Impact on Wellness and Recovery Goals

Peer support specialists help beneficiaries identify and pursue their own goals. By sitting with beneficiaries and engaging in open discussions, peer support specialists empower individuals to believe in their ability to set and achieve those goals. The relationship with a peer support specialist serves as a source of encouragement and motivation for beneficiaries to move forward in their wellness and recovery journey. Through collaborative goal setting, beneficiaries gain a sense of ownership and empowerment over their own lives. Peer support specialists provide guidance and support as beneficiaries work towards their goals, instilling a belief in their capacity to overcome challenges and make meaningful progress.

In addition to practical assistance, peer support specialists offer emotional support and serve as thought partners for beneficiaries. Beneficiaries value the emotional support provided by peer support specialists during their wellness journey. Peer support specialists become trusted confidants, creating a safe space for beneficiaries to express their thoughts and emotions. Moreover, peer support specialists help beneficiaries learn from old habits and make positive choices. They provide guidance, encouragement, and alternative perspectives, helping beneficiaries navigate challenges and make decisions that align with their wellness and

recovery goals. Beneficiaries rely on the thought partnership of peer support specialists to stay on track and maintain their progress.

Partner Agency Staff Perceptions of Peers' Impact on Wellness and Recovery Goals

Agency staff expressed that peer support specialists support beneficiaries by helping them become more self-sufficient in reaching their wellness and recovery goals over time. Through role-playing and practicing conversations and confrontation, beneficiaries gain confidence in effectively communicating the signs and symptoms they are experiencing during appointments. This skill-building approach equips beneficiaries with the tools to advocate for themselves, ensuring that their voice is heard, and their treatment aligns with their goals.

Peer support specialists help beneficiaries by providing consistent support and helping them develop a sense of agency in their wellness and recovery journey. The emotional support, thought partnership, and guidance offered by peer support specialists contribute to beneficiaries' overall well-being and promote positive choices.

MOST Program Beneficiary Perceptions of Wellness and Recovery Goals

The focus group enabled participants to how the peer support specialist supports the progress they make toward their personal wellness and recovery goals. Conversations throughout the focus group suggested several factors that were important for achieving wellness and recovery goals. Key to the dialogue was the elevated importance of a supportive environment and the logistical support that the peer specialist provides. Beneficiaries reflected on how the MOST staff and peer support specialist create this sort of environment through thoughtful interactions and showing that they understand the mental health issues that beneficiaries may be going through at any moment. Equally important was the logistical support that the peer support specialist provides. Beneficiaries mentioned that the reminder calls help them stay on track toward meeting their goals, as they struggle with memory issues and, at times, a lack of motivation.

The support that the MOST program provides before and during appointments was supplemented by other support for basic needs such as finding shelter, home, or a place to stay, providing food supplies or gift cards, and even helping find employment or social security income.

Additionally, as shown in Table 2, 94% of Follow-up Survey respondents shared that peer support has been helpful for making progress on mental health and wellness recovery goals.

Overall, information shared by beneficiaries suggests that the MOST program, in part due to the peer support specialist, is providing effective support and assistance to individuals in achieving their recovery goals. The MOST program helps individuals feel comfortable with mental health support by cultivating a supportive environment. And after helping beneficiaries make their appointments, MOST staff then look for additional ways to support beneficiaries' additional needs, giving them space to work through mental and emotional issues.

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. Findings from each evaluation strategy are presented below.

MOST Program Staff Perceptions of Peers' Impact on Reducing No-Show Rate

Peer support specialists help beneficiaries keep their mental health appointments through appointment reminders and check-ins. While the MOST program staff expressed a strong believe that peer support specialists are helpful in reducing the no-show rate for mental health appointments, it was mentioned that beneficiaries may still forget or be resistant to appointments, resulting in occasional missed appointments. However, reminder calls, a key activity of the peer support specialist, were mentioned as a very helpful prompt for beneficiaries, especially for those who may struggle with memory or organizational skills.

Peer support specialists also maintain regular check-ins with beneficiaries between appointments. These check-ins serve multiple purposes, including providing friendly reminders about upcoming appointments. By maintaining ongoing communication, peer support specialists not only reinforce the importance of attending appointments but also offer support and encouragement to beneficiaries. This personal connection helps to keep beneficiaries engaged in their wellness and recovery journey and reinforces their commitment to attending appointments.

Another way in which peer support specialists help beneficiaries keep their mental health appointments is by offering transportation assistance. Some program staff mentioned that peer support specialists go the extra mile by picking up beneficiaries from their homes and accompanying them to their appointments. By ensuring that beneficiaries have a reliable means of reaching their appointments, peer support specialists help eliminate transportation-related barriers that may hinder attendance. This support not only increases the likelihood of beneficiaries attending their appointments but also demonstrates the dedication of peer support specialists to the well-being and care of their beneficiaries.

Partner Agency Staff Perceptions of Peers' Impact on Reducing No-Show Rate

While agency staff had limited firsthand knowledge of the specific ways in which peer support specialists contribute to appointment adherence, they highlighted the potential benefits of peer support in appointment reminders. By offering reminder assistance, peer support specialists provide an additional layer of support and encouragement to ensure that beneficiaries stay on track with their mental health appointments.

Moreover, peer support specialists can assist beneficiaries in establishing scheduling patterns that promote regular attendance. Through this joint effort, the peer support specialist works to empower beneficiaries to take ownership of their appointments and prioritize their well-being.

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

MOST Program Beneficiary Perceptions of Attendance of Appointments

Consistent with follow up surveys, beneficiaries in the focus group confirmed that the support from the peer specialist helps them get to their appointment on time. The reminder calls were confirmed as really important as they often forget about appointments due to memory loss caused by medication. Additionally, when peers are unable to make it to an appointment because they don't have transportation, they shared that the peer support specialist is happy to provide the needed transportation.

Conversations regarding appointments went past the logistical support. Peers also mentioned that the emotional support provided by the peer specialist has had an impact on their attendance at appointments. Feeling cared for and supported through random check in calls and emotional support through other barriers motivates them to make their appointments. Participants also highlighted this type of socio-emotional support as consistent and reliable, evidence of the high levels of trust and rapport needed for beneficiaries to feel and remain connected to care.

Additionally, beneficiaries were asked on the Follow-up Survey whether having peer support helps them keep their mental health appointments. Out of 32 responses on the Follow-up Survey, 84% 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 ten family members who responded, seven agreed that peer support helped their child keep their mental health appointments. Three remaining responses selected "I don't know/Not Applicable."

Secondary Data Analysis of Appointment Attendance

For the adult beneficiaries that were enrolled in the MOST Program, 1,518 appointments were scheduled. Of those scheduled appointments, 85% were attended. On average, beneficiaries attended 11.5 appointments and missed an average of 4.3 appointments. Overall, approximately 15% of appointments were missed.

Of the children enrolled in the MOST program, 725 appointments were scheduled. Of scheduled appointments, 57% were attended. On average, child beneficiaries attended 7.5 appointments and missed an average of 6.0 appointments. Overall, approximately 43% of appointments were missed.

Outcome 4: Transform Telepsychiatric Services from Medical to a 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. Findings from each evaluation strategy are presented below.

MOST Program Staff Perceptions on Shifting to a Wellness and Recovery-Based Model of Care

Peer involvement is highly valued within this model as it emphasizes the importance of addressing the individual's overall well-being, including their family, job, and personal beliefs. Unlike a strictly medical approach, the wellness and recovery model considers various pathways to wellness, such as yoga, religion, and other avenues. Peer support specialists provide additional support to beneficiaries, filling gaps in care, and addressing aspects beyond medical treatment. By advocating for beneficiaries, and fostering human connection, peer involvement aligns with the person-centered approach of the wellness and recovery model, empowering beneficiaries to make choices that align with their unique strengths, struggles, and goals.

One of the advantages of peer involvement in transforming telepsychiatric services is the creation of non-hierarchical relationships. Peer support specialists bring a different dynamic to interactions compared to medical personnel. As equals who can relate to beneficiaries' experiences, they provide validation, understanding, and support without the perceived hierarchy often associated with medical professionals. This equality in the relationship is crucial for engaging beneficiaries and encouraging their active participation in their treatment. Furthermore, by incorporating insights from peer support specialists, clinicians, and other team members, a collaborative team approach is fostered. This approach ensures that the beneficiary's needs and preferences are comprehensively understood and addressed. The integration of different perspectives allows for a more holistic understanding of the individual's well-being and facilitates a more effective and personalized approach to care.

Partner Agency Staff Perceptions on Shifting to a Wellness and Recovery-Based Model of Care

Peer support is instrumental in the transformation of telepsychiatric services as it provides beneficiaries with relatability and inspiration. Peer support specialists oftentimes have gone through similar experiences and can understand the beneficiaries' current challenges. The peer support specialist serves as role models and sources of inspiration for beneficiaries, instilling hope and demonstrating that recovery is possible.

Another key aspect of peer support that works to transform psychiatric services to a wellness and recovery model is its commitment to skill development and practice. The peer support specialist assists beneficiaries in learning how to advocate for themselves, express their signs and symptoms effectively, and engage in meaningful conversations during appointments. Activities such as role-playing, practicing confrontation, and rehearsing conversations are utilized to build beneficiaries' skills and confidence. Peer support offers a safe space for

beneficiaries to practice and be heard, enabling them to find their voice and actively participate in their treatment.

Peer support plays a crucial role in the transformation of telepsychiatric services from a medical model to a wellness and recovery-based model of care as a holistic element of telepsychiatric services that recognizes the individuality of each beneficiary. Thus, in turn, improves the overall wellness and recovery of beneficiaries in a telepsychiatric setting.

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

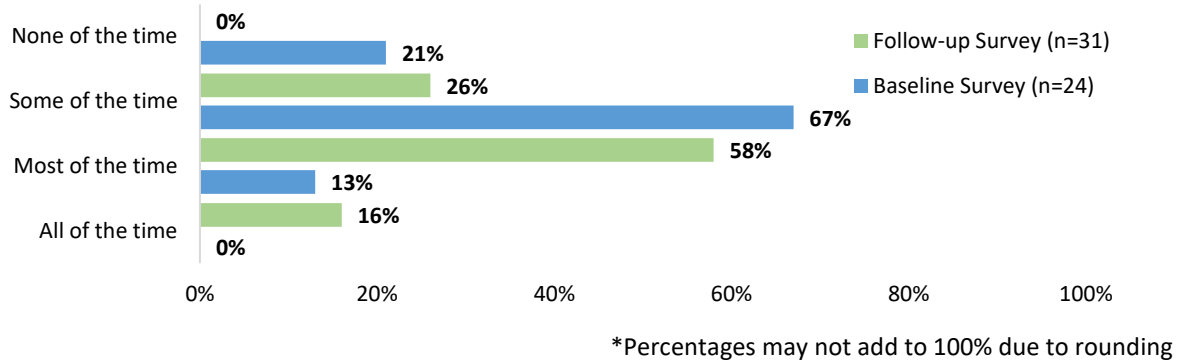
About two-thirds (65%) of those who have completed the Baseline Survey indicated that they played an active role in the development of personal goals. Follow-up survey respondents indicated a stronger level of participation with 89% of individuals indicating that they set their own mental health goals (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=23)		Follow-up Survey (n=31)	
	Yes	No	Agree	Disagree
I make my own wellness and recovery goals for my mental health. (n=23, 35)	65%	35%	89%	11%
I have wellness and recovery goals for my mental health. (n=27)	-	-	97%	3%
In this program, I help make decisions about my mental health recovery. (n=27)	-	-	88%	12%
This program helps me with more than just my medical needs. (n=29)	-	-	88%	12%
This program helped me rely on myself to improve my well-being. (n=10)	-	-	90%	10%

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*



*Percentages may not add to 100% due to rounding

Key to any psychiatric service is effective medication management. During the focus group, beneficiaries expressed appreciation for the care provided by the psychiatrist, saying he helps them find the right medication and sticks with it if it is helpful. They shared negative experiences with previous doctors who tried different medications without considering their effect on mental health issues.

Key to a wellness and recovery-based model of care is a person-centered approach that, in addition to effective medication management, addresses social determinants of mental health. Evidence of this model can be gleaned from the beneficiary focus group through conversations regarding the individualized care that beneficiaries receive. This support not only includes support with finding shelter, a home, or food supplies. Beneficiaries also spoke of receiving gift cards and transportation to services other than mental health appointments. Beneficiaries described a comfortable and supportive environment with staff taking time to help individuals with their lives.

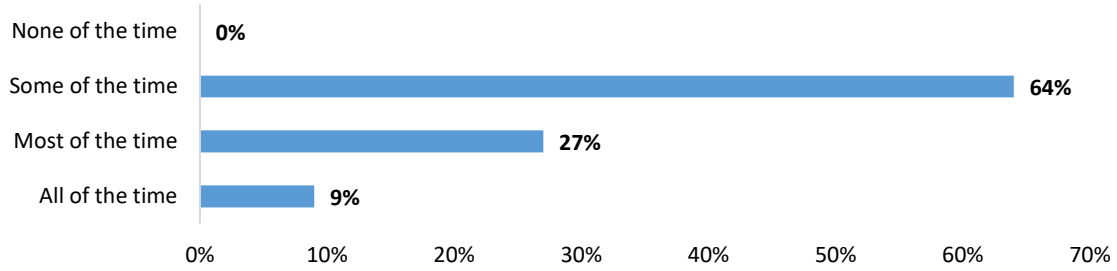
Lastly, beneficiaries described an experience with the MOST program that also values the importance of support and follow up care. Beneficiaries described the doctors, staff, and peer specialists as empathetic and understanding of their mental health issues. The consistent care, transportation, reminders for appointments, and peer support provided helps individuals to better understand and manage their mental health issues.

<u>Family Member Perceptions on Transforming the Approach to Mental Health Services</u>

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 100% of 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=11) and reflect agreement that the MOST program helps with more than just medical needs (n=10).

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 Levels of Care

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

Sixty-nine beneficiaries were discharged from the MOST Program, 13 of whom were transitioned to a lower level of care (19%). Nine beneficiaries were discharged for other reasons including:

- Non-compliance
- Loss of contact
- Relocation
- Incarceration
- Death

Outcome 2: Reduced Wait Times for Initial and Follow-up Appointments

Information about wait times from referral to initial appointment is collected using the MOST Program Tracking Log.

All MOST Program 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 of adults referred to the MOST Program were able to be seen by MOST program staff the same day.

Figure 3. Adult Beneficiary Wait Times

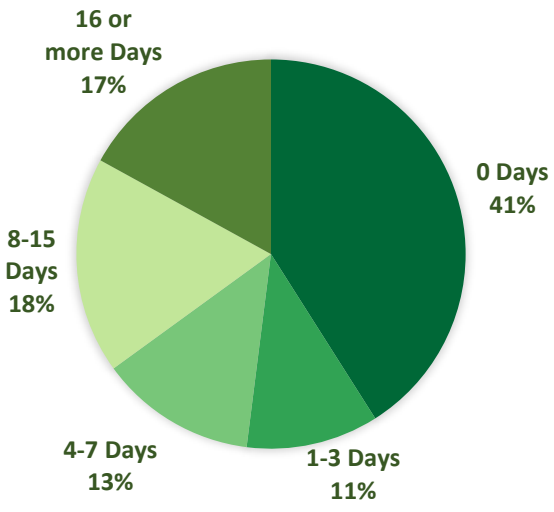


Figure 4. Child Beneficiary Wait Times

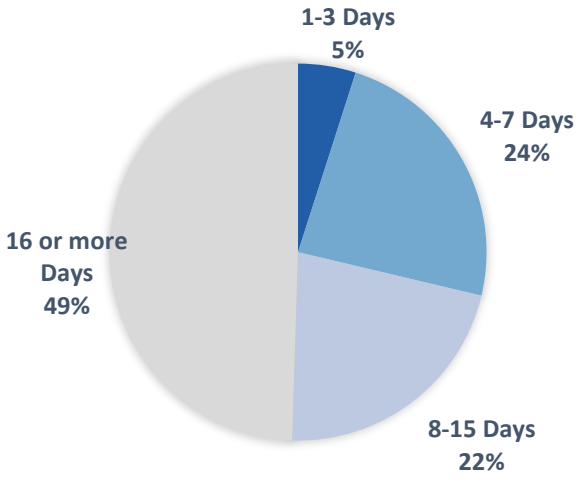


Figure 4 reflects the wait times of child beneficiaries. Due to interruptions with the hiring and onboarding of a child clinician, wait times are high for those who have received services this fiscal year; however, the proportion of children with wait times more than 15 days dropped from 64% to 49% from the first year of child services to the final evaluation report. The average wait time also dropped from 33 days to 28 days.

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. Due to program staff turnover, this data was not available for beneficiaries from the 2022-2023 fiscal year. Additionally, only beneficiaries that had been enrolled in the MOST program for at least a month were included. Hospitalization rates were calculated as annual rates. Among 97 beneficiaries, 63 individuals had a total of 91 hospitalizations prior to their enrollment in the MOST program.

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 overall, there were actually fewer beneficiaries 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 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=24)	50%	33%	17%
Have you been hospitalized for mental illness since enrolling in the MOST program? (n=31)	17%	78%	5%

Outcome 4: Reduced Number of Individuals Seen by Emergency Room for Crisis

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. Due to Program Staff turnover, this data was not available for beneficiaries from the 2022-2023 fiscal year. Additionally, 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 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 are in Table 8 below. The number of individuals who self-reported an emergency department crisis evaluation visit since MOST program enrollment is 23% 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)	54%	33%	13%
Have you had a mental health crisis evaluation at the emergency department since enrolling in the MOST program? (n=31)	31%	56%	13%

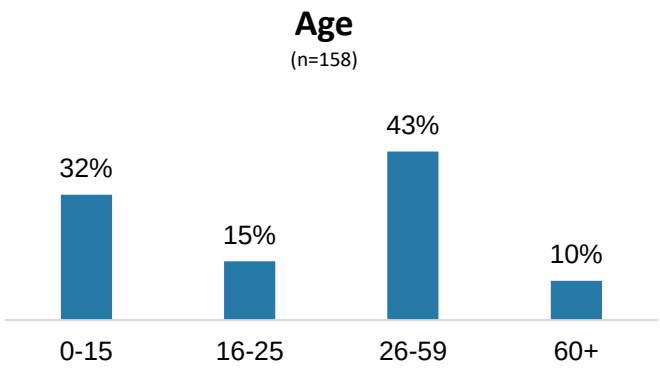
Outcome 5: Reduced Recidivism for Individuals with Mental Illness

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 are in Table 9 below. The percentage of individuals reporting an arrest since enrolling in the MOST program dropped 28% 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)	42%	50%	8%
Have you been arrested or booked into jail since enrolling in the MOST program? (n=31)	14%	69%	17%

Program Information

During the life cycle of the MOST Program, a total of 158 beneficiaries (102 adults, 56 children) were provided telepsychiatry services. Demographic information for both child and adult beneficiaries served is displayed below.



Primary Language
(n=160)

94% English

6% Spanish

Gender Identity
(n=159)

Female	51%
Male	47%
Transgender	1%
Genderqueer	0%
Questioning	0%
Another Gender Identity	1%

Sexual Orientation
(n=97)

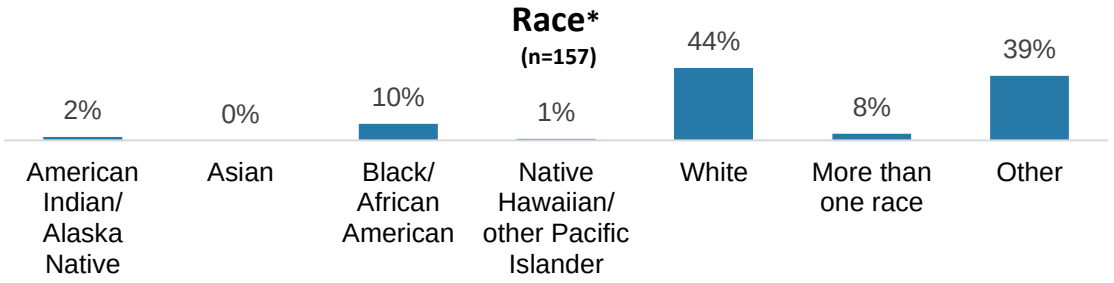
Bisexual	3%
Gay or Lesbian	3%
Heterosexual or Straight	93%
Queer	0%
Questioning	0%
Another Sexual Orientation	1%

Sex at Birth
(n=160)

52% Female

48% Male

Four beneficiaries identified as a veteran



Ethnicity*

(n=125)

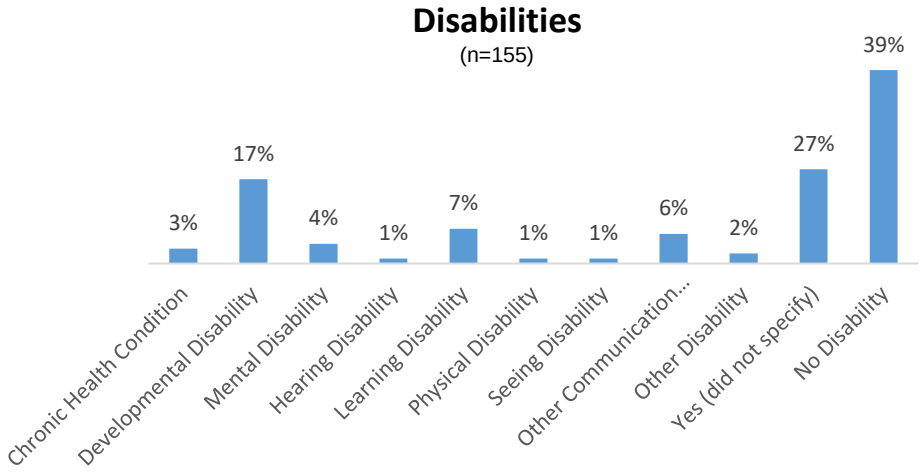
Hispanic/Latino

Caribbean	0%
Central American	6%
Mexican/Mexican American/Chicano	46%
Puerto Rican	0%
South American	0%
Other	30%
Multiple	0%

Non-Hispanic/Latino

African	9%	Filipino	2%
Asian Indian/South Asian	1%	Japanese	0%
Cambodian	0%	Korean	0%
Chinese	0%	Middle Eastern	0%
Eastern European	0%	Vietnamese	0%
European	3%	Other	42%
Multiple	2%		

*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. Program staff and beneficiaries both reported positive value of peer involvement in psychiatric care.
- Beneficiaries felt the progress they were making toward achieving their goals were largely attributed to the additional support they receive with their basic needs. This support provides more mental space to work toward their recovery goals.
- Wait times were shorter for adult beneficiaries than the county average of 26 days. Just under half of the adult beneficiaries seen throughout the program (41%) had no wait time 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.

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.

<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.

- *Survey Distribution and Completion.* The majority of adult participants served by the MOST program did not complete the Adult Baseline Survey and around a third of beneficiaries completed a Follow Up survey. Eleven of 52 child beneficiaries (21%) had a family member complete a Family 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.

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Kings

D Three-Year Program and Expenditure Plan Annual Update

D Annual Revenue and Expenditure Report

Local Mental Health Director	Program Lead
Name: Lisa D. Lewis, PhD	Name: Brenda Tamayo-Pagan
Telephone Number: (559) 852-2382	Telephone Number: (559) 852-2386
E-mail: Lisa.Lewis@co.kings.ca.us	E-mail: Brenda.Tamayopagan@co.kings.ca.us

County Mental Health Mailing Address :

Kings County Behavioral Health
1400 W. Lacey Blvd, Bldg. 13
Hanford, CA 93230

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

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on 06/11/2024 _

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

All documents in the attached Plan are true and correct.

Lisa D. Lewis, PhD

Local Mental Health Director/Designee (PRINT)

Lisa D. Lewis, PhD

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Signature Date

County: Kings

Erik Urena, CPA

Kings County Auditor-Controller (Print)

Signature Date